STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505128	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to inform the resident and/or their legal representative, in advance, of the risks and benefits associated with the use of psychotropic medications (medications capable of affecting the mind, emotions, and behavior) and obtain informed consent prior to administering the medications for 1 of 5 residents (Resident 77) reviewed for unnecessary medications. These failures prevented residents and/or legal representatives from making informed decisions about the use of multiple antidepressant medications, and precluded them from exercising their right to refuse/decline the proposed medications. Findings included . Resident 77 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 07/28/2024, showed the resident had moderate cognitive impairment, a diagnosis of depressive disorder and received antidepressant medication. Review of the electronic health record showed Resident 77 had orders, dated 07/21/2024, for duloxetine and bupropion (antidepressant medications) for depression. Review of the Psychopharmacologic Medication Informed Consent forms showed the risks versus benefits of antidepressant medication therapy were explained, and informed consent for their use was obtained on 07/23/2024. The July 2024 Medication Administration Record (MAR) showed facility nurses administered Resident 77 bupropion on 07/22/2024, and duloxetine once on 07/21/2024 and twice on 07/22/2024, prior to obtaining the resident's and/or the resident's representative's consent for their use. On 08/12/2024 at 3:44 PM, Staff B, Director of Nursing Services, said facility staff should have obtained Resident 77's or their representative's consent prior to administering the antidepressant medications, but acknowledged they failed to do so. Reference WAC 388-97-0260

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to have a system in place which ensured the Office of the State Long-Term Care Ombudsman (an advocacy group for residents in a nursing homes) received required resident discharge information for 2 of 5 residents (Resident 43 & 31) reviewed for hospitalization . These failures placed residents at risk for being inappropriately discharged , not understanding their rights, and prevented the Ombudsman from having the opportunity to educate and advocate for residents during the discharge process. Findings included . 1) Resident 43's Discharge Minimum Data Set (MDS, an assessment tool), dated 04/30/2024, showed the resident had an unplanned transfer to an acute care hospital on 04/30/2024, with return anticipated. Review of Resident 43's electronic health record (EHR) showed there was no documentation present showing the State Ombudsman Office was provided a written notice detailing the reasons for transfer as required. On 08/12/2024 at 3:24 PM, Staff D, Social Services Director (SSD), explained they emailed resident discharge/transfers to the Ombudsman's office monthly and had a record of the notifications. When asked if the Ombudsmans' office was notified of Resident 43's 04/30/2024 transfer to the hospital, Staff D, SSD, stated, No, I don't have that one. 2) Resident 31's Discharge MDS, dated [DATE], showed the resident had an unplanned transfer to an acute care hospital on 07/07/2024, with return anticipated. Review of Resident 43's EHR showed no documentation was present showing the State Ombudsman Office was provided a written notice detailing the reasons for transfer as required. On 08/12/2024 at 3:24 PM, when asked if there was documentation or an email showing the Ombudsman's office was notified of Resident 31's 07/07/2024 transfer to the hospital Staff D, SSD, stated, No. Reference WAC 388-97-0120 (2) (a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to provide residents/resident's representatives bed hold notices at the time of transfer, or within 24 hours of an emergent transfer for 1 of 5 residents (Resident 43) reviewed for hospitalization . This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Resident 43 admitted to the facility on [DATE]. Review of Discharge Minimum Data Set (MDS, an assessment tool), dated 04/30/2024, showed the resident had an unplanned transfer to the hospital on 04/30/2024. Review of Resident 43's electronic health record (EHR) showed there was no documentation present to show the resident, or their representative were provided a bed hold notice upon transfer as required. On 08/12/2024 at 3:39 PM, when asked if there was documentation to show Resident 43 or their representative were provided a written bed hold notice at the time of transfer, Staff B, Director of Nursing Services stated, No. Reference WAC 388-97-0120 (4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to accurately assess 2 of 28 sampled residents (Residents 69 & 43) whose Minimum Data Sets (MDS, an assessment tool) were reviewed. Failure to accurately identify active diagnoses, the presence and type of intravenous access, the administration of IV medications, and to assess a resident's cognitive patterns, placed residents at risk for unidentified and/or unmet care needs. Findings included . <Resident 69> Resident 69 readmitted to the facility on [DATE] with a Peripherally Inserted Central Catheter (PICC) to right upper arm and orders for ceftriaxone (an antibiotic) intravenously (IV) daily for a bone and bone marrow infection (osteomyelitis), with direction to infuse via valved single lumen PICC, and an order for vancomycin (antibiotic) IV daily for osteomyelitis Resident 69's July 2024 Medication Administration Record (MAR) showed Resident 69 was administered the IV Vancomycin and the IV ceftriaxone on 07/18/2024. Review of the 07/18/2024 5-day MDS, showed the resident did not have an active diagnosis of osteomyelitis, did not receive antibiotic therapy, received IV medication, but had no IV access. On 08/12/2024 at 2:48 PM, Staff T, MDS Coordinator, said Resident 69's 07/17/2024 5-day MDS was inaccurately coded, and should have included an active diagnosis of osteomyelitis, and that the resident had IV access and received antibiotic therapy during the assessment period. <Resident 43> Resident 43 admitted to the facility on [DATE]. Review of the 06/14/2024 Quarterly MDS showed facility staff did not attempt to perform a Brief Interview for Mental Status (BIMS), despite instruction to attempt to conduct the interview with all residents. Staff documented the interview should not be conducted due to the resident being rarely or never understood. On 08/06/2024 at 1:09 PM, while interviewing Resident 43, Staff J, Licensed Practical Nurse, entered the room and stated, I don't know if you know, but [Resident 43] is completely with it. If you ask yes or no questions [Resident 43] will tell you exactly what he wants. On 08/07/2024 at 11:43 AM, Staff C, Assistant Director of Nursing, also stated that Resident 43 was able to clearly make their needs known if asked yes or no questions. On 08/12/2024 at 3:04 PM, Staff T, MDS Coordinator, said staff should have conducted a BIMS to assess the resident's cognitive patterns, but was not. Reference WAC 388-97-1000 (1)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to provide Care Conferences (a conference where staff and residents/families talk about life in the facility, review the progress of each patient and make adjustments, as needed, to their care), for 5 of 5 sampled residents (Residents 13, 17, 23, 28, and 44) reviewed for provision of care conferences, and failed to ensure care plans were reviewed, revised, and accurately reflected resident care needs for 3 of 31 sample residents (Residents 68, 69 and 31) reviewed for care plan timing and revision. These failures placed residents at risk of not feeling involved in the development of their plan of care, unmet needs, decreased quality of care and a diminished quality of life. Findings included . <Care Conferences> <Resident 13> Resident 13 was admitted to the facility on [DATE] with diagnoses including chronic kidney failure (damaged kidneys that cannot filter the blood the way it should) and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), an assessment tool, dated 06/15/2024 documented the resident was cognitively intact and felt it was very important to have family involved in discussions about their care. On 08/06/2024 at 12:17 pm, Resident 13 said they had not had a care conference and thought the facility should have them. Review of the electronic health record (EHR) showed a care conference was conducted on 11/16/2023 and on 06/10/2024. On 08/09/2024 at 12:39 am, Staff D, Social Services Director (SSD) said Resident 13 had not had quarterly care conferences and said the facility recently identified the concern and had been working to get all the residents a quarterly care conference. On 08/12/2024 at 11:12 am, Staff B, Registered Nurse (RN) and Director of Nursing (DON), said Resident 13 should have had a care conference somewhere between the two identified in the EHR and her expectation was to have quarterly care conferences or documentation in the record if the resident had refused. 45203 <Resident 17> Resident 17 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE] documented Resident 17 was cognitively intact, medically complex, and expressed it was very important for family to be involved in discussion about their care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/06/2024 at 2:53 pm, Resident 17 said the facility did not have care conferences and they had not had one since they had been off of Medicare services. Review of Resident 17's EHR from 12/14/2023 through 08/08/2024 showed a care conference was conducted on 01/16/2024. No other care conferences were documented. <Resident 23> Resident 23 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented Resident 23 had moderate cognitive impairment and felt it was important to have family involved in discussions about their care. On 08/06/2024 at 10:37am, Resident 23 said they thought they were supposed to have care conferences, they used to have them, but had not had any recently. Review of Resident 23's EHR showed the most recent care conference was documented on 03/06/2023. <Resident 28> Resident 28 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented Resident 28 had moderate cognitive impairment and felt it was very important to have family involved in discussion about their care. Review of Resident 28's EHR showed the most recent care conference was 04/19/2023. <Resident 44> Resident 44 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented Resident 44 was cognitively intact, medically complex, and felt it was very important for family to be involved in discussions about care. On 08/06/2024 at 10:19am, Resident 44 reported they had not had a care conference since admission. Review of Resident 44's EHR showed one care conference was conducted on 06/24/2024. On 08/08/2024 at 1:35 pm, Staff D said care conferences for long term care residents were held quarterly. Staff D said they reached out to the families and scheduled them. Staff D said she documented the offer in progress notes and completed a care conference note in the record. Staff D said it had been challenging to complete all of the care conferences. At 3:44pm, Staff D said she had just completed a care conference with Resident 28 and reached out to family of Residents 17 and 44. She attributed the lapse to not having enough time to complete everything; due to staffing challenges. Staff D reported answering more call lights, and 1:1 time for residents. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/09/2024 at 2:48pm, Staff B, RN, DON, said care conferences for long term care residents were expected to be offered quarterly and if there was a change in the resident. Staff B said the facility had identified, approximately two months ago, that care conferences were not being completed and they, did a ton of care conferences, and tried to catch up. Staff B attributed the care conferences not being completed to just overload. 37044 <Care Plans> <Resident 68> Resident 68 admitted to the facility on [DATE]. On 08/05/2025 at 11:43 AM, Resident 68 stated, I can't hear you. I had a pocket talker but last week in therapy it went dead. They took it to get new batteries and they haven't given it back yet. On 08/07/2024 at 1:34 PM, Resident 68 was observed sitting in their room utilizing a pocket talker (amplifies sound) to communicate with staff. When asked about hearing aids Resident 43 said they had them, but they did not work. An alteration in sensory/communication care plan related to being hard of hearing, initiated 06/25/2024, directed staff to assist with placing hearing aid in resident's ear, replace batteries in hearing aid as needed, and to turn off the TV/radio as needed to reduce environmental noise. The care plan did not identify that the resident's hearing aides were non-functional or identify that the resident was utilizing a pocket talker for communication. On 08/12/2024 at 3:31PM, Staff G, Unit Manager, said Resident 43's use of a pocket talker as their primary hearing assistive device should have been care planned, but acknowledged it was not. <Resident 69> Resident 69 readmitted to the facility on [DATE]. The resident's admission orders showed the resident had a Peripherally Inserted Central catheter (PICC) to their right upper arm, and orders for ceftriaxone (an antibiotic) intravenously (IV) daily for a bone and bone marrow infection (osteomyelitis), with direction to infuse via valved single lumen PICC, and an order for IV vancomycin (antibiotic) daily for osteomyelitis. Review of Resident 69's comprehensive care plan showed there was no mention of the resident's osteomyelitis, type and location of IV access, or need for ongoing IV antibiotics. On 08/09/2024 at 3:09 PM, Staff C, Assistant Director of Nursing (ADON), said the type and location of the resident's IV access, care instructions, ongoing IV antibiotic therapy and diagnosis of osteomyelitis should have been care planned, but were not. <Resident 31> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 31 admitted to the facility on [DATE]. Review of the 06/15/2024 Admission MDS showed the resident had IV access, received IV medications and antibiotics for a diagnosis of osteomyelitis. A 07/18/2024 central line insertion report showed the resident had a tunneled single lumen central catheter placed to their right chest for long term antibiotic therapy related to osteomyelitis. Review of Resident 31's comprehensive care plan showed no care plans had been developed/implemented to address resident's osteomyelitis, type and location of IV access, or need for ongoing IV antibiotic therapy. On 08/09/2024 at 3:09 PM, Staff C, ADON, said the type and location of the resident's IV access, care instructions, ongoing IV antibiotic therapy and diagnosis of osteomyelitis should have been care planned, but were not. Reference WAC 388-97-1020(2)(e)(f)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 3 of 28 sample residents (Residents 132, 69 & 43) reviewed for professional standards. The failure to follow and/or clarify incomplete physician's orders, and to only sign for tasks that were completed, placed residents at risk for medication errors, unidentified and/or delayed treatment of complications related to intravenous (IV) therapy, and other potential negative health outcomes. Findings included . 1) Resident 132 admitted to the facility on [DATE] with orders to use a Continuous Positive Airway Pressure (CPAP, a machine that uses mild air pressure to keep breathing airways open while you sleep) at night. The CPAP orders included: apply CPAP at bedtime, CPAP settings per resident's home settings; and wash CPAP mask and tubing with soap and water daily and let air dry. On 08/05/2024 at 3:42 PM, when asked what their home CPAP settings were, Resident 132 said they had not brought their CPAP machine to the facility, and indicated they did not plan to because they would be discharging within a week. The August Medication and Treatment Administration Records (MAR/TAR) showed facility nurses signed that they validated the Resident's CPAP machine was set to the resident's home settings on 08/03/2024, 08/04/2024 and 08/05/2024, and that they washed the CPAP mask and tubing with soap and water and let them air dry on 08/01/2024, 08/04/2024, 08/05/2024, 08/08/2024, 08/09/2024, 08/10/2024, 08/11/2024 and 08/12/2024. On 08/12/2024 at 4:23 PM, Staff A, Administrator, confirmed Resident 132's CPAP was never present in the facility. On 08/12/2024 at 4:29 PM, when asked how facility nurses were cleaning Resident 132's CPAP mask and tubing and validating it was set to the resident's home settings when it was never present in the facility, Staff B, Director of Nursing Services, indicated they were signed off as completed in error, and said it was the expectation that nurses only sign for those tasks they completed. 2) Resident 69 readmitted to the facility on [DATE] with a Peripherally Inserted Central catheter (PICC) to right upper arm and orders for ceftriaxone (an antibiotic) intravenously (IV) daily for a bone and bone marrow infection (osteomyelitis), with direction to infuse via valved single lumen PICC, and an order for vancomycin (antibiotic) IV daily for osteomyelitis. Review of Resident 69's IV medication and PICC maintenance and monitoring orders showed no orders were in place to obtain initial and weekly external length or arm circumference measurements; to perform weekly PICC dressing changes; to monitor the IV insertion site for signs and symptoms of infection; to change the needleless connector caps at least weekly and after blood draws; when to flush the PICC, what solution should be used, or at what frequency. Additionally, the type and location of the IV access, and whether it was valved or non-valved was not identified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/2024 at 2:57 PM, Staff C, Assistant Director of Nursing (ADON), acknowledged the PICC maintenance and monitoring orders were incomplete said facility nurses should have identified the incomplete orders and clarified them but failed to do so. During an interview on 08/05/2024 at 4:07 PM, Resident 69 said they had been struggling with bouts of constipation. Resident 69 had a 07/05/2024 order for Milk of Magnesia (MOM) administer as needed if resident does not have a bowel movement (BM) on third day (after eight shifts). The July 2024 bowel record showed Resident 69 had no BM from 07/20/2024 - 07/23/2024 (4 days). Review of the July 2024 MAR showed no as needed MOM was administered. On 08/12/2024 at 12:25 PM, when asked if the nurse administered the as needed MOM after the eighth shift without a BM as ordered, Staff C, Assistant Director of Nursing, stated, No. 3) Resident 43 admitted to the facility on [DATE]. Review of the 06/14/2024 Quarterly Minimum Data Set (MDS, an assessment tool), showed for the entire seven days of the assessment period, the resident received 51% or more of their caloric intake and 501 ml of fluid per day from enteral feeding. On 08/06/2024 at 12:34 PM, a 1000ml bottle of Osmolyte 1.5 enteral solution was observed infusing at 75 ml per hour via pump. A 1000 ml top fill bag piggyback labeled H2O showed it was hung on 08/06/2024 at 1:00 AM and was supposed to infuse at 45 ml per hour x 20 hours per day to provide a total of 900 ml of water flushes per day. However, it remained full of 1000 ml of clear liquid fluid. On 08/06/2024 at 12:37 PM, the enteral pump showed it was programmed to deliver 0 ml of water flushes, every 0 hours, and that a total of 0 ml had infused. Facility staff had failed to program the enteral pump to infuse the water flush at 45 ml per hour times 20 hours a day as ordered. A similar observation was made on 08/06/2024 at 2:13 PM. Review of the August 2024 MAR showed on 08/06/2024, the day shift nurse signed off that Resident 43 received 273 ml of water flushes on day shift, despite the top fill flush bag, which was hung at 1:00 AM, remaining full, with 1000 ml of clear fluid in it. The enteral pump display showed it had not been programmed to infuse the water flushes. On 08/07/2024 at 3:56 PM, Staff C, ADON, said the nurse 273 ml of water flushes documented as infused was in error and reiterated it was the expectation that nurses only record and/or sign for care they delivered. Reference WAC 388-97-0860(2)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation, interview, and record review, the facility failed to ensure consistent restorative services were provided for 4 of 6 sampled residents (Residents 17, 23, 28, and 65) reviewed for range of motion (ROM) and mobility. This failure placed residents at risk for avoidable decline and diminished quality of life. Findings included . <Resident 65> Resident 65 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (disrupted blood flow to the brain cells depriving them of vital nutrients which can cause parts of the brain to die off) and hemiplegia (paralysis of one side of the body). The Quarterly Minimum Data Set (MDS), an assessment tool, dated 08/01/2024, documented the resident was cognitively intact and was dependent to needing partial assistance with Activities of Daily Living (ADLs). The care plan, initiated 01/23/2024, included restorative program interventions initiated on 05/02/2024 for transfers related to self-care performance deficit and the care plan, initiated on 03/15/2024, included restorative program interventions for range of motion related to limited physical mobility. A review of Resident 65's Restorative Care flowsheets for 7/1/2024 through 7/31/2024 showed the resident received range of motion (ROM) with documented minutes of restorative services on 8 of 31 days and received transfers with documented minutes of restorative services on 17 of 31 days. On 08/08/2024 at 2:53 PM, Staff H, Restorative Aid (RA) said Resident 65 had a goal of restorative therapy daily. Staff H said he had worked with resident 65 a couple of days here and there with large gaps where Resident 65 did not get anything because Staff H was pulled from restorative to work the floor. On 08/09/2024 at 9:57 AM, Resident 65 said they received restorative therapy at least once a week. On 08/12/2024 at 10:45 AM, Staff S, Registered Nurse (RN) said she was sure Resident 65 was on Restorative Therapy, but would have to pull the RAs often to the floor. At 11:15 AM, Staff B, RN and Director of Nursing said the RAs were certified nursing assistants (CNA) too and the facility must prioritize by pulling the RAs to the floor when they needed CNAs. 45203 <Resident 17> (continued on next page)

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	505128	A. Building B. Wing	08/12/2024

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Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 17 was admitted to the facility on [DATE]. The quarterly MDS, an assessment tool, dated 06/22/2024, documented Resident 17 was cognitively intact, medically complex, and required substantial to maximal assistance for ADLs. The care plan, initiated 12/14/2023, included interventions, initiated on 03/25/2024, for restorative services for the focus of limited mobility related to weakness. Restorative interventions included TheraBand, omni cycle, and sit to stand with parallel bars. A therapy to nursing communication note, dated 08/02/2024 at 11:08 am, documented Resident 17 was observed during a restorative therapy session and was not appropriate for physical therapy services to resume and would need to progress further in transfers under his current restorative program. Review of Resident 17's Restorative Care flowsheets for 07/08/2024 to 08/08/2024 showed the resident received documented minutes of restorative services on 10 of 31 days. On 08/08/2024 at 2:26 PM, Resident 17 said he used to receive therapy services and now only receives restorative therapy about once a week, saying, the restorative aids are pulled to the floor, they were told, due to staff shortages. Resident 17 said the restorative aid got pulled to the floor a lot and said, I do the best I can on my own, all I know is I want to be able to stand up and go home. <Resident 23> Resident 23 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE] documented Resident 23 had moderate cognitive impairment, and required substantial to maximal assistance for ADLs. The care plan, initiated 12/21/2020, included interventions, initiated on 06/07/2022, for restorative services for the focus of limited physical mobility related to weakness. Restorative interventions included active range of motion and ambulation with parallel bars. Review of Resident 23's Restorative Care flowsheets for 07/08/2024 to 08/08/2024 showed the resident received documented minutes of restorative services on 20 of 31 days. On 08/06/2024 at 10:34 AM, Resident 23 said she supposedly gets restorative services, but they are pulled to the floor 90% of the time. When asked what impact that has on them, Resident 17 replied, well, you just slide downhill and don't get any better. On 08/08/2024 at 12:35 PM, Staff H, Nursing Assistant (NA), Restorative Aid, said they were pulled to the floor frequently. Staff H said this could have a negative impact on the residents and tried to prioritize those residents on a passive range of motion program to prevent contractures. <Resident 28> (continued on next page)

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	505128	A. Building B. Wing	08/12/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 28 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented Resident 28 had moderate cognitive impairment and required substantial to maximal assistance for ADLs. The care plan, initiated on 12/20/2021, included interventions for restorative services related to the focus of limited physical mobility related to weakness. Restorative interventions included active and passive range of motion to left (affected) side to prevent formation of contracture (a permanent tightening of muscles, tendons, skin, and other tissues that can cause joints to shorten and become stiff, preventing normal movement of a body part or joint). Review of Resident 28's Restorative Care flowsheets for 07/08/2024 to 08/08/2024 showed the resident received documented minutes of restorative services on 9 of 31 days. On 08/09/2023 at 8:55 AM,, Resident 28 said he did not receive restorative therapy services. When asked specifically about passive range of motion to his affected side, Resident 28 replied, no, they don't do that. At 12:58 PM, Staff H, said Resident 28 was not receiving passive range of motion to the left upper extremity at the frequency he would prefer, unfortunately I am pulled to the floor a lot. At 2:15 PM, Staff B, Registered Nurse, Director of Nursing, said the facility had two restorative aids and when asked how often they were pulled to the floor, Staff B replied, it varies, at least once or twice a week. Staff B said they felt this did have a negative impact on providing restorative services to the residents. See F725 Reference WAC 388-97-1060 (3)(d) 37044

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	505128	A. Building B. Wing	08/12/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was administered in accordance with physician's orders and professional standards of practice for 1 of 1 resident (Resident 43) reviewed for enteral nutrition. The facility failed to accurately record the amount of enteral formula and water flushes administered, to identify and clarify incomplete enteral orders to include route of administration (e.g., gastric tube), method of delivery (gravity, via pump etc.) and the time the enteral formula infusion was to start and finish. These failures placed residents at risk for receiving inadequate nutrition, hydration, weight loss and other potential adverse health outcomes. Findings included . <Facility Policy> Review of the facility's Enteral Tubes policy, revised 12/23/2023, showed 60 ml piston syringes and open system top fill feeding bags, should be replaced every 24 hours. Piston syringes (60 ML) were to be rinsed thoroughly with tap water after use and placed in a labeled dry plastic bag at the bedside. 1) Resident 43 admitted to the facility on [DATE]. Review of the 06/14/2024 Quarterly Minimum Data Set (MDS, an assessment tool), showed for the entire seven days of the assessment period, the resident received 51% or more of their caloric intake and 501 ml of fluid per day from enteral feeding. A tube feeding care plan, revised 04/09/2024, directed staff to administer tube feeding and water flushes per physicians' order, elevate head of bed (HOB) at least 30 degrees during and thirty minutes after tube feeding, check for tube placement prior to feeding and medication administration, monitor weights weekly, and administer Tube feed Osmolyte 1.5 at 75 ml per hour (75 ml/hr) x 20 hours/on and 4 hours off, for a total volume delivered of 1500 ml every 24 hours. Review of electronic health record showed Resident 43 had the following enteral nutrition orders: a) Water flushes at 45 ml an hour, times twenty hours a day, off at 9:00 AM and on at 1:00 PM, to provide 900 ml of water flushes per day. b) Osmolyte 1.5 enteral solution at 75 ml/hr., on for 20 hours and off for four hours to deliver a total of 1500 ml of enteral solution per day. c) Flush with peg tube with 30 ml of water pre and post medication administration, every shift. d) Replace tube feeding syringe and tubing every 24 hours and as needed, every night shift. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/06/2024 at 12:34 PM, Resident 43 was observed in their room receiving Osmolyte 1.5 enteral solution via pump at 75 ml/hr. A 60 ml piston syringe was hanging from the pump pole date 08/05/2024. A 1000 ml top fill bag piggyback was attached to the enteral pump, labeled H2O. Documentation on the side of the bag showed it was hung on 08/06/2024 at 1:00 AM and was to infuse at 45 ml per hour. However, it remained full of 1000 ml of clear liquid. Observation of the pump display screen showed it was set to deliver flushes at a rate of 0 ml every 0 hrs. A similar observation was made on 08/06/2024 at 1:44 PM. The August 2024 Medication Administration Record (MAR) showed the nurse signed they provided the water flushes as ordered. The August 2024 MAR showed an order for Osmolyte 1.5 infuse at 75 ml/hr for 20 hours to deliver a total of 1500 ml. Each shift recorded the amount of Osmolyte infused on their shift. The order did not identify what times the enteral feeding should start/stop, or the method or route of delivery. Review of the July and August 2024 MARs showed there was no direction or space provided for staff to total the amount infused each day, to ensure the ordered amount of Osmolyte was delivered. When shift totals were tallied it showed the following 24-hour totals: Osmolyte totals: 07/06/2024- 1781 ml 07/09/2024- 2385 ml 07/10/2024- 2000 ml 07/11/2024- 2275 ml 07/16/2024- 1900 ml 07/17/2024- 2275 ml 07/18/2024- 2275 ml 07/22/2024- 2190 ml 07/23/2024- 2309 ml 07/24/2024- 2265 ml 07/27/2024- 2475 ml 07/29/2024- 3507 ml 07/30/2024- 2388 ml (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The July 2024 MAR showed an order to provide water flushes at 45 ml/hr x 20 hours, on at 1:00 PM and off at 9:00 AM, to provide a 24-hour total of 900 ml of water. Day shift was to deliver 180 ml of water, evening shift 360 ml and night shift 360 ml. The order did not identify the route or method of delivery to be used. No direction or space was provided for staff to tally the 24-hour total of water flushes delivered. When the daily totals were calculated it showed the following: 07/06/2024- 1127 ml 07/29/2023- 1590 ml 08/02/3034- 1381 ml 08/03/2024- 630 ml 08/04/2024- 990 ml 08/06/2024- 993 ml On 08/07/2024 at 3:56 PM, Staff C, Assistant Director of Nursing (ADON), explained that each nurse was expected to zero the pump and the end of their shift and record the amount of formula and water flushes that infused. Staff C indicated because the solutions were infused via a programmed pump at set rates it was not necessary for staff to calculate the 24-hour totals infused. On 08/07/2024 at 4:23 PM, when asked if the formula and water infusion order should identify the route and method of delivery, Staff C, ADON, stated they should and acknowledged Resident 43's did not. On 08/09/2024 at 11:45 AM, Staff C confirmed that facility nurses were inaccurately recording the amounts of water flushes and enteral formula that was provided per day. Staff C indicated some nurses were not zeroing the pump at the end of the shift thus the next nurse would record the total amount infused on the pump rather than just what infused on their shift. Reference WAC 388-97-1060 (3)(f)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure Intravenous (IV) services were provided in accordance with professional standards of practice and facility policy for 2 of 2 residents (Resident 69 & 31) reviewed for IV therapy. The facility failed to provide Peripherally Inserted Central Catheter (PICC, a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) care, maintenance and monitoring to include changing needleless injection caps, flushes, dressing changes, monitoring the external length to verify the line had not migrated, and monitoring insertion site for signs and symptoms of infection. These failures placed the resident at risk for loss of vascular access, infection, and other potential negative health outcomes. Findings included . <Facility Policy> Review of the facility's Central Vascular Access Device (CVAD) Dressing Change, Needleless Connector Change, and Flushing and Locking policies, all revised 06/ 01/2021, showed CVADs included PICCs, non-tunneled catheters (subclavian, jugular, femoral), Tunneled catheters, and Implanted venous ports. Staff were directed to: a) Perform CVAD dressing changes every seven days and as needed. b) Measure CVADs external length upon admission/during the initial assessment, weekly with dressing changes, upon suspicion of a change in length or if signs or symptoms of complications were present. c) Measure the upper arm circumference of residents with Peripherally inserted central catheters (PICCs) upon admission and/or with the initial assessment and then at least weekly. d) Assess the vascular access insertion site upon admission, during dressing changes, before and after administration of intermittent infusions, at least every 2 hours during continuous therapy, and at least once every shift when not in use. e) Change needleless connectors upon admission; at least every seven days; after blood draws; and any time the integrity of the needleless connector is in question. f) Specific flush/lock orders must be obtained, documented, and submitted to the pharmacy. 1) Resident 69 readmitted to the facility on [DATE]. On 08/06/2024 at 12:03 PM, Resident 69 was observed with a single lumen, valved PICC to their right upper arm. Review of Resident 69's physician's orders showed the following 07/17/2024 IV medication and PICC maintenance and monitoring orders: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Ceftriaxone (an antibiotic) intravenously (IV) daily for a bone and bone marrow infection (osteomyelitis), b) Vancomycin (an antibiotic) IV daily for osteomyelitis. The orders did not include direction: to obtain initial and weekly external length or arm circumference measurements; to perform weekly PICC dressing changes; to monitor the IV insertion site for signs and symptoms of infection; to change the needleless connector caps at least weekly and after blood draws; when to flush the PICC, what solution should be used, or at what frequency. Additionally, the type and location of the IV access, and whether it was valved or non-valved was not identified. On 08/09/2024 at 2:57 PM, Staff C, Assistant Director of Nursing (ADON), said Resident 69s IV orders were incomplete. The PICC maintenance, monitoring, and flushing orders were never initiated. Staff C said facility nurses should have identified the PICC and IV orders were incomplete and should have clarified them but failed to do so. 2) Resident 31 readmitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had IV access and received IV medication during the assessment period. On 08/06/2024 at 10:35 AM, Resident 31 was observed a tunneled single lumen central catheter to their right upper chest. The central line dressing was dated, 07/26/2024. Review of Resident 31's physician's orders showed the following IV medication and central line maintenance, and monitoring orders were in place: a) Weekly IV dressing change. b) Measure external catheter length upon admission and with weekly dressing change. c) Flush with 10 ml NS before and after medication administration. d) Change primary administration set every 24-hours. The orders did not include direction to monitor the IV insertion site for signs and symptoms of infection; to change the needleless connector caps at least weekly; or identify the type and location of the IV access, and whether it was valved or non-valved. A 08/09/2024 order directed nursing to infuse one liter of IV normal saline (NS) at 75 milliliters (ml) per hour, continuous until completed. Review of the electronic health record (EHR) showed no documentation was present to show facility nurses assessed Resident 31's central line insertion site every two during the continuous infusion of NS. Additionally, no documentation was found to indicate what the external length of Resident 31's central line was upon admission, or what the weekly measurements were sense. The August 2024 MAR showed that staff were directed to measure the external length of the central catheter weekly with dressing changes, but no place was provided to record the external length. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/09/2024 at 3:13 PM, when asked if there was any documentation to show Resident 31's central line external length was measured upon admission/ after placement and then weekly thereafter, the needleless connector caps were changed weekly, or that staff were routinely assessing the IV insertion site, to include every two hours during the continuous infusion of NS Staff C, ADON, said, No, not that's documented. Reference WAC 388-97-1060 (3)(j)(ii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45203 Based on observation, interview, and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services as evidenced by information provided in Resident/Surveyor interviews for 6 residents (Residents 67, 55, 11, 24, 65 and 2) interviewed, and 6 staff (Staff B, J, H, M, N & 1 anonymous staff) interviewed. The facility had insufficient staff to ensure residents received assistance with Activities of Daily Living and restorative services. These failures placed residents at risk for unmet care needs, decreased physical abilities and a diminished quality of life. Findings included . Resident 67 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS), an assessment tool, dated 06/13/2024, documented Resident 67 had severe cognitive impairment, was medically complex and dependent on staff for activities of daily living (ADLs). The care plan, initiated on 06/06/2024, showed Resident 67 required two person assist with mechanical lift for transfers. <Observation> On 08/06/2024 at 9:03 AM, Resident 67 was observed sitting in his wheelchair, in his room with spouse at his side and the call light on. The call light was answered by Staff D, Social Services director, who was not able to meet the residents need of being transferred to bed. Staff F was observed reporting to Staff J, Licensed Practical Nurse (LPN), Resident 67's request to transfer to bed. Resident 67's spouse said she was told that Staff K, Nursing Assistant (NA), would be there to help as soon as they could. Room and call light was continuously observed and at 9:50 AM, 47 minutes after the call light was initiated, Resident 67's call light was answered by Staff L, NA, who said they were on a lunch break and Staff K, NA, RA, was in charge of the hall. Staff asked Resident 67 what they needed and Resident 67 was not able to communicate their needs. The surveyor asked Staff L, if they would usually assist the resident back to bed after breakfast and they replied, they usually like to keep them up to participate in activities. Staff L was informed that Resident 67's spouse had placed the call light on, Staff L, said she would check with her to see what the resident needed. Staff L was observed entering another room that did not have a call light on. At 11:21 AM, Resident 67's spouse, also a resident at the facility, said Staff L had not inquired of her what Resident 67's need was and said she would have preferred Resident 67 to have been assisted back to bed. <Record Review> Review of the April 10, 2024 Resident Council Meeting minutes showed the nursing concern of call lights taking too long and being turned off before needs were met. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the May 8, 2024, Resident Council Meeting minutes showed the nursing concern of call lights being turned off before the need was met. Review of the June 5, 2024, Resident Council Meeting minutes showed the nursing concerns of call lights being turned off before needs are met and night shift does not have enough staff. <Resident Interviews> On 08/05/2024 at 1:53 PM, Resident 55 said call light times could be anywhere from 15 minutes to 2.5 hours and said the weekends were generally bad and holidays are atrocious. At 2:10 PM, Resident 11 said it took forever for staff to answer the call light. At 2:15 PM, Resident 24 said they don't have enough people around and when they do help, they are extremely rushed, they need more help. At 2:57 PM, Resident 2 said at night it took 4-5 hours waiting for someone to change their shorts. On 08/06/2024 at 9:55 AM, Resident 65 said, it sometimes took awhile for staff to get to us and they waited an hour during the day time. On 08/07/2024 at 1:31 PM, resident council members expressed concern regarding staffing, saying they just don't have enough people, call light times can be long, and weekend staffing is not enough. <Staff Interviews> 08/07/2024 at 10:45 AM, Staff J, LPN, said she is usually responsible for providing care for 24-26 residents on her shift. Staff J did not feel there was enough staff to meet resident needs. Staff J said providing showers and meeting the basic needs can be tough. On 08/08/2024 at 12:35 PM, Staff H, Nursing Assistant (NA) and Restorative Aide said he was frequently pulled to the floor. He said there was enough staff to meet the basic needs of residents. At 12:46 PM, Staff N, NA, said they usually have around 10 residents to care for, but sometimes it could be 15-20. Some days they do not have enough time to meet resident needs. At 1:12 PM Staff N said she usually has to stay two hours after the end of her shift to ensure residents have showers and to complete her charting. She stated, I have to do this all of the time. At 12:55 PM, Staff M, NA, said there was not enough staff to meet resident needs, they frequently are not able to complete showers and would substitute a bed bath or stay late. On 08/09/2024 at 10:05 AM, a staff member who wished to remain anonymous, said there was not enough staff to meet resident needs. They are not always able to complete all tasks assigned for their shift and sometimes vital signs are hard to obtain and wound care may not get completed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/09/2024 at 2:24 PM, Staff B, RN, DNS, said they would have to say they do not have enough staff to meet the resident's needs, especially as it related to restorative services. Staff B said they try to staff with 8 NA's but some days they only have 6-7. Staff B said she would expect a call light to be answered, ideally within 5 minutes, but did not think it was unreasonable for the need to be met within 15-20 minutes. When asked if she would expect Resident 67 to wait as long as they did for their needs to be met, Staff B said she would rather they not have to wait that long. Refer to F688 Reference WAC 388-97-1080 (1)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37044 Based on observation, interview and record review, the facility failed to ensure the menu was followed for 4 of 4 residents (Residents 28, 50, 67 & 2) with mechanical soft or puree diets, whose meals were observed during tray line. Failure to provide accurate portion sizes, placed residents at risk of unmet nutritional needs, and potential negative outcomes. Findings included . Review of the facility's menu showed for lunch on 08/12/2024 smothered chicken, parslied rice, brussels sprouts and a dinner roll would be served. >Portion Sizes< Review of the menu showed residents on D1 pureed diets would receive: A #8 (4-5 ounces) scoop of pureed chicken. A #12 (2.5-3 ounces) scoop of pureed brussels sprouts. A # 16 (2-2.5 ounces) scoop of pureed dinner roll D2 mechanical soft diets would receive: A #12 (2.5-3 ounces) scoop of pureed brussels sprouts. Observation of the steam table on 08/12/2024 at 11:20 AM showed the pureed chicken, pureed brussels sprouts, and pureed dinner roll had a #8 scoops in them for serving. Observation of tray line from 10:49 AM - 11:20 AM, showed dietary staff served the following: Resident 2 (D1 pureed diet) - pureed brussels sprouts and dinner roll with a # 8 scoop. Resident 67 (D2 mechanical soft diet)- Pureed brussels sprouts with a #8 scoop. Resident 28 (D2 mechanical soft diet)- Pureed brussels sprouts with a #8 scoop. Resident 50 (D2 mechanical soft diet)- Pureed brussels sprouts with a #8 scoop. On 08/12/2024 at 11:29 AM, when asked about the appropriate scoop size to be used for D1 and D2 diets Staff F, Dietary Manager, stated, It was the wrong scoop size, those are all number 8 scoops. The puree brussels sprouts should be a number 12 and the puree dinner roll a number 16. Staff F then intervened and provided the dietary staff the proper scoop sizes before completing tray line. Reference WAC 388-97-1100(1).

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	505128	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45203 Based on observation, interviews, and record review, the facility failed to prepare and serve foods in a manner that conserved nutritive value, palatability and that ensured meals served were appetizing and at the proper temperature for 5 of 8 (Residents 17, 23, 28, 32, and 8) sampled residents reviewed for dining and 2 of 2 residents (Residents 2 and 57) on pureed diets.The failure to ensure meals were served at appropriate temperatures, with a good presentation, and that were palatable, placed residents at risk for decreased satisfaction with meals, poor intake, weight loss, and a diminished quality of life. Findings included . <Observation> On 08/05/2024 at 11:45 AM, a cart with five meal trays was brought out of the kitchen and placed in the assisted dining room. At 12:02 PM, Staff K, Nursing Assistant (NA), said the cart was for residents for the north hall. At 12:08 PM, Staff N, NA, said the cart was for south hall residents who were supposed to eat in the dining room. At 12:11 PM, Staff were observed removing the cart (which had sat without plate warmers for 23 minutes) from the assisted dining room and transporting it to the south hall to be served to the residents. Surveyor intervened and asked Staff Q, NA, if they were aware the cart had sat for 23 minutes prior to their arrival, and they said no. Staff Q said the south hall staff should have notified the kitchen if residents were not going to the dining room and the kitchen staff would have put the meals on the hall cart. Staff Q brought the cart back to the kitchen. At 12:14 PM, Staff R, Cook, obtained food temperature of 2 of 5 meal trays. The hot foods temped at 101 degrees Fahrenheit (F) and 113 F and the cold food 64 F. Staff R prepared new trays for the five resident meals that were returned to the kitchen, but ran out of mashed potatoes and the meat entree and had to prepare new. Staff R said she would prefer staff to inform the kitchen if a resident is not going to the dining room for meals so they could send the meal on the hall cart. She would not expect a tray to be served to a resident if it had been sitting out for 23 minutes. <Resident Interviews> On 08/05/2024 at 12:53 PM, Resident 8 said, I don't like the food, hot foods are not hot enough. At 1:33 PM, Resident 23 said hot foods were not hot and the cold foods were not cold, and they felt too much chicken was served. At 2:26 PM, Resident 17 said the hot food was not always hot and he, never has hot eggs in the morning. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:15 PM, Resident 28 said he was served foods he didn't like, and the temperature of the food was not always right. On 08/06/2024 12:43 PM, Resident 32 said, hot food could be stone cold, breakfast scrambled eggs were often cold. On 08/07/2024 at 1:31 PM, during Resident Council review, residents expressed there were not snacks, such as sandwiches, available after the kitchen closes. <Record Review> Review of Resident Council Meeting minutes for April 10, 2024, showed kitchen/dining concern that food always arrived cold, noodles were crunchy, and fries were soggy. Review of Resident Council Meeting minutes for June 5, 2024, showed kitchen/dining concerned that eggs and oatmeal are cold by the time they were served. Bacon was chewy and greasy. Review of Resident Council Meeting minutes for July 10, 2024, showed that meat was overcooked, and the gravy was too salty. On 08/12/2024 at 4:13 PM Staff A, Administrator said the QAPI committee had identified dietary concerns and there was a subcommittee working on it. 37044 Observation of meal preparation for the breakfast/lunch meals on 08/12/2024 7:57 AM showed a request was made to observe Staff T, Cook, prepare the pureed meals. Staff T indicated they had already prepared all the pureed meals for both the breakfast and lunch meals. When asked about the process Staff T explained they prepared the pureed chicken for the lunch meal as follows: after cooking the chicken for the regular textured diets, whatever amount was left, they put in the blender and pulsed it. Then added chicken broth and milk and pulsed it again until it was the correct texture. If it was too thick, more liquid would be added, if too thin, more thickener was added. When asked if they followed the recipe Staff T stated, No. On 08/12/2024 at 8:06 AM, Staff F, Dietary Manager, stated, I am going to be honest; they don't use a recipe when they puree. When asked if pureed meals had recipes Staff F said they did and provided it. Review of the pureed smothered chicken recipe it provided measurements for chicken, liquid, and thickener to be used in preparation of the meal. Reference WAC 388-97-1100(1)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50392 Based on observation and interview the facility failed to ensure staff compliance with current infection control guidelines and standards of practice for donning (putting on) of personal protective equipment (PPE) for 1 of 4 residents (Resident 40), reviewed for infection control. This failure placed residents at an increased risk for exposure to cross contamination (harmful spread of illness), transmission of diseases and a diminished quality of life. Findings included . Facility policy titled Enhanced Barrier Precautions (EBP) Policy and Procedure, dated 08/2023, showed Enhanced Barrier Precautions (EBP) expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [Multidrug-resistant Organisms] to staff hands and clothing. Examples of high-contact resident care activities requiring gown and glove use for EBP include: o Dressing o Bathing/showering o Transferring o Providing hygiene o Changing linens o Changing briefs or assisting with toileting o Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator o Wound care: any skin opening requiring a dressing Resident 40 admitted to the facility 08/16/2021. The Minimum Data Set (an assessment tool), dated 07/20/2024, indicated Resident 40 was cognitively intact and had an indwelling catheter (an alternative urinary elimination tube). Resident 40 was on Enhanced Barrier Precautions (an infection control strategy used in nursing homes to reduce the spread of MDRO's) due to their indwelling catheter. On 08/08/2024 at 1:03 PM, Staff O, Certified Nursing Assistant (CNA), was observed changing Resident 40's brief without wearing a gown. Staff O said that she does not wear a gown when she changes Resident 40's brief. On 08/08/2024 at 1:08 PM, Staff O, CNA and Staff N, CNA were observed transferring Resident 40 with a Hoyer (a device used to transfer a resident) from bed to wheelchair, neither Staff O nor Staff N were wearing gowns during the transfer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/09/2024 at 11:14 AM, Staff C, Infection Preventionist, said that when changing a brief or transferring a resident who is on EBP, staff should have worn a gown and gloves. On 08/12/2024 at 11:06 AM, Staff P, Resident Care Manager, said that Resident 40 was on EBP due to having a urinary catheter. She said her expectation is that staff wear a gown and gloves when changing a brief of a resident who is on EBP. WAC reference 388-97 -1320 (2)(a)