

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Soundview Rehabilitation and Health Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 27th Street Anacortes, WA 98221	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were evaluated and assessed for safe administration of medications for 2 of 3 residents (Residents 26, and 134), reviewed for self-medication administration. The failure to complete a self-administration of medication assessment placed the residents at risk for medication errors, adverse medication interactions, and complications.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Self-Administration of Medications, undated stated as part of the evaluation comprehensive assessment the resident will be assessed for cognition and physical ability to determine self-administration would be safe or clinically appropriate .once resident was assessed and deemed safe and appropriate, the medical record will be documented and the care plan updated . self-administered medications will be stored in a safe and secure place, not accessible to other residents.</p> <p>&lt;RESIDENT 26&gt;</p> <p>Resident 26 admitted to the facility on [DATE] with diagnoses that included depression, muscle weakness, and cognitive communication deficit. The admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] showed that the resident had intact cognition.</p> <p>In an observation and interview on 05/08/2025 at 11:05 AM, Resident 26 was observed to have a respiratory inhaler (handheld medical device that delivers medication directly into the lungs through inhalation) on their over-the-bed table at the bedside. The resident stated that they had recently recovered from a respiratory infection and were still using their inhaler (they pointed to the one on the table) to help with their breathing.</p> <p>In an observation on 05/09/2025 at 8:04 AM, Resident 26 was observed to have their inhaler on the over-the-bed table at the bedside.</p> <p>In an observation on 05/12/2025 at 8:12 AM, Resident 26 was observed to have their inhaler on the over-the-bed table at the bedside.</p> <p>&lt;RESIDENT 134&gt;</p> <p>Resident 134 admitted to the facility on [DATE] with diagnoses that included pneumonia, and disease of the digestive system. The admission MDS assessment had not been completed as of 05/12/2025.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 134's medical record showed on 05/07/2025 the resident was alert and orientated to person, place, time and situation, able to make all their needs known.</p> <p>In an observation and interview on 05/08/2025 at 2:52 PM, Resident 134 stated they use a respiratory inhaler due to recent respiratory infection and pointed to their shirt pocket and stated they keep it there.</p> <p>Review of Resident 134's medical record showed a progress note dated 05/10/2025, the nurse documented that the resident had a respiratory inhaler at their bedside.</p> <p>In an interview on 05/13/2025 at 12:11 PM, Staff L, Licensed Practical Nurse (LPN) stated residents were allowed to self-administer medications. Staff L stated the facility must ensure the residents understand the appropriate use of the medication, and they must keep them locked up.</p> <p>In an interview on 05/14/2025 at 11:59 AM, Staff B, Director of Nursing Services stated that they were notified that Resident 134 had a respiratory inhaler at bedside on 05/10/2025. Staff B stated they were not aware that Resident 26 had a respiratory inhaler at bedside. Staff B confirmed that the expectation was that any resident that would like to self-administer medications must have a safety and physical assessment, and the medications should be kept secure.</p> <p>Reference WAC 388-97-1060(3)(I), 0440</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure call lights (an alerting device for staff to assist residents in need) were within reach for 2 of 3 residents (Residents 4, and 6), reviewed for accommodation of needs. This failure placed the residents at risk for delayed care, accidents/falls, anxiety, and a diminished quality of life.</p> <p>&lt;Resident 4&gt;</p> <p>Resident 4 was a long-term resident at the facility. According to the quarterly MDS (an assessment tool), dated 02/18/2025, Resident 4 was severely cognitively impaired.</p> <p>During an observation on 05/09/2025 at 10:44 AM, Resident 4 was in bed with no call light within reach.</p> <p>During an observation on 05/09/2025 11:21 AM, Resident 4 was in bed with no call light within reach.</p> <p>During an observation on 05/09/2025 at 11:43 AM, Resident 4 was in bed with no call light within reach.</p> <p>During multiple observations on 05/12/2025 at 8:45 AM, 9:08 AM, 10:17 AM, 10:41 AM, 12:11 PM, 1:31 PM, and 1:53 PM, Resident 4 was in bed, with no call light within reach. The call light was noted to be hanging on a curtain.</p> <p>During an interview on 05/09/2025 at 11:43 AM, Staff P, Nursing Assistant Certified (NAC), stated that all residents should have their call light within reach. Staff P then indicated that they had forgotten to ensure that Resident 4 had a call light within reach.</p> <p>&lt;Resident 6&gt;</p> <p>Resident 6 was a long-term resident of the facility. According to the quarterly MDS assessment dated [DATE], Resident 6 was severely cognitively impaired.</p> <p>During an observation on 05/12/2025 at 8:42 AM, Resident 6 was in bed, and the call light was out of reach. Resident 6 was yelling at the time of this observation.</p> <p>During an observation on 05/12/2025 at 1:29 PM, Resident 6 was in bed, and the call light was out of reach. Resident 6 was yelling at the time of this observation.</p> <p>During an interview on 05/13/2025 at 1:46 PM, Staff B, Interim Director of Nursing Services, stated that all residents should always have a call light in reach, even if they are unsure of how to use it.</p> <p>Reference WAC 388-97-0860 (2)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure professional standards were met for 1 of 1 sampled residents (Resident 134) reviewed for intravenous (IV - into the vein) medication administration, 3 of 5 residents (Residents 18, 19, and 29) reviewed for unnecessary medication review, and for 1 of 2 residents (Resident 19) reviewed for pressure ulcers. These failures placed the residents at risk of complications, worsening infections, delay in healing, and adverse outcomes.</p> <p>Findings include .</p> <p>Review of the facility policy titled, Introduction and Intravenous Policies, undated states the nursing staff should review physician orders, evaluate the appropriateness of the orders, verify medication compatibility prior to administration, maintain the IV site and system .all IV administration tubing should be labeled with date, time, and nurse initials .tubing should be changed every twenty-four hours for intermittent infusions . all dressing should be assessed and documented every eight hours as needed, and should be labeled with date, time, gauge and length .short peripheral catheter should have a access site assessment, skin integrity, type of therapy and patency of device.</p> <p>Review of facility policy titled, Medication and Flexible Pass Time, revised 10/27/2023 stated that all medications will be passed according to physician orders, and medication guidelines .facility will assess vitals prior to administration of certain medications.</p> <p>&lt;INTRA VENOUS THERAPY&gt;</p> <p>Resident 134 admitted to the facility on [DATE] with diagnoses that included pneumonia, and disease of the digestive system. The admission Minimum Data Set (MDS- an assessment tool) assessment had not been completed as of 05/12/2025.</p> <p>Review of Resident 134 medical record showed on 05/07/2025 the resident was alert and orientated to person, place, time and situation, able to make all their needs known.</p> <p>Review of Resident 134 physician orders dated 05/06/2025, showed the following:</p> <ul style="list-style-type: none"> - Zosyn (antibiotic) IV solution every eight hours for infection till 05/16/2025, - central line (PICC - IV inserted into arm that goes directly to central large vein above the heart), - flush with saline, and heparin (blood thinning), - monitor the PICC for complications, - change dressing to PICC line every 7 days and as needed. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 05/08/2025 at 11:12 AM, Resident 134 was lying asleep in their bed, there was an IV pump on, and a medication bag was hanging from the pump, fluid could be seen dripping into tubing chamber. The tubing was attached to an IV peripheral device in the right crease of the elbow of the resident. The IV tubing was not dated.</p> <p>In an observation and interview on 05/08/2025 at 2:52 PM, Resident 134 stated that they went to the emergency room at the local hospital and stayed in the emergency room for about 24 hours, then they were transferred to this facility. The resident stated they had put the IV in their right arm when they went to the emergency room on [DATE]. Resident 134 had a peripheral IV device to right arm, the dressing was not dated, or timed, the edges of the dressing were frayed, and the tape was peeling off the skin of the resident. The IV tubing end was connected to a port on the same line, there was no safety cap used at the end for infection control safety.</p> <p>In observations on 05/09/2025 at 8:03 AM, and 10:46 AM, Resident 134 was observed to have the same IV device to the right arm, dressing was discolored, not dated or timed, and edges were frayed and peeling.</p> <p>In an observation and interview on 05/12/2025 at 8:05 AM, Resident 134 was observed to have the same IV device to the right arm, dressing was discolored, not dated or timed, and edges were frayed and peeling. Resident 134 stated that over the weekend the IV was leaking at the insertion site of their skin and they had to hold the IV in place with their fingers to keep it from leaking while they were administering the IV antibiotic. The IV tubing end was connected to a port on the same line, there was no safety cap used at the end for infection control safety.</p> <p>In an observation and interview on 05/12/2025 at 9:35 AM, Staff G, Licensed Practical Nurse (LPN) was observed to administer a dose of the IV antibiotic to Resident 134. Staff G was cleaning the IV tube insertion site of the resident's device, the resident explained to Staff G that the IV site had been leaking all weekend and that they had been using their finger to hold it down to keep it from leaking out on their skin. Staff G disconnected the end of the IV tubing from a port on the same tubing line. Staff G was asked if that was standard nursing practice to have the IV line attached to a port when not in use, and they stated there should not be a safety cap, however here at this facility that's what they had seen done. Staff G connected the tubing to the resident's IV device and started to administer the medication and stated it appeared fine now. Staff G stated that the resident had a peripheral device that should only be used for a few days then replaced. Staff G stated they were unsure why Resident 134's physician orders indicated the resident had a PICC line, when they did not. Staff G was asked if they assessed the dressing site of the IV device, and they replied, that was horrible, and it should be changed and that they would notify someone to change the dressing.</p> <p>In an interview on 05/13/2025 at 12:11 PM, Staff L, LPN stated that the standard of practice for use of a peripheral IV device was that they are only good for about a few days. Staff L confirmed Resident 134 had a peripheral IV device to their right arm, that appeared old and needed to be replaced. Staff L also stated the physician orders for maintenance and management of the IV device were incorrect and that the resident did not have a PICC line.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/14/2025 at 11:59 AM, Staff B, Director of Nursing Services (DNS) stated they were not aware of the old, frayed peripheral IV device to Resident 134 till they were notified on 05/13/2025. Staff B confirmed the residents did have a peripheral IV device in their right arm that had been placed previously in the emergency room on [DATE]. Staff B also confirmed the orders for PICC management were not accurate.</p> <p>&lt;UNNECESSARY MEDICATIONS&gt;</p> <p>RESIDENT 18</p> <p>Resident 18 admitted to the facility on [DATE] with diagnoses that included type two diabetes, and degeneration of the brain. The Significant Change in Condition MDS dated [DATE] showed the residents had sever cognitive impairment and were receiving insulin injections for blood sugar management.</p> <p>Review of Resident 18's electronic medication administration record (EMAR) for March 2025 showed the resident an order for Humalog insulin injections for managing their blood sugar, with parameter to not give if the residents blood sugar level was less than 140. On 03/13/2025, 03/30/2025, and 03/31/2025 the residents blood sugar level was less than 140 and the insulin was documented as given outside of the parameters.</p> <p>In a review of Resident 18's electronic medication administration record (EMAR) for April 2025, documented the resident had an order dated 04/01/2025 - 04/11/2025 for Humalog insulin injections to manage their blood sugar, with parameter to not give if the residents blood sugar level was less than 130. On 04/03/2025, 04/04/2025, and 04/08/2025 the residents blood sugar level was less than 140 and the insulin was documented as given outside of the parameters.</p> <p>Review of Resident 18's electronic medication administration record (EMAR) dated April 2025 showed the resident an order dated 04/13/2025 - 04/30/2025 for Humalog insulin injections for managing their blood sugar, with parameter to not give if the residents blood sugar level was less than 140. On 04/14/2025, 04/22/2025, 04/23/2025, 04/24/2025, 04/27/2025, 04/28/2025, twice on 04/30/2025 the blood sugar level was less than 140 and the insulin was documented as given outside of the parameters.</p> <p>In an interview on 05/13/2025 at 12:11 PM, Staff L stated parameters for residents and insulin are usually resident specific, and the expectation if they are followed, and they should notify the provider whenever they must hold a medication.</p> <p>In an interview on 05/14/2025 at 11:59 AM, Staff B stated that the pharmacist reviewed the medications and administration monthly and they will usually notify them if there are any errors. Staff B stated they were not aware that Resident 18 was given insulin outside of the physician established parameters.</p> <p>&lt;RESIDENT 19&gt;</p> <p>Review of Resident 19's physician order summary, dated 05/09/2025, showed an order for Oxycodone (strong pain medication that can cause addiction) Oral Tablet 5 MG-Give by mouth as needed every four hours for Pain: Severe (7-10), initiated on 03/05/2025.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the March 2025 eMAR showed the following doses were administered outside of the pain rating of 7-10: 03/07/2025 at 7:20 AM rating of 4, 03/07/2025 at 1:40 PM rating of 5, 03/10/2025 at 8:42 AM rating of 5, 03/07/2025 at 7:39 PM rating of 4, 03/11/2025 at 7:47 AM rating of 5, 03/11/2025 at 12:08 PM rating of 5, 03/14/2025 at 7:53 AM rating of 5, 03/17/2025 at 8:18 AM rating of 4, 03/17/2025 at 2:25 PM rating of 5, 03/18/2025 at 5:42 AM rating of 6, 03/18/2025 at 12:33 PM rating of 5, 03/19/2025 at 2:01 PM rating of 4, 03/20/2025 at 4:36 PM rating of 6, 03/21/2025 at 7:42 AM rating of 5, 03/23/2025 at 8:33 AM rating of 4, 03/24/2025 at 7:00 AM rating of 5, 03/24/2025 at 5:09 PM rating of 5, 03/24/2025 at 9:09 PM rating of 5, 03/25/2025 at 7:57 AM rating of 4, 03/26/2025 at 4:25 PM rating of 5, 03/27/2025 at 7:44 AM rating of 4, 03/27/2025 at 3:34 PM rating of 6, 03/28/2025 at 7:39 AM rating of 4, 03/29/2025 at 1:29 AM rating of 6, 03/30/2025 at 7:19 AM rating of 5, 03/30/2025 at 6:59 PM rating of 6, 03/31/2025 at 7:48 AM rating of 5 and 03/31/2025 at 4:08 AM rating of 3.</p> <p>Review of the April 2025 eMAR showed the following doses were administered outside of the pain rating of 7-10: 04/01/2025 8:28 AM rating of 5, 04/01/2025 7:38 AM rating of 4, 04/02/2025 7:39 AM rating of 4, 04/02/2025 12:41 PM rating of 4, 04/07/2025 7:03 AM rating of 5, 04/08/2025 7:15 PM rating of 5, 04/09/2025 12:43 AM rating of 6, 04/09/2025 6:46 AM rating of 5, 04/09/2025 3:12 PM rating of 6, 04/10/2025 7:15 AM rating of 5, 04/11/2025 6:48 AM rating of 5, 04/12/2025 8:09 AM rating of 6, 04/12/2025 12:20 PM rating of 6, 04/12/2025 8:18 PM rating of 6, 04/13/2025 12:30 PM rating of 6, 04/13/2025 4:50 PM rating of 6, 04/14/2025 8:50 AM rating of 5, 04/15/2025 3:09 PM rating of 6, 04/16/2025 1:55 PM rating of 6, 04/17/2025 3:23 PM rating of 5, 04/17/2025 8:14 PM rating of 3, 04/18/2025 8:47 AM rating of 6, 04/18/2025 6:40 PM rating of 5, 04/19/2025 8:07 AM rating of 6, 04/19/2025 12:06 PM rating of 6, 04/19/2025 4:31 PM rating of 6, 04/19/2025 8:28 PM rating of 6, 04/20/2025 6:00 AM rating of 6, 04/20/2025 9:33 AM rating of 6, 04/20/2025 1:13 PM rating of 6, 04/20/2025 5:20 PM rating of 6, 04/21/2025 5:00 AM rating of 6, 04/21/2025 4:29 PM rating of 5, 04/25/2025 6:44 AM rating of 5, 04/25/2025 10:44 AM rating of 5, 04/25/2025 3:04 PM rating of 5, 04/25/2025 7:50 PM rating of 5, 04/26/2025 7:33 AM rating of 6, 04/26/2025 11:23 AM rating of 6, 04/26/2025 5:11 PM rating of 6, 04/27/2025 6:29 AM rating of 6, 04/27/2025 12:01 PM rating of 6, and 04/27/2025 5:31 PM rating of 6.</p> <p>Review of the May 2025 eMAR from 05/01-05/09/2025, showed the following doses were administered outside of the pain rating of 7-10: 05/01/2025 8:16 PM rating of 4, 05/02/2025 6:52 AM rating of 6, 05/02/2025 12:17 PM rating of 6, 05/03/2025 6:41 AM rating of 6, 05/03/2025 12:18 PM rating of 6, 05/03/2025 4:20 PM rating of 6, 05/03/2025 8:34 PM rating of 6, 05/04/2025 6:29 AM rating of 6, 05/04/2025 4:15 PM rating of 6, 05/04/2025 8:15 PM rating of 5, 05/05/2025 10:47 PM rating of 5, 05/07/2025 10:17 AM rating of 5, 05/07/2025 3:33 PM rating of 4, 05/07/2025 8:03 PM rating of 6, 05/08/2025 7:38 AM rating of 5, 05/08/2025 1:34 PM rating of 4, 05/09/2025 5:23 AM rating of 5, and 05/09/2025 9:29 AM rating of 6.</p> <p>During an interview on 05/13/2025 at 2:43 PM, Staff F, LPN, stated that Resident 19's physician order for oxycodone showed it should be given for pain rating of 7-10. Staff F reported that they had given Resident 19 oxycodone on 05/12/2025 with a pain rating of 6 and that they should have contacted the provider to update the orders.</p> <p>During an interview on 05/14/2025 at 10:50 AM, Staff B stated they expected the nurses to give oxycodone within the doctor's parameters and giving oxycodone for a rating of 4-6 was not appropriate.</p> <p>&lt;PRESSURE RELIEVING DEVICES&gt;</p> <p>Resident 19 readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on interviews and record reviews, the facility failed to complete annual staff performance reviews as required for 3 of 5 sampled staff (Staff N, S, and T). The facility also did not ensure that the required 12 hours of education based on these evaluations were completed for 2 of 5 staff members (Staff S and T). This failure placed residents at risk of receiving care from inadequately trained and/or underqualified staff, which diminished the quality of life.</p> <p>Findings Included .</p> <p>Review of the document titled 'CNA_hours_HCA_12mos', documented that from April 2024 to May 2025, Staff M was missing 5 of 12 hours of annual education, and Staff T was missing 2 of 12 hours of yearly education.</p> <p>A review of employee files on 05/12/2025, provided by the Facility Administrator, revealed that there were no annual evaluations for staff members N, S, and T.</p> <p>During an interview on 05/14/2025 at 10:52 AM, Staff A, Administrator, stated that Staff T was missing 2 of the 12 required hours of education and annual evaluations, Staff S was missing 5 of the required 12 hours of education and annual evaluations, and Staff N was missing annual evaluations.</p> <p>Reference WAC 388-97-1680 (2) (a-c)</p>

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NAME OF PROVIDER OR SUPPLIER Soundview Rehabilitation and Health Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 27th Street Anacortes, WA 98221	
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &it;RESIDENT 134&gt;</p> <p>Resident 134 admitted to the facility on [DATE] with diagnoses that included pneumonia, and disease of the digestive system.</p> <p>Review of Resident 134's physician orders showed the resident had an order for Zosyn solution (antibiotic) given through an intravenous (IV - into the vein) line, given every eight hours, scheduled at 8:00 AM, 4:00 PM, and 12:00 AM.</p> <p>In an observation and interview on 05/12/2025 at 9:35 AM, Staff G was observed to administer Resident 134's IV antibiotic. The medication was given one and half hours late after the physician orders indicated it was to be administered. Staff G stated they administered the medications to residents down the hallway in order, not by a set time.</p> <p>In an interview on 05/14/2025 at 11:59 AM, Staff B, Director of Nursing Services stated the facility policy was that all medications should be given within an hour time that they are due. Staff B was unaware that Resident 134's IV antibiotic was given late.</p> <p>Reference WAC 388-97-1060 (3)(k)(ii)</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent (%), unit of measure). During observation of 25 opportunities for error, 2 of the 25 medications were administered late, resulting in an error rate of 8 %. These failures placed residents at risk for side effects, unnecessary medications, and/or reduced medication effectiveness due to improper administration.</p> <p>Findings included .</p> <p>&it;Resident 24&gt;</p> <p>Resident 24 was a short-term resident at the facility. According to the admission MDS assessment dated [DATE], the resident was not cognitively impaired.</p> <p>According to the National Institute of Health (NIH), Levothyroxine, which was a medication administered for thyroid issues, is absorbed better in the body when it is taken on an empty stomach and should be administered 30 to 60 minutes before breakfast.</p> <p>During an observation on 05/12/2025 at 8:32 AM, Staff G, Agency Licensed Practical Nurse (LPN), administered Resident 24's 7:00 AM dose of Levothyroxine 1.5 hours after it was scheduled.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly label and/or discard undated, opened vials of aplisol (solution used to test for persons with possible Tuberculosis- an infectious respiratory disease) and ensure refrigerated drugs were stored at proper temperatures in 1 of 1 medication rooms. This failure placed the residents at risk of receiving compromised or ineffective medications.</p> <p>Findings included .</p> <p>Review of a facility policy titled, Storage of Medications, dated [DATE], Documented that the facility should maintain a temperature log and record temperatures at least once a day.</p> <p>&lt;REFRIGERATOR TEMPERATURE LOGS&gt;</p> <p>Review of the temperature log for the medication refrigerator in the medication room for [DATE] showed no temperature was recorded for [DATE], [DATE], [DATE] or [DATE].</p> <p>Review of the temperature log for the medication refrigerator in the medication room for [DATE]-13th, 2025, showed no temperature was recorded for [DATE], [DATE], [DATE], [DATE] or [DATE].</p> <p>During an interview on [DATE] at 2:29 PM, Staff B, interim Director of Nursing, stated the facility practice was to check the temperature of the refrigerator once daily and that the night shift staff should be doing it.</p> <p>&lt;UNDATED VIAL&gt;</p> <p>During an observation on [DATE] at 11:48 AM, there were two open vials of aplisol solution inside the refrigerator in the medication room. The label on the vial documented the product expired 30 days after opening. The label did not have a date when it was opened.</p> <p>During an observation and interview on [DATE] at 12:04 PM, Staff G, Licensed Practical Nurse, stated the aplisol vial was only good for 30 days after opening. Staff G stated that the vials were not dated when they were opened, and they needed to be discarded.</p> <p>Reference WAC 388-97-1300 (2)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>Based on interviews and record reviews, the facility failed to designate a person to serve as the director of food and nutrition services with 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.</p> <p>Findings included .</p> <p>Review of the key personnel list, provided by the facility during the entrance conference meeting on 05/08/2025, showed no staff names were listed under the dietary manager.</p> <p>During an interview on 05/08/2025 at 8:53 AM, Staff E, Dietary Services, stated that the kitchen did not currently have a dietary manager. Staff E stated there had been a dietary manager with certification, but they no longer work for the company.</p> <p>During an interview on 05/12/2025 at 11:15 AM, Staff A, Administrator, stated the facility did not have a dietary manager and the person filling in did not have dietary credentials.</p> <p>Reference WAC 388-97-1160 (1)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interviews, the facility failed to properly store, distribute and serve food in accordance with professional standard for food service safety. The facility failed to store perishable foods properly and failed to dispose of outdated foods timely in 2 of 2 storage areas. These failures placed residents at risk of food borne illness.</p> <p>Findings included .</p> <p>During an observation and interview of the dry food storage room on 05/08/2025 at 9:18 AM, individual 1. 5-ounce containers of honey mustard dressing were noted in a cardboard box on a shelf. The cardboard box documented must be refrigerated. The individual containers showed keep refrigerated on the label. Staff E, Dietary services, stated they would need to dispose of the dressing as it was not kept in the refrigerator.</p> <p>On 05/08/2025 at 12:27 PM, the pantry area in the resident dining room was reviewed. A plastic container of shredded cheese was noted in the refrigerator with a sticker that showed exp date May 3rd, a bin of individual 1.5 ounce containers of honey mustard dressing was sitting on the counter, the label showed to Keep refrigerated, a half loaf of bread had a sticker that showed exp date May 4th, and individual packages of chocolate chip cookies had a manufacturer expiration date of 05/05/2025.</p> <p>During an interview on 05/08/2025 at 12:31 PM, Staff H, Nursing Assistant Certified, stated the kitchen was to stock the pantry daily. Staff H stated the bread, and the dressing needed to be disposed of. Staff H stated the shredded cheese needed to be disposed of and placed it into the garbage can.</p> <p>During an observation and interview on 05/08/2025 at 12:35 PM, Staff E reviewed the panty and stated the bread, and the chocolate chip cookies were expired and needed to be discarded. Staff E stated the dressing needed to be disposed of as it had not been kept refrigerated.</p> <p>Reference WAC 388-97-1100(2)(3)</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation and interview, the facility failed to dispose of garbage properly for 2 of 2 dumpsters. Failure to ensure garbage was disposed of properly and the area was clean and free of litter, placed residents at risk for contamination of their environment by attracting bugs, rodents, birds and other germ carrying vectors.</p> <p>Findings included .</p> <p>During an observation on 05/08/25 at 3:04 PM, there were two dumpsters outside the facility. Neither dumpster had the lids closed. An unnamed staff person was observed placing garbage inside the dumpster, and did not close the lid. Surrounding the dumpsters, there were plastic bags of garbage, one of which had a tin can inside, protein drink carton with straw sticking out the top, scattered debris behind the dumpsters and two 5-gallon buckets filled with a thick sludge material with water sitting on top of the sludge. Beside the dumpster area was a knee-high pile of yard waste (branches and pinecones,) three mattresses, a cloth recliner chair and four mini refrigerators. There were flies noted flying around the area.</p> <p>During an observation on 05/08/25 at 4:23 PM, observed a seagull inside one of the dumpsters and then flew off with a piece of garbage in its beak. None of the lids were closed on either dumpster.</p> <p>During an observation on 05/09/25 at 8:19 AM, the lids to both dumpsters were open.</p> <p>During an observation on 05/12/25 at 8:14 AM, the lids to the dumpster on the left side were closed. The lids to the dumpster on the right side were open.</p> <p>During an observation on 05/12/25 at 4:40 PM, the lids to both dumpsters were open.</p> <p>During an observation on 05/12/25 at 7:40 AM, the lids to both dumpsters were open.</p> <p>During an interview and observation on 05/13/25 at 12:40 PM, Staff A, Administrator, observed the dumpsters and surrounding area with surveyor. Around the dumpsters were plastic bags of garbage, a protein drink carton with a straw sticking out the top, scattered debris of random papers, used gloves behind the dumpsters and two 5-gallon buckets filled with thick sludge material. Beside the dumpster area was a pile of yard waste, three mattresses, a cloth recliner chair and four mini refrigerators. Staff A stated that the facility has had some issues with squirrels and mice around the dumpsters which was why they had the rodent trap behind the dumpster. Staff A did not know what the sludge material inside the 5-gallon buckets was. Staff A stated the lids to the dumpsters should be kept closed and they needed to clean up the area.</p> <p>Reference WAC 388-97-1320 (4)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &it;RESIDENT 11&gt;</p> <p>Resident 11 was admitted to the facility on [DATE], with diagnoses that include bipolar disorder with depression, and anxiety disorder.</p> <p>Review of Resident 11's physician orders showed an order dated 11/16/2024, to monitor for adverse side effects related to the use of an antipsychotic medication such as sedation, drowsiness, dry mouth, blurred vision, constipation, shuffling gait, drooling, weight gain, tremors, postural hypotension, sweating, loss of appetite, and urinary retention three times a day.</p> <p>The following was missing documentation:</p> <ul style="list-style-type: none"> - March 2025: 03/26/2025, and 03/28/2025, - April 2025: 04/06/2025, and 04/21/2025, - May 2025: 05/01/2025, 05/02/2025, 05/05/2025, and 05/08/2025. <p>Review of Resident 11's physician orders showed an order dated 11/26/2024, to monitor adverse side effects related to the use of an antidepressant medication such as isolation, suicidal thoughts, withdrawal; decline in ability, constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, and weight loss three times a day. The following was missing documentation:</p> <ul style="list-style-type: none"> - March 2025: 03/26/2025, and 03/28/2025, - April 2025: 04/06/2025, and 04/21/2025, - May 2025: 05/01/2025, 05/02/2025, 05/05/2025, and 05/08/2025. <p>Review of Resident 11's physician orders showed an order dated 01/28/2025, to document targeted behaviors related to the resident's bipolar disorder such as hallucinations, delusions, and mood swings three times a day. The following was missing documentation:</p> <ul style="list-style-type: none"> - March 2025: 03/02/2025, 03/26/2025, and 03/28/2025, - April 2025: 04/06/2025, and 04/21/2025, - May 2025: 05/01/2025, 05/02/2025, 05/05/2025, and 05/08/2025. <p>Review of Resident 11's physician orders showed an order dated 11/25/2024, to document targeted behaviors related to the resident's depression such as refusing care, tearfulness, and angry outburst three times a day. The following was missing documentation:</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- March 2025: 03/02/2025, 03/26/2025, and 03/28/2025,</p> <p>- April 2025: 04/06/2025, and 04/21/2025,</p> <p>- May 2025: 05/01/2025, 05/02/2025, 05/05/2025, and 05/08/2025.</p> <p>In an interview on 05/13/2025 at 12:11 PM, Staff L, LPN stated the expectation was that all licensed staff are to complete their documentation by the end of their shift, and if not, they are to notify the DNS.</p> <p>In an interview on 05/14/2025 at 11:59 AM, Staff B, DNS stated they were not aware that the licensed staff had not been completing their documentation at the end of each shift, and that the expectation was that all licensed staff are to complete their documentation at the end of the shift.</p> <p>Reference WAC 388-97-1720 (1)(a)(i)(ii)(iii)(j)</p> <p>Based on interview and record review, the facility failed to ensure a system in which resident's records were complete, accurate, and accessible for 1 of 5 residents (Resident 11) reviewed for unnecessary medications and 1 of 3 residents (Resident 383) reviewed for pain. The facility failed to ensure the residents' medical records had active orders and complete and accurate Medical Administration Records (MAR) which placed the residents at risk for medical complications, unmet care needs, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled Medication and Flexible Pass Time, revised 10/27/2023, stated to double check the MAR prior to giving medication and to follow the ten rights of medication administration.</p> <p>Review of a facility's undated policy titled, Ten Rights of Medication Administration, documented right response and right documentation were part of the ten rights.</p> <p>&lt;Resident 383&gt;</p> <p>During a review of the narcotic book (record of medication administration of medications with high risk of addiction), Resident 383 had a dose of Hydromorphone (pain medication) signed out on 05/09/2025 at 12:15 AM. Review of Resident 383's orders showed no active physician order for the Hydromorphone and the May 2025 MAR showed no documentation that the pain medication was administered to the resident at that date and time.</p> <p>During a joint interview on 05/13/2025 at 2:31 PM with Staff B, Director of Nursing Services (DNS) and Staff G, Licensed Practical Nure (LPN), reviewed Resident 383's electronic medical record (EMR) and MAR. They confirmed no dose was documented as administered on the MAR or in the progress note, the only documentation was in the narcotic book.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview on 05/13/25 at 3:15 PM with Staff F, Registered Nurse (RN) and Staff G, LPN, Staff F reported the order for the pain medication was not confirmed in the orders until 05/09/2025 at 5:03 PM, which was after the pain medication was signed out of the narcotic book on 05/09/2025 at 12:15 AM. Staff F and Staff G confirmed that the pain medication did not have documentation for the dose given on 05/09/2025 at 12:15 AM in Resident 383's clinical record.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &it;HAND HYGIENE&gt;</p> <p>During an observation on 05/12/2025 at 12:45 PM, Staff R, NAC and Staff M, NAC provided incontinent care to Resident 12. Staff M applied gloves, then cleansed the perineum the resident. Staff R then assisted the resident to turn onto their side so Staff M could cleanse the buttocks and remove the soiled brief. Staff M then opened the clean brief with their contaminated gloves and placed it under the resident. Staff M opened the drawer of the nightstand with their contaminated gloved hand, removed a packet of skin barrier, squeezed the contents into their gloved hand and rubbed it onto the resident's buttocks. Staff M then used the contaminated gloved hand to secure the brief in place and then removed the used gloves.</p> <p>During an interview on 05/12/2025 at 12:54 PM, Staff M stated they realized that they had not removed their gloves or did hand hygiene while providing incontinent care. Staff M reported they normally wear multiple gloves and remove a pair in between tasks.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff were com-pliant with Infection Prevention and Control Guidelines and standards of practice for 2 of 2 units (Ship Harbor and Portage) reviewed for transmission-based precautions (TBP) for residents (Residents 4, 12, and 28) who had tested positive for Coronavirus Disease 2019 (COVID-19 -an infectious disease-causing respiratory illness with symptoms) The facility failed to ensure licensed staff implemented the use of Enhanced Barrier Precautions (EBP) for 2 of 2 residents (Residents 19, and 134) while they provided direct care to residents on EBP, failed to ensure staff were compliant with appropriate hand hygiene practices during perineal care (process of cleaning genitals and anal area) for 1 of 1 resident (Resident 12), and failed to ensure they had a system in place for the transport of clean linens for 1 of 1 laundry rooms. These failures placed all residents and staff at risk of potential infection.</p> <p>Findings included .</p> <p>Review of the facility policy titled, COVID-19 Policy & Procedure, undated stated minimum personal protection equipment (PPE) for care of residents with COVID-19 included gown, gloves, National Institute for Occupational Safety and Health (NIOSH) approved respirator such as an N95 (specialize mask that provides greater protection that a surgical mask), and eye protection, the facility was to follow the current Center for Disease and Control (CDC) standards.</p> <p>Review of facility document titled, Aerosol Isolation Precautions revised 10/09/2020 documented everyone must clean hands before and after leaving the room, use an N95 respirator, eye protection, gown and glove when exiting remove all items, and perform hand hygiene.</p> <p>Review of the facility policy titled, Enhanced Barrier Precautions, dated 04/01/2024 stated that EBP was used to reduce the spread of potential multi-drug resistant organisms to residents .and was implemented through use of gown and gloves during high contact resident care activities when contact precautions do not apply such as device care, and wound care .EBP was indicated in residents who have wounds, and/or indwelling medical devices such as intravenous (IV) lines, and catheters.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Handwashing/Hand Hygiene, undated documented all staff shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections, examples of when to implement hand hygiene are before and after contact with residents, before and after donning (wearing) gloves, and before and after handling soiled objects.</p> <p>Review of a facility procedure, titled Perineal care procedure (cleansing of genital and anal area), dated 2017, documented staff were to provide peri-care and remove soiled gloves before touching the residents' clothing, privacy curtain, etc.</p> <p>&lt;TRANSMISSION BASED PRECAUTIONS&gt;</p> <p>RESIDENT 12</p> <p>Resident 12 admitted to the facility on [DATE] with diagnoses that included dementia, and history of stroke.</p> <p>Review of Resident 12's medical record they tested positive for COVID-19 on 04/30/2025 and the resident was placed on aerosol isolation precautions.</p> <p>In a continuous observation on 05/05/2025 at 10:01 AM, Staff H, Nursing Assistant Certified (NAC) was observed to have a surgical mask on their face as they approached room [ROOM NUMBER] (Resident 12 resided). Staff H was observed to place an isolation gown, gloves and eye protection over their surgical mask. Staff I, NAC approached the door with an N95 respirator on their face, and proceeded to place an isolation gown, gloves and eye protection on, they both entered the room of Resident 12. At 10:09 AM, Staff H exited the room, removed their surgical mask and placed it in the trash and placed a new surgical mask on their face. Staff I continued to wear their same N95 and did not replace with a new one. Staff I then proceeded to enter the room of another resident that was not infected with COVID-19.</p> <p>In an interview on 05/08/2025 at 10:19 AM, Staff H stated they were educated to wear gown, goggles, gloves and mask when they provide care to COVID-19 residents. Staff H stated they were recently fit tested for a proper N95 respirator. Staff H was asked when they wear N95 respirators, and they responded when they provide care to COVID-19 positive residents. Staff H then stated they should have worn an N95 when they entered the room for Resident 12 and that a surgical mask was not appropriate PPE.</p> <p>In an interview on 05/08/2025 at 10:20 AM, Staff I stated they had only worked at the facility for three days. Staff I stated they had education on infection control policies and procedures for the facility. Staff I stated they had been fit-tested for a N95 respirator. Staff I was asked what the procedure was after they provided care to a COVID positive resident, and stated they are to remove all the PPE. Staff I stated they forgot to remove and replace their N95 respirator after they provided care to Resident 12.</p> <p>&lt;RESIDENT 28&gt;</p> <p>Resident 28 was admitted to the facility on [DATE] and resided in room [ROOM NUMBER]-1.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER Soundview Rehabilitation and Health Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 27th Street Anacortes, WA 98221	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 28's progress note, dated 05/02/2025 at 8:19 AM, showed that they had tested positive for Covid-19, and isolation precautions were put into place.</p> <p>During an observation on 05/09/2025 at 11:04 AM, Staff Q, Physical Therapy Assistant, was observed standing in the doorway of room [ROOM NUMBER] wearing a surgical mask. There was a sign on the door to room [ROOM NUMBER] that showed aerosol isolation precautions were in place. Staff Q applied a disposable gown and gloves and entered the room. Staff Q did not wear an N-95 or eye protection as the sign showed.</p> <p>During an interview on 05/09/2025 at 11:29 AM, Staff Q reviewed the sign on the doorway that showed they should have worn a N-95 and eye protection when entering the room. Staff Q stated they did not have a good reason why they had not followed the precautions.</p> <p>During an observation on 05/09/25 at 12:22 PM, Staff H, NAC delivered a lunch tray to room [ROOM NUMBER]. Staff H entered the room wearing their surgical mask, dropped the tray off, exited the room and left the door open. Staff H did not put on an N95 mask gown, gloves, or eye protection before entering the room as the sign indicated. The sign also documented to keep the door closed.</p> <p>During an interview on 05/09/25 at 12:43 PM, Staff H reviewed the sign on the door with the surveyor. Staff H stated they had not worn a respirator, gown, eye protection or gloves prior to entering the room and did not close the door after exiting as they had not read the sign.</p> <p>&lt;ENHANCED BARRIER PRECAUTIONS&gt;</p> <p>&lt;RESIDENT 134&gt;</p> <p>Resident 134 admitted to the facility on [DATE] with diagnoses that included pneumonia, and disease of the digestive system.</p> <p>Review of medical provider note dated 05/07/2025 resident was receiving IV antibiotics for diverticulitis (infection of the wall lining) of the large intestine and had IV indwelling device to their right arm for administration of IV antibiotics.</p> <p>In an observation on 05/08/2025 at 11:12 AM, room [ROOM NUMBER] had an EBP sign on the door that stated if the staff were to provide direct care such as device care or use, all staff are required to wear gowns and gloves for that care.</p> <p>In an observation and interview on 05/12/2025 at 9:35 AM, Staff G, Licensed Practical Nurse (LPN) stated they were going to administer the residents' IV antibiotics. Staff G stated they were going to gather their supplies, which included IV antibiotic medication to infuse, saline flush, alcohol wipes, and gloves. Staff G entered the room, performed hand hygiene and placed gloves on, Staff G did not place a gown on to provide direct care to the residents. Staff G continued to clean the IV valve insertion site on Resident 134, prepared the medication on the IV pump, and connected the tubing to the resident's IV insertion site. Staff G was asked what EBP sign on the door meant, they stated Resident 134 was on EBP for their IV device to their right arm. Staff G then stated they should have worn more PPE like a gown while they had administered Resident 134's IV antibiotic.</p> <p>&lt;RESIDENT 19&gt;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 19 re-admitted to the facility on [DATE] into room [ROOM NUMBER]-1.</p> <p>Review of the MDS, dated [DATE], showed Resident 19 had two pressure ulcers (bed sores).</p> <p>During an observation on 05/12/2025 at 11:33 AM, there was a sign posted on the door to room [ROOM NUMBER] that showed EBP, and staff were to wear gowns and gloves for high contact care activities including wound care.</p> <p>During an observation on 05/12/2025 at 11:33 AM, Staff F, LPN, applied gloves prior to completing wound care for Resident 19. Staff F did not wear a gown.</p> <p>During an interview on 05/12/2025 at 11:52 AM, Staff F stated they did not use a gown during wound care as they had not realized that Resident 19 was on EBP.</p> <p>&lt;Linen Management&gt;</p> <p>In an observation on 05/09/2025 at 11:52 AM, Staff J, Laundry was observed to transport clean linen from outside of the building where the laundry room was located, into the building with their bare hands. Linen was exposed and not covered.</p> <p>In an interview on 05/13/2025 at 9:15 AM, Staff K, Housekeeping Manager stated that staff are instructed to transport clean linen's covered when going to and from the facility.</p> <p>In an interview on 05/14/2025 at 9:47 AM, Staff D, LPN/Infection Preventionist (IP) stated they just stated as the IP in February. Staff D stated their role was to ensure all the staff were following the facility infection control policies and procedures, including staff performing proper hand hygiene practice, TBP, isolation requirements, EBP, and proper transport and storage of linens. Staff G stated the expectation for all staff was for any resident that was COVID positive all staff were to wear a gown, eye protection, gloves, and their fit tested N95 respirator. Staff D stated that when they had the first resident test positive in April, they completed education with the staff on proper PPE that was required for the care of COVID positive residents. Staff D stated they had not been able to educate the staff on EBP in detail. Staff D stated they thought that the staff probably did not fully understand the guidance for EBP and were planning on providing more education with them.</p> <p>In a joint interview on 05/14/2025 at 11:59 AM, Staff A, Administrator and Staff B, Director of Nursing Services (DNS), Staff B stated that they had not educated the staff completely on EBP, and they needed to work on some of the confusion that may lead to non-compliance with it. Staff A they were not aware of the non-compliance with infection control procedures, and that they are working on purchasing a covered linen cart that would be useful for staff for transporting.</p> <p>&lt;Transmission Based Precautions&gt;</p> <p>Resident 4</p> <p>Resident 4 was a long-term resident at the facility. According to the Quarterly MDS assessment dated [DATE], Resident 4 was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the document titled Progress Note, printed on 05/09/2025 at 3:02 PM, indicated that Resident 4 was on alert due to a COVID-19 diagnosis. The resident was to remain on precautions until 05/15/2025, which required staff to wear N95 masks, gowns, eye protection, and gloves.</p> <p>During an observation on 05/12/2025 at 08:58 AM, Staff O entered Resident 4's room without eye protection or an N95 mask.</p> <p>During an interview on 05/12/2025 at 01:30 PM, Staff O stated that the resident had just tested positive for COVID-19. Staff O then stated that upon entering the resident's room, they were supposed to wear an N95 mask, gown, and gloves; however, there were no N95 masks in the supply drawer, so she did not wear one. Additionally, she was unaware that eye protection should have been worn.</p> <p>During the observation on 05/12/2025 at 1:30 PM, Staff O was seen exiting Resident 4's room with an N95 mask partially covering a surgical mask. She then removed the N95 and placed it in her pocket.</p> <p>Reference WAC 388-97- 1320(1)(a)(c)(3)</p>