STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Federal Way	1045 South 308th Street Federal Way, WA 98003

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50511 Based on interview and record review, the facility failed to provide adequate care in a manner that promoted dignity for 1 of 2 (Resident 31) residents reviewed for dignity, and 1 supplemental resident (Resident 16) reviewed for care conference choices. The failure to provide adequate notice prior to a care conference and honor resident's preferences left residents at risk for feelings of diminished self-worth and embarrassment. Findings included . <Facility Policy> According to the facility's revised 09/26/2024 Dignity policy, each resident had the right to be treated with dignity and respect. Interactions and activities with residents by staff would focus on maintaining and enhancing the resident's self-esteem, and self-worth and incorporate the resident's goals preferences and choices. Staff must respect the resident's individuality as well as honor the value of their input. <Resident 31> According to a 02/18/2025 Admission Minimum Data Set (MDS-an assessment tool), Resident 31 could make themselves understood and understood others in conversation. Resident 31 had a cognitive communication deficit and needed assistance with personal care due to muscle weakness and chronic pain. Review of the 02/13/2025 Mood Care Plan (CP) showed Resident 31 was at risk for changes in mood or behavior due to their medical conditions. The goals listed on the CP showed Resident 31 desired to be consulted with decisions and with participation in their care. Staff were to consult with the resident regarding their preferences for daily routines. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/11/25 at 9:22 AM Resident 31 stated they were furious with the staff because staff woke them up at 3 AM in the morning to take their vitals and again at 5 AM to ask if they had a wet diaper. Resident 31 stated they asked staff to stop waking them me up during the night, but they did not. Resident 31 stated they felt like they only had a couple nights of decent sleep since their admission to the facility, because staff kept waking them up during the night. Resident 31 stated when they asked the evening nurse for their as-needed sleep medicine so they could sleep more, the nurse on duty told them it was too late for them to receive their sleep medicine and told them they could not have it. Resident 31 stated the staff made them feel they were not respected when they asked for their medication to sleep through the night and was told they could not have it. In an interview on 03/13/2025 at 10:25 AM Resident 31 stated they put up a handwritten note on their door to stop the caregivers from waking them up. Resident 31 stated they again asked for their sleep medicine because they needed it, but the nurse would not give it to them because it was after 8 PM. In an interview on 03/17/2025 at 9:19 AM Resident 31 stated they did not like that care staff called them mama and hated when they woke them up at 5 AM in the morning and stated, mama we need to change your diaper. Resident 31 stated they felt very disrespected when the staff talked to them in this way. In an interview on 03/17/2025 at 9:30 AM Resident 31 stated they told staff on the evening shift the hallway was very loud during bedtime. Resident 31 stated they asked the staff to turn down the television volume from another resident's room however staff stated they could not make the other resident turn the volume down on their TV. Resident 31 stated they did not think this was fair to keep another resident's TV volume up during the night as other residents had a right to have quiet time during the night so they could sleep. In an interview on 03/18/2025 at 10:12 Staff E (Social Services Assistant) stated the facility was aware of the loud televisions and asked the nursing staff to help educate other residents about turning down the volume of their televisions at night, but they also had their rights. Staff E stated they could offer headphones to Resident 31 to help decrease noise but did not yet. In an interview on 03/18/2025 at 11:03 AM Staff H (Unit Care Coordinator) stated there should be designated quiet times at night for residents to sleep better and expected noise levels should go down at 10 PM. Staff H stated they needed to educate other residents and staff about honoring quiet times but did not complete this education yet. Staff H stated they expected staff to anticipate residents' needs ahead of time so they would not have to wake residents up for vitals and toileting during the night. Staff H stated the staff should respect residents and not use terms such as mama if this was not their preferred name. Staff H stated the as-needed sleep medicine did not have a designated time when it must be given, and staff should have checked with the provider first to clarify when the medicine should not be given but did not. Staff H stated the staff should have honored Resident 31's preferences for as-needed medication and to not wake Resident 31 during the night but did not. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/18/2025 at 12:31 PM Staff B (Director of Nursing) stated they would like staff to check on residents during the night to complete toileting rounds if residents were incontinent. For residents that do not want to be waken up during the night, Staff B stated staff should honor their preferences and remind the resident to call staff if they needed assistance. Staff B stated the facility should have assessed Resident 31 and completed a risk versus benefit agreement regarding the risk for skin breakdown if the staff did not wake them up during the night. Staff B stated Resident 31's preferences and risk vs benefit's agreement should have been listed on the CP but were not. 42203 <Resident 16> According to the 01/21/2025 Admission MDS, Resident 16 had intact hearing and vision and was able to be understood and understand others in conversation. The MDS showed Resident 16 had intact memory and exhibited no behaviors. According to a 01/14/2025 Admission/Readmission Note the facility's former Social Services Director documented Resident 16's family member was their support person and was interested in her being present for the care conference. According to a 01/30/2025 progress note Staff E wrote that Resident 16's collateral contact called and expressed frustration at not being in attendance at Resident 16's care conference. Resident 16's collateral contact stated they should be given ample warning about attendance and stated Resident 16 told them they would have liked to at least brush her hair and wash [their] face . The note showed Staff T spoke with Resident 16 about the situation and the resident stated they would like the facility to be more cognizant of [the resident's] space and her hygienic dignity moving forward . In an interview on 03/12/2025 at 9:28 AM Resident 16 expressed frustration regarding not being prepared for their care conference. When asked if they had any concerns with their care at the facility, Resident 16 addressed this lack of preparation. Resident 16 stated they were awoken without warning by the former Social Services Director and four other staff who announced it was time from a care conference without providing time for Resident 16 to dress and do their hair for the conference. Resident 16 stated it was undignified to not be given the opportunity to wash, dress, and do their hair prior to the care conference. In an interview on 03/18/2025 at 11:47 AM Staff E stated the former Social Services Director forgot to call Resident 16's collateral contact. Staff E stated they attended the care conference and when they entered Resident 16's room, the resident was not showered or groomed and was uncomfortable. Staff E stated, we should not have done it that way. REFERENCE: WAC 388-97-0180(1-4).

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to obtain resident consent for the Covid-19 (C19) vaccination for 4 of 5 sampled residents (Residents 8, 14, 13, & 64) reviewed for vaccinations, obtain resident consent prior to administration of psychotropic medication for 1 of 5 residents (Resident 14) reviewed for unnecessary medications, and obtain consent prior to utilization of a tilt-in-space wheelchair for 1 of 9 residents (Resident 63) reviewed for positioning and mobility. This failure placed residents at risk for loss of autonomy, entrapment, injury, and loss of the opportunity for alternative treatment options. Findings included . <Policy> According to the facility's 09/10/2024 Resident Rights policy, residents had the right to be informed in advance of the care of the care to be furnished. The policy showed residents had the right to refuse treatment. According to the facility's 09/06/2024 Physical Restraint Use policy defined a physical restraint as any device that was attached to the resident, could not easily be removed by the resident and restricted the resident's freedom of movement. The policy indicated informed consent must be obtained from the resident or their representative prior to use. According to facility policy titled, Covid-19 (SARS-CoV-2) Vaccination Program Policy for Residents, revised 11/27/2024, showed the facility would offer all residents the C19 vaccine. The policy showed the facility would educate residents or their representatives regarding the benefits and potential side effects associated with the C19 vaccine. The policy showed the resident records would include documentation that the resident was provided education regarding the benefits and potential risks associated with the C19 vaccine and documentation of the resident's consent or declination. The policy showed the facility would offer and educate all residents on the C19 vaccine each time the C19 vaccine supplies were available to the facility. According to facility policy titled, Psychotropic Medication Informed Consent, revised 09/16/2024 showed the facility would obtain consent or refusal for the use of psychotropic medications. The policy showed psychotropic medication would not be started until after approved by the resident and, if appropriate, their family and/or representative(s). <C19 vaccination consent> <Resident 8> Review of Resident 8's health records showed a 10/14/2025 Infection progress note the resident received the C19 vaccination. Resident 8's health records did not show consent was obtained for the C19 vaccine prior to administration. <Resident 14> (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 14's health records showed a 10/14/2025 Infection progress note the resident received the C19 vaccination. Resident 14's health records did not show consent was obtained for the C19 vaccine prior to administration. <Resident 13> Review of Resident 13's health records showed a 10/14/2025 Infection progress note the resident received the C19 vaccination. Resident 13's health records did not show consent was obtained for the C19 vaccine prior to administration. <Resident 64> Review of Resident 64's health records did not show they were offered the C19 vaccine for the 2024-2025 C19 booster vaccine. Resident 64's health records did not show consent was obtained for the C19 vaccination for the 2024-2025 vaccine booster. <Psychotropic Medication Consent> <Resident 14> According to a 01/23/2025 Annual Minimum Data Set (MDS - an assessment tool) Resident 14 admitted to the facility on [DATE]. The MDS showed Resident 14 had diagnoses of, but not limited to, anxiety disorder, depression, bipolar, and psychotic disorder. The MDS showed resident 14 received an antipsychotic medication during the assessment period. Review of a 12/13/2023 use of psychotropic medications Care Plan (CP) showed the facility was to administer psychotropic medications per physician orders. Review of Resident 14's health records showed a physician order on 05/24/2024 for an antipsychotic medication to be administered daily. Resident 14's health records showed consent for the antipsychotic medication was not obtained until 01/10/2025, 7.5 months after the medication was started. In an interview on 03/14/2025 at 11:05 AM Staff I (Infection Preventionist) reviewed Residents 8, 14, 13, and 64 health records for the 2024-2025 C19 vaccination consent and was unable to provide. Staff I stated they did not have documentation of consent for the C19 vaccine for Residents 8, 13, 14, or 64 but understood it should be in the resident's records. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) reviewed Resident 14's health records and stated they did not obtain Resident 14's consent for the psychotropic medication prior to initiating but should have. Staff F stated it was important to obtain consent for psychotropic medications prior to administration to ensure the resident had a say in their care and for their rights. In an interview on 03/17/2025 at 11:50 AM Staff B (Director of Nursing) stated they expected Staff I to obtain consent prior to administration of the C19 vaccine. In an interview on 03/18/2025 at 8:57 AM Staff B stated they expected staff to obtain consent for psychotropic medications prior to administering as part of the residents right to be informed. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42203 <Tilt-in-Space Wheelchair Consent> <Resident 63> According to the 01/22/25 Annual Minimum Data Set (MDS - an assessment tool) Resident 63 was cognitively intact and used a wheelchair. In an interview on 03/11/2025 at 10:55 AM Resident 63 expressed concerns about awaiting training for their wheelchair facility staff told them they would receive. Observation at that time showed Resident 63 in a tilt-in-space wheelchair (a specialized wheelchair that can adjust the positioning of a resident from upright to tilted back and cannot be adjusted by the user of the chair). Record review showed no evidence the facility obtained Resident 63's consent prior to providing the wheelchair. In an interview on 03/18/2025 at 10:36 AM 03/18/2025 at 10:30 AM Staff B stated they expected consent to be obtained prior to use of a tilt-in-space wheelchair. Staff B stated the facility should have but did not contain Resident 63's consent. REFERENCE: WAC 388-97-0260, -0200(2), -0300(3)(a).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 42203 Base on record review, and interview, the facility failed to implement a system to ensure Advanced Directives (AD) were in place for 3 (Residents 63, 14, & 77) of 7 residents reviewed for ADs. The facility failed to provide information indicating residents were informed, educated, or offered assistance to formulate an AD. This failure placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care. Findings included . <Facility Policy>According to the facility's 09/26/2024 AD Policy showed residents or their representatives would receive materials explaining their right to formulate an AD upon admission. The policy showed if a resident already had an AD, the facility's social worker would request a copy and and add it to the resident's record. <Resident 63> According to the 01/22/25 Annual Minimum Data Set (MDS - an assessment tool) Resident 63 had intact cognition and diagnoses including heart failure and a kidney condition. According to the Resident is [their] own decision maker . Care Plan (CP) Resident 63 had a goal for their AD to be honored. Record review showed no AD documentation on file for Resident 63. There was no documentation indicating Resident 63 received materials explaining their right to formulate an AD. In an interview on 03/18/2025 at 11:24 AM Staff E (Social Services Assistant) stated they did not see an AD on file for Resident 63. Staff E stated either an AD should be in place for Resident 63 or there should be evidence the resident's right to formulate an AD was explained to them. 47836 <Resident 14> According to a 01/23/2025 Annual MDS Resident 14 had moderate memory impairment. The MDS showed Resident 14 had diagnoses of, but not limited to, a drop in blood pressure with change in position and high cholesterol. In an interview on 03/12/2025 at 9:37 AM Resident 14 stated they did not have an advanced directive, and the facility did not offer to assist them in obtaining one. Review of Resident 14's health records showed no AD documentation. Resident 14's records showed no documentation indicating they received materials explaining their right to formulate an AD. <Resident 77> (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 11/05/2024 Admission MDS Resident 77 had moderate memory impairment. The MDS showed Resident 77 had diagnoses of, but not limited to, Diabetes (unstable blood sugar levels) and Parkinson's (a degenerative neurological disorder). Review of Resident 77's health records showed no AD documentation. Resident 77's records showed no documentation indicating they received materials explaining their right to formulate an AD. In an interview on 03/17/2025 at 1:52 PM Staff E stated Resident 14 and 77 did not have documentation in their records indicating their right to formulate an AD was ever discussed or reviewed with them. Staff E stated it was important to help all residents in formulating an AD so their wishes could be carried out if/when they were unable to speak for themselves. In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected staff to discuss and provide assistance in formulating an AD with all residents upon admission and review quarterly with each care conference. REFERENCE: WAC 388-97-0280(3)(c)(i-ii), -0300(1)(b)(3)(a-c).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review the facility failed to ensure a safe, clean, and comfortable environment was provided to residents. Facility failure to keep rooms free of wall gouges, room furniture in good repair, and hot water at a comfortable temperature for 2 of 4 units (Units 400 & 100) left residents at risk for a less-than-homelike environment. Findings included . <Policy> According to a facility policy titled, Resident Belongings and Home Like Environment, revised 06/12/2024, the facility would provide a safe, clean, comfortable, and homelike environment. <room [ROOM NUMBER]> Observations on 3/11/2025 at 1:54 PM showed room [ROOM NUMBER] had deep gouges and exposed drywall on the wall behind the head of the resident bed. <room [ROOM NUMBER]> Observations on 03/17/2025 at 9:40 AM showed room [ROOM NUMBER] had deep gouges and exposed drywall on the wall behind the head of the resident bed. <room [ROOM NUMBER]> In an interview on 03/18/2025 at 10:00 AM Resident 43 stated they told the facility the water in their bathroom sink was always too cold and they had to wait at least 5 minutes for the water to get warm. In an interview on 03/18/25 at 12:43 PM Staff Y (Maintenance Director) stated staff were to notify maintenance staff on all issues in the rooms and their job was to keep the facilities homelike for residents. 47836 <room [ROOM NUMBER]-1> Observation on 03/18/2025 at 12:43 PM showed gouges on the wall at the head of the bed and on the right side of the bed. <room [ROOM NUMBER]-2> Observation on 03/18/2025 at 12:43 PM showed the nightstand with trim across the front ripped off with exposed rough wood. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<room [ROOM NUMBER]-2> Observation on 03/18/2025 at 12:43 PM showed gouges on the wall at the head of the bed. In an interview on 03/18/2025 at 12:43 PM Staff Y stated it was their job to maintain a homelike environment for the residents. Staff Y stated they were unaware of the repairs needed to rooms 410, 412, 106, and 110. Staff Y stated they depended on floor staff to notify maintenance in their communication book when repairs were needed but these issues had not been bought to the attention of the maintenance department. REFERENCE: WAC 388-97-0880.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on interview and record review, the facility failed to ensure a system by which residents/representatives received required written notice at time of transfer/discharge, or as soon as soon as practicable and ensure a system by which the office of the State Long-Term Care Ombudsman (LTCO - an advocacy group for individuals residing in nursing homes) received required resident transfer/discharge information for 2 of 3 residents (Residents 8 & 69) reviewed for hospitalization s. Failure to ensure written transfer notifications were provided to residents and/or their representatives, in a language and manner they understood, placed residents at risk for not having an opportunity to make an informed decision about the transfer/discharge. The failure to ensure required notifications were completed, prevented the LTCO office the opportunity to educate residents and advocate for them regarding the discharge process. Findings included . <Policy> According to a facility policy titled, Notice of Transfers and Discharges, revised 10/29/2024, the facility would notify the resident and/or representative of the reason for transfer as soon as practicable before transfer or discharge. The policy showed the reason for transfer or discharge, the date of transfer/discharge, the location to which the resident was transferred, and a statement of the residents appeal rights including the contact information and information on how to obtain an appeal form and assistance in completing the form would be included within the notice form. The policy showed a copy of the notice form would be sent to the LTCO. <Resident 8> According to a 12/24/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 8 had no memory impairment. The MDS showed Resident 8's most recent reentry into the facility was on 08/08/2024. Review of Resident 8's health records showed they were hospitalized on [DATE]. Resident 8's health records did not contain documentation of written transfer notifications being provided to the resident. In an interview on 03/12/2025 at 1:44 PM Resident 8 stated they went to hospital on 08/04/02024 for respiratory symptoms. Resident 8 stated they did not receive written transfer notification for the transfer. <Resident 69> According to a 02/11/2025 Admission MDS Resident 69 had moderate memory impairment. The MDS showed Resident 69's representative participated and assisted in the assessment. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 69's health records showed they were hospitalized on [DATE]. Resident 69's health records did not contain documentation of written transfer notifications being provided to the resident. In an interview on 03/11/2025 at 10:09 AM Resident 69's family member stated Resident 69 went back to hospital on 02/24/02025. Resident 69's representative stated they did not receive written transfer notification for the transfer. In an interview on 03/17/2025 at 1:52 PM Staff E (Social Service Assistant) stated the social service department did not provide the required written transfer notice to residents or notify the LTCO of resident transfers. In an interview on 03/17/2025 at 2:00 PM Staff F (Unit Care Coordinator) stated they did not have residents or representatives sign that they received a copy of the written transfer notification form for the transfer. Staff F stated they understood the form should be provided to the resident/representative, so they knew their rights related to the transfer/discharge. In an interview on 03/17/2025 at 2:31 PM Staff A (Regional [NAME] President) stated it was the social service departments responsibility to provide written notice of transfer to the resident and/or representative and notify the LTCO about the transfer/discharge. REFERENCE: WAC 388-97-0140(1)(a-c)(i-iii).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Federal Way	1045 South 308th Street Federal Way, WA 98003

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on record review and interview, the facility failed to provide the resident and/or the representative a written notice of the facility's bed hold policy, at the time of transfer or within 24 hours, for 3 of 3 residents (Residents 8, 69, & 64) reviewed for hospitalization s. This failure placed residents and their representatives at risk of not being informed of their right to, and the cost of, holding the residents bed while hospitalized that was necessary for decision making. Findings included . <Policy> According to a facility policy titled, Bed-Hold, revised 09/05/2024, the facility would give the resident a copy of the facilities bed hold policy upon transfer or within 24 hours of transfer. The policy showed documentation of providing the bed hold policy would be in the residents records for each transfer/discharge. <Resident 8> According to a 12/24/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 8 had no memory impairment. The MDS showed Resident 8's most recent reentry into the facility was on 08/08/2024. Review of Resident 8's health records showed they were hospitalized on [DATE]. Resident 8's health records did not contain documentation of written notification of the facility's bed hold policy being provided to the resident for this transfer. In an interview on 03/12/2025 at 1:44 PM Resident 8 stated they went to hospital on 08/04/02024 for respiratory symptoms. Resident 8 stated they did not receive written notification of the facility's bed hold policy for the transfer. <Resident 69> According to a 02/11/2025 Admission MDS Resident 69 had moderate memory impairment. The MDS showed Resident 69's representative participated and assisted in the assessment. Review of Resident 69's health records showed they were hospitalized on [DATE]. Resident 69's health records did not contain documentation of written notification of the facility's bed hold policy being provided to the resident. In an interview on 03/11/2025 at 10:09 AM Resident 69's family member stated Resident 69 went back to hospital on 02/24/02025. Resident 69's representative stated they did not receive written notification of the facility's bed hold policy for the transfer. <Resident 64> (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 12/13/2024 Annual MDS Resident 64 had no memory impairment. The MDS showed Resident 64 had an indwelling urinary catheter. Review of Resident 64's health records showed they were hospitalized on [DATE]. Resident 64's health records did not contain documentation of written notification of the facility's bed hold policy provided to Resident 64 and/or their representative a time of the transfer. In an interview on 03/12/2025 at 10:30 AM Resident 64 stated they went back to hospital on 03/21/02024 for their urinary catheter. Resident 64 stated they did not receive written notification of the facility's bed hold policy for the transfer. In an interview on 03/17/2025 at 1:52 PM Staff E (Social Service Assistant) stated the social service department did not provide the required written notice of the facility's bed hold policy to residents and/or their representative at the time of transfers. In an interview on 03/17/2025 at 2:00 PM Staff F (Unit Care Coordinator) stated they did not have Resident's 8, 69, or 64, or their representatives sign that they received a copy of the facility's bed hold policy at time of transfers. Staff F stated it was important to ensure the residents were notified of the bed hold policy with each transfer so the facility would hold their bed until they returned if they so wished, and the resident was aware of the associated costs to hold their bed. In an interview on 03/17/2025 at 2:31 PM Staff B (Director of Nursing) stated they expected nurses to provide a copy of the facility's bed hold policy to the resident and/or representative at time of transfer and retain documentation of doing so in the resident's records as required. Staff B stated it was important to ensure the resident was notified of their rights to hold the bed and the cost of holding the bed. REFERENCE: WAC 388-97-0120(4).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 50511 Based on interview and record review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR - a mental health screening required prior to nursing home admission) evaluation was completed and/or incorporated into the Care Plan (CP) for 2 of 8 residents (Residents 26, 43) reviewed for PASRR. This failure placed residents at risk for unmet mental health care needs, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's revised 09/24/2024 PASRR policy the facility would ensure potential admissions were screened for possible Serious Mental Illness (SMI) or Intellectual Disabilities (ID). A positive Level I screening required an in-depth evaluation by the state authority, known as a PASRR Level II. The PASRR process required the facility to notify the appropriate state mental health authority when a resident with a mental disorder or intellectual disability had a significant change in their physical or mental condition. The policy showed recommendations from the PASRR Level II determination and PASARR evaluation report would be incorporated into the person-centered CP as well as in transitions of care. <Resident 26> According to the 09/06/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 26 had non-Alzheimer's dementia, depression, and history of a stroke. Review of the revised 10/20/2024 Behavior CP showed Resident 26 had behavior problems towards staff and staff were to provide care in pairs, monitor for behavior and interference with care, and approach carefully. Review of the 04/14/2021 Mood CP showed Resident 26 had the potential to be verbally aggressive related to mental and emotional illness related to having a stroke. Staff were to intervene before agitation escalated and if Resident 26 was aggressive, staff were to calmly walk away. Review of progress notes from 09/16/2024, 10/13/2024, and 11/08/2024 showed Resident 26 dug their fingernails into the nursing aide's arms during care, made racial slurs, and scratched or called staff names. Review of a 01/22/2025 progress note showed Resident 26 had behaviors that included verbal and physical aggression, resistance to care, and inappropriate communication with male staff. Record review showed a 04/02/2021 Level I PASRR screening on file showing Level II services were not required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an 11/03/2024 progress note showed the Social Services Director documented they sent for Level II PASRR review. There was no documentation found in the medical record that showed a Level II referral was made to address Resident 26's changes in condition. <Resident 43> According to the 12/3/2024 Annual MDS, Resident 43 had non-Alzheimer's dementia, anxiety, depression and Post-Traumatic Stress Disorder (PTSD). Review of the 01/24/2024 psychosocial CP showed Resident 43 had a psychosocial wellbeing problem related to depression, anxiety, and PTSD. Staff were to provide behavioral health consults as needed and administer medications as ordered. Record review showed an 08/24/2024 Level I PASRR screening on file that showed a Level II evaluation referral was required for Resident 43. Documentation in the record did not show a Level II referral was made for Resident 43. In an interview on 03/18/2025 at 10:02 AM Staff E (Social Services Assistant) stated they were aware that PASSRs needed to be reviewed, but because the social services department was understaffed, they were not able to review and complete PASSR II screenings. Staff E stated they knew the importance of PASSR Level II referrals and stated these were needed so mental health needs could be attended to. Staff E stated the facility was not currently working on PASSR Level II referrals and did not have a process in place to update PASSR screenings for residents with changes of condition. In an interview on 03/18/2025 at 12:47 PM Staff A (Regional [NAME] President) stated it was important that PASSR screenings be completed and updated to help screen for appropriate levels of care and appropriate mental health resources. Staff A stated PASSR screenings for changes of condition should be done and PASRR Level II referrals should be made but was not. REFERENCE: WAC 388-97-1915(2)(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** 47836 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were completed for 2 of 6 residents (Resident 64 & 69) reviewed for PASRR screening. The failure to ensure PASRR screening was complete and accurate left residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . <Policy> According to a facility policy titled, Pre-admission Screening and Resident Review, revised 09/26/2024, showed if a level I PASRR indicated Serious Mental Illness (SMI), a level II PASSR referral to the state designated authority would be made prior to admission to the facility. <Resident 64> According to a 12/13/2024 Annual Minimum Data Set (MDS- an assessment tool) Resident 64 admitted to the facility on [DATE]. The MDS showed Resident 64 had diagnoses of, but not limited to, anxiety disorder and depression. Review of Resident 64's health records showed they had SMI indicators of mood and anxiety disorders on the 01/12/2024 PASRR level I but no level II evaluation was indicated because the person does not show indicators of SMI. <Resident 69> According to a 02/11/2025 Admission MDS Resident 69 admitted to the facility on [DATE]. The MDS showed Resident 69 had diagnoses of, but not limited to, dementia, depression, and bipolar. Review of Resident 69's health records showed a 05/09/2024 PASRR level I with SMI indicators and a PASRR level II referral was required for the SMI indicators. The 05/09/2024 PASRR level I was completed at a sister facility before Resident 69 was transferred to the current facility on 02/05/2025. Resident 69's health records showed no PASRR level II or referral for the level II. In an interview on 03/17/2025 at 1:52 PM Staff E (Social Service Assistant) stated Resident's 64 was not referred for a level II PASRR but should have been since they had SMI indicators on the level I PASRR. Staff E stated Resident 69's PASRR I from the sister facility should have been reviewed for accuracy and completion at time of transfer but it was not. Staff E stated they did not have a PASRR level II referral for Resident 69. Staff E stated it was important to complete the PASRR process on all residents accurately to ensure the residents received the mental health services they needed or would benefit from. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/18/2025 at 11:14 AM A (Regional [NAME] President) stated if a resident had a SMI or SMI was marked on the PASRR level I, they expected social services to submit a PASRR level II referral and retain documentation of doing so in the resident's records, to ensure residents received necessary mental health services and care. REFERENCE: WAC 388-97-1915(1)(2)(a-c)(4).

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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** 42203 Based on observation, interview, and record review the facility failed to ensure residents' Care Plans (CPs) were comprehensive and implemented for 6 of 18 (Residents 139, 63, 6, 8, 69, & 14) sample residents whose CPs were reviewed. This failure placed residents at risk for unmet care needs, frustration, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 09/11/2024 Comprehensive Care Plans and Revisions policy, the facility would develop a comprehensive CP for each resident within seven days of completion of a comprehensive assessment. <Resident 139> According to the 03/04/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 139 required substantial/maximal assistance with bathing and had a moderate memory impairment. The MDS showed Resident 139 admitted to the facility on [DATE]. The MDS showed Resident 139 had a highly transmissible gastrointestinal infection that required isolation. Review of the 02/27/2025 ADL Assistance . CP included a goal for Resident 139 to return to their former level of comfort. This CP included no directions addressing Resident 139's bathing needs. No other CP was developed to address Resident 139's needs related to bathing. In an interview on 03/17/2025 at 2:23 PM Staff H (Unit Care Coordinator) reviewed Resident 139's CP. Staff H stated the CP did not but should address Resident 63's needs and preferences related to bathing type and frequency but did not. <Resident 63> According to the 01/22/2025 Annual MDS Resident 63 had intact memory and diagnoses including heart failure, weakness, and a history of a traumatic fracture. The MDS showed Resident 63 used a manual wheelchair. Observation on 03/11/2025 at 10:55 AM showed Resident 63 sitting on a tilt-in-space wheelchair (a specialized wheelchair that can adjust the positioning of a resident from upright to tilted back and cannot be adjusted by the user of the chair.) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed the 02/21/2024 Resident at risk for falls . Care Plan (CP) Resident 63 included a 02/26/2024 intervention for a DEVICE: TILT-N-SPACE [wheelchair] while out of bed to assist with proper positioning, pressure relief and comfort. There were no other directions in Resident 63's CP regarding the purpose or proper use of the tilt-in-space wheelchair. There were no other CPs developed showing how and when to use the chair, or how much if at all, and for how long to tilt Resident 63 when seated in the chair. In an interview on 03/18/2025 08:51 AM Staff B (Director of Nursing) stated it was important for CPs to comprehensively address each resident's care needs. <Resident 6> According to the 12/31/2024 Quarterly MDS Resident 6 had diagnoses including an obstructive breathing condition and heart failure. The MDS showed Resident 6 used oxygen therapy. Record review showed a 02/14/2024 physician's order for oxygen at two liters per minute via nasal cannula (tubing that delivers supplemental oxygen directly to the nostrils) to keep Resident 6's oxygen saturation (the amount of oxygen in the blood) above 90%. The order showed if Resident 6 was in respiratory distress the oxygen rate could be increased to 3 liters per minute. According to the 09/16/2024 resident has heart failure CP staff should provide oxygen via nasal prongs at two liters per minute. This CP did not reflect the 02/14/2024 order's direction to provide oxygen at three liters when needed. According to the 12/01/2022 resident has oxygen therapy . CP directed staff to observe for signs and symptoms if respiratory distress and provide reassurance and allay anxiety . and stay with the resident during episodes of respiratory distress. This CP did not direct staff to provide oxygen at three liters per minute when the resident had respiratory distress. In an interview on 03/18/2025 08:51 AM Staff B stated it was important for the CP to reflect the physician's orders and for the CP to be comprehensive. 47836 <Resident 8> According to a 12/24/2024 Annual MDS Resident 8 had no memory impairment. The MDS showed Resident 8 had no bed rails used with their bed. Review of Resident 8's records showed a 01/23/2023 evaluation for use of bed rails indicating quarter bed rails were recommended for Resident 8. Resident 8's health records showed no CP developed for the quarter bed rails. Observation on 03/12/2025 at 2:08 PM showed bilateral quarter bed rails to Resident 8's bed. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) stated Resident 8 did not have a CP for the bilateral quarter bed rails used to their bed. Staff F stated it was important to have a bed rail CP so staff would know to monitor for safety concerns related to the bed rail use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 69> According to a 02/11/2025 Admission MDS Resident 69 had moderate memory impairment. The MDS showed Resident 69 had no restraints used on their bed. Observation and record review on 03/11/2025 at 10:20 AM showed 69's left side of bed against the wall. Review of Resident 69's records showed no CP for the left side of their bed against the wall. In an interview on 03/17/2025 at 8:28 AM Staff F stated Resident 69 did not have a CP for their left side of bed against the wall but should. Staff F stated it was important to have a CP for Resident 69's bed against the wall, so staff knew to monitor for safety concerns such as entrapment. In an interview on 03/18/2025 at 8:57 AM Staff B stated they expected staff to develop and implement a CP for the use of bed rails and bed against the wall. Staff B stated it was important to develop a CP if bed rails or a bed against the wall was a part of their care, so staff were aware for safety measures. <Resident 14> According to a 01/23/2025 Annual MDS Resident 14 had moderate memory impairment. The MDS showed Resident 14 had diagnoses of but not limited to, neuropathy and blindness in one eye. Review of Resident 14's health records showed a 02/26/2025 physician order for an Antidiabetic medication. Resident 14's health records showed no CP for Diabetes. In an interview on 03/17/2025 at 8:28 AM Staff F stated Resident 14 was being treated for prediabetes and should have a Diabetes CP but did not. Staff F stated it was important to include the Diabetes in Resident 14's CP, so staff knew how to care for the resident. In an interview on 03/18/2025 at 11:21 AM Staff C (Regional Director of Clinical Services) stated they expected staff to develop and implement a CP for Residents with Prediabetes. Refer to F658 Services Meet Professional Standards. Refer to F700 Bedrails. REFERENCE: WAC 388-97-1020(1)(2)(a)(b).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to facilitate quarterly care conferences for 5 of 8 residents (Resident 63, 77, 8, 14, & 64) reviewed for care planning, and failed to ensure Care Plans (CPs) were revised as required for 1 of 19 samples residents (Resident 80). Theses failures placed residents at risk for unmet care needs, unnecessary care, frustration, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 09/05/2024 Comprehensive Care Plans and Conferences policy, the facility would ensure each resident, and their representative if applicable, would be involved in developing the CP. The policy showed the facility had a responsibility to assist residents to engage in the care planning process by holding the care conference at the time of day when the resident functioned best, and to encourage the resident's representative to participate in the care planning and attend the care conference. The policy showed CPs should be reviewed and revised after each MDS assessment (MDS assessments occur at a minimum on a quarterly basis). <Care Conferences> <Resident 63> According to the 01/22/2025 Annual Minimum Data Set (MDS - an assessment tool) Resident 63 had intact memory. The MDS showed it was very important to Resident 62 to be able to take care of their personal belongings, choose their bedtime, have books, newspapers, and magazines to read, and keep up with the news. In an interview on 03/12/2025 at 1:38 PM Resident 63 stated they did not recall attending any recent care conferences. Resident 63 stated they would like to participate. Record review showed an 11/13/2024 progress note showing a former Social Services Director invited Resident 63 to a care conference. The note showed Resident 63's physician, and a Resident Care Manager also attended. There was no evidence Resident 63 participated in a more recent care conference. In an interview on 03/18/2025 at 11:27 AM Staff E (Social Services Assistant) stated the reason Resident 63 did not attend a more recent care conference was the facility was currently without a Social Services Director. Staff T stated Resident 63 should have been but was not provided the opportunity to participate in their care planning. 47836 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 77> According to a 11/05/2025 Admission MDS Resident 77 had a moderate memory impairment. The MDS showed it was very important to Resident 77 to choose bathing preferences, have family involved in discussions about their care, and do things with groups of people. Review of Resident 77's health records showed a baseline CP was completed on 10/31/2024 with no further documentation of care conferences being held. In an interview on 03/11/2025 at 1:32 PM Resident 77 stated they had not had a care conference while at the facility. <Resident 8> According to a 12/24/2024 Annual MDS Resident 8 had no memory impairment. The MDS showed Resident 8 admitted to the facility on [DATE]. The MDS showed it was very important to Resident 8 to choose bathing preferences, choose own bedtime, have family involved in discussions about their care, and do their favorite activities. Review of Resident 8's health records showed a baseline CP was conducted on 01/24/2023 with no further documentation of care conferences being held. In an interview on 03/12/2025 at 1:25 PM Resident 8 stated they couldn't remember the last time they had a care conference. <Resident 14> According to a 01/23/2025 Annual MDS Resident 14 had moderate memory impairment. The MDS showed Resident 14 admitted to the facility on [DATE]. Review of Resident 14's health records showed a baseline CP was conducted on 06/17/2022 with no further documentation of care conferences being held. In an interview on 03/12/2025 at 9:12 AM Resident 14 stated they had not had a care conference since being in the facility. <Resident 64> According to a 12/13/2024 Annual MDS Resident 64 had no memory impairment. The MDS showed Resident 64 admitted to the facility on [DATE]. Review of Resident 64's health records showed a baseline CP was conducted on 01/13/2024 with no further documentation of care conferences being held. In an interview on 03/12/2025 at 10:16 AM Resident 14 stated they had not had a care conference since being in the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/17/2025 at 1:52 PM Staff E reviewed Resident 77, 8, 14, and 64's health records stating they had not had care conferences per policy and regulations. Staff E stated they were expected to conduct a care conference within 48 hours of admission and then quarterly and as requested by the resident or representative. Staff E stated a care conference included the resident and their representative, social services, nurse manager, rehab director if the resident was receiving therapy services, activities department, and dietary manager. Staff E stated it was important to conduct care conferences per regulation to ensure the resident and care team were all on the same page regarding the resident's care and the residents' goals were included in their plan of care. In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected staff to hold care conferences with residents within 48 hours of admission, quarterly, and upon resident/representative request. 50511 <Care Plan Revision> <Resident 80> According to the 01/28/2025 Admission MDS Resident 80 had diagnoses including depression, muscle weakness, and a cognitive communication deficit. The MDS showed Resident 80 was dependent on staff for eating. Review of 02/04/2025 Eating CP showed staff were to provide Resident 80 with one-on-one assistance with eating. Interview on 03/11/2025 at 2:37 PM Resident 80 stated they lost weight, and they had a hard time of keeping food down when they ate. Interview on 03/18/2025 at 9:26 AM Resident 80 stated they ate their breakfast and fed themselves during meals. Resident 80 stated staff did not help them to eat. In an interview on 03/18/2025 at 9:44 AM Staff EE (Certified Nursing Assistant) stated staff assisted Resident 80 with eating, but it depended on Resident 80's mood. In an interview on 03/18/2025 at 10:53 AM Staff H (Unit Care Coordinator) stated Resident 80 often refused to eat but could feed themselves and did not need assistance. In an interview on 03/18/2025 at 12:28 PM Staff B stated the CP needed to be updated once Resident 80's one-on-one eating assistance needs changed, but was not. REFERENCE: WAC 388-97-1020(2)(c)(d), (4)(c)(i-ii).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to ensure physician orders were clarified for 3 of 5 sampled residents (Residents 8, 14, & 13) reviewed for unnecessary medications, and failed to ensure residents with multiple as-needed (PRN) pain medications had parameters to their orders for 3 of 5 residents (Residents 13, 14, & 8) reviewed for pain. These failures placed residents at risk for ineffective treatments, unmet pain management needs, overmedication, medications errors, and delayed treatment. Findings included . <Clarifying Orders> <Resident 8> According to a 12/24/2024 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 8 had no memory impairment. The MDS showed Resident 8 admitted to the facility on [DATE]. The MDS showed Resident 8 had no bed rails in use on their bed. Review of Resident 8's health records showed a 01/23/2023 evaluation for use of bed rails documenting the use of bilateral quarter bed rails to Resident 8's bed. Resident 8's health records showed no physician order for the bilateral quarter bed rails. An observation on 03/12/2025 at 2:08 PM showed bilateral quarter bed rails to Resident 8's bed. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) stated Resident 8 did not have a physician order for the bilateral bed rails but should. In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected staff to obtain a physician order for the use of bed rails. <Resident 14> According to a 01/23/2025 Annual MDS Resident 14 had moderate memory impairment. The MDS showed Resident 14 admitted to the facility on [DATE]. Review of Resident 14's health records showed a 01/30/2025 lab value indicative of Prediabetes (blood sugar levels above normal). Resident 14's health records showed a 02/27/2025 physician order for an antidiabetic medication. Resident 14's health records showed no physician order to monitor for signs and symptoms of low or high blood sugar levels. In an interview on 03/17/2025 at 8:28 AM Staff F reviewed Resident 14's health records and stated they should have a physician order to monitor for signs and symptoms of a low or high blood sugar level for the prediabetes but did not. Staff F stated it was important to monitor for signs and symptoms of low or high blood sugar levels when someone is prediabetic to ensure safe blood sugar levels are maintained for the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 13> According to a 10/18/2024 Annual MDS Resident 13 reentered the facility on 05/17/2022. The MDS showed Resident 13 had diagnoses of, but not limited to, Diabetes (unstable blood sugar), chronic pain syndrome, and hyperlipidemia (elevated blood cholesterol levels). The MDS showed Resident 13 experienced severe pain frequently that affected their sleep and their day-to-day activities. The MDS showed Resident 13 experienced severe pain frequently that affected their sleep and their day-to-day activities. Review of Resident 13's health records showed an 11/11/2024 physician order for a medication that lowered cholesterol levels and a 10/25/2024 physician order for a high dose supplement to be administered weekly. Residents 13's health records showed no physician order to monitor the resident for signs and symptoms of low/high blood sugar levels for their diabetes diagnosis. Resident 13's health records showed no documentation of blood levels for the two medications that affected the resident's blood sugar or lipid levels. In an interview on 03/17/2025 at 8:28 AM Staff F reviewed Resident 13's health records and stated they should have a physician order to monitor for signs and symptoms of a low or high blood sugar level, have lab results showing the blood levels for the two medications that affected their blood sugar and lipid levels but did not. Staff F stated it was important to monitor for signs and symptoms of low or high blood sugar levels when someone is diabetic to ensure safe blood sugar levels are maintained for the resident. Staff F stated it was important when starting a medication that affected the blood levels, to know what the residents blood levels were to ensure they needed the medication, and they were receiving the appropriate dose if they did need it. In an interview on 03/18/2024 at 11:21 AM Staff C (Regional Director of Clinical Services) stated they expected staff to obtain a physician order for blood sugar notification parameters of low/high blood sugar levels and to monitor for signs and symptoms of a low or high blood sugar level in residents receiving antidiabetic medications or with a diagnosis of prediabetes/diabetes. Staff C stated they expected staff to implement a Care Plan (CP) when a resident had a diagnosis of prediabetes/diabetes. Staff C stated if a resident received a medication that affected blood levels that a lab would be obtained documenting the residents initial blood level to support administration of the medication. <Pain Medication Parameters> <Resident 13> Review of Resident 13's health records showed an 11/08/2024 Pain CP with a goal the resident would not have interruptions in normal activities. Resident 13's health records showed orders for two different pain medications as needed without any parameters for administration in place. In an interview on 03/17/2025 at 8:28 AM Staff F stated Resident 13's pain medication orders did not have parameters in place for administration but should. Staff F stated it was important to include parameters to ensure staff were not overmedicating or under-medicating a resident for their pain level and implement nonpharmacologic pain interventions. <Resident 14> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 01/23/2025 Annual MDS Resident 14 received scheduled pain medication but did not receive nonpharmacological pain interventions or as needed pain medications. The MDS showed Resident 14 experienced a 10 out 10 pain level on the Numeric Pain Scale almost constantly. The MDS showed the pain Resident 14 experienced frequently affected their sleep and their day-to-day activities. The MDS showed Resident 14 had diagnoses of, but not limited to, a disease of muscle or muscle tissue and peripheral nerve damage with nerve pain. Review of Resident 14's health records showed a 06/05/2024 Pain CP with a goal the resident would not have interruptions in normal activities. Resident 14's health records showed orders for a narcotic pain medication as needed without any parameters in place or implementation of nonpharmacologic interventions. In an interview on 03/17/2025 at 8:28 AM Staff F stated Resident 14 did not have pain medication parameters for their as needed narcotic pain medications but should. Staff F stated it was important to have parameters in place for Resident 14's narcotic pain medication to ensure they weren't overmedicating the resident when narcotic medication wasn't needed. Staff F stated it was important to try nonpharmacologic interventions for pain relief. <Resident 8> According to a 12/24/2024 Annual MDS Resident 8 received scheduled and as needed pain medication but did not receive nonpharmacological pain. The MDS showed Resident 8 experienced a 6 out of 10 pain level on the numeric pain scale frequently. The MDS showed the pain Resident 8 experienced occasionally affected their sleep and their day-to-day activities. The MDS showed Resident 8 had diagnoses of, but not limited to, restless leg syndrome. Review of Resident 8's health records showed an 07/08/2024 at risk for pain CP with intervention to evaluate the effectiveness of pain interventions. Resident 8's health records showed orders an order that an acceptable level of pain for the resident was a 4 out 10. Resident 8's records included orders for three different pain medications as needed without any parameters in place. Resident 8's records showed no orders for nonpharmacological pain interventions. In an interview on 03/17/2025 at 8:28 AM Staff F stated Resident 8's pain medications did not have parameters in place, and they did not have orders for nonpharmacological pain interventions but should. Staff F stated it was important to have the pain medication parameters in place for Resident 8's pain medication so staff would administer the mild, non-narcotic pain medications for pain levels 1-5 out of 10 and the stronger narcotic pain medications for pain levels 6-10. Staff F stated it was important to have nonpharmacological pain interventions in place because sometimes repositioning or other nonpharmacological interventions may help for the resident's discomfort and medications would not be necessary. In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected pain medication orders to include parameters and nonpharmacological pain interventions. Staff B stated it was important to ensure staff were medicating residents pain levels appropriately. Refer to F656 - Implement Care Plan. Refer to F700 - Bedrails. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFERENCE: WAC 388-97-1620(2)(b)(ii).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to provide necessary care and services for 1 of 1 resident (Resident 77) reviewed for communication. Failure to provide communication assistance for residents where English was a second language placed residents at risk of miscommunication, unmet care needs, and quality of care. Findings included . <Policy> According to a facility policy titled, Language Access Services and Effective Communication, revised 01/07/2025, the facility would ensure residents, where English was not their primary language, would have access to interpreters/translators and other aides needed without cost. <Resident 77> According to an 11/05/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 77 admitted to the facility on [DATE]. The MDS showed Resident 77's preferred language was their primary language. The assessment showed Resident 77 needed an interpreter to communicate with the doctor and health care staff. Review of an 11/08/2024 communication problem related to language barrier . Care Plan (CP) Resident 77 spoke limited English, and their primary language was birth language. The CP showed staff would observe for effectiveness of assistive devices for communication. The CP showed the translators phone number would be posted in Resident 77's room. The CP showed staff were to provide translation services to communicate with Resident 77 so the resident would be able to make their basic needs known. Observation and interview on 03/11/2025 at 1:53 PM Resident 77 stated their primary language was not English. Resident 77 stated they would ask staff for help sometimes and when the staff didn't understand them, they would walk away and not respond to their request. Resident 77 stated they were unaware of translation assistance or devices to assist them in communication with staff. Observation at this time showed no communication assistive devices in Resident 77's room and no translator services phone number posted for the resident. Resident 77 opened all drawers in room to show they had not received any communication assistive devices. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) stated they had not provided Resident 77 with communication boards or the translators phone number as the CP instructed but should have. Staff F stated it was important to provide residents communication assistive devices when English was a second language to ensure they could make themselves understood and understand others. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected staff to provide communication boards with pictures related to basic needs to residents when English was not their primary language. Staff B stated they expected staff to provide the translation services phone number to residents that needed those services for communication. Staff B stated it was important to ensure good communication between the resident and staff to guide their care and ensure they're meeting the residents needs. REFERENCE: WAC 388-97-1060(2)(a)(v).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL - bathing etc.) to residents dependent on staff assistance for 1 (Resident 139) of 5 residents reviewed for ADL. The failure to provide bathing assistance to residents placed residents at risk for poor hygiene, skin breakdown, and feelings of diminished self-worth. <Facility Policy> According to the facility's 09/10/2024 ADL policy showed residents unable to perform their own ADL would receive the necessary assistance to maintain good grooming, and personal hygiene. <Resident 139> According to the 03/04/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 139 required substantial/maximal assistance with bathing and had a moderate memory impairment. The MDS showed Resident 139 admitted to the facility on [DATE]. The MDS showed Resident 139 had a highly transmissible gastrointestinal infection that required isolation. According to the 02/27/2025 bathing preferences form Resident 139 preferred a bed bath in the morning twice a week. The form indicated Resident 139 required maximal assistance with bathing. Review of the 02/27/2025 ADL Assistance . Care Plan (CP) included a goal for Resident 139 to return to their former level of comfort. This CP included no directions addressing Resident 139's bathing needs. There was no other CP addressing Resident 139's need for bathing assistance. Review of the bathing records showed from the date of admission, 02/27/2025 through 03/17/2025 (18 days) Resident 139 received only one bed bath on 03/08/2025 with only one documented refusal of bathing on 03/07/2025. In an interview on 03/12/2025 at 10:29 AM Resident 139 stated they wanted assistance with bathing. Resident 139 showed their fingernails were long and soiled and stated they needed help to trim them. In an interview on 03/17/2025 at 2:23 PM Staff X (LPN) stated it was important to provide bathing assistance to residents who needed assistance. Staff X reviewed the bathing records and stated Resident 139 did not receive the bathing assistance they required but should have. REFERENCE: WAC 388-97-1060 (2)(c).

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to implement a system to ensure Physician's Orders for Life Saving Treatments (POLSTs) were implemented for 2 of 22 sample residents (Residents 32 & 16) and one supplemental resident (Resident 60), related to lifesaving treatment orders. The failure to follow the POLST instructions for Cardiopulmonary Resuscitation (CPR) (Resident 32) or ensure the POLST was readily available (Residents 16 & 60) placed residents at risk for receiving unwanted CPR, avoidable trauma, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's [DATE] CPR policy, when a resident admitted to the facility, staff would verify if the resident had any Advanced Directives (legal documents that provide instructions for medical care when a resident cannot communicate their own wishes) and if not, verify if the resident did not wish to receive CPR. The policy showed if the resident did not want CPR, a physician's order would be obtained (this information would be documented on a POLST form). According to the facility's [DATE] Advanced Directives and Advanced Care Planning policy, all residents would receive lifesaving treatment unless they had Do Not Resuscitate (DNR) documentation in place, in which case the DNR directive would be honored. The policy showed a physician's order would be obtained reflecting the DNR status. The policy showed the Director of Nursing (DON) would establish a system to inform all direct care staff of residents' DNR status. <Resident 32> According to the [DATE] Significant Change Minimum Data Set (MDS - an assessment tool) Resident 32 had diagnoses including cancer, multiple heart conditions, high blood pressure, stage-3 kidney disease, diabetes mellitus (a condition making blood sugar regulation more difficult), high cholesterol, and Chronic Obstructive Pulmonary Disease (lung disease). The MDS showed Resident 32 experienced shortness of breath when lying down. Observation on [DATE] at 1:49 PM showed a staff member announced a Code Blue (medical emergency) for room [ROOM NUMBER] (Resident 32's room). At that time at the ,d+[DATE] Unit nurse station Staff I (Infection Preventionist) was observed calling out from the nurse station toward room [ROOM NUMBER] to attempt resuscitation. At 01:50 PM a voice carried from room [ROOM NUMBER] stating it is bed 3. At that point Staff I yelled Gosh you guys, no CPR for bed 3 - selective treatment for BED 3! You have got to say which bed! At 1:58 PM the paramedics arrived at the facility and took over treatment. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:48 PM Staff I stated they heard the housekeeper make the Code Blue alert for Resident 32. Staff I stated they heard the housekeeper say it was for room [ROOM NUMBER], bed 1. Staff I stated they looked at the POLST book (a binder held at the nurse station which was to include the POLST forms of every resident for the 100 and 200 units) and called out 207, bed 1 - full code, selective treatment. Staff I stated shortly thereafter they overhead Code Blue ,d+[DATE] at which point Staff I provided the correct information for Resident 32. Staff I stated by that point CPR was already initiated which meant it was necessary to continue until the paramedics took over treatment. In an interview on [DATE] at 8:46 AM with Staff B (Interim Director of Nursing) and Staff C (Regional Director of Clinical Services) Staff B explained Resident 32 was found unresponsive by a facility volunteer who alerted Staff K (Licensed Practical Nurse) who immediately went to Staff I's office for help. Staff B stated Staff I reviewed the POLST and said full code which was not correct for Resident 32. Staff B confirmed three other nurses went to room [ROOM NUMBER] and started CPR and continued until the paramedics arrived. Staff B stated staff should have properly identified the resident and referred to the correct POLST but did not. Staff C stated the facility identified the root cause of the miscommunication was the fact the POLST book was organized by room, rather than by resident name. <Resident 16> According to the [DATE] Admission MDS Resident 16 had intact memory. The MDS showed Resident 16 had diagnoses including anemia and a right femur (thigh bone) fracture. Review of the POLST book on [DATE] at 10:03 AM showed no POLST available for Resident 16. There was also no POLST in Resident 16's chart. In an interview at that time Staff C confirmed there was no POLST in the book and stated it may be in Resident 16's chart or with the medical records department. In an interview on [DATE] at 10:05 AM Staff L confirmed they did not have a POLST for Resident 16's POLST. In an interview on [DATE] at 11:22 AM Staff B stated they were unable to find Resident 16's POLST and it was necessary for Resident 16 to complete a new POLST form. Staff B confirmed the POLST book was the first place nurses would look for a POLST. <Resident 60> Review of the POLST book on [DATE] at 11:18 AM showed there was no POLST for Resident 60 in the POLST book. In an interview at that time Staff B took note that the POLST was not in the POLST book. REFERENCE: WAC [DATE] (1).

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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** 47836 Based on record review and interview the facility failed to ensure 3 of 3 residents (Resident 8, 13, & 64) reviewed for Edema (fluid retention in the body) received the necessary care and services they required in accordance with professional standards of practice. The facility failure to assess and monitor residents with edema placed residents at risk for complications, worsening conditions, and a diminished quality of life. Findings included . <Resident 8> According to a 12/24/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 8 reentered the facility on 08/08/2024. The MDS showed Resident 8 had diagnoses of, but not limited to, heart failure with edema. The MDS showed Resident 8 received diuretic medication during the assessment period. Review of an 11/02/2023 diuretic therapy Care Plan (CP) showed Resident 8 received diuretic medication for edema. Review of Resident 8's health records showed a 08/08/2024 physician's order for a diuretic medication given daily for edema. Resident 8's health records showed no physician's order to assess and monitor edema. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) reviewed Resident 8's health records and stated they did not have documentation of monitoring the resident's edema, but it should be monitored every shift. Staff F stated it was important to monitor edema every shift to best manage heart failure with edema and prevent them from fluid overload. <Resident 13> According to a 10/18/2024 Annual MDS Resident 13 reentered the facility on 05/17/2022. The MDS showed Resident 13 had diagnoses of, but not limited to, heart failure with edema and kidney failure. The MDS showed Resident 13 received diuretic medication during the assessment period. Review of an 09/13/2022 hypertension (high blood pressure) CP showed the facility would notify the doctor of edema. Review of Resident 13's health records showed a 10/21/2024 physician order for a diuretic medication given daily for edema. Resident 13's health records showed a 01/11/2023 physician order to monitor the resident's weight monthly. These records showed the facility only weighed Resident 13 10 times out of 27 opportunities since the 01/11/2023 monthly weight order. Resident 13's health records showed no physician order to assess and monitor their edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/17/2025 at 8:28 AM Staff F reviewed Resident 13's health records and stated they did not have documentation of monitoring the resident's edema, but it should be monitored every shift. Staff F reviewed Resident 13's weight monitoring and stated they were not monitoring the resident's weight per physician orders but should have. Staff F stated it was important to monitor edema every shift to best manage heart failure with edema and prevent them from fluid overload. Staff F stated it was important to monitor a resident weight more frequently with weight changes and while taking diuretic medications to ensure the edema is getting better also that they are not diuresing (removing fluid from the body) too much fluid from the resident causing them to become dehydrated. <Resident 64> According to a 12/13/2024 Annual MDS Resident 64 admitted to the facility on [DATE]. The MDS showed Resident 64 had no memory impairment. Observation and interview on 03/12/2025 at 10:18 AM Showed Resident 64 with bilateral lower extremity edema. At this time Resident 64 stated their weight has been slowly increasing since they admitted to the facility due to retaining water. Review of Resident 64's health records showed a 02/14/2025 physician order for a diuretic medication given daily for edema. Resident 64's health records showed no physician order to assess and monitor their edema. In an interview on 03/17/2025 at 8:28 AM Staff F reviewed Resident 64's health records and stated they did not have documentation of monitoring the resident's edema, but it should be monitored every shift. Staff F stated it was important to monitor edema every shift to best manage the edema and prevent them from fluid overload. In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected staff to monitor and document edema every shift. Staff B stated they expected staff to monitor weight for residents with edema more frequently and/or as per physician orders. Staff F stated if a resident refused to have their weight monitored, they expected staff to document the refusal. REFERENCE: WAC 388-97-1060(1).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to provide an environment free of accident hazards for 2 of 4 units (Units 100 & 200), ensure wheelchairs were assessed for safety prior to use for 1 of 9 residents (Resident 63) reviewed for positioning/mobility, and failed to ensure sharps and chemicals were stored safely for 1 of 4 shower rooms (100 Hall Shower Room) reviewed. The failure to ensure hot water was maintained within safe limits, wheelchairs were assessed for safety prior to use, and shower rooms were free of hazards placed residents at risk for burns, exposure to sharps and chemicals, wheelchair accidents, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 01/21/2025 Hot Water Temperature Inspection Policy, the facility would monitor temperatures weekly. The policy showed hot water temperatures could reach hazardous temperatures in hand sinks, showers, and tubs accessible to residents, and many residents in long-term care facilities had conditions that increased risk for burns. The policy showed a hot water temperature of 120 degrees Fahrenheit (F) could cause a third-degree burn with five minutes of exposure, a temperature of 124 F could cause a third degree burn with three minutes of exposure, and a temperature of 127 F could cause a third degree burn with one minute of exposure. According to a facility policy titled, Storage of Chemicals, revised 06/17/2024, the residents environment would remain free of accident hazards. The policy showed each resident would receive supervision around chemicals to prevent accidents. The policy showed chemicals not in use would be stored out of reach of residents. <Hot Water Temperatures> Observation of hot water temperatures on the 200 unit on 03/11/2025 showed: at 10:09 AM the hot water temperature in room [ROOM NUMBER] was measured at 124.1 F; at 10:11 AM the hot water temperature in room [ROOM NUMBER] was measured at 120 F; at 11:08 AM the hot water temperature in room [ROOM NUMBER] was measured at 121.7 F; at 11:13 AM the hot water temperature in room [ROOM NUMBER] was measured at 120.7 F; at 12:29 PM the sink in the 100/200 Unit shower room's hot water temperature was measured at 125.1 F. Observation of the 100 unit on 03/11/2025 between 11:00 AM and 11:15 AM showed: the temperature in room [ROOM NUMBER] was measured at 122.7 F; the temperature in room [ROOM NUMBER] was measured at 122.3 F; the temperature in room [ROOM NUMBER] was measured at 122.5 F; the temperature in room [ROOM NUMBER] was measured at 117.3 F; the temperature in room [ROOM NUMBER] was measured at 118.9 F; the temperature in room [ROOM NUMBER] was measured at 115.3 F. In an interview on 03/11/2025 at 11:25 AM Staff Y (Maintenance Director) stated they monitored water temperatures weekly. Staff Y said the facility aimed to maintain water temperatures below 120 F for resident safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/12/2025 at 11:10 AM Staff Z (Maintenance Assistant) stated this morning the facility identified a failed component in the hot water line that caused temperatures to rise above the safe limit and required repair. <Wheelchair Assessment> <Resident 63> According to the 01/22/25 Annual Minimum Data Set (MDS - an assessment tool) Resident 63 had intact memory and diagnoses including heart failure, weakness, and a history of traumatic fracture. The MDS showed Resident 63 used a manual wheelchair. In an interview on 03/11/2025 at 10:55 AM Resident 63 stated they were awaiting training for their new wheelchair. Resident 63 was observed to be in a tilt-in-space wheelchair (a specialized wheelchair that could adjust the positioning of a resident from upright to tilted back and could not be adjusted by the user of the chair.) Record review showed the 02/21/2024 Resident at risk for falls . Care Plan (CP) Resident 63 included a 02/26/2024 intervention for a DEVICE: TILT-N-SPACE [wheelchair] while out of bed to assist with proper positioning, pressure relief and comfort. There were no other directions in Resident 63's CP regarding the purpose or proper use of the tilt-in-space wheelchair. Record showed no evidence the Resident 63's tilt-in-space wheelchair use was assessed for safe use by the resident. In an interview on 03/14/2025 at 2:13 PM Staff BB (Senior Director of Rehab Services) stated the therapy department completed wheelchair safety assessments for residents. Staff BB stated wheelchairs were reassessed by the therapy department on a quarterly basis. In an interview on 03/18/2025 at 10:17 AM Staff BB stated Resident 63 was provided the tilt-in-space wheelchair from the facility's pool of wheelchairs because it was the wheelchair that best suited the resident's longer frame. Staff BB stated because the chair was not provided for the purposes of tilting the resident, they did not complete a safety assessment for Resident 63. At that time Staff BB produced a therapy discharge summary showing Resident 63 was provided the tilt-in-space wheelchair as a placeholder. The discharge summary showed the wheelchair just happens to be tilt-in-space . and was signed as completed on 03/14/2025 at 3:34 PM. In an interview on 03/18/2025 at 10:30 AM Staff B (Director of Nursing) stated their expectation was that any wheelchair, including a tilt-in-space wheelchair, should be assessed for safety periodically. 47836 <Chemicals and Sharps> <100 Hall Shower Room> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/11/2025 at 12:07 PM showed Staff M (Certified Nursing Assistant) exit the shower room leaving a resident unattended in the shower room. Observation at this time showed a cabinet in the shower room wide open with razors accessible and a bottle of disinfectant cleaner sitting on the half wall of the shower within reach of the resident. Staff M returned to the shower room at 12:09 PM and stated they were not supposed to leave residents unattended in the shower room. Staff M stated the chemical cleaner, and razors should have been locked up and not accessible to residents for their safety. Staff M stated they were never given a key to the cabinet and were never informed of where one was to ensure it was kept locked. In an interview on 03/17/2025 at 11:50 AM Staff B (Director of Nursing) stated they expected disinfectants and razors to be stored behind locked doors, out of reach to residents. Staff B stated it was important that chemicals and sharps were stored properly behind locked doors for resident safety. REFERENCE WAC: 388-97-1060 (3)(g), -3320.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation and interview the facility failed to ensure fresh water was offered for 5 of 5 residents (Residents 8, 14, 13, 69, & 64) reviewed for hydration. Failure to offer fresh water daily placed residents at risk of dehydration, potential risk for medical complications, and decreased quality of life. Findings included <Policy> According to a facility policy titled, Hydration and Nutrition, revised 09/10/2024, each resident would be offered fluids to maintain proper hydration. The policy showed fluids would always be available to residents and a hydration cart may be utilized. <Resident 8> According to a 12/24/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 8 reentered the facility on 08/08/2024. The MDS showed Resident 8 had no memory impairment. In an observation and interview on 03/12/2025 at 1:30 PM Resident 8's water pitcher was empty. At this time Resident 8 stated the staff do not offer fresh water and they only get it if they ask. Observations on 03/13/2025 at 10:16 AM, 03/14/2025 at 2:17 PM, 03/17/2025 at 8:28 AM, and 03/18/2025 at 8:39 AM showed Resident 8 without fresh water available. <Resident 14> According to a 01/23/2025 Annual MDS Resident 14 admitted to the facility on [DATE]. The MDS showed Resident 14 had moderate memory impairment. In an observation and interview on 03/12/2025 at 9:18 AM Resident 14's water pitcher was empty. At this time Resident 14 stated the staff do not offer fresh water and they only get it if they ask. Observations on 03/13/2025 at 10:40 AM, 03/14/2025 at 9:02 AM, and 03/18/2025 at 8:40 AM showed Resident 14 without fresh water available at bedside. <Resident 13> According to a 10/18/2024 Annual MDS Resident 13 reentered the facility on 05/17/2022. The MDS showed Resident 13 had diagnoses of, but not limited to, heart failure with edema and kidney failure. In an observation and interview on 03/12/2025 at 12:56 PM Resident 13's water pitcher was empty. Resident 13 stated the staff do not offer fresh water and they only get it if they ask. Observations on 03/13/2025 at 9:26 AM, 03/14/2025 at 1:25 PM, and 03/18/2025 at 8:47 AM showed Resident 13 without fresh water available. <Resident 69> (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 02/11/2025 Admission MDS Resident 69 admitted to the facility on [DATE]. The MDS showed Resident 69 had moderate memory impairment. The MDS showed Resident 69's representative participated in the assessment. In an observation and interview on 03/11/2025 at 10:02 AM Resident 69's water pitcher was empty. Resident 69's family member stated the resident was on thickened fluids and staff do not offer fresh water. Resident 69's representative stated they only get fluids on meal their trays. Observations on 03/12/2025 at 9:27 AM, 03/13/2025 at 1:12 PM, 03/14/2025 at 9:07 AM, and 03/18/2025 at 8:42 AM showed Resident 69 without fresh water available. <Resident 64> According to a 12/13/2024 Annual MDS Resident 64 admitted to the facility on [DATE]. The MDS showed Resident 64 had no memory impairment. In an observation and interview on 03/12/2025 at 9:29 AM Resident 64's water pitcher was empty. At this time Resident 64 stated the staff do not offer fresh water and they only get something to drink if they ask. Observations on 03/13/2025 at 10:30 AM, 03/14/2025 at 1:45 PM, and 03/18/2025 at 8:45 AM showed Resident 64 without fresh water available. In an interview on 03/11/2025 at 12:07 Staff M (Certified Nursing Assistant) stated they would bring residents fresh water if they asked otherwise, they received fluids on their meal trays. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) stated they expected staff to offer and provide fresh water pitchers every shift. Staff F stated resident should not have to ask for fluids and staff should automatically offer at the beginning of their shift or per resident preference. Staff F stated it was important for staff to automatically offer fluids to residents because some residents could not ask or may forget to ask for fresh water. Staff F stated it was important to offer and provide fluids to residents to ensure they stay hydrated. In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected staff to offer fresh water to residents as part of their care each shift. Staff B stated it was important to offer and provide fluids to residents to ensure they are staying hydrated. REFERENCE: WAC 388-97-1060(3)(i).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50511 Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents (Resident 43) reviewed for respiratory care, were provided the care they required, consistent with professional standards of practice. Failure to ensure oxygen delivery was provided according to physician ordered flow rates and failure to monitor oxygen equipment, placed residents at risk of respiratory discomfort, oxygen-related accidents, and a decreased quality of life. Findings Included . <Facility Policy> According to the revised 10/11/2024 Oxygen Administration Policy, the facility must ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice and the person-centered care plan. Oxygen orders should be written for a specific flow rate required by the resident. <Resident 43> According to the 12/03/2024 Annual Minimum data set (MDS - an assessment tool) Resident 43 had a diagnosis of chronic obstructive pulmonary disease (COPD) and required oxygen therapy. According to the 12/03/2024 COPD care plan (CP), staff were directed to administer oxygen at a setting of 2 Liters Per Minute (LPM) continuously. Record review showed 08/20/2024 physician's order for oxygen at 2 LPM continuously through nasal cannula (NC). Observations on 03/11/2025 at 10:55 AM, 03/11/2025 at 2:23 PM, 03/13/2025 at 10:53 AM and 03/14/2025 at 9:23 AM, showed Resident 43's oxygen flow rate set at 3 LPM via NC. Observation and interview on 03/13/2025 at 10:53 AM showed the other end of the oxygen tubing placed in Resident 43's nose was lying on the floor and not connected to the oxygen concentrator. Observation showed the oxygen flow rate was set to 3 LPM instead of 2 LPM. Staff G (Licensed Practical Nurse) verified the tubing was on the floor and not connected to the concentrator and stated it should be connected. In an observation and interview on 03/14/2025 at 10:35 AM Staff G verified the oxygen was set at 3 LPM instead of 2 LPM. Staff G was unsure of the oxygen order and stated they thought the order showed the oxygen should be set between 2 to 3 LPM and needed to check the medication orders. Staff G stated it was important for residents to get the right amount of oxygen so they could breathe better. In an interview on 03/18/2025 at 10:50 AM Staff H (Unit Care Coordinator) stated staff should check oxygen levels, check to see oxygen tubing was connected, and check oxygen settings to determine if the correct rate was administered. Staff H stated it was important for residents to receive the right amount of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/18/2025 at 12:24 PM Staff B (Director of Nursing) stated oxygen should be administered according to the orders and nurses should round every shift for residents with oxygen to check for oxygen needs. Staff B stated it was important to follow the physician's orders for the resident's specific rate determined by their health conditions. REFERENCE: WAC 388-97-1060 (3)(j)(vi).

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to obtain consent prior to implementing bed rails/bed against the wall for 2 of 3 residents (Resident 8 & 69) and complete a safety assessment for the bed against the wall for 1 of 3 residents (Resident 69) reviewed for accident hazards. The failure to obtain consent and complete a safety assessment prior to implementing bed rails/bed against the wall placed residents at risk for injury, entrapment, and other negative health outcomes. Findings included . <Policy> According to facility policy titled, Bed Rails - Safe and Effective Use of Bed Rails, revised 09/06/2024, the facility would review the risks and benefits of bed rail use with the resident/representative prior to installation, complete a safety assessment, and obtain the resident/representatives consent. The policy showed a comprehensive care plan would be developed for the use of bed rails within 48 hours of installation. <Resident 8> According to a 12/24/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 8 admitted to the facility on [DATE]. The MDS showed Resident 8 had no bed rails in use on their bed. Review of Resident 8's health records showed a 01/23/2023 evaluation for the use of bilateral quarter bed rails to Resident 8's bed. Resident 8's health records showed no consent for the bilateral quarter bed rails. An observation on 03/12/2025 at 2:08 PM showed bilateral quarter bed rails to Resident 8's bed. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) reviewed Resident 8's health records and stated Resident 8 had bed rails but consent was not obtained prior to them being installed to their bed. Staff F stated it was important to obtain consent from the resident prior to installing bed rails to their bed to ensure the resident wants the bed rails. <Resident 69> According to a 02/11/2025 Admission MDS Resident 69 admitted to the facility on [DATE]. The MDS showed Resident 69 had no restraints in use on their bed. Observation on 03/11/2025 at 10:20 AM showed Resident 77's left side of bed against the wall. Review of Resident 69's health records on 03/17/2025 showed no safety assessment or consent for the bed against the wall. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/17/2025 at 8:28 AM Staff F reviewed Resident 77's health records and stated staff were expected to obtain consent and complete a safety assessment prior to placing a resident's bed against the wall but they did not. Staff F stated it was important to obtain consent and complete a safety assessment for the bed against the wall to ensure injuries or entrapment would not happen to the resident. In an interview on 03/18/2025 at 8:57 AM Staff B (Director of Nursing) stated they expected staff to obtain consent and complete a safety assessment prior to installation of bed rails or placing a bed against the wall. Refer to F656 - Implement Care Plan. Refer to F658 - Services Provided Meet Professional Standards. REFERENCE: WAC 388-97-1060(3)(g), -0260.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 50511 Based on observation, interview, and record review, the facility failed to ensure 1 of 4 sampled residents (Resident 80) reviewed for mood and behavior was evaluated for potential mental health services to address demonstrated ongoing behaviors and failed to notify the provider of changes in behavior. This failure placed Resident 80 at risk for untreated mental health issues and other negative health issues. Findings included . <Resident 80> According to the 01/28/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 80 had diagnoses including depression, a cognitive communication deficit, and failure to thrive and received an antidepressant medication. Review of the 02/04/2025 Antidepressant Care Plan (CP) showed staff were to report changes in behavior and mood. Review of a 01/24/2025 physician order showed staff were to monitor Resident 80's exhibited behavior including verbal abuse. Staff were to redirect the resident and provide one-on-one services and chart in the progress notes. Review of the progress notes showed nursing staff documented on 03/04/2025, 03/09/2025 and 03/11/2025 that Resident 80 demonstrated refusals of care. Review of March 2025 care staff task sheet showed on 03/09/2025, 03/11/2025, 03/12/2025, 03/15/2025 Resident 80 was agitated. On 03/01/2025, 03/04/2025, 03/08/2025, 03/09/2025, 03/10/2025, 03/11/2025, 03/12/2025, 03/14/2025 and 03/15/2025, staff documented Resident 80 refused to eat. Record reviewed showed no evidence the facility assessed Resident 80's refusals of care, agitation, and refusals to eat, or notified the provider of behavior changes. In an interview on 03/11/2025 at 2:40 PM Resident 80 stated the facility would not let their dog visit anymore and stated they were upset with the facility. Resident 80 stated even though they were hungry they did not want to eat. Observation on 03/13/2025 at 10:39 AM showed Resident 80 lying in their bed, the room was dark, and the lights were off. Resident 80 stated I am not doing very good but declined to say what was bothering them. In an interview on 03/18/2025 at 10:02 AM, Staff E (Social Services Assistant) stated if they knew about Resident 80's refusals they would have called the family to report the refusals of care and work on a plan to correct the behaviors. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/18/25 at 10:53 AM Staff H (Unit Care Manager) stated Resident 80 could become aggressive and would refuse to eat. Staff H stated Resident 80 often refused care and stated they could not force services on residents. Staff H stated they expected staff to report refusals of care and after that, the Director of Nursing and the social worker would meet to discuss refusals. Staff H stated staff should notify the provider and if applicable, should make a referral for hospice care, but this did not happen. In an interview on 03/18/2025 at 12:19 PM Staff B (Director of Nursing) stated for Resident 80's refusals of care, staff should reapproach and help to change the resident's mind. Staff B stated staff should document refusals. Staff B stated the facility should have notified the doctor that Resident 80 refused medications, treatments, and care. Staff B stated Resident 80 had the right to refuse care, but their doctor needed to be notified as it could impact their overall care. REFERENCE: WAC 388-97-1060(3)(e).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review the facility failed to: ensure medication refrigerator temperatures were monitored for 1 of 2 medication rooms (100/200 Unit); ensure expired medications and biologicals were disposed of appropriately for 1 of 2 medication rooms (300/400 Unit); and ensure medications and biologicals were secured for 1 of 6 Residents (Resident 31) reviewed for medication storage. These failures placed residents at risk for receiving the wrong medications, expired medications, and other negative health outcomes. Findings included . <Facility policy> According to the revised 09/13/2024 Medication Storage in Refrigerator/Freezer policy the facility would ensure all medications and biological were stored in the appropriate temperatures. Safe temperatures for refrigeration were between the range of 36 degrees to 46 degrees Fahrenheit. <Medication room [ROOM NUMBER]/200> Observation on 03/13/2025 at 2:33 PM of 100/200-unit medication room showed the medication refrigerator temperature was at 49 degrees, above the recommended temperature range. There was no refrigerator temperature log to show staff monitored the refrigerator temperatures routinely. In an interview on 03/13/2025 at 2:35 PM Staff I (Infection Preventionist) observed the medication refrigerator and stated it was used to store staff vaccinations. Staff I stated the temperature of 49 degrees was too high to store medications effectively. Staff I was not sure who was responsible for checking the temperatures of the medication refrigerator. In an in interview on 03/18/2025 at 12:35 PM Staff B (Director of Nursing) stated they did not know who checked the medication room refrigerator temperatures but should be checked for optimal efficiencies of medications. In an interview on 03/18/2025 at 12:56 PM Staff A (Regional VP) stated they did not know who checked the medication refrigerator temperatures but expected the nurses to check this daily since they are the only ones who had the keys. Staff A stated this was important as medications could go bad quickly and would be unsafe. <Medication room [ROOM NUMBER]/400 unit> Observation on 03/13/2025 at 12:14 PM of the medication room for the 300/400 units showed an expired antibiotic medication was found in the medication refrigerator with a use-by date of 03/06/2025. Also observed was a bottle of a suspension powder used to treat high levels of potassium which expired in 2023 for a resident who discharged in May 2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/13/2025 at 12:20 PM Staff H (Unit Care Coordinator) stated there should not be any expired medications in the medication room. Staff H stated they were responsible for getting rid of expired medications but did not. <Resident 31> According to a 02/18/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 31 could make themselves understood and understood others in conversation. The MDS showed Resident 31 had a cognitive communication deficit and a diagnosis of non-Alzheimer's dementia. Observation on 03/11/2025 at 9:09 AM showed a bottle of medicated power used for skin rashes with another resident's name placed on Resident 31's nightstand. In an interview on 3/11/2025 at 9:42 AM Staff X (Licensed Practical Nurse) stated they did not know why the bottle of powdered medication was in Resident 31's room and stated it should not be there for Resident 31's safety. In an interview on 03/18/2025 at 10:38 AM Staff H stated the staff should not leave medications in any resident's room. Staff H stated Resident 31 had confusion and it was not safe to leave medications in their room for any reason. REFERENCE: WAC 388-97-1300(2).

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42203 Based on interview and record review, the facility failed to ensure the Dietary Manager (Staff J) had the required qualifications to perform their duties for 1 of 1 facility kitchens. The failure to ensure a Dietary Manager without the required certification had fulltime support from a Registered Dietician (RD) placed all residents at risk of receiving a menu prepared by staff without the required competencies and skills to provide food and nutrition services. Findings included . During kitchen rounds on 03/11/25 Staff J at 8:35 AM (Incoming Dietary Director) provided access to the kitchen and stated they were in charge. In an interview on 03/18/2025 at 11:14 AM Staff J stated they did not complete the required dietary manager training. Staff J stated the previous Dietary Director left sooner than anticipated. Staff J stated the facility's Registered Dietician (RD) did not work a fulltime schedule at the facility. In an interview on 03/18/2025 at 12:01 PM Staff Q (RD) stated they were also the dietician for a sister facility. Staff Q stated they worked at the facility on Tuesdays and Thursdays, indicating they did not work in the facility fulltime as required when the dietary manager did not have the necessary certification. REFERENCE: WAC 388-97-1160 (1).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47836 Based on observation, interview, and record review the facility failed to ensure confidentiality of resident records was maintained for 1 of 4 medication carts (100 hall medication cart) reviewed. This failure placed residents at risk for a violation of their rights to privacy. Findings included . <Policy> According to a facility policy titled, Resident Rights, revised 09/10/2024, the facility must protect and promote the rights of the residents. The policy showed residents had the right to privacy and confidentiality of their medical information. <100 hall medication cart> In an observation and interview on 03/11/2025 at 12:33 PM Staff O (Licensed Practical Nurse) walked away from their medication cart with a list of all residents on 100 hall with their health information unsecured and in view. Staff O stated they were expected to maintain confidentiality of all resident information but did not. Staff O stated it was important to maintain confidentiality of resident information for their rights. In an observation and interview on 03/12/2025 at 12:33 PM Staff P (Registered Nurse) walked away from their medication cart with a list of all residents on 100 hall with their health information unsecured and in view. Staff P stated they were expected to protect resident information and not leave in sight for others to view but they forgot. Staff P stated it was important to protect resident information for their rights. In an interview on 03/17/2025 at 11:50 AM Staff B (Director of Nursing) stated they expected staff to secure all resident information before walking away from it. Staff B stated it was important to maintain confidentiality of resident information for their right to privacy. REFERENCE: WAC 388-97-1720(1)(c), -0360(1-3).

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 50511 Based on observation, interview, and record review the facility failed to ensure effective coordination of care between the facility and hospice staff and failed to implement and develop a coordinated Care Plan (CP) for 1 of 2 residents (Resident 25) reviewed for hospice services. The failure to implement a system by which consistent communication between the facility and hospice staff occurred placed residents at risk for not for receiving necessary care and services, avoidable discomfort, and other negative health outcomes. Findings included . <Facility Policy> According to facility's revised 11/19/2024 Hospice policy, the facility would ensure the resident's CP included the most recent hospice plan of care and a description of services provided by the facility to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing. The facility must designate a member of the team to ensure the resident received quality care in collaboration with the facility staff and the hospice staff. <Resident 25> According to a 02/19/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 25 had diagnoses including Multiple Sclerosis (MS - a chronic neurological condition) and muscle weakness and received hospice care services. Record review showed the 12/05/2024 Hospice CP include a goal for a facility representative to coordinate care with the hospice services. The CP included interventions for staff to adjust the provision of Activities of Daily Living (ADL - dressing, grooming, bathing, eating etc.) to compensate for Resident 25's changing abilities, and to encourage participation to the extent the resident wished. The CP did not show how staff were to work with the hospice services team to coordinate care or to report changes in care regarding Resident 25' wellbeing. Review of Resident 25's Kardex (nursing aides' instruction sheet) did not show what care was to be provided by the facility and what care by hospice services. Review of Resident 25's medical record did not show documentation of the hospice plan of care and did not include documentation or notes from hospice visits to Resident 25. Review of the hospice binder at the nurse's station on 03/11/2025 at 10:50 AM showed the binder contained the demographics page of Resident 25's hospice admission. The binder did not contain a coordinated CP, instructions for care, or visit notes from the hospice team. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/14/2025 at 10:24 AM Staff G (Licensed Practical Nurse) stated the facility nurses provided wound treatment to Resident 25 when the hospice nurse did not come in to provide wound treatments. Staff G was not able to recall what time and when the hospice nurse usually came to the facility so they could know whether to provide treatment or not. In an interview on 03/17/2025 at 9:53 AM Staff AA (Registered Nurse) stated they could not give Resident 25 too much pain medication because Resident 25 was on hospice, and hospice managed Resident 25's pain instead of the facility. In an interview on 03/18/2025 at 10:19 AM Staff S (Certified Nursing Assistant) stated did not receive training on hospice care. Staff S stated they referred to the hospice book at the nurse's station and the Kardex regarding hospice care needed for Resident 25 but was unsure where the hospice binder was at that time. In an interview on 03/14/2025 at 1:20 PM, Staff H (Unit Care Coordinator) stated it was important to integrate hospice services into Resident 25's CP. Staff H stated it was important that hospice services placed documentation in the hospice binder, but they did not. Staff H stated they always asked the hospice nurse for a verbal report but was not sure if hospice coordinated with floor nurses when Staff H was not in the facility. Staff H stated Resident 25's hospice service did not document directly into Resident 25's medical record and the facility had to access the hospice services medical record system, but that system was not currently accessible to the facility. In an interview on 03/18/2025 at 12:02 PM Staff B (Director of Nursing - DON) stated it was important to coordinate care with hospice care, to review the care plans, and to determine the resident's preferences. Staff B stated the DON, and the unit care coordinators should coordinate services with the hospice team and hospice should provide the facility with visit notes. Staff B stated they were unsure where the hospice notes were kept but if notes were left by hospice services, they should be scanned into the resident's medical record but were not. REFERENCE: WAC 388-97-1060(1).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review the facility failed to appropriately store resident respiratory equipment for 1 of 3 sampled resident (Resident 69) reviewed for respiratory care, follow physician orders for Transmission Based Precautions (TBP) for 1 of 2 residents (Resident 84) reviewed for antibiotic use, and appropriately use Personal Protective Equipment (PPE) in accordance with Enhanced Barrier Precautions (EBP - infection control measures used to reduce the spread of multidrug-resistant organisms) for 1 of 3 residents (Residents 25) reviewed for infection control and one facility staff. These failures placed residents at risk for the development and transmission of communicable diseases and an unclean environment. Findings included . <Policy> According to the facility's 06/13/2024 Infection Prevention and Control Program policy the facility must establish and maintain an effective infection control program. The policy showed the facility would implement appropriate TBP and PPE use when required. <Respiratory Equipment> <Resident 69> According to a 02/11/2025 Admission Minimum Data Set (MDS - an assessment tool) Resident 69 admitted to the facility on [DATE]. The MDS showed Resident 69 had no respiratory infections. Review of Resident 69's health records showed they were transferred to an acute care hospital for a respiratory illness on 02/24/2025. Resident 69's health records showed a 02/28/2025 physician order for a respiratory medication to be administered via Small Volume Nebulizer (SVN - a machine that creates as mist out of liquid medication for inhalation) machine. In an observation and interview on 03/11/2025 at 10:07 AM Resident 69's representative stated the staff stored the residents SVN machine on their roommate's nightstand. Observation at this time and on 03/12/2025 at 10:15 AM, 03/13/2025 at 9:23 AM, 03/14/2025 at 10:05 AM, and 03/17/2025 at 10:41 AM showed Resident 69's SVN machine on the roommate's nightstand. In an interview on 03/17/2025 at 8:28 AM Staff F (Unit Care Coordinator) reviewed Resident 69's health records and stated the SVN machine was for Resident 69 and the SVN machine should be stored in Resident 69's area of the room, not in the roommates' side. Staff F stated it was important to keep each resident's equipment in their own area of the room for infection prevention. In an interview on 03/18/2025 at 8:57 am Staff B (Director of Nursing) stated they expected the SVN machine be stored in Resident 69's area of the room. Staff B stated this was important for infection control and residents' rights to their space. 42203 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<TBP Implementation> <Resident 84> According to the 02/21/2025 Admission MDS Resident 84 had a Multidrug-resistant Organism (MDRO - a difficult to treat infectious organism) infection and surgical wounds. The MDS showed Resident 84 used an antibiotic medication. According to a 02/17/2025 physician's order Resident 84 required contact precautions (a type of TBP requiring anyone who entered the room to utilize specified Person Protective Equipment (PPE) before entry) related to their MDRO infection. Observation on 03/12/25 at 12:28 PM showed Enhanced Barrier Precautions (a system of PPE usage required for certain conditions that only required facility staff to use PPE when close contact with the resident was anticipated) were in place instead of the contact precautions ordered. In an interview on 03/18/2025 at 1:07 PM Staff B stated the sign on the door should reflect the order but did not. 50511 <Enhanced Barrier Precautions> <Resident 25> According to the 02/19/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 25 had a neurological condition that affected their muscles and had skin pressure injuries on their lower back. Review of the revised 10/29/2024 Moisture Acquired Skin Damage (MASD) CP, Resident 25 had pressure wound areas to their lower back and right hip. Staff were directed to use EBP when providing care that included the use of gowns, gloves, and masks. Observation on 03/12/2025 at 10:12 AM showed no EBP signage on the door to Resident 25's room to direct staff to use EBP while providing care. Staff R (CNA) and Staff S (CNA) were observed assisting Resident 25 to turn and provided incontinence care. Neither Staff R or Staff S wore protective gowns while providing care to the wound areas. The pressure area on Resident 25's lower back had broken red skin and bled. The other two wounds on the lower hip areas had intact skin and was red and white in appearance. Staff R left the room with their gloves still on and walked down the hallway to call the nurse. Observation on 03/12/2025 at 10:23 AM showed Staff R provided incontinence care to Resident 25 who was in bed 3. Staff R left Resident 25 to get more incontinent supplies from their closet located in the front of the room while passing residents in bed 1 and bed 2 to obtain supplies.Staff R did not remove their soiled gloves or sanitize their hands before obtaining new supplies. In an interview on 03/12/2025 at 10:33 AM Staff R stated the room was not labeled as an EBP room and they only needed to wear gloves while providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Housekeeping > In an observation on 03/13/2025 at 10:42 AM, room [ROOM NUMBER] had signage on the door that showed EBP precautions for the room. Staff T (Housekeeping Assistant) was observed to finish cleaning room [ROOM NUMBER]. Staff T removed their EBP gown outside of the room and placed the gown on the bottom of their housekeeping cart instead of disposing of the gown inside the room in the designated soiled garbage bin. In an observation on 03/14/2025 at 11:26 AM Staff T stepped out of room [ROOM NUMBER] and removed their soiled gown outside of the room instead of inside of the room where the garbage bin was located. In an interview on 03/14/2025 at 2:08 PM Staff I (Infection Preventionist) stated staff were to sanitize their hands before going in and going out of EBP rooms. Staff I stated all residents with indwelling devices, wounds, or requiring dressing changes should have EBP signage on the door to notify staff to use EBP. Staff I stated this was important to prevent the spread of infection. Staff I stated Resident 25 should have EBP signage because of their pressure wounds but did not. Staff I stated staff should remove gowns and gloves before coming out of the room. Staff I stated staff were trained on this but needed additional training. In an interview on 03/18/2025 at 9:52 AM Staff T stated they knew to wear a gown and mask while in an EBP room and should have taken gown off in the room and not in the hallway. In an interview on 03/18/2025 at 12:14 PM Staff H (RN Unit Care Manager) stated staff were expected to use PPE when they saw bodily fluids or blood. Staff H stated the EBP sign should specify what staff need to wear and when it was needed and should be posted on the Resident 25's door but was not. In an interview on 03/18/25 at 12:14 PM, Staff B (Director of Nursing) stated they would expect EBP signage on the door to direct staff when to use PPE and staff should know when to use personal protective equipment (PPE-gloves, masks, gowns) during care. REFERENCE: WAC 388-97-1320 (1)(a)(c), (2)(a)(c), (4),(5)(b)(c).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 47836 Based on interview and record review, the facility failed to provide education for the influenza vaccination and administer a pneumococcal (pneumonia) vaccination within the recommended timeframe for 4 (Residents 8,14, 13, & 64) of 5 residents reviewed for vaccinations. This failure placed residents at risk of experiencing complications, not being able to make an informed decision, and contracting pneumonia, with its associated complications. Findings included . <Policy> According to a facility policy titled, Pneumococcal Vaccine Policy for Residents, revised 01/28/2025, each resident would be offered the pneumococcal vaccine. The policy showed there would be documentation in resident health records of historical pneumococcal vaccination. The policy showed the facility would readdress refusals annually and show documentation of doing so. The policy showed education would be provided to the residents regarding the benefits and potential side effects and consent would be obtained. According to the facility policy titled, Influenza Vaccine Policy for Residents, revised 01/28/2025, the facility would provide education regarding the risks and potential benefits of the Influenza vaccine prior to administration. The policy showed each resident would be offered the vaccine annually between October 31st through March 31st. The policy showed resident records would have documentation supporting the resident received education regarding the risks and benefits of the vaccine, consent or declination, and administration of the vaccine. <Resident 8> Review of Resident 8's health records showed they received the influenza vaccination on 10/14/2024. Resident 8's health records showed no documentation that education was provided for the influenza vaccine prior to administration. Resident 8's health records showed no documentation of the pneumococcal vaccination being offered or their historical immunization status. <Resident 14> Review of Resident 14's health records showed they received the influenza vaccination on 10/14/2024. Resident 14's health records showed no documentation that education was provided for the influenza vaccine prior to administration. Resident 14's health records showed no documentation of the pneumococcal vaccination being offered or their historical immunization status. <Resident 13> Review of Resident 13's health records showed they received the influenza vaccination on 10/14/2024. Resident 13's health records showed no documentation that education was provided for the influenza vaccine prior to administration. Resident 13's health records showed no documentation of the pneumococcal vaccination being offered or their historical immunization status. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 64> Review of Resident 64's health records showed no documentation of the influenza or pneumococcal vaccine being offered for the 2024-2025 season. Resident 64's health records showed no documentation of historical immunization status. In an interview on 03/14/2025 at 11:05 AM Staff I (Infection Preventionist) stated they did not have documentation of education or consent for the influenza vaccines for Residents 8, 14, 13, or 64 for the 2024-2025 season. Staff I stated they were expected to obtain a copy of each resident's immunization records from the department of health and scan into the residents health records but did not for Residents 8, 14, 13, or 64. Staff I stated it was important to educate residents and obtain consent prior to administration of vaccines to ensure they were aware of the risks and benefits of the vaccine. Staff I stated it was important to obtain residents vaccination status from the department of health upon admit to the facility to ensure they were up to date with the recommended vaccinations and decrease the chances of them acquiring a communicable disease. REFERENCE: WAC 388-97-1340(2).

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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. 47836 Based on record review and interview, the facility failed to provide education on the benefits and potential side effects of the Covid-19 (C19) vaccination for 4 of 5 sampled residents (Resident 8, 14, 13, & 64) and provide education on the benefits and potential side effects of the C19 vaccination for 1 of 1 sampled staff (Staff U - Restorative Aide) reviewed for vaccinations. This failure placed residents, their representatives, and staff at risk of not being given the opportunity to make an informed decision regarding their medical care, potential complications of a communicable disease, and a decreased quality of life. Findings included . <Policy> According to a facility policy titled, Covid-19 (SARS-CoV-2) Vaccination Program Policy for Associates, revised 11/27/2024, showed the facility would provide education regarding the benefits and potential side effects associated with the C19 vaccine and offer the vaccine unless it was medically contraindicated, or staff member had already been immunized. The policy showed the facility would maintain a copy of the education material provided to each staff member. According to facility policy titled, Covid-19 (SARS-CoV-2) Vaccination Program Policy for Residents, revised 11/27/2024, showed the facility would offer all residents the C19 vaccine. The policy showed the facility would educate residents or their representatives regarding the benefits and potential side effects associated with the C19 vaccine. The policy showed the resident records would include documentation that the resident was provided education regarding the benefits and potential risks associated with the C19 vaccine and documentation of the resident's consent or declination. The policy showed the facility would offer and educate all residents on the C19 vaccine each time the C19 vaccine supplies were available to the facility. <Resident 8> Review of Resident 8's health records showed a 10/14/2025 Infection progress note the resident received the C19 vaccination. Resident 8's health records did not show education was provided on the benefits and potential side effects of the C19 vaccination. <Resident 14> Review of Resident 14's health records showed a 10/14/2025 Infection progress note the resident received the C19 vaccination. Resident 14's health records did not show education was provided on the benefits and potential side effects of the C19 vaccination. <Resident 13> (continued on next page)

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Life Care Center of Federal Way	1045 South 308th Street Federal Way, WA 98003

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 13's health records showed a 10/14/2025 Infection progress note the resident received the C19 vaccination. Resident 13's health records did not show education was provided on the benefits and potential side effects of the C19 vaccination. <Resident 64> Review of Resident 64's health records did not show they were offered the C19 vaccine for the 2024-2025 C19 booster vaccine. Resident 64's health records did not show education was provided on the benefits and potential side effects of the C19 vaccination for the 2024-2025 vaccine booster. <Staff U> In an interview on 03/14/2025 at 11:05 AM Staff I (Infection Preventionist) stated they did not educate Staff U or any staff on the C19 vaccination risks and benefits. Staff I stated they did not know they were required to educate all staff and residents on the C19 vaccine and retain documentation of doing so. Staff I stated they were expected to pull all residents immunization records from the health department and save in the resident's records to document which vaccinations the resident received but they did not. Staff I reviewed Residents 8, 14, 13, and 64's health records for the 2024-2025 C19 vaccination education of the benefits and potential side effects of the vaccine. Staff I stated they did not have documentation of education for the C19 vaccine for Residents 8, 13, 14, or 64 but understood the importance of having it in the resident's records. In an interview on 03/17/2025 at 11:50 AM Staff B (Director of Nursing) stated they expected Staff I to educate all staff and residents on the risks and benefits for the C19 vaccination. Staff B stated they expected Staff I to retain documentation of the education for all employees and residents. REFERENCE: WAC 388-97-0200(2), -0300(3)(a).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505188	A. Building B. Wing	03/18/2025

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 42203 Based on observation, interview, and record review the facility failed to ensure qualified nursing staff were provided training and specialized training for 4 of 5 staff members (Staff I [Infection Preventionist], Staff K [Licensed Practical Nurse], Staff CC [Certified Nursing Assistant - CNA] and Staff S [CNA] sampled for staff training. These failures placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the undated Facility Assessment showed staff were to be trained upon hire, annually, and as needed in the areas of communication, resident rights-ensuring staff were educated on residents rights and to properly care for its residents, abuse and neglect, infection control, person centered care, resident changes in condition, cultural competency, and quality assurance and performance improvement. Review of staff training records did not show documentation (Staff I, Staff K & Staff CC) received training upon hire or annual training of facility assessment trainings. In an interview on 03/17/2025 at 12:18 PM Staff DD (Staffing Coordinator) stated the facility did not have a Staff Development Coordinator to keep track of staff trainings. Staff DD stated they relied on staff to come to them when they needed to do their trainings. Staff DD stated the trainings were made available to the staff through their online health training site and provided the general curriculum of the table of contents of the facility's online trainings. Staff DD stated they thought the Director of Nursing kept copies of the training records but was not sure. Review of the facility's Annual General Curriculum table of contents from their online health training vendor showed there were no specialized training curriculum available for dementia care, behavioral health, or hospice care. In an interview on 03/17/2025 at 1:42 PM Staff C (Regional Director of Clinical Services) stated the facility should have completed all the required trainings for Staff I, Staff K, and Staff CC but did not. <Specialized Training> In an interview on 03/18/2025 at 10:19 AM Staff S (CNA) stated they did not receive training on hospice care. In an interview on 03/18/2025 at 10:38 AM Staff H (Unit Care Coordinator) stated they did not know if staff were trained on hospice care and did not have any proof that this training was provided by the facility. Staff H stated training on hospice was important as the facility had many residents receiving hospice care. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/18/2025 at 12:16 PM Staff B (Director of Nursing) stated they did not know about specialized training on hospice care and did not think the facility provided this. REFERENCE: WAC 388-97-1680(1)(2)(a)(b)(ii)(c).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50511 Based on interview and record review, the facility failed to implement a system to ensure 1 of 1 (Staff CC) nursing aides reviewed for training received the required training for continued competency of no less than 12 hours per year. The failure to implement a system to provide mandatory training on dementia management, abuse prevention, and other specialized resident needs placed residents at risk for abuse, neglect, emotional distress, and physical injury. Findings included . In an interview and record review on 03/17/2025 at 1:42 PM, Staff C (Regional Director of Clinical Services) reviewed the personnel file for Staff CC and found no training documents related to abuse, neglect, exploitation, infection control, communication, resident rights, or cultural competency after Staff CC's hire date of 08/05/2024. Staff C stated the facility currently had no staff development coordinator who tracked nursing assistants continuing education and annual training requirements for mandatory topics or the topics related to resident population's special needs. REFERENCE: WAC 388-97-1680(2)(a-c).