STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505185	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympic View Care	1116 E Lauridsen Boulevard Port Angeles, WA 98362

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

(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 - Some	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 observation, interview and record review, the facility failed to ensure informed consent was obtained prior to administering psychotropic medications, and/or ensure consent forms accurately identified the type of medication (drug class) and associated risks and benefits of use for 3 of 5 residents (Resident 62, 48, & 28) reviewed for unnecessary medications. These failures placed residents and/or their representatives at risk of not being fully informed about the care and treatment related to the risks and benefits associated with end-of-life care and psychotropic medications and a diminished quality of life. Findings included . 1) Resident 62 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 04/24/2025, showed the resident was severely cognitively impaired, had a diagnosis of depression, demonstrated signs and symptoms of delirium (a serious change in mental abilities, resulting in confused thinking and a lack of awareness of someone's surroundings) such as an altered level of consciousness and inattention, and required antipsychotic and antidepressant medication during the assessment period. Review of the May 2025 Medication Administration Record (MAR) showed Resident 62 had an order for aripiprazole (an antipsychotic medication) every morning for depression. A Psychopharmacologic Medication Informed Consent form, dated 04/21/2025, showed the resident was prescribed aripiprazole, which staff identified as an antidepressant, and education was provided about the risks and benefits associated with antidepressant medications. The document showed Resident 26 provided informed consent to initiate the antipsychotic medication, despite being assessed with severe cognitive impairment and signs and symptoms of delirium. On 05/12/2025 at 3:37 PM, Staff C, Resident Care Manager (RCM), said the informed consent form for Resident 62's aripiprazole inaccurately identified the medication as an antidepressant rather than an antipsychotic. Staff C confirmed this resulted in the resident being educated about the risks and benefits associated with antidepressant medications rather than antipsychotic medications. When asked if it was possible for Resident 62 to make an informed decision about the use of aripiprazole, given staff provided inaccurate information about the type of medication it was and the associated risk and benefits of Staff C stated, No. 50392 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident 48 was admitted to the facility on [DATE]. The Significant change MDS, dated [DATE], documented Resident 48 was rarely/never understood, and decision making was severely impaired. Resident 48 had diagnoses that included depression and anxiety disorder. Review of Resident 48's orders showed she had the following physician's orders: 1. Antipsychotic medication, quetiapine, 25 MG (milligrams), give 1 tablet two times a day, ordered 01/03/2025. (This was an increase from the previous dose of quetiapine, 25 MG, give 0.5 tablet two times a day.) 2. Antianxiety medication, lorazepam, ordered 03/24/2025. Review of Resident 28's consents showed no consent for the increase in the dose for quetiapine, ordered on 01/03/2025. Review of Resident 28's records showed no consent for the medication lorazepam. On 05/12/2025 at 10:30 AM, when asked if consent was obtained with the the quetiapine dose change, Staff C said she could not find a consent for the higher dose and it should have been done. When asked if there was consent for the lorazepam medication, Staff C said there was not, and there should have been a psychotropic consent evaluation. Staff C said consents are done with dose changes or when orders change. 50945 3) Resident 28 was admitted to the facility on [DATE] with a diagnosis of dementia. The Quarterly MDS, dated [DATE], showed Resident 28 was rarely understood or rarely understands. Review of Resident 28's consents for psychotropic medications the resident was currently taking, showed the following: 1. Antipsychotic medication, quetiapine, originally consented 12/31/2024 by resident 2. Antidepressant medication, trazadone, no consent found 3. Antidepressant medication, escitalopram, consent obtained 12/31/2024 by resident. During an interview on 05/12/2025 at 2:09 PM, Staff C, RCM, said Resident 28 was unable to provide informed consent. When asked about consent for quetiapine and escitalopram on 12/31/2024, Staff C said it was not documented but the resident's son was there. When asked if the son could provide consent when they were not the active power of attorney (POA), Staff C said the POA should have given consent, not the son. Staff C was unable to find a consent for trazadone. During an interview on 05/13/2025 at 10:43 AM, Staff B, DNS, said their expectation for informed consent is that it be obtained prior to initiating psychotropic medications, and documented on. That consent should be obtained by the resident if they are their own party, if not, then their POA. Reference WAC 388-97-0300(3)(a), -0260,-1020(4)(a-b)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure residents were included in care conferences and discussions on their person-centered plans of care for 7 of 18 sampled residents (Resident 58, 56, 37, 15, 24, 45, & 28). This failure placed residents at risk of having services discontinued or started without being fully informed or involved, not having preferences honored at end of life, and unidentified/unmet care needs. Findings included . 1) Resident 58 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 58 was able to be understood and understands. Review of Resident 58's Portable Orders for Life-Sustaining Treatment (POLST), signed [DATE], showed Resident 58 had elected no Cardiopulmonary Resuscitation (CPR) in the event they were found with no pulse and/or were not breathing. For situations when the individual had a pulse and/or was breathing, there were three options to choose from: full treatment, selective treatment, or comfort focused treatment. Selective treatment was, Primary goal is treating medical conditions while avoiding invasive measures whenever possible. Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. Transfer to hospital if indicated. Avoid intensive care if possible. This was not selected on Resident 58's form. Resident 58 had elected comfort-focused treatment, Primary goal is maximizing comfort. Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort. Individual prefers no transfer to hospital. EMS [Emergency Medical Services]: consider contacting medical control to determine if transport is indicated to provide adequate comfort. Review of Resident 58's electronic health record (EHR) showed they had been to the hospital three times in [DATE]: [DATE] to [DATE],[DATE] to [DATE], and [DATE] to [DATE]. Review of Resident 58's care plan for discharge, showed Resident 58 wished to return/discharge to home after their wound healed. During an interview on [DATE] at 8:10 AM, Resident 58 was asked if the facility had obtained their permission to be sent to the hospital, and said no. When asked if there was a scenario in which they would want to go to the hospital, Resident 58 said yes, they would want to go if they had an infection that needed to be cleared up. After reviewing the three options on the POLST (full treatment, selective treatment, or comfort focused treatment), Resident 58 said they would like to be transferred to the hospital if it would save their life. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:41 AM, Staff B, DNS, when asked if there was any documentation outside of the POLST form for resident preferences, said during care conferences or in the care plan. Staff B said the expectation was for documentation if there were any changes in resident preferences. When asked about Resident 58 being sent to the hospital three times, Staff B looked in the care plan and said they did not see anything specific in the care plan regarding this, and the progress notes did not have verbiage that the resident consented to the transfers. When asked if Resident 58 had consented, then what were their expectations for Resident 58 being re-evaluated on their preferences, Staff B said they expected another conversation and to see if they needed to modify Resident 58's goals of care. Regarding the POLST not being updated since the hospitalization s, Staff B said their expectation was for there to be documentation if a conversation occurred. When asked if it was possible residents could elect comfort care thinking it was related to down the line, not their current status, Staff B said if residents had elected for comfort measures only, then in the event they changed their mind or wanted to be sent to the hospital, they had the option and could change this any time 2) Resident 56 was admitted to the facility on [DATE] and had diagnoses of malnutrition and depression. The Significant Change MDS, dated [DATE], showed Resident 56 was able to be understood and understands, had several days of feeling down, depressed, or hopeless, and had half or more of the days feeling little interest or pleasure in doing things. Review of Resident 56's medications showed they were taking bupropion, an antidepressant for depression and smoking cessation, with a start date of [DATE]. Review of Resident 56's progress note from [DATE], showed Resident 56 had expressed to nursing staff that they were done, tired, did not want CPR, or to be sent to the hospital. Staff documented that Resident 56 understood their medications would be discontinued, and morphine (opioid medication) and ativan (antianxiety medication) would be started to keep them comfortable. Resident 56 was noted to have refused medications and eating. The note said a new POLST was signed by the resident that day. Review of Resident 56's provider progress note, date of service [DATE], documented Patient discussed with [provider] that he has lost his appetite and also reviews this with me today. He is trying to keep caloric intake up with protein shakes, etc. Review of Resident 56's records showed they had weights discontinued on [DATE], and their last weight was taken on [DATE]. During an interview on [DATE] at 3:56 PM, Resident 56 reported they had lost weight and were not okay with this. Review of two interdisciplinary notes, from [DATE] and [DATE], showed that Resident 56 had weight warnings for significant weight loss. The notes listed those in attendance, but did not list the resident. Nutritional plans of care were reviewed, no documentation was found of Resident 56 being involved or made aware of the decisions to not change the plan of care and to continue not obtaining weights. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 56's care plans showed a care plan, initiated on [DATE], for Palliative/Hospice Care/End of Life Care per resident request with the interventions of Provide end of life care as needed to meet the needs of the resident. None of the interventions showed Resident 56 had been involved in planning their end-of-life (EOL) care, nor had their individualized preferences/goals been reviewed or obtained. Resident 56 also had an anti-anxiety medication care plan, initiated on [DATE], which did not involve the resident's goals for the medication usage during EOL. During an interview on [DATE] at 9:52 AM, Resident 56 was asked about their preference on having their weight obtained, said they wanted to have weights obtained to let their body be in a healthier state, and said they would like this to be done weekly. When asked about EOL preferences, Resident 56 said they did not remember a general discussion on preferences. On [DATE] at 3:05 PM, when asked if they had been told how long they had to live, Resident 56 said no. When asked about their plan of care regarding EOL and their anti-anxiety medication, said they were currently not having any symptoms of anxiety but were open to taking the medication if they did, and to their knowledge had never taken it. On [DATE] at 10:10 AM, Staff C, Resident Care Manager (RCM), was interviewed with Staff G, Registered Dietician, present. Staff G reported that after Christmas, Resident 56 had been having an emotional time with sadness. On [DATE] at 10:40 AM, Staff C, RCM, was not able to find any documentation that Resident 56 was notified of the [DATE] significant weight loss. When asked if there was a discussion with the resident about the weight loss and interventions available, Staff C was unable to provide documentation and said it should have been documented. On [DATE] at 10:49 AM, Staff C was asked what Resident 56's EOL goals were. Staff C said it used to be that Resident 56 did not want to go to the hospital and wanted to die. Staff C added that it sounded like this needed to be reassessed. After reviewing Resident 56's palliative/hospice care/EOL care plan, Staff C said there was not much to go off of regarding Resident 56's preferences, and it needed to be more individualized. When asked how staff would know how to honor Resident 56's personal preferences regarding EOL care, Staff C said they would not know unless the care plan was individualized. When asked if there was a difference in Resident 56's care now versus if they were actively dying, Staff C said yes, for now they would be getting weights, trying to get Resident 56 out of bed, and trying to do more. If Resident 56 was actively dying, then they would be monitoring and trying to keep the resident comfortable and going by the resident's wishes. On [DATE] at 8:41 AM, when asked how the facility knew residents were not going through a period of depression when they had the initial decision, since the provider had mentioned that a resident refusing medication could initiate a conversation for end of care services, Staff B, DNS said the nurses should continue to have those conversations, behavior health should be involved, and they should look for a reason. 46793 3) Resident 37 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 37 was cognitively intact. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order, dated [DATE], documented Resident 37 had weights discontinued, related to comfort care status. Resident 37's Palliative/EOL needs care plan documented Resident 37 was initiated for EOL care services on [DATE]. On [DATE] at 8:16 AM, Resident 37 said they were unaware that they had been placed on EOL care, no one had ever talked to them about it. Resident 37 said hospice services had never been discussed or offered by the facility. On [DATE] at 2:02 PM, Resident 37's Durable Power of Attorney (DPOA, legal decision maker) said no one from the facility had spoken with them or offered services regarding end-of-life care or hospice. On [DATE] at 8:22 AM, Staff C, RCM, said when placing a resident on EOL care services the provider had a conversation with the resident and /or the resident representative, the conversation would be documented in the EHR. When asked about Resident 37's reason for transition to EOL care services, Staff C said she was unable to speak to that and it would need to be a conversation with the provider. When asked to look for documentation about the provider's conversation, regarding why Resident 37 was placed on EOL care, Staff C was unable to locate documentation supporting a conversation with Resident 37 or their representative. On [DATE] at 9:20AM, Staff B, DNS, said when a resident was placed on EOL services the provider would have a conversation with the resident or family regarding services. Staff B said providers notes were documented in a different system and then transferred to the facility's EHR. Staff B said they had been witness to and had their own discussion with the provider and residents about EOL services. When asked to look for documentation about the provider's conversation, regarding why Resident 37 was placed on EOL care, Staff B said it would take too long to look through all the provider's notes. When explained that Staff C had reviewed the EHR for EOL documentation and none was found, Staff B said the expectation was there should have been a documented conversation from the provider in the EHR regard EOL care services. 4) Resident 15 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 15 was severely cognitively impaired. A physician's order, dated [DATE], documented Resident 15 had weights discontinued, related to comfort care status. Resident 15's Palliative/EOL needs care plan documented Resident 15 was initiated for EOL care services on [DATE]. On [DATE] at 9:24 AM, Resident 15's DPOA, said the facility had never spoken to them about EOL care or hospice services. Resident 15's DPOA said they knew Resident 15 had dementia, but did not feel Resident 15 should have been on EOL care yet. Resident 15's DPOA said they know no one had spoken with them about EOL services, because they always thought EOL services would mean taking Resident 15 out of the facility and they did not want Resident 15 moved from the facility. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:22 AM, Staff C, RCM, reviewed Residents 15's EHR, to locate provider documentation regarding a conversation with Resident 15's DPOA. Staff C located a provider's note, dated [DATE], documenting Resident 15's weight had been discontinued, but no other documentation supporting a conversation had taken place with the resident or the resident's DPOA. Staff C said there absolutely should have been documentation supporting a conversation with the resident or the resident's DPOA. On [DATE] at 9:20AM, Staff B, DNS, said the expectation was that a conversation was documented from the provider regarding placing a resident on EOL care services. 50392 5) Resident 24 admitted to the facility [DATE]. The Quarterly MDS, dated [DATE], documented Resident 24 was rarely/never understood, rarely/never understood others and was severely impaired in making decisions of daily life. A physician's order, dated [DATE], was for D/C (discontinue) weights due to comfort care. A physician's order, dated [DATE], was for Do Not Resuscitate (DNR)-comfort care. On [DATE] at 10:58 AM, Resident 24's DPOA, when asked about Resident 24's health, said from what they had seen, Resident 24 had lost tons of weight. When asked if they knew what comfort care was, Resident 24's DPOA said no, they did not know anything about it. When asked if Resident 24 was on comfort care at the facility, the DPOA said I probably did, I don't know they don't tell me a whole lot there. When asked about Resident 24's weight loss and how she could tell Resident 24 had lost weight, the DPOA said by his legs, feet, arms and face, he looks like a skeleton. Resident 24's DPOA said they had asked the facility questions, but they did not like to answer the questions. When Resident 24's DPOA was asked if they would want periodical weights done for Resident 24 to monitor if he was losing weight, said that would be good. 6) Resident 45 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 45 was able to be understood and understands. On [DATE] at 8:22 AM, Resident 45 said it had been a while since they had a care conference. Resident 45 reported they wanted to leave/discharge. Review of the discharge care plan, updated [DATE], did not show that Resident 45 was hoping to discharge. During an interview on [DATE] at 10:31 AM, Staff B, DNS, after looking in the EHR, said they could not find a care conference evaluation for Resident 45 for [DATE], and their expectation was for there to have been documentation that a care conference occurred and who attended. After asking about Resident 45's discharge plan, Staff B said the resident's family member was not ready yet to have them discharged , this was not in the care plan and should have been. 7) Resident 28 was admitted to the facility on [DATE] with a diagnosis of dementia. The Quarterly MDS, dated [DATE], showed Resident 28 was rarely understood or rarely understands. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:03 PM, Resident 56's family member said they did not think a care conference had occurred recently. Review of a social work form from [DATE], showed no documentation on if any care conference had occurred for Resident 28's representatives. During an interview on [DATE] at 10:31 AM, Staff B, DNS, said they did not see a record that a care conference had been done for Resident 28 on [DATE], that the MDS assessment was done on [DATE], and yes there should have been a care conference. Reference WAC [DATE](1)(a), -1020(2)(f)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interviews and record review, the facility failed to immediately notify the physician and resident representative of significant changes in physical condition, for 2 of 5 residents (Resident 15 & 28) reviewed for nutrition. This failure placed residents at risk for a delay in medical/nutritional treatment and not having their representatives involved in the health care decision making process for timely care and services. Findings included . 1) Resident 15 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/09/2025, documented Resident 15 was severely cognitively impaired. The electronic health record (EHR) documented Resident 15's weight as 100.1 pounds (lbs) on 03/03/2024, the last documented weight in the weights/vitals tabs. On 05/07/2025, the resident weighed 85.8 lbs which was a -14.29 % loss in twelve months. A Nutritional Assessment, dated 03/07/2025, documented Resident 15 weighed 111.6 lbs on 09/21/2024. This weight was not documented under the weights/vitals tab. On 05/07/2025, the resident weighed 85.8 lbs which was a -23.12 % loss since 09/21/2024. On 05/08/2025 at 9:24 AM, Resident 15's Durable Power of Attorney (DPOA, legal decision marker) said they had noticed Resident 15 had been losing weight because the residents arms and legs were thin. When informed of Resident 15's current weight loss, Resident 15's DPOA confirmed no one from the facility had notified them of the significant weight loss. Resident 15's DPOA said he was concerned Resident 15 had lost that much weight. On 05/09/2025 at 8:22 AM, Staff C, Resident Care Manager (RCM), said when a resident had lost weight the DPOA, provider and Registered Dietitian (RD) should have been notified, even if the weight loss was expected. Staff C reviewed the EHR and confirmed neither the DPOA, provider or RD had been notified of the weight loss. On 05/09/2025 at 9:20AM, Staff B, Director of Nursing Services (DNS), said when a resident was losing weight, the nutritional team had a weekly meeting to discuss weights, quality of care, and quality of life interventions. Staff B said the provider, DPOA, and RD needed to be notified when a resident lost weight. Staff B reviewed Resident 15's EHR and confirmed there was no notification to the DPOA, RD or provider of the 05/07/2024 significant weight loss. 50945 2) Resident 28 was admitted to the facility on [DATE] with a diagnosis of dementia. The Quarterly MDS, dated [DATE], showed Resident 28 was rarely understood or rarely understands. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/05/2025 at 2:04 PM, Resident 28's family member reported they were concerned Resident 28 was losing weight, they could see the weight loss on Resident 28's shoulders, and that Resident 28 had a high level of activity/moved around a lot. Review of the facility's weight binder, on 05/08/2025, showed Resident 28 had a weight obtained sometime in May 2025, at 156.2 lbs. There was no specific date listed for the weight. Using 05/08/2025, as the best approximation of the date the weight was obtained, review of weights showed the following: 1 month: On 04/06/2025, the resident weighed 166.6 lbs. On 05/08/2025, the resident weighed 156.2 pounds which was a -6.24 % Loss. 3 month: On 02/04/2025, the resident weighed 169.4 lbs. On 05/08/2025, the resident weighed 156.2 pounds which was a -7.79 % Loss. During an interview on 05/12/2025 at 1:59 PM, Staff C, RCM, said weights should be put into the EHR right away. Staff C reviewed the EHR and confirmed Resident 28's May 2025 weight was not yet put in the EHR. When asked if the weight not being inputted into the EHR meant the power of attorney had not been notified yet, Staff C agreed and said and they would make sure this would happen. During an interview on 05/13/2025 at 10:43 AM, Staff B, DNS, when asked how they met the requirement for notification of changes when staff were not inputting weights into the EHR right away, said the weight binder was just to make it easier for the certified nursing assistants to document, but the expectation was that nursing would put the numbers into the EHR on the same shift. Regarding Resident 28's weight not being inputted into the EHR right away, Staff B said it was now in the EHR and triggered as a significant weight change, and they would have expected weights to have been put in the EHR on the same shift and notifications made to the provider. Reference WAC 388-97-0320

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review the facility failed to comprehensively assess for the use of bed rails/mobility bars, the use of a bed against the wall, and a wander guard for 4 of 4 sample residents (Residents 19, 20, 3 and 24) reviewed for physical restraints. This failure placed residents at risk of potential injury, potential restraint, unmet care needs, and a diminished quality of life. Findings included . <Wander Guard> 1) Resident 19 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 04/21/2025, documented Resident 19 was moderately cognitively impaired and had a wander/elopement alarm used daily. A review of Resident 19's Electronic Health Record (EHR) showed an order dated 03/04/2025 for a wander guard placement due to elopement risk related to psychosis (a condition where a person experiences a significant loss of contact with reality, often marked by hallucinations, delusions, and disordered thinking). On 05/09/2025 at 9:29 AM, Staff C, Registered Nurse (RN)/Resident Care Manager (RCM), said a resident should have an order for the wander guard and a safety evaluation and it should be care planned. Staff C said, I am not seeing a safety evaluation and ideally there should be one. On 05/12/2025 at 11:30 AM, Staff B, Director of Nursing (DNS), said she did not see an elopement and safe device evaluation and it should have been completed. <Bed Against the Wall> 2) Resident 20 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 20 was cognitively intact. A review of Resident 20's EHR showed an order dated 02/17/2025 for Safety device: Bed against wall and a document titled Safety Device Data Collection, Evaluation, and Information dated 02/17/2025 said it provided information to the resident and power of attorney (POA) and was signed by the DNS. On 05/13/2025 at 11:05 AM, Staff B, DNS, said she could not find a Physical Therapy (PT) evaluation or documentation of less restrictive options tried first in the EHR before Resident 20's bed was placed against the wall. Staff B said her expectation was for a PT evaluation to be completed and interventions be documented and attempted before the bed was placed against the wall. 50392 <Loose mobility bars> (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Resident 3 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 3 was severely cognitively impaired. Record review showed a physician's order, dated 01/06/2023, for two bed mobility bars for safe mobility. On 05/06/2025 at 8:44 AM, Resident 3's right and left mobility bars were assessed for stability and found to be loose, the bars moved forward towards the bed mattress as well as side to side. On 05/09/2025 at 9:50 AM, Staff J, Certified Nursing Assistant, when asked if Resident 3 used their mobility bars, said, yes they did when prompted and sometimes on their own. When asked if the mobility bars were supposed to be loose, Staff J physically moved the right mobility bar and said, I'm not sure why it is moving so much, it seems loose and I will put it in the maintenance log, it should have a little give but not like that. When Staff J checked the left mobility bar, she said, It moves forward a little, it seems better than the other one. Staff J said I think they should be solid, they shouldn't move. On 05/09/2025 at 11:47 AM, Staff C, RN/RCM, said mobility bars should be stationery and solid, if they move around a resident could get hurt. On 05/09/2025 at 11:52 AM, Staff C went to Resident 3's room and physically moved the left mobility bar. When asked if it was loose, Staff C said Yes, maintenance puts these on, that is concerning. Staff C then moved the right mobility bar, moved it and said, Oh, that is not good. Staff C said the right mobility was loose, and she would make sure it got fixed. When asked about the potential risks of loose rails, Staff C said, falls and injuries. When asked if entrapment was also a risk, Staff C said Yes, it seems extreme, but they could get trapped and die. On 05/12/2025 at 9:41 AM, Staff C, said Resident 3's loose bed rails did not meet her expectations and if staff noted a bed rail was loose it should have been fixed as soon as possible. <Lack of comprehensive assessment for bed mobility bars> On 05/12/2025 at 9:41 AM, Staff C, RCM, when asked if documentation of an assessment (evaluates for safety or entrapment concerns) for bed mobility bars had been done for Resident 3, Staff C said it would be found in the EHR under Progress Notes, that to her knowledge there was not a specific form the facility used to document the assessment, and she could not locate an assessment in progress notes for Resident 3. Staff C said she thought the therapy department completed assessment. On 05/12/2025 at 1:05 PM, Staff K, Physical Therapy Assistant/Therapy Director, when asked who completed the evaluations/assessments for safety equipment like bed rails or beds against the wall, Staff K said therapists make recommendations but the evaluation/assessment come from nursing. It was up to the nursing staff to do the evaluation. Staff K said after therapy makes a recommendation, a communication note goes into the EHR to nursing and it was up to nursing to follow up and do the final assessment for safety. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/12/2025 at 1:08 PM, when told the Therapy Director said they make recommendations and it is up to nursing to do the assessment and asked to provide documentation that Resident 3 was assessed prior to bed rails being applied, Staff C, RCM said, ideally the nurse would do an assessment, but she had thought therapy did it. Staff C said she would have to get back to me. No further documentation was received. On 05/13/2025 at 2:58 PM, Staff C was asked for documentation that less restrictive alternatives were attempted for Resident 3 prior to putting on the mobility bars, Staff C said she could not see anything in the EHR. <Lack of assessment, orders, or care plan for bed against the wall> 4) Resident 24 admitted to the facility 03/06/2020. The Quarterly MDS, dated [DATE], documented Resident 24 was rarely/never understood, rarely/never understood others and was severely impaired in making decisions of daily life. On 05/06/2025 at 8:18 AM, Resident 24's bed was observed to be pressed against a fall mattress, which was between the bed and the wall. On 05/08/2025 at 9:18 AM, Resident 24's bed was observed against the wall, with no fall mattress in between the bed and the wall. On 05/12/2025 at 12:31 PM, when asked what elements needed to be in place before a bed was put against the wall, staff S said a safety device evaluation, orders, it should be added to the care plan, and a consent obtained. When asked if there was an assessment done for Resident 24's bed against the wall, Staff C said therapy would have done the assessment. When asked if there was an order for the bed against the wall, Staff C said she could not locate an order. When asked if there was a care plan for Resident 24's bed against the wall, Staff C said she could not see it, and it should be there. On 05/12/2025 1:05 PM, Staff K, said nursing would do the assessment for a bed being placed against the wall. On 05/12/2025 at 1:08 PM, Staff C was asked to provide documentation that an assessment had been completed for Resident 24's bed being placed against the wall. No further documentation was provided. On 05/13/2025 at 2:58 PM, when asked to provide documentation of a less restrictive alternative had been attempted prior to putting Resident 24's bed against the wall, Staff C said she did not see anything in the EHR. On 05/13/2025 at 1:26 PM, when asked who in the facility was responsible for assessing the risks for each resident with devices or interventions, such as risk of entrapment, Staff B, DNS, said the process started with rehabilitation (therapy), and then goes to the RCM's. Staff B said before the device or safety intervention were implemented the RCM would document any interventions that were tried before the safety device was put into place.When asked where assessments were documented, Staff B said along with interventions that were attempted, her expectation was that any initial interventions and assessment would be documented under progress notes or an evaluation prior to device or safety intervention being implemented. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0620(1)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure residents were free of chemical restraints for 5 of 6 residents (Residents 39, 62, 48, 28 and 56) reviewed for unnecessary medications or pain. The failure to ensure psychotropic medications (drugs that affect behavior, mood, thoughts and perception) had adequate indications for use, resident specific target behaviors (TB) were identified and monitored, gradual dose reductions (GDRs) were performed, non-drug interventions were attempted prior to administration of as needed (PRN) psychotropic medications, and PRN psychotropic medication orders did not exceed 14 days unless a documented clinical rationale was provided, placed residents at risk of receiving unnecessary psychotropic medications, experiencing adverse side effects such as sedation, decline in physical function, and other negative health outcomes. Findings included . 1) Resident 39 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/15/2025, showed the resident was cognitively intact, had diagnoses of depression, anxiety, and bipolar disorder, and required antianxiety and antidepressant medication during the assessment period. Review of the electronic health record (EHR) showed Resident 39 had the following psychotropic medication orders: a) Buspirone (an antianxiety medication) 30 milligrams (mg) twice daily for major depressive disorder. b) Duloxetine (an antidepressant medication) 30 mg every morning and 60 mg at bedtime for major depressive disorder. A mood and behavior problem related to diagnoses of Post Traumatic Stress Disorder (PTSD), bipolar and anxiety disorders care plan, revised 03/03/2025, identified the TBs for anxiety disorder as Anxiety D/O [disorder], and the TBs for the resident's PTSD and Bipolar disorder as Bipolar disease and PTSD and directed staff to document the number of occurrences of each. On 05/13/2025 at 12:27 PM, Staff C, Resident Care Manager (RCM), said TBs should reflect the behaviors that manifest from the underlying diagnoses of anxiety, PTSD, and bipolar. Staff C said TBs should not be a restatement of the diagnosis. When asked how the facility could assess the effectiveness of each medication if the TB behavior had not been identified for each specific medication, Staff C indicated they could not. Additionally, Staff C confirmed Resident 39's buspirone was for anxiety, not depression as documented in the order. 2) Resident 62 was admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident had severe cognitive impairment, a diagnosis of depression, demonstrated signs and symptoms of delirium (a serious change in mental abilities, resulting in confused thinking and a lack of awareness of someone's surroundings), altered level of consciousness and inattention, and required antipsychotic and antidepressant medication during the assessment period. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the May 2025 Medication Administration Record (MAR) showed Resident 62 had the following psychotropic medication orders: a) Aripiprazole (an antipsychotic) every morning for depression. b) Quetiapine (an antipsychotic) twice a day for depression. c) Duloxetine (an antidepressant) daily for depression. A hospital discharge summary, dated 04/21/2025, showed the resident received Aripiprazole and Quetiapine for hallucinations and delirium secondary to sepsis. The Psychopharmacologic Medication Informed Consent form, dated 04/21/2025, for the use of aripiprazole (an antipsychotic), which staff identified as an antidepressant, documented it was for depression. A Psychopharmacologic Medication Informed Consent form, dated 04/21/2025, for the use of quetiapine (an antipsychotic), documented it was for depression. A pharmacy Admission Medication Review Report, dated 11/27/2024 (prior admission), documented Resident 62 received two antipsychotic medications, quetiapine and aripiprazole for psychosis. The following recommendation was made, Please consider risk vs benefit and consider dose reduction or perhaps discontinuation of quetiapine. Under Physician Response, the provider checked the box I have re-evaluated this therapy and DO NOT wish to implement any changes due to the reasons below. Under Rationale the provider documented New admit. Requires both antipsychotics at this time. No clinical rationale for performing a GDR or discontinuing the quetiapine as recommended were provided. An antidepressant medication care plan, dated 04/30/2025, showed a goal of Will be free from discomfort or adverse reactions related to antidepressant therapy. No goal was established for the use of the antidepressant medication (e.g. a decrease in the TBs the medication was initiated to treat). The TBs for duloxetine were identified as self-isolation, and withdrawn and loss of interest in usual activities. An antipsychotic use care plan, dated 04/30/2025, documented Resident 62 received antipsychotic medications to treat depression. The goal of the antipsychotic therapy was to have no negative outcomes or drug related complications from antipsychotic medication use. The care plan failed to identify any goals for the use of the antipsychotic medications. Additionally, the TBs the antipsychotic medications were initiated to treat, were not identified. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/12/2025 at 4:05 PM, Staff C, RCM, confirmed the hospital discharge summary indicated the quetiapine and aripiprazole were for hallucinations and delirium related urinary sepsis. When asked if Resident 62 had completed their antibiotics for their urinary tract infection, Staff C stated, Yes. When asked what the indication for use was for the antipsychotic medications, Staff C reviewed documentation and stated, It changed from delirium to depression. I have not seen any behaviors related to delirium since he has been here. It doesn't look like he needs to be on the these [Antipsychotics]. Staff C, acknowledged there was no clear indication for use for the quetiapine and aripiprazole, no TBs were identified, and no goal for the antipsychotic medication therapy was established. 50392 3) Resident 48 was admitted to the facility 02/07/2024 and had diagnoses of depression and anxiety disorder. The Significant Change MDS, dated [DATE], showed Resident 48 was rarely or never understood by others, and sometimes understands. Review of Resident 48's medication orders showed lorazepam, ordered 03/24/2025, every 4 hours as needed for end of life (EOL) care, anxiety for 6 months. Review of Resident 48's EHR showed no documentation was located that Resident 48 was assessed by the provider every 14 days with a clinical rationale documented for the ongoing use of lorazepam, or documentation that other treatments were deemed clinically contraindicated. Record review of the May 2025 MAR showed that TBs were ordered for Resident 48's anxiety disorder. When reviewing the order, it showed the TB to be treated was anxiety disorder, and staff were instructed to document the number of occurrences. The order did not include what Resident 48's anxiety typically looked like, or any anxiety symptoms that might be treated with the listed interventions or documented on. Review of Resident 48's record showed no Non Pharmacological Interventions (NPIs) were in place for the anxiety medication lorazepam. On 05/12/2025 at 10:30 AM, Staff C, when asked to provide documentation that the provider had assessed Resident 48 every 14 days and had a clinical rational based on that assessment and documentation that it was useful/reasoning for ongoing use, Staff C said Resident 48 had episodes of tearfulness, was at times panicked, had panic attacks, and the staff had tried taking her outside for fresh air, activities around the facility, and nothing was working so they put her on lorazepam as needed. When asked if the use of lorazepam was reviewed by the provider every 14 days, Staff C said it should be done every 14 days, and she thought it was. Staff C said a 6-month order was not acceptable for that type of medication, and did not provide additional documentation. Staff C said that TBs for Resident 48 should have been specific for her anxiety, such as crying or putting a blanket over her face, it needed to be more specific. When asked if staff were providing and documenting NPIs prior to giving Resident 48 as needed lorazepam, Staff C said they would try things such as activities, taking Resident 48 outside for fresh air, and calling Resident 48's daughter, but that the NPIs were not specific for the medication lorazepam, and should be individualized for each medication, monitored, tracked and updated by adding to the interventions. 50945 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Resident 28 was admitted to the facility on [DATE] with diagnoses of dementia, insomnia (trouble sleeping), and depression. The Quarterly MDS, dated [DATE], showed Resident 28 was rarely understood or rarely understands. Resident 28's orders were reviewed and five psychotropic medications were found: 1. Antidepressant: escitalopram, in the morning for dementia with behavioral disturbance 2. Antidepressant: trazodone, at bedtime for sleep issue 3. Antipsychotic: quetiapine, in the morning and in the evening for dementia 4. Antipsychotic: olanzapine, at bedtime for delusions 5. Antianxiety: lorazepam, as needed every 8 hours for agitation Review of the EHR showed no active diagnosis for psychosis or anxiety. Review of Resident 28's TBs showed they had monitors for aggressive behavior, anxiety, and depression with none specifying what medication they were linked to or if they were for dementia behaviors. Documentation of the behaviors observed in the MAR/TAR said no, instead of describing what behaviors there were. Review of TBs on the TAR showed blanks (no documentation) on 02/14/2025 for the 6:00 AM to 6:00 PM shift and 03/08/2025 and 03/13/2025 for 6:00 PM to 6:00 AM shifts. Review of as needed lorazepam usage, showed there was no option for staff to document NPIs on the order. Resident 28 did have a NPI order for shift, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. Three dates in April were reviewed and were as follows: 1. 04/01/2025, lorazepam was given at 2:00 PM for anxiety and agitation. Under the TB monitors, no aggression or anxiety was noted for the 6:00 AM to 6:00 PM shift, no NPI was documented on these monitors. 2. 04/03/2025, lorazepam was given at 11:02 AM for anxiety/agitation. Under the TB monitors, no aggression or anxiety was noted for the 6:00 AM to 6:00 PM shift, no NPI was documented as given on these monitors. 3. 04/11/2025, lorazepam was given at 8:00 AM for anxiety and agitation. Under the TB monitors, no aggression or anxiety was noted for the 6:00 AM to 6:00 PM shift, no NPI was documented as given on these monitors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/12/2025 at 1:42 PM, Staff Q, Licensed Practical Nurse, when asked what Resident 28's anxiety looked like, said fidgety, they would redirect with snacks or walk with them, the resident tries to get out (of the building). Staff Q said yesterday Resident 28 became aggressive and threw their coffee on an aide after trying to redirect, but was fine after that and did not remember the incident. Staff Q said they would give medications, it would not work immediately and could take hours, and then Resident 28 would sleep for hours. Staff Q said Resident 28 is rarely aggressive. When asked about the NO documentation on the behavior observed section of the TB monitors, Staff Q said it was not detailed enough. When asked about Resident 28's depression, Staff Q said they talk about work, but its more confusion, they are not alert and oriented to reality, and staff would provide a busy box to distract. When asked how they assess episodes of worthlessness, down, loss of pleasure from usual activities, Staff Q said no they were not able to assess any of these because if you ask Resident 28 a question, they answer something totally different. During an interview on 05/12/2025 at 2:09 PM, Staff C, RCM, when asked if it was common for residents who have dementia to have anxiety with it, said yes. For possible triggers to make Resident 28 anxious, Staff C said them not being able to get up, being seated or in bed, needing to be redirected to sitting in their chair, and wanting to go (be on the move). For NPI for Resident 28's behaviors, Staff C said they participate in activities, hit on wood, read the paper, follow staff up and down the halls (from wheelchair). When asked if they looked into any route causes for the behaviors that led to the prescription for lorazepam, Staff C said just the dementia. Staff C added that in Resident 28's past, they were a hard worker, always working on cars or in the shop, and they sometimes say they need firewood or a case of beer. When asked how they would know a TB, such as anxiety or aggression, was related to medication usage and not just dementia, Staff C said they would say dementia, that the medication might be having the opposite effect rather than helping. Staff C said after taking medications, Resident 28 can have an increase in behaviors including restlessness. Staff C looked in the EHR and agreed the orders for TB monitors did not distinguish between the class of medications being monitored and that NPI were not being monitored on the lorazepam order itself. During this interview, when asked about blanks on the TAR for TB monitors, Staff C said this did not meet expectations as it meant it was not done. When asked about staff documenting a number of behaviors, and then NO as behavior observed, Staff C said this counteracted the number of behaviors and should have listed what the behavior was. When asked if Resident 28's agitation, which may or may not have been related to dementia, if it had a threshold for the level of agitation that was acceptable, Staff C said agitation would be expected, the threshold should be made clear, and they should have a baseline documented for Resident 28. When asked how the facility was attempting to minimize the usage of lorazepam, Staff C said by making it a last resort, trying different things such as activities, movies, fresh air, and this should be clear in the orders and care plans. Staff C confirmed the current order for lorazepam had been active since 04/09/2025 and was over 14 days, and that Resident 28's order on 01/07/2025 which ended on 02/14/2025, was over 14 days. During this interview, Staff C was asked about Resident 28's TB monitor for depression that said, Worthlessness, down, loss of pleasure from usual activities, and said it was almost impossible to assess for the resident, that they were limited by only being able to assess non-verbal questions. When asked about the gradual dose reduction being contraindicated on 03/14/2025 due to resident continues to exhibit behaviors, psych provider to follow, and asked why if behaviors can be anticipated in residents with a diagnosis of dementia, said right right. When asked about the fasting blood glucose and lipid profile requested by the psych provider on 04/20/2025, Staff C said it was not done due to Resident 28 being noncompliant, they did not want to continue because it was making the resident uncomfortable, and they took that as a refusal. Staff C, when asked if there was documentation of this, said there should be but there probably was not. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Resident 56 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 56 was able to be understood and understands. Review of Resident 56's orders showed lorazepam was first ordered on 12/27/2024. The most recent order for lorazepam showed it had a start date of 04/09/2025, was past the 14 days allowed, and had no end date listed. Review of the MAR for December 2024, January 2025, February 2025, March 2025, April 2025, and May 2025 showed Resident 56 was not taking lorazepam. During an interview on 05/08/2025 at 1:30 PM, Staff P, Physicians Assistant, when asked about the lorazepam order, said that residents suddenly want to take lorazepam and the facility might not have it available, they had to reorder it every two weeks, and they had it happen when at 2:00 AM on a Sunday a resident had nothing. Staff P then added that a provider was on call 24 hours a day and staff could always call for lorazepam. During an interview on 05/09/2025 at 10:10 AM, Staff C, RCM, said for as needed psychotropic medication, it was dependent on resident symptoms and was based on the individual. When asked if Resident 56's lack of lorazepam usage meant they did not have any mild anxiety, air hunger, or EOL symptoms, Staff C said that was their understanding. When asked if the 04/09/2025 lorazepam order that was discontinued the previous day, if this was greater than 14 days and had previously not had an end date, Staff C said yes, there was not an end date listed until yesterday (when it was discontinued). Reference WAC 388-97-0620 (1)(a) .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to provide written bed hold notices at the time of transfer to the hospital for 2 of 4 sampled residents (Residents 19 and 39) and ombudsman notification for 3 of 4 sample residents (Residents 19, 75 & 39) 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, protection of resident rights during transfers, and a diminished quality of life. Findings included . 1) Resident 19 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 04/21/2025, documented Resident 19 was moderately cognitively impaired. A review of the Electronic Health Record (EHR) showed Resident 19 was transferred to the hospital on 04/15/2025 and returned to the facility on [DATE]. Resident 19's EHR showed documentation that Resident 19's bed hold notice was dated 04/15/2025 and signed on 05/05/2025 (greater than 24 hours after transfer). On 05/09/2025 at 9:29 AM, Staff C, Registered Nurse (RN)/Resident Care Manager (RCM) said the bed hold was not signed on 04/15/2025 and it looks like Resident 19 was not notified within 24 hours. On 05/09/2025 at 11:30 AM, Staff B, Director of Nursing (DNS), said the Bed hold should be dated, signed and locked on the same day. A review of a document titled [Facility] residents leaving the building during the month of April 2025 dated 05/02/2025 did not list Resident 19. On 05/09/2025 at 1:06 PM, Staff A, Administrator, said she did not put Resident 19 on the list because she did not think they stayed overnight. After looking in the EHR, Staff A said, the Ombudsman did not receive notification and they should have. A review of a documented dated 05/12/2025 said I realized when I sent you our report, I missed the residents that went to the hospital but returned again. Resident 19 was listed. On 05/13/2025 at 10:17 AM, Staff A, Administrator, said she sent this document yesterday, on the 12th, and wanted to provide it so we could see she corrected her error. 50392 2) Resident 75 admitted to the facility 02/04/2025. The Admission, MDS, dated [DATE], documented Resident 75 was cognitively intact. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 02/06/2025 Alert Progress note, Resident 75 requested to sign out of the facility against medical device to go home. A second note on 02/06/2025 noted Resident 75 had exited the facility via a cab and was in route to her house against medical advice. On 05/09/2025 at 9:33 AM, Staff A, Administrator, was asked to provide documentation that the ombudsman had been notified of Resident 75's discharge. Staff A said she would look for it. On 05/12/2025 at 3:16 PM, Staff A was asked again for the documentation that ombudsman had been notified of Resident 75's discharge and was unable to provide documentation. On 05/13/2025 at 10:50 AM, Staff A provided a written document that stated she was unable to find the February report to the Ombudsman. 37044 3) Resident 39 was admitted to the facility on [DATE]. Review of the 01/30/2025 discharge MDS, showed the resident was transferred to acute care on 01/30/2025, return anticipated. Review of the EHR showed no documentation was present to show Resident 39 was offered a bed hold as required. On 05/13/2025 at 2:50 PM, Staff C, RCM, said they were unable to find documentation to show that a bed hold was offered. On 05/13/2025 at 3:03 PM, when asked for documentation to show the ombudsman was notified of Resident 39's 01/30/2025 transfer to acute care Staff A said she would look for some. No further documentation was provided. Reference WAC 388-97-0120 (4)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) assessment accurately reflected residents' mental health diagnoses for 2 of 5 sampled residents (Residents 62 & 48) reviewed for unnecessary medications. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary mental health services to meet their mental health needs. Findings included . 1) Resident 62 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 04/24/2025, showed the resident had severe cognitive impairment, a diagnosis of depression, and demonstrated signs and symptoms of delirium (a serious change in mental abilities, resulting in confused thinking and a lack of awareness of someone's surroundings) including inattention and altered levels of consciousness. Resident 62 received both antipsychotic and antidepressant medication during the assessment period. A level 1 PASRR, dated 04/16/2025, assessed Resident 62 had no indicators of serious mental illness (SMI), and did not require a level 2 PASRR referral. Review of the electronic health record (EHR) showed Resident 62 had 04/21/2025 orders for the following: - aripiprazole (an antipsychotic) every morning for delirium related to acute cystitis (infection of the bladder). - duloxetine (an antidepressant) every morning for depression. - quetiapine (an antipsychotic) daily at bedtime for depression. On 05/12/2025 at 3:52 PM, Staff C, Resident Care Manager, said Resident 62's level 1 PASRR was inaccurately completed and needed to be updated. Staff C said Resident 62's diagnoses of depression and delirium/psychosis should have been identified and level 2 PASRR referral made. 50392 2) Resident 48 was admitted to the facility 02/07/2024. The Significant Change MDS, dated [DATE], showed they rarely or never understood others, and were sometimes understood. Resident 48 had diagnoses of depression (mood disorder characterized by persistent feeling of sadness) and anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations). The level 1 PASRR, completed 02/06/2024, did not show documentation of the diagnoses of depression or anxiety disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A level 2 PASRR assessment, dated 02/29/2024, which used the inaccurate level 1 PASRR assessment, that failed to identify the resident's underlying mental health diagnoses of depression and anxiety disorder, to invaliadate the level 2 PASRR referral. On 05/08/2025 at 3:21 PM, Staff A, Administrator, acknowledged Resident 48 had diagnosis of depression and anxiety. When reviewing with Staff A the level 1 from 02/06/2024 did not include the depression and anxiety diagnosis, and the Invalidation assessment was based on the level 1, Staff A was asked if the facility should have caught this and completed a new level 1 and referral for level 2. Staff A said, yes, we should have caught it, that was our error. Refer to F-605 Reference WAC 388-97-1915 (1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to provide residents with care plans that were comprehensive, individualized and person centered, updated, and/or accurate for 11 of 18 sampled residents (Residents 28, 56, 45, 63, 39, 127, 20, 16, 37, 15, & 24) reviewed. This failure placed residents at risk of unidentified and unmet care needs, and a diminished quality of life. Findings included . 1) Resident 28 was admitted to the facility on [DATE] with diagnoses of dementia and depression. The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 28 was rarely understood or rarely understands. Review of Resident 28's past 30 days of meals monitor, showed three meals were refused. Review of Resident 28's nutritional risk care plan, showed standard interventions to monitor and record food/fluid intake, monitor weight, obtain and monitor labs, and serve diet as ordered. The care plan did not mention any refusals of meals or any alternatives/preferences if Resident 28 did not want to eat the provided meal. During an interview on 05/12/2025 at 1:59 PM, Staff C, Resident Care Manager (RCM), when asked about Resident 28 being at risk for weight loss, said the facility was using snacks to calm the resident, providing them throughout the day as a non-pharmacological interventions (NPI) for when the resident was upset. When asked about there being documentation that Resident 28 refused meals, Staff C said yes this should be in the care plan, and it should also include interventions or alternatives when refusals occur. Review of Resident 28's anti-anxiety medication care plan listed it was related to a diagnosis of anxiety disorder, and did not list it was related to dementia. Resident 28 did not have an active diagnosis of anxiety disorder. During an interview on 05/12/2025 at 2:09 PM, Staff C, RCM, said Resident 28 had depression and dementia, but no diagnosis of anxiety. When asked if the care plan listed what an acceptable level of agitation was for Resident 28, Staff C said they would expect this in the care plan and it was not there. Review of Resident 28's impaired cognition/dementia care plan, showed interventions of asking yes/no questions, monitoring changes in cognitive function, providing simple, consistent, directive sentences, breaking tasks into one step at a time, and provide the resident with necessary cues-stop and return if agitated. During an interview on 05/12/2025 at 2:09 PM, Staff C, RCM, listed some interventions to help with Resident 28's anxiety as activities, following staff up and down halls, reading a paper, and hitting on wood. Resident 28 was described to be impulsive. When asked if Resident 28's care plans were updated to include what were possible triggers or what interventions were used for behaviors, Staff C said it was not individualized for him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/13/2025 at 10:43 AM, Staff B, Director of Nursing [NAME] (DNS), was asked if the facility did any of the following: develop a care plan with measurable goals and interventions to address the care and treatment for a resident with dementia, create a care plan that was individualized and person-centered, and monitored the effectiveness of the interventions. Staff B looked in the electronic health record (EHR) and said no, they did not see anything specific to Resident 28. When told there was a lack of documentation supporting the facility had used the care plan to identify, document, and communicate specific targeted behaviors and expressions of distress, as well as desired outcomes, and implemented individualized, person-centered interventions, Staff B said their expectation for residents with a dementia diagnosis, was there would be documentation on how they were presenting, identified goals and interventions, to assist the staff to navigate their care. 2) Resident 56 was admitted to the facility on [DATE], and had diagnoses of malnutrition and chronic pain. The Significant Change MDS, dated [DATE], showed Resident 56 was able to be understood and understands. Review of Resident 56's anti-anxiety medications care plan, showed medication was related to anxiety disorder. No diagnosis of anxiety was found in the EHR. During an interview on 05/09/2025 at 10:10 AM, Staff C, RCM, looked at Resident 56's care plans and regarding the care plan saying Resident 56 had anxiety disorder, said Resident 56 did not have a diagnosis of anxiety. Review of Resident 56's acute/chronic pain care plan, showed it was not resident specific as it did not include pain goals for the chronic pain, specifics on medications being given to the resident, what did and did not work for pain management for the resident, and NPI that was effective for the resident. During an interview on 05/07/2025 at 2:25 PM, Staff N, Licensed Practical Nurse (LPN), was asked about Resident 56's pain. Staff N said that when Resident 56 was outside of the window for morphine, that no other medication from Resident 56's orders worked (ibuprofen), and if offered, Resident 56 would say it did not help. For NPI for pain management, Staff N said turning and distraction could help. During an interview on 05/09/2025 at 10:10 AM, Staff C, RCM, said a pain care plan should include where the pain was, what medication was being given for the pain, goals to achieve such as a 2/10 pain goal, any interventions, and NPI such as activities and games. When asked about Resident 56's alleged refusals for ibuprofen or NPI, Staff C looked at Resident 56's care plan and said it was a pain template and not individualized. Review of Resident 56's progress notes showed they were reviewed for significant weight loss on 02/14/2025 and 03/06/2025. Review of Resident 56's care plans showed this weight loss was not added. During an interview on 05/09/2025 at 10:40 AM, Staff C, RCM, said Resident 56's significant weight loss should have been added to the care plan. On 05/05/2025 at 4:05 PM, Resident 56 reported having both constipation and diarrhea. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 56 had no bowel movement documented from 04/19/2025 to 04/24/2025. Review of Resident 56's care plans showed no constipation care plan, with no goals and interventions. During an interview on 05/09/2025 at 10:31 AM, Staff C, RCM, said Resident 56 had risk factors for constipation and said they should have had a care plan for this and did not have one. Resident 56's care plan on palliative/hospice care/end of life care showed no individualized interventions and goals. Under interventions it only had two: 1.Provide end of life care as needed to meet the needs of the resident. 2.Adjust/review Advance Directive as needed. During an interview on 05/09/2025 at 10:49 AM, Staff C, RCM, said Resident 56's end of life care plan was not individualized, there was not much for staff to go off of, was not individualized enough for staff to know how to honor Resident 56's personal preferences, and did not include religious preferences. 3) Resident 45 was admitted to the facility on [DATE], with a diagnosis of kidney disease. Review of the Quarterly MDS, dated [DATE], showed Resident 45 was understood by others and understands, and was receiving dialysis treatments. Review of Resident 45's care plans showed the dialysis care plan was minimal and missing specifics including contact information for dialysis concerns and dialysis weight goals. During an interview on 05/09/2025 at 10:58 AM, Staff C, RCM, when asked about Resident 45's care plan for dialysis, said the care plan should have the residents goal weight and had to follow up to obtain this number. When asked if the care plan had information such as access site for dialysis, arm to avoid, who to contact for dialysis related emergencies and their contact information, Staff C said there were no specifics. Review of Resident 45's care plan for discharge, showed there was no active discharge plan. Under interventions, it stated, Does not wish to discharge from the center at this time. No active discharge plan in place. On 05/06/2025 at 8:22 AM, Resident 45 said they had wanted to leave/discharge. During an interview on 05/13/2025 at 10:27 AM, Staff B, DNS, said Resident 45's family member was not ready for Resident 45 to be discharged , this should have been in the care plan and was not. Staff B said the last time there was a care conference the RCM updated them that the goal was to discharge, but the home was not ready. 37044 4) Resident 62 was admitted to the facility on [DATE]. Review of the 04/21/2025 hospital discharge summery showed the resident was receiving aripiprazole and quetiapine (antipsychotic medications) for hallucinations and acute delirium secondary to sepsis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An antipsychotic use care plan, dated 04/30/2025, documented Resident 62 received antipsychotic medications for depression. The goal of the antipsychotic therapy was to have no negative outcomes or drug related complications from antipsychotic medication use. The care plan failed to identify any goals for the use of the antipsychotic medications. Additionally, the specific target behaviors (TBs) the antipsychotic medications were initiated to treat were not identified (e.g. hallucinations, delirium). On 05/12/2025 at 3:37 PM, Staff C, RCM, acknowledged the care plan was not personalized or resident specific and said the goal of antipsychotic medication treatment should have been identified, the resident's delirium and hallucinations should have been addressed, and the specific TBs each medication was initiated to treat should have been identified. An antidepressant medication care plan, dated 04/30/2025, showed a goal of Will be free from discomfort or adverse reactions related to antidepressant therapy. No goal was established for the use of the antidepressant medication (e.g. a decrease in the TBs the medication was initiated to treat.) The TBs were identified as isolation, withdrawn and loss of interest in usual activities. On 05/12/2025 at 3:37 PM, Staff C, RCM, said the care plan should have included the goal of antidepressant medication therapy. 5) Resident 39 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident had diagnoses of Post Traumatic Stress Disorder (PTSD), bipolar disorder, and anxiety disorder, and received antianxiety and antidepressant medications during the assessment period. A mood and behavior problem related to diagnoses of PTSD, bipolar and anxiety disorders care plan, revised 03/03/2025, identified the TBs for anxiety disorder as Anxiety D/O [disorder], and the TBs for the resident's PTSD and Bipolar disorder as Bipolar disease and PTSD and directed staff to document the number of occurrences of each. On 05/13/2025 at 12:27 PM, Staff C, RCM, said TBs should reflect the behaviors that manifest from the underlying diagnoses of anxiety, PTSD, and bipolar. Staff C said TBs should not be a restatement of the diagnosis. 6) Resident 127 was admitted to the facility on [DATE]. On 05/06/2025 at 11:25 AM, Resident 127 was observed to have dark discoloration that encompassed both forearms from elbow to wrist. The resident said they had been that way for years and indicated it was senile purpura (a condition that causes purple, brown, or red bruises on the skin, especially on the arms and hands.) Review of Resident 127's comprehensive care plan showed the senile purpura was not addressed. On 05/12/2025 at 3:27 PM, Staff C, RCM, said the senile purpura to both of Resident 127's forearms should have been care planned. 42960 7) Resident 20 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 20 received non-medication interventions and pain medications as needed. Resident 20 was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 20's care plan showed a focus of Potential for/Actual acute/chronic pain as described or exhibited by non-verbal indicators related to right ankle fracture Initiated on 12/23/2024 and revised on 01/31/2025. The interventions include anticipating need for pain relief and responding to any complaint of pain and monitor/record/report to nurse resident complaints of pain or requests for pain treatment. On 05/12/2025 at 10:30 AM Staff C, RCM, said while looking at the care plan for pain that it was a template and indicated it was not resident centered or individualized for Resident 20. On 05/12/2025 at 11:30 AM Staff B, DNS, said Resident 20's pain care plan was a basic template, and she did not see any specifics. Staff B said it should have contained customized interventions to counteract their pain. 8) Resident 16 was admitted to the facility on [DATE]. The Quarterly MDS dated [DATE] indicated they were moderately cognitively impaired. A review of Resident 16's care plan showed a focus of dependent on staff for activities, cognitive stimulation, social interaction related to immobility initiated on 02/17/2022 and revised on 01/31/2025. The interventions included ensuring the activities resident attends are compatible with physical and mental capabilities; compatible with known interests and preferences; adapted as needed; compatible with individual needs and abilities; and appropriate age and staff will provide one to one time every week. On 05/09/2025 at 11:58 AM Staff C, RCM, said while looking at Resident 16's activity care plan that it should include specific activities Resident 16 likes to do such as watch movies. On 05/12/2025 at 11:30 AM Staff B, DNS, said Resident 16's activity care plan was not individualized and person centered and it should contain examples of what kind of activities they like to do. A review of Resident 16's comfort care, care plan shows a focus of an advance directive initiated on 07/09/2024 and revised on 02/05/2025 with an intervention of refer to Cardiopulmonary Resuscitation consent form for specific instructions - comfort care. On 05/09/2025 at 11:58 AM Staff C, RCM, said that the comfort care, care plan did not direct staff on how to care for Resident 16 and it should have contained specific things for Resident 16 that provide comfort. On 05/12/2025 at 11:30 AM Staff B, DNS, said the comfort care care plan did not have anything customized to Resident 16's care and preferences. 46793 9) Resident 37 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 37 was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 37's Palliative/End of Life needs care plan documented Resident 37 was initiated for end-of-life care services on 05/06/2024. Resident 37's Palliative/End of Life needs care plan documented, Provide end of life care as needed to meet the needs of the resident. Adjust/review Advance Directive as needed. Alert MD with resident status changes. The care plan provided no individual resident centered preferences, goals or interventions. 10) Resident 15 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 15 was severely cognitively impaired. Resident 15's Palliative/End of Life needs care plan documented Resident 15 was initiated for end-of-life care services on 05/06/2024. Resident 15's Palliative/End of Life needs care plan documented, Provide end of life care as needed to meet the needs of the resident. Adjust/review Advance Directive as needed. Alert MD with resident status changes. The care plan provided no individual resident centered preferences, goals or interventions. On 05/09/2025 at 8:22 AM, Staff C, RCM, reviewed Residents 37's and 15's Palliative/End of Life needs care plan, then stated, the care plans were absolutely not individualized person centered and they should have been. At 9:20 AM, Staff B, DNS, reviewed Residents 37's and 15's Palliative/End of Life needs care plan and said those were cookie cutter(meaning all the same) care plans. Staff B said the expectation was that care plans should be individualized person-centered plans. 50392 11) Resident 24 admitted to the facility 03/06/2020. The Quarterly MDS, dated [DATE], documented Resident 24 was rarely/never understood, rarely/never understood others and was severely impaired in making decisions of daily life. On 05/06/2025 at 8:18 AM, Resident 24's bed was observed to be pressed against a fall mattress, which was between the bed and the wall. On 05/08/2025 at 9:18 AM, Resident 24's bed was observed against the wall, with no fall mattress in between the bed and the wall. Review of Resident 24's care plan showed that there was no care plan in place for their bed being against the wall. On 05/12/2025 at 12:31 Staff C, RCM when asked what elements needed to be in place before a bed was put against the wall said, a safety device evaluation, orders, it should be added to the care plan, and a consent. When asked if there was a care plan for Resident 24's bed against the wall, Staff C said she could not see it, and it should be there. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 24's care plans showed there was a Palliative Care End of Life needs care plan. For a goal it documented Resident 24's palliative needs will be met. The care plan did not specify the palliative needs for Resident 24. Under interventions the care plan documented provide end of life care as needed to meet the needs of resident, again it did not specify what Resident 24's end of life care needs might be. Another intervention listed on the care plan was Alert MD with resident status changes, it did not specify what type of changes staff should alert the MD for. On 05/12/2025 at 9:55 AM, when asked if Resident 24's palliative care plan was person centered and individualized Staff C said, it is cookie cutter, it is not individualized as it should be. Refer to F553 Reference WAC 388-97-1020(1), (2)(a)(b)

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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 2 of 32 residents (Residents 127 & 20). Facility staff's failure to administer medications in accordance with physician's orders, and to complete assessments and treatments as ordered placed residents at risk for ineffective treatment of disease processes, medication adverse side effects and other potential adverse health outcomes. Findings included . 1) Resident 127 admitted to the facility on [DATE] with orders for intravenous (IV) cefazolin (antibiotic) every eight hours at 8:00 AM, 4:00 PM and midnight. Review of Resident 127's Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had diagnoses of pneumonia (infection in lungs) and sepsis (infection in blood), and received IV antibiotics via Peripherally Inserted Central Catheter (PICC - long, flexible, thin tube inserted into a vein in your arm, usually the upper arm, and threaded up to a larger vein near your heart). Review of Resident 127's April and May 2025 Medication Administration Records (MAR) showed Resident 127's midnight dose of IV cefazolin was not consistently administered at the ordered time/intervals: - On 04/25/2025 the midnight dose was administered at 2:53 AM, 3 hours late. - On 04/27/2025 the midnight dose was administered at 6:27 AM, 6.5 hours late. - On 04/28/2025 the midnight dose was administered at 5:31 AM, 5.5 hours late. - On 04/30/2025 the midnight dose was administered at 5:35 AM, 5.5 hours late. - On 05/02/2025 the midnight dose was administered at 4:50 AM, 5 hours late. - On 05/05/2025 the midnight dose was administered at 4:23 AM, 4.5 hours late. On 05/09/2025 at 11:33 AM, Staff C, Resident Care Manager (RCM), said facility nurses failed to administer Resident 127's IV cefazolin in accordance with the physician's order or professional standards of practice. Review of the April and May 2025 MAR and TAR showed Resident 127 had an order to change the PICC dressing every 72 hours, with instruction to measure the external length catheter and resident's arm circumference with each dresing change. The MAR/TAR did not provide a place for staff to record the measurements. Review of the Electronic Health Record (EHR) showed no PICC external catheter length or resident's arm circumference measurements were documented, upon admission or with the 72-hour dressing changes as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR/TAR showed facility nurses signed they measured the arm circumference and PICC external length with PICC dressing changes on 04/26/2025, 04/29/2025, 05/05/2025 and 05/08/2025 as ordered. On 05/09/2025 at 11:25 AM, Staff C, Resident Care Manager, acknowledged there was no documentation to show staff measured Resident 127's arm circumference and PICC line external length upon admission or with the 72 hour PICC dressing changes. When asked if facility nurses erroneously signed for tasks they did not complete Staff C, RCM, said yes. Resident 127 had an order to monitor IV insertion site for signs and symptoms of infection every shift. Review of the April and May 2025 Treatment Administration Records (TAR) showed staff failed to sign they completed the task on 04/24/2025 at 6:00 AM; 04/26/2025 at 6:00 PM; 04/28/2025 at 6:00 AM; and 04/29/2025 at 6:00 PM. Resident 127 had an order for oxygen at two liters per minute continuously via nasal canula to keep oxygen saturation greater than 92%. Review of the April 2025 TAR showed staff failed to sign they administered the oxygen on 04/26/2025 evening shift; 04/29/2025 day shift; and 04/29/2025 evening shift. Resident 127 had an order to check oxygen saturation every shift. Review of the April 2025 TAR showed staff failed to check the resident's oxygen saturation on 04/26/2025 evening shift; 04/28/2025 day shift; and 04/29/2025 evening shift. Review of Resident 127's May 2025 TAR showed Resident 127 had an order for staff to measure their upper arm circumference and the external length of their PICC upon admission and every 72 hours with the PICC dressing change. Review of the May 2025 TAR showed staff failed to sign the task off as completed on 05/01/2025 and 05/08/2025. Staff did sign the task was completed on 05/05/2025, but review of the EHR showed no documentation of the resident's arm circumference PICC external length was present. Resident 127 had an order to change their primary administration set (IV tubing) every 24 hours. Review of the May 2025 TAR showed staff failed to sign the task off as completed on 05/03/2025, 05/04/2025 and 05/08/2025. On 05/12/2025 at 3:41 PM, Staff C, RCM, said it was the expectation nurses administer medications and perform treatments as ordered by physician, and to only sign for tasks they completed. 42960 <Blanks on the MAR and TAR> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Resident 20 was admitted to the facility on [DATE] with multiple diagnosis including depression and atrial fibrillation (a common type of arrhythmia where the heart beats irregularly and often rapidly). The Quarterly MDS, dated [DATE], documented Resident 20 was cognitively intact. A review of Resident 20's MAR and TAR for April 2025 showed the listed orders had blank boxes (no documentation) on the dates and times below: -High Calorie/High Protein Nectar Thick Liquids three times a day for supplement for healing on 04/13/2025, 04/15/2025, and 04/16/2025 at 2:00 PM. -Eliquis two times a day on 04/13/2025, 04/15/2025, and 04/16/2025 at 2:00 PM. -Monitor for Antidepressant Medication side effects every shift on 04/09/2025, 04/16/2025, 04/23/2025, 04/24/2025, and 04/28/2025 from 6:00 AM to 6:00 PM, and on 04/17/2025 and 04/18/2025 from 6:00 PM to 6:00 AM. -Monitor for Antipsychotic Medication side effects every shift on 04/09/2025, 04/16/2025, 04/23/2025, 04/24/2025, and 04/28/2025 from 6:00 AM to 6:00 PM, and on 04/17/2025 and 04/18/2025 from 6:00 PM to 6:00 AM. -Target Behavior: Insomnia document every shift on 04/09/2025, 04/16/2025, 04/23/2025, 04/24/2025, and 04/28/2025 from 6:00 AM to 6:00 PM, and on 04/17/2025 and 04/18/2025 from 6:00 PM to 6:00 AM. - Target Behavior: Major Depressive Disorder document every shift on 04/09/2025, 04/16/2025, 04/23/2025, 04/24/2025, and 04/28/2025 from 6:00 AM to 6:00 PM, and on 04/17/2025 and 04/18/2025 from 6:00 PM to 6:00 AM. On 05/09/2025 at 9:45 AM, Staff C, RCM said the blanks on the MAR/TAR meant it was not given, or it was not done, and it should be given and if not it should be documented why if there was a refusal of another reason. On 05/12/2025 at 11:30 AM, Staff B, Director of Nursing said the blanks mean they were not documented on the MAR or TAR, and she said any medication or treatment should be documented on administration. Refer to F760 Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure the bowel protocol was implemented, bowel movements were monitored and/or documented on, for 2 of 6 residents (Residents 56 & 48) reviewed for unnecessary medication and constipation. This failure placed residents at risk of bowel obstructions, pain, and a diminished quality of life. Findings included . Review of the facility's policy titled, Management of Constipation, revised 11/2023, showed the facility monitored bowel movements through point of care documentation (computer charting system used most frequently by nursing assitants) and clinical alerts. After 64 hours of no/small bowel movement, the nurse would assess and determine if the bowel protocol would be initiated and document findings, and interventions would be documented on the clinical alert. The standard bowel protocol would be as follows: 1. Milk of Magnesia (MOM) after 8 shifts of no bowel movement 2. Bisacodyl suppository if no results from the MOM 3. Fleets Enema if no results from the Bisacodyl suppository 1) Resident 56 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 56 was able to be understood and understands. During an interview on 05/05/2025 at 4:05 PM, Resident 56 reported they had both constipation and diarrhea. Review of Resident 56's orders showed three bowel stimulation orders: 1. Dulcolax suppository (Bisacodyl), insert 1 suppository rectally every 24 hours as needed for constipation if no results from MOM after 12 hours 2. Senna oral tablet, give 2 tablets by mouth every 6 hours as needed for constipation 3. MiraLax oral packet, give 1 packet by mouth one time a day for constipation hold for loose stool Review of the previous 30 days of bowel movements, showed Resident 56 had no documented bowel movements from 04/19/2025 to 04/24/2025 (6 days). Review of the electronic health record (EHR) showed no bowel medications were given during those dates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/2025 at 10:31 AM, Staff C, Resident Care Manager (RCM), said they started the bowel protocol medications and would progress through the steps until a bowel movement was charted. Staff C alert charting should also be started. For Resident 56, Staff C said that based on the charting it looked like the resident had not had a bowel movement during those days, but the resident had reported they had one verbally. When asked if this was confirmed, due to no staff being identified and the resident being dependent on staff for changing their brief, Staff C said the they thought the conversation had happened the week of April 21st, but siad they did not have documentation of this conversation and there should have been. Staff C reviewed the EHR and confirmed there were not bowel medications given during that time frame, and there was no alert charting. 50392 2) Resident 48 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 48 was rarely or never understood and sometimes understands, and had constipation during the assessment window. Review of Resident 48's medications for bowel stimulation showed three medications: 1. MOM, by mouth as needed for constipation, give at bedtime or at resident preferred time if no bowel movement on 3rd day 2. Dulcolax suppository(Bisacodyl), insert 1 suppository rectally every 24 hours as needed for constipation if no results from MOM after 12 hours. 3. Fleet enema, insert 1 application rectally every 24 hours as needed for constipation if no results from Dulcolax in 4-6 hours. If no results from enema, notify provider. Review of Resident 48's bowel record showed three stretches of no bowel movement from 04/18/2025 to 04/22/2025 (5 days), 04/26/2025 to 04/29/2025 (4 days), and 05/01/2025 to 05/05/2025 (5 days). Review of the EHR showed no bowel medications were given during those days. Review of Resident 48's care plan for alteration in bowel elimination showed they had the goal of a normal bowel movement at least every 3rd day, with interventions to follow the facility protocol for bowel management. On 05/12/2025 at 10:13 AM, Staff C, RCM, after reviewing Resident 48's bowel records and the three stretches without bowel movements, said the bowel medications were either not started or not documented on, and it should have been done. Reference WAC 388-97-1060 (1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on interview and record review the facility failed to consistently provide weekly skin assessments and failed to implement supplements as recommended for wound healing for a pressure ulcer (PU, injury to the skin and underlying tissue due to prolonged pressure) for 1 of 2 sampled residents (Resident 24) reviewed for pressure ulcers. These failures placed residents at risk of developing avoidable pressure ulcers and/or delayed healing of pressure ulcers and a diminished quality of life. Findings included . Review of the facility policy, titled Documentation-Skin Conditions revised on 12/2024 documented weekly skin assessments were to be documented weekly using the Total Body Skin Evaluation. <Failed to do weekly skin assessments> Resident 24 admitted to the facility 03/06/2020. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 01/23/2025, documented Resident 24 had one Stage 3 (involves damage to the innermost layer of skin tissue, exposing the fatty tissue underneath), PU. On 05/08/2025 Staff O, Wound Care Nurse Practitioner said Resident 24's Stage 3 PU had been identified on 06/13/2024. Record review showed Resident 24 had a Total Body Skin Evaluation (assessment) done on 05/14/2025 (no PU identified on this assessment) and did not have another Total Body Skin assessment until over 4 weeks later, on 06/19/2024 (PU documented). On 05/12/2025 at 12:41 PM, Staff C, Resident Care Manager, when asked what type of evaluations were completed for skin assessments said, Total Body Evalutions were to be done weekly by floor nurses. When asked if [NAME] Body Evaluations were being done weekly for Resident 24, Staff C looked in the Electronic Health Record (EHR) and said it did not look like they were being completed weekly, and it did not meet her expectations. When asked what the facility was doing to prevent Resident 24 from developing the Stage 3 PU, Staff C said repositioning, peri care, putting barrier cream on, and if staff were completing the Total Body Evaluation's the PU could have been prevented. Staff C said if there was a red mark on the skin, it could have been prevented before the skin opened (PU developed). When asked if the Total Body Evaluations were being completed prior to Resident 24 developing the PU, Staff C said, not as often as they should have been, not weekly. Staff C acknowledged the missing assessments between 05/14/2024 and 06/19/2024 and said staff missing those assessments was not acceptable. <Failure to provide wound healing supplement> On 05/08/2025 at 9:31 AM, Staff O, Wound Care Nurse Practitioner, when asked if she had made any nutrition recommendations for wound healing, said she had recommended a supplement, Arginade (Powdered supplement which is added to a liquid that can improve wound healing) to the facilities Registered Dietician, a couple of months previously. Staff O said she made recommendations, and it was up to the facility staff to follow up on them. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 24's EHR documented the following Wound Pros Progress Report signed by Staff O: On 11/18/2024 conversation with facility dietician (Staff G's first name indicated here) about significant wound. She is prescribing nutritional supplements. Recommend Vitamin C and zinc, and Arginaid wound supplement. Record search of Resident 24's orders showed no order for Arginaid had been implemented. On 05/08/2025 at 12:38 PM, Staff G, Registered Dietician, when asked what specific supplements the facility used to promote wound healing said, Arginaid, it truly works. When asked what steps the facility was taking to promote wound healing for Resident 24, Staff G said Resident 24 had Arginaid and Zinc in the past. Staff G said Arginaid was started in November of 2024, and Resident 24 had taken it for a whole month. When asked to provide documentation that Resident 24 had received the supplement Arginaid, Staff G looked at Resident 24's orders and Medication Administration record and said, I can't seem to find it. Staff G said that since Resident 24 required honey thick fluids (a thicker consistency of liquids) and that Arginaid is not a honey thick liquid that maybe staff couldn't do it and that was why it wasn't done. When asked if Arginaid could have been made honey thick consistency (with added thickener) for Resident 24, Staff G said it was worth trying. On 05/08/2025 at 2:03 PM, Staff G said Resident 24 had tried the supplement Arginaid mixed in thickened water, that nursing had said they were ok mixing it for Resident 24 and that Resident 24 was liking it. When asked why this had not been attempted at the time the recommendation was made for Resident 24, Staff G said Arginaid would have had to have been put in a liquid that could be thickened to honey thick consistency, kitchen staff couldn't do it, but nursing could. Reference WAC 388-97-1060 (3)(b)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 for 1 of 1 resident (Resident 127) reviewed for IV therapy. The facility failed to provide Peripherally Inserted Central Catheter (PICC line, 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, PICC dressing changes, measuring external length to verify the line had not migrated, and arm circumference to monitor for swelling. deep vein thrombosis. These failures placed residents at risk for loss of vascular access, infection, and other potential negative outcomes. Findings included . Resident 127 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 04/29/2025, showed the resident was cognitively impaired, had a diagnosis of pneumonia and received IV antibiotic therapy via PICC during the assessment period. Review of Resident 127's electronic health record (EHR) showed the following IV therapy orders: a) Cefazolin IV every 8 hours for six weeks for a diagnosis of bacteremia. b) Flush unused lumens with 10 milliliters (ml) normal saline and follow with heparin every 8 hours. c) Monitor IV insertion site for signs and symptoms of infection every shift. d) Change the PICC dressing every 72 hours. Measure the external catheter length and resident's arm circumference with each dressing change. The physician orders did not include direction to: a) Flush the PICC dressing before and after medication administration. b) To change the needleless injection caps on each lumen with dressing changes, after each blood draw and as needed. On 05/06/2025 at 11:18 AM, Resident 127 a PICC was observed to the resident's right upper arm. The PICC dressing was clean, dry, and intact, and dated 05/05/2025. Review of the May 2025 Medication and Treatment Administration Records (MAR/TAR) showed on 05/01/2025 Resident 127's PICC dressing was due to be changed, the external catheter length measured, as well as the resident's arm circumference. Further review showed no place was provided to record the measurements and staff failed to sign that the tasks were completed as ordered. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/2025, Resident 127's PICC dressing change, and measuring of the external length and the residents arm circumference were again due. The TAR showed that the nurse signed off that the tasks were completed. On 05/09/2025 at 10:31 AM, Resident 127's PICC dressing was still dated 05/05/2025, This showed the dressing was not changed on 05/08/2025 as ordered and signed for. Review of the EHR showed no PICC external catheter length or resident arm circumference measurements were documented. On 05/09/2025 at 11:25 AM, Staff C, Resident Care Manager, acknowledged there was no documentation to show staff measured Resident 127's arm circumference and PICC line external length upon admission and every 72 hours with the PICC dressing changes as ordered. Staff C also confirmed there were no orders in place to change the needleless injection caps, to flush the PICC line before and after medication administration. Staff C confirmed facility nurses had erroneously signed for tasks they did not complete on 04/26/2025, 04/29/2025, 05/05/2025 and 05/08/2025. Reference WAC 388-97-1060 (3)(j)(ii)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37044 Based on interview and record review, the facility failed to have a system in place that ensured periodic reconciliation and accounting for all controlled medications, for 1 of 1 medication carts (East B cart) reviewed for narcotic records. The failure to consistently reconcile controlled medications at shift change and to co-sign the ledger to show both nurses validated the accuracy of the medication count, placed residents at risk for misappropriation of their medication and detracted from the facility's ability to promptly identify potential diversion. Findings included . On 05/09/2025 at 7:52 AM, two controlled medication books/ ledger were observed on the East B medication cart. One ledger contained the count for schedule two medications (drugs that have a high potential for abuse and are regulated under the Controlled Substances Act) and the other for schedule three and four medications (drugs with low to moderate potential for abuse and/or addiction). On 05/09/2025 at 11:18 AM, Staff C, Resident Care Manager (RCM), said facility nurses were supposed to count all schedule two, three and four medications at shift change (twice a day due to 12-hour shifts). After counting and validating all medications were accounted for, both nurses would co-sign each medication ledger to validate that the counts were correct. Review of schedule three and four medication ledger showed facility nurses signed the ledger to validate the schedule three and four medications were accounted for as follows: - In January 2025, nurses signed the schedule three and four medication count was correct for one of 62 shift changes (01/17/2025). - In February 2025, nurses signed the schedule three and four medication count was correct for 0 of 56 shift changes. - In March 2025, nurses signed the schedule three and four medication count was correct for one of 62 shift changes (03/20/2025). During an interview on 05/09/2025 at 7:45 AM, when asked why nurses were not signing that the schedule three and four medications were counted and the count was accurate at shift change, Staff L, Licensed Practical Nurse, stated, Some nurses sign in that book, some don't. I figure we did the count we can just sign once for both books. On 05/09/2025 at 11:34 AM, Staff C, RCM, said nurses were expected to count controlled medications daily at shift change with both nurses (oncoming and off going) signing each ledger to validate the counts were accurate. When asked if that had occurred for the schedule three and four medications on the East B cart Staff C stated, No. Reference WAC 388-97-1300(1)(b)(ii), (c)(ii-iv)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview and record review, the facility failed to ensure residents were free from unnecessary medications by providing and documenting on non-pharmacological interventions (NPI) for pain management, having parameters for medications, and/or using non-opioid medications for 4 of 6 residents (Residents 56, 37, 40 & 48) reviewed for unnecessary medications or pain. This failure placed residents at risk of medication tolerance, increased pain, and a diminished quality of life. Findings included . 1) Resident 56 was admitted to the facility on [DATE] with diagnoses of chronic pain and muscle spasm. The Significant Change Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 56 was able to be understood and understands. Review of Resident 56's pain orders showed they had two as needed medications for pain: 1. Morphine, an opioid (strong pain medication), for every 3 hours as needed for end of life care (not listed for pain, no parameters/pain score listed on when to give). 2. Ibuprofen, a non-opioid, for every 8 hours as needed for headache/pain (no parameters/pain score listed on when to give). Review of the Medication Administration Record (MAR) showed the following: -04/01/2025 to 04/30/2025: morphine was given 14 times, with no ibuprofen given on any of those dates. Ibuprofen was only administered one day (04/01/2025). Morphine was given 3 times for 4/10 pain, and once for 5/10 pain. -05/01/2025 to 05/06/2025: morphine was given 5 times; no ibuprofen given. Morphine was given once for 5/10 pain, and once for 0/10 pain. Review of the electronic health record (EHR) showed no order for NPI interventions. Review of Resident 56's care plan showed NPI should be provided for pain management, such as position change, relaxation techniques, massage, smooth linens, mobility or physical activity. On 05/07/2025 at 12:13 PM, Resident 56 had their call light on due to 4/10 pain. On 05/07/2025 at 12:32 PM, Staff went into the room and told Resident 56 they would find the nurse to give pain medication. On 05/07/2025 at 1:02 PM, Resident 56 reported they were told they were outside of the timeframe to receive medication (last given at 10:14 AM that day, next dose could be given at 1:14 PM). On 05/07/2025 at 1:37 PM, Staff N, Licensed Practical Nurse (LPN), gave Resident 56 morphine and left the room. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/2025 at 1:38 PM, Resident 56 reported no NPI was given, they were not offered ibuprofen, and yes they would have taken ibuprofen. On 05/07/2025 at 2:25 PM, Staff N, LPN, said Resident 56's pain was an 8/10 when the morphine dose was given. When asked if anything improved Resident 56's pain, said morphine. When asked what NPI works for Resident 56, Staff N said turning or distraction can help. Staff N, when asked about Resident 56 being outside of the window for morphine, acknowledged they had not offered other pain medications (ibuprofen) for this specific occurrence, nor did they offer NPI. During an interview on 05/09/2025 at 10:10 AM, Staff C, Resident Care Manager (RCM), said NPIs should be offered every shift and when residents were requesting pain medication. When asked how the facility was preventing the use of unnecessary medication if pain medication orders do not have parameters on them for when to administer, Staff C said by using NPI such as going on a walk, going outside, repositioning, and that medication should not be the first step. Staff C said if a resident was not due for a narcotic/opioid pain medication, then they should be offered as needed ibuprofen or acetaminophen/Tylenol. When asked about Resident 56's ibuprofen and morphine orders not having parameters, Staff C said yes they should have parameters. When asked about there being no documented NPI for the pain medications given in March, April, and May 2025, Staff C said this did not meet expectations. 46793 2) Resident 37 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 37 was cognitively intact. A physician's order dated 07/25/2022, documented, Assess for pain and provide non pharmalogical interventions to reduce pain and document effectiveness. 1-Repositioning 2-Relaxation 3- Diversional Activities 4-Redirection. Doc number used and effectiveness. Resident 37's April and May 2025 MAR and Treatment Administration Record (TAR) documented NPIs 1-4 were used daily, even on days when Resident 37 reported no pain. The April and May 2025 MAR & TAR showed no documentation of effectiveness. Progress notes provided no documentation to support what NPIs were being used, only stated pain and did not document effectiveness. 3) Resident 40 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 40 was severely cognitively impaired. A physician's order dated 08/23/2023, documented, Assess for pain and provide non pharmalogical interventions to reduce pain and document effectiveness. 1-Repositioning 2-Relaxation 3- Diversional Activities 4-Redirection. Doc number used and effectiveness. Resident 40's April and May 2025 MAR and TAR documented NPIs 1-4 were used daily, even on days when Resident 40 reported no pain. The April and May 2025 MAR & TAR showed no documentation of effectiveness. Progress notes provided no documentation to support what NPIs were being used, only stated pain and did not document effectiveness. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/09/2025 at 8:22 AM, Staff C, RCM, reviewed Resident 37's and Resident 40's MAR and TAR's, and said they say the exact same thing. Staff C said the actual intervention needed to documented, along with the effectiveness of the NPIs. On 05/09/2025 at 9:20AM, Staff B, Director of Nursing Services (DNS), said the copy and paste item was removed from the system and they believed staff have completed the listed NPIs. When shown the MAR and TAR's for Resident 37 and Resident 40, Staff B confirmed the exact NPIs used and their effectiveness were not documented. When progress notes for both residents were shown, documenting pain only, Staff B confirmed NPIs and the effectiveness should have been documented. 50392 4) Resident 48 was admitted to the facility 02/07/2024. The Significant Change MDS, dated [DATE], showed Resident 48 was rarely or never understood, and sometimes understood. Review of Resident 48's physician pain orders showed they had the following pain medication order in place, dated 04/30/2025: morphine, give by mouth two times a day for pain management AND give by mouth every 2 hours as needed for moderate pain, air hunger, EOL (End of Life) symptoms AND Give by mouth every 2 hours as needed for severe pain, air hunger, EOL symptoms. Review of the EHR showed there was NPI monitoring for pain and staff were instructed to provide NPI to reduce pain and document effectiveness every shift, these instructions were not linked to the morphine order. Review of Resident 48's April 2025 MAR showed staff had administered morphine 12 times, it was unclear if they attempted NPI's prior to administering the pain medication as the NPI's were not linked to the morphine order. On 05/12/2025 at 10:30 AM, Staff C, RCM, reviewed Resident 48's morphine order, and when asked how the nurse would know what was moderate pain versus severe pain without the order listing a numerical pain scale to follow (0/10 pain scale, 0 being none, with 10 being the worst), Staff C said the provider inputing the order should have added the pain scale with parameters. Regarding EOL symptoms, Staff C said the order should be more specific. Staff C, when asked if staff were providing and documenting NPIs that were attempted prior to morphine being given, said no, they did not see it in the EHR and they should be. Staff C said there should be a plan and documentation of NPI's for morphine. When asked for documentation that the facility was monitoring for adverse side effects of the administered morphine (such as slow or stopped breathing, signs of increased effort to breath, mental status changes), Staff C said they were not seeing that the facility was doing that for morphine, but it should be there for sure. Reference WAC 388-97-1060 (3)(k)(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure 1 of 1 resident (Resident 127) reviewed for intravenous (IV) therapy, was free of significant medication errors. The failure to administer IV antibiotics at ordered times/intervals, placed residents at risk for ineffective treatment of infection, prolonged antibiotic therapy and associated adverse side effects. Findings included . Resident 127 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (an assessment tool), dated 04/29/2025, showed the resident was cognitively intact, had a diagnosis of bilateral lower lobe pneumonia (infection in both sides of lower lungs), and received IV antibiotics during the assessment period. Review of the electronic health record (EHR) showed the resident had a 04/23/2025 order for IV Cefazolin (antibiotic) every eight hours at 8:00 AM, 4:00 PM and Midnight, with direction to infuse over one hour via Peripherally Inserted Central Catheter. Review of the April 2025 Medication Administration Record (MAR) showed Resident 127's IV cefazolin was administered as follows: - On 04/27/2025 the midnight dose of IV cefazolin was administered on 04/27/2025 at 6:27 AM, six and half hours after the scheduled time and 14 hours after the previous dose (04/26/2025 at 4:00 PM). The nurse then administered the 04/27/2025 8:00 AM dose at 9:29 AM, two hours after the previous dose completed. -On 04/28/2025 the midnight dose of IV cefazolin was administered on 04/28/2025 at 5:31 AM, five and half hours after the scheduled time and 13 hours after the previous dose. The nurse then administered the 04/28/2025 8:00 AM dose at 8:35 AM, two hours and four minutes after the previous dose completed. -On 04/30/2025 the midnight dose of IV cefazolin was administered on 04/30/2025 at 5:35 AM, five and half hours after the scheduled time and 14 hours after the previous dose. The nurse then administered the 04/30/2025 8:00 AM dose at 8:47 AM, two hours and 12 minutes after the previous dose completed. -On 05/02/2025 the midnight dose of IV cefazolin was administered on 05/02/2025 at 4:50 AM, five hours late and 13 hours after the previous dose. The nurse then administered the 05/02/2025 8:00 AM dose at 8:19 AM, two hours and 29 minutes after the previous dose completed. -On 05/05/2025 the midnight dose of IV cefazolin was administered on 05/05/2025 at 4:23 AM, four and a half hours late and 13 hours after the previous dose. The 05/05/2025 8:00 AM dose was then administered at 8:19 AM, two hours and 56 minutes after the previous dose completed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/2025 at 11:33 AM, when asked if facility nurses administered Resident 127's IV cefazolin at the prescribed times and intervals, Staff C, Resident Care Manager, stated, No. Staff C confirmed facility nurses' pattern of administering the resident's midnight doses four to five hours late and then failed to adjust the administration time of the next dose. Staff C acknowledged this resulted in 13-14 hours between the 4:00 PM and midnight dose, and 2-3 hours between the midnight and 8:00 AM dose, rather than every eight hours as ordered. Reference WAC 388-97-1060 (3)(k)(iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37044 Based on observation, interview and record review, the facility failed to ensure medications were stored at proper temperatures, dated when opened when required, and expired medications were discarded in accordance with professional standards of practice for 2 of 2 medication rooms (East and [NAME] Medication rooms) and 1 of 2 medication carts (West A cart) reviewed. This placed residents at risk of taking and/or receiving expired/outdated medications and biologicals. Findings included . <East Medication Room> On 05/13/2025 at 11:40 AM, observation of the medication refrigerator showed it contained 11 bags of intravenous cefazolin (to be stored at 37.5 - 41 degrees Fahrenheit (F)), multiple unopened insulin pens (to be stored at 36 - 46 degrees F), and an opened multi-use vial of Tuberculin purified protein derivative (PPD, to be stored at 35 - 45 degrees F). Review of the refrigerator temperature log showed staff had not checked the medication refrigerator temperature since October 2024 (greater than six months prior). On 05/09/2025 at 11:42 AM, Staff C, Resident Care Manager (RCM), said nurses should have been checking and recording the medication refrigerator internal temperature at least once daily, but acknowledged they failed to do so. <West Medication Room> On 05/09/2025 at 11:56 AM, a multi-use vial of Tuberculin PPD was stored in the freezer and had an open date of 03/18/2025 (56 days prior). On 05/09/2025 at 11:58 AM, Staff C, RCM, said the Tuberculin vial should have been stored in the refrigerator between 35 - 45 degrees F and discarded 30 days after the open date, but was not. <East A Medication Cart> Review of the East medication cart showed the following: 1) Resident 45 had a medication card of benzonatate 100 mg which expired 06/19/2024. 2) Resident 16 had a medication card of mirtazapine 7.5 mg that expired 05/31/2024. On 05/13/2025 at 12:24 PM, Staff C, RCM, said the above referenced medications were expired and needed to be discarded. Reference WAC 388-97-1300 (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46793 Based on observation, interview and record review the facility failed to store food for residents in accordance with professional standards for 2 of 2 nursing station refrigerators (East, West) reviewed for food service safety. The failure to maintain documented refrigerator temperature logs placed residents at risk of foodborne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and diminished quality of life. Findings included . Review of the following refrigerator temperature logs located at nurses stations included the following out of range temperatures (greater than 40 degrees Fahrenheit (F): February 2025 [NAME] refrigerator: 5th 43F AM shift/ 5th 43F PM shift 8th 43F AM shift 9th 42F AM shift 10th 43F AM shift 15th 43F AM shift 16th 44F AM shift there was no documentation of corrective action taken. February 2025 East refrigerator: 11th 43F AM shift 12th 45F AM shift 19th 43F AM shift there was no documentation of corrective action taken. March 2025 [NAME] refrigerator: 4th 45F AM shift 7th 43F AM shift (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11th 49F AM/42F PM shifts 12th 43F PM shift 13th 43F AM/47F PM shifts 14th 47F PM shifts 15th 45F AM/46F PM shifts 16th 43F PM shift 17th 47F PM shift 18th 44F PM shift 19th 43F AM/44F PM shifts 20th 44F AM/44F PM shifts 21st 44F PM shift 22nd 44F PM shift 23rd 44F PM shift 25th 45F AM/44F PM shifts 26th 43F AM shift 29th 44F PM shift a line was drawn through comments section Kept Fridge Shut marked next to line. April 2025 [NAME] refrigerator: 21st 42F AM shifts 22nd 45F AM shifts 23rd 42F AM shifts 28th 42F PM shifts there was no documentation of corrective action taken. April 2025 East refrigerator: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9th 44 PM 12th 42 PM 14th 43 PM 15th 45 PM 16th 48 PM 17th 47 PM 18th 47 PM 19th 47 PM 20th 47 PM 21st 47 PM 22nd 47 PM 23rd 47 PM 24th 47 PM 26th 42 PM there was no documentation of corrective action taken. On 05/07/2025 at 10:39 AM, Staff I, Dietary Manager, said refrigerator temperatures were supposed to be 40 degrees or below. When asked what the process was for when a refrigerator temperature was out of range, Staff I said staff would make sure the door was closed, wait and hour then come back and recheck the refrigerator temperature. Staff I said if the problem persisted, then they would contact maintenance and the Administrator. When shown multiple dates of out-of-range refrigerator temperatures with no corrective action documented, Staff I said the corrective action should have been documented. Staff I said out of range refrigerator temperatures were not acceptable. Reference WAC 388-97-1100 (3), 2980.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure the binding arbitration agreements (legal document that required the use of a third party to resolve disputes) were reviewed in a manner that explicitly informed the resident or their representative of what they were consenting to, or were understood in their entirety, for 3 of 3 residents (Residents 39, 126, & 127) reviewed for binding arbitration. This failure placed residents at risk for legal complications and a diminished quality of life. Findings included . 1) Resident 39 was admitted to the facility on [DATE]. Resident 39 signed their binding arbitration agreement on 11/25/2024. Review of the electronic health record showed Resident 39 was admitted after being in the hospital for sepsis (infection of the blood) and was re-hospitalized on [DATE] with altered mental status. During an interview on 05/07/2025 at 10:57 AM, Resident 39 was asked what their understanding of the arbitration process was, and said they did not really know. When asked if they knew they were giving up their right to litigation in a court proceeding,Resident 39 said no. When asked if they were told of their right to terminate or withdraw the agreement within 30 days of signing, Resident 39 said they did not think so. Resident 39 stated, I think maybe we went over it too quickly. I would not have signed it. They did not explain it in totality. Resident 39 explained that when they were admitted , they were getting over a urinary tract infection, had previously been hallucinating while at the hospital, and was unsure they had the mental acuity to agree to the binding arbitration agreement at that time. 2) Resident 126 was admitted to the facility on [DATE]. Resident 126's Power of Attorney (POA) signed the binding arbitration agreement on 05/05/2025. During an interview on 05/06/2025 at 3:17 PM, Resident 126's POA was asked if they understood they were giving up their right to litigation in a court proceeding and answered no. When asked what their understanding of the arbitration agreement was, Resident 126's POA said they had no idea what it involved. When asked if the arbitration agreement was explained in a way they understood, Resident 126's POA said no and stated, I want nothing to do with the arbitration agreement. 3) Resident 127 was admitted to the facility on [DATE]. Resident 127's responsible party signed the binding arbitration agreement on 04/25/2025. On 05/06/2025 at 3:25 PM, when asked who filled out their admission paperwork, Resident 127 stated, I was out of it. During an interview on 05/06/2025 at 3:37 PM, Resident 127's responsible party said they did not know what they signed and stated, I was in a state, my husband was dying for all I knew. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/2025 at 1:16 PM, Staff D, Business Office Manager, said they went over the binding arbitration agreements. When asked how they ensure the resident or representative understood the terms of the arbitration agreement, Staff D said they explained that it was mediation, that if they had a grievance it would go in front of an administrative judge, and if they did not like the result then they could go to court. Staff D said the agreement did not keep the residents from going to court, just added another step. When asked how they ensure the agreement was explained in a form or manner that accommodated the residents or his/her representative's needs, Staff D said they would change the wording, let them know it was voluntary, that it was for mediation for if they had a grievance that they wanted to sue or reach a court level decision, and that by signing the document they were giving both parties an opportunity to go before an administrative judge prior to including the court. During an interview on 05/09/2025 at 12:06 PM, Staff A, Administrator, said their expectation for staff reviewing the binding arbitration agreements was for them to be explained in a way for them to be understood. When asked what, This agreement waives the right to trial by judge or jury meant, Staff A said they (the residents/representatives) could not take it to court. When asked if it met expectations that 3 of 3 residents/representatives answered no, to if they understood they were giving up the right to litigation in a court proceeding, Staff A stated, probably not. No Associated WAC

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 42960 Based on interview and record review, the facility failed to show evidence of an ongoing, effective, comprehensive, data-driven Quality Assurance and Performance Improvement program (QAPI, a program that focused on the full range of care and services provided by the facility that included clinical care, quality of life and resident choice). The facility failed to provide evidence of documentation that demonstrated the development, implementation, and evaluation of a performance improvement activity for 1 of 1 sampled Process Improvement Projects (PIP) reviewed. The facility failed to provide evidence of the medical director participating in the QAPI program. This failure placed residents at risk for ongoing unmet care needs and a diminished quality of life. Findings included . Record review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Process effective July 2015, stated, The center pursues the highest quality of care and services for their customers through a data-driven, proactive approach to improving the quality of life, care, and services. The activities of QAPI involve members at all levels of our organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement corrective plan; and continuously monitor effectiveness of interventions. Each Center leadership team with Client Support Center is accountable for actively participating in the formalized and documented Quality Assurance and Performance Improvement (QAPI) process that includes efficient mechanisms for monitoring, revising, analyzing, documenting and improving process .The committee will be accountable to develop and implement corrective measures or, when necessary, initiate an action plan or assign a Performance Improvement Project(PIP). On 05/13/2025 at 2:22 PM, Staff A, Administrator, said she did not have sign-in sheets for the QAPI meetings or proof that the medical director attended the QAPI meetings at least quarterly. Staff A said the medical director was not local and does not always come in. Staff A was asked to provide documentation of a QAPI plan the facility was working on that had been successful for the committee and she said no, I don't have a plan. When Staff A was asked if they were working on anything currently? she said, let me think about it. And when Staff A was asked if they'd worked on anything in the past? she said, let me think about it. On 05/13/2025 at 3:08 PM, Staff A, Administrator, said she would follow up with the state agency and provide documentation of a Process Improvement Plan (PIP) within 48 hours of exit. On 05/13/2025 at 3:50 PM, Staff A provided a document titled [facility] QAPI meeting March 25, 2025. The document was sparse and did contain the relevant information. Staff A did not provide a PIP or sign-in sheets from the facility's QAPI meetings. Reference: WAC 388-97-1760 (1)(2)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on interview and record review, the facility failed to implement an Antibiotic Stewardship Program that ensured accurate and complete information (signs/symptoms) was collected monitored and/or documented on for 2 of 3 monthly infection line listings (a document that tracks resident infections) reviewed (February 2025 & April 2025). The facility also failed to implement a process for documenting on McGeer's Criteria (tool that provided criteria to show if antibiotics were indicated), that included provider notification, intervention implemented (if provider wanted to continue or stop the antibiotic and the reason for it), and an accurate list for tracking residents that did and did not meet criteria, for 1 of 1 residents (Resident 26) reviewed for McGeer's Criteria. These failures placed residents at risk for unnecessary antibiotic use, development of [NAME]-drug-resistant organisms (MDROs), and other negative health outcomes. Findings included . Review of the facility's policy titled, Antibiotic Stewardship, revised October 2019, documented the purpose of the antibiotic stewardship program was to monitor the use of antibiotics. The facility policy documented orientation, training and education of staff would emphasize the importance of antibiotic stewardship and would include how inappropriate use of antibiotics affects individual residents and the overall community. Review of the Nebraska Antimicrobial Stewardship Assessment and Promotion Program's document titled, Revised McGeer Criteria for Infection Surveillance Checklist, dated 11/05/2024, lists criteria for treatment with antibiotics. For cellulitis (a common, potentially serious bacterial skin infection), soft tissue, or wound infection, the resident must meet the following criteria: 1.Must fulfill at least 1 criterion- Pus at wound, skin, or soft tissue site. Or 2. At least four of the following new or increasing signs or symptoms: A. Heat (warmth) at affected site B. Redness (erythema) at affected site C. Swelling at affected site D. Tenderness or pain at affected site E. Serous (clear fluid) drainage at the affected site. F. At least one of the following: Fever, Leukocytosis (a high level of white blood cells in the blood), Acute change in mental status, Acute functional decline. <Failure to meet McGeer's Criteria and add to April Line Listing> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505185	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympic View Care	1116 E Lauridsen Boulevard Port Angeles, WA 98362

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 26 admitted to the facility 06/21/2020. Resident 26 had a diagnosis of Bullous Pemphigoid (a rare skin condition causing large, fluid-filled blisters). An order in the electronic health record (EHR) showed Resident 26 was prescribed an antibiotic on 03/04/2025, doxycycline, two times a day for left thigh cellulitis for 10 days. A physician progress note, dated 03/04/2025, documented Resident 26 had new redness of left thigh lesion and no other new symptoms were listed. The resident was noted to still be taking a topical steroid skin medication for skin lesions, which was instructed to not be applied to the infected lesion. Another provider progress note, also dated 03/04/2025, documented Resident 26 had new redness surrounding the left thigh lesion, without abscess (collection of pus) or lymphangitis (infection or inflammation of the lymphatic vessels) noted. Review of the March 2025 Infection Control Line Listing showed Resident 26 had an entry on 03/04/2025 for a wound infection of the left thigh. The signs and symptoms listed were serosanguinous drainage (common wound drainage that is a combination of clear watery fluid and blood, typically normal and expected during wound healing) and redness. No other symptoms were found. Review of Resident 26's vital signs showed there were no temperature readings done in 2025, the facility did not rule out if the resident had a fever on 03/04/2025. Review of McGeer's Criteria and the EHR showed Resident 26 did not meet the criteria for antibiotic treatment. A second order in the EHR showed Resident 26 was prescribed an antibiotic on 04/28/2025, doxycycline, two times a day for cellulitis of the left hand for 10 days. A physician documentation progress note, dated 04/25/2025, documented due to increased redness left hand concern? new infection. Started patient on Doxycycline, Probiotic and dose of Oxycodone QHS [every night] for pain relief. Will recheck next week and if infection improved will start short course of oral steroids. She has an appointment to see dermatologist in May. Review of McGeer's Criteria and the EHR showed Resident 26 again did not meet criteria for antibiotic treatment. Review of the April 2025 Infection Control Line Listing, showed it was missing the entry for Resident 26. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/13/2025 at 8:27 AM, Staff A, Administrator/ Infection Preventionist, was interviewed along with Staff B, Director of Nursing. When asked if McGeer's criteria was the infection assessment tool the facility used to determine if a resident required antibiotic treatment, Staff B confirmed it was. Staff B confirmed the facility was using McGeer's Criteria when a provider prescribed an antibiotic. When asked how the facility communicated McGeer's criteria to the provider when residents were not meeting criteria, Staff B said it was communicated, the decision was made by the provider to continue or discontinue the antibiotic, and their expectation was for the provider to have documented this conversation. When asked where the documentation was of McGeer's criteria being reviewed, Staff B said it would help if the provider documented that. Staff B was unable to recall any specifics regarding the two 10-day courses of antibiotics prescribed for Resident 26 or if McGeer's criteria was reviewed by the facility. When asked how the facility was meeting antibiotic stewardship for Resident 26, Staff B said she could not recall a specific conversation before the initiation of antibiotics, that there was usually a discussion had if McGeer's criteria was met or not, and that the reasoning for antibiotics should have been documented by the provider. Regarding the second course of doxycycline started on 04/28/2025 not being on the April Infection Control Line Listing, Staff B said any antibiotic started should be on the line listing. On 05/15/2025 at 2:13 PM, Additional documentation was received from Staff A, Administrator, with an Infection Screening Evaluation that can be utilized in the EHR. This screening tool was based on McGeer's or Loeb's (another clinical decision-making tool to determine if an antibiotic should be started for suspected infections) criteria. The last completed Infection Screening Evaluation found in the EHR for Resident 26 was from 2022. <Incomplete Line Listing Documentation> Review of the February 2025 line listing showed, under type of symptoms/diagnosis, the following entries lacked documentation of signs/symptoms: 1. Date of onset lists hospitalization -Type of Symptoms/Diagnosis lists Cholecystitis [inflamed gallbladder] (No signs/symptoms documented) 2. Date of onset lists hospitalization -Type of Symptoms/Diagnosis lists UTI [urinary tract infection](No signs/symptoms documented) 3. Date of onset lists 02/06/2025- Type of Symptoms/Diagnosis lists Wound Infection-continued ongoing infection (No signs/symptoms documented) 4. Date of onset lists hospitalization - Type of Symptoms/Diagnosis lists Osteomyelitis [bone and muscle infection] (No signs/symptoms documented) 5. Date of onset lists hospitalization - Type of Symptoms/Diagnosis lists UTI (No signs/symptoms documented) 6. Date of onset lists hospitalization - Type of Symptoms/Diagnosis lists Cellulitis LUE [skin infection left upper extremity] (No signs/symptoms documented) 7. Date of onset lists hospitalization - Type of Symptoms/Diagnosis lists Osteomyelitis (No signs/symptoms documented) (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Date of onset lists 02/21/2025- Type of Symptoms/Diagnosis lists Foley removal, followed by urology [tube into bladder/urinary tract and bladder specialist] (No signs/symptoms documented) 9. Date of onset lists 02/14/2025- Type of Symptoms/Diagnosis lists Went to ER (emergency room) for edema, rtn with UTI [returned with urinary tract infection] (No signs/symptoms documented) 10. Date of onset is blank- Type of Symptoms/Diagnosis is also blank, treatment was Cipro (antibiotic) started on 02/25/2025 (No signs/symptoms documented) 11. Date of onset lists 02/03/2025- Type of Symptoms/Diagnosis lists UTI- had a fall, went to hospital (No signs/symptoms documented) 12. Date of onset lists hospitalization - Type of Symptoms/Diagnosis lists Cellulitis BLE (Both lower extremities) (No signs/symptoms documented) 13. Date of onset lists hospitalization - Type of Symptoms/Diagnosis lists Sepsis [blood infection] (No signs/symptoms documented) 14. Date of onset lists hospitalization - Type of Symptoms/Diagnosis lists Cellulitis (No signs/symptoms documented) On 05/13/2025 at 8:27 AM, when asked if signs and symptoms should be tracked on the line listing, Staff B said symptoms should be documented and kept together to be tracked. No Associated WAC .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 50392 Based on interview and record review, the facility failed to have a system in place for maintaining documentation of staff screening, education, offering and current COVID-19 (a contagious disease caused by the coronavirus SARS-CoV-2) vaccination status for 12 of 12 months (May 2024 - May 2025) reviewed. These failures placed residents and staff at risk of contracting COVID-19, related complications and a diminished quality of life. Findings included . On 05/06/2025 at 1:06 PM, when asked to provide documentation of screening, education, offering and current COVID-19 vaccination status for staff, Staff A, Administrator and Infection Preventionist said they did not have any staff that agreed to take the COVID-19 vaccination. Staff A said they would talk about the importance of it, but they all had a choice. Staff A said they had last year's records, but did not have this year's records because all staff had refused the vaccination. On 05/10/2025 at 11:06 AM, Staff A was emailed a request for documentation of screening, education, offering and current COVID-19 vaccination status for 3 staff members. A subsequent email was received on 5/13/2025 at 11:45 AM, from Staff A, with an attached statement that facility staff were offered the Covid-19 vaccine, and a Vaccine Information Statement (VIS) was also attached but no staff records of screening, education, offering and current COVID-19 vaccination status was provided. Reference WAC 388-97-1320