STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to provide care and services that ensured privacy in a manner that maintained and promoted resident rights and resident dignity for 2 of 3 sampled residents (Residents 46 & 276) reviewed for dignity concerns. Failure to dress residents, provide privacy, and assist with toileting placed residents at risk for diminished resident rights, feelings of institutionalization, embarrassment, frustration, disrespect, and diminished self-worth. Findings included . <Resident 46> According to the 09/11/2023 Significant Change Minimum Data Set (an assessment tool), Resident 46 admitted to the facility on [DATE], had multiple medical conditions and impaired memory. Resident 46 was assessed to require one to two-person extensive assistance with transfers, dressing, toileting, and oral hygiene. Observations on 03/17/2024 at 11:23 AM and 2:02 PM, 03/18/2024 at 9:00 AM, and 03/19/2024 at 9:16 AM showed Resident 46 was lying in their bed wearing only a brief. The door and privacy curtain were open allowing staff, other residents, and visitors to see Resident 46 lying in their brief from the hallway. In an interview on 03/19/2024 at 9:35 AM, Resident 46 stated they did not want to wear clothes. Review of Resident 46's comprehensive Care Plan (CP) showed staff did not include Resident 46's refusals to wear clothes or preferred to lay in bed with no clothes on. In an interview on 03/20/2024 at 1:18 PM, Staff P (Social Services Assistant) stated they were aware of Resident 46 refused to wear clothes in bed, but they did not document the refusals in Resident 46's record. In an interview on 03/20/2024 at 1:25 PM, Staff O (Social Services Director) stated staff should have documented Resident 46's preferences/refusals in the CP to direct staff to provide privacy to Resident 46. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/20/2024 at 1:42 PM, Staff C (Assistant Director of Nursing) stated staff should have offered Resident 46 assistance to get dressed and document the refusals in Resident 46's record. Staff C stated staff should have provided privacy by pulling the privacy curtain and closing the door per Resident 46's preferences, but they did not. 46479 <Resident 276> Review of a 03/12/2024 emergency department provider note showed Resident 276 arrived to the emergency department after a fall resulting in a fractured pelvis. This note showed Resident 276 denied bladder or bowel dysfunction. The provider note showed prior to the fall, Resident 276 was independent with Activities of Daily Living (ADL). Review of a 03/13/2024 hospital Occupational Therapy (OT) evaluation showed OT recommended Resident 276 use a bedside commode for toileting. Review of a 03/15/2024 facility OT evaluation and plan of treatment document showed Resident 276 admitted to the facility on [DATE]. The evaluation showed prior to admission to the facility, Resident 27 was independent with toileting needs. The functional skills portion of this assessment showed Resident 276 was dependent on staff for toileting hygiene and transferring to the toilet. Review of the 03/15/2024 ADL CP showed Resident 276 was not toileted due to having incontinence of their bowel and bladder. This CP directed staff to provide total assistance to Resident 276 for all their incontinent care and hygiene needs. In an interview on 03/17/2024 at 12:06 PM, Resident 276 stated they were up all night, no one checked on me. Resident 276 stated they had to lie in their dirty underwear all night. Resident 276 stated staff told the resident to go pee and number two in my diaper. Resident 276 stated they knew when they had to go to the bathroom, and they were not incontinent of bowel or bladder. In an interview on 03/19/2024 at 6:58 AM, Resident 276 stated they were still using their diaper as a bathroom. In an interview on 03/22/2024 at 8:39 AM, Staff C stated staff referred to hospital documents to assist with initial CP development and assessment of toileting needs. Staff C stated staff should never encourage a resident to use their brief instead of a toilet and stated if a resident wanted to use the toilet, they had the right to do so. Staff C stated if there were barriers to using the toilet, the staff should seek alternative methods to meet the resident's needs. REFERENCE: WAC 388-97-0180.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 46471 Based on interview and record review, the facility failed to ensure 21 of 24 residents (Residents 33, 31, 9, 21, 11, 19, 23, 15, 17, 1, 20, 7, 8, 2, 5, 42, 51, 12, 46, 4, 37, 41, 40, & 27) who had a Trust Account with the facility had their funds covered by a surety bond. This failure placed residents at risk to be unable to recover their money in the event of loss of funds from their account. Findings included . <Facility Document> According to the 07/09/2021 Surety Bond, the facility purchased a surety bond to secure and/or replace residents' personal funds that were deposited with the facility, including any interest accrued by these accounts, if misappropriated, misplaced or otherwise lost, withheld, or improperly distributed. The document showed the bond amount covered was not to exceed $21,000 and was effective on 06/30/2021. Record review of the facility's Trial Balance report showed 24 residents had funds in trust accounts. Three of the personal fund accounts totaled $21,036.60 (surety bond limit). The trust account report showed a total current balance of $33,771.68 for all 24 residents as of 03/18/2024, and was in excess of the facility's purchased surety bond. In an interview on 03/21/2024 at 1:26 PM, Staff R (Business Office Manager) stated the surety bond should be more than the total amount in the trust accounts. Staff R confirmed the facility's surety bond did not cover the current facility trust account balance. REFERENCE: WAC 388-97-0340(6).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review the facility failed to ensure residents were informed and provided written information concerning their rights to accept, refuse, or formulate an Advance Directive (AD) for 6 of 21 residents (Residents 60, 44, 28, 30, 226, & 3) reviewed for ADs. This failure placed residents at risk for not having a surrogate decision maker when unable to make their own healthcare decisions. This failure placed the residents at risk of losing their rights to have their stated preferences/decisions regarding end-of-life care followed. Findings included . <Facility Policy> Review of the facility's policy titled Advanced Directives, revised May 2023, showed facility staff would determine upon admission whether the resident had an AD and if not, the resident would be offered information regarding ADs. This policy showed staff would document in the resident's record whether an AD was executed and each offering of information to the resident regarding ADs. <Resident 60> According to the 02/21/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 60 had multiple complex medical conditions including kidney failure with dependence on dialysis (a treatment to filter waste from the blood) and unstable blood sugar levels in the body. Review of the 11/20/2023 Social Services (SS) progress note showed Resident 60's representative would drop off healthcare Durable Power of Attorney (DPOA) paperwork. There was no copy of an AD for Resident 60 showing their family had DPOA. In an interview on 03/20/2024 at 12:40 PM, Staff O (SS Director) stated they communicated with Resident 60's representative, but did not follow up. Staff O stated they should have followed up and assisted the resident to initiate an AD, but they did not. <Resident 44> According to the 02/29/2024 Annual MDS, Resident 44 was admitted to the facility on [DATE], had clear speech and was able to understand others during communication. The assessment showed Resident 44 had multiple medical conditions including weakness to one side of their body from a stroke, and a brain injury related to cancer. In an interview on 03/19/2024 at 12:37 PM, Resident 44 stated they did not have an AD. Resident 44 stated they were not offered assistance from the facility to initiate an AD. Review of Resident 44's medical records showed there was no AD or DPOA paperwork in Resident 44's record. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/20/2024 at 12:50 PM, Staff O reviewed Resident 44's record and stated there was no AD or DPOA paperwork in Resident 44's record. Staff O stated they should have followed up with Resident 44's representative about AD or DPOA paperwork, but they did not. <Resident 28> According to the 02/19/2024 Admission MDS, Resident 28 admitted to the facility on [DATE], had clear speech and was able to make their own decisions. The assessment showed Resident 28 had complex medical conditions including uncontrolled blood sugars and heart failure. In an interview on 03/20/2024 at 11:29 AM, Resident 28 stated they did not have an AD or a DPOA. Resident 28 stated staff did not communicate with them about initiating an AD. Resident 28 stated they did not meet with SS staff since they were admitted to the facility. Review of Resident 28's medical record showed no documentation of an AD or DPOA paperwork in Resident 28's record. In an interview on 03/20/2024 at 12:52 PM, Staff O reviewed Resident 28's record and stated there was no AD or DPOA paperwork in Resident 28's record. Staff O stated they should have offered assistance to initiate an AD for Resident 28, but they did not. 46471 <Resident 30> According to the 02/29/2024 Quarterly MDS, Resident 30 had clear speech and had medical conditions including chronic pain, heart disease, memory impairment, anxiety, and mood disorder. Review of Resident 30's medical records showed a 01/04/2019 AD Policy Record form indicating Resident 30 did not have a written AD and that information and assistance was offered. The facility was not able to provide any documentation to support a follow-up was made for Resident 30. In an interview on 03/19/2024 at 8:19 AM, Staff O stated offering assistance to formulate and/or obtain an AD was important so the resident would have a support system in place in the event where they could no longer voice their own needs from memory decline. Staff O stated Resident 30 should have an AD or guardianship in place, but did not. <Resident 226> According to 02/22/2024 Admission MDS, Resident 226 admitted to the facility on [DATE], had clear speech, understands, and understood others during communication. The MDS showed Resident 226 had medical conditions including a systemic infection, lung disease, and malnutrition. In an interview on 03/17/2024 at 1:32 PM, Resident 226 stated they did not have an AD and was not provided education or offered assistance by staff. Resident 226 stated they wanted to involve their family member in formulating an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 226's SS notes from 02/15/2024 until 03/20/2024 did not show documentation to support Resident 226 was educated or provided assistance to initiate an AD. In an interview on 03/19/2024 at 8:19 AM, Staff O stated, .we missed that one. 46479 <Resident 3> Review of the 02/29/2024 Admission MDS showed Resident 3 had diagnoses of heart failure, end stage kidney failure requiring dialysis, and a fracture to their lower leg. Review of Resident 3's SS admission evaluation showed Resident 3 did not have an AD. This form did not indicate if Resident 3 wished to formulate an AD or if Resident 3 was offered assistance to formulate an AD. In an interview on 03/19/2024 at 8:19 AM, Staff O stated ADs were reviewed on admission and quarterly. If a resident did not have an AD, they were offered a packet with information regarding ADs. Staff O stated they did not document Resident 3 was provided information regarding ADs. REFERENCE: WAC 388-97-0280(3)(c)(i-ii).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46471 Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Notice of Medicare Non-coverage (SNF-NOMNC - a required form notifying the resident that their skilled services coverage was ending and would no longer be covered by their Medicare A benefits) as required for 1 of 3 residents (Resident 68) reviewed for beneficiary notification. This failure placed Resident 68 and other residents at risk for not being fully informed and losing their right to an appeals process. Findings included . <Facility Policy> According to the facility policy titled, SNF Beneficiary Notices Under Medicare Part A, revised 11/14/2022, the facility would inform Medicare A beneficiaries when they no longer met the skilled coverage criteria. The policy showed a NOMNC was given by the facility to all Medicare beneficiaries at least two days before the end of their Medicare covered Part A stay because the notice contained information regarding the beneficiary's right to an expedited appeals process review by a Quality Improvement Organization. <Resident 68> The 02/21/2024 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 68 admitted to the facility under their skilled Medicare A benefits with a start of care date of 02/14/2024. The Discharge MDS showed Resident 68's Medicare A benefits ended on 02/29/2024. Review of the facility census showed Resident 68 discharged to the community on 02/29/2024. A 02/26/2024 physician progress note showed Resident 68 verbalized they were ready for discharge on 02/29/2024 in the afternoon once their antibiotic therapy was completed. The 02/29/2024 nursing progress note showed Resident 68 was discharged to their home accompanied by their family member. Review of Resident 68's medical records did not show a NOMNC was not provided at least two days prior to the last covered day. In an interview of 03/19/2024 at 8:51 AM, Staff O (Social Services Director) stated it was important to provide beneficiary notices to residents whose skilled services were ending so residents could prepare themselves for a safe discharge or they could exercise their right to an appeals process if/when residents felt they needed more services. Staff O stated they should have, but did not provide Resident 68 a NOMNC as required. REFERENCE: WAC 388-97-0300(1)(e), (5), (6).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42203 Based on observation and interview, the facility failed to ensure a clean, comfortable, and homelike environment for 4 of 4 halls. The failure to ensure resident rooms were free of wall scrapes, to provide an environment free of institutional-style overhead paging, to ensure resident bedroom windows had adequate coverings, and to ensure sufficiently warm water temperatures in resident bathrooms left residents at risk for a diminished quality of life, and a less than homelike environment. Findings included . <Walls> Observation on 03/17/0224 at 8:52 AM showed the wall behind bed 1 in room [ROOM NUMBER] had considerable scrapes where the head of the bed rubbed against the wall. There were black marks and gashes of exposed drywall. Observation on 03/17/2024 at 9:20 AM showed the baseboard in room [ROOM NUMBER]'s bathroom and on the wall outside the bathroom door had multiple dents and had areas where the paint was scraped off. Observation on 03/19/2024 at 10:07 AM showed in B hallway, in front of room [ROOM NUMBER] and 17, wallpaper was coming off. In an interview on 03/22/2024 at 12:09 PM, Staff U (Maintenance Director) stated keeping up with maintenance of the facility's walls was a chronic problem. Staff U observed the scraped wall behind bed 1 in room [ROOM NUMBER] and stated it needed to be painted. 46471 <Overhead Paging> Observation on 03/18/2024 at 9:17 AM, showed an overhead announcement was made regarding a resident needing assistance from a nursing staff in their room. Observation on 03/18/2024 at 10:22 AM, showed an overhead announcement was made informing residents who wanted to attend the activity to gather in the main dining room. Observation on 03/18/2024 at 1:30 PM, showed an overhead announcement was made requesting a nurse to answer a phone call and get report for a resident who was getting admitted to the facility. In an interview on 03/22/2024 at 8:58 AM, Staff L (Chief Nursing Officer) stated it was important to provide residents with a homelike environment and to decrease and/or eliminate institutional characteristics such as using the overhead paging system, .this [facility] is their [residents] home, we [staff] should be respectful of it . <Window Treatments> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 226> According to 02/22/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 226 had clear speech, understands, and understood others during communication. Observation and interview on 03/17/24 at 1:43 PM showed some of Resident 226's bed was by the window and the blinds were missing pieces/broken, allowing sunlight to enter the room when the blinds were closed. Resident 226 stated the condition of their window treatment affected them because they sunburned easily and often, the sunlight coming from the window in the afternoon was intense. In an interview on 03/22/2024 at 8:58 AM, Staff L stated the facility should be maintained to provide residents a homelike environment. In an interview on 03/22/2024 at 9:58 AM, Staff U (Maintenance Director) stated it was important to provide residents a homelike environment, so the residents felt comfortable living in it. Staff U confirmed the condition of the window blinds in Resident 226's room and stated, Yes, the blinds needed repair. 46479 <Cold Water> <Resident 277> In an interview on 03/17/2024 at 10:54 AM, Resident 277 stated the water was cold in the bathroom when they would wash their hands and face. In an observation on 03/18/2024 at 12:32 PM, the surveyor turned the water on in the bathroom and let it run for one minute. The water temperature at that time was 80.7 degrees Fahrenheit (a more appropriate water temperature for a swimming pool than water from a hot water tank). <Resident 58> In an observation and interview on 03/18/2024 at 9:26 AM, Resident 58 stated the water in the bathroom was cold. Resident 58 stated staff gave the resident a cold washcloth earlier in the morning and stated [staff] had the water going for a while. In an observation at that time, the surveyor turned the hot water on and left it running for one minute, the water remained cool and did not get warm after one minute. Observations on 03/22/2024 at 10:10 AM showed the hot water in the bathrooms of room [ROOM NUMBER], 32, 45, and room [ROOM NUMBER] remained cool. In an interview on 03/22/2024 at 9:58 AM, Staff U stated they were aware of the cold water in resident rooms since August of 2023. Staff U stated there was an issue with a value that was not resolved. REFERENCE: WAC 388-97-0880.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on observations, interviews, and record review, the facility failed to initiate and complete a thorough grievance investigation for 2 of 2 residents (Residents 42 & 71) who were reviewed for grievances. The facility failed to ensure there was a resolution for lost property (Resident 42) and how the environmental noise affected their quality of life (Resident 71). These failures placed residents at risk for frustration and a diminished quality of life. Findings included . <Facility Policy> According to the facility policy titled, Grievances, revised 02/2024, employee responsibilities in the grievance process included: (1) initiating the Resident Grievance Report for all concerns brought forth by residents, and (2) immediately providing the completed report to the Grievance Officer or designee. The policy showed the responsible department for the grievance identified would communicate with the resident/representative and would attempt to resolve the issue within five days. The policy showed the Grievance Officer or designee would follow-up with the resident/resident representative about the grievance to ascertain satisfaction with the resolution of the reported concern. <Resident 42> Review of the 01/05/2024 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 42 had clear speech, understands, and understood others during communication. On 03/18/2024 at 9:26 AM, Resident 42 stated their white blouse/shirt, which had their name on it, went missing last week and was not found, or given any update by staff. Resident 42 stated they recall telling Staff S (Certified Nursing Assistant), . [Staff S] filled out a form for me. Review of the facility Grievance Logs from 09/15/2023 until 03/18/2024 showed no listed grievance from Resident 42. In an interview on 03/21/2024 at 9:11 AM, Staff S stated when residents tell them personal property was missing, they would initiate the grievance form and would hand it to social services. When asked if they recall Resident 42 telling them their clothes were missing and filling out a grievance form for the resident, Staff S stated, Yes, I gave the form to Staff O [Social Services Director]. In an interview on 03/21/2024 at 9:26 AM, Staff O stated they did not receive any grievance form from Staff S. Staff O reviewed the copies of grievance forms they kept for monitoring and stated there was none for Resident 42. Staff O stated it was important to complete a grievance form for residents with missing properties to ensure a resolution, either found or replaced, was achieved. <Resident 71> (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 02/29/2024 Admission MDS showed Resident 71 admitted to the facility on [DATE], had clear speech, their memory was intact, and they understood others during communication. Review of the facility census showed Resident 71 was in room [ROOM NUMBER]-2 from 02/25/2024 until 03/14/2024, and then moved to room [ROOM NUMBER]-1 on 03/15/2024. On 03/17/2024 at 11:16 AM, Resident 71 stated they verbalized concerns to social services staff regarding the noise level (when they were still residing in room [ROOM NUMBER]-2) and losing sleep because their roommate kept yelling for help during the day and throughout the night. Resident 71 stated they were moved to the next room over, in room [ROOM NUMBER]-1, but they remained to be bothered by the resident's calling out behavior, .last night, the yelling ran for four hours and it was too difficult to get some sleep . Resident 71's current roommate (in room [ROOM NUMBER]-2) validated Resident 71's statement and stated they were bothered both by the noise level especially at night. This roommate stated they formally wrote a grievance report themselves regarding the same issue. Review of the facility provided Grievance Logs from 09/15/2023 until 03/18/2024 showed there was no grievance investigation initiated for Resident 71. The log showed the resident in room [ROOM NUMBER]-2 filed their grievance on 03/04/2024 and showed a resolution was achieved. In an interview on 03/21/2024 at 8:30 AM, Staff A (Administrator) stated it was important to have a grievance process so the residents would have a voice, their rights addressed, and gave the facility the opportunity to improve, .keeps us [staff] aware of what is going on, of any lingering issues, to be able to identify trends and help improve the facility environment . Staff A stated they expected all employees to know and complete the grievance process. In an interview on 03/21/2024 at 9:28 AM, Staff V (Life Enrichment Director) stated Resident 71 grieved about their yelling roommate during the resident council meeting but they did not think about initiating a grievance investigation or following up accordingly to ensure a resolution was achieved. REFERENCE: WAC 388-97-0460.

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45941 Based on interview and record review, the facility failed to ensure a system by which the Office of the State Long-Term Care Ombudsman (LTCO) received required resident discharge information for 3 of 4 sampled residents (Residents 60, 49, & 42) reviewed for discharge to the hospital. Failure to ensure required notification was completed, prevented the Ombudsman's office the opportunity to educate residents and advocate for them regarding the discharge process. Findings included . <Facility Policy> According to the facility policy titled, Bed-Hold: Notification Notice of Bed-Hold Policy and Return (Voluntary Transfer to Hospital and Therapeutic Leave, revised 09/2022, the facility would provide the LTCO a copy of the transfer/discharge notices completed for hospitalized residents. <Resident 60> According to the 11/10/2023 and 01/12/2024 Discharge Minimum Data Sets (MDS - an assessment tool), Resident 60 was discharged to an acute hospital twice: On 11/10/2023 and was readmitted to the facility on [DATE]; and on 01/12/2024 and was readmitted on [DATE] respectively. Review of Resident 60's medical records did not show documentation indicating the LTCO was notified of the resident's hospital transfers for either the 11/10/2023 or 01/12/2024 discharge as required. 46479 <Resident 49> Review of a 03/10/2024 Nursing Progress Note (NPN) showed nursing staff assessed Resident 49 with shortness of breath and a low blood-oxygen level. The NPN showed Resident 49 was transferred to the hospital by ambulance. Review of Resident 49's census information showed the resident was hospitalized on [DATE] and readmitted to the facility on [DATE]. Record review did not show documentation indicating the LTCO was notified of Resident 49's transfer as required for their 03/10/2024 hospital transfer. 46471 <Resident 42> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/05/2024 Annual MDS, Resident 42 had clear speech, understands and understood others during communication, and had medical conditions including unstable blood sugar levels in the body and malnutrition. In an interview on 03/18/2024 at 9:11 AM, Resident 42 stated they recalled being sent out to the hospital because of a bladder infection. Review of Resident 42's records showed a 05/23/2023 NPN indicating Resident 42 had increased confusion and the physician ordered to transfer the resident to the hospital for further evaluation. Review of Resident 42's census information showed the resident was discharged to the hospital on 05/23/2023 and readmitted to the facility on [DATE]. The facility was not able to provide any documentation to show the LTCO was notified for Resident 42's hospitalization as required. In an interview on 03/21/2024 at 10:23 AM, Staff O (Social Services Director) stated they did not complete the state's LTCO notification process or maintained communication logs in the facility's record. In a joint interview on 03/22/2024 at 9:39 AM, both Staff A (Administrator) and Staff L (Chief Nursing Officer) stated they expected the social services department to notify the ombudsman of residents' transfer/discharge to the hospital as required. Staff L confirmed the facility's ombudsman notification process was not being followed. REFERENCE: WAC 388-97-0120(1)(2).

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45941 Based on interview and record review, the facility failed to provide the resident and/or the resident's representative a written notice of the facility's bed hold policy, at the time of transfer or within 24 hours, for 3 of 4 sampled resident's (Residents 60, 49, & 42) reviewed for discharge. This failure placed the residents and/or their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized . Findings included . <Facility Policy> According to the facility policy titled, Bed-Hold: Notification Notice of Bed-Hold Policy and Return (Voluntary Transfer to Hospital and Therapeutic Leave, revised 09/2022, the resident and/or representative would be provided a written notice of the bed hold policy. The policy showed, within 24 hours after transfer, the facility would elicit verbal communication regarding the resident/representative's choice whether to accept or decline a bed hold. The policy showed the resident/representative's bed hold decision was documented in the resident's medical records (progress notes) or in the business office file. <Resident 60> According to the 11/10/2023 and 01/12/2024 Discharge Minimum Data Sets (an assessment tool), Resident 60 was discharged to an acute hospital twice: On 11/10/2023 and was readmitted to the facility on [DATE]; and on 01/12/2024 and was readmitted on [DATE]. Review of Resident 60's medical records did not show bed hold documentation to indicate Resident 60 or their representative accepted or declined a bed hold for both occurrences during their hospitalization . 46479 <Resident 49> Review of a 03/10/2024 Nursing Progress Note (NPN) showed Resident 49 was transferred to the hospital for shortness of breath and a low blood-oxygen level. Review of a 03/11/2024 Transfer/Discharge Notice/Bed Hold form for Resident 49 showed the bed hold portion of the document did not indicate whether the resident accepted or declined a bed hold. 46471 <Resident 42> (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 42's medical records showed a 05/23/2023 NPN indicating the resident had increased confusion and the physician ordered the resident's transfer to the hospital for further evaluation. Review of Resident 42's census information showed the resident was discharged to the hospital on 05/23/2023. Review of Resident 42's 05/24/2023 Transfer/Discharge Notice/Bed Hold form showed the bed hold portion of the document did not indicate whether Resident 42 accepted or declined a bed hold. In an interview on 03/20/2024 at 11:43 AM, Staff C (Assistant Director of Nursing) stated it was a resident's right to be notified of the facility's bed hold policy to assist the resident in making an informed decision, . whether to hold their bed and be accountable for the expenses that would be incurred or to decline the bed hold and be amenable to being given a different room/bed upon their return to our facility. Staff C stated the facility's bed hold notice did not include an acknowledgment that indicated the resident/representative's choice regarding their bed hold status and the document should show the decision made by the resident/representative. In a joint interview on 03/22/2024 at 9:39 AM, both Staff A (Administrator) and Staff L (Chief Nursing Officer) stated they expected staff to conduct the facility's bed hold process as required. Staff L confirmed the current bed hold electronic form documented in residents' medical records did not support and/or ensure resident rights were safeguarded because the option to select a choice was lacking. REFERENCE: WAC 388-97-0120(4).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to identify the need for and complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) for 1 of 21 sample residents (Resident 15). The failure to identify and complete a SCSA MDS left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings included . Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, (RAI, a manual directing staff on requirements for completion of a Minimum Data Set- MDS) dated [DATE] showed a SCSA must be completed within 14 calendar days after the facility determined or should have determined there was a significant change in the resident's physical or mental condition. An SCSA was appropriate if there were consistent patterns of changes, with either two or more areas of decline. <Resident 15> According to the 02/25/2024 Quarterly MDS Resident 15 usually understood and was understood by others in conversation and had severe memory impairment. The MDS showed Resident 15 had an acute onset change in mental status with inattention and disorganized thinking. The MDS showed Resident 15 had hallucinations and behaviors including intruding on others' privacy. The MDS showed Resident 15 required supervision/touching assistance for eating and oral hygiene, and partial/moderate assistance with lower body dressing and putting on/taking off footwear. Prior to the 02/25/2024 Quarterly MDS, the facility last completed an MDS assessment on 11/25/2023. The 11/25/2023 Quarterly MDS showed Resident 15 understood and was understood by others. This MDS did not indicate the presence of an acute onset mental status change. The MDS did not show Resident 15 had hallucinations. The MDS showed Resident 15 showed no behaviors during the assessment period. The MDS showed Resident 15 required set up/clean up assistance for eating and oral hygiene, and supervision/touching assistance for lower body dressing and putting on/taking off footwear. A 02/03/2024 nursing to therapy communication progress note showed Resident 15 was experiencing a possible change in condition in the following areas: Transfers, Positioning/Bed mobility, Falls, Safety/Judgment. A 02/13/2024 alert progress note showed Resident 15 hallucinated that two snakes were on their bed. In an interview on 03/22/2024 at 9:12 AM, Staff D (MDS Coordinator) stated a resident required a SCSA MDS when facility staff identified a resident had a significant decline in two or more areas. When asked if the facility should have identified Resident 15 required a SCSA MDS, Staff D stated they realized after completion of the 02/27/2024 Quarterly MDS they may have missed the opportunity to complete a SCSA MDS, That was a problem. For some reason, I did not do one. Staff D stated they emailed their regional nurse who asked Staff D if they wanted to start a SCSA MDS for Resident 15. Staff D stated they declined but should have said yes. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97 -1000 (3)(b).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 42203 Based on observation, interview, and record review the facility failed to ensure 8 of 24 residents' (Residents 55, 6, 7, 15, 27, 44, 60, & 42) Minimum Data Set (MDS - an assessment tool) were completed accurately to reflect the resident's condition. This failure placed residents at risk for unidentified and/or unmet needs. Findings included . <Facility Policy> The facility's revised 03/2024 MDS/RAI [Resident Assessment Instrument] policy showed the facility adhered to the Long-Term Care RAI 3.0 User's Manual for all policies related to MDS completion. <Resident 55> According to the 02/03/2024 Annual MDS Resident 55 had a severe memory impairment and required substantial/maximal assistance or was totally dependent on staff for care. The MDS showed Resident 55 had diagnoses including a history of stroke, and difficulty swallowing. The MDS showed Resident 55 had a feeding tube (a tube connected directly to the stomach to provide nutrition artificially). According to this MDS, Resident 55 received less than 25% of their daily caloric intake, and a daily average of less than 500 Cubic Centimeters (CCs) of artificial nutrition via their feeding tube daily during the assessment lookback period (from 0128/2024 through 02/03/2024). Review of the Physician's Orders (POs) showed a 07/18/2023 PO showing Resident 55 should not receive food or medication by mouth, and a 07/11/2023 PO to provide 1200 Milliliters (ML) of 1.5 calories/ML liquid nutrition daily via a feeding tube. The January 2024 Medication Administration Record (MAR) showed on 01/28/2024, 01/29/2024, 01/30/2024, and 01/31/2024 Resident 55 received 1200 ML of liquid nutrition which represented 100% of their caloric intake. The February 2024 MAR showed on 02/01/2024, 02/02/2024, and 02/03/2024 Resident 55 received 1200 ML of liquid nutrition which represented 100% of their caloric intake. This showed the MDS was inaccurate in assessing Resident 55 received 25% or less of their caloric intake via the feeding tube. In an interview on 03/20/2024 at 12:43 PM Staff D (MDS Specialist - Registered Nurse) stated the 02/03/2024 Annual MDS did not accurately reflect Resident 55's status regarding the total amount in ML, and percentage of their total nutrition provided via a feeding tube. Staff D stated that part of the MDS was complete by a contractor remotely. Staff D stated the MDS should have but did not accurately reflect the percentage of dietary intake the tube feeding tube provided for Resident 55. <Resident 6> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/04/2024 Annual MDS Resident 6 did not receive nutrition through a feeding tube while a resident. The MDS showed Resident 6 received 25% or less of their nutrition and a daily average of less than 500 CCs of artificial nutrition via their feeding tube daily during the assessment lookback period. Review of Resident 6's POs showed no tube feeding orders. <Resident 7> According to the 02/08/2024 Quarterly MDS Resident 7 did not receive nutrition through a feeding tube while a resident. The MDS showed Resident 7 received 25% or less of their nutrition and a daily average of less than 500 CCs of artificial nutrition via their feeding tube daily during the assessment lookback period. Review of Resident 7's POs showed no tube feeding orders. <Resident 15> According to the 02/25/2024 Quarterly MDS Resident 15 did not receive nutrition through a feeding tube while a resident. The MDS showed Resident 15 received 25% or less of their nutrition and a daily average of less than 500 CCs of artificial nutrition via their feeding tube daily during the assessment lookback period. Review of Resident 15's POs showed no tube feeding orders. <Resident 27> According to the 12/08/2024 Annual MDS Resident 27 did not receive nutrition through a feeding tube while a resident. The MDS showed Resident 27 received 25% or less of their nutrition and a daily average of less than 500 CCs of artificial nutrition via their feeding tube daily during the assessment lookback period. Review of Resident 27's POs showed no tube feeding orders. <Resident 44> According to a 02/19/2024 Annual MDS, Resident 44 did not receive nutrition through a feeding tube while a resident. The MDS showed Resident 44 received 25% or less of their nutrition and a daily average of less than 500 CCs of artificial nutrition via their feeding tube daily during the assessment period. Review of Resident 44's POs showed no tube feeding orders. <Resident 60> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 02/21/2024 Quarterly MDS, Resident 60 did not receive nutrition through a feeding tube while a resident. The MDS showed Resident 60 received 25% or less of their nutrition and a daily average of less than 500 CCs of artificial nutrition via their feeding tube daily during the assessment period. Review of Resident 60's POs showed no tube feeding orders. In an interview on 03/20/2024 at 12:43 PM Staff D stated the most recent quarterly and Annual MDSs for Residents 6, 7, 15, 27, 44, and 60 were all inaccurate with regard to tube feeding. Staff D stated because the residents did not use feeding tubes, the sections assessing the amount of nutrition these residents received should have been marked with dashes rather than given a value. 46471 <Resident 42> According to the 01/05/2024 Annual MDS, Resident 42 had clear speech, understands and understood others during communication, and had a diagnosis of diabetes (unstable blood sugar levels in the body). The MDS showed Resident 42 had adequate vision. The 11/02/2023 vision care plan showed Resident 42 had altered sensory function related to their visual disturbance. On 03/18/2024 at 9:17 AM, Resident 42 was in bed wearing their eyeglasses and was observed squinting while reading their electronic device. Resident 42 stated their eyes were bad and the grade in their eyeglasses were no longer appropriate. Resident 42 attempted to read the facility's daily activity chronicle but was only able to read the heading and stated they could not read the rest. Review of Resident 42's medical records showed a 05/23/2023 physician note indicating the resident had a diagnosis of diabetic eye disease (eye complication characterized by poor vision). A 06/05/2023 physician note showed Resident 42 complained of seeing double and was referred to see a specialist to rule out stroke (brain damage). In an interview on 03/20/2024 at 11:58 AM, Staff D stated it was important to ensure the MDS was completed accurately because it was the basis of the CP for resident care. Staff D stated they did identify Resident 42's vision impairment and the MDS was coded inaccurately. In an interview on 03/22/2024 at 8:31 AM, Staff A (Administrator) stated having adequate vision enabled resident's independence in performing their activities of daily living. In an interview on 03/22/2024 at 8:42 AM, Staff L (Chief Nursing Officer) stated Resident 42's vision deficit should have, but was not properly assessed during the MDS completion. Refer to F685- Treatment/Devices to Maintain Hearing/Vision. REFERENCE: WAC 388-97-1000(1)(b). 45941

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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 42203 Based on record review and interview, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR - a mental health screening required before transfer to a nursing home) assessments were revised to reflect mental health changes for 2 of 5 residents (Residents 7 & 44) reviewed for PASRRs. This failure left residents at risk for risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . <Facility Policy> According to the facility's April 2023 PASRR Requirements policy, if at any time the facility found a previous Level 1 PASRR was incomplete, erroneous, or no longer accurate the facility would immediately complete a new Level 1 PASSR screening. The policy showed as applicable the facility would submit the new level 1 to the state agency for consideration of Level 2 services. <Resident 7> According to the 02/08/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 7 had moderate memory impairment and verbal behaviors four-to-six times a week that interfered with activities, created a risk for injury, and disrupted care or the environment. The MDS showed Resident 7 had diagnoses including traumatic brain dysfunction, depression, and psychotic disorder. Record review showed the facility completed a Level 1 PASRR for Resident 7 on 06/23/2022. The 06/23/2022 Level 1 PASRR showed Resident 7 had depression, anxiety, and a psychotic disorder. The Level 1 PASRR showed Resident 7 was more resistant to care and verbally [and] physically aggressive . when staff provided care and indicated a Level 2 evaluation (a process to assess a resident's need for specialized mental health/behavioral services) was required. The revised 08/01/2023 new Level 1 PASRR completed . Care Plan (CP) included a goal for a Level 2 PASRR evaluation to be completed and recommendations implemented by 08/31/2022 for Resident 7. This CP included a 06/24/2022 intervention showing the facility's social services department would refer Resident 7 for a Level 2 PASRR evaluation. Record review showed no Level 2 PASRR was included in Resident 7's record. In an interview on 03/19/2024 at 10:35 AM, Staff O (Social Services Director) stated the purpose of a Level 1 PASRR screening was to assess residents for Serious Mental Illness (SMI) and intellectual disabilities. Staff O stated PASRR screenings were to be completed prior to admission, and when significant changes occurred such as increased behaviors, and if an initial screening was identified as incorrect. Staff O reviewed Resident 7's record and stated they did not see any follow up to the 06/23/2022 Level 1 PASRR. Staff O stated either a Level 2 evaluation or level 2 denial letter should be Resident 7's chart but was not. Staff O stated they would provide any additional documentation if located. No additional information was provided. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45941 <Resident 44> According to the 02/19/2024 Annual MDS, Resident 44 had diagnoses including brain cancer, dementia (loss of brain function which affects thinking and behavior), and psychotic disorder with delusions. The assessment showed Resident 44 received antipsychotic medication on a routine basis during the assessment period. This assessment showed Resident 44 had behaviors including threatening and cursing at others that put others at significant risk for physical injury. The assessment showed Resident 44's behavior worsened and affected Resident 44's participation in activities. Review of the 01/03/2023 Level I PASRR showed Resident 44 was identified with an SMI indicator for depression and no dementia diagnosis, and Level II PASRR evaluation was not required. Review of a 03/06/2024 psychiatrist's progress note showed Resident 44 was easily irritable, with intermittent anxiety during exam. The note showed Resident 44 declined medications for anxiety and stated, I do not want any more medications. The psychiatrist recommended staff continue monitoring Resident 44's behaviors for psychotic features. Review of the March 2024 Medication Administration Record showed Resident 44 received an antipsychotic medication every day for psychosis due to their diagnosis. In an interview on 03/20/2024 at 1:05 PM, Staff O stated Resident 44's Level I PASRR was updated on 01/03/2024 and a Level II PASRR was not indicated. Staff O stated Resident 44's behaviors worsened and the resident received antipsychotic medications twice daily. Staff O reviewed Resident 44's Level I PASRR and stated the form was inaccurate and required revision to refer to Level II evaluation in accordance with to Resident 44's current mental status. REFERENCE: WAC 388-97-1915 (1)(2)(a-c).

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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, record review, and interview the facility failed to ensure Care Plans (CP) were updated and/or revised as needed to reflect person-centered care for 3 of 21 (Residents 15, 276, & 226) sample residents whose CPs were reviewed, and failed to provide CP meetings for 3 of 5 sample residents (Residents 71, 28, & 44) reviewed for CP meetings. The failure to update and/or revise CPs or provide CP meetings left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings inlcuded . <Facility Policy> Review of the Care Planning Process facility policy revised 05/19/2023 showed the comprehensive CP was an interdisciplinary tool that must have measurable objectives with time frames and described the services to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The CP must be reviewed and revised at a minimum on admission, quarterly, and with a significant change in condition. <CP Updates/Revisions> <Resident 15> According to the 02/25/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 15 had diagnoses including a seizure disorder. Review of Resident 15's Physician's Orders (POs) showed 03/01/2023 and 10/24/2023 POs for a daily medication to treat seizures. Review of the 06/22/2022 seizure disorder CP showed this CP was not updated to include Resident 15's treatment with an anti-seizure medication. In an interview on 03/22/2024 at 9:45 AM, Staff B (Director of Nursing - DON) stated it was important for CPs to be updated for accuracy. Staff B stated Resident 15's CP should be updated to address the use of an anti-seizure medication. 46479 <Resident 276> Review of a 03/12/2024 emergency department provider note showed Resident 276 arrived at the emergency department after a fall resulting in a fractured pelvis. The note showed Resident 276 denied bowel or bladder dysfunction. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 03/13/2024 hospital Occupational Therapy (OT) evaluation showed OT recommended Resident 276 use a bedside commode for toileting. Review of a 03/15/2024 facility OT evaluation and plan of treatment showed Resident 276 admitted to the facility on [DATE]. The evaluation showed Resident 276 was independent with toileting prior to their fall. The functional skills portion of this assessment showed Resident 276 was dependent on staff for transferring to the toilet. Review of Resident 276's 03/15/2024 activity of daily living CP showed a different resident's name other than Resident 276's name. This CP identified the resident was incontinent of bowel and bladder and was not toileted. This CP did not address the correct resident or accurately identify Resident 276's needs. In an interview on 03/17/2024 at 12:06 PM, Resident 276 stated staff told the resident to pee in their diaper. In an interview on 03/19/2024 at 6:58 AM, Resident 276 stated they were still using their diaper as a bathroom. In an interview on 03/20/2024 at 11:19 AM, Staff Z (OT) stated they were able to assist Resident 276 to the toilet three times the previous day. In an interview on 03/22/2024 at 8:39 AM, Staff C (Assistant DON) stated Resident 276's CP was not accurate and confirmed it needed to be updated. 46471 <Resident 226> According to 02/22/2024 Admission MDS, Resident 226 had clear speech, understood others during communication, and had medical conditions including systemic infection, pulmonary disease, and muscle weakness. Observation on 03/17/2024 at 9:00 AM showed Resident 226 lying in bed and receiving three Liters Per Minute (LPM) of supplemental oxygen via a nasal cannula; an oxygen concentrator (a medical device that delivered supplemental oxygen) with a humidifier was on and situated next to Resident 226's bed. Review of a 02/27/2024 PO showed staff were to administer two LPM of supplemental oxygen to Resident 226 every 12 hours as needed for shortness of breath. Review of the 02/15/2024 respiratory CP showed Resident 226 had asthma related to allergies and directed nursing staff to monitor the resident's oxygen saturation (amount of oxygen in the blood). The CP did not show Resident 226 received supplemental oxygen. In an interview on 03/19/2024 at 1:31 PM, Staff C confirmed the use of supplemental oxygen was not captured in Resident 226's CP and stated the resident's CP should be revised, but was not. <CP Meetings> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 71> Review of the 02/29/2024 Admission MDS showed Resident 71 admitted to the facility on [DATE], had clear speech, their memory was intact, and understood others during communication. On 03/17/2024 at 12:04 PM, Resident 71 stated they did not recall being involved in the discussion of their CP or had a CP meeting since their admission. Review of Resident 71's social services progress notes from 02/22/2024 until 03/20/2024 did not show documentation that a CP meeting was conducted for the resident. In an interview on 03/21/2024 at 9:57 AM, Staff O (Social Services Director) stated a CP meeting was important to have because the meeting allowed the resident the opportunity to be informed of their care and to solicit their input. Staff O confirmed there was no CP meeting held for Resident 71 and stated they should have conducted one, but did not. 45941 <Resident 28> According to the 02/19/2024 Admission MDS, Resident 28 admitted to the facility on [DATE], had clear speech, and no memory impairment. The assessment showed Resident 28 had complex medical conditions including uncontrolled blood sugars and heart failure. In an interview on 03/17/2024 at 11:41 AM, Resident 28 stated they did not have a CP meeting since they admitted to the facility. Review of Resident 28's record did not show documentation Resident 28 had a CP meeting since their admission. In an interview on 03/20/2024 at 1:12 PM, Staff O reviewed Resident 28's record and confirmed there was no documentation regarding a CP meeting. Staff O stated they should have a CP meeting with the resident, but they did not. <Resident 44> According to the 02/29/2024 Annual MDS, Resident 44 was admitted to the facility on [DATE], had clear speech and no impaired memory. The assessment showed Resident 44 had multiple medical conditions including weakness to one side of their body from a stroke, and brain injury related to cancer. In an interview on 03/18/2024 at 9:29 AM, Resident 44 stated they did not recall having CP meeting for a long time. Review of Resident 44's record showed Resident 44's last CP meeting was documented on 01/10/2023, over 14 months ago. (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 03/20/2024 at 12:58 PM, Staff O reviewed Resident 44's record and confirmed Resident 44 did not have a CP meeting for over a year. Staff O stated there should be CP meetings scheduled on admission, quarterly, annually, and as needed for any condition changes. Staff O stated they should have scheduled a CP meeting for Resident 44 quarterly, but they did not. REFERENCE: WAC 388-97-1020(2)(c)(d).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42203 Based on observation, interview, and record review the facility failed to ensure: Physician's Orders (POs) were clarified for 2 (Residents 6 & 30) of 21 sample residents; blood pressure was measured as ordered for 2 (Residents 15 & 7) of 21 sample residents; and POs were followed for 2 (Residents 55 & 52) sample residents. These failures placed residents at risk for unmet care needs, inappropriate care, falling, weight loss, and other negative health outcomes. Findings included . <Clarifying Orders> <Resident 6> According to the 01/04/2023 Annual Minimum Data Set (MDS - an assessment tool) Resident 6 had medically complex diagnoses including insomnia, muscle spasms and three Stage 4 Pressure Ulcers (open areas of skin caused by pressure over bony prominences; Stage 4 indicating full thickness tissue loss with exposed bone, tendon, or muscle). The MDS showed Resident 6 received as-needed pain medications, and experienced pain that occasionally affected their sleep and day-to-day activities. Record review showed Resident 6 had two as-needed pain POs: a 01/08/2024 PO for a non-narcotic pain medication, give 500 Milligram (MG) by mouth every six hours as needed for pain or fever; a 02/21/2024 PO for a narcotic pain medication, give 10 MG every eight hours as needed for chronic pain. Neither order had parameters to show nurses under what circumstances each medication should be administered. Review of the March 2024 Medication Administration Record (MAR) showed Resident 6 was not provided their as-needed non-narcotic pain medication from 03/01/2024 through 03/18/2024. The March 2024 MAR showed Resident 6 was provided the narcotic pain medication six times from 03/01/2024 through 03/18/2024: once for a pain of 3 out of 10, once for a pain of 4 out of 10, three times for 5 out of 10 pain, and once for a pain of 7 out of 10. In an interview on 03/22/2024 11:08 AM Staff B (Director of Nursing) stated the narcotic pain medication should be administered for moderate to severe pain, and the non-narcotic pain medication should be used for mild pain. Staff B stated the orders did not specify when to administer which medication, and nurses should offer the non-narcotic medication first. <Resident 30> According to the 02/29/2024 Quarterly MDS, Resident 30 had clear speech and medical conditions including memory impairment, anxiety, and mood disorder. The MDS showed Resident 30 exhibited wandering behavior that occurred daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An 11/24/2023 behavior CP showed Resident 30 was an elopement risk because of their exit-seeking behavior and the resident wore a wander guard alarm (a safety device that sounded when near an exit) provided by the facility. A 02/21/2024 CP intervention directed the staff to monitor the resident's wander guard alarm. Observation on 03/17/2024 at 8:31 AM showed a wander guard alarm for Resident 30's wandering behavior was placed around the resident's left leg/ankle. Review of the March 2023 Treatment Administration Record (TAR) showed a 11/24/2023 order to check the wander guard alarm placement and the skin underneath the device on Resident 30's right ankle. The TAR order was signed off as completed by nurses on all three shifts (day, evening, and night) from 03/01/2024 until 03/19/2024. In an interview on 03/21/2024 at 12:46 PM, Staff C (Assistant Director of Nursing) confirmed the wander guard alarm was located on the left ankle of Resident 30 and not the right ankle as written in the TAR order. Staff C stated nurses should not be signing off on the TAR that the wander guard alarm placement and the skin integrity were checked because the order was incorrect. <Orthostatic Blood Pressure Measurement> <Resident 15> According to the 02/25/2024 Quarterly MDS Resident 15 had diagnoses including debility (physical weakness), seizures, psychotic disorder, bipolar disorder, and a history of falling. The MDS showed Resident 15 had two or more falls since the prior MDS assessment, and took antipsychotic and diuretic, opioid, and antidepressant medications. Resident 15's POs included 03/01/2023 POs to measure their orthostatic blood pressure (a safety measure where a resident's blood pressure is measured when lying, then sitting, and if practical, standing to monitor for changes in blood pressure with changes in elevation that could cause dizziness and falls). Review of the December 2023 MAR showed on 12/21/2023 Resident 15's blood pressure was measured at 118/72 when lying, 118/72 when sitting, and 118/72 when standing, indicating no change in blood pressure with change in elevation. Review of the January 2024 MAR showed on 01/20/2023 Resident 15's blood pressure was measured at 114/83 when lying, 114/83 when sitting, and 114/83 when standing, indicating no change in blood pressure with change in elevation. Review of the February 2024 MAR showed on 02/19/2023 Resident 15's blood pressure was measured at 122/66 when lying, 122/66 when sitting, and 122/66 when standing, indicating no change in blood pressure with change in elevation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/22/2024 at 9:45 AM Staff B stated orthostatic blood pressure were measured to monitor changes in blood pressure with elevation. Staff B stated it was unusual for blood pressure to stay the same when moving from lying to sitting, or from sitting to standing. Staff B reviewed the December 2023 through February 2024 MARs and stated it might be that staff documented incorrectly when Resident 15 refused or was unable to participate at the time to move from lying to sitting to standing. Staff B stated if that was the case the nurse should have documented as such on the MAR. <Resident 7> According to the 02/08/2024 Quarterly MDS Resident 7 had diagnoses including traumatic brain dysfunction, a seizure disorder, depression, and a mental health diagnosis. The MDS showed Resident 7 received antipsychotic, antidepressant, and narcotic pain medications. Review of Resident 7's POs showed 07/28/2022 POs to measure their orthostatic blood pressure lying and sitting every 30 days. Staff were not required to measure Resident 7's standing blood pressure as Resident 7 was not assessed to be safe to stand. Review of the January 2024 MAR showed on 03/21/2024 Resident 7's lying blood pressure was 112/65, and their sitting blood pressure was also 112/65. Review of the February 2024 MAR showed on 03/19/2024 Resident 7's lying blood pressure was 110/59, and their sitting blood pressure was also 110/59. In an interview on 03/22/2024 at 9:45 AM Staff B stated it was unlikely that Resident 7's blood pressure would not change with the change in elevation from lying to sitting. Staff C stated it was important to follow the PO and accurately document Resident 7's orthostatic blood pressure. <Following Orders> <Resident 55> According to the 02/03/2024 Annual MDS Resident 27 had severe memory impairment, and diagnoses including non-traumatic brain dysfunction, difficulty swallowing, dementia, and the presence of a feeding tube hole. The MDS showed Resident 55 received nutrition through a feeding tube. Review of Resident 55's POs showed a 07/11/2023 PO to provide 1200 ML of artificial nutrition via feeding tube at @ 60 ML/hour for 20 hours. The PO showed staff should start the pump at 12PM daily and finish the feeding at 8AM or until the total volume of 1200 ml was infused. The PO showed staff should document the total amount provided in ML. A 07/18/2023 order showed Resident 55 should not receive food or medications by mouth. The 03/05/2023 tube feeding Care Plan (CP) showed Resident 55's daily feeding should start at 12 PM and end at 8 AM or when 1200 ML was infused. Review of Resident 55's weight records showed no significant weight loss between 09/27/2023 and 03/15/2024. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Observation on 03/18/2024 at 12:41 PM showed the bottle of artificial nutrition was started on 03/18/2024 at 05:00 AM, rather than at 12 PM as ordered. The bottle had 875 ML of the artificial nutrition left, indicating the bottle was not started per the PO.

Observation on 03/19/2024 at 10:31 AM showed Resident 55's feeding pump was off. The artificial nutrition bag was not labeled to indicate when the feeding started but the tubing from the bottle was labeled at 3:20 PM. There was 800 ML of artificial nutrition left in the bottle, indicating the bottle was not started per the PO.

Observation on 03/21/2024 at 9:51 AM showed Resident 55's feeding pump was off. The bottle of artificial nutrition was labeled 03/21/2024 but the time it was started was not added. The bottle had 775 ML of the artificial nutrition remaining.

Observation on 03/22/2024 at 7:58 AM showed the artificial nutrition bottle labeled 03/22/2024 and did not include a time.

In an interview on 03/22/2024 at 8:23 AM Staff C (assistant Director of Nursing) stated nurses should provide Resident 55's artificial nutrition as ordered. Staff C stated the feeding should start at 12 PM and finish at 8 AM. Staff C stated nurses should label the artificial nutrition and tubing with a date and time.

46471

<Resident 52>

According to the 02/17/2024 Annual MDS, Resident 52 had clear speech, their memory was intact, and had medical conditions including heart failure, high blood pressure, and irregular heart rate/rhythm.

In an observation and interview on 03/17/2024 at 08:10 AM, Resident 52 was observed sitting in their wheelchair. Both their legs were wrapped with compression stockings. Resident 52 stated they took a diuretic (a medication that helped reduce fluid build-up in the body) daily to manage the swelling on their legs and their high blood pressure.

Review of Resident 52's POs showed a 02/27/2024 order for a diuretic daily. The order came with parameters instructing the nurse to hold the diuretic if Resident 52's heart rate was less than 60 beats per minute (BPM) and to notify the physician.

The March 2024 Medication Administration Record (MAR) showed, on 03/01/2024, Resident 52's heart rate was 55 BPM; the diuretic was administered to Resident 52 and was not held by the nurse as ordered. Review of Resident 52's progress notes from 03/01/2024 until 03/18/2024 did not show the nurse notified the physician as instructed.

In an interview on 03/20/2024 at 10:46 AM, Staff C confirmed the diuretic was administered outside the parameters by the nurse as shown in the MAR and stated there was no physician notification documented in Resident 52's medical records. Staff C stated they expected the nurses to follow medication parameters as ordered for resident safety.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 42203 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) for 3 of 5 (Residents 9, 30, & 46) who were assessed to be dependent on staff for ADLs, and 1 supplemental resident (Resident 27). The failure to provide ADL assistance as required left residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes. Findings included . <Facility Policy> According to facility's 12/20/2022 Personal Needs policy showed the facility would provide ADL support to all residents who required assistance. The policy showed residents' ADL needs would be care planned, and identified bathing, nail care, and oral care would be provided by the facility. 45941 <Resident 46> According to the 12/12/2023 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 46 had impaired memory and had a diagnosis of depression. The MDS showed Resident 46 required maximal assistance from staff with transferring, toileting, and personal hygiene. The MDS showed Resident 46 did not refuse care during the assessment period. The 06/06/2023 revised ADL Self Care deficit Care Plan (CP) showed Resident 46 required one person assistance for bathing and personal hygiene. The CP showed Resident 46 did not have a preference for nail care. Observations on 03/17/2024 at 11:25 AM, 03/18/2024 at 11:51 AM, and 03/21/2024 at 9:08 AM, showed Resident 46's fingernails were long and dirty, and their toenails were thick and curled under. In an interview on 03/20/2024 at 11:17 AM, Staff N (LPN - Licensed Practical Nurse) confirmed Resident 46 had long fingernails. Staff N stated the shower aide should have clipped Resident 46's fingernails. Staff N stated they would check with Social Services (SS) to add Resident 46 to the podiatrist list. In an interview on 03/20/2024 at 1:38 PM, Staff C (Assistant Director of Nursing) stated nail care was important for dependent residents. Staff C stated shower aides and nurses were educated to clip resident's nails weekly, but staff did not follow the instructions. Staff C stated staff should have clipped Resident 46's fingernails weekly, but they did not. Staff C stated staff should have notified SS so they could add Resident 46 to the podiatrist list for toenail care. 46471 <Resident 9> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/15/2024 Quarterly MDS, Resident 9 had medical conditions including severe memory impairment, depression, contractures, and adult failure to thrive. The MDS showed Resident 9 had functional limitations with their Range of Motion (ROM) on all four extremities and was assessed to require maximal assistance from staff for their oral hygiene. The 02/14/2024 ADL CP showed Resident 9 had a self-care performance deficit because of their cognitive impairment and limited ROM. A 04/29/2016 CP intervention showed Resident 9 needed one person assistance with their oral care. On 03/17/2024 at 10:08 AM, Resident 9 was observed sitting in their wheelchair and when the resident smiled, their teeth were noted black colored and severely carious/decayed. Food residue lined Resident 9's gum line and some were lodged in between the resident's front teeth. During a resident's representative interview on 03/17/2024 at 5:10 PM, Resident 9's representative stated they told staff the resident's teeth needed to be brushed more frequently because the representative observed Resident 9's teeth were unclean when they came to visit. In an observation and interview on 03/20/2024 at 2:33 PM, Resident 9 was observed in bed after eating their lunch with food residue still in their teeth/mouth. Staff N confirmed Resident 9's oral health condition and stated the resident's teeth needed better cleaning. <Resident 30> According to the 02/29/2024 Quarterly MDS, Resident 30 had clear speech and had medical conditions including memory impairment, anxiety, and a mood disorder. The MDS showed Resident 30 was assessed to require assistance with their personal hygiene. The 11/22/2023 ADL CP showed Resident 30 had a self-care performance deficit because of their cognitive impairment. A CP intervention directed staff to provide Resident 30 minimal to moderate assistance with their grooming and personal hygiene. In an observation and interview on 03/17/2024 at 8:38 AM, Resident 30's fingernails were observed to be long, some jagged, and with black residue under the nails. Resident 30 stated they wanted staff to trim and clean them. Similar observations regarding the condition of Resident 30's fingernails were observed on 03/19/2024 at 12:33 PM. In an interview on 03/20/2024 at 2:28 PM, Staff OO (Certified Nursing Assistant - CNA) stated it was important to keep residents' nails clean and trimmed for infection prevention, .germs could get lodged under the nails and that would be bad for residents with memory impairment, especially when they pick up and eat their food with their hands . Observation on 03/20/2024 at 9:10 AM showed Resident 30 was wearing a red stripped shirt and a pair of red and black plaid pants. On 03/21/2024 at 8:12 AM of the following day, Resident 30 was observed wearing the same set of clothes with brown stains on the left lower portion of the shirt. In an interview on 03/21/2024 at 12:21 PM, Staff KK (CNA) stated they were assigned to Resident 30 on 03/20/2024 during day shift and confirmed the clothes Resident 30 was wearing at that time were the clothes they helped the resident put on the day prior. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/21/2024 at 12:25 PM, Staff NN (CNA) stated they were the nursing aide assigned to Resident 30. Staff NN stated they did not assist Resident 30 with changing their clothes, .[Resident 30] was up and already dressed when I came in this morning. In an interview on 03/21/2024 at 12:28 PM, Staff C confirmed Resident 30 was wearing the same clothing from the previous day and stated, .yes, I have noticed the same thing too. Staff C stated the nursing staff should have provided Resident 30 dressing assistance but did not. In an interview on 03/21/2024 at 12:41 PM, Staff B (Director of Nursing) stated personal hygiene and grooming assistance, including nail care, should be provided to residents who were dependent on staff for resident comfort and dignity. <Resident 27> According to the 12/08/2024 Quarterly MDS Resident 27 had moderate memory impairment and diagnoses including dementia, one-sided paralysis, and heart conditions. The MDS showed Resident 27 required partial to moderate assistance with personal hygiene. According to the 11/17/2021 ADL self-care performance deficit CP, Resident 27 required total assistance with personal hygiene tasks. Resident 27's Kardex (instruction to CNAs) showed Resident 27 required total assistance with personal hygiene tasks. Observation on 03/17/2024 at 1:16 PM showed Resident 27's nails were dirty, with a brown residue under the nails. At that time, Resident 27 stated their nails should be cleaned. Observation on 03/22/2024 at 10:23 AM showed Resident 27's fingernails were dirty with a brown residue under the nails. At that time Staff LL (LPN) stated Resident 27's nails were dirty. Staff LL offered to clean and trim Resident 27's fingernails Resident 27 refused fingernail trimming stating they like the length but stated they wanted their fingernails cleaned because they were dirty. REFERENCE: WAC 388-97-1060(2)(c).

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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. 42203 Based on observation, interview, and record review, the facility failed to identify and provide care and services in accordance with the resident's goals and professional standards of practice in the areas of skin care/treatment and self-medication administration for 3 of 21 residents (Resident 15, 30, & 52) reviewed for quality of care. These failures placed residents at risk for undiagnosed condition of the skin and soft tissues, skin breakdown, unsafe medication administration, and a decreased quality of life. Findings included . <Resident 15> According to the 02/25/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 15 had highly impaired memory and medical diagnoses including heart failure, diabetes (unstable blood sugar in the body), mental health diagnoses, and heart failure. The MDS showed Resident 15 was assessed with no skin impairments. In an interview on 03/17/2024 at 8:31 AM, Resident 15 stated they were supposed to get a growth on the right side of their neck treated. Resident 15 stated nothing was done yet. Resident 15 showed a small lump under the skin on the right side of their neck. Review of the Physician's Orders (POs) showed a 02/29/2024 PO to complete a total body skin check each week. Review of Resident 15's comprehensive Care Plan (CP) showed no CP addressing the assessment or treatment of the lump on Resident 15's neck. A 10/24/2023 progress note showed an order was made for an ultrasound of Resident 15's neck and sent to the medical records department. Progress notes on 12/15/2023 and 03/05/2024 showed repeated orders for an ultrasound for Resident 15's neck In an interview on 03/21/2024 at 10:07 AM, Staff W (Medical Records) stated when an order was created for a resident, the nurse manager reviewed the order and send it to medical records. Once medical records processed the order requiring an appointment, the information was sent to the transportation coordinator, who would schedule the appointment. Staff W stated if they received the 10/24/2023 order, they would have processed it and notified the transportation coordinator of the resident's need for an appointment and transportation. In an interview on 03/21/2024 at 10:10 AM, Staff X (Transportation Coordinator) stated they did not receive notification from Staff W regarding Resident 15's 10/24/2023 PO for an ultrasound. (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 03/21/2024 at 10:48 AM, Staff B (Director of Nursing) provided documentation showing Resident 15 had an ultrasound of their neck on 03/06/2024, four months and 14 days after the original PO. The ultrasound showed a 1.9 x 1.0 x 1.7 centimeter mass. Staff B stated Resident 15 was referred to an Ear-Nose-Throat specialist after the ultrasound. Staff B stated the ultrasound should have, but was not provided timely. 46471 <Resident 30> The 02/29/2024 Quarterly MDS showed Resident 30 had clear speech and medical conditions including memory impairment, mental health diagnoses, and malnutrition. The MDS showed Resident 30 did not have skin issues during the assessment period. Observation and interview on 03/17/2024 at 8:36 AM showed Resident 30 had very thin, fragile skin. An adhesive dressing was on the resident's right forearm. Resident 30 stated they were unsure of what was underneath the dressing at the time, but believed it had something to do with them scratching their arm. The same observations where Resident 30 had an adhesive dressing were made on 03/18/2024 at 12:42 PM, on 03/19/2024 at 10:07 AM, on 03/20/2024 at 1:14 PM, and on 03/21/2024 at 8:45 AM. Review of a 03/08/2024 facility incident report showed Resident 30 had a skin impairment of unknown origin on the right forearm. The report showed the provider was notified and Resident 30 was diagnosed with dermatitis (a skin condition characterized by swelling and irritation) and was prescribed a medicated cream to be applied for five days. A 03/08/2024 skin CP showed Resident 30's right forearm dermatitis was identified and a CP intervention showed a skin treatment was to be done daily until the condition was healed. Review of the POs showed a 03/08/2024 order directing staff to cleanse the resident's right forearm irritation with normal saline, pat dry, apply a non-adhesive (non-stick) dressing, and wrap the right forearm with a cloth mesh (net-like) dressing. Review of the March 2024 Treatment Administration Record (TAR) showed the nurses signed off on the right forearm treatment as completed from 03/17/2024 until 03/20/2024 without using the dressing materials as ordered. During the skin/wound care observation on 03/21/2024 at 2:40 PM with Staff JJ (Licensed Practical Nurse), the skin on Resident 30's right forearm was observed dry and healing; the areas where the old adhesive dressing was attached was bright red. In an interview on 03/21/2024 at 2:23 PM, Staff C (Assistant Director of Nursing) confirmed the adhesive dressing applied by the nurses on Resident 30's right forearm from 03/17/2024 until 03/20/2024 as observed was not the treatment ordered for the resident. Staff C stated they expected the nurses to follow the PO/TAR as ordered for resident safety. <Resident 52> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 02/17/2024 Annual MDS, Resident 52 had clear speech, their memory was intact, and had medical conditions including diabetes. The MDS showed Resident 52 was administered insulin (injectable diabetes medication) daily during the assessment period. The 03/05/2024 diabetes CP showed Resident 52 was monitored by staff for diabetic medication effectiveness and side effects. Review of Resident 52's POs showed a 03/06/2024 order for insulin administration twice a day for the resident's diabetes. Review of the March 2024 Medication Administration Record (MAR) showed, from 03/07/2024 until 03/18/2024, Resident 52's injection site was not being rotated. The MAR report showed Resident 52's insulin was injected on their left abdominal area in 13 out of 23 opportunities of the medication being administered. On 03/19/2024 at 11:31 AM, Resident 52 stated they injected their own insulin, .they [nurses] give me my insulin pen and I inject it in my abdomen myself . Review of Resident 52's medical records did not show a self-administration of medication assessment was completed for the resident. In an interview on 03/20/2024 at 10:46 AM, Staff C confirmed Resident 52 was not assessed or evaluated for self-administration of their insulin. Staff C stated the nurses should be administering Resident 52's injectable medication themselves, .[nurses] need to perform the assessment first if [Resident 52] chooses to administer [insulin] on their own . Staff C stated they expected the nurses to rotate the insulin injection sites to decrease the risks of increased skin bruising and tissue damage. In an interview on 03/22/2024 at 8:27 AM, Staff L (Chief Nursing Officer) stated they expected the nurses to complete a self-medication administration assessment first before letting a resident do it themselves for resident safety. REFERENCE: WAC 388-97-1060(1).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 46471 Based on observation, interview, and record review, the facility failed to ensure residents with vision deficits were assessed and provided Assistive Devices (ADs) to maintain vision abilities for 1 of 1 residents (Resident 42) reviewed for vision needs. These failures placed Resident 42 and other residents at risk for unmet care needs and a decreased quality of life. Findings included . <Facility Policy> Review of the facility's policy titled, Vision and Hearing, revised 05/2023, the facility would assist residents in obtaining routine and prompt vision/hearing care. The policy showed the social services department would identify residents who needed eye examinations and would coordinate routine services. <Resident 42> According to the 01/05/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 42 had clear speech, understands and understood others during communication, and had a diagnosis of diabetes (unstable blood sugar levels in the body). The MDS showed it was very important for Resident 42 to have reading materials. The MDS showed Resident 42 had adequate vision and used a pair of eyeglasses as an AD. The 11/02/2023 vision care plan showed Resident 42 had altered sensory function related to their visual disturbance and listed vision consults as an intervention. On 03/18/2024 at 9:17 AM, Resident 42 was in bed wearing their eyeglasses and was observed squinting while reading their electronic device. Resident 42 stated their eyes were bad and their eyeglasses were no longer appropriate. Resident 42 stated it was a while since they last saw an eye doctor. Resident 42 stated they needed assistance to have their eyes checked so they could get a new pair of eyeglasses. Review of Resident 42's medical records showed a 05/23/2023 physician note indicating the resident had a diagnosis of diabetic eye disease (eye complication characterized by poor vision). A 06/05/2023 physician note showed Resident 42 complained of seeing double and was referred to see a specialist to rule out stroke (brain damage). The facility was not able to provide any documentation to support Resident 42 was provided an eye consultation to address their need for new prescription eyeglasses. In an interview on 03/21/2024 at 10:02 AM, Staff O (Social Services Director) stated they were not aware Resident 42 needed vision care services. Staff O confirmed Resident 42 was not in the list of residents to be seen for routine vision services. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/22/2024 at 8:31 AM, Staff A (Administrator) stated it was important to ensure vision care and services were provided to residents for better quality of life. Staff A stated adequate vision enabled resident's independence in performing their activities of daily living including their reading enjoyment. In an interview on 03/22/2024 at 8:42 AM, Staff L (Chief Nursing Officer) stated Resident 42's vision deficit should have, but was not properly assessed during the MDS completion. Refer to F641- Accuracy of Assessments. REFERENCE: WAC 388-97-1060(3)(a).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42203 Based on observation, interview, and record review the facility failed to ensure 1 of 5 residents (Resident 6) reviewed for Pressure Ulcers (PU) were provided ordered interventions they required for the prevention or worsening of PU. This failure to implement pressure reducing devices in accordance with physician's orders placed residents at risk for PU development, worsening of PU, pain, and a diminished quality of life. Findings included . <Facility Policy> The facility's revised 02/03/2023 Pressure Ulcer Prevention and Treatment policy showed all residents would be assessed for the risk of acquiring a PU, and individualized interventions would be identified and implemented. The policy identified support surfaces such as a bed or a wheelchair as possible interventions. <Resident 6> According to the 01/04/2023 Annual Minimum Data Set (MDS - an assessment tool) Resident 6 had medically complex diagnoses including Diabetes Mellitus (DM - a condition making regulation of blood sugar more difficult), Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) PU, and the presence of bacteria in their blood. The MDS showed Resident 6 had three Stage 4 PU, two present on admission. Review of the Physician's Orders showed a 02/20/2024 order for an air mattress (to help reduce pressure). The order directed staff to set the air mattress at a weight of 270 pounds (Lbs.) Record review showed Resident 6's current weight was 242 Lbs. taken on 03/15/2024. The 10/24/2023 air mattress with bolsters [related to] weakness to promote wound healing and pressure reduction . care plan had a goal for Resident 6 to be free of complications from use of an air mattress. The care plan directed staff to set the air mattress at 270 Lbs. Observation on 03/20/2024 at 12:22 PM showed Resident 6's air mattress set at 360 Lbs. rather than the 270 Lbs. ordered, which made the mattress firmer than ordered. There was a label attached to the air mattress pump directing staff to ensure the mattress was set at 270 Lbs. Resident 6's air mattress was observed to be set at 360 Lbs. on 03/21/2024 at 8:20 AM. At this time Staff T (Licensed Practical Nurse) confirmed the mattress was set at 360 Lbs. Staff T tried to adjust the mattress and struggled for several seconds before noticing and pressing the lock/unlock button. Once the mattress settings were unlocked, Staff T set the mattress to the correct setting of 270 Lbs. Staff T stated it was the responsibility of nurses to ensure the mattress was set correctly. Staff T stated they routinely checked the mattress for placement but did not realize they were required to also check the mattress pressure setting. Staff T stated they were unsure why the mattress was not set at 270 Lbs. as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/22/2024 at 11:02 AM Staff B (Director of Nursing) stated it was important for Resident 6's air mattress to be set correctly to prevent the development of more PU. REFERENCE: WAC 388-97-1060 (3)(b).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 42203 Based on observation, interview, and record review the facility failed to ensure restorative nursing services were provided for 3 of 4 residents (Residents 7, 55, & 44) reviewed for rehab/restorative. This failure left residents at risk for diminished Range of Motion (ROM), loss of function, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's revised 12/2022 Restorative Nursing policy, the facility would utilize the facility's Restorative Nursing Program (RNP) as needed to help residents attain or maintain their highest practicable level of physical, mental, and psychosocial functioning. The policy identified splinting as one type of RNP. <Resident 7> According to the 02/08/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 7 had a moderate memory impairment and diagnoses including traumatic brain dysfunction, left-sided paralysis following a stroke, and a left-hand contracture (a permanent tightening of the muscles, tendons, and nearby tissues that causing ROM issues in joints). The MDS showed Resident 7 did not refuse care during the assessment's seven-day lookback period and did not receive restorative nursing services during the lookback period. A 03/28/2022 Physician's Order (PO) showed staff should apply a splint (a device to stretch tightened muscles and tendons to prevent worsening of contractures) to Resident 7's left hand contracture each morning. The PO showed staff should remove the splint after eight hours. The 08/23/2023 self-care deficit related to stroke Care Plan (CP) included an intervention for staff to place a splint on Resident 7's left hand each morning. The CP showed the splint should be removed after eight hours, corresponding with the PO. Observation on 03/18/2024 at 9:59 AM showed Resident 7's left hand was clenched in a fist. There was no splint applied to Resident 7's left hand. Observation on 03/19/2024 at 10:14 AM showed Resident 7 up in their wheelchair. There was no splint observed on Resident 7's hand. At that time, Resident 7 stated nursing staff never splinted left hand. Observation on 03/20/2024 at 9:51 AM showed Resident 7 did not have a splint on their left hand at that time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview 03/21/2024 at 10:53 AM Staff L (Chief Nursing Officer) stated it was important to provide RNPs including splinting programs to maintain or improve residents' health. Staff L stated staff should provide the RNP as care planned. Staff L said the splinting should be done daily per the CP schedule. <Resident 55> According to the 02/03/2024 Annual MDS Resident 55 had diagnoses including non-traumatic brain dysfunction, a history of stroke, right-sided paralysis, and a contracture. The MDS showed Resident 55 required substantial to maximal assistance with toileting, dressing, personal hygiene, and moving side to side in bed, and was totally dependent on staff for transfers and showering. The MDS showed Resident 55 did not refuse care during the MDS's seven-day lookback period. A 03/05/2024 PO directed staff to splint Resident 55's right hand all day. The PO showed it was permissable to remove the splint for up to half an hour with turning. The PO showed the splint should be removed at night. The revised 01/25/2024 self-care performance deficit CP showed Resident 55 required daily splinting of their right hand. The CP showed to splint the right hand all day and stated it was permissable to leave off for up to 30 minutes, and to remove at night. Observation on 03/18/2024 at 12:44 PM showed Resident 55 in bed with no splint to their right hand. Resident 55 stated they did not recall staff ever splinting their hand. Further observations of Resident 55 with no splint on their right hand were made on 03/20/2024 at 12:26 PM and on 03/21/2024 at 1:03 PM In an interview on 03/21/2024 at 1:47 PM, Staff J (Certified Nursing Assistant) stated they never assisted Resident 55 with their splint because that was the responsibility of the restorative aide. Staff J stated they occasionally saw Resident 55's right hand splinted. In an interview 03/21/2024 at 10:53 AM Staff L stated Resident 55 should have received their RNP program according to the order and the CP. 45941 <Resident 44> According to a 02/19/2024 Annual MDS Resident 44 had functional limitations in their ROM on the left side of their body and was provided therapy services until 02/16/2024. The MDS showed Resident 44 did not reject care from staff. Review of a revised 08/31/2023 self-care deficit CP showed directions to restorative staff to place a splint on Resident 44's left hand three to six hours as tolerated three to six times per week and check skin before and after splint application. Observations on 03/17/2024 at 11:21 AM, 03/18/2024 at 9:34 AM, 03/19/2024 at 12:05 PM, and 03/21/2024 at 9:33 AM showed Resident 44 lying in their bed and their left hand was clenched in a fist. There was no splint applied to Resident 44's left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/21/2024 at 9:49 AM, Resident 44 stated the restorative aide never splinted left hand. Resident 44 stated their family needed to learn how to apply the splint themselves during their last visit with Resident 44. In an interview on 03/21/2024 at 9:53 AM, Staff S (Restorative aide) stated they did not apply splint to Resident 44's left hand as assigned. Staff S stated they should have provided the splinting program every day, but they did not. In an interview on 03/21/2024 at 10:53 AM, Staff L stated it was important to provide the RNP including ROM and splinting programs to improve resident's health and to prevent further contractures (joint tightenening). Staff L stated staff should provide the RNP as plan of care. Staff L stated the splinting program should be done as assigned to Resident 44's left hand to prevent further contracture, but it was not done. Refer to: F725 Sufficient Nursing Staff. REFERENCE: WAC 388-97-1060 (3)(d).

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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 45941

Based on observation, interview, and record review the facility failed to identify, assess, and implement interventions to prevent accidents for 3 of 6 residents (Residents 60, 71, & 72) reviewed for accidents. The facility failed to identify and assess 1 of 1 resident (Resident 60) for smoking, 1 of 1 resident (Resident 71) for a bolster air mattress (an air inflated mattress with propped up support to prevent accidental roll-outs), and 1 of 1 resident (Resident 72) for wander guard monitoring related to an elopement risk. These failures left residents at risk for injury, entrapment, and elopement.

Findings included .

<Facility Policy>

Record review of the facility policy titled, Smoking, updated on 08/2022, showed the facility would screen all residents who smoked upon admission, quarterly, and as needed to determine any special needs and to assess their ability to smoke independently. The policy showed the facility would store all smoking materials in a locked storage cabinet in the resident's room, at the nurse's station, or another designated location in the facility.

<Smoking>

<Resident 60>

According to the 02/21/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 60 had clear speech, their memory was intact, and they understood others during communication. The MDS showed Resident 60 required minimal assistance with transfers, toileting, and bed mobility. The MDS showed Resident 60 used a wheelchair (w/c) for mobility.

In an interview on 03/17/2024 at 1:33 PM, Resident 60 stated they smoked twice a day and had their smoking materials in their jacket. Resident 60 stated they knew the rule to not to smoke on facility property.

Review of Resident 60's record showed Resident 60 did not have a smoking assessment completed.

In an interview on 03/19/2024 at 7:58 AM, Staff N (Licensed Practical Nurse - LPN) stated staff knew Resident 60 was smoking and kept smoking materials with them. Staff N stated Resident 60 was alert enough to know to smoke safely away from the facility property.

In an interview on 03/19/2024 at 9:32 AM, Staff L (Chief Nursing Officer) stated the facility was a nonsmoking facility. Staff L stated they were unaware Resident 60 smoked or that Resident 60 kept smoking materials in their jacket. Staff L stated the expectation was to assess residents who smoked to determine if they were safe to smoke independently or needed supervision, but they did not complete the smoking assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/2024 at 9:36 AM, Staff A (Administrator) stated they were unaware Resident 60 smoked. Staff A stated staff should have notified the supervisor, completed the smoking assessment to determine if Resident 60 needed to be supervised, and the smoking material locked for safety reasons but they did not. 46471 <Bolster Air Mattress> <Facility Policy> According to the facility policy titled, Safety Device Application, revised 04/07/2023, a resident must be thoroughly evaluated for the use of safety devices by the Interdisciplinary Team. The policy showed the least restrictive safety device would be used by the facility as indicated by the resident's condition. <Resident 71> Review of the 02/29/2024 Admission MDS showed Resident 71 admitted to the facility on [DATE], had clear speech, their memory was intact, and understood others during communication. The MDS showed Resident 71 did not have any skin issues and was not a fall risk. Review of the facility census showed Resident 71 was in room [ROOM NUMBER]-2 from 02/25/2024 until 03/14/2024, and then moved to room [ROOM NUMBER]-1 on 03/15/2024. In an observation and interview on 03/17/2024 at 11:02 PM, Resident 71 was lying on a bolster air mattress in bed. Resident 71 stated the mattress and bed came that way when they were transferred in the room, .the mattress wasn't like this in the other room. Resident 71's roommate in room [ROOM NUMBER] stated the prior resident who discharged used it [bolster mattress]. Resident 71 stated they had difficulty transferring into their wheelchair freely to go to the bathroom because the raised bolsters hindered their movement. The 02/22/2024 Activities of Daily Living Care Plan (CP) showed Resident 71 required minimal staff assistance for transferring and toileting. Review of Resident 71's medical records did not show an assessment was completed regarding the resident's use of a bolster air mattress. In an interview on 03/17/2024 at 11:26 AM, Staff U (Maintenance Director) stated they were responsible for switching the bed back to a regular mattress when a resident who used one was discharged from the facility. Staff U stated it was important to ensure residents were using the appropriate mattress for safety, .we [staff] could not just give a resident any mattress . In an interview on 03/17/2024 at 11:39 AM, Staff JJ (LPN) stated the use of bolster air mattress could make residents feel trapped in their bed especially when the resident was mobile, .it would be difficult for them [residents] to self-transfer .they can also fall . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/17/2024 at 11:53 AM, Staff B stated an assessment must be conducted first before any device was used/put in place for residents that could compromise their safety, including a bolster air mattress. Staff B stated Resident 71 did not have a safety assessment completed because the resident did not need a bolster air mattress. Staff B stated the mattress should be removed and replaced with a regular bed. 46479 <Wander Guard Alarm> <Resident 72> Review of the 02/29/2024 Admission MDS showed Resident 72 had a diagnosis of a progressive memory loss disorder and was able to walk around their room and facility. This assessment showed Resident 72 wandered four to six days of the assessment period and used a wander guard alarm daily. Review of a 02/23/2024 Elopement CP showed Resident 72 was at risk for elopement related to attempting to exit the facility without supervision. Interventions included allowing Resident 72 to wander safely throughout the facility and Resident 72 had a wander alarm device to their right ankle. In an interview on 03/17/2024 at 8:45 AM, Resident 72 stated they were ready to go home and the resident provided most of their own care. In an observation on 03/17/2024 at 9:45 AM, Resident 72 was walking up and down the hallway looking for coffee. Review of Resident 72's March 2024 Medication Administration Record showed staff checked placement of Resident 72's wander guard alarm device twice daily. This MAR showed staff documented Resident 72 was without their wander guard alarm in place on the evening of 03/16/2024, both shifts on 03/17/2024, both shifts on 03/18/2024. Observation on 03/19/2024 at 10:30 AM showed Resident 72 without a wander guard alarm to either ankle. In an interview and observation on that day at 10:35 AM, Staff FF (Certified Nurse's Assistant) confirmed Resident 72 was missing their wander guard alarm. In an interview at that same time, Staff A (Administrator) stated Resident 72 sometimes removed their wander guard alarm and there should be a note in Resident 72's record related to self-removal of the device. In an observation and interview on 03/19/2024 at 10:51 AM, Staff HH (Licensed Practical Nurse) stated Resident 72 had a wander guard alarm. Staff HH stated they thought they saw Resident 72's wander guard alarm around 6:00 AM that morning. Staff HH checked Resident 72's right and left ankle and confirmed the wander guard alarm was missing. Review of Resident 72's Nursing Progress Notes (NPN) showed no progress notes on 03/16/2024, 03/17/2024, or 03/18/2024 related to the missing wander guard alarm. A NPN on 03/19/2024 at 11:18 AM showed Resident 72 was observed without the wander guard alarm. This note shows Resident 72 placed on increased supervised checks for monitoring at the present time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/21/2024 at 1:36 PM, Staff B (Director of Nursing - DON) stated if a resident's wander guard alarm was displaced, the resident would be placed on 15-minute safety checks and additional staff would be implemented to help with monitoring the resident. Staff B stated the 15-minute checks should be documented but was unable to provide documentation at that time. In a follow up interview on 03/22/2024 at 10:10 AM, Staff B stated they expected staff to notify the DON when a wander guard alarm was noted to be missing. Staff B stated 15-minute safety checks should be implemented immediately and Resident 72 should be placed on alert on 03/16/2024 when the device was first noted to be missing. At that time, Staff B stated staff put Resident 72 on alert but Staff B stated they did not have documentation for it. REFERENCE: WAC 388-97-1060(3)(g).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to ensure 2 of 2 sampled residents (Residents 176 & 226) reviewed for respiratory care received care and services consistent with professional standards of practice. The facility's failure to deliver oxygen therapy according to the physician ordered flow rates (Resident 176 & 226) and to ensure correct equipment use (Resident 226) placed residents at risk for potential negative outcomes such as over or under oxygenation, respiratory discomfort, and a decreased quality of life. Findings included . <Facility Policy> According to the facility policy titled, Oxygen Management, revised 08/2023, the facility would require that a physician's order be obtained prior to the administration of oxygen and all orders of oxygen therapy must include duration of use. The policy showed equipment used, including the oxygen concentrator (a medical device that delivered supplemental oxygen) and the prefilled humidifier to prevent possible nasal dryness. <Resident 176> Resident 176 admitted to the facility on [DATE] with a diagnosis of asthma (a lung disease with narrowing of the airway, inflammation, and difficulty breathing) and kidney failure. Observations on 03/17/2024 at 9:36 AM and 03/18/2024 at 8:10 AM showed Resident 176 was lying in bed and receiving supplemental oxygen at two Liter Per Minute (LPM) via a nasal cannula (a device that delivered extra oxygen through a tube and into the nose). Review of Resident 176's March 2024 Physician Orders (POs) showed there was no order to administer oxygen treatment to Resident 176. In an interview on 03/18/2024 at 10:24 AM, Staff N (Licensed Practical Nurse - LPN) reviewed Resident 176's record and stated there should be a PO to administer oxygen for Resident 176, but there was none. In an interview on 03/20/2024 at 11:41 AM, Staff C (Assistant Director of Nursing) stated staff should have called the physician and received the oxygen orders for Resident 176 prior to the administration, but they did not. Staff C stated staff should not provide any treatment without a PO. 46471 <Resident 226> According to 02/22/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 226 had clear speech, understood others during communication, and had medical conditions including systemic infection, pulmonary disease, and muscle weakness. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 02/15/2024 respiratory Care Plan (CP) showed Resident 226 had asthma due to allergies, and directed nursing staff to monitor the resident's oxygen saturation (amount of oxygen in the blood). The CP did not show supplemental oxygen was being administered to Resident 226. On 03/17/2024 at 9:00 AM, Resident 226 was observed lying in bed and receiving three LPM of supplemental oxygen via a nasal cannula; the humidifier bottle attached to the oxygen concentrator was observed empty. Review of Resident 226's PO showed a 02/27/2024 order to administer two LPM of supplemental oxygen every 12 hours PRN (as needed basis) for shortness of breath. In an interview on 03/17/2024 at 11:43 AM, Staff JJ (LPN) stated the amount of supplemental oxygen ordered for Resident 226 was two LPM and not three LPM as observed. Staff JJ stated the humidifier bottle should be changed to avoid nasal injuries (nosebleed) and prevent Resident 226's nasal airways from drying up, but was not. Observations and interview on 03/17/2024 at 9:00 AM, 03/18/2024 at 10:17 AM, and 03/19/2024 at 12:48 showed Resident 226 was administered supplemental oxygen. Resident 226 stated they were using supplemental oxygen continuously and would take the nasal cannula off when personal care was being provided to them in bed, .only when [staff] are turning and changing me in bed. I need to have it [supplemental oxygen] on all the time even if I am just lying here so I don't get short of breath. Review of the March 2024 Medication Administration Record (MAR) did not show the PRN order was being signed off by the nurses who administered the supplemental oxygen to Resident 226. The facility was not able to provide any documentation to support the nurses did account for the PRN order administered as observed. In an interview on 03/19/2024 at 1:31 PM, Staff C stated the administration of PRN supplemental oxygen should be documented in the MAR so the physician could track Resident 226's supplemental oxygen use and determine if the order needed adjustment. Staff C stated the nurses should have, but did not notify the physician regarding Resident 226's duration of supplemental oxygen use (PRN versus continuous). REFERENCE: WAC 388-97-1060 (3)(j)(vi).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45941 Based on interview and record review, the facility failed to ensure ongoing communication and collaboration about resident's health with the kidney center occured regarding dialysis (a procedure to clean and filter the body's waste products) treatment and services for 2 of 2 sampled residents (Resident 60 & 3) reviewed for dialysis care. These failures placed residents at risk for unmet care needs, unidentified medical complications, and adverse health outcomes. Findings included . <Facility Policy> According to the facility's undated Dialysis Management (a type of dialysis treatment done in a clinic) policy the facility would coordinate with the dialysis center to ensure the resident's treatments needs were met. The policy directed nurses to ensure there was ongoing communication between the nursing home and dialysis staff. <Resident 60> According to the 02/21/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 60 had multiple complex medical conditions including kidney failure with dependence on dialysis and uncontrolled blood sugars. The MDS showed Resident 60 required dialysis. Review of Resident 60's Physician Orders (POs) showed the following: an 02/08/2024 PO for dialysis three times a week at a local kidney center, an 01/30/2024 PO directing nurses to complete a dialysis communication form including vital signs and medication list with Resident 60 to the dialysis center on dialysis days; an 01/30/2024 PO directing nurses to receive the communication form back from the dialysis center when Resident 60 returned to the facility. The 01/30/2024 PO directed nurses to contact the dialysis center if they did not receive the dialysis communication form back from the dialysis center and to notify medical records to follow up. The 11/14/2023 Hemodialysis Care Plan (CP) showed Resident 60 required hemodialysis related to their diagnosis of End Stage Renal Disease (ESRD). The Hemodialysis CP interventions directed staff to monitor the resident for post dialysis bleeding, seizures, and septic shock. Review of the dialysis communication sheets on 03/20/2024 showed the sheets were divided into three sections. The first section was to be completed by facility staff prior to Resident 60's departure to the dialysis center and included areas for nurses to document the resident's vital signs taken at the facility (including the resident's weight), identify the location of the dialysis access site, document the resident's pain level, and concerns, if any. The second section was to be completed by the dialysis center and included areas for the center staff to document Resident 60's vital signs at dialysis, their weight before and after the treatment, the location of the resident's access site, the times the treatment began and ended, and areas to document if any medications were provided, and any changes occurred during dialysis. The third section included areas where a nurse should document Resident 60's vitals upon return to the facility, an area to document nurses assessed blood flow at the access site, and signature that they received the communication form back. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the dialysis binder for Resident 60 showed only four communication forms for the month of February and March 2024. Two out of four communication forms were incomplete. Review of Resident 60's progress notes from 12/01/2023 to 03/19/2024 showed no progress notes indicating nursing staff followed up with the dialysis center to obtain the post dialysis paperwork. In an interview on 03/20/2024 at 1:27 PM, Staff C (Assistant Director of Nursing - ADON) stated the facility's process was to send the completed dialysis communication form with the resident to the dialysis center on dialysis days and dialysis staff would fill the form out and send it back with the resident to the facility. Staff C stated facility nurse received the communication form from the resident, reviewed the communication form and send it to medical record to be scanned into the resident's medical records. Staff reviewed the dialysis binder for Resident 60 and only four forms were filed, and no other communication forms were scanned in Resident 60's record. Staff C stated the dialysis communication sheets were an important tool to facilitate communication between the facility and the dialysis center. Staff C stated it was important for nurses to complete the sheets so Resident 60's health status was adequately communicated between the facility and the dialysis center. Staff C stated nurses should have followed the PO to send and receive the communication form to and from the dialysis center, but they did not. 46479 <Resident 3> Review of the 02/29/2024 Admission MDS showed Resident 3 had a diagnosis of ESRD requiring dialysis. The MDS showed Resident 3 did not have an impaired memory. Review of the 03/18/2024 PO's showed a 02/23/2024 order directing staff to document the facility received post dialysis paperwork from the dialysis center upon Resident 3's return to the facility. This order directed staff to call the dialysis center if post dialysis paperwork was not received and document in a progress note. Review of Resident 3's March 2023 medication administration record showed staff documented on every dialysis day from 03/01/2024 to 03/19/2024 that the post dialysis paperwork was not received from the dialysis center. Review of Resident 3's progress notes from 03/01/2024 to 03/19/2024 showed no progress notes indicating nursing staff followed up with the dialysis center to obtain the post dialysis paperwork. In an interview on 03/21/2024 at 8:44 AM, Staff W (Medical Records) stated they collected post dialysis paperwork from a box at the nurse's station. Staff W stated residents on dialysis should have their own binder they take to and from dialysis that included post dialysis paperwork. Staff W stated they did not have Resident 3's post dialysis paperwork. In an interview on 03/21/2024 at 8:47 AM, Resident 3 stated they did not have a binder they took with them to dialysis. Resident 3 stated yesterday was the first day the dialysis center sent paperwork back with the resident. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/21/2024 at 9:06 AM, Staff Y (Licensed Practical Nurse), stated the dialysis center was supposed to send post dialysis paperwork back to the facility with Resident 3. Staff Y stated if the dialysis center did not send paperwork back, the nurse was supposed to call the dialysis center to obtain the paperwork. In an interview on 03/21/2024 at 9:45 AM, Staff B (Director of Nursing) stated the post dialysis paperwork was important to obtain because it was a form of communication between the dialysis center and the facility. Staff B stated the form would include recommendations from the dialysis center and specific things to monitor the resident for post dialysis treatment. Staff B stated nursing staff should be calling the dialysis center to obtain post dialysis paperwork and document in Resident 3's record that the dialysis center was contacted, but staff did not. In an interview on 03/21/2024 at 10:01 AM, Staff L (Chief Nursing Officer) confirmed there was no post dialysis paperwork in the facility for Resident 3. REFERENCE: WAC 388-97-1900 (1), (6)(a-c).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46479 Based on observation, interview, and record review, the facility failed to have sufficient nursing staff to provide timely assistance with toileting and call light response in accordance with established clinical standards as evidenced by information provided from 8 (Resident 52, 3, 228, 276, 60, 178, 44, & 277) resident interviews, information provided by 2 (Resident 22 & 7) Resident Council residents, review of facility grievance forms for Residents 10, 8, 60, & 48, call light reports for Resident 277, 276, & 56, and staff interviews provided by Staff KK (Certified Nursing Assistant - CNA), Staff MM (Registered Nurse), and Staff N (Licensed Practical Nurse). The facility had insufficient staff to ensure Restorative Nursing Programs (RNPs) were provided to Residents 7, 55, & 44. These failures placed residents at risk for unmet care needs and other negative health outcomes. Findings included . <Facility Policy> Review of the Resident Call System facility policy dated 09/2022 showed when a resident utilized the call light system, staff should respond to the resident's needs in a reasonable amount of time. <Resident Interviews> <Resident 52> In an interview on 03/17/2024 at 8:10 AM, Resident 52 stated they had to wait for two and a half hours on a regular basis to get assistance and the wait time usually occurred after 3:00 AM on a given day. Resident 52 stated they used the bed pan or bedside commode on their own when they did not get help. <Resident 3> In an interview on 03/17/2024 at 10:10 AM, Resident 3 stated staff did not come when the resident called. Resident 3 stated it usually took an hour or so for staff to answer the call light. Resident 3 said I usually take myself to the bathroom to keep from wetting myself. <Resident 228> In an interview on 03/17/2024 at 11:39 AM, Resident 228 stated staff were respectful but the facility was understaffed. Resident 228 stated Sundays were especially bad and it sometimes took staff several hours to answer Resident 228's call light. <Resident 276> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/17/2024 at 12:06 PM, Resident 276 stated they had to lie in their soiled undergarments all night. Resident 276 stated a male staff person answered their call light after Resident 276 waited for more than one hour. The male staff person told Resident 276 the staff member needed to get another staff member help to provide care to Resident 276. Resident 276 stated the staff member never came back. <Resident 60> In an interview on 03/17/2024 at 1:33 PM, Resident 60 stated I do not think they have enough staff .my call light does not get answered on time, I have to sit in my [bowel movement]. <Resident 178> In an interview on 03/18/2024 at 9:14 AM, Resident 178 stated they had to wait a long time at night when they needed to be changed. Resident 178 stated sometimes staff come sooner but most of the time, there were not enough staff. <Resident 44> In an interview on 03/18/2024 at 9:39 AM, Resident 44 stated the facility did not have enough staff. Resident 44 stated they usually waited 30 to 40 minutes to get the call light answered if they needed to be cleaned for a bowel movement. <Resident 277> In an interview on 03/18/2024 at 1:21 PM, Resident 277 stated staff were sometimes pretty slow to answer the call light. Resident 277 stated at 3:30 AM, they had to [urinate] in the bed because staff did not answer the call light in time. Resident 277 stated day time call light response was slow but nighttime was worse. <Resident Council Interviews> <Resident 22> During a resident council meeting on 03/21/2024 at 11:00 AM, Resident 22 stated [staff] could be faster with call lights, it's like [staff] don't care. Resident 22 stated they called the front desk on occasion when their call light was not answered. Resident 22 stated they waited over an hour for the staff to assist the resident to lie down. <Resident 7> During the resident council meeting on 03/21/2024 at 11:12 AM, Resident 7 stated staff take too long to answer their call light. Resident 7 stated If I scream, then they come. <Grievance Forms> <Resident 10> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 01/24/2024 grievance form showed Resident 10 stated call lights were not answered timely at night. <Resident 8> A 01/24/2024 grievance form showed Resident 8 stated there were not enough staff, nurse's aides needed more training on the evening and night shift. <Resident 60> A 02/01/2024 grievance form showed Resident 60 stated nurse's assistants do not answer call lights timely. This form showed Resident 60 stated yesterday it took [staff] 40 minutes to get my light, I was almost late for dialysis [outpatient appointment to filter waste from blood]. <Resident 48> A 02/21/2024 grievance form filed by Resident 48's spouse showed Resident 48 had their call light on for an hour around 4:00 PM. After waiting an hour, Resident 48 called their spouse who called the facility and was put on a 20-minute hold. Resident 48's spouse called the facility again, staff answered and told Resident 48's spouse they would send staff in to assist Resident 48. Resident 48 called their spouse after an additional 20 minutes passed without receiving assistance. <Call Light Report> <Resident 277> Review of the facility's call light report showed on 03/15/2024 at 2:31 AM, Resident 277 turned on their call light. This report showed the call light was answered at 2:49 AM, 18 minutes later. Review of the call light report showed on 03/15/2024 at 8:32 AM, Resident 277 turned on their call light. At 8:57 AM, the call light was answered, nearly 25 minutes later. Review of the call light report showed on 03/15/2024 at 7:47 PM, Resident 277 turned their call light on. At 8:09 PM, the call light was answered, 20 minutes later. Review of the call light report showed on 03/19/2024 at 10:41 PM, Resident 277 turned their call light on. At 11:04 PM, Resident 277's call light was answered, 23 minutes later. <Resident 276> Review of the call light report showed on 03/17/2024 at 7:55 PM, Resident 276 turned on their call light. At 8:14 PM, Resident 276's call light was answered, 19 minutes later. Review of the call light report showed on 03/18/2024 at 10:22 PM, Resident 276 turned on their call light. At 10:40 PM, Resident 276's call light was answered, 18 minutes later. Review of the call light report showed on 03/20/2024 at 5:57 AM, Resident 276 turned on their call light. At 6:36 AM, Resident 276's call light was answered, 39 minutes later. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 56> In an observation and interview on 03/19/2024 at 5:09 AM, Resident 56 had their call light on. The call light monitoring system at the nurse's station showed Resident 56's call light was on for 44 minutes. In an interview at that time, Resident 56 stated they needed a bed pan. Resident 56 stated they turned their call light on around 4:00 AM. Resident 56 stated they eventually used their cell phone to call the nurse's station to get help. Resident 56 stated staff provided assistance about 15 minutes after the phone call. When Resident 56 was told their call light was on for 44 minutes, Resident 56 replied yes, that is pretty accurate. <Staff Interviews> <Staff KK> In an interview on 03/17/2024 at 8:10 AM, Staff KK stated staffing was up and down. Staff KK stated they used to work night shift but the night shift was always short-staffed so they decided to move to day shift. <Staff MM> In an interview on 03/20/2024 at 8:59 AM, Staff MM stated they were normally a night shift nurse. Staff MM stated they were asked to stay over for a couple of hours that morning after working the night shift because of a staffing conflict. <Staff N> In in interview on 03/20/2024 at 10:08 AM, Staff N was orienting a new nurse and stated they were responsible for residents on both Hall C and Hall D that day. Staff N stated there were days when there were four nurses and days when there were only three nurses and today is one of those days [where there were only three nurses]. <RNP> <Resident 7> A 03/28/2023 Physician's Order (PO) directed staff to apply a splint to Resident 7's left hand each morning and remove the splint after eight hours. Observations on 03/18/2024 at 9:59 AM, 3/19/2024 at 10:14 AM, and 03/20/2024 at 9:51 AM showed Resident 7 without the splint to their left hand. <Resident 55> A 03/05/2024 PO directed staff to apply a splint to Resident 55's right hand daily. Observations on 03/18/2024 at 12:44 PM, 03/20/2024 at 12:26 PM, and on 03/21/2024 at 1:03 PM showed Resident 55 without the splint to their right hand. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/21/2024 at 1:47 PM, Staff J (CNA) stated it was the restorative aide's responsibility to apply the splint to Resident 55's right hand. <Resident 44> Review of an 08/31/2023 Self-Care Deficit care plan directed restorative staff to place a splint on Resident 44's left hand for three to six hours as tolerated, three to six times weekly. Observations on 03/17/2024 at 11:21 AM, 03/18/2024 at 9:34 AM, 03/19/2024 at 12:05 PM, and 03/21/2024 at 9:33 AM showed Resident 44 without a splint to their left hand. In an interview on 03/21/2024 at 9:49 AM, Resident 44 stated the restorative aide never splinted the resident's left hand. In an interview on 03/21/2024 at 2:57 PM Staff C (Assistant Director of Nursing) stated when staff called in, restorative aides would sometimes be pulled to work the floor instead of their restorative duties. In a joint interview on 03/21/2024 at 2:44 PM, Staff B (Director of Nursing) stated they expected call lights to be answered in a timely manner. Staff L (Chief Nursing Officer) stated a timely manner meant a call light should be answered within 15 minutes. Staff B acknowledged night shift had a trend toward long call light response times and they were aware of the grievances regarding long call light wait times. Staff B stated their expectation was that staff performed rounding on residents every two hours by checking if the resident needed toileting assistance, repositioning assistance, or if the resident had any pain, or other needs. Refer to: F688 Increase/prevent Decrease in Range of Motion/mobility. REFERENCE: WAC 388-97-1080(1).

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on observation, interview, and record review, the facility failed to provide medically-related social service interventions that addressed refusal of care for 1 of 2 residents (Resident 226) reviewed for rehabilitation services and 1 of 5 residents (Resident 52) reviewed for unnecessary medications. Failure to have a process for resident refusals, identify, and find ways to support residents needs related to refusals placed residents at risk for early termination of skilled care benefits (Resident 226), unnecessary use of pain medications (Resident 52), unmet care needs, and a decreased quality of life. Findings included . <Skilled Services> <Facility Policy> Review of the undated facility policy titled, Therapy Policy and Procedures, showed the facility's therapy evaluations served as a care plan (CP) and should clearly indicate why therapy services was reasonable and medically necessary. The policy showed the facility would conduct Interdisciplinary Team (IDT) communication, including nursing, social services, and rehabilitative department, to discuss resident's progress to therapy. <Resident 226> According to 02/22/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 226 had clear speech, understood others during communication, and had medical conditions including systemic infection, pulmonary disease, and muscle weakness. Review of the facility census showed Resident 226 admitted to the facility on [DATE] under their managed Medicare A benefits for skilled services. The census showed Resident 226's skilled services ended on 03/03/2024, 17 days after their admission. In an observation and interview on 03/17/2024 at 1:51 PM, Resident 226 was observed lying in bed and weak to move independently. Resident 226 stated their skilled rehabilitation services ended and they needed more therapy, .I am not even walking yet . Resident 226 stated they were independent with their activities of daily living prior to them falling at home. Review of Resident 226's Physical Therapy (PT) session notes showed the resident refused PT services on 02/19/2024, 02/23/2024, and 02/26/2024. Review of Resident 226's Occupational Therapy (OT) session notes showed the resident refused OT services on 02/22/2024, 02/23/2024, 02/26/2024, and 03/06/2024. Review of the 03/07/2024 PT Discharge Summary showed discharged per Physician or Case Manager as the reason why Resident 226's skilled care ended. The summary showed the therapist's recommendation was for Resident 226 to continue with skilled services. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/21/2024 at 10:12 AM, Staff O (Social Services Director) stated Resident 226's skilled services ended because the resident did not meet skilled criteria due to the resident's refusals. Staff O stated they did not follow-up with Resident 226 to determine the reason behind the resident's continued refusal to therapy. Staff O stated they needed to have a process in place that addressed resident refusals with care. In an interview on 03/21/2024 at 12:57 PM, Staff AA (Director of Rehabilitation) stated skilled services end when residents achieved their therapy goals and/or attained their prior level of function. Staff AA stated they notified the nursing department regarding Resident 226's barriers to therapy participation including episodes of dizziness, pain, and physical readiness (toileted and up in the wheelchair) for therapy. Staff AA confirmed Resident 226's skilled services coverage ended because of the documented refusals in the resident's therapy notes that were reviewed by the insurance case manager. In an interview on 03/22/2024 at 9:12 AM, Staff L (Chief Nursing Officer) stated they expected collaboration between the IDT to address resident's therapy refusals. Staff LL stated the IDT should have, but did not ensure residents remained eligible of their skilled benefits and received the rehabilitation services they were assessed to require. <Pain Medication> <Resident 52> According to the 02/17/2024 Annual MDS, Resident 52 had clear speech, their memory was intact, and had medical conditions including nerve pain, neck pain, chronic (long-standing) pain, and muscle spasms. The MDS showed Resident 52's pain occasionally interfered with their sleep and rarely affected their day-to-day activities during the assessment period. Review of Resident 52's 03/05/2024 pain CP showed a 02/09/2023 CP intervention directing staff to discuss concerns the resident had regarding their pain management with the physician and the consulting pharmacist. In an observation and interview on 03/17/2024 at 08:10 AM, Resident 52 was observed sitting in their wheelchair while decluttering their nightstand without any pain issues and stated their pain varies throughout the day, some days were better than others. Resident 52 expressed having multiple pain issues including neck pain that radiated to their left shoulder/arm and pain on both their knees. Resident 52 stated they were being administered several pain medications. Review of the March 2024 Medication Administration Record (MAR) on 03/18/2024 showed Resident 52 was prescribed four pain medications including: A sublingual (under the tongue) dissolving film for their chronic pain twice a day; a patch for the left shoulder daily at night; a gel for their left shoulder four times a day; and a cream for their bilateral knees twice a day. The MAR showed Resident 52 refused the pain patch 11 out of 17 days; refused the pain gel at least once 12 out of 17 days; and refused the pain cream at least once 14 out of 17 days. Review of Resident 52's progress notes from 03/01/2024 until 03/17/2024 did not show the nurse notified the physician and/or consulting pharmacist regarding the resident's refusal to receive the pain patch, pain gel, and pain cream. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/20/2024 at 10:46 AM, Staff C (Assistant Director of Nursing) stated it was important to ensure Resident 52's medication list was reviewed for unnecessary medication use to decrease the resident's pill burden [the number of medications taken or administered to a person on a regular basis] since Resident 52 was refusing to receive them. Staff C stated the nurses should, but did not notify the physician regarding Resident 52's medication refusals for proper reassessment and better care planning. REFERENCE: WAC 388-97-0960(1).

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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. 46471 Based on observation and interview, the facility failed to ensure expired medications were disposed of timely and controlled pain medications were properly secured for 1 of 1 medication room reviewed for medication storage. This failure placed residents at risk for receiving medications with decreased effectiveness and predisposes the staff to potentially diverting medications (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber). Findings included . <Facility Policy> Review of the facility policy titled, Storage and Expiration, Dating of Medications, Biologicals [a therapeutic substance such as a vaccine or drug], revised 08/07/2023, the facility would ensure medications and biologicals that expired were destroyed or returned to the pharmacy. The policy showed after controlled substances (medications prone to misuse and abuse) were received and added in the inventory, the facility would ensure they were immediately placed in a separate compartment within the locked medication carts. <Medication Room> Observation of the medication room on 03/18/2024 at 12:08 PM with Staff M (Infection Preventionist) showed 10 single-dose syringes of Covid-19 (a respiratory infection) injectable medication with a beyond use date of 03/14/2024 inside the medication refrigerator and 13 swab collection tubes in the overhead cabinet that expired 10/31/2023. Observed a plastic bag of medications located at the bottom drawer of a metal cabinet and inside the bag were: 30 tablets of blood pressure medications that expired 09/28/2023; 30 capsules of nerve pain medications that expired 11/30/2023; 37 tablets of antidepressant medications that expired 09/28/2023, and 15 tablets of antianxiety medications that expired 09/21/2023. At the same date and time, 21 tablets of narcotic (controlled substance) pain medications were observed inside the same plastic bag of expired medications and the drawer where these medications were located was left unlocked/unsecured. In an interview on 03/18/2024 at 12:47 PM, Staff M stated the expired injectable medications and swab collection tubes should be discarded/thrown away to ensure resident safety and to avoid obtaining false positive/negative results if/when the expired collection kit was used. Staff M stated medications that were meant to be returned to the pharmacy should not be left forgotten because it was unsafe. Staff M stated the staff need to be educated on how to dispose medications properly when residents discharge from the facility. Staff M stated controlled substances, including narcotic pain medications, should not be left unattended and must be kept locked/safe at all times. (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 03/22/2024 at 9:12 AM, Staff A (Administrator) stated it was important to audit the facility's medication storage room for presence of expired medications to ensure resident safety. Staff A stated they expected the nursing staff to ensure controlled substances such as narcotic pain medications were locked up at all times for staff accountability because these were high-risk medications and must be safeguarded. REFERENCE: WAC 388-97-1300 (1)(b)(ii), (c)(ii-iv). 45941

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on observation, interviews, and record review the facility failed to assess and ensure prompt dental care and services were provided for 2 of 9 residents (Residents 42 and 46) reviewed for oral/dental health. The facility's failure to assess and/or follow-up on dental exam recommendations placed resident at risk for oral pain, unmet dental needs, and a diminished quality of life. Findings included . <Facility Policy> According to the facility policy titled, Dental Services, revised 12/30/2022, the facility would assist the residents in obtaining routine and 24-hour emergency dental care. The policy showed the social services department would coordinate dental services including prompt referrals and would document all dental interventions performed in the resident's medical record. <Resident 42> Review of the 01/05/2024 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 42 admitted to the facility on [DATE], had clear speech, and understood others during communication. The MDS showed Resident 42 had broken teeth and needed set-up and clean-up assistance from staff for their oral care/hygiene. The 06/12/2023 oral/dental Care Plan (CP) showed Resident 42 was identified with broken teeth. A 12/12/2022 CP intervention directed staff to coordinate arrangements for dental care and to monitor/document/report signs and symptoms of oral/dental problems needing attention to the physician. On 03/18/2024 at 9:14 AM, Resident 42's two front lower teeth were observed broken and the root of these teeth were exposed. Resident 42 stated their teeth broke and fell out a while back and that the resident had not seen the dentist since their admission to the facility. A 03/01/2023 physician order showed Resident 42 had an order to see the dentist as needed. Review of Resident 42's medical records showed an 02/06/2023 dental consultation recommending dental cleaning, dental x-rays (a diagnostic procedure), and the extraction of several identified teeth. A following dental consultation dated 11/16/2023 showed the same referral for teeth extractions identified from the previous dental consultation on 02/06/2023. The facility was not able to provide any documentation to support the dental recommendations were performed, followed-up, or completed. In an interview on 03/21/2024 at 10:35 AM, Staff O (Social Services Director) stated the facility offered both in-house and outside dental care and services and the social services department was responsible for managing resident's oral/dental health. Staff O confirmed Resident 42 was not seen by the dentist since the resident's last dental consult and the recommendations were not done. Staff O stated the facility's dental tracking process needed improvement. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/22/2024 at 8:50 AM, Staff A (Administrator) stated it was important to provide oral/dental care and services to residents who needed them to foster nutritional health/support and to enhance residents' dignity and quality of life. 45941 <Resident 46> According to the 12/12/2023 Quarterly MDS, Resident 46 had impaired memory and did not have broken teeth. The MDS showed Resident 46 required maximal assistance from staff with their oral care. The MDS showed Resident 46 had no refusals of care during the assessment period. According to the 09/11/2023 Significant Change MDS, Resident 46 had inflamed gums and loose teeth. Observations on 03/17/2024 at 11:27 AM showed Resident 46 had no teeth or dentures in their mouth. Review of Resident 46's dental consult dated 11/02/2022 showed the resident had remaining 2 lower teeth that were very loose and required a follow-up appointment ASAP (as soon as possible). Resident 46's record review showed there was no follow-up documentation related to Resident 46's dental care. The facility was not able to provide any documentation to support Resident 46 was provided dental care and services after the 11/02/2022 dental consultation. In an interview on 03/20/2024 at 1:14 PM, Staff O confirmed there was no documentation indicating the facility followed-up with Resident 46's dental consult recommendations. Staff O stated the staff should have assessed the resident's oral/dental status and followed-up on the recommendations made by the dentist, but they did not. REFERENCE: WAC 388-97-1060(3)(j)(vii).

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F 0808

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.

46471

Based on interview and record review, the facility failed to ensure 1 of 4 sample residents (Residents 52) reviewed for food concerns received the diet prescribed to them, and 5 supplemental residents (Residents 227, 13, 37, 39, & 20). Failure to ensure residents received their diet as ordered, placed residents at risk for an inappropriate diet and related negative health outcomes.

Findings included .

<Resident 52>

According to the 02/17/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 52 had clear speech, their memory was intact, and had medical conditions including heart failure, high blood pressure, localized edema, and diabetes (unstable blood sugar levels). The MDS showed Resident 52 was administered injectable and oral medication to treat high blood sugar level daily during the assessment period.

The 02/15/2024 therapeutic diet care plan showed the staff should encourage food choices consistent with Resident 52's medical conditions and listed an intervention directing staff to serve the diet as ordered.

Review of Resident 52's physician orders showed a 03/03/2023 dietary order indicating Resident 52 was on a Consistent Carbohydrate (CCHO) diet.

Observation and interview on 03/17/2024 at 8:10 AM showed Resident 52 was served breakfast in their room; their tray was observed to have a piece of ham, two pancakes, one small syrup package, five packets of regular sugar, a glass of apple juice, a glass of milk, a cup of cream of wheat. Resident 52 stated they had heart failure and the ham had too much salt content in it which was bad for their existing medical condition. Resident 52 stated they could not understand why the staff kept on giving them regular sugar packets with their coffee, .I am diabetic, and I cannot have these [regular sugar] and pulled out their own supply of artificial sweetener.

In an interview on 03/20/2024 at 10:08 AM, Staff F (Registered Dietician) stated, for residents with heart failure and blood pressure issues, they would try to liberalize [remove or loosen restrictions] the diet by asking the resident's preferences for salt intake and would document this information in their assessment notes.

Review of a 02/08/2024 nutrition evaluation showed Resident 52's diagnosis of heart failure was identified in the assessment, including the presence of bilateral lower extremity edema as the clinical manifestation. The evaluation did not show Resident 52's preference not to eat foods high in salt content was captured during the assessment.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/20/2024 at 10:42 PM, Staff C (Assistant Director of Nursing) stated the nursing aides were responsible for passing the beverages including the sugar packets. Staff C stated they expected staff to look at the resident's meal ticket and/or the Kardex (directions to staff regarding how to provide care) and refer to these resources when distributing beverages. Staff C stated Resident 52 should be served artificial sweetener and not regular sugar packets because of the resident's medical condition. 42203 <Trayline Observations> Review of the facility's breakout menu (a menu showing required portion sizes, texture alterations, and substitutions for residents with identified nutritional needs) showed residents on a CCHO diet should be served half a portion of the cake on the regular menu. The breakout menu showed for resident's requiring the cardiac diet, staff should serve pears. Observation of the facility's lunch preparation on 03/21/2024 at 11:39 AM showed three four staff preparing resident lunch trays: Staff E (Dietary Manager), Staff K (Dietary Aide), Staff BB (Dishwasher), and Staff CC (Cook). Staff K set up trays with silverware, napkins, and desserts. At 11:59 PM Staff E reminded Staff K that Cardiac gets pear, CCHO gets half a cake. At 12:02 PM Staff K prepared the lunch tray for Resident 227. Staff K served Resident 227 pears. Resident 227's tray ticket indicated they required a CCHO tray. (Review showed Resident 227's record included a 03/20/2024 order for a CCHO diet.) At 12:09 PM Staff K prepared the lunch tray for Resident 13. Staff K served Resident 13 pears. Resident 13's tray ticket indicated they required a CCHO tray. (Review showed Resident 13's record included a 05/02/2023 order for a CCHO diet.) At 12:13 PM Staff K prepared the lunch tray for Resident 37. Staff K served Resident 37 pears. Resident 37's tray ticket indicated they required a CCHO tray. (Review showed Resident 37's record included a 06/18/2023 order for a CCHO diet.) At 12:16 PM Staff K prepared the lunch tray for Resident 39. Staff K served Resident 39 pears. Resident 39's tray ticket indicated they required a CCHO tray. (Review showed Resident 39's record included a 04/11/2023 order for a CCHO diet.) At 12:21 PM Staff K prepared the lunch tray for Resident 20. Staff K served Resident 20 pears. Resident 20's tray ticket indicated they required a CCHO tray. (Review showed Resident 20's record included a 11/07/2023 order for a CCHO diet.) At 12:42 PM the tray with the incorrect dessert was observed to be provided to Resident 39. At 12:46 PM the tray with the incorrect dessert was observed to be provided to Resident 227. In an interview on 03/22/2024 at 8:05 AM Staff F stated the lunch menu for 03/21/2024 had a half serving of cake for CCHO residents. Staff F stated they expected dietary orders to be followed. Staff F stated the residents with CCHO diets should have received half a serving of cake per the menu. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/22/2024 at 12:29 PM Staff E stated the residents with CCHO diets should have been provided the correct dessert. Staff E stated Staff K was nervous. REFERENCE: WAC 388-97-1200 (1).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation and interview the facility failed to store and prepare food under sanitary conditions for 1 of 1 kitchens. The failure to ensure food items in the dietary department were properly labeled and stored, adequate hand washing supplies were available to dietary staff, and food brought to residents from outside the facility was properly, placed residents at risk for consuming expired/spoiled foods and potential exposure to food-borne illness. Findings included . <Facility Policies> According to the facility's [DATE] Preventing Food Illness - Food Handling policy, food would be stored, handled, and served in a manner to minimize the risk of foodborne illness. According to the facility's undated Safe Handling for Foods from Visitors facility staff would remind visitors to let a member of staff know when they brought food from outside the facility to a resident. The policy showed if the food brought in was intended to be eaten later, facility staff were responsible to ensure the food was contained adequately, labeled with the resident name and date of receipt, and refrigerated if not shelf stable. <Handwashing Sinks> Observation on [DATE] (a Sunday) at 07:55 AM showed no paper towels were available from either of the two handwashing sinks in the facility's kitchen. A cloth rag was placed on top of each dispenser and staff were observed using the cloth rags to dry their hands after washing. In an interview at that time, Staff G (Cook) stated that supplies of spare paper towels were locked away on weekends and if dietary staff used a roll to its end on the weekend they needed to wait until Monday to refill the paper towel dispensers. Observation on [DATE] at 8:43 AM showed the kitchen towel dispensers remained empty. At this time, a roll of paper towels was placed on top pf each dispenser, allowing staff to dry their hands with paper towels but still preventing staff from dispensing the towels in a manner that prevented the rest of the roll from contamination. At [DATE] at 11:04 AM, Staff A (Administrator) and Staff C (Assistant Director of Nursing) observed the paper towels placed on top of the empty dispensers in the facility kitchen. Staff C expressed frustration at the situation and stated staff education would be necessary. <Extractor Fan Cleanliness> Observation on [DATE] 08:08 AM showed an extractor fan located directly above the steam table where staff prepare meal trays for residents. The fan was covered in a layer of black-ish dusty and grease. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The fan was noted to still be covered with greasy dusty build up on [DATE] at 12:39 PM. Dust, grease, and grime was observed to be stuck on the ceiling next to the fan, spreading out in a triangular shape to a support beam where more dust/grease splatter collected. In an interview on [DATE] at 12:29 PM Staff E (Dietary Manager) stated they were aware of the buildup of dust and grease over the food preparation area. Staff E stated it had the potential to contaminate resident meals. Staff E stated they notified the facility's maintenance department, but the problem was not yet fixed. <Cold Storage> Observation on [DATE] of the facility's cold storage from 7:58 AM to 8:03 AM showed an opened bag of shredded lettuce in the refrigerator, a frozen, undated zip-top food storage bag containing cubed ham, and a refrigerated, open, undated ham loaf. Staff did not add a date to the lettuce bag indicating when they opened it. The lettuce was observed to be slimy and spoiled. The frozen cubed ham was covered in ice crystals (freezer burn). The refrigerated ham loaf was partially in its vacuum-packed plastic packaging, and staff wrapped the open end with plastic kitchen wrap. In an interview on [DATE] at 8:02 AM, Staff G stated all opened food should have a date of opening to indicate how long it was appropriate to use. Staff G stated these foods were stored in a way that meant they should now be disposed of. In an interview on [DATE] at 10:09 AM Staff D stated all opened food packages should be labeled with a date upon opening. Staff D stated spoiled and/or inappropriately stored food should be disposed of. <Outside Food> Observation on [DATE] at 9:55 AM showed a reusable plastic container of bean stew on the dresser nearest the door in room [ROOM NUMBER]. The container did not have a date of receipt or the resident's name. The container of bean stew was observed on the dresser in room [ROOM NUMBER] again on [DATE] at 9:47 AM and 1:55 PM. On [DATE] at 2:39 PM Staff I (Director of Infection Prevention) observed the stew on the counter and stated it should be disposed of. Staff I stated the bean stew should have been handled more thoughtfully, and in accordance with the facility's outside food policy. In an interview on [DATE] at 10:09 AM Staff D stated the handling of food brought by guests to residents was the responsibility of the nursing department. Staff D stated the food in room [ROOM NUMBER] should have been but was not stored correctly. REFERENCE: WAC [DATE] (3), -2980.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER North Auburn Rehab & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	

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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 46471 Based on interview and record review, the facility failed to ensure the arbitration agreement was signed by the resident's Durable Power of Attorney (DPOA) for financial affairs as required for 1 of 1 residents (Resident 41) whose Arbitration Agreements (AA) were reviewed. This failure placed Resident 41 and residents at risk of forfeiture of their right to a jury or court trial and a diminished quality of life. Findings included . <Resident 41> According to the 03/03/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 41 was non-English speaking, non-communicative, had memory impairment, and was incapable of daily decision-making. In an interview on 03/17/2024 at 10:05 AM, Staff Q (Regional Director of Operations) stated the AA was offered to residents and their representatives during admission and was conducted by the facility's Business Office Manager (BOM). Staff Q stated on Resident 41 had an active AA on file. Review of Resident 41's AA 03/18/2024 showed the resident's name was not written in the AA and was signed by Resident 41's representative on 07/23/2021. In an interview on 03/20/2024 at 8:40 AM, Staff Q confirmed Resident 41's name was not written in the AA and stated the AA would not be considered valid without the name of the resident who entered into the AA. In an interview on 03/21/2024 at 1:19 PM, Staff P (Social Services Assistant) stated Resident 41 did not have an DPOA for financial affairs on file. The facility was not able to provide any documentation to support and/or validate Resident 46's representative, who signed the arbitration agreement on the resident's behalf, was the same representative responsible for Resident 41's financial affairs to ensure validity of the AA as required. In an interview on 03/21/2024 at 1:26 PM, Staff R (BOM) stated it was important to ensure AAs were understood by residents and/or their representatives for legal and liability purposes. Staff R stated they acquired the AA responsibility recently on January 2024 and had not received education from the facility regarding AA. Staff R stated, when obtaining a resident representative's signature for the AA, they were under the impression they needed to follow the order of responsible payee for the resident, .all I know is that AA is just a part of the admission agreement/packet which I have to complete. On 03/22/2024 at 11:59 AM, Staff L (Chief Nursing Officer) stated the facility did not have policies and procedure in place for residents who entered into a binding AA. REFERENCE: WAC 388-97-1620(2)(a)(b)(i), -0180(1-4).