STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505216	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soundview Rehabilitation and Health Care Inc	1105 27th Street Anacortes, WA 98221

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview, and record review, the facility failed to ensure that each resident was treated with respect, dignity and failed to promote and protect the rights of each resident for 4 of 4 sampled residents (Residents 12, 19, 27 and 23) reviewed for dignity. This failure had the potential to result in psychological harm to residents when staff members failed to treat residents in a dignified manner and honor their rights. Findings included . Review of the undated facility policy, Resident Rights, showed employees shall treat residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility and include the right to a dignified existence, be free from abuse, participate in care planning and treatment, and be supported by the facility to exercise their rights. Review of the admission packet included an undated copy of Your Rights as a Resident, showed residents have the right to choose their activities, schedules, and health care they want. Residents have the right to plan aspects of their life in the facility taking into consideration those things that are significant and important to them. <RESIDENT 12> Resident 12 admitted to the facility on [DATE] with diagnoses to include cardiac disease and anxiety. Review of the End of the Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 03/22/2024, showed the resident had no cognitive impairment. The MDS showed it was very important for the resident to choose their bedtime, do their favorite activities, and go outside to get fresh air when the weather was good. In an interview on 05/20/2024 at 2:31 PM, Resident 12 was asked if they were treated with respect and dignity. Resident 12 said, Maybe slightly humiliated. I asked them (staff) to do something, and they said no. I wanted a chair moved by the window during the northern lights so I could get a chance to see them. The aides told me no because they wanted me to be in bed so I would not fall. It is their excuse for everything. They discourage me to get out of bed at all. Review of the Incident Reporting log and grievance log, dated 04/01/2024 to 05/28/2024, showed no entry logged for Resident 12. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 19> Resident 19 admitted to the facility on [DATE] with diagnoses to include End-stage renal (kidney) disease (is an advanced stage of chronic kidney disease, when the kidneys can no longer filter wastes and fluids from the body), depression. According to the Admission MDS assessment, dated 04/15/2024, showed the resident had no cognitive impairment. In an interview on 05/20/2024 at 9:32 AM, Resident 19 said that on Saturday (May 18th) they were in such pain with diarrhea. The resident said It was a very long time until they got to get back to bed. The resident said they were dropped off at 2:15 PM from dialysis and they did not get them back to bed until after 10:00 PM. They said they were stuck in their wheelchair (w/c) a long, long time. They said they were placed in their w/c around 5:30 in the morning to go to dialysis and it was a very long day to be up. Resident 19 said the staff told them they were short staffed. Resident 19 said they had their call light on, and staff would check in on them and would say they would be back. Resident 19 stated they felt they must have offended the staff and had now been labeled. The resident said staff attitudes have changed towards them. The resident said they had to wait a very long time for care in the evenings. Resident 19 said they chose this facility as they were told they would get specialized care. The resident said they felt like the staff resented them when they asked for things. The resident stated they felt like they must have the reputation as a difficult patient. The resident stated staff told them they put their call light on too much and were taking care away from other patients. The resident would not say who the staff member or members were. Resident 19 stated they asked for a glycerin suppository and were told it had not been enough days without a bowel movement. The resident said they had arm bruises from hanging over the bed rail trying to relieve their constipation. The resident said they told the nurse and that they knew their body and wanted a suppository. They said they did not offer to call their doctor and instead they called the Director of Nursing in who said they were not eligible for the suppository as they did not meet the criteria. In an interview on 05/22/2024 at 12:35 PM, Resident 19 said the night shift staff were short with them. The resident said their family member wanted to talk to management, but they told their family member not too or they might get worse treatment. The resident said they were told they were on the light too much and taking time away from other residents. The resident said they only put the light on if they need to be changed. The resident said they now wait until there was a smell before they call them. In an interview on 05/23/2024 at 2:43 PM, Staff I, Nursing Assistant Certified (NAC), said the resident was dependent for all care. Staff I said Resident 19 did not use their call light too much and called when they were dirty when they have diarrhea. Staff I said the resident could be impatient when they had to go help other residents who need two persons assist. Review of the May Incident Reporting log and grievance logs, dated 04/01/2024 to 05/28/2024, showed no entry regarding Resident 19. <RESIDENT 27> Resident 27 admitted to the facility on [DATE] with multiple orthopedic conditions. Review of the Admission MDS assessment, date 04/29/2024, the resident had no cognitive impairment. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/20/2024 at 11:24 AM, Resident 27 said they felt humiliated. The resident stated there had been several times, at least times four times when they requested to be changed when they had a bowel movement they had to wait, sometimes up to an hour. The resident stated they did not want to sit in their waste as feces was not good on the skin. The resident said it was not respectful to make them wait. Resident 27 said this occurred due to lack of staffing. The resident said they were understaffed so it was hard for them to get to them when they had so many residents. The resident said last night, there were only two aides in the whole facility for both sides on the evening shift. The resident said they ate dinner then waited an hour to get help. They said they were told they needed to wait. Review of the May Incident Reporting log and grievance logs, dated 04/01/2024 to 05/28/2024, showed no entry regarding Resident 27. <RESIDENT 23> Resident 23 admitted on [DATE] with multiple cardiac diagnoses, restlessness, agitation, and anxiety. According to the Admission MDS assessment, dated 03/20/2024, the resident had no cognitive impairment, and it was very important to choose their own bedtime and stay up past 8:00 PM. In an interview on 05/22/2024 at 10:28 AM, Resident 23 said they didn't like being told to go to bed. They said around 10:00 at night, they were told by staff at the desk that they needed to get out of the hall and go to bed because they were in staff's way. They said they did not like to be told when to go to bed and it made them feel like a child. The resident said they were old enough to decide when they should go to bed. They said they used to be a truck driver and they slept at different times. The resident commented they liked to be in the hallway as they were in bed a lot. They said they liked to be able to get up and walk as it took away their leg cramps. In an interview on 05/23/2024 at 2:45 PM, Staff I said Resident 23 did not really sleep at night, choosing to cat nap and liked to be up. Staff I said there was no set bedtime for residents. Review of the May Incident Reporting log and grievance logs, dated 04/01/2024 to 05/28/2024, showed no entry regarding Resident 23. In an interview on 05/30/2024 at 11:10 AM, Staff A, Chief Operating Officer (COO), stated the residents were to have a dignified existence and be treated with respect and dignity. Staff A said these could be abuse allegations. Cross reference: 483.35 Nursing Services, F725 Refer to WAC 388-97-0180(1-4)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interview, and record review, the facility failed to ensure the provided liability notice was completed accurately for 3 of 3 sampled residents (Residents 135, 136, and 137) reviewed for liability notices. This failure placed residents at risk of not being fully informed of the potential cost of continued services. Findings included . <RESIDENT 135> Resident 135 was admitted to the facility on [DATE] with diagnoses to include urinary tract infection (bladder infection), and congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should). Review of Resident 135's required form, the Skilled Nursing Facility Advanced Beneficiary Notice (SNF/ABN - a form that provides information to the beneficiary so that they can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility), showed the facility used an expired ABN form, there was no resident name documented, and there were blank spaces where information should have been filled in to indicate which option the resident chose. <RESIDENT 136> Resident 136 was admitted to the facility on [DATE] with diagnoses to include spinal fusion, spinal stenosis (spaces inside the bones of the spine get small). Review of Resident 136's required SNF/ABN form, showed the facility used an expired ABN form and there was no option checked to indicate which choice was the resident's, the form had blank spaces where information should have been filled in to indicate which option the resident chose. <RESIDENT 137> Resident 137 was admitted to the facility on [DATE] with diagnoses to include urinary tract infection, weakness, and a history of falls. Review of Resident 137's required form, SNF/ABN showed the facility used an expired ABN form and there were blank spaces where information should have been filled in to indicate which option the resident chose. In an interview on [DATE] at 2:13 PM, Staff A, Chief Operating Officer, stated the ABN forms provided were expired and not correct. Staff A stated social service staff were responsible to fill out the documents and they were on vacation. Staff A stated they now have the correct forms. Staff A acknowledged the provided ABN forms were not completed and there was missing information. Refer to WAC [DATE] (1)(e)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observations, interviews, record review, the facility failed to develop and/or implement policies and procedures for ensuring a communicable disease outbreak for Coronavirus Disease 2019 COVID-19) was reported to the state reporting agency (Complaint Resolution Unit - CRU) 1 of 1 disease outbreaks reviewed and failed to report 1 or 1 residents (Resident 32) reviewed for death. The facility failed to report a communicable disease outbreak in the facility, failed to report an unexpected death in the facility, and failed to log either on the state reporting log. This failure to report to the required state agency and log the outbreaks and unexpected deaths on the state reporting log placed all residents at risk for unidentified and uninvestigated concerns. Findings included . Review of the facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, dated 09/21/2022, showed the facility reporting requirements, guidelines, and timelines are found in the Nursing Home Guidelines, The Purple Book . findings will be logged with in five working days of the incident. Review of the Nursing Home Guidelines, The Purple Book, revised 2015, showed that facilities are to report all communicable disease outbreaks, and unexpected deaths to the state reporting hotline within 24 hours, and to log on the state reporting line within five days. Review of the facility policy titled, Infection Prevention and Control Program, dated June/2023, showed that outbreak management was a process that consists of . reporting the information to the appropriate authorities. <COMMUNICABLE DISEASE OUTBREAK> Review of the infection log dated 12/22/2023 - 04/30/2024 showed the facility had a COVID-19 outbreak from 02/21/2024 - 03/09/2024. The log showed 29 residents contracted COVID-19. The log did not reflect staff effected by the outbreak. Review of the Complaint Resolution Unit [(CRU) Washington State Reporting Hotline Center], intake log for February and March of 2024 there was no report filed from the facility that they had a communicable disease outbreak. Review of the state reporting logs for February and March of 2024 showed no COVID-19 outbreak was logged in the state reporting logs. In an interview on 05/28/2024 at 1:41 PM, Staff B, Registered Nurse/Director of Nursing Services (DNS) stated they were not aware they needed to report communicable disease outbreaks to the state reporting line, nor were they aware that they were required to log that communicable disease outbreak on the state reporting log. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/29/2024 at 9:14 AM, Staff A, Chief Operating Officer, stated they were unaware the facility had not reported or logged the communicable disease outbreak on the state reporting log. 43954 <UNEXPECTED DEATH> Resident 32 admitted to the facility on [DATE] with diagnoses to include acute pulmonary edema, Chronic Obstructive Pulmonary Disease (COPD - chronic inflammatory lung disease that makes it difficult to breathe by restricting air flow), and Congestive Heart Failure (CHF - chronic condition in which the heart doesn't pump blood as well as it should). Review of Resident 32's progress note, dated 05/04/2024 at 8:36 PM, social services documented the discharge plan was to return home with family support. Review of Resident 32's electronic medical records showed they passed away on 05/05/2024 while at the facility. Review of Resident 32's progress note, dated 05/05/2024 at 9:41 PM, showed they were found unresponsive in their bed. Review of Resident 32's current medical records showed no communication between the facility and the coroner related to their unexpected death. Review of the facility provided state reporting log, dated May 2024, showed no unexpected death was logged for Resident 32. In an interview on 05/24/2024 at 1:15 PM, Staff B stated they would call family, notify the provider, and the funeral home related to an unexpected death. Staff B stated if the resident was a full code, they would provide measures until emergency personnel arrived to take over. Staff B stated Resident 32 was admitted on [DATE] and stated this was an unexpected death. Staff B stated they were unaware some unexpected deaths should be logged, reported and/or investigated. Staff B stated Resident 32 was a no code with selective interventions and was unable to provide documentation of where the information came from or what interventions the resident wanted. There was no Advance Directive or Physician Orders for Life Sustaining Treatment (POLST) form found in resident medical records. Staff B stated medical records also may have a copy of Resident 32's POLST. In an interview on 05/24/2024 at 1:48 PM, Staff E, Health Information Management, stated they did not have a copy of Resident 32's POLST form and stated if the medical provider had not signed the POLST form, they would have thrown it away as it would not be valid. In an interview on 05/24/2024 at 2:13 PM, Staff A stated Staff B contacted the coroner related to Resident 32's unexpected death and was unable to locate documentation in Resident 32's medical records. Requested further information related to communication with the coroner. No further information provided. This is a repeat citation from survey dated 03/13/2023. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to WAC 388-97-0640(2)(b)(5)(a)(6)(c)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview, and record review the facility failed to provide written notice to 4 of 4 residents (Resident 18, 240, 241 and 242) and their family member in a manner, which they understood, of the facility's intention and justification for discharging the resident. The facility also failed to provide the resident and their family member information on their right to appeal the discharge decision, including contact data for advocacy groups. Findings included . Review of an undated facility policy titled, Your Rights as A Resident, showed that notice of transfer or discharge must be given at least 30 days ahead of time, except that it may be given on shorter notice (but still as soon as practicable before transfer or discharge). You have the right to expect that the facility will provide you with sufficient preparation and orientation to ensure a safe and orderly transfer or discharge. Review of the facility policy, Discharge Against Medical Advice (AMA), dated 10/27/2023, showed the facility will advise residents of the risks of early, unplanned discharge, and provide appropriate referrals and discharge instructions whenever possible. The policy directs the nurse or social worker to: -Advise resident of the risks to their health & well-being if they choose to leave with an unstable medical condition. - Obtain and witness the resident's signature on AMA form. - Provide referrals for medical, psychiatric, or other services as needed. - Notify the Medical Provider on-call of any resident wishing to leave AMA. - Provide residents with discharge instructions & review medications. If available, send an emergency supply (7 days or more) of medications with the resident. -Notify the resident's community Primary Care Physicians of the AMA discharge and attempt to offer/obtain an appointment for follow-up care. -Notify Adult Protective Services - Notify Police if applicable. - Notify family/Power of Attorney/Guardian as needed. <RESIDENT 18> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 18 admitted to the facility 06/07/2023 and was a long-term care resident. According to the Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 05/23/2024, the resident had no cognitive impairment. Review of Resident 18's progress note, dated 11/02/2023 at 1:25 PM, showed the resident was transported to the hospital. The note showed no information regarding what information was given to the resident at the time of the discharge notice. Review of Resident 18's social service note, dated 11/03/2023, showed the notice of transfer was completed. Review of Resident 18's progress note, dated 03/02/2024 at 5:52 PM, showed the resident was transported to the hospital. The note showed no information regarding what information was given to the resident at the time of the discharge notice. Review of the Resident 18's progress note, dated 04/09/2024 at 6:45 AM, showed the resident was transferred by ambulance to the hospital. The note showed no information regarding what information was given to the resident at the time of the discharge notice. Review of Resident 18's progress note, dated 05/16/2024 at 5:41 PM, showed the resident was sent to the hospital on 05/15/2024 and social services completed the Nursing Home Transfer Notice. The note showed no information regarding what information was given to the resident at the time of the discharge notice. Review of Resident 18's medical records, showed the nursing facility notice of action (NOA) form was sent to Aging and Long-Term Support Administration (ALTSA) on 11/03/2023, 03/04/2024, 04/09/2024 and 05/19/2024. The NOA informs ALTSA, the resident was no longer a resident at the facility (the facility used an incorrect form that did not provide resident with information on their right to appeal the discharge decision, including contact data for advocacy groups). In an interview on 05/28/2024 at 11:17 AM, Staff A, Chief Operating Officer (COO), said the facility had been using the NOA form for transfer discharges rather than the transfer discharge notice to the residents. In an interview on 05/28/2024 at 3:02 PM, Staff M, Licensed Practical Nurse (LPN), said when a resident was transferred to the hospital, they were to send the resident's face sheet, medication list, progress notes and SBAR (Situation, Background, Assess, and Recommend) form with the resident. In an interview on 05/28/2024 9:51 AM, Resident 18 stated they did not receive or sign any paperwork when they were transferred to the hospital the last four times. In an interview on 05/29/2024 at 11:14 AM, Staff A said they were not doing the notice of transfer as there was confusion with the NOA. Staff A stated the social worker should have been doing the notice of transfer discharge, but they were not providing the accurate form. 47047 <RESIDENT 240> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 240 admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (a condition that causes muscles to break down), schizophrenia (serious mental health disorder that affects a person's thought process and behavior), and osteoarthritis (degenerative joint disease). Review Resident 240 progress notes, dated 12/06/2023 through 03/04/2024, showed the resident admitted to the facility on [DATE] and discharged on [DATE] against medical advice (AMA). A progress note, dated 02/27/2024, showed that Staff F, Social Services Director (SSD), spoke with Resident 240's representative on 02/27/2024 and informed them the planned discharge scheduled for 02/29/2024 would be considered AMA due to Resident 240's testing positive for COVID (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise [a general feeling of discomfort/uneasiness], headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death). Review of Resident 240's current Electronic Medical Record (EMR), showed no documentation that a Notice of Transfer/Discharge was completed. In an interview on 05/22/2024 at 2:43 PM, Collateral Contact 1 (CC 1), Resident 240's family member, stated they signed a document at the time of discharge but did not know what the document was and did not get a copy. In an interview on 05/23/2024 at 10:05 AM, Staff F stated they could not recall Resident 240's discharge or details of the discharge. Staff F stated a discharge was a collaborative effort between social services and the nursing staff. <RESIDENT 241> Resident 241 admitted to the facility on [DATE] with diagnoses that included left hip repair after a fall at home and shingles (viral infection that causes a rash). Review of Resident 241's progress notes dated 11/26/2023 through 12/4/2023, showed resident left the facility AMA on 12/3/2023. A progress note dated 12/4/2024 showed that Staff F, SSD, filled out the Adult Protective Services (APS) intake report and faxed it. Review of Resident 241's Electronic Medical Record (EMR), showed no documentation that a Notice of Transfer/Discharge had been completed. <RESIDENT 242> Resident 242 admitted to the facility on [DATE] with diagnoses that included stroke and high blood pressure. Review of Resident 242's progress notes, dated 03/13/2024 through 04/03/2024, showed the resident left the facility AMA on 04/03/2024. A progress note, dated 04/03/2024, showed Staff N, Registered Nurse (RN), documented Resident 242 had left the facility AMA, with their spouse, belongings, medications, and instructions. Review of Resident 242's Electronic Medical Record (EMR), showed no documentation that a Notice of Transfer/Discharge was completed. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/28/2024 at 11:05 AM Staff E, Health Information, stated there was no notice of transfer/discharge notification as part of Resident 240, 241, and 242's medical record. In an interview on 05/28/2024 at 11:17 AM, Staff A said the facility had been using the NOA form for transfer/discharges rather than the transfer discharge notice to the residents. Refer to 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. 36787 Based on interview, and record review, the facility failed to provide a written bed-hold notice, at the time of transfer or within 24 hours of transfer to the hospital, for 1 of 1 resident (Resident 18) reviewed for hospitalization . This failure placed the resident at risk for a lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Resident 18 admitted to the facility 06/07/2023 and was a long-term care resident. According to the Admission Minimum Data Set (an assessment tool) assessment, dated 05/03/2024, the resident had no cognitive impairment. Review of Resident 18's progress note, dated 11/02/2023 at 1:25 PM, showed the resident was transported to the hospital. The note showed no information regarding offering the resident a bed hold. Review of Resident 18's social service note, dated 11/03/2023, showed there was no mention of offering a bed hold to the resident. Review of Resident 18's progress note, on 03/02/2024 at 5:52 PM, showed the resident was transported to the hospital. The note showed no information regarding offering them a bed hold. Review of the Resident 18's progress note, on 04/09/2024 at 6:45 AM, showed the resident was transferred by ambulance to the hospital. The note showed no information regarding a bed hold offered to the resident. Review of Resident 18's progress note, dated 05/16/2024 at 5:41 PM, showed the resident was sent to the hospital on 05/15/2024. There was no documentation about a bed hold. In an interview on 05/28/2024 at 11:17 AM, Staff A, Chief Operating Officer (COO), said the facility does offer residents bed holds. Staff A said they did not have any bed hold documentation for Resident 18. In an interview on 05/28/2024 at 3:02 PM, Staff M, Licensed Practical Nurse (LPN), said when a resident was transferred to the hospital, they were to send the resident's face sheet, medication list, progress notes and SBAR (Situation, Background, Assess, and Recommendation - is a framework for communication between members of the health care team about a resident's condition) form with the resident. Staff M said bed holds were completed if the resident was able. In an interview on 05/28/2024 9:51 AM, Resident 18 stated they did not receive or sign any paperwork when they were transferred the last four times to the hospital. In a follow up interview on 05/29/2024 at 11:19 AM, Staff A said bed holds were not being completed. Staff A said bed holds should be done when the resident was going out to the hospital. Staff A said there were checklists in place for the staff to follow. (continued on next page)

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	505216	A. Building B. Wing	05/29/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to WAC 388-97-0120 (4)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) screening for residents for a serious mental illness (SMI), intellectual disability (ID) or a related condition was completed if the scheduled discharge did not occur for 1 of 5 sampled residents (Resident 19) reviewed. Additionally, the facility failed to ensure a resident with a Level 1 PASRR screening form was complete prior to admission to the nursing facility for 1 of 8 sample residents (Resident 240) reviewed. These failures placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health and/or intellectual disability care needs. Findings included . <RESIDENT 19> Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Level I (pre-screen to determine if a resident may have a SMI, ID, or related condition and is typically completed by the referring entity) PASRR form showed no Level II (an in-depth evaluation to determine if a resident has a SMI, ID, or related condition and is completed by a representative from the state intellectual disability authority or a representative from the state mental illness authority) evaluation was indicated due to exempted hospital discharge, but a Level II must be completed if scheduled discharge did not occur. Review of Resident 19's medical record showed no Level II PASRR was completed after the resident had been in the facility greater than 30 days. 47047 <RESIDENT 240> Resident 240 admitted to the facility on [DATE] with diagnosis that included schizophrenia (serious mental health disorder that affects a person's thought process and behavior). Review of PASRR Level I, dated 11/30/2023, showed Resident 240 had serious mental illness indicators and a Level II evaluation was required. Review of the notice of determination, dated 12/05/2023, showed Resident 240 was referred to for a Level II evaluation and met the requirements for nursing home level of care. Review of Resident 240's progress note, dated 12/08/2023, Staff F, Social Services Director (SSD), wrote the resident required a Level II evaluation, the Level I was completed at the hospital, and the Level II would be sent to the facility on ce completed. No other documentation was found in Resident 240's Electronic Medical Record (EMR). In an interview on 05/23/2024 at 10:05 AM, Staff F stated they were responsible to ensuring that residents requiring a Level II evaluation were completed and part of the resident's medical record. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/29/2024 at 10:26 AM, Staff E, Health Information Manager, stated Resident 240's medical record did not contain a Level II evaluation. In an interview on 05/29/2024 at 12:00 PM, Staff A, Chief Operating Officer (COO), said PASRR's were to be completed upon admit, revised when indicated or inaccurate and included in the medical record. Refer to WAC 388-97-1915 (1)(2)

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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** 36787 Based on interview, and record review, the facility failed to review and revise care plans for 2 of 4 sampled residents (Resident 18 and 19) reviewed for care planning. These failures placed residents at risk for lack of consistent interventions, unmet care needs, adverse health effects, and a diminished quality of life. Findings included . <RESIDENT 18> Resident 18 admitted on [DATE] with diagnoses which included respiratory failure, kidney failure, and polyneuropathy (nerve disease that impairs sensation and movement). The resident had six hospitalization s since admission and most recently readmitted on [DATE]. Review of the bowel monitors, dated 02/15/2024 to 05/06/2024, showed Resident 18 had no bowel movement from 02/23/2024 to 03/03/2024 (10 days), 03/07/2024 to 03/12/2024 (six days), 04/30/2024 to 05/06/2024 (seven days). Review Resident 18's Admission Care Area Assessment (CAA - a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned), dated 05/03/2024, showed the dehydration/fluid maintenance area was triggered due to constipation likely due to decreased bed mobility. The CAA showed the assessor would proceed the constipation to the care plan. Review of Resident 18's care plan, initiated on 06/14/2023, did not show a problem of constipation. <RESIDENT19> Resident 19 admitted on [DATE] with diagnoses which included end stage renal (is an advanced stage of chronic kidney disease, when the kidneys can no longer filter wastes and fluids from the body) disease with dependance on renal dialysis (process to removes waste and excess fluids from the blood when kidneys are unable to do so). Review of the care plan initiated on 04/08/2024, showed Resident 19 went to dialysis three times a week and would have no complications from dialysis. The care plan showed to avoid drawing blood and for taking a blood pressure in the arm with the graft (dialysis access site) but did not direct staff which arm to avoid. The care plan was revised on 04/17/2024 to include a right chest central line (a flexible tube into the chest to provide access for dialysis) and to monitor for complications. Care of the central line was absent from the care plan. The care plan did not include delineation of tasks between the kidney center and the facility so the facility staff would know what care they were responsible for. The care plan was not resident specific and included areas in parentheses that cued staff the area needed to be modified per individual resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/24/2024 at 3:05 PM, Staff A, Chief Operating Officer (COO), said they did not have a policy for care planning or dialysis care. In an interview on 05/28/2024 at 3:02 PM, Staff M, Licensed Practical Nurse (LPN), said care plan revisions were completed by the Resident Care Manager (RCM). Staff M said they would revise some care plans as they used to be an RCM. Staff M said they often added equipment the resident used to the care plans. In an interview on 05/29/2024 at 12:11 AM, Staff A said the expectation was for the assessment information was to be gathered and documented. Staff A said the baseline care plan was to be to be developed within 72 hours of admit. The comprehensive care plan was initiated within five days ideally, but seven days was ok. Staff A said the RCM initiated the baseline and comprehensive care plans and the Director of Nursing Services signed off on them. This is a repeat citation from survey dated 03/13/2023. Refer to WAC 388-97-1020(5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview and record review, the facility failed to ensure professional standards were met for 2 of 2 (18 and 235) residents reviewed for bowel management, 2 of 2 (9 and 30) residents reviewed for percutaneous endoscopic gastrostomy (PEG) tube (tube inserted into the stomach to aid in supplemental nutrition), 1 of 1 (Resident 8) residents reviewed for a toileting plan, and 1 of 1 (Resident 6) residents reviewed for positioning and comfort. The facility failed to ensure licensed nurses administered necessary bowel medication to prevent constipation, failed to ensure nursing staff offered toileting to a resident when necessary, failed to ensure a hospice (end of life) resident was positioned for comfort, and failed to ensure licensed nurses stored unused supplemental formula according to manufacturer guidelines, used clean supplies, and that the supplies were labeled and dated. These failures placed the residents at risk for complications, potential infections, and adverse outcomes. Findings include . <CONSTIPATION> <RESIDENT 18> Resident 18 admitted on [DATE] with heart failure, diabetes and chronic obstructive pulmonary disease (COPD, a chronic inflammatory lung disease that obstructs airflow). Review of Resident 18's admission Minimum Data Set (MDS-an assessment tool) dated 05/03/2024, showed the resident had no cognitive impairment and was able to make their needs known. The MDS showed the resident had constipation present. In an interview on 05/20/2024 at 11:55 AM, Resident 18 stated they had issues related to constipation and a problem getting their stool out. In an interview on 05/24/2024 at 10:31 AM, Resident 18 said their usual pattern was having a BM every other day before they admitted . Resident 18 said they sometimes went 8 days without a BM. The resident said it was really painful when they had a BM. They described their stool as hard logs. Resident 18 said maybe the nurses needed to give me Miralax every day. Review of the physician's orders showed Resident 18 received Miralax (laxative) for constipation every morning from 11/29/2023 until 03/04/2024 and Sennosides at bedtime every day for constipation from 11/08/2023 until 04/26/2024. Review of Resident 18's Medication Administration Record (MAR) for May 2024 showed they could receive as needed bowel medications during their stay. The orders were in place as needed if the resident did not have a BM in 3 + days. The orders directed nurses to administer Miralax 17 grams (GM) then Bisacodyl 5 milligrams (MG) one tab then Bisacodyl suppository. If the medications were not effective nurses were to call the doctor. Further, the nurses were to call the MD after day 5 with no BM. The bowel medication as needed orders did not specify at whcih time each specific medication should be administered. A new order for Sennosides 17.6 MG was ordered daily at bedtime on 05/19/2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the bowel monitors showed Resident 18 had no bowel movement from 02/23/2024 to 03/02/2024. Review of the MAR for February 2024 showed the resident did not receive the as needed bowel medications from 02/23/2024 through 02/29/2024. Review of the bowel monitors showed Resident 18 had no bowel movement from 03/07/2024 to 03/12/2024. Review of the MAR for March 2024 showed the resident did not receive bowel medications from 03/01/2024 until 03/02/2024 and 03/07/2024 to 03/12/2024. The MAR showed the resident received Miralax, an as needed bowel medication on 03/24/2024 at 7:37 AM which was effective. The resident received another Miralax dose on 03/25/2024 at 7:42 AM that was ineffective then two days later, Miralax was administered on 03/28/2024 at 8:39 AM which was effective. The medications were administered outside of the physician's orders. Review of the bowel monitors showed Resident 18 had no bowel movement from 04/30/2024 to 05/06/2024. Review of the MAR for May 2024 showed the resident received a Bisacodyl tablet on 05/07/2024 at 9:29 AM that was not effective. The resident received Miralax on 05/08/2024 at 7:25 AM, which was effective. The bowel medications were not administered per the physician orders. Review of Resident 18's care plan dated 05/15/2024 showed no focus on constipation. In an interview on 05/23/2024 at 2:41 PM, Staff I, Nurse's Aide Assistant (NAC) said Resident 18 had constipation and they would encourage the resident to sit on the commode. Staff I said they reported episodes of constipation to the nurse. In an interview on 05/24/2024 at 12:57 PM, Staff G, NAC said Resident 18 had extra-large BM's. Staff G said Resident 18 did not have BM's that often and they were few and far between. Staff G said they felt bad for the resident because it hurt them when they did have a BM. In an interview on 05/24/2024 at 1:51 PM, Staff M, Licensed Practical Nurse (LPN) said the bowel protocol was if they were 3 days with no BM, on the 3rd day the nurses are to give Miralax then on day 4 Bisacodyl 5 MG tablet and on day 5 they would give a Bisacodyl suppository or any of the above. Staff M said they would look at their bowel pattern as residents know their bodies better than us. Staff M said the preferred order was Miralax, Bisacodyl tab and then the suppository. <RESIDENT 235> Resident 235 was admitted to the facility on [DATE] with diagnoses that included hip replacement, chronic obstructive pulmonary disease (COPD), and high blood pressure. Review of Resident 235's admission MDS dated [DATE] showed they were alert and oriented and able to make their needs known. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 235's MAR for May 2024 showed they received Docusate Sodium Oral Capsule100 milligrams (mg) by mouth two times a day for constipation with the direction to hold the medication for loose stools.The MAR for May 2024 provided an order for medications as needed for constipation if Resident 235 had not had a bowel movement in three days. Resident 235 had not received any of the as needed medications. Review of Resident 235's baseline care plan dated 05/15/2024 showed no focus on constipation. In an interview on 05/20/2024 at 10:09 AM Resident 235 stated they had issues related to constipation and sensing the need to have a bowel movement. Review of Resident 235's documented bowel movements for May 2024 showed they did not have a bowel movement on 05/18/2024, 05/19/2024, 05/20/2024 and 05/21/2024. In an interview on 05/23/2024 at 2:09 PM Staff M, Licensed Practical Nurse (LPN) stated Resident 235 had not complained of constipation. Staff M stated they had spoken to Resident 235, and they complained of having a difficult time completely emptying their bowels and adjustments to their medication was being initiated. Staff M stated they were unaware of Resident 235 not having a bowel movement for four days. In an interview on 05/28/2024 at 9:50AM Staff C, Resident Care Manager (RCM) stated all residents have standing orders and a bowel protocol if a bowel movement is not had in three days. Staff C stated that they and Staff B, Director of Nurses, run a daily report of bowel movements and they look at the reports as a team. Staff C stated that if the bowel protocol was not followed then there should have been a progress note as to the reason. In an interview on 05/29/2024 at 12:!5 PM, Staff A, Chief Operating Officer (COO) said the expectation was that bowel monitors were reviewed daily and addressed at stand up meeting. 44110 <TUBE FEEDING> RESIDENT 30 Resident 30 admitted to the facility on [DATE] with diagnoses including history of a stroke with right side weakness, and difficulty swallowing. The resident admitted to the facility with a PEG tube for nutritional supplemental feeding due to their difficulty with swallowing. The admission MDS assessment dated [DATE] showed the resident was unable to speak, could make needs known, had a supplemental diet from tube feedings for more than 51% of their meal intake. Review of Resident 30's physician orders showed the resident was to receive supplemental nutrition through their PEG tube three times a day. There were no physician orders for when the license nursing staff were to replace the tube feeding supplies, how they should be labeled and maintained. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 30's care plan dated 05/14/2024 that resident was at risk for nutritional risk related to their tube feeding for nutrition and hydration. Interventions were to administer supplements as ordered, tube feedings as ordered by the provider. The care plan did not direct licensed nursing staff on when to replace the tube feeding supplies, how they should be labeled and maintained. In an observation on 05/20/2024 at 10:12 AM, there was a tube feeding pole with clear bag attached to a pump. The bag has no markings on it, and there was a small amount of tan liquid at the bottom of the bag. There are no markings on the tubing. On the nightstand next to the bed there was a graduate cylinder with no markings, inside the cylinder was a large plastic syringe wrapped in its paper wrapping. The syringe has no markings, the paper had 5/5 written on it. In an observation on 05/21/2024 at 8:52 AM, there was a tube feeding pole with clear bag attached to a pump. The bag has no markings on it, the bag was a fourth way filled with tan liquid, the tubing attached from the clear bag to the pump has not markings. On the nightstand was an opened bottle with about a third of the tan fluid. The label reads Glucerna 1.2 Cal. The back of the bottle states once opened, reclose, and cover and refrigerate, and it was good for 48 hours. The bottle was not marked there was no name, date, flow rate listed. There was a graduate cylinder with no markings, inside the cylinder was a large plastic syringe wrapped in its paper wrapping. The syringe has no markings, the paper had 5/5 written on it. In an observation on 05/22/2024 at 8:17 AM, there was a tube feeding pole with clear bag attached to a pump. The bag has no markings on it, the bag was almost empty small amount of tan liquid in the bottom of bag, the tubing attached from the clear bag to the pump has not markings. There was another clear bag with a clear substance attached via tubing to the pump, there was no markings on tube or bag. There was a graduate cylinder with no markings, inside the cylinder was a large plastic syringe wrapped in its paper wrapping. The syringe has no markings. RESIDENT 9 Resident 9 admitted to the facility on [DATE] with diagnoses including history of a stroke with left side weakness, and difficulty swallowing. The resident admitted with a PEG tube. The annual MDS assessment dated [DATE] showed the resident had intact cognition, required set up assistance for meals, had coughing/choking with meals and/or medication administration, they received 25% or less of their nutritional needs, and 501 milliliters or more for hydration through the PEG. In an observation on 05/20/2024 at 9:18 AM, Resident 9's bedside nightstand had a graduate cylinder with a large plastic syringe inside, the cylinder had the date 05/16/2024 on it, the syringe was undated. In an interview on 05/20/2024 at 1:57 PM, Resident 9 stated they eat their meals in the dining room, but they use the PEG tube for medication administration, it was too hard for them to swallow the medications. In an observation on 05/21/2024 at 8:49 AM, Resident 9 bedside nightstand had a graduate cylinder with a large plastic syringe inside, the cylinder had the date 05/16/2024 on it, the syringe was undated. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 05/22/2024 at 10:13 AM, Resident 9 bedside nightstand had a graduate cylinder with a large plastic syringe inside, the cylinder had the date 05/16/2024 on it, the syringe was undated. In an observation on 05/23/2024 at 11:33 AM, Resident 9 bedside nightstand had a graduate cylinder with a large plastic syringe inside, the cylinder had the date 05/16/2024 on it, the syringe was undated. In an observation on 05/24/2024 at 10:53 AM, Resident 9 bedside nightstand had a graduate cylinder with a large plastic syringe inside, the cylinder had the date 05/16/2024 on it, the syringe was dated 05/24/2024. In an observation on 05/28/24 9:49 AM, Resident 9 bedside nightstand had a graduate cylinder with a large plastic syringe inside, the cylinder had the date 05/16/2024 on it, the syringe was undated. In an interview on 05/24/2024 at 8:26 AM, Staff W, Registered Nurse (RN) stated that they use the tube feeding supplies that are in the room for administration of the nutrition supplement and medications as necessary. On 05/24/2024 at 3:05 PM, a request for policy and procedure for PEG tube care, maintenance and use was requested. On 05/28/2024 at 12:20 PM, Staff A, Chief Operating Officer stated the facility did not have a policy and procedure for PEG tube care, maintenance, and use. <POSITIONING> <RESIDENT 6> Resident 6 admitted to the facility on [DATE] for hospice services, diagnoses include history of stroke with weakness to the right side, and adult failure to thrive. The resident has severe cognition impairment and requires maximum assistance for all activities of daily living. Review of Resident 6's physician orders showed an order dated 05/03/2024, for the resident to utilize a tilt-n-space wheelchair for comfort and positioning, there were no direction for use. Review of Resident 6's care plan showed a focus dated 05/08/2024 that the resident was at risk for altered comfort and pain related to their end-of-life care. Interventions included dated 05/08/2024 that the resident would need assistance for turning and repositioning. Resident 6 had a focus care plan dated 05/08/2024 for an actual skin impairment, with an intervention to turn and reposition the resident every two hours for comfort and prevention of further skin breakdown. Review of Resident 6's medical record showed no progress notes related to the resident refusing care, or repositioning. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's Hospice agreement plan dated 04/22/2024 - 06/20/2024 showed that the resident was to have heel protection boots when in bed, a tilt-n-space wheelchair with a ROHO (cushion that provided comfort and pressure relief), and calf sling. The facility was to provide the wheelchair, cushion, and sling. In observations on 05/20/2024 at 9:12 AM, 10:04 AM, 11:02 AM, 12:00 PM Resident 6 was observed in their tilt-n-space wheelchair tilted in the same position for all observations and no change in their position. The resident was observed to be seated on a ROHO cushion. In observations on 05/21/2024 at 8:51 AM, 10:02 AM, 11:19 AM, 12:24 PM, Resident 6 was observed in their tilt-n-space wheelchair tilted in the same position for all observations and no change in their position. The resident was observed to be seated on a ROHO cushion. In a continuous observation on 05/22/2024 at 8:37 AM, Resident 6 was observed in their tilt-n-space wheelchair, seated on a ROHO cushion. The resident was observed from 8:37 AM - 12:07 PM to be seated in their wheelchair, tilted in the same position on their ROHO cushion. No staff were observed to reposition the resident during the observed time. In an observation on 05/23/2024 at 9:09 AM, Resident 6 was observed in their tilt-n-space wheelchair, next to the nurse's station asleep. In an interview on 05/23/2024 at 10:03 AM, Staff K, NAC stated Resident 6 was to be repositioned every two hours and laid down in between meals. Staff K was asked who assesses the ROHO cushion for air, they stated they just look at it and feel if it has air in it. In an observation on 05/23/2024 at 1:45 PM, Resident 6 was observed lying in bed. They did not have on any heel protection boots. In an interview on 05/23/2024 at 1:47 PM, Staff X, NAC stated they had assisted Resident 6 to lie down in bed. Staff X stated that the resident was to wear heel protection boots while in bed. Staff X was asked why the resident was not wearing them, and they stated they like to give the resident a break sometimes from them. In an interview on 05/24/2024 at 8:26 AM, Staff W, RN stated Resident 6 was unclear what a ROHO cushion was and was unclear who and how to monitor one. In an observation on 05/28/2024 at 9:47 AM, Resident 6 was observed in their tilt-n-space wheelchair, next to the nurse's station asleep. In an interview on 05/28/2024 at 10:36 AM, Staff N, RN stated Resident 6 was to get up for breakfast then return to bed. Staff N stated they should be repositioned every two hours for comfort and skin management. Staff N stated they were told the therapy department managed the ROHO cushion for Resident 6 and was not trained on how to determine if the cushion was appropriately inflated. (continued on next page)

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	505216	A. Building B. Wing	05/29/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/28/2024 at 12:05 PM, Staff C, RN/Resident Care Manager (RCM) stated they have been a nurse manager at the facility for almost of year, they are the only RCM. Staff C stated TF supplies should be replaced every 24-hours, and that it was their expectation that the licensed nurses were labeling the nutritional formula with the name of the resident, date it was opened and rate of flow. Staff C stated they expected the licensed nurses to also ensure that all supplies such and tubing, bags, graduate cylinders, and syringes were labeled and dated as well. Staff C stated any unused formula should be properly closed, labeled, and refrigerated and discarded after 24 hours. Staff C stated that the physician orders and care plan should reflect how and when to store, change out, and label the PEG tube feeding supplies. Staff C was asked to look at Resident 30 and Resident 9's physician orders, and they confirmed there was no orders or care plan for either resident that reflected that process. Staff C stated the facility standard of care was all resident should be repositioned every two hours. Staff C stated their expectation was that Resident 6 was not to be left in their wheelchair all day. Staff C stated they had spoken with Hospice, and they preferred the resident to only be up for one meal, Staff C agreed this was not reflected in the plan of care. Staff C stated all ROHO cushions should be filled to specifications, they stated they were unclear on the process for that and would need to follow up on that matter. In an interview on 05/28/2024 at 1:41 PM, Staff B, Director of Nursing Services (DNS) stated that their expectation was their licensed nursing staff were labeling all PEG tube feeding supplies with name, and date of use. Staff B stated they should be changed out every 24-hours, and that the formula was to be refrigerated and discarded after 24 hours. Staff B was unaware there were no physician orders or care plan directions of care related to the storage, labeling and use for the PEG tube feeding supplies. Staff B stated that Resident 6 should be repositioned every two hours, and that they should only be out of bed for one meal a day. Staff B stated the resident should not have been observed in the wheelchair from extended hours throughout the day. Staff A stated that therapy department managed and monitored the ROHO cushions. In an interview on 05/28/2024 at 2:49 PM, Staff Y, Director of Rehabilitation stated if they assign a ROHO cushion then they would monitor and manage. Staff Y stated Resident 6 was on hospice services and they had not been managing or monitoring the residents ROHO cushion. 47047 <TOILETING PLAN> <RESIDENT 8> Resident 8 was readmitted to the facility on [DATE] with diagnoses that included aphasia (loss of ability to understand or express speech), stroke and high blood pressure. In an interview on 05/20/2024 at 3:30 PM Collateral Contact 3 (CC 3), Resident 8's family member, stated they were concerned the facility was not following Resident 8's care plan for toileting. CC 3 stated they were concerned for Resident 8 having to toilet in their brief and becoming constipated. Review of Resident 8's care plan dated 04/05/2024 showed they had a long history of bladder incontinence related to impaired mobility and cognitive deficits. Interventions included a bladder retraining program with toileting Resident 8 every two hours and as needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a continuous observation on 05/22/2024 at 8:37 AM through 12:45 AM, Resident 8 was observed as below: -At 8:37 AM Resident 8 was sitting in her wheelchair by the nurse's station. -From 9:52 AM until 10:35 AM Resident 8 was taken to Resident Council Meeting. -From 10:35 AM until 11:43 AM Resident 8 was in an activity in the dining room. -From 12:00 PM until 12:45 PM Resident 8 was in the dining room for lunch. -At 12:45 PM Resident 8 was taken to their room for a brief change. Resident 8 went at least three hours and 23 minutes without being checked or toileted. In an interview on 05/22/2024 at 12:56 PM Staff I, Nurse's Assistant Certified (NAC) and Staff X, NAC stated Resident 8 had just been checked and changed and had not voided. Staff I stated Resident 8 is a mix of being continent and incontinent. Staff I stated Resident 8 was offered toileting at 9:00 AM or 9:15 AM and did not void. Staff I stated Resident 8 voided last at 7:15 AM that morning. Staff X stated Resident 8 was on a toileting program and should be toileted on the commode every two hours and as needed. In an interview on 05/23/2024 at 1:53 PM Staff M, LPN, stated Resident 8 was on a toileting program and would refuse at times. Staff M stated Resident 8 was mostly incontinent. In an interview on 05/28/2024 at 10:14 AM Staff C, RCM, stated Resident 8 is offered toileting every two to four hours, essentially before and after meals. Staff C stated if Resident 8 appeared uncomfortable or squirmy the staff would check and change them. When asked about the toileting program for Resident 8, Staff C stated the facility was trying to address Resident 8's family member's concern. No other information was provided. In an interview on 05/28/2024 at 10:29 AM, Staff Q, RN said they made a list to pass onto day shiftof residents who had not had a BM. Staff Q said if a resident had a small BM that did not count as a BM. Staff Q said bowel meds are to be started if they had no BM in 3 days and they believed the first step was to give Bisacodyl. Staff Q said they did not administer any bowel medications on night shift ir the reisdent would be up all night. Staff Q said my job is to tell nurses who hasn't gone and nothing more. Refer to WAC 388-97-1620(2)(b)(i)(ii)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview, and record review, the facility failed to develop, implement, and document a person-centered discharge planning process for 3 of 3 discharged residents (Resident 240, 241 and 242) when reviewed for discharge planning. Failure to initiate and update a discharge plan consistent with the resident's or their representatives' expressed desires and goals led to the residents leaving the facility against medical advice (AMA) and placed the residents at risk for medical complications, a decreased sense of self-worth and poor quality of life. Findings included . Review of the facility policy, Discharge Against Medical Advice (AMA), dated 10/27/2023, showed the facility will advise residents of the risks of early, unplanned discharge, and provide appropriate referrals and discharge instructions whenever possible. The policy directs the nurse or social worker to: -Advise resident of the risks to their health and well-being if they choose to leave with an unstable medical condition. -Obtain and witness resident's signature on AMA form. - Provide referrals for medical, psychiatric, or other services as needed. - Notify the Medical Provider on-call of any resident wishing to leave AMA. - Provide residents with discharge instructions and review medications. If available, send an Emergency supply (7 days or more) of medications with resident. -Notify the resident's community Primary Care Physicians of the AMA discharge and attempt to offer/obtain an appointment for follow-up care. - Notify Adult Protective Services (APS). - Notify Police if applicable. - Notify family/Power of Attorney (POA)/Guardian as needed. <RESIDENT 240> Resident 240 admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (a condition that causes muscles to break down), schizophrenia (serious mental health disorder that affects a person's thought process and behavior), and osteoarthritis (degenerative joint disease). (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 240's Care Plan, dated 12/03/2024, showed they were to remain a long-term resident at the facility. Review of a care conference summary, dated 12/13/2024, showed Resident 240 may need to stay at the facility for long term care if they were unable to return to their prior level of function. The summary noted Resident 240 had an apartment which was being maintained for them in the community. Review of physician progress note, dated 01/12/2024, showed Resident 240 was seen by the nurse practitioner. Resident 240 was noted to be at the facility for medical management, skilled nursing, and physical/occupational therapies. Review Resident 240's progress notes, dated 12/06/2023 through 03/04/2024 showed the resident admitted to the facility on [DATE] and discharged [DATE] against medical advice (AMA). A progress note dated 02/27/2024 showed Staff F, Social Services Director (SSD), spoke with Resident 240's representative on 02/27/2024 and informed them the planned discharge scheduled for 02/29/2024 would be considered AMA due to Resident 240's testing positive for Coronavirus Disease 2019 (COVID-19, an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise [a general feeling of discomfort/uneasiness], headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death). There was no documentation in Resident 240's medical record of discussions with the resident about AMA risks, physician notification, notification to the resident's community physician, or any attempts to schedule an appointment for follow up care. Review of Resident 240's Discharge Minimum Data Set (MDS-an assessment tool) assessment, dated 02/29/2024, showed their discharge plan was they would return home. Review of a progress note, dated 03/04/2024, showed the facility received a telephone call from Collateral Contact 1 (CC 1), Resident 240's family member, about Resident 240's prescriptions. CC 1 was directed to contact Resident 240's primary care provider to schedule an appointment. In an interview on 05/22/2024 at 2:43 PM, CC 1 stated they signed a document at the time of discharge but did not know what the document was and did not get a copy. CC 1 stated Resident 240's discharge had been planned and was not aware that it was considered AMA. CC 1 stated Resident 240 left with five days of medication and no discharge instructions. CC 1 stated they had to coordinate a medical appointment with Resident 240 primary care physician for more medications. CC1 stated Resident 240 had to go without a weeks' worth of medication due to the appointment availability. In a review of Resident 240's medical records showed Resident 240's primary care physician reached out to the facility for records on 03/04/2024. In an interview on 05/23/2024 at 11:29 AM, Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS), stated Resident 240's discharge was AMA because they had tested positive for COVID-19, and the facility felt it was unsafe for them to return home. Staff B stated the facility had been working on a discharge for Resident 240 to return home. Staff B stated they consulted with the attending physician about the discharge. When asked to provide documentation of the consultation, no documentation was provided. Staff B stated Resident 240's medications were sent with them. When asked for documentation of what medications and the amount sent with Resident 240, there was no documentation provided. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<RESIDENT 241> Resident 241 admitted to the facility on [DATE] with diagnoses that included left hip repair after a fall at home and shingles (viral infection that causes a rash). Review of Resident 241's care plan, dated 11/27/2023, showed they resided in their own home, was independent with their daily care, driving, and managing their medications prior to admission to the facility, with a plan to return home with their family member staying with them. Interventions included ordering durable medical equipment as needed, ordering home health services, and scheduling an appointment with their community provider. Review of the last provider note, dated 12/01/2023, showed Resident 240 was admitted to the facility for medical management, skilled nursing, and physical/occupational therapies. The note did not contain any information regarding discharge planning. Review of Resident 241's Discharge MDS assessment, dated 12/3/2023, showed the discharge was unplanned and they had returned home. Review of Resident 241's progress notes, dated 11/26/2023 through 12/4/2023, showed the resident left the facility AMA on 12/03/2023. A progress note, dated 12/04/2023, showed Staff F filled out the APS intake report and faxed it. There was no documentation in Resident 241's medical record of discussions with the resident about AMA risks, physician notification, notification to the resident's community physician, or any attempts to schedule an appointment for follow up care. <RESIDENT 242> Resident 242 admitted to the facility on [DATE] with diagnoses that included stroke and high blood pressure. Review of Resident 242's care plan, dated 03/20/2024, showed they planned to discharge home with their spouse as their primary caretaker. The intervention included establishing a pre discharge plan with Resident 242's family member and was evaluated on a weekly basis. In a review of discharge planning note, dated 03/26/2024, showed Resident 242 would discharge to their home with their spouse and home health support. In a review of the last physician note, dated 04/02/2024, showed Resident 242's family wished for a discharge soon. No other information was found in the note in reference to discharge planning. Review of Resident 242's progress notes, dated 03/13/2024 through 04/03/2023, showed the resident left the facility AMA on 04/03/2024. Review of a progress note, dated 04/03/2024, showed Staff N, RN, documented Resident 242 had left the facility AMA, with their family member, belongings, medications, and instructions. There was no documentation in Resident 241's medical record of discussions with the resident about AMA risks, physician notification, notification to the resident's community physician, or any attempts to schedule an appointment for follow up care. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 242's Discharge MDS assessment, dated 04/03/2024, showed the discharge was unplanned and they returned home. There was no other documentation found in Resident 242's medical records to support that home health had been secured and discharge instructions had been provided to the resident at discharge. In an interview on 05/23/2024 at 10:05 AM, Staff F stated they were responsible to discharge planning. Staff F stated AMA discharges were a collaborative effort with the director of therapy, DNS, and the resident care manager. Staff F stated they were responsible for reporting to APS when a resident left the facility AMA. Staff F stated the nursing staff complete the actual discharge and provide the AMA document. In an interview on 05/28/2024 at 11:23 AM, Staff A, Chief Operating Officer, stated the facility was following some of the process but not all the process for AMA discharges. Staff A stated the process included notification and contact of the physician and concise documentation of medications that were sent with the residents. Refer to WAC 388-97-0080(4)(a)(5)

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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. 47047 Based on observation, interview, and record review, the facility failed to ensure 1 of 2 residents (Resident 4) was provided physician ordered pressure relief interventions. Failure to implement use of off-loading boots, in accordance with the wound care team's recommendation, placed residents at risk for pressure ulcer (PU is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear [a combination of downward pressure and friction]) development, worsening of their PU, and a diminished quality of life. Findings included . Resident 4 was admitted to the facility 04/14/2024 with diagnoses that included congestive heart failure, atrial fibrillation (irregular heartbeat), and an unstageable (full thickness tissue loss where the depth of the sore is completely obscured by eschar in the wound bed) PU on their left and right buttock. Review of Resident 4's wound care progress note, dated 04/18/2024, showed the treatment recommendations included always use offloading (a way to redistribute pressure) booties and an air bed. The note showed Resident 4 reported they had the left heel ulcer for some time. Review of Resident 4's Minimum Data Set (MDS-an assessment tool) assessment, dated 04/21/2024, showed the resident had three unstageable PU's, two of which were present upon admission to the facility. Review of the Care Area Assessment (CAA - a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned), dated 04/22/2024 showed Resident 4 developed an unstageable left heel ulcer and was at risk for development of additional ulcers. Review of Resident 4's care plan, dated 04/26/2024, showed a focus PU area with interventions that included float/elevate their heels and a alternating pressure mattress (helps redistributes body weight). Review of the Medication Administration Record (MAR), dated 05/01/2024 to 05/28/2024), directed nursing staff to always float/elevate Resident 4's heels while they were in bed. On 05/20/2024 at 3:03 PM, observed Resident 4 sitting in their wheelchair in their room, wearing nonskid socks. In an interview on 05/20/2024 at 3:03 PM, Resident 4 stated they had the heel ulcer for some time. On 05/22/2024 at 10:28 AM, Resident 4 was observed lying in their bed, their feet were not elevated, and a green off-loading boot sitting in a basin on their bedside table. (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 05/28/2024 at 10:10 AM, Staff C, Registered Nurse/Resident Care Manager, stated interventions for Resident 4's left heel ulcer included using an off-loading green boot to keep the pressure off their heel. Staff C stated they expected staff to check on Resident 4 at least once a shift to ensure the boot was positioned properly. Staff C stated Resident 4 should always wear the green boot when in bed and it would be good for them to always wear it. This is a repeat citation from survey dated 01/18/2024. Refer to WAC 388-97-1060(3)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview, and record review, the facility failed to ensure adequate supervision to prevent accidents for 1 of 1 resident (Resident 7) reviewed for falls. The facility failed to adequately supervise Resident 7 who had 9 falls in 90 days, and placed residents who were assessed to be fall risk and placed residents at risk for injury and negative outcomes. Findings included . Review of the facility policy titled, Fall Assessment and Management, revised 09/21/2022, showed the facility will establish ad resident-centered fall prevention plan based on relevant assessment information .nursing staff, physician and pharmacist will review the residents medications that could relate to falls .staff will look for possible links between falls . the staff will identify resident specific risk and causes to try an prevent the resident from falling. Resident 7 admitted to the facility on [DATE] with diagnoses including dementia, and cognitive communication deficit. Review of the Quarterly Minimum Data Set (an assessment tool) assessment, dated 05/14/2024, showed the resident had sever cognition impairment and was currently taking an anti-psychotic medication with no gradual dose reduction attempted. The resident required substantial one person assistance for bed mobility, transfers, personal hygiene, and toileting. Review of Resident 7's current physician orders, showed the resident was on an anti-psychotic medication that could cause sedation, drowsiness, blurred vision, unstable gait (walking), and postural hypotension (dramatic decrease in blood pressure related to change in position). Review of Resident 7's care plan showed a focus area, dated 11/22/2023, the resident was at risk for fall related to gait and balance problems, high risk medications and cognition deficits. Interventions included, dated 11/22/2023, showed to use a soft touch call light, resident was encouraged to wear shoes or non-skid socks, therapy to evaluate, and ensure environment was free of hazards. On 02/05/2024, an intervention to follow the facility fall policy was added to the plan of care. On 4/22/2024, an intervention to not leave the resident unattended was added to the plan of care. On 05/21/2024, an intervention to have a low bed was added to the plan of care. On 05/21/2024, interventions to not leave the resident alone and use a soft touch call light were duplicated (these interventions were already in place on the plan of care). Review of the facility state reporting logs for 02/20/2024 - 05/20/2024, showed the resident had nine unwitnessed falls in the last 90 days. Review of Resident 7's falls investigations for the last 90 days showed the following: - On 02/12/2024 at 3:00 PM, the resident had an unwitnessed fall in the activity room. The intervention was to remind the resident to ask for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 02/19/2024 at 1:15 PM, the resident had an unwitnessed fall, in their restroom. The resident had a bruise to their head and no changes to the plan of care. - On 02/21/2024 at 4:50 PM, the resident had an unwitnessed fall in their room, the investigation had no summary or changes to the plan of care. - On 02/28/2024 7:15 PM, the resident had an unwitnessed fall in their room. There were no changes to the plan of care. - On 03/17/2024 at 1:15 AM, the resident had an unwitnessed fall in their restroom, the resident had bruising to the right side of their head and below their right ear. An intervention was to remind the resident to use their call light. - On 04/10/2024 at 5:40 PM, the resident had an unwitnessed fall in their room. The investigation showed the resident had a urinary tract infection and there were no changes to the care plan. - On 04/14/2024 at 4:10 PM, the resident had an unwitnessed fall when they were left unattended in the restroom. The resident obtained a head laceration and was sent to the hospital. They returned to with two staples to their scalp. The plan of care directed staff to not leave the resident unattended was not followed. - 04/22/2024 at 7:55 AM, the resident had an unwitnessed fall in the resident's room. The intervention was to place bed in low position. - 05/15/2024 at 4:55 PM, the resident had an unwitnessed fall in their room. The investigation stated the resident was impulsive, and there were no changes to plan of care. In an interview on 05/24/2024 at 10:12 AM, Staff L, Nursing Assistant Certified (NAC), stated Resident 7 had fallen a lot, and that there were times the resident would refuse to let staff assist them. Staff L stated the resident believed they could do things on their own and does not understand they needed assistance. Staff L stated they thought the resident had sun-downing (increase in abnormal behaviors during the evening hours) episodes, as the behaviors and falls appear to be more in the afternoon, evening time. In an interview on 05/28/2024 at 10:36 AM, Staff N, Registered Nurse (RN), stated Resident 7 was a high fall risk, as they believed they could perform activities of daily living independently. Staff N stated the resident had fallen often recently, hit their head, and required staples. Staff N stated they tried to keep the resident safe, the resident had frequent delusions they were working or need to go to the store. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soundview Rehabilitation and Health Care Inc	1105 27th Street Anacortes, WA 98221

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/28/2024 at 12:05 PM, Staff C RN/Resident Care Manager (RCM), confirmed they were the unit nurse manager for Resident 7. Staff C stated Resident 7 was very confused, a lack of safety awareness, had delusions they needed to go to the store or work often. Staff C confirmed the resident was only alert to themself, and close family members. Staff C stated the resident was a high fall risk and was very impulsive. Staff C was asked what the process was for reviewing residents that were high fall risk, or had multiple falls, Staff C stated they would have to inquire with the Staff B, RN/Director of Nursing Services (DNS) as they were not sure. Staff C was asked if the resident's sun-downing behaviors, or the anti-psychotic medication the resident was prescribed and administered could have contributed to their falls, Staff C stated they would have to inquire with the Staff B as they were not sure. In an interview on 05/28/2024 at 1:41 PM, Staff B stated Resident 7 was impulsive, a high fall risk because they would self-transfer to bed and to the toilet. Staff B stated the resident's roommate would shut the door at times and that left the resident unattended often. Staff B was asked what the process was for reviewing falls and conducting an analysis to prevent further falls or injury, they stated they discussed this in the morning meeting and plan. Staff B stated they had discussed that therapy would see the resident, changed out the call light, ensured the resident was not left unattended, and the bed was in low position. Staff B was not aware that several of the interventions summarized on the investigations completed were already interventions in place. Staff B stated the interdisciplinary team (IDT) never considered the residents sun-down behavior or they were administered an anti-psychotic medication that could contribute to increased falls. Staff B stated the facility should do better at updating the plan of care. In an interview on 05/29/2024 at 9:14 AM, Staff A, Chief Operating Officer, stated their expectation for fall review was the IDT was reviewing the big picture. Staff A stated they should review Resident 7's health record, assessments, and conducted a root cause analysis as to why they fell . Staff A stated all changes and updates to the plan of care should be completed. Staff A stated there had been a lack of oversight and completion regarding Resident 7's fall investigations. This is a repeat citation from survey dated 03/13/2023. Refer to WAC 388-97-1060(3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review, the facility failed to ensure 2 of 2 sampled residents (Resident 13 and 235) reviewed for use and care of a catheter (a flexible tube inserted into the bladder to drain urine), received appropriate care and services, to minimize the risk of associated urinary tract infections. This failure placed residents at risk for discomfort, loss of dignity, continued urinary tract infections and other health complications. Findings included . Review of the facility policy, Catheter Care, Urinary, dated 2024, showed the facility's purpose was to prevent urinary catheter-associated complications, including urinary tract infections. This included infection control practices directed staff to use aseptic (a set of guidelines to eliminate pathogens [organisms] and reduce infection risk during medical procedures) technique when handling or manipulating the catheter drainage system. <RESIDENT 13> Resident 13 admitted to the facility on [DATE] with diagnoses that included injury of the urethra (a duct by which urine in transported from the bladder), urinary tract infection and heart failure. In an observation on 05/21/2024 at 2:22 PM, an unnamed Nursing Assistant Certified (NAC) emptied Resident 13's catheter bag. The unnamed NAC drained Resident 13's catheter bag, while wearing gloves, without the use of antiseptic to clean the drain tube before or after draining the catheter bag. <RESIDENT 235> Resident 235 was admitted to the facility on [DATE] with diagnoses that included hip replacement, chronic obstructive pulmonary disease (chronic inflammatory lung disease that obstructs airflow), and high blood pressure. Review of Resident 235's hospital discharge summary, dated 05/13/2024, showed Resident 235 needed a follow up appointment with the urologist (a medical specialty that deals with the urinary system) in the next five to seven days for urinary retention (the inability to urinate or empty the bladder completely) and use of a catheter. Review of Resident 235's provider progress note, dated 05/22/2024, showed the resident had a scheduled appointment with urology on 05/28/2024, more than five to seven days after admission to the facility. In an observation on 05/20/2024 at 10:09 AM, Resident 235 was observed in their room, their catheter bag was uncovered and hooked to their walker and completely full of urine. Resident 235's room door was open, and their full catheter bag could be seen from their doorway. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 05/20/2024 at 10:20 AM, Staff K, NAC, entered Resident 235's room and the resident asked Staff K to empty their catheter bag. In an interview on 05/20/2024 at 10:28 AM, Staff K stated they emptied Resident 235's catheter which had 2400 cubic centimeters (cc) drained from their catheter bag. Staff K stated that catheter bags should be drained at least once a shift and as needed. Staff K stated Resident 235's bag should be covered for dignity. In an interview on 05/21/2024 at 2:37 PM, Resident 235 stated the staff do not put on a gown or mask when draining their catheter bag and do not clean the drain tube before or after draining. In an interview on 05/23/2024 at 2:01 PM, Staff M, Licensed Practical Nurse, stated the NAC's reported urine output from residents with catheters at the end of their shift. Staff M stated catheter bags were typically drained when they were about half full. Staff M stated they were unable to recall if the end of the drain tube should be cleaned with an alcohol wipe or not. In an interview on 05/28/2024 at 9:43 AM, Staff C, Registered Nurse/Resident Care Manager, stated their expectation of catheter care included cleaning and emptying the catheter bag every shift and as needed. Staff C stated the drainage tube on the catheter bag needed to be wiped with an alcohol wipe after draining the urine from the catheter bag. Refer to WAC 388-97-1060 (3)(c)

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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** 47047 Based on observation, interview, and record review, the facility failed to ensure 1 of 2 sampled residents (Resident 237) reviewed for respiratory care and services were provided care consistent with professional standards of practice. The facility failed to ensure there was an order with parameters in place and failed to ensure oxygen (O2) tubing was appropriately maintained, changed regularly, and dated. This failure placed residents at risk for receiving care and services that were not physician ordered, unmet care needs and a diminished quality of life. Findings included . Resident 237 admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- chronic inflammatory lung disease that causes obstructed airflow from the lungs), anxiety disorder, and cachexia (great weight loss and muscle loss). Review of Resident 237's 05/01/2024 to 05/28/2024, Medication Administration Record (MAR), showed a physician order to check resident's O2 saturations (percentage of oxygen in a person's blood) every shift and titrate (to achieve the targeted saturation for the resident) O2 to maintain saturations above 89 percent. There were no instructions found on changing the O2 tubing. Review of Resident 237's care plan, dated 05/03/2024, showed the resident had O2 therapy and required O2. There were no interventions to change O2 tubing and no set parameters to define the O2 flow rate. On 05/20/2024 at 12:36 PM, Resident 237 was observed in their room, sitting upright in their bed, using a nasal canula (a tube that delivers oxygen into a resident's nose). A concentrator (a machine that delivers O2 through a nasal canula) next to Resident 237's bed with a flow rate setting of two liters per minute. The O2 tubing was not dated. In an interview on 05/20/2024 at 12:22 PM, Resident 237 stated they had asked the staff to increase the O2 setting rate to two liters per minute. Resident 237 stated it was difficult for them to catch their breath. On 05/21/2024 at 1:30 PM, observed Resident 237 was sitting upright in their bed. Observed the flow rate setting on the O2 concentrator at one liter per minute. The O2 tubing was not dated. On 05/22/2024 at 10:45 AM, observed Resident 237 in their room, sitting on their bed. Observed the O2 flow rate setting on the concentrator at one and a half liters per minute. The O2 tubing was not dated. In an interview on 05/22/2024 at 10:45 AM, Resident 237 stated the O2 tubing had been changed once since their admission to the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/23/2024 at 2:15 PM, Staff M, Licensed Practical Nurse, stated Resident 237 had an order for O2 therapy. When asked what the flow rate was, Staff M stated that it was supposed to be one and a half liters per minute, but there was no order. Staff M stated O2 tubing was to be changed and dated on Sundays. In an interview on 05/28/2024 at 12:20 PM, Staff A, Chief Operating Officer, stated there was no facility policy/procedure for O2. This is a repeat citation from survey dated 03/13/2023. Refer to WAC 388-97-1060 (3)(j)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to ensure 1 of 1 sampled residents (Resident 19) reviewed for dialysis services received consistent, ongoing communication and collaboration with the dialysis facility regarding care and services for dialysis residents, including the failure to consistently and accurately complete Resident 19's pre and post dialysis assessments and to obtain and review the dialysis run sheets, prevented staff from identifying how many liters of fluid were removed, what complications, if any, occurred (low blood pressure etc.) and what medications were administered, what labs were drawn, the lab results, and whether there were order changes and/or any follow up required. The nursing home failed to communicate, and to coordinate medication administration arrangements on dialysis days. Additional failed practice included that the facility did not have a policy to delineate each of the facility and the dialysis center responsibilities. The lack of consistent communication between the facility and the dialysis center about what occurred during and after dialysis, placed residents at risk for unmet care needs, inadequate quality of care, unidentified medical complications and other potential/negative health outcomes. Findings included . The facility's, Long Term Care Facility Dialysis Compliance Agreement, dated 12/07/2022, showed the parties desire to promote continuity of care and treatment appropriate to the needs of their patients, to use the skills and resources of their facilities in a coordinated and cooperative fashion to facilitate the provision of care to residents requiring dialysis, and to assure communication of information between the facility and the provider. The facility retains primary responsibility for the care plan, education, and staff's ability to perform necessary interventions for dialysis residents if necessary. Coordination of care may include the following: -The day(s), date(s), time(s), and place of dialysis therapy. - Transportation arrangements. - Information transmitted to the provider by the facility. - Information transmitted to the facility by the provider. - Dialysis access orders. Resident 19 was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease, dependent on dialysis (a procedure that substitutes for the functions of the kidneys). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 19's care plan, initiated on 04/08/2024, revealed the care plan lacked resident centered interventions and collaboration of dialysis care by the nursing home and dialysis staff. The care plan did not indicate what care or medications the facility would provide, nor what care the dialysis center would provide. The care plan directed staff not to draw blood or take blood pressure in the arm with the graft but did not specify which arm to avoid. The care plan did not include the location of dialysis, contact information, or the Nephrologist (physician specializing in kidneys) name or contact information. The care plan lacked care of the access site and monitoring for risk factors and managing complications such as hemorrhage, access site infection, hypotension and whom to report concerns to. There was no care plan approach to administering medications before, during, or after dialysis. In an interview on 05/20/2024 at 9:32 AM, Resident 19 stated they had been on dialysis since 2008 and knew their routine well. Resident 19 stated they were not getting their (phosphorus) binders (medication that prevents the body from absorbing the phosphorus from food they eat). Their lab work on Saturday (05/18/2024) showed their potassium lab result was high. Resident 19 said they were not on a fluid restriction. Review of Resident 19's April 2024 Medication Administration Record (MAR), showed an order on 04/10/2024 for the resident to have a Complete Metabolic Panel (CMP) and complete blood count (CBC) labs drawn upon admission. Review of a pharmacist recommendation on 05/23/2024, showed Resident 19 did not appear to have labs drawn since admission and the pharmacist requested the facility draw a thyroid Stimulating Hormone (TSH), Basic Metabolic Panel (BMP) and a CBC. Review of Resident 19's clinical record did not include any lab values other than a stool sample on 04/15/2024. Review of the current physician orders, showed Resident 19 was to be on a 1500 milliliter (ML) fluid restriction. The resident was to receive Sevelamer 800 MG -two tablets twice a day and 800 MG 3 tablets one time a day for hyperphosphatemia beginning 05/21/2024. There was no binder medication on the physician orders until 05/21/2024. The physician orders did not clarify which medications were to be given before, during, and after dialysis. In an interview on 05/24/2024 at 1:06 PM, Resident 19 said they did not receive their morning medications on days when they went out to dialysis. In an interview on 05/24/2024 at 1:55 PM, Staff M, Licensed Practical Nurse (LPN), said they just learned today there was a dialysis assessment that had to completed and Resident 19 had a dialysis communication binder. Staff M said the nurses should find out what medications were to be given before dialysis, after dialysis or if they were to be held on their dialysis day. Staff M looked at Resident 19's MAR and said there were no directions as to medications on dialysis days. Staff M said there should orders specifying what to do on dialysis days. Review of the form titled, Hemodialysis Communication, dated from 04/09/2024 through 05/27/2024, showed Resident 19 had incomplete assessment information on 20 of 22 dialysis dates reviewed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 04/11/2024, 04/13/2024, 04/20/2024, 04/25/2024, 05/07/2024, and 05/18/2024, the form showed the pre-treatment and post treatment vital signs were not obtained. -On 04/16/2024, 04/18/2024, 04/23/2024, 04/27/2024, 05/09/2024, 05/11/2024, 05/25/2024, and 05/27/2024, the facility could not locate the communication sheet - On 04/30/2024, 05/02/2024, 05/14/2024, 05/16/2024, 05/21/2024, and 05/23/2024, showed the facility's post treatment vital signs were not completed. In an interview on 05/28/2024 at 10:16 AM, Staff A, Chief Operating Officer (COO), said the facility did not have a dialysis policy. Staff A said the expectation was there was a comprehensive care plan that included communication between both doctors, and detailed responsibilities. Dialysis communication sheets were requested, Staff A said they were unaware Resident 19 did not receive their medications on dialysis mornings and they would look into it. In an interview on 05/28/2024 at 11:57 AM, Staff A said, Unfortunately the pattern of missed documentation continues. Of the three days you asked for, there was one completed. Staff A said Staff B, Registered Nurse (RN)/Director of Nursing Services, was finding out who the nurses were and addressing this. In an interview on 05/28/2024 at 3:10 PM, Staff N, RN, said they were told that the night shift nurses sent the day shift medications with the resident when they left. Staff N said Staff B had talked with the night nurse about Resident 19's medications a week ago. In an interview on 05/29/2024 at 10:45 AM, Staff Q, RN, said maybe twice in the past five months had the dialysis communication binder made it back to the facility after dialysis. Staff Q said they called the dialysis center but still do not get the binder back, so they wrote data on a piece of paper. Staff Q said they reported this issue to Staff B who said they would look into it and never heard back. Staff Q said the dialysis center told them the facility needed to send Resident 19's medications over with them when they went to dialysis, but Staff Q did not know which ones. Staff Q said they called Staff B at home and asked what medications they should send with the resident. Staff B advised them to send a pack of pills in a clear package. Staff Q told Staff B they did not know how the kidney center could identify the medications or doses. Staff Q said they did not send any medications including insulin with Resident 19 and administered only their pain pill prior to transportation to the dialysis center. Staff Q said the day shift nurses know they did not send the medications. Staff Q said they thought the day shift nurses administered the medication when the resident returned from dialysis. Staff Q said this information would be helpful to know but there was no information on the MAR, orders, or care plan about the medications or dialysis sheets. Refer to WAC 388-97-1900(1)(6)(a-c)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36787 Based on interview, and record review, the facility failed to provide sufficient qualified staff to provide care and services for 5 of 23 sampled residents (Residents 9, 185, 85, 27 and 18), 1 of 2 family complaints and 2 of 2 anonymous complaints that had concerns related to staffing on 2 of 2 halls (Portage and Ship Harbor). The facility had insufficient staff to ensure residents received prompt call light response, assistance with activities of daily living including toileting, oral care, repositioning, and meal assistance and to ensure care was completed in accordance with established clinical standards, the facility assessment, and resident's needs and preferences. These failures placed residents at risk to experience feelings of frustration, vulnerability, diminished quality of life, and unmet care needs. Findings included . <FACILITY ASSESSMENT> Review of the facility's assessment, dated 11/22/2023, showed the average daily census was 31 and the facility averaged one to four admits and one to four discharges daily. The assessment showed the Director of Nursing Services determined the staff to resident ratios based on acuity of the residents in each hall and skills and training of nursing staff. The DNS was responsible to adjust staffing schedules as needed in care of call off for illness. <ADMISSION CENSUS> Review of the facility's last 30 days of admission data, dated 05/21/2024, showed the facility admitted 17 residents. <STAFFING PATTERN> Review of the facility provided staffing pattern for the last 30 days, dated 04/20/2024 through 05/20/2024, showed that 24 of the 30 days did not have 24-hour Registered Nurse (RN) coverage in the facility. In an interview on 05/24/2024 at 2:13 PM, Staff A, Chief Operating Officer (COO), stated they were aware the facility did not have 24-hour RN coverage and stated that the facility had staffing issues and were unable to apply for a RN staffing waiver. <RESIDENT INTERVIEWS> <RESIDENT 19> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/20/2024 at 9:32 AM, Resident 19 said that on Saturday (May 18th) they were in such pain with diarrhea. The resident said It was a very long time until they got to get back to bed. The resident said they were dropped off at 2:15 PM from dialysis and they did not get them back to bed until after 10:00 PM. They said they were stuck in their chair a long, long time. Resident 19 said they were placed in their wheelchair (w/c) around 5:30 AM to go to dialysis and it was a very long day to be up. Resident 19 said the staff told them they were short staffed. Resident 19 said they had their call light on, and staff would check in on them and would say they would be back. Resident 19 stated they felt they must have offended the staff and had now been labeled. The resident said staff attitudes have changed towards them. Resident 19 said the staff were very efficient however they were short with them. The resident said they have to wait a very long time for care in the evenings. Resident 19 said they chose this facility as they were told they would get specialized care. The resident said they thought staff resented them when they ask for things. The resident stated they felt like they must have the reputation as a difficult patient. The resident stated staff told them they put their call light on too much and were taking care away from other patients. The resident would not say who the staff member or members were who had stated this to them. Resident 19 said if they were in pain or needed care, then they needed care. The resident said they understood levels of care as they used to work at the facility. <RESIDENT 185> In an interview on 05/20/2024 at 9:52 AM, Resident 185 stated said they had just admitted Friday, but Saturday was rough. Resident 185 said they put their call light on and had to wait a really long time, longer than 30 minutes. The resident stated they were not happy and when the male staff member responded they seemed frustrated that they had their call light on. Resident 185 said they knew the facility was understaffed. They said they were upset and ended up self-transferring into their w/c on their own since they could not wait any longer. <RESIDENT 85> In an interview on 05/20/2024 at 10:13 AM, Resident 85 said their only concern was staffing. Resident 85 said their roommate (Resident 19) was up way too many hours after dialysis on Saturday and it was not right. Resident 85 said the management had a lot of meetings the week prior, and staff were off the floor with only one aide covering for hours, from two to four PM. <RESIDENT 27> In an interview on 05/20/2024 at 11:24 AM, Resident 27 said they felt humiliated. The resident stated there had been a number of times, at least times four times when they requested to be changed when they had a bowel movement they had to wait, sometimes up to an hour. The resident stated they did not want to sit in their waste as feces was not good on the skin. The resident said it was not respectful to make them wait. Resident 27 said this occurred due to lack of staffing. The resident said they are understaffed so it was hard for them to get to them when they had so many residents. The resident said last night, there were only two aides in the whole facility for both sides on the evening shift. The resident said they ate dinner then waited an hour to get help. They said they were told they needed to wait. The resident reported call light waits are longer on evenings and nights. <RESIDENT 18> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/20/2024 at 11:57 AM, Resident 18 said if the aides were busy the wait times are over a half an hour. <FAMILY INTERVIEWS> In a phone interview on 05/20/2024 at 3:30 PM, Collateral Contact (CC) 3, Resident 8's family member, said they were concerned that their loved one was not being assisted to the toilet every two to three hours so they (Resident 8) would have to go in their brief. CC 3 said they were concerned for staff who worked so much. <ANONYMOUS CONCERNS> Review of an anonymous complaint (AC-1), received on 05/09/2024, stated the facility was understaffed, especially on evening and night shifts. AC-1 stated they sometimes have only one nursing assistant on for the shift and reported resident cares were not getting done due to lack of staffing to provide basic and preventative care. In an anonymous interview, date and time not included to protect anonymity, Anonymous Staff A (AS-A), stated that suddenly the facility was short staffed. AS-A said, they had worked a shift with 36 or 37 residents and two nurses. They said one nurse helped them, but the other nurse didn't. AS-A stated the facility was short staffed a lot. AS-A stated the nurse's called management, but they do not come into help. AS-A said the staffing posting was not accurate and that it said three aides were on yesterday when there were only two aides scheduled. AS-A said they met with the new Administrator about their staffing concerns and felt blown off. AS-A said the facility had lots of dependent residents who required two staff to turn them. AS-A said they kept admitting residents when there were staffing issues. AS-A stated they had three new admits on a Sunday (date not included to protect anonymity). AS-A said there was not enough staff for all these residents, but they did the best they can. AS-A said the residents complained about the long call light times and that there was not enough staff. AS-A said the residents are worried because we look so tired. AS-A said there just was not enough of us. The aides all talk about how short staffed they work. <RESIDENT COUNCIL MINUTES> -Review of the resident council minutes, dated 05/16/2023, showed the residents voiced the facility needed more aides and nursing staff to function properly and better. Residents asked that aides did not check on the residents throughout the shift to anticipate resident needs. Residents reported call light times were terrible and they did not want the restorative aide pulled to the floor from their duties. - Review of the resident council minutes, dated 06/08/2023, showed the residents reported call light response times were slower on evening shift and more aides needed to be hired. Residents said to enhance their stay they don't want the restorative aide pulled to the floor. - Review of the resident council minutes, dated 07/18/2023, showed the residents reported call lights seemed to be getting worse especially on evening shift. Residents commented more aides would be nice. Residents said that more restorative care would be nice and for the restorative aide not to be pulled to the floor all the time. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of the resident council minutes, dated 08/22/2023, showed the residents reported night shift seemed to be slower on responding to call lights. The residents requested weekend restorative aide and for the facility to stop pulling the restorative aide to the floor. - Review of the resident council minutes, dated 09/27/2023, showed the residents reported aides needed to be more present. Residents said that aides and nurses tell them they were short staffed and that was why they (staff) were short tempered. - Review of the resident council minutes, dated 10/17/2023, the residents said they would like more showers. - Review of the resident council minutes, dated 11/21/2023, showed the residents would like the aides to check rooms routinely, so residents don't have to hit the call lights for things that were not important. - Review of the resident council minutes, dated 12/28/2023, showed the residents reported there were long delays with call lights. The residents said they would like staff to make themselves more available and do rounds before lights were necessary. The residents voiced concern that it was easy to tell some aides were not happy working with them. - Review of the resident council minutes, dated 01/16/2024, showed the residents reported they would like staff not to act so rushed as they feel they cannot ask questions. Residents reported staff give them attitude when they ask for hydration or hydration with ice, and it makes them not want to ask for help because of negative attitudes. Cold food delivery was reported as well. - Review of the resident council minutes, dated 02/29/2024, showed the residents reported response time to call lights needed improvement and they would like facility to hire more aides. Residents voiced concern about night shift aides needed to work on bedside manner and being empathetic to resident needs. - Review of the resident council minutes, dated 03/06/2024, showed the residents reported call light response time needed to be improved. - Review of the resident council minutes, dated 04/30/2024, showed the residents reported their stay would be more helpful if staff would come back to assist after they turn off their call light and state when they will return. Residents said the staff tend not to come back. <RESIDENT COUNCIL MEETING> During a resident council meeting with the surveyor on 05/22/2024 at 10:03 AM, residents were asked about staffing in the facility: - Resident 185 stated they felt bad for the staff because they were unable to do their jobs properly because of management. Resident 185 said last week was horrible. They stated the facility did not have a sufficient number of staff. - Resident 9 stated when the facility is short staffed, there is a delay in their call light being answered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<STAFF INTERVIEWS> In an interview on 05/23/2024 at 2:29 PM, Staff I, Nursing Assistant Certified (NAC), said they were working a double shift that day. Staff I said there were times when there were only two aides on the PM shift, and they could not get everything done. Staff I said currently there were five residents who required to be transferred with a mechanical lift with two-person assist. Staff I said there were seven residents who required two staff for bed mobility. Staff I said when there were only two aides, they could not assist the residents who required feeding assistance on time as that left one aide on the floor to pass hall trays, and no one to answer the call lights. Staff I said there were four residents who depended on the aides to help them eat and others that required supervision and cueing at meals. Staff I said the aides did not get to oral care or turning residents every two hours when there were two aides on evening shift. Staff I said they couldn't take their breaks or there was one aide on the floor. In an interview on 05/23/2023 at 2:49 PM, Staff AA, NAC, said there was usually two aides on evening shift. Staff AA said in January (2024) the facility went down from three NAC's on evening shift to two NAC's. Staff AA said there were also more residents to care for now than back in January (2024). Staff AA said management just told them Well there are only two of you. Staff AA said they had to prioritize which residents needed feeding assistance. Staff AA said if residents did not eat well, they were left in bed with their head of bed up to 90 degrees and their trays in front of them. Staff AA said they tried to get to everyone when there were just two NAC's working. Staff AA said it was hard when residents were on their call lights every five minutes. Staff AA said there have been six recent times when there was only one aide on shift and one nurse, and that management was aware. In an interview on 05/23/2024 at 4:07 PM, Staff A was asked to provide the nursing and NAC hours per shift beginning March 1, 2024. Staff A, COO said they could provide the daily staffing sheets. Staff A was asked about the staffing sheets for Tuesday (05/21/2024) evening shift, showed there were three NAC's on when there were only two NAC's working that shift. Staff A said they had night shift call ins. In an interview on 05/24/2024 at 12:36 PM, Staff G, NAC, said there were times when there were only two aides on evening shift, and it happened more often than it should. Staff G said sometimes two aides were sick and there was only one aide. Staff G said the resident notice when they were short staffed because wait times were longer. Staff G said they tried not to tell the residents they were short staffed. Staff G said there were five mechanical lift residents and ten residents who required two person assistance for bed mobility. In an interview on 05/24/2024 at 1:24 PM, Staff L, NAC/Scheduler, said the facility's current open positions were two full time and part time evening shifts NAC's. Staff L said management wanted them to have three NAC's on evenings but when somebody calls out, there was no coverage. Staff L said the staff complain to them that they cannot provide the care with two NAC's on evening shift. Staff L said they were told they could absolutely not have agency assist us. In an interview on 05/28/2024 at 9:41 AM, Staff L said there have been evening shifts with only one aide, but the Administrator would often stay to help. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/28/2024 at 10:29 AM, Staff Q, Registered Nurse (RN), said they were the only nurse for up to thirty-seven residents and did not have enough time to complete their required work each day. Staff Q said the evening shift before them were to have three aides but when they had one, they could not complete their responsibilities. Staff Q said they did not feel supported from upper management. Staff Q said they told Staff B, Director of Nursing Services (DNS), if they were left with one aide, they would need to hire another nurse. In an interview on 05/28/2024 at 9:23 AM, Staff Z, Licensed Practical Nurse (LPN), said they tried to get all their tasks completed. Staff Z said there were times there was only one aide on evening shift and at times the administrator would help out, but they were not an aide. Staff Z said they were concerned that there was only one restorative aide who only works during the week and was pulled to the floor from their duties. In an interview on 05/29/2024 at 12:25 PM, Staff A were informed there were numerous complaints from residents about call light response times on evening and night shifts as well as family and staff concerns. Staff A said they had rapid response help them with staffing, but they were below the 3.4-hour mandate overall. Staff A said the facility saw a spike in census over the past month, so the staff were used to caring for less residents. Staff A said they had the same staffing for some time. Staff A said they completed a wage analysis and added staff bonuses and sign on bonuses. Staff A said they used agency in August but felt they were destructive. Staff A said they only had two open positions on evening shift. Refer to WAC 388-97-1080 (1)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 36787 Based on interview, and record review, the facility failed to ensure Licensed Nurses (LN) and Nursing Assistants Certified (NAC) had the appropriate competencies, skills sets and proficiencies to provide nursing and related services for each resident in accordance with the facility assessment when nursing staff failed to demonstrate the knowledge, skills and abilities to perform nursing services for 6 of 6 sampled staff (Staff C, D, H, P, S, and BB) reviewed for competent nursing staff. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the Facility Assessment, updated on 11/22/2023, showed nurse aides would participate in an annual skill fair and are assessed annually for care competencies by qualified nurses. Licensed nurses were also assessed each year for skills/competencies by qualified nurses and consultant educators, in various areas such as IV (intravenous) care, medicine administration/pass, and wound care. The facility would address areas of weakness as determined in nurse aides' performance reviews. Copies of these competency assessments were available for review. Staff C, Registered Nurse (RN)/Resident Care Manager, was hired by the facility on 06/14/2023. Staff C's training records did not include documentation they were assessed to be competent to provide nursing services to the facility's resident population. Staff D, RN, was hired by the facility on 12/01/2019. Staff D's training records did not include documentation they were assessed to be competent to provide nursing services to the facility's resident population. Staff H, NAC, was hired 05/10/2023. Staff H's training records did not include documentation they were assessed to be competent to provide nursing services to the facility's resident population. Staff P, RN, was hired 12/01/2019. Staff P's training records did not include documentation they were assessed to be competent to provide nursing services to the facility's resident population. Staff S, Licensed Practical Nurse (LPN), was hired 01/23/2024. Staff S's training records did not include documentation they were assessed to be competent to provide nursing services to the facility's resident population. Staff BB, NAC, was hired 09/26/2023. Staff BB's training records did not include documentation they were assessed to be competent to provide nursing services to the facility's resident population. In an interview on 05/24/2024 at 10:53 AM, Staff A, Chief Operating Officer, stated competencies had not been completed for any staff and they were completing them now. Refer to WAC 388-97-1080 (1), -1090 (1), -1680 (2)(a)(b)(i-ii)(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview, and record review, the facility failed to consistently provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 sampled residents (Resident 19). Failure to ensure timely processing and administration of ordered medications placed residents at risk for discomfort and pain, anxiety, and unmet needs. Findings included . Resident 19 admitted to the facility on [DATE] with diagnoses to include end stage renal (kidney) disease (is an advanced stage of chronic kidney disease, when the kidneys can no longer filter wastes and fluids from the body), depression, and gout. Review of the Admission Minimum Data Set (an assessment tool) assessment, dated 04/15/2024, showed Resident 19 was alert, oriented and able to make their needs known. Resident 19 had moderate pain and was on a scheduled pain medication regimen with as needed pain medications and non-medication interventions for pain relief. Resident 19 had pain frequently that interfered with their sleep, therapy, and day to day activities. Review of Resident 19's 04/09/2024 to 04/30/2024 Medication Administration Record (MAR), showed the resident was to receive Lidocaine external patch 4% to their back topically every morning for pain beginning 04/09/2024. Review of the MAR documentation showed on 04/23/2024, the lidocaine patch was not administered, and was coded as 6 (hospitalized). Review of the progress notes showed the resident was not hospitalized on [DATE]. On 04/25/2024, the lidocaine patch was not administered and was coded as the resident was out of facility. There was no documentation explaining why the medication was not administered. Review of Resident 19's 05/01/2024 through 05/23/20204 MAR documentation showed: -On 05/07/2024, 05/09/2024, and 05/23/2024, the lidocaine patch was not administered, and was coded the resident was out of facility. - On 05/20/2024 ad 05/21/2024, the lidocaine patch was not administered, and was coded a 5, which indicated the medication was held/see nurse notes. Review of Resident 19's progress notes for 05/07/2024, 05/09/2024, 05/20/2024, 05/21/2024 and 05/23/2024, showed there was not documentation as to why the medication was not administered. In an interview on 05/22/2024 at 12:35 PM, Resident 19 stated they were sleepy as the facility was out of their Lidocaine patches and they had to resort to pain pills. Resident 19 said they were getting too many pain pills and were sleepy as a result. The resident said the nurse told them they were out of their lidocaine patches although they had observed their roommate getting a patch placed on them. Resident 19 stated I don't know what is going on. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the central supply order posted at the nurses station showed an entry for 05/24/2024 for 5 boxes of Lidocaine patches. In an interview on 05/24/2024 at 1:06 PM, Resident 19 said they went five to seven days without their Lidocaine patches. The resident said they had increased their pain medications to what was allowed but became sedated. The resident commented the pain medications were too much. In an interview on 05/28/2024 at 3:02 PM, Staff M, Licensed Practical Nurse (LPN), said the facility did run out of Resident 19's Lidocaine patches for a few days. Staff M said they had a lot of residents using them but had not had a delivery. Staff M said they notified the doctor but did not document that. Staff M said they did not inform the Director of Nursing Services about the missed medications or that they were out of the Lidocaine patches. In an interview on 05/29/2024 at 12:34 PM, Staff A, Chief Operating Officer, said they were unaware of the issue with Resident 19 not receiving their medication. Staff A said this was an issue to fix right now. Refer to WAC 388-97-1300 (1)(b)(ii)(3)(a)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to ensure 2 of 5 sampled residents (Resident 7 and 27) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure person-centered behavioral interventions were in place, appropriate indications were present for psychotropic medications and that residents received gradual dose reductions. These failures placed the residents at risk for medication-related complications and for receiving unnecessary psychotropic medication. Finding included . As referenced in the Food and Drug Administration (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. Review of facility policy titled, Antipsychotic and Psychotropic Medication Use, dated 10/28/2023, showed antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses including dementia, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 05/14/2024, showed the resident had severe cognition impairment, with one to three episodes of rejection of care during the seven-day look back period. The resident was currently taking an anti-psychotic medication with no gradual dose reduction (GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) attempted. Review of Resident 7's current physician orders, showed an order for quetiapine fumarate 12.5 milligrams (mg) daily for the diagnosis of dementia with behavioral disturbances, started 11/14/2023. There was an order directing the license nurse to monitor and document the number of times Resident 7 exhibited agitation and psychosis every shift, start date of 02/16/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's electronic medication administration record (EMAR), dated 03/01/2024 to 05/28/2024, showed no monitoring for the resident's non-pharmacological interventions to prevent, or the effectiveness of the interventions. The documentation/monitoring of their behaviors was as follows: - March 2024, there was a dash for one day, and a plus sign on another day, and there was no other documentation provided. - April 2024, the documentation showed a plus sign on three different dates, and there was no other documentation provided. - 05/01/2024 - 05/28/2024, the licensed nurse documented their behavior occurred once, and there was no other documentation provided. In an interview on 05/24/2024 at 8:26 AM, Staff W, Registered Nurse (RN), stated that most of the orders are processed by either Staff B, RN/Director of Nursing Services (DNS), or Staff C, RN/Resident Care Manager (RCM). Staff W stated the behavior monitoring was updated by Staff B and/or Staff C. Staff W stated if the resident was on alert for a new behavior the nurses would document this information in the progress notes. In an interview on 05/28/2024 at 10:36 AM, Staff N, RN, stated they monitor and document the resident behaviors in the electronic medical record and on the behavioral charting. Staff N stated if there was a new behavior they would document it in the resident's progress notes. Staff N stated Resident 7 had intermittent sundown (abnormal behavior in the evening times) behavior and could be difficult at times. In an interview on 05/28/2024 at 12:05 PM, Staff C stated it was the expectation that they monitor all residents with behaviors. Staff C was not aware if the facility monitored interventions or the effectiveness of those interventions. Staff C stated when a resident admitted to the facility either themselves or Staff B had been responsible for updating the physician orders and consents to treat and administer the psychotropic of medications. Staff C was not aware of Resident 7's Abnormal Involuntary Movement Scale Assessment (AIMS assessment required to be completed on admission for any resident on an anti-psychotic medication to assess) was not completed on admission and was not conducted till February/2024. Staff C was not aware that dementia with behaviors was not an acceptable indication for use of an anti-psychotic medication. Staff C stated Resident 7 had been on the medication at home, and that was all they were aware of. In an interview on 05/28/2024 at 1:41 PM, Staff B said that themselves or Staff C had been responsible for new admission paperwork such as verification of physician orders, obtaining consents for medications, and updated behavior monitoring and diagnosis. Staff B stated it was their expectation that all psychotropic medications have behavior monitoring with non-pharmacological interventions, and effectiveness of interventions for the licensed staff to document on every shift. Staff B was not aware dementia with behaviors was not an acceptable indication for use of an anti-psychotic medication, and this was listed as a diagnosis for Resident 7 anti-psychotic medication. Staff B was not aware the AIMS assessment was not completed on admission for Resident 7 or that there were no non-pharmacological interventions in place on the physician orders. <RESIDENT 27> (continued on next page)

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	505216	A. Building B. Wing	05/29/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 27 admitted on [DATE] with diagnoses to include kidney disease and diabetes. Review of Resident 27's Admission MDS assessment, dated 04/29/2024, showed the resident had no cognitive impairment and was taking an antidepressant. The MDS showed the resident had depression and an anxiety disorder. Review of Resident 27's current diagnoses list did not include an anxiety disorder or depression. Review of Resident 27's current physician's orders, showed an order for escitalopram 5 mg (antidepressant) on admit and was increased to 10 mg on 05/16/2024. Review of Resident 27's the pharmacist medication review, dated 05/22/2024, directed staff to add behavior monitoring for the use of escitalopram. Review of the EMAR on 05/24/2024, showed there was no behavior monitor in place for escitalopram. This is a repeat citation from survey dated 03/13/2023. Refer to WAC 388-97-1060(3)(k) 44110

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44110 Based on observations, and interview the facility failed to ensure drugs and biologicals were stored in accordance with state and federal laws 1 of 1 medication storage rooms. The facility failed ensure vaccines were dated when opened and failed to ensure Schedule II-V (Substances with a high potential for abuse which may lead to severe psychological or physical dependence) controlled medications were in a separate locked permanently affixed compartment, and access to the locked box was not accessible to others. These failures placed residents at risk for having unintended access to drugs that should have been securely stored. Findings include . Review of the facility policy titled, Controlled Substances, dated 2024, showed only authorized staff should have access to controlled drugs . controlled medication was locked at all times and access was recorded .the Director of Nursing Services (DNS) maintains a list of who has access to controlled substances containers. In an observation and interview on 05/24/2024 at 1:32 PM, with Staff C, Registered Nurse (RN)/Resident Care Managers (RCM) present the medication refrigerator in the medication room was observed to have a can of [NAME] Light Beer with no name or date, there were two bottles of Afluria (influenza vaccine) that were both opened with no date of when the bottles were opened, one open bottle of Apisol (used to administer a tuberculin (TB) skin test for TB screens) that was undated, and a locked black box that was not affixed to the refrigerator. Staff C stated they did not have a key for the box. In an observation and interview on 05/24/2024 at 1:45 PM, with Staff C and Staff B, RN/DNS were asked to unlock the black lock box in the medication refrigerator. Staff B and Staff C said that was going to be a problem we are not sure who has the key to that box. Staff C then stated they knew the nurse cart for the Ship Harbor hall did not have a key, they would go ask the nurse on the Portage hall to see if they had a key for the black lock box. Staff W, RN, then walked down to the medication storage room and retrieved a key that was hanging on the wall near the door, that was labeled lock box and handed it to Staff C. Staff C then proceeded to open the black lock box which had four unopened vials of Lorazepam (Scheduled IV injectable anti-anxiety medication), and one unopened liquid bottle of Lorazepam (for ingestion). Staff C stated that the lock box keys should not be located on the wall and was unaware the box must be permanently affixed to the refrigerator. In an interview on 05/29/2024 at 9:14 AM, Staff A, Chief Operating Officer, stated they were unaware the key for the black narcotic lock box was hanging on a wall, or that the lock box needed to be permanently affixed to the refrigerator. This is a repeat citation from survey dated 03/13/2023. Refer to WAC 388-97-1300(2)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 47047 Based on interview, and record review, the facility failed to ensure the person designated to serve as the Director of Food and Nutrition Services (Staff J) had the proper qualifications. This failure placed all residents at risk of receiving dietary services from staff without the required competencies and skills to carry out food and nutrition services. Findings included . In a review of the staff list showed Staff J had been employed at the facility since 12/07/2021. On 05/23/2024 11:12 AM, Staff J, Dietary Manager (DM), stated they were not a certified DM. Staff J stated they been in the position for a short time and was not enrolled in a program to obtain their certification. On 05/23/2024 at 12:14 PM Staff A, Chief Operating Officer, stated Staff J had been in the position a short time and they were working getting Staff J enrolled in a program to obtain their certification. Refer to WAC 388-97-1160 (2)(3)(a)(b)(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observation, interview, and record review the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and national standards of practice for 2 of 2 hallways (Portage and Ship Harbor) throughout the facility. The facility failed to ensure the implementation of Enhanced Barrier Precautions (EBP) for 14 of 14 residents (Resident 30, 6, 9, 19, 17, 12, 2, 13, 16, 4, 235, 188, 189, and 190) reviewed for transmission-based precautions. The facility failed to establish an infection surveillance plan for a Coronavirus Disease 2019 Outbreak (COVID-19 -an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise [a general feeling of discomfort/uneasiness], headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) for 29 of 35 residents. they failed to implement a respiratory protection plan (RPP) for 28 of 59 employed staff, and failed to assess, monitor, and establish a water management plan for the facility that could place the facility residents and staff at an increased risk for Legionella or other opportunistic waterborne pathogens in the facility's water system. These failures place all residents and staff at risk for potential infections. Findings include . Review of the facility policy titled, Infection Prevention and Control Program, dated June/2023, showed that the elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, outbreak management, prevention of infection, and employee health and safety. The facility will include an infection control risk assessment to assist in guiding practice, utilization of current standards of practice and recognize guidelines. Review of the facility policy titled, Respiratory Protection Plan, undated, showed the facility will have a designated program administrator who will oversee the development, and effectiveness of the program to protect against transmission of certain airborne diseases for their employees such as Nursing Assistant Certified (NAC), Licensed Nurses, maintenance staff, housekeeping staff, rehabilitation therapists, administrative staff, and others. The program administrator will ensure the program was reviewed regularly, ensure policies and procedures are followed, respirator (type of breathing mask that filters certain particles) use was monitored, and education as needed was given. Review of the facility policy titled, Enhance Barrier Precautions, dated 04/01/2024, showed that EBP are utilized to prevent the spread of MDRO's to residents. EBP employ targeted gown and glove use during high contact resident care activities for residents with wounds or device/indwelling tube care. High contact activities could be but not limited to dressing, bathing, transferring, providing hygiene, changing linens, and/or assisting with toileting. Staff are trained prior to caring for residents on EBP's. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Center for Disease and Control (CDC) document titled, Implementation of Personal Protective Equipment (PPE) use in nursing homes to prevent spread of multidrug-resistant organisms (MDROs), updated 04/02/2024, showed the following: EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. <ENHANCED BARRIED PRECAUTIONS> RESIDENT 30 Resident 30 admitted to the facility on [DATE] with diagnoses including history of a stroke with right side weakness, and difficulty swallowing. The resident admitted to the facility with an indwelling urinary catheter (tubing inserted into bladder to aid in urination), and a percutaneous endoscopic gastrostomy (PEG -tube inserted into the stomach to aid in supplemental nutrition) tube. In an observation on 05/20/2024 at 8:58 AM, Resident 30 was observed lying in their bed, an unknown staff member was in the room assisting the resident with personal care. The unknown staff member was wearing gloves, no other PPE was used. There was no implementation of EBP. In an interview on 05/21/2024 at 2:32 PM, Collateral Contact (CC) 2, family member of Resident 30, stated they come to the facility every day and sit with the resident most of the day. CC2 stated when the staff come into the resident's room to provide catheter care or PEG tube care they only wear gloves, no other PPE was used. In a continuous observation and interview on 05/22/2024 at 9:39 AM, Staff V, Occupational Therapist (OT), was observed to enter Resident 30's room and ask the resident if they were ready to get out of bed. Staff V was observed to place gloves on, and no other PPE. Resident 30 requested privacy. At 10:17 AM, Staff V was observed to exit the resident's room. Staff V stated they assisted the resident to get out of bed, they assisted the resident to the restroom, and assisted the resident to get dressed and into their wheelchair. Staff V stated they only wore gloves for PPE and stated they had not been educated on EBP. Staff V stated if the resident was on transmission-based precautions (TBP) there would be sign notification on the door directing what type of care was required, and an isolation bin with appropriate PPE supplies outside of the room. RESIDENT 6 Resident 6 admitted to the facility on [DATE] with diagnoses including history of a stroke, with right side weakness. The resident admitted to the facility with an indwelling urinary catheter (tubing inserted into bladder to aid in urination). In an observation on 05/21/2024 at 1:03 PM, Staff L, NAC, was observed to assist Resident 6 back to their room to provide personal care. Staff L was observed to enter room, with gloves, no other PPE was used. There was no implementation of EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a continuous observation and interview on 05/22/2024 at 12:31 PM, Staff L assisted Resident 6 to their room in a wheelchair and lie them down in bed using a mechanical lift. Staff L was observed to place gloves on their hands, as they assisted the resident to transfer from wheelchair to bed. Staff L was observed serval times during the transfer to handle the resident's urinary catheter bag with only gloves as their only PPE. Staff L stated they only used gloves as PPE to provide care to Resident 6, as they did not have an active infection and were not on any transmission-based precautions. RESDIENT 9 Resident 9 admitted to the facility on [DATE] with diagnoses including history of a stroke with left side weakness, and difficulty swallowing. The resident admitted with a PEG tube. RESIDENT 19 Resident 19 admitted to the facility on [DATE] with diagnoses including kidney disease, and diabetes. The resident admitted with a central venous line (small tube inserted into vein directly to the heart). RESIDENT 17 Resident 17 admitted to the facility on [DATE] with diagnoses including atrial fibrillation (irregular heart function), fracture of right leg and left collar bone. The resident admitted to the facility with a wound to right hip and buttocks. RESIDENT 12 Resident 12 admitted to the facility on [DATE] with diagnoses including obstruction of kidneys and urinary flow. The resident admitted with a left nephrostomy tube (tube inserted into the kidney for urinary function). RESIDENT 2 Resident 2 admitted to the facility on [DATE] with diagnoses including heart failure and diabetes. As of 05/20/2024, the resident had an open wound to their abdomen. RESIDENT 13 Resident 13 admitted to the facility on [DATE] with diagnoses including urinary infection and kidney failure. The resident admitted to the facility with an indwelling urinary catheter, and two open wounds to their buttocks. RESIDENT 16 Resident 16 admitted to the facility on [DATE] with diagnoses including fracture of the left leg, kidney failure and diabetes. The resident admitted to the facility with multiple open wounds to the right foot and buttocks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	RESIDENT 4 Resident 4 admitted to the facility on [DATE] with diagnoses including heart failure, respiratory failure, bone infection to left foot. The resident admitted to the facility with an indwelling urinary catheter, and open wounds to left foot. RESIDENT 235 Resident 235 admitted to the facility on [DATE] with diagnoses including surgical hip replacement, urinary dysfunction. The resident admitted to the facility with an indwelling urinary catheter, and open wound to left hip. In an observation on 05/20/2024 at 10:28 AM, an unknown staff member was observed to empty Resident 235's catheter with gloves, no other PPE was used. There was no implementation of EBP. RESIDENT 188 Resident 188 admitted to the facility on [DATE] with diagnoses including kidney disease, and high blood pressure. The resident admitted with a chest port (small implantable device directly attached to a vein). RESIDENT 189 Resident 189 admitted to the facility on [DATE] with diagnoses including surgical left hip replacement, and dysfunctional bladder. The resident admitted to the facility with an indwelling urinary catheter, and open wound to left hip. RESIDENT 190 Resident 190 admitted to the facility on [DATE] with diagnoses including surgical aftercare of skin and subcutaneous tissue (fat layer) to their back, and urinary retention. The resident admitted to the facility with an indwelling urinary catheter, and open wound to their back. OBSERVATIONS/INTERVIEWS In an observation on 05/20/2024 at 1:58 PM, during walking rounds no resident in the facility was observed to be on EBP. In an observation on 05/22/2024 at 8:33 AM, during walking rounds no resident in the facility was observed to be on EBP. In an observation on 05/23/2024 at 9:30 AM, during walking rounds no resident in the facility was observed to be on EBP. In an interview on 05/23/2024 at 10:03 AM, Staff K, NAC, stated they direct the individual care based on the care plan. Staff K stated they were not clear on what EBP was, and that at this time there was no resident on any TBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 05/24/2024 at 10:12 AM, Staff L stated they were not clear as to what EBP was, and that at this time there was no resident on any TBP. In an observation on 05/24/2024 at 9:30 AM, during walking rounds no resident in the facility was observed to be on EBP. In an interview on 05/24/2024 at 11:54 AM, Staff U, Licensed Practical Nurse (LPN), stated they were going to be the infection preventionist for the facility starting 06/01/2024. Staff U stated were not clear on what EBP was, they stated they were not sure about the process or how and when to apply them. In an observation on 05/28/2024 at 9:57 AM, during walking rounds no resident in the facility was observed to be on EBP. In an interview on 05/28/2024 at 10:36 AM, Staff N, Registered Nurse (RN), stated they had not had any education on EBP. In an interview on 05/28/2024 at 12:05 PM, Staff C, RN/Resident Care Manager stated that residents with wounds or indwelling tubes only required standard precautions. Staff C was not aware of EBP, and stated they assumed when Staff U took over the infection prevention role, they would be handling that. In an observation on 05/29/2024 at 8:30 AM, during walking rounds no resident in the facility was observed to be on EBP. <OUTBREAK MANAGEMENT> RESIDENT 187 Resident 187 admitted to the facility 02/15/2024, diagnoses to including liver disease, and diabetes. The resident was alert and oriented, able to make their needs known, and was at the facility for rehabilitation with the goal to return home when stable. The resident had no respiratory concerns and was not on any supplemental oxygen. Review of the infection control log 12/22/2023 - 04/30/2024, showed that Resident 187 contracted COVID-19 on 02/27/2024. The log showed the resident had functional decline and signs of a common cold. The log showed the resident was resolved on 03/09/2024. Review of Resident 187 medical record showed on 03/05/2024, showed the resident was found to be weak, with shallow respirations, and required supplemental oxygen to breathe. The resident was discharged on [DATE] home on hospice (end of life) services. Review of the infection log dated 12/22/2023 - 04/30/2024, showed the facility had a COVID-19 outbreak from 02/21/2024 - 03/09/2024. The log showed 29 residents contracted COVID-19. The log did not reflect staff effected by the outbreak. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 05/23/2024 at 3:55 PM, Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS), stated the outbreak was hard, practically the whole building except six residents had contracted COVID-19, and a lot of the staff too. In an interview on 05/24/2024 at 10:12 AM, Staff L stated that the COVID-19 outbreak was overwhelming, and spread quickly throughout the building, and that a lot of staff were out sick. In an interview on 05/24/2024 at 11:07 AM, Staff T, Regional Clinical Nurse, a request was made for the analysis of the COVID-19 outbreak. Staff T provided copy of infection log, the documentation had no analysis, surveillance monitoring, employee data, or review of the outbreak. <RESPIRATORY PROTECTION PLAN> In a review of an untitled document on 05/20/2024, was submitted by the facility with their respiratory protection policy and procedure. The untitled document was not dated and listed the all the staff for the facility, their date of hire and the date when they were due for a fit test. There were 59 employees listed, and there were 28 that had not been fit tested . The staff not fit tested included, NAC's, licensed nurses, therapy staff, kitchen staff, housekeepers, and administration staff. In an interview on 05/24/2024 at 11:54 AM, Staff U, LPN, stated they had just recently had training to conduct respirator screening, and that they would become the Respiratory Program Administrator starting 06/01/2024. Staff U stated the facility had not had anyone in that role since the previous infection preventionist left in December/2023. <WATER MANGEMENT> On 05/21/2024 a request to the facility was made for the facility water management plan for Legionella and other potential water borne pathogens. None was received. On 05/24/2024 a second request was made to the facility for their facility water management plan for Legionella and other potential water borne pathogens. None was received. In an interview on 05/28/2024 at 1:41 PM, Staff B confirmed the facility was not currently complying with the infection control national standards as they had not implemented EBP at this time. Staff B stated they had expressed to the higher ups that they needed to implement EBP but the higher ups were not happy about it. Staff B stated it was hard to get new things implemented with an interim administration. Staff B was asked why an assessment of the COVID-19 outbreak was not completed, Staff B stated they did not complete a summary, and that they had just been piecing it together. Staff B was asked if there was a report for how many staff contracted COVID-19 during the outbreak, Staff B was unable to provide that information. Staff B was asked about the facility Respiratory Protection Plan, and they stated that Staff U would take that over when they came on to the facility 06/01/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 05/29/2024 at 9:14 AM, Staff A, Chief Operating Officer, stated the facility had been aware that EBP should be implemented. Staff A stated they were not aware of the details; however, they knew that Staff T, had started education on EBP about six months ago. Staff A stated the facility was to implement in a three-step process and was unable to provide an answer as to why it had not been completed. Staff A was unaware that the COVID-19 outbreak was not investigated, and stated their expectation was for all investigations there would be a root cause analysis completed with the interdisciplinary team to see how the facility could do better for the residents. Staff A was unaware that there was no facility infection risk assessment, or that there was no water management plan. No further information was provided. Refer to WAC 388-97-1320(1)(a)(2)(a-c)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44110 Based on interview, and record review, the facility failed to ensure the designated Infection Preventionist (IP) met the qualifications for experience, education, and training or certification for the role to assume responsibility for the facility's Infection Prevention Control Program (IPCP). This failure placed residents, family members, and staff at risk for unmet infection control issues and lack of oversite of the facility staff's infection control practices. Findings included . Review of the facility policy titled, Infection Prevention and Control Program (IPCP), dated June/2023, showed that the facility was to designate an infection prevention specialist (Infection Preventionist [IP]) who would be responsible for coordinating and overseeing the IPCP. The IP would incorporate the antibiotic stewardship program, and would be qualified through special training certification, education, and experience . Duties included but not limited to surveillance, antibiotic stewardship, data analysis, outbreak management, prevention on infections, immunizations, safe injectable medication administration, and employee health and safety. In an interview on 05/20/2024 at 9:22 AM, Staff A, Chief Operating Officer, stated Staff B, Registered Nurse/Director of Nursing Services, was the facility's IP. In a review of the credentials provided by the facility on 05/20/2024 as their IP credentials, was a certificate of participation for another licensed nursing facility not associated with this facility for participation an infection control assessment and response program from March 1, 2018. No facility staff name was listed on the certification. No other certification was provided. Review of the staff roster provided by the facility on 05/20/2024 reflected there was no IP on the facility's staff roster. In an interview on 05/20/2024 at 1:23 PM, Staff A stated the facility was in a transition period for the IP role. They have hired a Licensed Practical Nurse (LPN) that had completed their training. Staff A was unable to give a date as to when this new employee would be in the IP role. In an interview on 05/23/2024 at 10:56 AM, Staff T, Clinical Regional Nurse, stated they have had turnover in the IP role, and they were not sure what had been completed with the infection control program related to antibiotic stewardship, analysis, and assessment of infections. In an interview on 05/24/2024 at 11:07 AM, Staff T stated they had been able to locate some of the antibiotic stewardship information for January 2024 - March of 2024, there was no information for April 2024 or May 2024. Review of the documents provided by the facility on 05/24/2024, showed a map of the facility with colored dots indicating infections of various types for January 2024 - March 2024. The documents had not analyzed, management, or assessment of the data. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505216	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Soundview Rehabilitation and Health Care Inc	1105 27th Street Anacortes, WA 98221

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 05/24/2024 at 11:54 AM, Staff U, LPN, stated were employed at the sister assisted living facility and would be taking over the IP role as of 06/01/2024. Staff U stated they had completed their IP certification as of March 6th, 2024. Staff U stated the facility had not had an IP since the last one left in December/2023 and that a whole bunch of us have just been piecing it together. Staff U stated that Staff B and Staff T had been responsible for most of the infection control practices at the facility. In an interview on 05/28/2024 at 1:41 PM, Staff B stated the IP role had been a mix of them and Staff T. Staff B was asked if they had an IP credentials or certification, and they responded by stating I have this one, and pointed to the certificate for from another facility (not associated with this facility) with no name on it. Staff B was asked if they could provide any documentation that showed they had participated in an infection control training program, and they stated they were not sure where that information was. Staff B was not aware if Staff T had any infection control specialized training for the role of IP (Staff T was unavailable for interview). In an interview on 05/29/2024 at 9:14 AM, Staff A agreed that the certification provided for the role of IP did not have a staff employee name, nor did it specify what the certification was for. Staff A was unaware of any other documentation to support Staff B or Staff T as qualified to fill the role as the IP for the facility. Refer to WAC 388-97-1320(1)(a)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 36787 Based on record review, and interview the facility failed to develop, implement and maintain an in-service training program ensure 2 of 2 Nursing Assistant's (Staff H and BB) reviewed for the required 12 hour of nurse aide training per year. The failure to ensure Nursing Assistants Certified (NACs) received 12 hour per year in-service training placed residents at risk for potential unmet care needs. Findings included . Review of the Facility Assessment, updated on 11/22/2023, showed the facility utilizes the following training topics during all staff in-services or department meetings at multiple times throughout the year: - Communication - effective communications for direct care staff with residents/family. Resident's rights and facility responsibilities - educate staff members on the rights of the resident and the responsibilities of a facility to properly care for its residents. - Abuse, neglect, and exploitation - educate staff on: (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or misappropriation of resident property; and (3) Care/management for persons with dementia and resident abuse prevention. - Infection control - education of staff on infection prevention and control standards, policies, and procedures, including proper hand hygiene and the use of personal protective equipment (PPE) in following isolation precautions as necessary. - Culture change (that is, person-centered and person-directed care). - Required in-service training for nurse aides (CNAs and NARs). In service training must: be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. -Include dementia management training and resident abuse prevention training. <EMPLOYEE FILE REVIEW> Review of Staff H, NAC, and BB, NAC, employee file showed each NAC did not have documented evidence of 12 hours of in-servicing. Review of the in-service records showed the facility failed to document how long the in-service lasted or the time it started. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/24/2024 at 10:35 AM, Staff A, Chief Operating Officer, brought in the annual training schedule for 2024 and said this was what the staff were supposed to do. Staff A said the training had not been done as of lately. Staff A said some staff have had training that included some of the topics. Refer to WAC 388-97-1680 (2)(a-c)