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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505226	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Healthcare Center	721 Otis Avenue Sunnyside, WA 98944

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to set-up a visually impaired resident's room to ensure it accommodated the individualized needs and preferences for 1 of 2 residents (Resident 6) reviewed for accommodation of needs and preferences. Resident 6 experienced psychosocial harm as evidenced by changes in their activity, behavior, and mood from their baseline due to their new physical environment that was not individualized for their preference of independent functioning. Findings included . <Resident 6> Review of the medical record showed Resident 6 admitted to the facility on [DATE] with diagnosis to include blindness (visually impaired), anxiety (a feeling of worry, nervousness, or unease), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and end stage renal disease (permanent kidney failure that requires a regular course of dialysis or a kidney transplant). The 09/30/2024 comprehensive assessment showed the resident required supervision or touching assistance with walking and transfers. The assessment showed listening to music was very important to them, had severely impaired vision, rarely socially isolated, and had an intact cognition during the review period. Review of Resident 6's care plan, dated 11/01/2024, showed the resident was legally blind in both eyes, high risk for falls, and preferred to have their room and belongings arranged to promote their independence. The care plan showed the resident liked their bed on the right side for a home like environment. The care plan did not address the change to the resident's new physical environment, nor addressed the bed currently being on the left side (which was a change from what Resident 6 was used to from the set up in their previous room). Review of a progress note, dated 09/14/2024, showed Resident 6 was on alert charting to be monitored for adjustment to a new roommate. Resident 6 stated they were uncomfortable with the new roommate due to the new roommate being messy, had a bad odor, and kept the air conditioner on all day. Resident 6 had conveyed these concerns to staff and the need for something to be done. Review of a nursing progress note, dated 11/15/2024 at 9:55 PM, showed Resident 6 had been moved to a new room (after two months residing in the same room with roommate that made them uncomfortable). (continued on next page)

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

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

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F 0558 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record showed no documentation of Resident 6 being oriented to their new physical environment by nursing or therapy staff. Review of a nursing progress note, dated 11/16/2024 at 11:13 PM, showed Resident 6 had complained to nursing staff of disliking the set-up of their new room. Resident 6 was accustomed to their old room setting. The resident verbalized their dislike the day after they had been moved to their new environment. Review of a nursing progress note, dated 11/17/2024 at 11:12 PM, showed the resident had complained of disliking the set-up of his new room and the closet was too small, two days after they had been moved to their new environment. During an interview on 11/17/2024 at 2:17 PM Resident 6 stated, I'm not happy with the new room. The resident stated they were blind and had trouble getting around their new room. Resident 6 stated that their bathroom was too small, and the toilet was too small. The resident stated they were frustrated and embarrassed because they had been told they had urinated all over the place. Review of a nursing progress note, dated 11/18/2024 at 6:50 AM, showed Resident 6 stated they were angry due to having to move out of their old room, three days after they had been moved to their new environment. During an interview on 11/18/2024 at 8:37 AM, Staff LL, Licensed Practical Nurse (LPN), stated that Resident 6 had previously complained about their new roommate. Staff LL stated that Resident 6 requested to have either their new roommate moved or they (Resident 6) would need to be moved. Staff LL stated that Resident 6 was moved to a new room on 11/15/2024, per their request. Staff LL further stated therapy staff were not involved with the move, and Staff LL, with help from maintenance staff, moved Resident 6 into the new room. Staff LL, stated an orientation to the new room should have been done. An observation on 11/19/2024 at 1:29 PM, showed Resident 6 fully dressed wearing a gray t-shirt, brown sweatpants, and shoes exiting the restroom when they had tripped over a bed control cord that was lying on the ground. The resident fell forward as they grabbed the bottom of bed and stood straight up, holding on to the handle of their wheelchair and frame of the bottom of bed. Resident 6 walked along the bed, touching the edge of the bed with their hand to determine where they were at since they could not see, until they were in the middle of the bed and sat down. (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/20/2024 at 9:02 AM Resident 6 stated I'm so frustrated with this place, I have been in the same clothes since Saturday. Resident 6 stated they could not find any of their clothes in the closet, they did not like being in the same clothes day after day. Resident 6 was in the same clothing as the previous day, a gray t-shirt and brown sweatpants. The resident stated, I'm not good in here (the new room they were placed in). Resident 6 explained the restroom was too small to sit down, and it did not flush well. Resident 6 stated they were having trouble washing their hands due to not being able to find the sink. They stated they could not get into the closet to find clean clothing to put on. I just don't know where I'm at. Resident 6 stated when they were in the old room they knew where everything was and felt comfortable going in and out of their room independently. The resident explained in the old room they knew when they got to the doorway because the window was on their left and all they had to do was turn right to walk down the hallway until they heard people around the dining room, and then turned left to get to the dining room for meals. The resident stated, I can't get out of this room because I'm not sure where I am. During an interview on 11/20/2024 at 10:07 AM Staff Y, Nursing Assistant (NA), stated Resident 6 was very upset with the new room. Resident 6 reported to Staff Y they could not find the sink, they could not get into the closet easily, and that the bathroom was too small. Staff Y stated Resident 6 was used to everything being on the right side of their room and now everything was on the left side in the new room. Staff Y stated that Resident 6 had weakness to their left side and their right side was the strong side. Staff Y stated the resident was so upset that they were not doing the things they had done in the past, like walking to the dining room, listening to their music, or playing around and teasing the staff like they normally did. Staff Y stated the resident was mad about the move. Staff Y stated they had encouraged the resident to use their call light for help, so they did not fall in their new room. Staff Y stated the resident really was not doing their normal routine and the resident was afraid they were going to fall when trying to get around in their new room. During an observation and concurrent interview on 11/20/2024 at 11:24 AM, Staff Z, NA, stated Resident 6 had been very quiet and looks sad. The resident was observed lying across their bed, shirtless, with their hands over their face and conveyed their frustration to Staff Z. Staff Z stated when the resident was in their previous room, the resident would sit at the side of the bed teasing/interacting with staff or walk around in the room listening/singing to their music. The resident would independently walk to the dining room with their cane for lunch; Staff Z stated the resident had not been doing that since their move to the new room. During an interview on 11/22/2024 at 10:20 AM, Resident 6's Representative (RR) stated they were very unhappy with the new room change for Resident 6. The RR stated no-one from the facility called to notify either of the RRs about the room change. The RR stated the resident had been in the old room since 2010 ([AGE] years). The RR stated .for a blind person . that was not right . for the facility to move (Resident 6) without even helping them get to know (their new) space is just wrong. The RR stated the resident could not find their way around their new room, they could get really hurt in here. During an interview on 11/22/2024 at 2:20 PM Staff B, Director of Nursing Services, stated the process for moving a resident to a different room, first we do have to ask the resident if they would like to move and notify the resident's family of the room move. Staff B stated that they thought the staff moved the resident into a room with a similar set-up. Staff B stated they were surprised Resident 6 had moved rooms. (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	Reference: WAC 388-97-0860(1)(a)(2)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to ensure a written notification of room changes including the reason for the move to the resident/resident representative for 1 of 2 resident (Residents 6) reviewed for room changes. This failure placed the resident at risk for feelings of frustration and an increased risk for accidents. Findings included . Review of the facility's policy titled, Room/Roommate & Change Notification, updated 05/2022, showed the Social Services Director/Designee notifies the resident and/or representative of the new room change or roommate (prior to the change), documents the decision and notification in the medical record and monitors the resident's acclimation to the new environment/roommate for 24 hours and documents in the medical record. <RESIDENT 6> Review of the medical record showed Resident 6 admitted on [DATE] with diagnosis to include blindness, anxiety (a feeling of worry, nervousness, or unease). The 09/30/2024 comprehensive assessment showed that the resident required supervision or touching assistance with walking and transfers. Review of Resident 6's medical record under the Census tab, showed Resident 6 transferred to a different room on 11/15/2024. Review of the progress notes dated 11/15/2024 through 11/19/2024 showed no confirmation that Resident 6 and/or their representative were notified prior to the room change and the reason for the move. During an interview on 11/22/2024 at 10:22 AM, Resident Representative (RR) stated they had not received a written or verbal notification from the facility prior to Resident 6's room change. During an interview on 11/21/2024 at 10:44 AM, Staff P, Social Service Director, stated they notified the resident and/or representative and obtained consent as soon as possible, prior to the move. Staff P stated they would document it in the roommate change form or document in the progress notes if the resident was verbally notified. Staff P further stated that resident would be placed on alert charting for 24 hours to monitor for their psychological well-being related to the room change. Additionally, Staff P stated the resident and/or the RR had not signed the notice of room change. During an interview on 11/22/2024 at 2:20 PM, Staff B, Director of Nursing Services stated the process for a room change was to obtain consent prior to the room change and make all of the appropriate notifications. Reference: (WAC) 388-97-0580 (b)(ii)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to report allegations of potential abuse and/or neglect to the State Agency, for 1 of 5 residents (Residents 69), reviewed for abuse/neglect. This failure placed the residents at risk for unidentified abuse/neglect, and the potential continued exposure to abuse and/or neglect. Findings included . Review of the facility's policy titled, Abuse - Screening, Training, Identification, Investigation, Reporting, and Protection, revised January 2023, showed that it was the facility's policy to report allegations of abuse to the appropriate reporting authority. <Resident 69> Review of the resident medical record showed they were admitted on [DATE] with a diagnosis including heart complications. Review of the 10/10/2024 comprehensive assessment showed the resident was cognitively intact an able to make their needs known. During an interview on 11/17/2024 at 3:42 PM, Resident 69 stated a night shift nursing assistant (NA) was rough when assisting the resident with perineal care (cleaning of the private areas on the body). Resident 69 stated the night shift NA was mean, and would come into the resident's room with a bad mood when providing care. Resident 69 stated the night shift NA would demand the resident to roll over and would then proceed to roughly push the resident to one side when providing perineal care. Resident 69 stated they had informed Staff II, NA, on the day shift and maybe mention it to another staff member. Additionally, the resident stated they had not seen the night shift NA since the last time they had worked, possibly two days ago. Review of the incident and grievance (a resident concern) reporting log for October through November 2024, showed that no grievance or allegation of abuse had been logged or reported to the State Agency. During an interview on 11/19/2024 at 9:43 AM, Staff II, stated they were unsure of the date but remembered talking with Resident 69 about a night shift NA that was rough with the resident and would demand Resident 69 to roll over, turned (Resident 69) all crazy and what not (referring to the night shift NA's rough handling of the resident). Staff II stated they informed Staff JJ, Licensed Practical Nurse (LPN), about Resident 69's allegations of rough handling and they had both talked with the resident about the incident. Additionally, Staff II stated they identified the night shift NA as Staff KK, NA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 9:47 AM, Staff JJ, LPN, stated they remembered talking with Resident 69 on one of the last days they had worked, 11/11/2024 to 11/13/2024, about Staff KK that was mean, rude and giving Resident 69 a hard time when using the call light. Staff JJ stated they did not remember the resident stating that Staff KK was rough with them but would answer the resident's call light with what do you want now? Additionally, Staff JJ stated they had reported it and management staff went and talked with the resident about it. During an interview on 11/20/2024 at 2:45 PM Staff P, Social Service Director, and Staff B, Director of Nursing Services (DNS), stated they were both unaware of Resident 69's allegation of rough handling by Staff KK. Staff B stated that Resident 69's concerns were allegations of abuse, they should have been reported to the DNS along with the State Agency, and the correct process was not followed. Reference: WAC 388-97-0640(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to conduct a thorough investigation into an allegation of abuse for 1 of 5 residents (Resident 69), reviewed for abuse and neglect. This failure placed the residents at risk for unidentified abuse, unmet care needs, and the potential for continued exposure to abuse and/or neglect. Findings included . Review of the facility's policy titled, Abuse - Screening, Training, Identification, Investigation, Reporting, and Protection, revised January 2023, showed that it was the facility's policy to protect residents from abuse and . All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated . The policy showed that facility staff were to identify inappropriate behaviors such as .derogatory language, rough handling . and that if a staff member was involved in allegation of abuse they were to be removed from their duties and .removed from the center until administrative personnel can complete a thorough investigation of reported incident . <Resident 69> Review of the resident medical record showed they were admitted on [DATE] with diagnosis including heart complications. Review of the 10/10/2024 comprehensive assessment showed the resident was cognitively intact an able to make their needs known. During an interview on 11/17/2024 at 3:42 PM, Resident 69 stated an allegation of rough handling by a night shift staff nursing assistant (NA) when the staff would come help the resident get changed. Resident 69 stated the NA was rude the linebacker (a player's position in football, and the resident's way of conveying the staff members rough handling). Resident 69 stated they had talked with Staff II, NA. Additionally, the resident stated that it may have been two days ago when the incident took place. Record review of the facility's incident and grievance (a resident concern) reporting log from October and November 2024, showed that no grievance or allegation of abuse had been investigated for Resident 69. During an interview on 11/19/2024 at 9:43 AM, Staff II, stated they were unsure of the date but had remembered talking with Resident 69 about a night shift NA that was demanding/rude towards the resident and was rough when providing perineal care. Staff II stated they informed Staff JJ, Licensed Practical Nurse (LPN) about the Resident 69's allegations of rough handling, both staff talked with Resident 69, and they identified the night shift NA as Staff KK During an interview on 11/20/2024 at 9:47 AM, Staff JJ, LPN, stated they had talked with Resident 69 about Staff KK who had been mean/rude to the resident and was giving the resident a hard time during the night shift. Staff JJ stated they recalled Resident 69 stating Staff KK would answer the call light with what do you want now, and Staff JJ reported the resident's concerns to management staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 2:45 PM, Staff P, Social Service Director, and Staff B, Director of Nursing Services, stated they had never received a report on Resident 69's allegation of rough handling against Staff KK. Staff B stated the investigation process should have been started when Resident 69 made the facility staff aware of the allegation of abuse and the correct process was not followed since they were not informed by Staff II or Staff JJ. During an interview on 11/22/2024 at 12:37 PM, Staff A, Administrator, stated the correct process was not followed for Resident 69's allegation of abuse and the investigation process should have been started. Staff A stated that Resident 69 should have been protected by having Staff KK taken off their shift while an investigation was being conducted. Reference: WAC 388-97-0640(6)(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44922 Based on observation, interview and record review, the facility failed to ensure a medication error rate less than 5 percent (%, unit of measure). During observation of 25 opportunities for error, 1 of 3 Licensed Nurses (LNs, Staff O), made three errors, an error rate of 12 %. This placed residents at risk for side effects, unnecessary medications, and/or reduced medication effectiveness due to improper administration. Findings included . Review of the policy titled Medication Administration-General Guidelines dated 08/2018, showed LNs would follow the Five Rights of medication administration: right resident, right drug, right dose, right route, and right time. The five rights should be followed with each medication and verified three times; when the medication is selected, removed from the container, and after the dose was prepared and put away. Review of the policy titled Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy dated 08/2018, showed medications would be ordered five to seven days before running out to ensure adequate supply is on hand. <Resident 16> Review of the resident's medical record showed they admitted with diagnoses to include diabetes (how the body uses blood sugar [glucose]) and a vitamin D deficiency (helps the body absorb calcium for bone health). The 10/27/2024 comprehensive assessment showed Resident 16's cognition was intact. An observation and concurrent interview on 11/21/2024 at 8:38 AM, showed Staff O, Licensed Practical Nurse, prepared Resident 16's morning medications. Resident 16 had an order for Vitamin D (a supplement used for maintaining healthy bones) 50 micrograms (mcg, a unit of measure)/2000 international units (iu, a unit of measure) to be given in the morning. Staff O dispensed one tablet out of a medication bottle that read 25 mcg/1000 iu so the resident should have received two tablets to equal the correct dose. Staff O administered the medications to Resident 16. Staff O then verified the incorrect dose had been given and stated, I didn't realize the bottle was only 25 mcg/1000 iu and Resident 16 should have received two tablets. Staff O stated they normally verified the correct dose was being administered but overlooked it that time. <Resident 32> Review of the resident's medical record showed they admitted with diagnoses to include diabetes and gout (a type of inflammation that causes pain, swelling, and redness in one or more joints). The 10/15/2024 comprehensive assessment showed the resident's cognition was moderately impaired. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and concurrent interview on 11/21/2024 at 9:16 AM, showed Staff O had prepared Resident 32's morning medication. Resident 32 had an order for Zofran (a brand of medication used to relieve nausea/vomiting) to be given prior to eating meals. Resident 32 also had an order for Colchicine (a medication used for gout pain) to be given in the morning. Staff O removed the bingo card (a card that held medications, with vertical columns, and the last column highlighted blue to indicate the medication needed to be reordered) to administer the Colchicine and the card was empty. Staff O stated they had been off for six days in a row and the medication was not ordered. Staff O also checked an emergency back-up kit that did not supply this medication so had to call the pharmacy to order the medication. The resident did not receive the colchicine medication. Also, when entering Resident 32's room to administer the morning medications, the resident had been served and ate their breakfast and refused to take any of the medications because they stated they had an upset stomach and thought they might have needed to have a bowel movement (the resident did not receive their Zofran prior to eating, which decreases stomach upset). Staff O additionally stated they were behind in their medication pass because they had helped the Nursing Assistants (NAs) with a difficult resident that morning and that was why Resident 32 did not receive their Zofran prior to receiving their breakfast. During an interview on 11/22/2024 at 2:02 PM, Staff B, Director of Nursing Services, stated the LNs should be ordering refills when they get to the highlighted blue column of the bingo cards (seven days prior to running out of medication) to give time for the medications to arrive. Staff B stated the LNs should be asking for help if they got behind to ensure the residents were receiving their medications timely. Staff B could not recall the last time the LNs had education on the five rights of medication administration, I am not sure if that is a part of our annual requirements. Reference: WAC 388-97-1300 (1)(a), (5)(b)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review the facility failed to ensure a resident had the cognitive capacity to understand the nature and implication of entering into a binding arbitration agreement used to settle disputes without a jury trial for 1 of 4 residents (Resident 72) reviewed for arbitration. This failure placed the resident at risk for a lack of understanding of the legal contract they had signed and their right to make a choice for a jury trial in the event of a dispute with the facility. Findings included . Review of the Code of Federal Regulations 483.70 (m)(2)(i,ii), F847 Entering Into Binding Arbitration Agreements, showed the facility must ensure the agreement is explained to the resident and/or their representative in a form and manner that the resident understands. The resident or their representative acknowledges that they understand the agreement. <Resident 72> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnosis including fracture of leg bone, heart complications and difficulty walking. The 10/20/2024 comprehensive assessment showed the resident had a severely impaired cognition. Review of Resident 72's care plan, dated 10/23/2024, showed Resident exhibits cognitive loss .discuss concerns regarding overall status/health with resident/family as needed . Review of Resident 72's arbitration document titled, Alternative Dispute Resolution Agreement Between Resident and Facility, dated 10/14/2024, showed that in the event of a dispute the resident would waive their right to a jury by trial in the federal or state court system and that the resident or their representative acknowledges full understanding of the arbitration agreement. The arbitration documented was signed by Resident 72 on 10/15/2024 and showed that no legal representative for the resident had signed the binding agreement. Additionally, Staff GG, Business Office Manager Assistant, signed as the facility's authorized agent. During an interview on 11/20/2024 at 9:13 AM, Resident 72, stated they were unaware of signing an arbitration agreement or what an arbitration agreement even was. The resident was confused and unable to recognize family members names when the names were stated by this surveyor, but then later recalled the family members name and thought they were going to be leaving the facility for a vacation. During an interview on 11/20/2024 at 10:04 AM, Resident 72's Representative (RR), stated they were the resident's power of attorney (POA) and was not aware of an arbitration agreement from the facility or that Resident 72 had entered into a binding arbitration agreement. When inquired about Resident 72 cognitive status and ability to understand written documents, the RR stated Resident 72 was confused not all there and could absolutely not agree to or sign documents for themselves. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sunnyside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 721 Otis Avenue Sunnyside, WA 98944	

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 10:33 AM, Staff HH, Admission Coordinator, stated they were in charge of explaining the arbitration agreement to all residents during the admission process to the facility in order to ensure that a resident and/or the RR understood what was being signed and that it was voluntary. Staff HH stated that when they were unavailable, Staff GG or the facility's Administrator were charged with completing the arbitration agreements. Staff HH stated they verified a resident ability to understand by communicating with nursing staff and they liked to have the resident's family present when signing the arbitration agreement. Additionally, Staff HH stated that a RR would sign as the legal representative if a resident was not cognitively intact or able to understand the arbitration agreement. During an interview on 11/20/2024 at 10:50 AM, Staff GG, stated they completed the admission process with Resident 72. Staff GG stated that when the arbitration agreement document came up the family member with Resident 72 stated that Staff GG should wait for the RR that was the POA, because the resident should not be signing things on their own. Staff GG stated that Resident 72 signed the arbitration agreement acknowledging that they understood the agreement and that no legal representative had signed the arbitration agreement for Resident 72. During an interview on 11/20/2024 at 11:35 AM, Staff M, Licensed Practical Nurse, stated they had completed the assessment of Resident 72 when they admitted on [DATE]. Staff M stated that Resident 72 had a severely impaired cognition when they admitted to the facility and was confused. During an interview on 11/20/2024 at 12:50 PM, Staff A, Administrator, stated they were present with Staff GG during Resident 72's admission process. Staff A stated that Resident 72 had signed the arbitration agreement acknowledging they understood the form. Staff A stated that a family member was present during the admission process, but did not sign as the legal representative for Resident 72. Staff A stated that since Resident 72 was cognitively impaired and not able to understand the arbitration agreement the resident's legal representative should have signed acknowledging the understanding of the binding arbitration agreement. Reference: WAC 388-97-1620(2)(b)(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43280 Based on observation, interview, and record review, the facility failed to implement components of their infection prevention and control precautions regarding Legionella (a bacteria that can cause a severe respiratory disease) testing protocols and procedures when the control measures (actions or steps taken), adopted to reduce the potential growth/spread of pathogens (bacteria, virus or other microorganisms that can cause diseases) in water, were not met for the water management program (WMP) reviewed for infection control. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarifying Requirements to Reduce Legionella Risk in Healthcare Facility Water Systems, dated 09/18/2018, showed the facility's WMP must, at a minimum: Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. Develops and implements a WMP that considers the American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) industry standard and the Center for Disease Control (CDC) toolkit. Specifies testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained. Maintains compliance with other applicable Federal, State and local requirements. Review of the facility's policy titled, Water Management Plan, revised April 2019, showed the facility would adopt control measures for each area at risk for the spread of Legionella. The control measures included . flushing water heaters monthly, disinfecting sinks and showers regularly, flushing unused sinks/showers to reduce stagnation (a state of water not flowing or moving) of water, visually inspecting appliances for signs of biofilm (a community of bacteria that stick together and to a surface forming a protective layer) growth, ensuring that expected water temperatures at fixtures are monitored . Additionally, the policy showed they would implement procedures to execute if control measures were not met. Review of the facility's WMP, dated 10/02/2023 showed the facility identified visual inspections of biofilm growth were needed for the ice machine, spa and eye wash stations. The control measures for the ice machine included, Ice machine is emptied and sanitized once a month and deep cleaned every three months . and replace the filter, cleaning coils (a series of tubes inside the machine that are part of the ice making process), sanitizing (to disinfect something) the interior and cleaning out/sanitizing the ice collecting bin. Additionally, the corrective actions taken when control limits were not maintained was .we will remove or will not use them . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 9:39 AM, Staff F, Maintenance Director, stated they were not aware of what the process would be if the WMP control measures for were not met. Staff F stated they were not involved in the development of the WMP, last reviewed on 10/02/2023, because they were not the Maintenance Director at that time. When showed the facility's WMP intervention when control limits were not met, Staff F stated they will have to rework this, and they could not just stop using or remove the control measures. During a concurrent observation and interview on 11/21/2024 at 9:54 AM, Staff F demonstrated how the ice machine was monitored by facility staff. Staff F opened the ice machine and a black, fuzzy, mold like biofilm growth was observed on the whole underside of the ice collecting bin after the metal shield plate was removed, that (black biofilm growth) should not be there. Staff F stated that Staff DD, Maintenance Assistant, preformed the monthly sanitizing of the ice machine per the facility WMP. During a concurrent interview on 11/21/2024 at 10:02 AM, Staff DD stated they did not sanitize the ice machine the past month. Staff F stated they were responsible for deep cleaning the ice machine but was unable completed all the required components of the ice machines deep cleaning when they checked it in August 2024, that (ice machine) needs to be deep cleaned. Additionally, Staff F stated the facility ice machine control measure was not being maintained. Record review of facility WMP control measures for the past 10 months, from January 2024 to October 2024, showed monthly flushing of the facility water heater had been completed three times out of the past 10 months (seven months without the water heaters being flushed), and monthly sanitization of the facility ice machine had been completed three times out of the past 10 months (seven months of the ice machine not being cleaned/disinfected). When documentation was requested to validate the last deep cleaning of the ice machine, none was provided by the facility. During an interview on 11/21/2024 at 11:11 AM, Staff A, Administrator, stated the black, fuzzy biofilm growth on the facility ice machine showed the control measures were not within acceptable ranges. When showed intervention, from the facility WMP, that were to be implemented if control measures were not maintained, Staff A stated the protocol currently in place was not right and the process needed to be fixed. During an interview on 11/22/2024 at 12:02 PM, Staff C, Infection Preventionist, stated the ice machine looked like mold had been growing in it and that it should have been regularly cleaned. Reference: WAC 388-97-1320 (1)(a)(2)(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 31168 Based on observation and interview the facility failed to provide a safe, functional, sanitary environment by not providing scheduled maintenance services for repairs or cleaning for 1 of 1 kitchen. This failed practice placed the residents at risk for cross contamination, food borne illness and negative health outcome. Findings included . <Ceiling> During an observation on 11/17/2024 at 9:00 AM, the ceiling over the hood where the dishwasher was located had chunks of plaster and dry wall locate on top of the hood. Above was part of missing plaster and or dry wall which had been missing and fell on to the hood. Additionally, there were hanging dust balls on the ceiling over the freezers and refrigerators in a 10-foot span across the ceiling with fuzzy black spots. During an interview on 11/17/2024 at 9:05 AM, Staff H, Dietary Manager (DM), stated that there had been a water leak above the area of where the dishwasher/hood had been located and it was patched. The ceiling fell out onto the hood and had been there for some time. They reported it to maintenance and the administrator. <Floors> During an observation on11/17/2024 at 9:10 AM, there was an open floor area in front of the sinks on the dirty side of the area measured eight and a half inches by three inches and one inch deep and the underflooring was exposed. During an interview on 11/17/2024 at 9:15 AM, Staff H, DM, stated that kitchen staff have almost tripped due to the indentation of that area of the floor that was missing. During an observation on 11/17/2024 at 9:20 AM, the following was noticed: There was a 30.5-inch-long seam separation of the linoleum flooring between front end of the stove and front of the door to the dry goods room. The dry goods room entry way leading to a second storage room had a piece of missing flooring and accumulative black substance over the missing flooring. The flooring was a different color, and a drain was placed in the middle of the flooring that had a slant to the floor with a black gummy substance located in the right corner. There was a 17.5-inch separation of the linoleum seam located on the opposite side of the stove pathway between the clean sink area. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was a15.25-inch linoleum seam open on the side of the steam table from clean side of the kitchen entry door. During an interview on 11/19/2024 at 10:30 AM, Staff F, Maintenance Director, stated they were responsible for cleaning and repairing those areas in the kitchen to including floor repairs, ceiling repairs, cleaning the ceiling areas. Staff F stated they had no schedule for repairing or cleaning the kitchen. Staff F stated that their system for preventive maintenance and requested and or maintenance services was not operational at this time. During an interview on 11/19/2024 at 2:00 PM, Staff A, Administrator stated that they needed to repair the kitchen floors and ceiling and that would require a kitchen project. Reference WAC 388-97-3220(1)