STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure newly admitted residents were informed in a timely manner (prior to or upon admission) of their rights and responsibilities and provided services as a resident in the facility for 3 (Resident 85, 139, & 339) of 5 residents reviewed. This failure placed residents at risk of not understanding their rights, a reduced ability to self-advocate, and a diminished quality of life. Findings included . Review of the facility's 03/17/2022 Admission Packet provided by staff, showed information and consent forms for the admission policies, resident rights, rules and operations of the nursing home, grievance process, right to choose their physician or contact information for the facility physician, charges for services, advanced directives and designation of a resident representative, privacy practices, healthcare privacy act, consent for release of medical information, bed hold policy, facility-initiated discharge policy, designation of funeral home, laundry services, policy on personal property, vaccination policies and consent, smoking policy, trust fund policy, arbitration agreement, information on state and local contacts for the State Hotline for abuse/neglect/complaints, contact for the State Ombudsman Program, Adult Protective Services, Medicaid Fraud Office, and information on the benefits/rights under Medicare. The admission packet contained multiple areas for the resident to sign acknowledgement to the facility policies, procedures and provide consent to the facility for specified care. <Resident 85> According to a 11/07/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 85 admitted to the facility on [DATE]. Review of Resident 85's records on 12/12/2024, over 30 days after the resident's admission, showed no admission packet was completed by staff upon admission. <Resident 139> According to a 12/03/2024 Admission MDS, Resident 139 admitted to the facility on [DATE]. Review of Resident 139's records on 12/12/2024, over two weeks after the resident's admission, showed no admission packet was completed by staff upon admission. (continued on next page)

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

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 339> According to a 12/11/2024 Admission MDS, Resident 339 admitted to the facility on [DATE]. Review of Resident 339's records on 12/12/2024, two weeks after the resident's admission, showed no admission packet was completed by staff upon admission. In an interview on 12/12/2024 at 1:52 PM, Staff O (Vice President for Business office) stated having a resident and/or their representative review and sign an admission packet was important so residents would be informed of their rights and understand the services they would be offered or receive in the facility. Staff O stated they were behind in getting admission packets done timely due to staffing changes. Staff O stated it was their expectation an admission packet be reviewed and signed with a resident and/or their representative within 72 hours from the date of admission. REFERENCE: WAC 388-97-0300(1)(a), (7)(b).

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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** 47836 Based on observation and interview, the facility failed to maintain a homelike environment for 17 of 67 resident rooms (Rooms 204, 215, 245, 100, 112, 101, 107, 242, 243, 246, 251, 253, 254, 256, 224, 240, & 241), 1 of 1 dining rooms (Main Dining Room), and 1 of 4 shower rooms (West 2 Shower Room) reviewed. These failures left residents at risk for a diminished quality of life and a less than homelike environment. Findings included . <room [ROOM NUMBER]> An observation on 12/08/2024 at 9:54 AM showed room [ROOM NUMBER]'s door did not latch and was unable to close completely. In an interview on 12/13/2024 at 9:51 AM Staff N (Regional Plant Operation Manager) stated it was important for the doors to latch and close completely for resident privacy and fire safety. <room [ROOM NUMBER]> An observation on 12/09/2024 at 9:28 AM showed a 3 inch diameter shallow hole in the floor tile between beds A and B. In an interview on 12/13/2024 at 9:51 AM Staff N stated it was important to make the repairs to the floors timely to maintain a homelike environment for the residents. <room [ROOM NUMBER]> An observation on 12/10/2024 at 12:00 PM showed room [ROOM NUMBER]'s window open without a screen. In an interview on 12/13/2024 at 9:51 AM Staff N stated they were aware of the missing screen. At this time Staff L (Maintenance Aide) stated they had measured for the screens and Staff N had ordered them a couple of months ago. Staff N stated they received the mesh screen material already but needed to purchase the frames. Staff N stated it was important to make repairs timely to maintain a homelike environment for the residents. Staff N stated the continued pest problems could be a result of the screens missing with the windows open. 43642 <room [ROOM NUMBER]- Bathroom> Observations on 12/08/2024 at 9:39 AM and 12/09/2024 at 2:12 PM showed a long screw with a pointed sharp tip sticking out of the wall between the toilet and the sink. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/13/2024 at 9:51 AM, Staff L stated there was a missing hook that should be covering the screw. <room [ROOM NUMBER]> Observations on 12/08/2024 at 10:04 AM showed room [ROOM NUMBER] bed B with deep gouges and exposed drywall under the resident's wall light. In an interview and observation on 12/13/2024 at 9:51 AM, Staff L stated the area needed to be repaired. <room [ROOM NUMBER]> Observations on 12/09/2024 at 8:48 AM showed room [ROOM NUMBER] bed B with deep gouges and exposed drywall on the wall at the head of resident's bed. In an interview and observation on 12/13/2024 at 9:51 AM, Staff L stated the area needed to be repaired. <room [ROOM NUMBER]> Observations on 12/09/2024 at 10:30 AM showed room [ROOM NUMBER] bed A with deep gouges and exposed drywall on the wall at the head of resident's bed. In an interview and observation on 12/13/2024 at 9:51 AM, Staff L stated the area needed to be repaired. <Dining Room> Observations on 12/08/2024 at 12:36 PM showed a long cabinet underneath a countertop in the dining room against the wall next to the kitchen. This cabinet had multiple drawers and doors with peeling and missing paint with warped and cracked wood surfaces. In an interview on 12/13/2024 at 10:47 AM, when asked if the dining room cabinet was in good repair, Staff C (Regional Director) stated the cabinet was not, cosmetically appealing. Staff C stated the cabinet would not be something they would want to look at every day. Staff C stated having an environment in good repair was important as the facility was the resident's home. 45941 <room [ROOM NUMBER]> Observation on 12/08/2024 at 10:09 AM showed room [ROOM NUMBER] walls had scratches and different color patches on the walls. Resident stated staff removed the hand sanitizer from the wall and never painted the wall. <room [ROOM NUMBER]> Observation on 12/08/2024 at 10:16 AM showed room [ROOM NUMBER] walls had scratches behind the head of bed A and bed B. Observation showed the wall had a hole size of a door knob behind the entrance door inside the room. <room [ROOM NUMBER]> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/08/2024 at 11:46 AM showed room [ROOM NUMBER] walls had scratches, tiles on the floor were chipped and had black stains on them. <room [ROOM NUMBER]> Observation on 12/08/2024 at 11:51 AM showed in room [ROOM NUMBER], resident's clothes, linens and other belongings were scattered on the floor. <room [ROOM NUMBER]> Observation on 12/08/2024 at 12:06 PM showed room [ROOM NUMBER], privacy curtain between bed A and B, was dirty, multiple stains of coffee or juice. <room [ROOM NUMBER]> Observation on 12/08/2024 at 12:45 PM showed room [ROOM NUMBER] was not clean and had strong urine odor. Resident stated they did not clean the room yet. <room [ROOM NUMBER]> Observation on 12/08/2024 at 8:55 AM and 12/09/2024 at 12:53 PM showed room [ROOM NUMBER] had no toilet in the bathroom and had a big hole in the bathroom wall. <West 2 Shower Room> Observation on 12/08/2024 at 12:50 PM showed [NAME] 2 shower room door was broken with multiple dents. Shower room had mold on the ceiling. In an interview on 12/13/2024 at 9:51 AM, Staff N stated they were aware of scratches on the walls, holes on the walls, chipped tiles in resident's rooms, missing toilet in resident's room, and broken shower door. Staff N stated it was important to make repairs timely to maintain a homelike environment for the residents. Staff N stated they needed to fix all these environmental issues. 50511 <room [ROOM NUMBER]> Observation on 12/08/2024 at 9:00 AM showed room [ROOM NUMBER]'s window had missing blinds allowing sunlight to come through the window when the blinds were fully closed. The bathroom in room [ROOM NUMBER] showed the faucet was dripping, although it was shutoff, and brownish black dirt soiled the bathroom floor. Observations at this time showed boxes stacked on top of the closet with a mattress pad partially folded up on top of the closet, inches below the ceiling. <room [ROOM NUMBER]> Observation on 12/8/2024 at 10:18 AM, showed room [ROOM NUMBER] had several dirty, mismatched and chipped tiles on the floor. Observations of room [ROOM NUMBER] on 12/10/2024 at 1:25 PM showed a damaged hole-like area to the surface of the bathroom door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<room [ROOM NUMBER]> Observation on 12/10/2024 at 9:22 AM, showed room [ROOM NUMBER] had mismatched tiles, brown and black dirt was observed in the grout between the tiles. Broken tiles were chipped and some had chips in the corner of the tiles making the tiles uneven to walk on. In an interview on 12/13/2024 at 9:51 AM, Staff L stated they completed daily rounds of the facility and kept a list of repairs needed, however Staff L stated they did not have the authority to order supplies to make repairs to the facility. In an interview on 12/13/2024 at 9:51 AM Staff N stated repairs were important and were needed to keep the facility homelike for residents. Staff N stated the tiles should be fixed in rooms [ROOM NUMBERS]. Staff N stated, they were aware of missing blinds in room [ROOM NUMBER] and the facility was looking at different options for the vertical blinds as they were not good. Refer to F925 - Maintains Effective Pest Control Program 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. 50511 Based on observation, interview, and record review the facility failed to implement their Grievance policy for 1 of 2 residents (Resident 1) reviewed for grievance reporting. The failure to report, initiate, investigate, and log grievances placed residents at risk for not having grievance resolution delayed or incomplete, feelings of frustration, and a diminished quality of life. Findings included . <Facility Policy> Review of a facility policy titled, Resident and Family Grievances, revised March 14, 2023, showed residents may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished regarding their Long Term Care (LTC) facility stay. The staff member receiving the grievance would record the nature and specifics of the grievance on the designated grievance form or assist the resident to complete the form. The grievance form would be forwarded to the grievance official as soon as practicable. The grievance official or designee would keep the resident appropriately apprised of progress towards resolution of the grievances. In accordance with the resident's right to obtain a written decision regarding their grievance the grievance official would issue a written decision on the grievance to the resident at the conclusion of the investigation. <Resident 1> According to the 09/23/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 1 could be understood and could understand others. Resident 1 was dependent on staff for lower body dressing and required substantial assistance with upper body dressing and personal hygiene. Resident 1 required set up assistance for eating and oral hygiene due to medically complex conditions including heart failure, morbid obesity and back pain. In an observation and interview on 12/08/2024 at 9:00 AM, Resident 1 stated their Grabber Reacher (an assistive device/tool) was missing for the past 4 days on 12/4/2024. Resident 1 stated the Grabber Reacher was in their room and then it just disappeared. Resident 1 stated they needed the Grabber Reacher, as they could not reach things around their bed without the tool. Resident 1 stated they reported this to the nursing staff and staff helped to look around the room for the item but Resident 1 did not hear from anyone about the missing item and did not receive a replacement. In an observation and interview on 12/13/2024 at 11:58 AM, Resident 1 stated they finally heard back from staff on their missing Grabber Reacher after the surveyors interviewed Resident 1 about their grievance. The facility provided Resident 1 with a new Grabber Reacher but the one received was not the right one. The Grabber Reacher Resident 1 received was too small and did not grab items all the way around like their previous one. Resident 1 stated staff were aware the replacement Grabber Reacher was not the right one. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff F (Resident Care Manager) on 12/12/2024 at 12:41 PM, Staff F stated they did not receive a grievance form for Resident 1's missing Grabber Reacher. Staff F stated their expectation was for care staff to report this to the nurse. Staff F also stated that anyone could fill out a grievance report and a form should have been filled out. Staff F stated they would help to fill the grievance form out if a resident could not fill one out for themselves. Staff F stated the grievance report was important as the facility was the resident's home and the grievance process was important so residents could feel like they were not being ignored. In an interview with Staff F on 12/13/2024 at 12:08 PM, Staff F stated they did not know the replacement Grabber Reacher was too small for Resident 1 and will order another one for them. Staff F stated they do not always document on grievance forms, as they try to just resolve the issue themselves. Staff F stated they would fill out a grievance form now for Resident 1's missing Grabber Reacher, 9 days after the grievance was reported to staff. In an interview on 12/13/2024 at 9:54 AM Staff B (Director of Nursing) stated staff knew where the green grievances forms were kept. Staff B stated they expected staff to fill a grievance form out upon report of a grievance. Documentation of the grievance and investigation should be kept on the green grievance form so the facility could track what was done, this would also create an acknowledgement with the resident about the resolution. REFERENCE: WAC 388-97-0460.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47836 Based on observation, record review, and interview the facility failed to ensure missing narcotics were reported to the State Survey Agency (SSA) within the required timeframe for 1 of 2 Narcotic Ledgers (East 2 Narcotic Ledger) reviewed for accuracy. Failure to complete required reporting of missing resident narcotics placed the residents at risk for further misappropriation of resident narcotic medications and the potential for uncontrolled pain. These failures placed the facility at risk for possible diversion of controlled substances. Findings included . <Policy> Review of the facility policy titled, Controlled Medication Storage, dated 01/2024, controlled substances were subject to special record keeping in the facility in accordance with federal, state, and other applicable laws and regulations. The policy showed any discrepancies in controlled substance medication counts would be investigated by the Director of Nursing and every reasonable effort would be made to reconcile the discrepancies. According to a facility policy titled, Incidents and Accidents, revised 01/2023, the facility would meet regulatory requirements for analysis and reporting of incidents. The policy showed incidents of misappropriation would be managed and reported according to the facility's abuse prevention policy. <Nursing Home Guidelines Purple Book> According to the Sixth Edition Nursing Home Guidelines Purple Book, dated October 2015, immediate telephone reporting was required when misappropriation of resident property had occurred. The Purple Book' showed it was the Nursing Homes responsibility to report all misappropriated resident property. <East 2 Narcotic Ledger> Observation and record review on 12/09/2024 at 3:13 PM of the East 2 narcotic lock box and ledger showed page 83 with 30 tablets remaining transferred to page 101. Review of page 101 showed the starting count as 29 tablets, 1 tablet missing from the remaining balance from page 83. Page 96 showed 14 tablets remaining with the whole page crossed off and no card of medications in the lock box for page 96. Page 99 showed 20 tablets remaining with the page crossed off and transferred to page 99 written in, balanced transferred to unit box was left blank, and no card of medications was in the lock box. Page 103 showed 20 tablets remaining with the whole page crossed off and no card of medications in the lock box for page 103. Page 111 and 112 was missing from the East 2 narcotic ledger, the pages were ripped out. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/09/2024 at 3:13 PM Staff I (Licensed Practical Nurse) stated they reported the missing narcotics to Staff F (Resident Care Manager) when counting off with the night nurse on 11/08/2024 and Staff F reconciled the narcotic count in the ledger. Staff I stated Staff B (Director of Nursing) was also notified of the missing narcotics. In an interview on 12/09/2024 at 3:15 PM Staff B stated they were notified of the missing narcotics and the pages torn out, pages 111 and 112, in the East 2 narcotic ledger by Staff I on 11/11/2024. Staff B stated they did not report the missing narcotics or the missing pages in the narcotic ledger to the SSA. In an interview on 12/11/2024 at 9:53 AM Staff B stated they did not know they needed to report the resident missing narcotics and missing narcotic ledger pages to the SSA at the time of the misappropriation but had reviewed the purple book guidelines and understood they should have. Staff B stated it was important to report missing narcotics to ensure a thorough investigation, prevent any further misappropriation of resident's narcotic medications, and prevent diversion of controlled substances within the facility. Refer to F610 - Thorough Investigation Refer to F755 - Pharmacy Procedures REFERENCE: WAC 399-97-0640(5)(a).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 47836 Based on observation, record review, and interview the facility failed to complete a thorough investigation of missing controlled substances (Narcotic Medications) for 1 of 2 Narcotic Ledgers (East 2 Narcotic Ledger) reviewed for accuracy. Failure to complete a thorough investigation placed residents at risk for uncontrolled pain, further misappropriation of resident narcotic medications, and possible staff diversion of controlled substances. Findings included . <Policy> According to a facility policy titled, Incidents and Accidents, revised 01/2023, the facility would complete incident reporting to ensure appropriate and immediate interventions were implemented and corrective actions were taken to prevent recurrence. The policy showed the facility would meet regulatory requirements for analysis and reporting of incidents. The policy showed the facility would complete an investigation for incidents that occurred on facility property and that involved a resident. Review of the facility policy titled, Controlled Medication Storage, dated 01/2024, controlled substances were subject to special record keeping in the facility in accordance with federal, state, and other applicable laws and regulations. The policy showed any discrepancies in controlled substance medication counts would be investigated by the Director of Nursing and every reasonable effort would be made to reconcile the discrepancies. <East 2 Narcotic Ledger> In an observation and interview on 12/09/2024 at 3:13 PM discrepancies were found in the East 2 narcotic lock box and ledger. At this time Staff I (Licensed Practical Nurse) stated they reported the discrepancies to Staff B (Director of Nursing). In an interview on 12/09/2024 at 3:15 PM Staff B stated they were notified of the missing narcotics and the pages torn out, pages 111 and 112, in the East 2 narcotic ledger by Staff I on 11/11/2024. Staff B stated they had completed an investigation by doing a narcotic audit of the East 2 narcotic ledger. Staff B stated they did not come to a conclusion as to what happened to the missing narcotics or missing narcotic pages that were ripped out of the ledger. Staff B stated they instructed Staff F (Registerd Nurse-RN Manager) and staff H (RN Manager) to make a notation on each page that was incorrect so that it was corrected in the narcotic ledger for future nurses accepting the keys to that medication cart, but they did not check to ensure Staff F and Staff H made the notations. Staff B stated they ordered a pharmacy narcotic audit which was completed on 12/05/2024 and 12/06/2024. Staff B stated the pharmacist did not report any other discrepancies at the time of the audit. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 12/10/2024 of the facility's investigation of the missing narcotics and missing pages from the East 2 narcotic ledger received from Staff B showed only page 48 was identified to be missing 30 Milliliters (ml) of a liquid narcotic and pages 111 and 112 was torn out. The investigation showed they were unable to reconcile the 30 ml quantity missing on page 48 or the two missing pages, pages 111 and 112. In an interview on 12/11/2024 at 12:34 PM Staff B stated they missed the discrepancies found on pages 83, 96, 99, 101, and 103. Staff B stated they performed a narcotic audit on East 2 Narcotic Ledger by comparing only the cards of narcotics they had in the East 2 medication cart lock box to the assigned pages. Staff B stated they did not investigate page to page in the East 2 Narcotic Ledger as part of their narcotic audit but should have. Staff B stated they did locate page 96, and page 99 after the surveyor notified them but should have found these at the time of the initial investigation and narcotic audit on 11/08/2024. Refer to F609 - Reporting of Alleged Violations Refer to F755 - Pharmacy Procedures REFERENCE: WAC 388-97-0640(6)(a)(b)(c).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43642 Based on interview and record review, the facility failed to ensure a system by which residents/representatives received required written notices at the time of transfer/discharge, or as soon as practicable for 3 of 4 residents (Residents 65, 18, and 39) reviewed for hospitalization s and 1 supplemental resident (Resident 139) reviewed. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> Review of a 09/01/2021 facility, Transfer and Discharge policy, showed for emergency transfers/discharges, the facility would provide a transfer notice as soon as practicable to the resident and their representative. <Resident 65> According to a 10/19/2024 Discharge Minimum Data Set (MDS - an assessment tool), Resident 65 was discharged emergently to an acute care hospital on 10/19/2024 with return anticipated. Record review showed Staff E (Director of Social Services) completed a Nursing Home Transfer or Discharge Notice on 10/19/2024 for Resident 65. On this form was a section to indicate to whom the notice was provided; and listed the resident or resident representative. Staff E documented in this section Resident 65 was sent to the emergency department and a copy of the form was, left at bedside. Resident 65 had no access to this form, which included their appeal rights, until after their return to the facility, six days later. In an interview on 12/13/2024 at 9:48 AM, Staff E stated the purpose of a transfer notice was to inform a resident of the reason they were being transferred to the hospital and included the resident's appeal rights in regards to a transfer and/or discharge from the facility. Staff E stated it was not their practice to provide the notice to a resident once they left the facility urgently. <Resident 139> According to a 11/20/2024 Discharge MDS, Resident 139 was discharged emergently to an acute care hospital on 11/20/2024 with return anticipated. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed Staff E completed a Nursing Home Transfer or Discharge Notice on 11/20/2024 for Resident 139. On this form was a section to indicate to whom the notice was provided and listed the resident or resident representative. Staff E documented in this section Resident 139 was sent to the emergency department and a copy of the form was, left at bedside. Resident 139 had no access to this form, which included their appeal rights, until after their return to the facility, seven days later. In an interview on 12/13/2024 at 9:48 AM, Staff E stated they were responsible for providing the written notice of transfer/discharge forms to the residents and stated they do not provide the form to a resident representative unless requested. Staff E stated they did not receive any requests to provide the form to a representative. Staff E stated Resident 65 and Resident 139, did not receive the notice of transfer/discharge until after they were readmitted to the facility and stated they did not provide the notices to their representatives. 45941 <Resident 18> Review of Resident 18's 12/04/2024 Discharge Return Anticipated MDS showed Resident 18 discharged to an acute care hospital on 12/04/2024. Record review on 12/11/2024 showed no documentation staff provided the required written notification to Resident 18 and/or their representative regarding their discharge. In an interview on 12/12/2024 at 12:34 PM, Staff J (Regional Social Services Director) reviewed Resident 18's record and was unable to locate a written notification copy provided to Resident 18 during transferred to the hospital In an interview on 12/13/2024 at 10:34 AM, Staff B (Director of Nursing) stated it was important to provide a written transfer notification to ensure the resident or resident representative was informed of the reason for transfer and to ensure the transfer was in alignment with the resident's stated goals for care and preferences, but the facility did not follow the facility policy. 47836 <Resident 39> Review of Resident 39's 08/28/2024 Discharge Return Anticipated MDS showed Resident 39 discharged to an acute care hospital on 08/28/2024. Record review of Resident 39's health records showed no documentation staff provided the required written transfer notification for the transfer on 08/28/2024. In an interview on 12/13/2024 at 8:24 AM Staff E stated Resident 39 did not receive a written transfer notification for their transfer on 08/28/2024 but should have. Staff E stated it was important to provide written transfer notification for resident rights. REFERENCE: WAC 388-97-0120 (2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to provide the resident and/or the resident's representative with a written notice of the facility's bed-hold policy, at the time of transfer or within 24 hours, for 3 of 4 sample residents (Resident 65, 18, & 39) reviewed for hospitalization and 1 supplemental resident (Resident 139) reviewed. This failure placed the residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized that was necessary for decision-making. Findings included . <Facility Policy> Review of a 12/2022 revised facility, Bed Hold Notice Upon Transfer policy, showed at the time of transfer for hospitalization or therapeutic leave, the facility would provide to the resident and/or the resident representative written notice which specifies the duration of the bed hold policy and addresses information explaining the return of the resident to the next available bed. This policy showed in the event of an emergency transfer of a resident, the facility would provide, within 24 hours, written notice of the facility's bed hold policy. <Resident 65> According to a 10/19/2024 Discharge Minimum Data Set (MDS - an assessment tool), Resident 65 was discharged emergently to an acute care hospital on 10/19/2024 with return anticipated. Review of Resident 65's records did not show the facility discussed and/or offered the resident or their representative a bed hold for the discharge to the hospital on 10/19/2024 as required. <Resident 139> According to a 11/20/2024 Discharge MDS, Resident 139 was discharged emergently to an acute care hospital on 11/20/2024 with return anticipated. Review of Resident 139's records did not show the facility discussed and/or offered the resident or their representative a bed hold for the discharge to the hospital on 11/20/2024 as required. In an interview on 12/13/2024 at 9:48 AM, Staff E (Director of Social Services) stated it was their expectation bed holds would be offered and would expect to see documentation of that in a resident's records. Staff E stated bed holds were the responsibility of the admissions department. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/13/2024 at 11:18 AM, Staff M (Admissions Director) stated it was their expectation the social services department and/or the nurses were responsible for obtaining bed holds. Staff M stated they would check with their supervisor to confirm this information. No further information was provided by Staff M. Staff M stated it was their expectation bed holds be completed within 24 hours of a resident's transfer to a hospital. Staff M reviewed the records for Resident 65 and Resident 139 and was not able to locate documentation they were offered and/or provided a bed hold as required. 45941 <Resident 18> Review of Resident 18's 12/04/2024 Discharge Return Anticipated MDS showed Resident 18 discharged to an acute care hospital on 12/04/2024. Review of Resident 18's record showed Resident 18 was sent to the hospital on 12/04/2024 and readmitted to the facility on [DATE]. Review of Resident 18's record on 12/11/2024 showed no documentation indicating a bed hold notification was provided to Resident 18 when they discharged to the hospital on 12/04/2024 as required. In an interview on 12/11/2024 at 10:22 AM, Staff B (Director of Nursing) stated the admission coordinator should have the bed hold notification record for residents discharged to the hospital. In an interview on 12/13/2024 at 11:18 AM, Staff M reviewed the records for Resident 18 and was not able to locate documentation they were offered and/or provided a bed hold as required. 47836 <Resident39> Review of Resident 39's 05/22/2024 Modified Discharge Return Anticipated MDS showed Resident 39 discharged to an acute care hospital on 05/22/2024. Review of Resident 39's census report showed they transferred out of facility on 05/22/2024, returned on 06/04/2024, and transferred out of facility again on 08/28/2024 and returned on 09/14/2024. Review of Resident 39's 08/28/2024 Discharge Return Anticipated MDS showed Resident 39 discharged to an acute care hospital on 08/28/2024. Record review of Resident 39's health records showed no documentation staff reviewed the facility bed hold policy with the resident or offered a bed hold for either of the transfers on 05/22/2024 or 08/28/2024 as required. In an interview on 12/13/2024 at 8:24 AM Staff E stated Resident 39 was not offered a bed hold for their transfers on 05/22/2024 or 08/28/2024 but should have been offered a bed hold. Staff E stated it was important to offer a bed hold for resident rights. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/13/2024 at 11:18 AM Staff M stated bed holds were not offered to Resident 39 for either transfers out of facility on 05/22/2024 and 08/28/2024. Staff M stated the bed hold policy should have been reviewed and offered to Resident 39 within 24 hours of both transfers out of facility on 05/22/2024 and 08/28/2024. REFERENCE: WAC 388-97-0120 (4).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51791 Based on observation, interview, and record review, the facility failed to ensure Care Plans (CP) were updated as needed to reflect changes in residents' care needs for 2 of 5 residents (Residents 3 & 39) reviewed for CP's. The facility failed to provide care conferences for 2 of 5 residents (Residents 39 & 49) reviewed. The failure to update CPs with changes in residents' health status and conduct care conferences placed residents at risk for unmet care needs, unnecessary care, and frustration. Findings included . <Facility Policy> Record review of the facility's 4/01/2021 policy titled Care Planning - Resident Participation showed the facility would support residents' right to be informed about and actively participate in their CP and treatment decisions. The CP process would include an assessment of the residents' strengths and needs and incorporate the residents' preferences. Record review of the facility's 3/17/2024 Admission Agreement showed residents had the right to participate in developing and being informed of changes to their care and/or treatment. <CP Revision> <Resident 3> Record review of the 10/25/2024 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 3 was assessed with altered mental status, disordered communication, and limited range of motion which placed them at risk of injury. Record review of a revised 11/04/2024 CP showed Resident 3 was at risk for serious fall-related injuries due to incontinence, weakness, impaired cognition, limited communication and anticoagulant use. Staff were directed to place bilateral floor mats, when Resident 3 was unattended. Record record review of Resident 3's physician orders showed an 11/21/2024 order, changing the bilateral mats to left side only. During observations on 12/10/2024 at 1:20 PM and 12/11/2024 at 6:39 AM, Resident 3 was observed in bed and unattended with no floor mats placed on either side of bed. In an interview on 12/12/2024 at 2:07 PM Staff G (Registered Nurse Manager) stated the facility failed to update the CP to reflect the physician's newest order, which resulted in a risk of inconsistent and uncoordinated care. 47836 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 39> Review of the 06/10/2024 Admission MDS showed Resident 39 readmitted to facility on 06/04/2024. The MDS showed Resident 39 was able to make themselves understood and usually understood others. The MDS showed Resident 39 had moderately impaired vision without corrective lenses available. Review of a 06/15/2024 Impaired Visual Function CP Resident 39 preferred to not wear glasses. In an interview on 12/12/2024 at 7:11 PM Resident 39's Representative (RR) stated they requested social services schedule Resident 39 an eye exam to get glasses on several occasions over the past few months verbally and in text messages. Review of Resident 39's RR text message communications showed requests to schedule an eye exam with a 10/23/2024 at 3:05 PM response from the facility's social worker that stated they would include Resident 39 on the list to be seen by the eye doctor. In an interview on 12/13/2024 at 8:24 Staff E (Social Service Director) stated the social worker Resident 39's RR communicated with was no longer an employee at the facility and quit about one and a half weeks before the date of this interview. Staff E stated there was no documentation in Resident 39's records showing the communication with the RR, but the previous social worker should have update Resident 39's CP to reflect their wishes for vision services. <Care Conference> <Resident 39> According to the 10/30/2024 Quarterly MDS Resident 39 had moderate cognitive impairment and had their legally authorized representative participate in the assessment. The MDS showed Resident 39 was able to make themselves understood and understood others. Review of Resident 39's records showed they admitted to the facility on [DATE]. These records showed Resident 39 was offered and received one care conference on 06/07/2024 since admission to the facility. In an interview on 12/08/2024 at 9:35 AM Resident 39 stated they were not offered a care conference. Resident 39 stated staff did not discuss their care plan with them or provide them with a copy of their care plan. In an interview on 12/12/2024 at 7:11 PM Resident 39's RR stated the facility staff had not attempted to schedule a care conference with them since the one they had right after Resident 39 admitted in June 2024. In an interview on 12/13/2024 at 8:24 Staff E stated Resident 39 only had one care conference on 06/07/2024 without any others offered. Staff E stated Resident 39 should have been offered care conferences quarterly. <Resident 49> According to the 11/27/2024 Quarterly MDS Resident 49 had no cognitive impairment. The MDS showed Resident 49 was able to make themselves understood and understood others. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 49's records showed they admitted to the facility on [DATE]. These records showed Resident 49 was offered and received care conferences on 06/17/2024 and 12/02/2024 with no other documentation of care conferences being offered. In an interview on 12/08/2024 at 10:12 AM Resident 49 stated they were offered and received only one care conference when they first admitted . Resident 49 stated they were not offered a copy of their plan of care. In an interview on 12/13/2024 at 8:24 AM Staff E stated Resident 49 was not offered care conferences per regulation. Staff E stated Resident 49 should have had a quarterly care conference offered in September of 2024 but was not. Staff E stated they expected care conferences to be offered upon admission, within 48-72, quarterly, and as needed. Staff E stated it was important to offer care conferences per regulation so residents could participate in their plan of care, express any concerns, and get questions they might have answered. Refer to F685 Vision Services Refer to F842 - Resident Records REFERENCE: WAC 388-97-1020(2)(c)(d)(e)(f),-(4)(b)(c)(i-ii)(f).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL), related to cleanliness and grooming for 3 (Residents 18, 22, & 3) of 18 sample residents reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with shaving (Resident 18), bathing (Residents 22 & 3), and nail care (Resident 18), placed the residents at risk for poor hygiene, long facial hair, embarrassment and diminished quality of life. Findings included . <Facility Policy> According to the facility's revised 08/2024 ADL policy, a resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's 2/2021 policy titled, Dignity, showed that the requirement for facility staff was to honor resident preferences. The policy stated that the facility would ensure residents were groomed as they wished and encouraged to dress in clothing that they prefer. The policy showed the Care Plan (CP) should include the resident's preferences. <Shaving and nail care> <Resident 18> According to the 09/23/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 18 admitted to the facility on [DATE] with left leg amputation below the knee, was assessed as cognitively intact, and required one person assistance with personal hygiene. Observations on 12/09/2024 at 10:48 AM, on 12/11/2024 at 8:55 AM, and on 12/12/2024 at 12:14 PM showed Resident 18 was in bed, was not shaved, and had long fingernails. Observation and interview on 12/12/2024 at 1:09 PM showed Resident 18 was up in a wheelchair in the dining room for lunch. Resident 18 was not shaved and had long facial hair. Resident 18 stated they needed staff assistance with shaving and staff shaved residents only on shower days. Resident 18 stated, I look like a homeless guy with this beard. I would like to be shaved at least every other day but did not happen. According to the 09/30/2024 ADL self-care performance deficit CP, Resident 18 required one person extensive assistance with bathing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/2024 at 10:31 AM, Staff B (Director of Nursing) stated they expected staff to check the resident's preferences related to ADLs and provide assistance as needed. If the resident refused, staff should document the refusals. Staff B reviewed Resident 18's record and stated the facility should have documented Resident 18's preferences and provided assistance with shaving their facial hair and clip their fingernails, but they did not. 50511 <Resident 22> According to the 12/05/2024 Annual MDS, Resident 22 admitted to the facility on [DATE] due to a stroke with weakness on one side of the body and was dependent on staff for bathing, dressing and personal hygiene. According to the revised 10/12/2024 ADL self-care performance deficit CP, Resident 22 had deficits due to left side body weakness and delusional disorder. Resident 22 required one-person total assistance with bathing, dressing, locomotion and personal care. Resident 22 needed one person stand by assistance with personal hygiene. Review of Resident 22's care staff task list from 12/01/2024 through 12/13/2024 showed no documentation of refusals for showers, dressing, personal hygiene, or dressing services. In an interview and observation on 12/10/2024 at 8:37 AM, Resident 22 stated they could not find their shoes and had just bought new shoes. Resident 22's hair was long just above the ears and hair appeared greasy. The resident's room smelled of urine. Observation on 12/10/2024 at 12:23 PM showed Resident 22's eyebrows were long and the resident had a moustache and beard. Resident 22 stated they wanted a haircut and to be shaved. Resident 22 was wearing a hospital gown. Observation on 12/11/2024 at 10:38 AM Resident 22 smelled like urine and hair was long and greasy. In an interview on 12/11/2024 at 10:45 AM Staff U (Certified Nursing Assistant - CNA) stated Resident 22 did not have any shoes, they had never seen Resident 22 with any shoes. Staff U stated Resident 22 was on the shower schedule but refused showers. Staff U stated staff offered assistance to the resident with shaving and changing but Resident 22 refused. In an interview on 12/11/2024 at 11:07 AM Staff Y (Licensed Practical Nurse), stated Resident 22 should have shoes on and should be getting up. Staff Y stated if Resident 22 refused showers, staff should document the refusals and notify the supervisor. In an interview on 12/13/2024 at 9:58 AM Staff B stated they needed to check why Resident 22 did not have any shoes and was not aware of this issue. Staff B stated for Resident 22 refusals of care, the approach for staff would be not to agitate the resident. Staff B stated if Resident 22 allowed beard care, staff could do it for the resident. Staff B stated staff should document if Resident 22 refused the care and notify the supervisor. Staff B stated Staff should make Resident 22 feel comfortable and must try and offer the care service. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51791 <Bathing> <Resident 3> Review of the 10/25/2024 Resident/Representative Preference Assessment showed that Resident 3's Health Care Power of Attorney (HCPOA) indicated the preference of bed baths twice per week. Review of the 10/25/2024 CP showed that the facility would monitor and document Resident 3's abilities for ADLs and assist as needed. Record review of the 10/25/2024 Admission MDS showed Resident 3 was assessed with altered mental status, disordered communication, limited range of motion and assistance was required by staff to complete bathing. On 12/08/2024 at 8:30 AM, the HCPOA stated they were concerned that bathing assistance from staff was inadequate to meet Resident 3's hygiene needs. The HCPOA stated Resident 3 should receive two baths per week but was only receiving one per week. Review of the 12/08/2024 facility bath schedule showed Resident 3 was scheduled for two showers per week on Monday evening and Thursday morning. Review of Resident 3's 11/2024 and 12/2024 daily documentation of care provided by the CNA showed Resident 3 was scheduled for 10 showers between 11/11/2024 and 12/12/2024. The documentation showed Resident 3, refused one shower, and only received four showers in 32 days, one per week. In an interview on 12/12/2024 at 10:31 AM, Staff B stated they expected staff to check the resident's preferences related to bathing and follow the CP. If the resident refused, staff should document the refusals in the resident's record. In an interview on 12/12/24 2:10 PM, Staff G (Resident Care Manager) stated Resident 3's bathing preferences should be written on the CP. Staff G reviewed the bath schedule and stated Resident 3 was scheduled two showers per week. Staff G reviewed Resident 3's bathing documentation and stated only one shower was documented per week. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, record review, and interview the facility failed to follow provider orders for 1 of 2 residents (Resident 35) reviewed for bed rails, failed to provide oxygen monitoring for 1 of 1 residents (Resident 27), failed to follow treatment as ordered by the physician, monitor, and document bruises for 3 of 12 residents (Residents 139, 15, and 45) reviewed for skin issues, and failed to provide interventions for nutrition refusals for 1 of 7 residents (Resident 71) reviewed for nutrition. These failures placed the residents at risk for poor clinical outcome and a decreased quality of life. Findings included . <Policy> According to a facility policy titled, Proper Use of Bed Rails, revised 11/2024, the facility would ensure correct installation, use, and maintenance of the bed rails. <Following Provider Orders> <Resident 35> According to a 11/13/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 35 had no bed rails in use. The MDS showed Resident 35 was dependent on staff to roll side to side in bed. The MDS showed lying to sitting in bed was not attempted for Resident 35 during the assessment period. Review of 06/08/2023 Activities of Daily Living (ADL) self-care performance deficit Care Plan (CP) related to right hand contracture, Resident 35 would have bilateral bed rails on their bed to assist with increased self-mobility. Review of Resident 35's records showed a 06/09/2023 provider order for bilateral bed rails to enhance bed mobility and independence. Resident 35's records showed a 06/09/2023 Physician's Order (PO) to check skin every shift for injury related to bed rails. Review of a 08/16/2023 bed rail use assessment form showed Resident 35 was assessed to require bilateral bed rails for assessed medical need, safety, treatment of a medical symptom/condition, and for mobility/transferring assistance. The assessment showed the bed rails would benefit Resident 35 in movement up or down in bed, assist resident in easier access to bed control, assist the resident turning side to side in bed, assist with balance while attempting to stand, and would assist the resident getting in and out of bed. According to the bed rail assessment, Resident 35 was able to transfer between positions, turn independently side to side in bed, and was able to safely exit/enter the bed. The assessment showed bed rails were recommended to be always used while in bed for Resident 35. Review of Resident 35's records showed a revised 12/15/2023 provider order for bilateral bed rails to enhance bed mobility and independence. Resident 35's records also showed a revised 12/15/2023 provider order to check skin every shift for injury related to bed rails. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 12/09/2024 at 9:29 AM, 12/10/2024 at 8:56 AM, and 12/11/2024 at 7:55 AM showed Resident 35 lying in bed with no bed rails installed to their bed. In an interview on 12/11/2024 at 9:15 AM, Staff F (Registered Nurse Manager) stated therapy would assess resident's needs for bed rails and provide recommendations. Staff F stated staff were expected to assess proper placement of bed rails and the resident's skin for any injuries every shift, and document in the TAR. Staff F stated Resident 35 was assessed to require bilateral bed rails to assist with bed mobility and for their safety. In an interview on 12/11/2024 at 1:10 PM Staff F stated Resident 35 did not have bed rails installed on their bed, but they should have as therapy assessed bilateral bed rails to be required. Staff F stated staff should not sign the TARs that the bed rails were in place when they were not. In an interview on 12/13/2024 at 9:12 AM Staff B (Director of Nursing) stated they expected staff to follow provider orders and recommendations. Staff B stated it was important to follow provider orders as part of the resident's CP. 50511 <Oxygen Monitoring> <Facility Policy> According to the facility's undated, Medication Administration policy dated 01/23 showed medications were to be administered in accordance with written orders of the prescriber. If necessary, the nurse would contact the prescriber for clarification of orders. The interaction would be documented in the nursing notes and elsewhere in the medical record. <Resident 27 > According to an 11/15/2024 Quarterly MDS Resident 27 had a disability related to cardiorespiratory conditions, heart failure and chronic obstructive pulmonary disease. Resident 27 had chronic respiratory failure with low oxygen and was on oxygen therapy. Resident 27 required assistance with transferring, moving from a lying to sitting position, and was not able to walk. Review of Resident 27's revised 07/03/2024 altered respiratory CP showed Resident 27 had difficulty breathing. Interventions listed on CP showed that Resident 27 would have oxygen delivered through nasal canula per the PO. Review of the 12/2024 Medication Administration Record (MAR) showed an order dated 06/25/2024 for Resident 27 to have continuous supplemental oxygen at 2 liters per minute. Nurses were required to initial that the oxygen concentrator was set at 2 liters of oxygen per minute. On 12/08/2024, 12/09/2024 and 12/20/2024 nurses initialed that oxygen was set at 2 liters. Observations on 12/08/2024 at 12:11 PM, 12/09/2024 at 1:11 PM, 12/10/2024 at 12:51 PM and 12/11/2024 at 6:48 AM showed Resident 27's oxygen setting was set at 2.5 liters of oxygen per minute. (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 12/11/2024 at 10:35 AM, Staff B stated staff were expected to check oxygen settings every shift according to the instructions provided on the MAR. Staff B stated staff should follow the PO, adjust the oxygen setting if incorrect, or follow up with physician if the order needed to be change from the original order of 2 liters of oxygen per minute. <Nutrition Refusals> <Resident 71> According to the 10/31/2024 Quarterly MDS, Resident 71 had dementia, diabetes, depression, a brain disorder, muscle weakness, and a cardiac pacemaker. Review of the antidepressant medication CP revised on 10/15/2024, showed that Resident 71's family stated that Resident 71 was sad or depressed when the resident refused to eat. Interventions listed on the CP showed staff were to provide monitoring of side effects and effectiveness of the antidepressant medications and provide calm reassurance. One of the side effects listed for antidepressant medications included monitoring for appetite loss and weight loss. No interventions were listed on the CP on what to do when Resident 71 refused to eat. Review of the ADL CP revised 10/15/2024 showed Resident 71 had deficits related to stroke-like symptoms. The CP showed Resident 71 had a brain disorder, dementia and behaviors due to refusals of care. Interventions for Resident 71 included one-person total assistance with ADL's, provide maximum assistance with eating, set up the food tray and provide encouragement to eat. The CP did not show interventions for what staff would do when Resident 71 refused care or refused to eat. The Nutrition CP revised on 10/15/2024, showed Resident 71 had a variable appetite, inadequate oral intake and frequent refusal of meals and medications. The goal listed on the CP was Resident 71 would maintain adequate nutritional status by maintaining their weight. Interventions listed on the CP showed staff were to monitor side effects and effectiveness of prescribed medications and to monitor for malnutrition. The CP did not provide instructions on what to do when Resident 71 refused to eat or be weighed. The Palliative Performance Score (PPS) score CP dated 11/07/2024, showed Resident 71 had a score of 40%. A score of 40% showed that Resident 71 was totally dependent on staff for ADLs, was bed bound and had poor appetite and dementia. The CP showed Resident 71 refused food and medication and did not want to be forced to eat or drink. The CP showed if Resident 71 was unable to be referred to hospice, then Resident 71 would be transitioned to palliative (comfort) care. An intervention listed on the CP showed staff were to assist with Resident 71's wishes and to adjust ADL's assistance due to resident's changing abilities. Staff were to work with nursing staff to provide maximum comfort. The CP did not describe what interventions provided comfort to Resident 71 and did not show interventions when Resident 71 refused to eat or drink. The CP was not revised to show Resident 71 had hospice or palliative care services in place. Review of the Kardex (care staff information sheet about resident's care) on 12/12/2024 showed staff were to report sad statements. No instructions were provided on the Kardex on what interventions were needed when Resident 71 refused care, refused medications, or refused to eat. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated 12/03/2024 by the facility ARNP (Advanced Registered Nurse Practitioner), showed Resident 71 had intermittent refusals of care and medications but was usually redirectable. Review of the 10/07/2024 care conference notes showed Resident 71 had no advanced directives or living wills set up to provide instructions on residents' wishes for care. Resident 71 only had a Physician's Order for Life Sustaining Treatment (POLST) for resuscitation and not receiving medically assisted nutrition. Review of the 12/2024 MAR for the review period of December 1 to 12, showed Resident 71 refused aspirin, depression medication, bedtime snack, hypertension medication, appetite suppressant, weekly weights, vitamin D and juice based or nutritional supplemental drinks every day. No documentation was found in the December MAR on who was notified of refusals. No documentation was found in the MAR of interventions staff were to provide when Resident 71 refused their medications, snacks, or being weighed. Review of the Capacity for Medical Decision form dated 4/24/2024 and signed by facility ARNP showed Resident 71 was unable to comprehend the risks, benefits and alternatives to medical decision and was not capable of making medical decisions on their own behalf due to dementia. In an interview on 12/08/2024 at 12:30 PM, Staff T (Restorative Aide) stated Resident 71 was able to feed themselves, but refused to eat. Staff T stated Resident 71 needed to be fed. In an observation on 12/09/2024 at 8:38 AM, Resident 71 stated no to a question about if they ate breakfast, observed Resident 71 stated no to all questions asked. Observed breakfast tray was set up approximately 15 minutes ago in room but was taken away 15 minutes later. Observations on 12/11/2024 at 8:24 AM, showed Staff U (Dietician) asked Resident 71 if they wanted breakfast and offered orange juice. Resident 71 stated no and Staff U removed tray. In an observation and interview on 12/11/2024 at 11:08 AM, Staff Y (Licensed Practical Nurse) stated Resident 71 did not have a weight taken this week. Observed December MAR showed an order dated 10/03/2024 for weekly weight checks. Staff did not weigh Resident 71 until surveyor requested. In an interview on 12/11/2024 at 12:38 PM, Staff Y had staff take Resident 71's weight using a mechanical lift and Resident 71 now weighed 149 pounds Staff Y stated there was a significant weight loss from last weight taken on 12/01/2024 which was documented as 168 pounds for a 19 pound weight loss. In an interview on 12/12/2024 1:06 PM, Staff J (Regional Social Services Director) stated social services staff should be immediately involved in resident refusals of care and services. There should be interventions and discussions with all involved and interventions should be updated in the CP. Staff J stated it was their expectation that nursing staff would notify the social services team of refusals of care and the effectiveness of refusal interventions, but notification did not happen. (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 12/13/2024 at 9:21 AM, Staff K (Dietary Manager) stated Resident 71 was very depressed. Staff K stated Resident 71 did not want to eat and just said no to questions. Staff K stated, when residents have dementia, we don't ask them if they want to eat, we just take the meal to the resident. In an interview on 12/13/2024 at 9:58 AM Staff B stated for residents with decline in health conditions due to refusals of care impacting their medical conditions, staff should notify the provider and family and make referrals to coordinate services. Staff should continue to re-approach the resident and try to manage the refusals. If the goal was to keep Resident 71 comfortable, staff should still try to offer care. Staff B stated, when care staff observed changes of condition for Resident 71, staff should have reported these changes to the nurse. Staff B stated the CP should address refusals and what to do when Resident 71 refused care. Staff B stated staff should have weighed Resident 71 however the goal was to keep Resident 71 comfortable by not weighing them. In an interview on 12/13/2024 at 1:23 PM Staff B stated we tried supplements but Resident 71 refused. Staff B stated if Resident 71 did not refuse hospice services, we could do more to help Resident 71 be more comfortable. 43642 <Resident 139> According to the 12/03/2024 Admission MDS Resident 139 had multiple medically complex diagnoses including liver disease. This MDS showed Resident 139 had recent major surgery. Review of a revised 11/27/2024 skin impairment CP showed staff identified the goal for Resident 139 was to have no complications related the alteration of the skin integrity. The CP listed interventions for staff to follow facility protocols for treatment of the injury and to refer Resident 139 to a contracted wound team for evaluation and treatment. Review of Resident 139's POs showed a 12/04/2024 order for staff to adjust the settings of a wound Vacuum-Assisted Closure (VAC - a device that uses suction to help in wound healing), to negative 75 Millimeters of Mercury (mmHg) continuous suction for a surgical wound to Resident 139's abdominal area. Observations on 12/08/2024 at 9:52 AM showed a wound VAC machine sitting on Resident 139's bedside table. This container was positioned upside down on the table, with the liquid collection chamber on the bottom. Observations on 12/09/2024 at 2:53 PM showed the wound VAC machine on Resident 139's bedside table with the liquid collection chamber on its side. On 12/10/2024 at 1:03 PM, Resident 139's wound VAC machine was sitting upright, with a label showing, must remain upright. The wound VAC machine was set at 125 mmHg. Observations on 12/11/2024 at 6:32 AM showed Staff G (Resident Care Manager) providing surgical wound care to Resident 139. Once finished, Staff G checked the wound VAC settings, which showed the setting was at 125 mmHg. Staff G adjusted the wound VAC settings to negative 75 mmHg. (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 12/13/2024 at 12:15 PM, Staff G stated the placement of a wound VAC machine should be checked every shift by nursing staff, with the proper function assessed, and to assure the physician ordered settings were followed. Staff G stated the wound VAC container should be positioned upright at all times for proper suction. Staff G stated Resident 139's wound VAC settings should have, but were not, set to negative 75 mmHg. Staff G stated incorrect settings could affect effective wound healing and it was their expectation nurse staff would follow the PO. 45941 <Resident 15> According to the 10/14/2024 Quarterly MDS, Resident 15 was alert and usually understood others. Resident 15 required one person assistance with ADLs. Review of December 2024 POs showed an 11/14/2024 order directed staff to clean Resident 15's right shin, apply antibiotic ointment, and cover with border gauge every day. Review of Resident 15's December 2024 Treatment Administration Record (TAR) showed licensed nurses signed every day that they provided the treatment as ordered by physician. Observations on 12/08/2024 at 10:06 AM, on 12/09/2024 at 9:02 AM, on 12/10/2024 at 9:19 AM and at 12:41 PM, and on 12/11/2024 at 11:43 AM showed Resident 15 was up in their wheelchair, had dry scabs on their lower legs and no dressing observed on their legs. In an interview on 12/11/2024 at 12:25 PM, Staff B stated it was their expectations from the staff they follow the POs. Staff B went to Resident 15's room with the surveyor and observed no dressing was applied on Resident 15's leg as ordered. During observation, Staff B noticed Resident 15 had no open skin issues, had only dry scabs on lower legs. Staff B reviewed Resident 15's record and stated staff should assess Resident 15's skin and notify the physician to change the order, but they did not. Staff B stated staff should not sign the treatment they did not provide. <Resident 45> According to the 11/12/2024 Quarterly MDS, Resident 45 admitted to the facility on [DATE] with muscle weakness and seizure disorder and had no memory impairment. The MDS showed Resident 67 had more than two falls since their admission in the facility. Observation on 12/08/2024 at 11:58 AM showed Resident 45 was lying on the floor in their room, screaming, I fell again, help me. Observation on 12/09/2024 at 9:20 AM showed Resident 45 was lying in their bed in hospital gown and observed multiple faded small bruises on both arms and another big purple bruise on left upper arm. In an interview on 12/10/2024 at 11:37 AM, Resident 45 stated they keep falling all the time and getting those bruises on their arms. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 45's record on 12/11/2024 showed no PO and no CP to direct staff to monitor the bruises on Resident 45's body for any changes and document. In an interview on 12/11/2024 at 12:13 PM, Staff B stated they expected the facility staff to perform skin check every week and after every fall and document in resident's record. Staff B reviewed Resident 45's record and stated staff should have assessed the resident's skin after the fall happened on 12/08/2024 and documented the bruises in Resident 45's record to monitor for any change, but they did not. 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. 47836 Based on observation, interview, and record review the facility failed to ensure residents with vision deficits were assessed and provided assistive devices to maintain vision abilities for 1 of 2 residents (Resident 39) reviewed for vision needs. These failures placed Resident 39 and other residents at risk for unmet care needs and a decreased quality of life. Findings included . <Policy> According to a facility policy titled, Hearing and Vision Services, revised 12/2022, the facility would identify and assess a resident's vision abilities through ongoing monitoring of sensory problems. The policy showed the social worker was responsible for assisting residents and their representatives in locating and utilizing any available resources for the provision of the vision services the resident needed. The policy showed the social worker would assist residents by making appointments and arranging transportation to and from vision provider services. The policy showed employees would assist the resident with the use of adaptive equipment needed to maintain vision such as talking books or magnifying lenses. <Resident 39> Review of the 06/10/2024 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 39 readmitted to facility on 06/04/2024. The MDS showed Resident 39 was able to make themselves understood and usually understood others. The MDS showed Resident 39 had moderately impaired vision without corrective lenses available. Review of a 06/15/2024 Impaired Visual Function Care Plan (CP) Resident 39 preferred to not wear glasses. The CP showed staff were to identify and record environmental factors affecting visual function. In an observation and interview on 12/08/2024 at 9:41 AM Resident 39 was unable to see their television and did not have glasses or any other visual assistive devices available for their use. Resident 39 stated their Resident Representative (RR) had talked with social services department and requested an eye exam because their eyesight was bad, and Resident 39 needed glasses. Resident 39 stated their RR told the social service department at the facility that they could not see their television and needed glasses. Resident 39 stated the facility kept putting the eye exam off and they were waiting for months. Resident 39 denied ever refusing eye exams and stated they were not offered an exam since being at the facility. (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 12/12/2024 at 7:11 PM Resident 39's RR stated they requested social services schedule Resident 39 an eye exam to get glasses on several occasions over the past few months verbally and in text messages. Review of Resident 39's RR text message communications showed requests to schedule an eye exam with a 10/23/2024 at 3:05 PM response from the facility's social worker stating they would include Resident 39 on the list to be seen by the eye doctor. Resident 39's RR stated Resident 39 was not seen by the eye doctor and did not receive any explanation as to why the appointments did not occur. In an interview on 12/13/2024 at 8:24 Staff E (Social Service Director) stated the social worker Resident 39's RR communicated with was no longer an employee at the facility and quit about one and a half weeks before the date of this interview. Staff E stated the previous social worker cleared their data from their laptop prior to turning it into the facility. Staff E stated there was no documentation in Resident 39's records showing the communication with the RR, but the previous social worker should have saved this in Resident 39's records. Staff E stated the eye doctor came monthly but Resident 39 was never put on the list to be seen. Staff E stated Resident 39 should have been included on the list when the previous social worker replied they would add them and was not sure why this did not happen. Refer to F657 - Care Plan Timing and Revision Refer to F842 - Resident Records 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. 50511 Based on observation, interview and record review the facility failed to ensure 2 of 5 residents (Resident 71 & 1) reviewed for Pressure Ulcers (PU- injury to the skin and underlying tissue due to prolonged pressure), received necessary care and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure to timely monitor, assess, report, and implement wound prevention recommendations and interventions placed residents at risk for deterioration in skin condition(s), pain, and diminished quality of life. <Facility Policy> Review of the revised 11/2024 Pressure Injury Prevention and Management policy, the facility was committed to the prevention of avoidable pressure injuries and to provide treatment and services to heal the injury, prevent infection and the development of additional pressure ulcers/injuries. The facility would establish and utilize a systematic approach for pressure injury prevention and management including prompt assessment and treatment. Nursing assistants would inspect the skin during baths and report any concerns to the resident's nurse immediately after the task. <Resident 71> According to the 10/31/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 71 had Non-Alzheimer's dementia, diabetes, depression, muscle weakness, and was at risk for pressure ulcer and injury. Review of the revised 02/04/2024 impairment to skin integrity Care Plan (CP) showed Resident 71 had potential for impairment to skin integrity due to incontinent of bowel and bladder and weakness. Interventions instructed staff to prevent skin injury, encourage good nutrition and hydration, monitor and report signs and symptoms of skin breakdown to the physician, complete weekly skin checks, and report abnormalities to the physician. Review of the 12/04/2024 weekly skin assessment showed Resident 71 had no new skin issues. Review of Resident 71's caregiver task sheet from 12/01/2024 thru 12/09/2024 showed staff documented no observation of skin issues. On 12/10/2024 staff documented a reddened area as a new issue. On 12/11/2024, 12/12/2024, and 12/13/2024 staff documented no observations of skin issues. Observation and interview on 12/09/2024 at 1:22 PM showed Staff W (Certified Nursing Assistant) was providing personal care to Resident 71. Observation of Resident 71 showed an open area on their coccyx area about 0.4 X 0.4 Centimeter (cm) with redness and had no dressing on it. Staff W stated they did not notice the open area before. (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 12/10/2024 at 10:47 AM, Staff X (License Practical Nurse) observed Resident 71's skin and stated Resident 71 had recurring pressure areas on their back. Staff X stated the wound was open and they would notify their nursing director. Staff X measured the wound approximately 0.5 by 0.5 cm in size with small amount of bloody drainage. Staff X stated the CNAs were supposed to notify the nurse and document the skin conditions to trigger the nurse to look at the wound. Staff X stated they were not notified about Resident 71's new skin issue from 12/9/24. In an interview on 12/13/2024 at 1:23 PM, Staff B (Director of Nursing) stated care staff were expected to notify the nurse of any skin changes. The nurses would obtain and implement new interventions. Staff B stated the staff did not follow facility policy for Resident 71's open area to their coccyx, but should have. <Resident 1> According to the 09/23/2024 MDS, Resident 1 had morbid obesity, back pain, severe pain due to damaged nerves, and osteoporosis (weakened bones). The MDS showed Resident 1 was dependent on staff for toileting hygiene, bathing, upper and lower body dressing and personal hygiene. Review of the revised 10/08/2024 impairment to skin integrity CP, showed Resident 1 had recurring moisture associated skin damage to the buttock, coccyx, and bilateral thighs. Resident 1 had a chronic wound to the right lower leg. Interventions listed on the CP instructed staff to keep the skin clean and dry, follow up with wound care recommendations given by the wound care specialist and monitor the size, treatment to the skin injury, and to report abnormalities and signs and symptoms of infection to the provider. The interventions included instructions for the licensed nurses to complete the weekly skin assessments. Review of Resident 1's December 2024 Treatment Administration Record (TAR) showed weekly skin checks were completed on 12/02/2024, 12/09/2024 and no new skin issues were identified. Review of December 2024 TAR showed Resident 1 refused the compression wraps treatment order on 12/09/2024 and 12/10/204. Review of Resident 1's record showed no documentation staff notified the provider or social services about Resident 1's refusals of treatments of compression wraps on right lower leg wound. There was no documentation that showed staff discussed with the resident the reason for refusals or notified the physician to receive alternative orders. Interview on 12/10/2024 at 9:00 AM showed Resident 1 stated their wound on the right leg was supposed to be dressed with a special type of dressing but staff did not have that dressing available last week. Observation of the right lower leg dressing showed it was soiled with yellow/brown drainage, with a strong odor. Resident 1 stated Staff F (Resident Care Manager) came to their room last night and told the nurses to change the soiled dressing but no one changed the dressing. Observation and interview on 12/10/2024 at 12:13 PM showed Staff X (Licensed Practical Nurse) observe Resident 1's loose undated gauze dressing on the right leg wound, saturated with drainage. Staff X observed the wound was draining onto Resident 1's bed and exhibited a strong odor. Staff X stated they would change the dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with the wound team on 12/11/2024 at 7:02 AM showed the wound care consultant along with Staff B stated, Resident 1 did not receive the skin graft dressing on right leg wound because there was a delay in the skin graft dressing delivery because of the holiday. Wound consultant measured the right leg wound as 3.5 x 2 x 0.2 cm open with drainage with odor. The wound care consultant stated they received the skin graft dressing today and would apply the dressing on Resident 1's wound for 7 days. The wound care consultant told Staff B if Resident 1 did not want to use the compression wraps, another tubular shaped bandage could be used. In an interview on 12/12/2024 at 12:57 PM Staff F (Resident Care Manager) stated their expectations was the direct-care staff would report any skin issues to the nurses on duty immediately and nurses would notify the provider to get treatment orders. Staff B stated staff should follow the physician orders and notify the physician if the dressing was not available, but they did not. REFERENCE: WAC 388-97-1060(3)(b).

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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** 50511 Based on observation, interview, and record review the facility failed to ensure the resident environment was free of accident hazards for 2 of 6 units (East Central 2 & [NAME] Central 2) sampled for accidents. This failure to store chemicals safely, placed residents at risk for exposure to unsafe chemicals. Findings included . <Facility Policy> Review of a facility policy titled, Environmental Services Safety Procedures, revised December 2024, showed the facility would validate general safety procedures were followed while performing housekeeping and/or laundry duties. Staff would validate the chemicals were properly stored and not left unattended in areas that were accessible to residents. When not in use, chemicals would be stored in a locking closet, cabinet or storage area for safety. Chemicals would be stored out of reach of residents and always locked up while in storage. Observation on 12/08/2024 at 8:30 AM, showed the second-floor central hall had a facility cabinet sink located by room [ROOM NUMBER]. One bottle of Insect killer ant, roach, and fly spray was found in an unsecured and unlocked drawer within the facility cabinet. The insect killer spray had a caution warning on the can. Observation on 12/08/2024 at 8:34 AM, the housekeeping supply closet on second floor central hall, did not have a lock on the door. Observed one bottle of enzymatic cleaner and one bottle of spray polish and cleanser on a shelf within the closet. Observation on 12/09/2024 at 9:31 AM showed the utility room located by the facility's stairwell was open. The door had a biohazard sticker on the door and a security number to access the room, but the door was ajar. Several bottles of no rinse foam cleanser conditioning for hair and skin, with a warning label that read for external use only were located in the utility room. There was a biohazard material only - no trash sign posted within the room. In an interview on 12/09/2024 at 9:28 AM Staff P (Housekeeping Aid), stated the chemicals should not be in the utility room/housekeeping closet. Staff P stated some staff may not be able to open the other locked housekeeping closets and may have put chemicals in the unlocked closet. Staff P stated the chemicals were not supposed to be there for resident's safety. Staff P then went to the facility sink cabinet on the second-floor unit and stated the insect killer bottle in the drawer should not have been there. In an interview on 12/10/2024 at 12:34 PM Staff C (Regional Administrator) stated chemicals should be locked up. Staff C stated per our policy, all chemicals should be locked up. This was important for safety as the facility does not want residents to eat or drink chemicals. Staff C stated some housekeeping closets had locks on them but not all of them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1060(3)(g).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47836 Based on observation, record review, and interview the facility failed to ensure Narcotic Ledgers were accurate for 1 of 2 Narcotic Ledgers (East 2 Narcotic Ledger) reviewed for accuracy. Failure to ensure accurate account of resident narcotic medications placed the residents at risk for uncontrolled pain, decreased quality of life, and possible diversion of controlled substances. Findings included . <Policy> Review of the facility policy titled, Controlled Medication Storage, dated 01/2024, controlled substances were subject to special record keeping in the facility in accordance with federal, state, and other applicable laws and regulations. <East 2 Narcotic Ledger> Observation and record review on 12/09/2024 at 3:13 PM of the East 2 narcotic lock box and ledger showed page 83 with 30 tablets remaining transferred to page 101. Review of page 101 showed the starting count was 29 tablets, 1 tablet missing from the remaining balance from page 83. Page 96 showed 14 tablets remaining with the whole page crossed off and no card of medications in the lock box for page 96. Page 99 showed 20 tablets remaining with the page crossed off and transferred to page 99 written in, balanced transferred to unit box was left blank, and no card of medications was in the lock box. Page 103 showed 20 tablets remaining with the whole page crossed off and no card of medications in the lock box for page 103. Page 111 and 112 was missing from the East 2 narcotic ledger, the pages were ripped out. In an interview on 12/09/2024 at 3:13 PM Staff I (Licensed Practical Nurse) stated they reported the missing narcotics to Staff F (Resident Care Manager) and Staff B (Director of Nursing) when first observed counting off with the night nurse on 11/08/2024. In an interview on 12/09/2024 at 3:15 PM Staff B stated they were notified of the missing narcotics and the pages torn out, pages 111 and 112, in the East 2 narcotic ledger by Staff I on 11/11/2024. Staff B stated they instructed Staff F (Registered Nurse Manager) and staff H (Registered Nurse Manager) to make a notation on each page that was incorrect so that it was corrected in the narcotic ledger for future nurses accepting the keys to that medication cart, but they did not check to ensure Staff F and Staff H made the notations. Staff B stated they ordered a pharmacy narcotic audit which was completed on 12/05/2024 and 12/06/2024. Staff B stated the pharmacist did not report any other discrepancies at the time of the audit. Refer to F609 - Reporting of Alleged Violations Refer to F610 - Thorough Investigation REFERENCE: WAC 388-97-1300(1)(b)(i-ii).

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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. 47836 Based on observation, record review, and interview the facility failed to ensure expired medications were removed timely from use in 2 of 2 medication carts (West 1 & East 2), 1 of 2 medication storage rooms (East 2 medication room), and cleanliness was maintained for 2 of 2 medications carts (West 1 & East 2 carts) reviewed for medication storage. This failure placed residents at risk of receiving expired medications, ineffective medications, potential infections, and a diminished quality of life. Findings included . <Policy> According to a facility policy titled, Medication Storage/Storage of Medications, dated 01/2023, showed expired, contaminated, discontinued, or deteriorated mediations and supplies would be immediately removed and disposed of. The policy showed staff would keep all medication storage areas clean. The policy showed medication storage conditions would be monitored and corrective action would be taken for problems identified. < [NAME] 1 Medication Cart> Observation, record review, and interview on 12/09/2024 at 1:22 PM showed a 09/30/2024 expired bottle of laboratory testing solution, a 12/2024 expired bottle of laxatives, and a bottle of pain medication with the expiration date worn off/illegible during the medication storage review of the [NAME] 1 medication cart. Review of the [NAME] 1 medication cart showed liquid medications spilled in bottom of the drawers with several medication bottles stuck to the drawers. In an interview at this time Staff BB (Licensed Practical Nurse-LPN/Supervisor) stated nurses were expected to ensure the carts were clean and expired medications were removed before handing off to next shift nurse. Staff BB stated the [NAME] 2 cart was not cleaned as expected and the expired medications should have been removed and disposed of. <East 2 Medication Cart> Observation, record review, and interview on 12/09/2024 at 2:32 PM showed a 11/3/2024 expired card of medications with four tablets remaining, and a 12/6/2024 expired card of medications with 30 tablets remaining. Review of the East 2 medication cart showed loose pills in the bottom of the drawers. In an interview at this time Staff I (LPN) stated they were expected to remove and dispose of the expired medications and clean the cart before handing off to the next shift nurse. Staff I stated the expired medications, and loose pills should have been removed and disposed of prior to accepting the cart from the night nurse but they were not. <West 2 Medication Room> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation, record review, and interview on 12/10/2024 at 12:52 PM showed a 06/30/2024 expired Intravenous (IV) start kit, fourteen 10/09/2024 expired IV sets, twenty one 02/15/2024 expired IV lock caps, three 02/13/2024 expired IV lock caps, three 03/21/2024 expired IV lock caps, twelve 07/17/2024 expired IV lock caps, twelve 09/16/2024 expired IV lock caps, fourteen 09/06/2024 expired IV lock caps, six 08/31/2024 expired IV lock caps, ten 10/10/2024 expired IV lock caps, eight 10/04/2024 expired IV lock caps, three 10/02/2024 expired IV lock caps, one 09/14/2024 expired IV flush, and one 05/31/2024 expired syringe with a needle in the [NAME] 2 medication storage room. In an interview at this time Staff I stated they were expected to keep the medication storage room free of expired medications and supplies and dispose of them before or by the expiration dates. Staff I stated the expired medications and supplies observed in East 2 medication storage room should have been disposed of by the listed expiration dates. In an interview on 12/11/2024 at 9:53 AM Staff B (Director of Nursing) stated they expected the nursing staff to dispose of expired medications by the expiration dates and keep the medication carts and storage rooms clean at all times. REFERENCE: WAC 388-97-1300(2).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 47836 Based on observation, interview, and record review, the facility failed to ensure prompt dental services were provided for 1 of 5 residents (Resident 39) reviewed for dental services. This failure placed residents at risk for oral discomfort and a diminished quality of life. Findings included . <Policy> Review of a facility policy titled, Dental Services, revised 12/2022, showed the facility would assist residents in obtaining routine and emergency dental care. The policy showed residents dental needs would be identified through a physical assessment and, oral and denture care would be provided in accordance with the resident's identified needs. The policy showed referrals to dental providers would be made by the facility for residents. The policy showed all actions and information regarding dental services, including any delays related to obtaining dental services, would be documented in the resident's medical records. <Resident 39> According to the 10/30/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 39 was able to make themselves understood and understood others. The MDS showed Resident 39 was dependent on staff for oral care. Review of a 06/23/2024 Alteration in Dentition and/or Oral Hygiene Care Plan (CP) showed staff would refer Resident 39 to the dentist/dental hygienist for evaluation and recommendations. The CP showed Resident 39 had no teeth or dentures available. In an observation and interview on 12/08/2024 at 9:41 AM Resident 39 had no teeth and no dentures available for their use. Resident 39 stated their Resident Representative (RR) talked with the social services department and requested a dental exam so Resident 39 could be fitted for dentures. Resident 39 stated the facility kept putting the dental exam off. Resident 39 stated they were waiting months for a dental appointment. Resident 39 denied ever refusing dental exams and stated they were not offered an exam since being at the facility. In an interview on 12/12/2024 at 7:11 PM Resident 39's RR stated they requested social services schedule Resident 39 a dental exam to get dentures on several occasions over the past few months. Resident 39's RR stated the facility social worker informed them they would put Resident 39 on the list to be seen by the dentist, but they were not. (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 12/13/2024 at 8:24 Staff E (Social Service Director) stated the social worker with whom Resident 39's RR communicated, was no longer an employee at the facility and quit about one and a half weeks before the date of this interview. Staff E stated the previous social worker cleared their data from their laptop prior to turning it into the facility. Staff E stated there was no documentation in Resident 39's records showing the communication with the RR, but the previous social worker should have documented this in Resident 39's records. Staff E stated they were unable to recall the last time the dentist was in the facility because they canceled due to illness and then the facility canceled the dental visits due to an infectious outbreak in the facility. Staff E stated Resident 39 was never put on the dentist list to be seen. Staff E stated Resident 39 should have been included on the dentist list when the previous social worker informed the RR they would add them and was not sure why this did not happen. REFERENCE: WAC 388-97-1060(1)(3)(j)(vii). .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43642 Based on observation, interview, and record review, the facility failed to ensure the menu was followed for 3 of 6 residents (Residents 83, 3, & 16) whose meals were observed during tray line. Failure to follow the menu as directed, according to the dietician approved spreadsheet, and provide accurate portion sizes, placed residents at risk of unmet nutritional needs, and potential negative outcomes. Findings included . <Facility Menu> Review of the facility's menu showed for lunch on 12/11/2024 beef stroganoff over noodles, buttered brussel sprouts, peach cobbler made from fresh, peeled, pitted, and sliced thin peaches, and a dinner roll would be served. The 12/11/2024 lunch menu showed low concentrated sweet diets had a canned peach cobbler instead of the fresh peach cobbler. <Following Menu> According to the facility's diet spreadsheet form provided by staff on 12/08/2024, all residents, except those who were on the low concentrated sweets diet, should receive a full serving of the peach cobbler dessert, which was to be made with fresh, peeled, pitted, and sliced thin peaches, according to the recipe provided by staff on 12/11/2024. Observations on 12/11/2024 starting at 11:45 AM, during lunch service showed staff were serving a canned fruit version of peach cobbler to all residents. There was no dessert available to serve which was made from fresh, peeled, pitted, and sliced thin peaches as directed on the spreadsheet. All of the peach cobbler desserts available to serve, were the same size, none were prepared with half of the amount, as directed on the spreadsheet, for the residents on a low concentrated sweets diet. <Portion Sizes> <Resident 83> Observations of meal service on 12/11/2024 starting at 11:57 AM, showed Staff CC prepared Resident 83's lunch tray. Staff CC used a green scoop when dishing up the brussel sprouts. When asked, Staff K (Dietary Manager) stated the green scoop was a 3 ounce (oz) serving size. After Resident 83's tray was served, Staff K changed the scoop size for the brussel sprouts to a 4 oz serving. Review of the spreadsheet showed Resident 83 should have received a 4 oz serving, rather than the 3 ounce scoop which was used. <Resident 3> Observations of meal service on 12/11/2024 starting at 11:57 AM, showed Staff CC prepared Resident 3's lunch tray without providing large portions of all the food as directed on the tray ticket. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 16> Observations of meal service on 12/11/2024 starting at 11:57 AM, showed Staff CC prepared Resident 16's lunch tray without providing large portions of all the food as directed on the tray ticket. During the meal service observations on 12/11/2024 starting at 11:57 AM, Staff K (Dietary Manager) stopped Staff CC (Dietary Cook) four times from serving trays without the large portions as directed. In an interview at this time, Staff K stated they were not usually standing at the tray line reading the resident meal tickets but indicated they were instructed to stay during meal service during survey observations. In an interview on 12/13/2024 at 8:46 AM, Staff C (Regional Administrator) stated it was their expectation staff follow the recipes and menus as directed by the dietician on the spreadsheet. Staff C stated the recipes were important to follow as they were designed for different diets and restrictions. Staff C stated they expected the cook to follow the diet orders and provide portion sizes as directed. Refer to 804- Nutritive Value/Appearance, Palatable/Preferred Temperature. Refer to 812- Food Procurement, Store/Prepare/Serve- Sanitary. REFERENCE: WAC 388-97-1180(1), -1200(1).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43642 Based on observation, interview and record review, the facility failed to prepare food in a manner that ensured meals were appetizing and palatable for 4 of 6 residents (Resident 43, 6, 74, 85) reviewed. This placed residents at risk for a decreased nutritional intake and dissatisfaction with meals. Findings included . Review of the facility's December 2024 food temperature log form showed directions to staff to place food on the tray line no more than 30 minutes prior to meal service. <Resident Interviews> <Resident 43> In an interview on 12/08/2024 at 10:18 AM, Resident 43 stated the quality of the food was not good at the facility. <Resident 6> In an interview on 12/08/2024 at 12:53 PM, Resident 6 stated they were unhappy with the food at the facility. <Resident 74> In an interview on 12/08/2024 at 1:30 PM, Resident 74 stated they were very unhappy with the food and stated it was too bland and often overcooked. <Resident 85> In an interview on 12/09/2024 at 9:15 AM, Resident 85 stated, this is the worst food, and stated they ordered food from outside the facility most of the time. Resident 85 stated the food was very bland, and the brussel sprouts were too plain and were served too often. <Meal Preparation> Review of the facility's menu showed for lunch on 12/11/2024 beef stroganoff over noodles, buttered brussel sprouts, peach cobbler, and a dinner roll would be served. Observations of meal preparations on 12/11/2024 starting at 9:01 AM showed staff putting a pot of water on the stove and began cooking brussel sprouts for the lunch service. Staff CC (Dietary Cook) finished cooking the noodles and put them on the steam table at 10:02 AM, an hour and a half prior to when the tray line service was scheduled to begin. <Meal Service> (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on tray service started on 12/11/2024 at 11:45 AM, an hour and 45 minutes after the noodles were placed on the steam table. Observations on 12/11/2024 at 12:08 PM, two hours after the noodles were placed on the steam table, showed brown crusted noodles stuck to the bottom of the bin, Staff CC scraped the bottom of the bin, scooped the noodles onto a resident's plate, added the beef, and then served them. <Test Tray> Observations of the test tray received from lunch service on 12/11/2024 at 1:04 PM, two hours after tray line started, showed beef with noodles, pale colored brussel sprouts, and a dessert. The brussel sprouts were mushy with no taste and some of the noodles had hard, dry, brown areas. In an interview on 12/13/2024 at 8:46 AM, Staff K (Dietary Manager) stated it was their expectation food would be on the steam table no more than 30 minutes before service starts. Staff K stated having the food on the steam table longer could affect the food quality and the nutritional value of the food. In an interview on 12/13/2024 at 10:30 AM, Staff V (Dietician) stated 30 minutes prior to meal service was the goal for moving foods on to the steam table. Staff V stated the food was at risk for losing nutrient quality the longer the heat was on the food. Refer to 803- Menus Meet Resident Needs/Prepared in Advance/Followed. Refer to 812- Food Procurement, Store/Prepare/Serve- Sanitary. REFERENCE: WAC 388-97-1100(1), (2).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43642 Based on observation, interview, and record review the facility failed to prepare and serve food under sanitary conditions in 1 of 1 kitchen. Failure to perform proper hand hygiene and glove use, properly clean kitchen equipment, adequately monitor food cooking temperatures, and ensure staff distributed and served food under sanitary conditions. These failures placed residents at risk of decreased nutritional intake, cross contamination leading to food-borne illness, and a diminished quality of life. Findings included . <Hand Hygiene> <Facility Policy> Record review of the facility's 5/21/2021 policy titled, Food Safety Requirements, showed staff would adhere to hygienic practices that prevent contamination of foods from hands or physical objects by proper hand washing and the appropriate use of gloves including changing them to reduce cross contamination. Observations on 12/11/2024 at 9:20 AM, showed Staff CC (Dietary Cook) preparing food. They removed their gloves, and, without performing hand hygiene, put on new gloves to continue preparing food. At 12/11/2024 at 9:26 AM, Staff CC was observed opening the garbage can with their gloved hand, picked up food that was dropped on the floor, removed gloves, put on new gloves without performing hand hygiene and resumed food preparation. Observations on 12/11/2024 at 10:03 AM, showed Staff CC went over to the sink to wash their hands. Staff CC turned on the water, rinsed their hands in the water, did not apply any soap, then got some paper towels to dry their hands. Staff CC then returned to the service area to continue preparing food. Observations on 12/11/2024 at 10:19 AM, showed Staff CC go over to the hand washing sink, turn the water on, touch the water with their hands, then immediately after, took some paper towels to dry their hands, and used the paper towels to turn off the water. Staff CC did not use soap when performing hand hygiene. Staff CC then returned to the service area to continue preparing food. Observations on 12/11/2024 at 11:44 AM, showed Staff CC preparing to start lunch meal service, Staff CC went to the sink to do hand hygiene, rinsed their hands in water, did not use soap, dried their hands with paper towels, and put on gloves. Staff CC began dishing up and serving meal trays. During meal service on 12/11/2024 at 12:02 PM, Staff CC removed their soiled gloves and put on a new set of gloves without performing hand hygiene. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 12/11/2024 at 1:09 PM, Staff K (Dietary Manager) stated it was their expectation staff perform hand hygiene when entering the kitchen, between tasks, if they touch any potentially contaminated surfaces, and between glove changes. Staff K stated staff should wash their hands for at least 20 seconds and to use soap and water. <Cross-contamination> <Facility Policy> Record review of the facility's 5/21/2021 policy titled, Food Safety Requirements, showed the facility would implement additional strategies to prevent cross-contamination of foods. Suggested strategies included washing hands before handling clean containers, touching only the outside surfaces and handles of tableware, and storing food items in a manner to prevent deterioration or contamination. Observations on 12/11/2024 at 9:01 AM showed a staff's personal phone placed inside a bin full of salt and pepper condiment packets in the area where food was cooked and prepared for tray line service. Observations on 12/11/2024 at 9:16 AM, Staff DD (Dietary Aide) filling cups with juice and putting on lids. During the process, Staff DD was placing their fingers inside the cup ledge when picking up the cups to carry to the juice machine. Observations on 12/11/2024 at 9:28 AM showed Staff CC putting raw chicken into a food bin with a gloved hand. Staff CC picked up a bottle of oil and drizzled it on the raw chicken while they used their gloved hands to spread the oil over the raw chicken. With the contaminated gloves, Staff CC picked up a bottle of seasoning and used on the chicken, mixed the chicken up with their gloved hands, and covered the container with tin foil. Staff CC opened the oven, using the same contaminated gloves, touched oven knobs, and put the chicken inside. Staff CC removed their gloves, washed hands less than 20 seconds and put on new gloves. On 12/11/2024 at 9:54 AM, Staff CC was observed to touch and move the contaminated bottle of seasoning, with their bare hands, so they could fill a pot of water from the sink. Staff CC then carried the pot of water to the stove using the handles with their contaminated hands. Staff CC removed their gloves, washed hands less than 20 seconds and put on new gloves. Observations on 12/11/2024 at 9:31 AM, showed Staff CC using gloved hands to place frozen hamburger patties on a tray. Staff CC wrapped the remaining hamburger up, touched the freezer door handle with their contaminated gloves, and placed the hamburger inside. Staff CC removed their gloves, and without performing hand hygiene, put on a new pair of gloves and began stirring some meat on the stove. Staff CC did not sanitize the freezer door handle after it was contaminated from touching the hamburger patties. Observations on 12/11/2024 at 12:14 PM, showed Staff CC touched the front of their face mask with their gloved hands, pick up a clean plate with their contaminated hand, and dish up food on the plate to serve. Staff CC continued to prepare plates of food for residents during meal service, while at times, touching the area of the plate where the food will be placed. On 12/11/2024 at 12:31 PM, Staff K gave directions to Staff CC to go wash their hands. Staff CC went to the sink to perform hand hygiene, rinsed hands in water without using soap, dried their hands, and returned to continue food preparation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on 12/11/2024 at 12:36 PM, showed the resident meal tray tickets sitting on a dirty cart used for holding the clean plates. Staff K was touching the tickets with their bare hands and handing them to Staff CC to prepare the food. Once the plate was prepared, Staff CC would put the plate up on a counter with the ticket under the plate. Staff DD would take the plate, the ticket would fall into a bin of rolls, touching the food. Staff DD would pick up the ticket and place it on a tray. Staff DD would use tongs, without gloves, and pick up a roll to place on the resident's tray. The tongs kept falling into the bin with the handles coming in contact with the rolls. Staff K gave directions to Staff DD to be careful with the tongs and make sure they do not fall into the bin with the rolls. The tongs continued to fall into the bin. Observations on 12/11/2024 at 12:44 PM showed Staff EE (Dietary Aide) take a paper menu, which a resident had written their food choices on, and placed it on a bin of clean and partially peeled cucumbers in the food preparation area. The paper was touching the food. In an interview on 12/11/2024 at 1:09 PM, Staff K stated staff's personal items should not be in the food preparation or service area in order to reduce the risk of cross-contamination. Staff K stated staff should not touch the rim of cups or the food area of plates with their bare hands or soiled gloves because there would be a risk of cross-contamination. Staff K stated this was important as the resident drinks out of the cup and eats the food from the plate. Staff K stated it was their expectation staff do not touch surface areas after handling raw meat and without performing proper hand hygiene, routinely sanitizing equipment area, and not touching food-ready surfaces with bare hands. <Food Temperatures> <Facility Policy> According to a 05/21/2021 facility, Food Safety Requirements policy, when preparing food, staff should take precautions in the food preparation process to prevent, reduce, or eliminate potential hazards. This policy showed when cooking foods, the foods should be prepared as directed until the recommended temperatures for the specific foods were reached. Review of the facility's beef stroganoff over noodles recipe, provided by staff on 12/11/2024, showed directions the beef's final internal cooking temperature should be 165 degrees Fahrenheit prior to turning off the heat, adding the remainder of the ingredients, and holding until ready to serve. Observations on 12/11/2024 at 10:02 AM, showed Staff CC removing noodles, beef, and vegetables from the ovens, and placed them on the steam table. Staff CC did not check the final food temperatures when they finished cooking the food. In an interview on 12/11/2024 at 10:11 AM, Staff CC stated they only check the temperatures of food prior to tray line service. In an interview on 12/11/2024 at 10:11 AM, Staff K stated it was their expectation staff check the temperatures of meats when they are pulled out of the oven, to assure the food got to the appropriate temperatures. Staff K stated they expected staff to check the temperatures of all foods again, just prior to starting tray line service. Staff K stated Staff CC should have checked the temperature of the meats when they moved them from the oven to the steam table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a December 2024 facility food temperature log on 12/11/2024 at 10:18 AM, showed no food temperatures were logged for the lunch food items once cooking was completed. During tray line service on 12/11/2024 at 11:17 AM, Staff CC and Staff K were checking food temperatures of all food prior to meal service. Staff K instructed Staff CC to put many of the food products, including some meats, back in the oven and/or on the stove to get the temperatures higher. <Soiled Surface Areas> <Facility Policy> Record review of the facility's 5/21/2021 policy titled, Food Safety Requirements, showed the facility would follow food service safety throughout the entire food handling process from procurement to service of food. All equipment would be cleaned and sanitized to prevent contamination. Observations on 12/11/2024 at 10:13 AM, showed the dish cart holding the clean plates for tray service had dried food and debris on the top next to the clean plates and many dried drips were going down the sides of the cart. In an interview on 12/11/2024 at 10:13 AM, Staff K observed the soiled dish cart and confirmed it needed to be cleaned and stated, I need to add that to the cleaning rotation. At 12:08 PM on 12/11/2024 staff were using clean plates from the soiled cart during the lunch meal service. In an interview on 12/11/2024 at 1:09 PM, Staff K stated sanitary conditions were important to prevent residents from getting sick and to decrease the risk for potential exposure to food-borne illnesses. Refer to 803- Menus Meet Resident Needs/Prepared in Advance/Followed. Refer to 804- Nutritive Value/Appearance, Palatable/Preferred Temperature. REFERENCE: WAC 97-388-1100(3), -2980.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 51791 Based on observation, interview, and record review the facility failed to keep all Protected Health Information (PHI) in the residents' records confidential and out of view from unauthorized individuals for 4 of 84 residents (Resident 340, 80, 10, & 39). This failure placed all former and current residents at risk for a violation of their right to privacy. Findings included . <Facility Policy> Record review of the facility's 9/1/2021 policy titled Health Information Portability and Accountability Act-HIPAA Security Measures policy showed that the facility would implement appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and/or records that were in electronic format. Record review of the facility's 2/2021 policy titled Dignity policy showed that the staff would protect confidential clinical information. Record review of the facility's 3/17/2024 Admission Agreement showed the resident has the right to personal privacy and confidentiality of their personal and clinical records. <Resident 340> An observation on 12/10/2024 at 1:14 PM, showed the electronic wall device on the first floor hallway displayed Resident 340's full name and care information. The device was unattended with no staff nearby. A visitor was observed passing by the visible PHI on two separate occasions. In an interview on 12/10/2024 at 1:50 PM, Staff Q, (Certified Nurse Assistant), stated they left the device open with PHI visible, because they were in a rush and forgot to log out. Staff Q stated PHI should not be left unattended or visible to unauthorized individuals. Staff Q stated Resident 340's right to privacy was violated. In an interview on 12/13/2024 at 11:26 AM, Staff R, (Medical Records Director), stated that no laptops or electronic screens used to display PHI should be left unattended nor visible to unauthorized individuals. Staff R stated the purpose is to protect residents' privacy. 47836 <Resident 80> Observation on 12/12/2024 at 8:09 AM Staff S (Registered Nurse) walked away from medication cart with computer open to Resident 80's medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/2024 at 8:10 AM Staff I (Licensed Practical Nurse) stated all resident information must be kept confidential, and they should have locked their computer before they walked away from it. Staff I stated it was important to keep resident information confidential for resident's privacy. <Resident 10> Observation on 12/10/2024 at 8:45 AM Staff I walked away from cart with computer open to Resident 10's medical records. In an interview on 12/10/2024 at 8:48 AM Staff I stated they didn't normally leave resident records unsecured. Staff I stated confidentiality of resident records was important for resident rights and privacy. <Resident 39> Observation on 12/12/2024 at 7:11 PM Resident 39's representative showed text message communications regarding Resident 39's care with a facility social worker. Review of Resident 39's records did not show documentation of the communication with Resident 39's representative and the social worker. In an interview on 12/13/2024 at 8:24 Staff E (Social Service Director) stated the social worker Resident 39's RR communicated with was no longer an employee at the facility and quit about one and a half weeks before the date of this interview. Staff E stated the previous social worker cleared their data from their laptop prior to turning it into the facility. Staff E stated there was no documentation in Resident 39's records showing the communication with the RR, but the previous social worker should have saved this in Resident 39's records. In an interview on 12/13/2024 at 9:12 AM Staff B (Director of Nursing) stated they expected staff to keep resident records confidential. Staff B stated they expected staff to lock computers before they walked away from them for resident's rights to privacy. Staff B stated they expected resident records to be accurately documented and readily accessible as required. REFERENCE: WAC 388-97-1720(1)(c),-0360(1).

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 45941 Based on interview and record review, the facility failed to ensure the arbitration agreement was explained in a form and manner that the resident and/or their representative understood for 3 of 3 residents (Resident 49, 23, and 43) reviewed for arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) agreement. This failure placed residents at risk for lacking understanding of the legal document signed, forfeiture (loss or giving up of something) of the right to a jury or court, and a diminished quality of life. Findings included . <Facility Policy> The facility's 08/08/2022 Binding Arbitration Agreements policy showed the facility would explain to residents and their representatives the arbitration agreement upon admission to the facility in a form and manner that the resident understood, including in a language they understood. The policy showed the admissions coordinator was responsible for any questions the resident may have about the contract. <Resident 49> According to the 11/27/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 49 was alert and oriented, and their memory was intact. The assessment showed Resident 49 had adequate vision and hearing and had clear speech during communication. Review of a 06/05/2024 electronically signed arbitration agreement showed Resident 49's name was captured in the signature line and indicated the resident was bound by the terms and condition of the agreement. In an interview on 12/11/2024 at 6:40 AM, Resident 49 stated they did not know about the arbitration agreement, and no one explained to them about this agreement. Resident 49 stated they did not know about 30 days revoking period for the arbitration agreement because they did not know that they entered into one. <Resident 23> According to the 11/14/2024 Quarterly MDS, Resident 23 was alert and oriented, and their memory was intact. The assessment showed Resident 23 had adequate vision and hearing. Review of Resident 23's arbitration agreement showed the contract was electronically signed by the resident on 07/08/2023. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2024 at 12:08 PM, Resident 23 stated they did not remember signing an arbitration agreement or know what an arbitration agreement was about. Resident 23 was presented with a copy of their signed arbitration agreement and Resident 23 stated they did not remember any staff talking to them about this agreement. <Resident 43> According to the 10/03/2024 Quarterly MDS, Resident 43 was alert and was able to make their own decisions. The assessment showed Resident 43 had adequate hearing, impaired vision, and had clear speech during communication. Review of a 08/27/2024 electronically signed arbitration agreement showed Resident 43's name was captured in the signature line and indicated the resident was bound by the terms and condition of the agreement. In an interview on 12/11/2024 at 10:24 AM, Resident 43 stated they signed a lot of papers during their readmission from the hospital. Resident 43 stated they did not know what the arbitration agreement was for. Resident 43 asked if any staff could explain what an arbitration agreement was. In an interview on 12/12/2024 at 11:22 AM, Staff B (Director of Nursing) stated admission coordinator was responsible for the facility's arbitration agreement process, and they assisted residents to sign the admission papers including the arbitration agreement upon admission. In an interview on 12/12/2024 at 2:22 PM, Staff O (Vice President for Business office) stated the admission coordinator who assisted residents to sign arbitration agreement was not an employee in the facility anymore. Staff O stated staff should have explained the details about an arbitration agreement to residents/their representatives before they signed an arbitration agreement. Staff O stated they were unsure where the disconnect was with the resident's arbitration agreement and they needed to do a better job explaining the contract in a form and manner that the resident's best understood. REFERENCE WAC: 388-97-1620(2)(a)(b)(i), -0180(1-4).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment to help prevent the transmission of communicable diseases. The facility failed to implement and/or follow isolation precautions for 4 of 7 residents (Resident 18, 71, 1, and 43) reviewed for Enhanced Barrier Precautions (EBP) , failed to follow Transmission Based Precaution for 1 of 1 residents (Resident 339) reviewed for TBP, failed to consistently perform Hand Hygiene (HH) for 1 of 1 residents (Resident 80), failed to clean the shower room, and failed to sanitize the ice machine. These failures placed the residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . <Facility Policy> According to the facility's 03/2023 Infection Control Policies and practices policy, the facility would maintain a safe, sanitary, and comfortable environment to help prevent and manage the transmission of diseases and infections. The facility would establish guidelines for implementing isolation precautions, including Standard and Transmission based Precautions; and would provide guidelines for hand hygiene, safe cleaning and processing of reusable resident care equipment. <Enhanced Barrier Precautions> <Resident 18> Observations on 12/08/2024 at 8:52 AM and 10:09 AM showed Resident 18 was lying in bed. The resident had an indwelling catheter (a tube inserted in bladder to drain urine) hanging on the bed frame. Observations showed no isolation sign outside or inside Resident 18's room to demonstrate EBP were required. In an interview on 12/08/2024 at 10:42 AM, Resident 18 stated they came back from the hospital with a catheter in their bladder. Review of Resident 18's clinical record showed a 12/06/2024 physician order that instructed staff to implement EBP related to Resident 18's indwelling catheter placement. In an interview on 12/08/2024 at 1:18 PM, Staff D (Infection Control Preventionist) stated it was their expectation residents with an indwelling catheter were placed on EBP. Staff D stated Resident 18 came back from the hospital with an indwelling catheter on 12/06/2024. Staff D stated the facility should have placed Resident 18 on EBP, but they did not. 43642 <Shower Room> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 12/08/2024 at 9:36 AM showed a shower room on West-1 unit with a shower drain cover full of debris and dried hair. The floor was dry. A log documenting shower room cleaning was found in the room. Staff documented in this log the last date of cleaning was listed as 08/28/2023. Observations on 12/10/2024 at 8:27 AM showed staff assisting a resident in the West-1 unit shower room. On 12/10/2024 at 8:48 AM, staff brought the resident out of the shower room, at which time observations showed the shower drain still contained the same debris and hair previously noted from 12/08/2024, two days earlier. Observations on 12/10/2024 at 8:55 AM showed Staff J (Registered Nurse Manager) enter the West-1 unit shower room and upon exit the drain was clean. In an interview on 12/10/2024 at 9:00 AM, Staff J stated it was their expectation staff sanitize the shower drain and surrounding area after each resident use. Staff J stated they cleaned out the shower and indicated it had a lot of build up from previous uses. Staff J stated they needed to do some training with staff and come up with a plan of who and when the shower would be cleaned. <Cross-Contamination> <Resident 80> Observations on 12/09/2024 at 10:30 AM showed Staff J wearing gloves and using a bottle of wound cleanser while performing wound care for Resident 80, Staff J put the bottle on the resident's bed, used it during resident care, and then placed it on the resident's overbed table. Staff J, while using the same soiled gloves, touched the resident's bed remote control to adjust the bed position. Staff J then removed their gloves, did not perform hand hygiene, and touched the call light to place it within Resident 80's reach. Staff J picked up the contaminated wound cleanser bottle, placed it on an isolation cart while they removed their gown, gloves, performed hand hygiene, picked up bottle again and placed the contaminated bottle inside the cart without sanitizing it. In an interview on 12/12/2024 at 2:58 PM, Staff D stated staff should utilize barriers to prevent supplies from having direct contact with a resident or their environment. Staff D stated if supplies were contaminated, staff should sanitize them before returning them to the treatment cart. Staff D stated it was important to sanitize contaminated items to break the chain of infection. <Transmission Based Precautions> <Resident 339> Observations on 12/09/2024 at 2:38 PM showed Resident 339 had a contact precautions sign posted on the wall near the resident's room. This sign stated providers and staff must: put on a gown and gloves before room entry and discard before room exit. This sign was located to the right of some Christmas decorations. Inside Resident 339's room was a provider without a gown or gloves and sitting in the resident's chair, next to the resident, who was in bed. In an interview on 12/09/2024 at 2:39 PM, Staff J stated the provider, forgot to gown up. Staff J stated they expected the provider to put on a gown and gloves prior to entering Resident 339's room. Staff J moved the posted sign closer to the entrance to the room to increase visibility. (continued on next page)

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	505202	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 12/09/2024 at 2:45 PM showed the provider exit Resident 339's room, perform hand hygiene, enter another resident's room and sit in a chair at that resident's bedside. On 12/09/2024 at 3:05 PM the provider continued to enter other resident rooms, after they had been in Resident 339's room without the required Personal Protective Equipment (PPE). In an interview on 12/12/2024 at 2:58 PM, Staff J stated for a resident on contact precautions, staff should put on a gown and gloves at the door, prior to entering the resident's room. Staff J stated it was their expectation if an isolation sign was posted at a resident's door, everyone should follow the required PPE identified in order to prevent the risk of spreading of infection. 50511 <Ice Machine> Observation on 12/11/2024 at 12:40 PM showed the first floor ice machine had a plastic cover over the ice inside of the ice machine. The white plastic cover had brown debris and a slimy pink debris along the edges and the bottom of the plastic cover. Observation of the cleaning log posted on the outside of the ice machine showed the last cleaning was completed on 12/06/2024 and the prior cleaning was completed on 11/10/2024. In an observation and interview on 12/11/2024 at 12:47 PM, Staff D checked the ice machine and wiped off slimy pink film and brown from the plastic cover within the ice machine. Staff D stated the ice machine should be cleaned weekly if not more, but it did not look like this was done recently. Staff D stated this should be reported by staff frequently using the ice machine, but was not. Staff D stated they did not routinely check the inside of the ice machine. Staff D stated it was important for the ice machine to be cleaned regularly otherwise infections could occur. In an interview on 12/13/2024 at 8:52 AM Staff L (Maintenance Assistant) stated they cleaned the outside of the ice machine weekly and cleaned the inside of the ice machine monthly but did not keep a log of cleaning of the inside of the ice machine. <Enhanced Barrier Precautions> <Resident 71> According to a 10/31/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 71 was admitted to the facility on [DATE] with a gall bladder obstruction. Review of a 10/15/2024 revised EBP Care Plan (CP) showed, Resident 71 had an indwelling gall bladder tube (inserted through the body) that was attached to a drainage bag located on the outside of Resident 71's right abdominal area. The goal listed on Resident 71's CP showed EBP would reduce the risk of transmission of multidrug resistant organisms (MDRO). Interventions showed for EBP, staff would use gowns and gloves during high contact resident care. High contact care activities listed on CP showed when assisting Resident 71 with dressing, bathing, transfers, linen changes, incontinent care and wound and/or indwelling device care. Posting of EBP signage and a supply bin of PPE would be placed outside of the resident's room so staff had access to PPE supplies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/09/2024 at 1:22 PM, Staff W (Certified Nursing Assistant) was observed to change the incontinent pad of Resident 71. Staff W had on gloves and a mask but did not have on a protective gown. There was no signage on the door to indicate Resident 71 was on EBP. Observation on 12/10/2024 at 8:43 AM, Resident 71 had a gall bladder drainage bag on the right side of their body. The drainage bag was leaking brown and yellow drainage on Resident 71's bed sheets. An EBP sign was not posted in Resident 71's room or on/near the door and there were no PPE supplies available. Review of the facility's list of residents on EBP precautions was supplied by Staff D on 12/11/2024 at 12:47 PM. The list did not show Resident 71 was on the EBP list. <Resident 1> Observation on 12/09/2024 at 8:32 AM, Resident 1 had a dressing on their right lower leg related to chronic open wound with drainage. Resident 1's room was observed to have EBP signage on the room door as well as EBP PPE supplies in a cart within Resident 1's room. Observation on 12/10/2024 at 12:13 PM Staff X (Licensed Practical Nurse - LPN) went into Resident 1's room to observe the wound to right lower leg. Staff X lifted up the blanket covering Resident 1's leg and wound dressing on the right side of Resident 1's lower leg. Staff X observed Resident 1's wound was wet and fluid drained onto their bed sheets. Staff X stated they would come back to change the dressing on Resident 1. Staff X did not put on a PPE gown before assessing Resident 1's wound as noted for EBP protocols. <Resident 43> Observation on 12/09/2024 at 8:38 AM showed Resident 43 had EBP signage posted on the wall near the resident's room. Resident 43 had a indwelling urinary catheter. The signage posted for EBP within the room read staff must put on a gown and gloves before room entry and discard the PPEs before exiting the room. Staff Z (MDS LPN) was observed to come into Resident 43's room to respond to the call light. Staff Z assisted Resident 43 with fixing their hospital gown and helped to slide and reposition Resident 43 in bed. Staff Z did not put on a protective gown on when they entered Resident 43's room. In an interview on 12/11/2024 at 9:16 AM, Staff D stated for residents on EBP, there should be a sign on the door, so staff knew when to wear PPE. Staff D stated for any device that goes into the body and for any open skin treatment, EBP should be in place. Staff D stated all staff were trained on EBP precautions and how to use PPE supplies. Staff D stated they were not aware that Resident 71 had an indwelling device and needed to be on EBP precautions. In an interview on 12/11/2024 at 9:34 AM Staff B (Director of Nursing) stated EBP had to be in place whenever staff were in close contact with resident's who had high contact activities. Staff B stated all staff needed to follow instruction on the EBP signage. Staff B stated Resident 71 should have had EBP precautions due to the gall bladder indwelling device. REFERENCE: WAC 388-97-1320 (1)(a), -1320 (1)(c), -1320 (3).

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation and interview, the facility failed to ensure an effective pest control program was in place to prevent insects from entering and or gathering in resident rooms for 3 (Resident 49, 43, & 22 rooms) of 18 sample resident rooms and common areas (West Central Sink, Second Floor Hallway, [NAME] Central Office, & Kitchen/Dining Room) of the facility. This failure placed residents at risk of infection and contributed to a less than homelike environment. Findings included . <Policy> According to a facility policy titled, Pest Control Program, revised 09/01/2022, the facility would maintain an effective pest control program that eradicated common household pests and rodents. The policy showed the facility would maintain a report system of issues that arise in between scheduled visits with the contracted pest service and would treat as indicated. <Resident 49> In an observation and interview on 12/11/2024 at 6:57 AM Resident 49 stated there's bugs all over in their room (room [ROOM NUMBER]), they did not know where they were coming from. Resident 49 stated they had a hard time sleeping at night because the bugs would fly in their face, waking them up. Resident 49 stated they had reported the bugs to the staff on multiple occasions, but they had not heard back from the staff on how they were going to get rid of them. In an interview on 12/13/2024 at 9:51 AM Staff N (Regional Plant Operation Manager) stated they were aware of the bugs in the halls and resident rooms. Staff N stated the monthly pest control services were not working in treatment of the bugs. Staff N stated the bugs could possibly be due to the open windows with missing screens in the resident's rooms. Staff N stated it was important the bugs be effectively treated for a homelike environment for the residents at the facility. 50511 <West Central Hallway Sink> In an observation and interview on 12/09/2024 at 9:28 AM, Staff P (Housekeeping aide) stated there used to be a lot of ants around the sink and Staff P had to use bleach because of the ants around the sink. Observation of a facility sign posted above the west central hallway sink, showed only pour water down the drain, fruit flies attracted by food. <Second Floor Hallway> Observation on 12/10/2024 at 12:42 PM showed fruit flies on the second floor in the hallways. <Resident 43> (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/10/2024 at 12:53 PM showed fruit flies in Resident 43's room. <Resident 22> Observation on 12/11/2024 at 10:38 AM showed fruit flies at the door of Resident 22's room. <West Central Office> Observation on 12/13/2024 at 9:54 AM showed fruit flies in Staff B's (Director of Nursing) office. 43642 <Kitchen/Dining Room> Observations of the kitchen dry food storage area on 12/08/2024 at 8:32 AM showed a fruit fly trap and a tray with clear liquid in a bowl sitting on one of the shelves. The bowl contained 10 fruit flies floating in the liquid and a few fruit flies flying near the trap. Observations on 12/11/2024 at 10:00 AM showed the door from the kitchen to the dining room was open, and flies were seen in the dining room. During food service observations on 12/11/2024 at 11:22 AM flies were noted in the air flying above the food in the tray line assembly area. There was food in pots of water on the stove and several flies flying over the pots. In an interview on 12/13/2024 at 8:46 AM, Staff K (Dietary Manager) stated the fruit flies were a problem for some time and they were seeking assistance from pest control. Refer to F584 - Safe/Clean/Comfortable/Homelike Environment. REFERENCE: WAC 388-97-3360(1)(2).