STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505204	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen Anne Healthcare	2717 Dexter Avenue North Seattle, WA 98109

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to ensure residents were evaluated, assessed, and obtained a physician order for safe administration of medications for 2 of 2 residents (Residents 30 & 48), reviewed for self-medication administration. The failure to complete a self-administration of medication assessment and obtain a physician's order placed the residents at risk for medication errors, adverse medication interactions, and complications. Findings included . Review of the facility's policy titled, Self-Administration of Medications, revised in February 2001, showed, Residents have the right to self-administer medications. It showed, As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The policy further showed, Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. RESIDENT 30 Review of the admission Minimum Data Set (MDS-an assessment tool) dated 12/13/2024 showed Resident 30 admitted to the facility on [DATE] and that they were cognitively intact. In an interview and observation on 01/29/2025 at 2:16 PM, Resident 30 stated that they take Vitamin D (supplement) because they did not get any sun. Resident 30 then took a bottle of Vitamin A & D [supplement] from their bedside table. Another observation and interview on 01/30/2025 at 2:47 PM, showed Resident 30 had one opened bottle of Turmeric (supplement) and one opened bottle of Vitamin A & D on their bedside table. Resident 30 stated that they administer it themselves. When asked if staff were aware of the medications they were taking, Resident 30 stated, I would imagine, I leave them out. In a follow up interview at 4:10 PM, Resident 30 stated that they had been taking it for three days and took the recommended dose on the bottle. Review of Resident 30's January 2025 Medication Administration Record (MAR) did not show an order for Vitamin A & D and Turmeric. Further review showed that Resident 30 had an order for Cholecalciferol (Vitamin D3-supplement) once a day for bone health with a start date of 01/26/2025. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 30's assessment tab in their Electronic Health Record (EHR) printed on 01/30/2025 did not show that a self-medication program was completed. RESIDENT 48 Review of the quarterly MDS dated [DATE] showed Resident 48 readmitted to the facility on [DATE]. Observation and interview on 01/29/2025 at 12:04 PM, showed Resident 48 took an opened tube of Terbinafine (an antifungal cream) from their bedside table and stated that their podiatrist (foot doctor) gave it to them for their foot. Resident 48 further stated that an unidentified nurse told them that they had to keep it [medication] over the counter [medication cart] and that they told the nurse no. Observation and interview on 01/30/2025 at 9:51 AM, showed one opened tube of Terbinafine on Resident 48's bedside table. Resident 48 stated that the nurse applied it on them two times a day, that sometimes they used it more than twice and sometimes not at all. Resident 48 further stated they had been using it before they came to the facility. Review of Resident 48's January 2025 MAR showed an order for Terbinafine Cream. Apply to feet topically two times a day for debrided nails with a start date of 01/18/2025. Review of Resident 48's assessment tab in the EHR printed on 01/30/2025 did not show that a self-medication program was completed. In an interview and joint observation on 01/30/2025 at 3:11 PM, Staff F, Licensed Practical Nurse, stated that they did not allow residents to keep their medications at the beside unless there was an order from the provider. Staff F stated that if it was an over the counter medication and the resident wanted to keep it with them, they would have to check with the provider and store the medication in the medication cart. When asked if residents were allowed to self-administer medications and keep it at the bedside, Staff F stated, No, unless there's an order. Joint observation showed that Resident 48 had one tube of Terbinafine on their bedside table. When asked if Resident 48 should have it at the bedside, Staff F stated, No and that they had to apply it for them. Joint record review of Resident 48's physician orders showed an order for Terbinafine. Staff F stated that it should not have been on their bedside table. Another joint observation showed Resident 30 had one bottle of Turmeric and one bottle of Vitamin A & D on their bedside table. Staff F stated that it should not have been on their bedside table and that Resident 30 should have had an order for the medications. Joint record review of Resident 30's physician orders showed that they did not have an order for Turmeric and Vitamin A & D. Staff F stated that they did not see an order for the medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/30/2025 at 3:47 PM, Staff E, Registered Nurse, stated that residents should not have had medications at bedside unless they had an order and that a self-medication program had to be completed. Staff E stated that Resident 48 did not have a self-medication program completed and that they should have had one. Staff E stated that Resident 30 did not have a self-medication program completed and that to their knowledge they did not know that Resident 30 was keeping the medications at bedside because they did not have an order for them. Staff E further stated that they always encourage residents/family to let the staff know before bringing medications/supplements in the facility. In a follow up interview at 4:04 PM, Staff E stated that if they were aware of the medications at resident's bedside and if resident request to self-administer the medications and want to keep it at the bedside, they would notify the provider and complete a self-medication program. Staff E further stated that their process was to lock up the medications until the provider gave an order, complete a self-medication program, assess the resident for safe medication administration, and safely store the medication at bedside. In an interview on 01/31/2025 at 1:38 PM, Staff B, Director of Nursing, stated that if a resident wanted to self-administer and keep their medications at bedside, they expected the resident to have a self-medication program and a physician's order that they can keep it at the bedside. Staff B stated that they would expect staff to ensure the resident's environment was safe by looking for medications at the bedside, or anything that they would need to secure. Staff B further stated that if Resident 30 and Resident 48 were observed with medications at the bedside, they would have expected staff to pick up the medications and complete a self-medication program if it was their wish to do it. Reference: (WAC) 388-97-1060(3)(l), 0440

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to accurately assess 2 of 25 residents (Residents 89 & 190), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding discharge status and insulin (medication/hormone that regulates blood sugar levels) injections placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The MDS manual further showed to mark/code medications given to the resident by any route. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 89 Review of Resident 89's face sheet showed they admitted to the facility on [DATE] and discharged from the facility on 12/24/2024. Review of Resident 89's progress note dated 12/24/2024 showed they discharged to the community. Review of the discharge MDS dated [DATE] showed Resident 89 was coded for discharge status to acute hospital. In an interview and joint record review on 01/31/2025 at 11:42 AM with Staff M, MDS Coordinator, they stated that they followed the RAI manual for completion of MDSs. Joint record review of Resident 89's discharge MDS, showed that it was coded/marked for discharge to acute hospital. Staff M stated Resident 89's MDS showed they discharged to the hospital. Another joint record review and interview with Staff M, showed Resident 89's progress notes indicated that they discharged against medical advice to the community. Staff M stated Resident 89's discharge MDS was inaccurate and that it should have been coded as discharged to the community. RESIDENT 190 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2025 Medication Administration Record showed Resident 190 was administered insulin on 01/17/2025, 01/18/2025, 01/20/2025, 01/21/2025, and 01/22/2025, for a total of five-days during the look back period. Review of the admission MDS dated [DATE] showed Resident 190 was marked that they received 6 injections and 6 insulin injections in Section N (Medications). Joint record review and interview on 01/31/2025 at 11:26 AM with Staff M, showed Resident 190's MDS was coded for 6 injections and 6 insulin injections, indicating that Resident 190 received insulin injections for six days. Staff M stated that Resident 190 received 6 insulin injections from 01/17/2025 through 01/22/2025. Another joint record review and interview with Staff M showed Resident 190's progress notes indicated that insulin was held and not given on 01/19/2025. Staff M stated that Resident 190's MDS was coded incorrectly and that they would modify it to show 5 injections and 5 insulin injections in Section N. On 02/03/2025 at 12:25 PM, Staff B, Director of Nursing, stated they expected MDSs were completed accurately. Staff B stated that Resident 89's discharge MDS was coded incorrectly. Staff B further stated they expected Resident 190's admission MDS to be coded accurately. Reference: (WAC) 388-97-1000 (1)(b)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to notify the State Pre-Admission Screening and Resident Review (PASARR or PASRR-an assessment used to identify people [residents] referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities, or related conditions are not inappropriately placed in nursing facilities for long term care) Coordinator after a significant change in status occurred for 1 of 7 residents (Resident 7), reviewed for PASARR. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, PASRR Policy, revised on 03/22/2024, showed, The PASRR determines that individuals are admitted appropriately to the nursing facility. It identifies people who have an intellectual disability or related concern, or a serious mental health illness, ensuring they receive the services needed. Resident 7 admitted to the facility on [DATE] with diagnoses that included depression (a mental health condition that involves intense feeling of sadness), paranoid personality disorder (a mental health condition characterized by a long-term pattern of extreme distrust and suspicion of others), and unspecified psychosis (a disorder where the individual experiences symptoms such as delusions, hallucinations, disorganized thinking and speech and emotional withdrawal). Review of the Level I PASARR updated on 09/10/2024, showed Resident 7 had SMI and required a Level II PASARR evaluation (a comprehensive evaluation for a positive Level I screening) referral. Review of the Certification of Terminal Illness dated 10/30/2024, showed Resident 7 had a terminal illness with a life expectancy of six months or less. It further showed that Resident 7 enrolled in hospice services on 10/29/2024. A review of Resident 7's Electronic Health Record (EHR) showed Resident 7 had a significant change in status Minimum Data Set (an assessment tool) dated on 11/04/2024. In an interview on 01/31/2025 at 12:55 PM, Staff Q, Social Services Director, stated that their process was to complete a new Level I PASARR and refer for Level II PASARR evaluation if a resident had a significant change in status. Staff Q stated that enrolling in hospice was considered a significant change in status. Staff Q stated that Resident 7 admitted to hospice on 10/29/2024 and there should have been a new Level I PASARR done for her change in condition. Staff Q further stated that they did not notify the PASARR coordinator about Resident 7's significant change in status. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 02/03/2025 at 12:14 PM, Staff A, Administrator, stated that their expectation for a resident who had a significant change in status, was that they would do a new one [Level I PASARR] or update the PASARR coordinator. Staff A stated that when a resident enrolled in hospice services it was considered a significant change in status, and they expected a new referral for Level II evaluation to be sent. Joint record review of Resident 7's EHR showed Resident 7 had a Level I PASARR updated on 09/10/2024, and that Resident 7 required a Level II PASARR evaluation referral. Further review of the EHR showed no documentation that a new Level I PASARR was sent for Level II PASARR evaluation after Resident 7 enrolled in hospice services. Staff A stated, I would say she would need to have a new one [Level I PASARR] after hospice enrollment. Reference: (WAC) 388-97-1975 (7)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to ensure physician's orders for oxygen were in place and/or followed according to professional standards of practice for 2 of 3 residents (Residents 85 & 12), reviewed for respiratory care. This failure placed the residents at risk for unmet care needs, and related respiratory complications. Findings included . Review of the facility's policy titled, Oxygen Administration, revised in October 2010, showed The purpose of this procedure is to provide guidelines for safe oxygen administration . Oxygen therapy is administered by way of an oxygen mask, nasal cannula [flexible tubing that sits inside the nostrils and delivers oxygen], and/or nasal catheter [flexible rubber or plastic tube with several holes near the tip inserted in the nostril] . Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. RESIDENT 85 Resident 85 admitted to the facility on [DATE] with diagnoses that included sarcoidosis of the lungs (a condition that causes inflammation and lumps in the lungs that can cause shortness of breath, cough, and fatigue) and chronic respiratory failure with hypoxia (insufficient oxygen in the blood). Observation on 01/27/2025 at 2:47 PM, showed Resident 85 was receiving oxygen from an oxygen concentrator via a nasal cannula at a rate of two and a half liters (unit of measurement) per minute. Resident 85 stated that they have used oxygen for a long time due to their sarcoidosis and that they use their oxygen continuously from an oxygen concentrator when in their room and from an oxygen tank when out of their room. Review of the physician's orders printed on 01/27/2025 did not show Resident 85 had orders for oxygen. Review of the hospital discharge summary dated 01/09/2025 showed Resident 85 received oxygen at two to three liters per minute via nasal cannula. Further review of the discharge summary showed continues on 3L NC [three liters per minute via nasal cannula]. Review of the physician's progress note dated 01/10/2025 showed, Plan: continuous oxygen at 2 L [two liters per minute] at rest and 4 L [four liters per minute] with activities per pulmonary [lung doctor] recommendations. On 01/29/2025 at 1:55 PM, Staff L, Certified Nursing Assistant, stated that Resident 85 used their oxygen all the time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 01/29/2025 at 2:12 PM with Staff N, Registered Nurse (RN), stated that Resident 85 was on continuous oxygen at a rate of two liters per minute. Joint record review of the physician's orders showed Resident 85 did not have orders for continuous oxygen. Staff N stated that there was an order to check oxygen saturation (percentage amount of oxygen in the blood - specifically in the red blood cells) as needed and that there should have been an order for how much oxygen Resident 85 was getting per minute. In an interview and joint record review on 01/29/2025 at 2:21 PM with Staff E, Resident Care Manager (RCM), stated they expected residents admitting with oxygen had an oxygen order in place. Staff E stated that oxygen orders would have information if the oxygen was as needed or continuously, and the amount of oxygen liters per minute. Joint record review of the physician's order dated 01/29/2025, showed Resident 85 had an order to increase the oxygen up to four liters per minute as needed. Staff E stated that Resident 85's order to increase oxygen was started on 01/29/2025. Joint record review of the hospital discharge summary indicated that Resident 85 was on two to three liters per minute of oxygen via nasal cannula. Staff E stated that Resident 85 should have had orders for oxygen since their admission [01/09/2025]. On 02/03/2025 at 12:34 PM, Staff B, Director of Nursing, stated they expected oxygen administration orders were in place for residents who admitted with supplemental oxygen. Staff B further stated that Resident 85 should have had an order for oxygen upon admission. 46912 RESIDENT 12 Resident 12 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breathe) and chronic respiratory failure. Review of Resident 12's January 2025 Medication Administration Record (MAR), showed an order for O2 [oxygen] @ [at] 2L/min [minute] via NC [nasal cannula] PRN [as needed] for SOB [shortness of breath]/cyanosis [when the skin, lips or nails turn blue due to a lack of oxygen in the blood], as needed for decreasing O2 sat [oxygen saturation] < [less than] 90% [percent], started on 12/02/2024. Observations on 01/27/2025 at 10:35 AM, on 01/28/2025 at 9:19 AM, on 01/29/2025 at 8:32 AM, and on 01/29/2025 at 12:05 PM, showed Resident 12 receiving oxygen from an oxygen concentrator via a nasal cannula at two and a half liters. In an interview on 01/28/2025 at 10:15 AM, Resident 12 stated they had been using oxygen continuously probably for a year at a low dose. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint observation on 01/29/2025 at 1:28 PM, Staff P, RN, stated that they would expect an order if a resident was using oxygen continuously. Staff P stated that Resident 12 was receiving continuous oxygen. Joint observation showed Resident 12 was receiving oxygen from an oxygen concentrator via a nasal cannula at two and a half liters. Staff P stated they were responsible for checking the oxygen whenever I go in [resident rooms]. Joint record review of Resident 12's January 2025 MAR showed an order for O2 @ 2 L/min via NC PRN for SOB/cyanosis, as needed for decreasing O2 sat < 90%. Staff P stated the order should be for continuous oxygen at two liters per minute and I'm going to adjust it [Resident 12's oxygen concentrator settings] to two liters. In an interview and joint record review on 01/29/2025 at 2:40 PM, Staff G, RCM, stated they would expect an order if a resident was receiving continuous oxygen therapy. Staff G stated, she's [Resident 12] on PRN oxygen and we are monitoring her oxygen sats [saturation] and if it goes below 90 percent. Joint record review of the vitals tab in Resident 12's electronic health record showed no documentation that Resident 12's oxygen saturation went below 90 percent. Staff G stated the documentation did not show that Resident 12's oxygen saturations dropped below 90 percent. Joint record review of Resident 12's January 2025 MAR showed no documentation that Resident 12 was using oxygen, Staff G stated, it should be documented. Staff G stated that Resident 12 should be on two liters of oxygen and not two and a half liters. Staff G further stated, I checked with the provider, and we are changing it [Resident 12's oxygen order] to continuous. In an interview on 02/03/2025 at 11:56 AM, Staff B stated that if a resident had been on PRN oxygen for a while, I would expect a new order for continuous oxygen. Staff B further stated that if a resident had an order to receive two liters of oxygen, I would not expect the oxygen settings to be at two and a half liters. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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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. 49619 Based on observation, interview, and record review, the facility failed to ensure a physician order was followed and/or clarified for 1 of 4 residents (Resident 194), reviewed for medication administration. This failure placed the resident at risk for receiving incorrect medication dosage and formula, adverse side effects, and a diminished quality of life. Findings included . Review of the facility's policy titled, Administering Medications, revised in April 2019, showed medications should be administered in accordance with the prescriber's orders. The policy further showed that the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Review of Resident 194's physician orders showed an order for Ferrous Sulfate (iron supplement) oral tablet delayed release 324 milligrams (mg-unit of measurement) initiated on 01/18/2025 to be given one time a day every other day. Observation on 01/30/2025 at 8:39 AM, showed Staff H, Licensed Practical Nurse, administered Ferrous Sulfate 325 mg to Resident 194 instead of the prescribed order above. In an interview on 01/30/2025 at 8:51 AM, Staff H stated that they administered the iron supplement (325 mg) they had in supply to Resident 194 and that they were not sure if it was delayed release as it was not labeled on the bottle. Staff H stated that they should confirm the order, read the order, then look for the medication and administer it. Staff H further stated that if the order did not match the medication, then they had to clarify the order with the provider and that they did not do that with Resident 194's iron supplement. Joint record review and interview on 01/30/2025 at 2:10 PM with Staff G, Resident Care Manager, showed a nursing progress note dated 01/30/2025 that Staff H had documented they had given iron 325 mg in error instead of iron 324 mg delayed release and they had notified the provider. Staff G stated that the staff should check the resident name, medication, dose, and route prior to administration. Staff G stated Staff H should have done this prior to administering the incorrect iron supplement to Resident 194. Staff G stated that Staff H should have clarified the order with the provider. Staff G further stated that the provider changed Resident 194's order to iron 325 mg (the facility's house stock). On 01/31/2025 at 1:22 PM, Staff B, Director of Nursing, stated their expectation was for nursing staff to check for the correct medication order, patient, dose, route, and strength. Staff B further stated that Staff H should have clarified the order with the provider. Reference: (WAC) 388-97-1300 (3)(a)

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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. 46912 Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP- precaution to protect residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections]) practices were followed for 1 of 9 residents (Resident 72), reviewed for infection control. In addition, the facility failed to ensure hand hygiene and proper glove use were followed for 1 of 3 residents (Resident 12), reviewed for wound care, and failed to ensure clean linens were carried appropriately for 1 of 1 resident (Resident 6), reviewed for laundry services. These failures placed the residents, staff, and visitors at an increased risk for infection and related complications. Findings included . Review of the facility's policy titled, Enhanced Barrier Precautions, dated 03/21/2024, showed, PPE [Personal Protective Equipment-equipment [gown, gloves, mask] worn to minimize exposure to hazards that cause illness] for enhanced barrier precautions is only necessary when performing high-contact care activities. It showed that that high contact activities included, providing hygiene. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in August 2019, showed to use an alcohol-based hand rub .or, alternatively, soap (antimicrobial or non-antimicrobial) and water .after removing gloves. ENHANCED BARRIER PRECAUTIONS RESIDENT 72 Review of Resident 72's admission minimum data set (an assessment tool), dated 01/29/2025, showed Resident 72 required substantial/maximal assistance (helper does more than half the effort) for oral hygiene. Review of Resident 72's infection care plan, revised on 11/15/2024, showed Resident 72 was on EBP. Observation and interview on 01/29/2025 at 10:33 AM, showed Staff O, Speech Therapist, enter Resident 72's room (EBP room) wearing gloves, and no other PPE. It showed Staff O using an oral swab and providing oral care for Resident 72. Staff O stated, if I need to give oral care, I just need gloves. Joint observation of the EBP signage outside Resident 72's room showed to wear gown and gloves when providing personal hygiene. Staff O stated that oral care was considered personal hygiene and I should wear a gown. In an interview on 02/03/2025 at 11:26 AM, Staff D, Infection Preventionist, stated that they expected staff to follow the protocol for residents on EBP. Staff D stated that staff should wear PPE (gown and gloves) when they have high contact with residents, which included providing hygiene. Staff D further stated that oral care was considered personal hygiene and staff should wear gown, gloves and a mask. (continued on next page)

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	505204	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen Anne Healthcare	2717 Dexter Avenue North Seattle, WA 98109

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/03/2025 at 11:56 AM, Staff B, Director of Nursing, stated that all staff, including therapy staff, should wear PPE when providing personal hygiene care to residents on EBP. Staff B stated that oral care was considered personal hygiene and staff should wear gloves, mask and gown. HAND HYGIENE/GLOVE USE RESIDENT 12 Review of Resident 12's comprehensive care plan, revised on 12/08/2024, showed Resident 12 had a pressure wound. Review of Resident 12's January 2025 Medication Administration Record, showed an order for daily dressing changes for wound care, started on 01/14/2025. Observation on 01/30/2025 at 11:14 AM, showed Staff H, Licensed Practical Nurse, was assisting to change Resident 12's briefs. Staff H used wipes to clean Resident 12, then took off their soiled gloves, put on clean gloves, and helped to put clean linens on the bed. No hand hygiene was done between glove changes. Observation on 01/30/2025 at 11:43 AM, showed Staff H perform hand hygiene, put on clean gloves and cleaned around the wound with gauze and wound cleanser. Staff H removed their soiled gloves and put on new gloves, and did not perform hand hygiene between glove changes. Staff H then applied the skin prep (used to protect the skin) around the wound, took off their soiled gloves, put on new gloves and applied the dressing. No hand hygiene was done between glove changes. In an interview on 01/30/2025 at 11:56 AM, Staff H stated that hand hygiene should be done between glove use and that they did not do this when performing Resident 12's dressing change. In an interview on 02/03/2025 at 11:26 AM, Staff D stated that they expected staff to perform hand hygiene before and after changing gloves, and we should be doing [hand hygiene] between glove use. In an interview on 02/03/2025 at 11:56 AM, Staff B stated that they expected staff to follow our policy for handwashing. Staff B further stated that hand hygiene should be done between glove use. 47218 TRANSPORTING CLEAN LINEN Review of the facility's policy titled, Infection Prevention and Control Program, revised in October 2018, showed that An infection prevention and control program is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. RESIDENT 6 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders printed on 01/27/2025 showed Resident 6 had an order for EBP. Further review of the physician orders showed Resident 6 had wounds on their right and left legs and was receiving wound care treatments. Observation and interview on 01/29/2025 at 9:34 AM, showed Staff I, Certified Nursing Assistants, carrying clean linens that included one white blanket, one blue blanket, one fitted sheet, and one flat sheet against Staff I's chest touching their clothes. Staff I stated that they were going to change Resident 6's bed linens. Staff I further stated that they carried the clean linens against their chest because [it] is hard to manage when we need to use Purell [brand name-hand sanitizer], we have to do it all the time, gel in and gel out. On 02/03/2025 at 11:59 AM, Staff K, Registered Nurse, stated that clean linens should be carried away from the body and not against the body. On 02/03/2025 at 12:01 PM, Staff L, Resident Care Manager, stated they expected that clean linens were carried away from staff's body or uniform. Staff L further stated that staff should not have had the clean linens touch their body when entering Resident 6's room. On 02/03/2025 at 12:07 PM, Staff D stated they did not expect staff to carry clean linens against their body. On 02/03/2025 at 12:24 PM, Staff B stated they expected staff to carry clean linens away from their body and that staff should not have carried the clean linens against their body to change Resident 6's linens. Reference: (WAC) 388-97-1320 (1)(a)(c)(3)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure the influenza vaccine (used to prevent influenza [an infection of the nose, throat, and lungs]), was provided for 1 of 5 residents (Resident 10), reviewed for immunizations. This failure placed the resident at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from influenza disease. Findings included . Review of the facility's policy titled, Influenza Vaccine, revised in March 2022, showed, Between October 1st [first] and March 31st [thirty first] each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. Resident 10 admitted to the facility on [DATE]. Review of the facility's document titled, Vaccination History and Consent, dated 01/09/2025, showed that Resident 10's representative consented to receive the influenza vaccine on 01/12/2025. It further showed that a nurse signed the form on 01/21/2025. Review of the electronic health record showed no documentation that Resident 10 was provided an influenza vaccination. In an interview and joint record review on 02/03/2025 at 11:00 AM, Staff D, Infection Preventionist, stated that they offered the influenza vaccine to residents on admission. Staff D stated that if a resident and/or their representative signed that they wanted to receive the influenza vaccine, they would order it and send out to the pharmacy. Joint record review of the Vaccination History and Consent, dated 01/09/2025, showed that Resident 10's representative consented to receive the influenza vaccine on 01/12/2025. Joint record review of Resident 10's January 2025 medication administration record showed that there was no documentation that Resident 10 received the influenza vaccine. Staff D stated, I don't see an order, I need to follow up and I don't know what happened. I think I missed this one. Staff C, Assistant Director of Nursing, stated that the influenza vaccine would be given to the resident usually within the week of signing that they wanted to receive the vaccine. In an interview on 02/03/2025 at 11:56 AM, Staff B, Director of Nursing, stated that they offered the influenza vaccine to every new admission, and once they accept it, the vaccine is ordered and administered. Staff B stated they expected the influenza vaccine to be ordered right after getting consent and would get the vaccine from the pharmacy in around three to four days. Reference: (WAC) 388-97-1340 (1)(2)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure the COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases can cause difficulty breathing and could result in impairment or death) vaccine was provided for 1 of 5 residents (Resident 10), reviewed for immunizations. The failure to provide the COVID-19 vaccination placed the resident at risk for contracting the COVID-19 virus and related complications. Findings included . Review of the Centers for Disease Control and Prevention online document titled, Staying Up to Date with COVID-19 Vaccines, dated 10/03/2024, showed that everyone ages 6 months and older should get a 2024-2025 COVID-19 vaccine. It showed that people ages 12-[AGE] years are up to date when they have received one dose of the 2024-2025 COVID-19 vaccine. It further showed that people ages [AGE] years and older are up to date when they have received two doses of any 2024-2025 COVID-19 vaccine 6 months apart. Review of the facility's policy titled, COVID-19 Vaccine, dated 08/11/2023, showed All residents and employees who have no medical contraindications to the vaccine will be offered the COVID-19 Vaccine. It further showed, The resident's medical record will include .each dose of COVID-19 vaccine administered. Resident 10 admitted to the facility on [DATE]. Review of the facility's document titled, Vaccination History and Consent, dated 01/09/2025, showed that Resident 10's representative consented to receive the COVID-19 vaccine on 01/12/2025. It further showed that a nurse signed the form on 01/21/2025. Review of Resident 10's electronic health record showed no documentation that Resident 10 was provided a COVID-19 vaccination. In an interview and joint record review on 02/03/2025 at 11:00 AM, Staff D, Infection Preventionist, stated that they offered the COVID-19 vaccine to residents on admission. Staff D stated that if a resident and/or their representative signed that they wanted to receive the COVID-19 vaccine, they would order it and send out to the pharmacy. Joint record review of the Vaccination History and Consent, dated 01/09/2025, showed that Resident 10's representative consented to receive the COVID-19 vaccine on 01/12/2025. Joint record review of Resident 10's January 2025 Medication Administration Record showed no documentation that Resident 10 received the COVID-19 vaccine. Staff D stated, I don't see an order, I need to follow up and I don't know what happened. I think I missed this one. Staff C, Assistant Director of Nursing, stated that they received the completed consent form from Resident 10's representative on 01/21/2025. Staff C further stated that the COVID-19 vaccine would be given to the resident usually within the week of signing that they wanted to receive the vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/03/2025 at 11:56 AM, Staff B, Director of Nursing, stated that they offer the COVID-19 vaccine to every new admission, and once they accept it, the vaccine is ordered and administered. Staff B stated they expected the COVID-19 vaccine to be ordered right after getting [the] consent and the vaccine would be ordered from the pharmacy and be available in the facility in around 3-4 days. No reference WAC