

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Fir Lane Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on interview, and record review, the facility failed to honor bathing and room preferences for 2 of 4 sampled residents (Residents 24 and 74) reviewed for choices. This failure placed residents at risk for poor hygiene, diminished quality of life and not being able to make choices considered important by the resident.</p> <p>Findings included .</p> <p>1) Resident 24 admitted to the facility on [DATE] with a neurological condition (condition that affects the brain, spinal cord, and nerves).</p> <p>During an interview on 05/05/2024 at 11:25 AM, Resident 24 stated, sometimes the aides don't have time for showers so there have been weeks that I've only received one instead of two.</p> <p>Review of the annual Minimum Data Set (MDS, a required assessment tool), dated 03/15/2024, showed Resident 24 was able to make their needs known and their preferences showers were very important to the resident.</p> <p>Review of Resident 24's care plan (CP) showed the resident was to have a bath or shower twice a week on Wednesday and Saturday.</p> <p>Review of Resident 24's bathing documentation in the resident's electronic health records (EHR), from 04/10/2024 through 05/01/2024 showed the resident did not have a bath/shower on 04/13/2024 or on 05/04/2024.</p> <p>During an interview on 05/07/2024 at 8:43 AM, Staff M, Residential Care Manager, said based on review of the EHR, Resident 24 was not receiving two showers per week and should have been. Staff M said all refusals should be documented.</p> <p>During an interview on 05/09/2024 at 11:58 AM, Staff B, Director of Nursing Services (DNS), said they were unable to locate shower sheets for the missing days to show Resident 24 was receiving two showers per week.</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) Resident 74 admitted to the facility on [DATE] with diagnoses including anxiety, depression and post-traumatic stress disorder (a mental health condition that develops following a traumatic event).</p> <p>During an interview on 05/06/2024 at 10:18 AM, Resident 74 said I have been in this room three weeks, I was told by social services I could go back to original room after quarantine, but now I'm being told I'm not going back to original room, I want to go back to my old room.</p> <p>During an interview on 05/09/2024 at 12:18 PM, Staff L, Certified Nursing Assistant, said Resident 74 complained everyday about going back to their old room. Staff L said they spoke with management about the resident's concern and were told the room assignments were not going to be changed.</p> <p>During an interview on 05/09/2024 at 11:54 AM, Staff B, Director of Nursing Services, said there was no plan to move Resident 74 back to their previous room because there was currently a new admission in the room.</p> <p>During an interview on 05/09/2024 at 12:21 PM, Staff A, Administrator, said they were aware Resident 74 was unhappy with their current room situation and intended to relocate the resident back to their previous room but had not done so yet. Staff A said all residents who were relocated due to quarantine should have the right to move back to their room if they prefer.</p> <p>Reference WAC 388-97-0900(1) (3)</p>		

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<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on interview and record review, the facility failed to ensure quarterly personal fund statements were provided to residents with personal fund accounts for 4 of 4 sampled residents (Residents 4, 5, 19 and 24) reviewed for personal fund accounts. This failure placed residents at risk of not having an accurate accounting of their personal funds held in trust by the facility.</p> <p>Findings included .</p> <p>1) Resident 24 admitted to the facility on [DATE] with diagnoses including a neurological condition (a condition that affect the brain, spinal cord, and nerves) and was able to make needs known.</p> <p>During an interview on 05/05/2024 at 11:38 AM, Resident 24 said they had a personal funds account with the facility but never received statements of their balance.</p> <p>Review of the Trial Balance document, dated 05/08/2024, showed Resident 24 had a balance which was held in trust by the facility. Further review showed Residents 4, 5 and 19 also had balances.</p> <p>During an interview on 05/08/2024 at 1:20 PM, Staff H, Business Office Manager said they did not consistently provide residents with a quarterly personal fund statement. Staff H was unable to provide a timeframe when the most recent quarterly statements were provided.</p> <p>During an interview on 05/09/2024 at 12:44 PM, Staff A, Administrator, said they were not aware that quarterly personal funds statements were not provided to residents. Staff A said the expectation was that business office staff would provide a personal funds statement to the resident and/or resident representative on a quarterly basis.</p> <p>Reference: WAC 388-97-0340(3)</p>

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on interview and record review, the facility failed to notify 1 of 1 sampled resident (Resident 19), who was a Medicaid recipient, when their personal fund account balances reached \$1800 (i.e. within \$200 of the \$2,000 resource limit beneficiaries could possess, without their Medicaid coverage being impacted). This failure placed the resident at risk for personal financial liability for their care and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 19 admitted to the facility on [DATE] with a diagnoses including diabetes and depression. Resident 19 was able to make needs known.</p> <p>Review of Resident 19's Medicaid award letter, dated 12/08/2023, showed that according to the rules, the resident could keep up to \$2,000 in resources, and if resources were over \$2,000, they would need to report it to the state agency.</p> <p>Review of the Trial Balance document, dated 05/08/2024, showed Resident 19 had a balance of \$2,888.64.</p> <p>Review of the personal fund account transactions history showed the balance had been over \$2,000 for an extended period from August 2023 through May 2024.</p> <p>During an interview on 05/08/2024 at 1:20 PM, Staff H, Business Office Manager said they did not consistently provide residents with a quarterly personal fund statement. Staff H said they had recently discussed the balance with Resident 19 however it was a challenge to assist with spending the money because the resident already had a burial trust and rarely got out of bed to go shopping.</p> <p>During an interview on 05/09/2024 at 12:44 PM, Staff A, Administrator, said there should have been ongoing conversation if a resident's trust fund balance was within or over the resource limit. Staff A said the expectation was that trust fund balances would be discussed and documented at quarterly conferences to address a spenddown of the funds if needed.</p> <p>Reference WAC 388-97-0340(4)(a)(b)(5)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on interview and record review the facility failed to initiate a resident grievance for 1 of 1 sampled resident (Resident 74) reviewed for grievances. This failure placed the resident at risk of not receiving a grievance resolution, a denial of personal rights and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of a the Grievance Policy Revised/Reviewed Date: 01/2023, 2/2024 showed:</p> <p>Employee Responsibilities</p> <p>Initiate the resident grievance report for all concerns.</p> <p>a. A resident/resident representative may complete the Resident Grievance Report and return it to an employee. The employee should maintain the anonymity of the resident/resident representative to the extent desired.</p> <p>b. Alternatively, the employee who receives the Grievance form from the resident/resident representative should assist the resident/resident representative as needed to complete the form. The employee shall maintain the anonymity of the resident/resident representative to the extent desired.</p> <p>Resident 74 admitted to the facility on [DATE] with diagnoses of anxiety, depression and post-traumatic stress disorder (a mental health condition that develops following a traumatic event).</p> <p>During an interview on 05/06/2024 at 10:18 AM, Resident 74 said I have been in this room three weeks, I was told by social services I could go back to original room after quarantine, but now I'm being told I'm not going back to original room, I want to go back to my old room. Resident 74 described the new room as ghetto and stated their previous room had a shower in it and they did not like the idea of using the shower room.</p> <p>Review of a progress note, dated 04/23/2024 at 5:35 PM, showed Resident 74 was on alert for airborne precautions related to COVID and a room change.</p> <p>During an interview on 05/09/2024 at 12:18 PM, Staff L, Certified Nursing Assistant, said Resident 74 complained everyday about going back to their old room. Staff L said they spoke with management about the resident's concern and were told the room assignments were not going to be changed.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/09/2024 at 11:54 AM, Staff B, Director of Nursing Services, said there was no plan to move Resident 74 back to their previous room because there was currently a new admission in the room and it was resident heavy on that side of the building for the nurse. Staff B said it was explained to Resident 74 several times and she just didn't like our answer. Staff B said they didn't understand why the private shower was a big deal because Resident 74 rarely utilized the shower when in the prior room. Staff B said they did not initiate a grievance nor were they aware if social services had initiated a grievance.</p> <p>Review of a document titled Grievance logs, dated November 1, 2023 through May 7, 2024, showed no grievance related to Resident 74's room change.</p> <p>During an interview on 05/09/2024 at 12:21 PM, Staff A, Administrator, said they were aware Resident 74 was unhappy with their current room situation but did not initiate a grievance because they intended to relocate the resident back to their previous room. Staff A said a grievance should have been initiated when Resident 74 repeatedly voiced a concern.</p> <p>Reference WAC 388-97-0460</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50488</p> <p>Based on interview and record review, the facility failed to follow the recommendations of the Preadmission Screen and Resident Review (PASARR, an in-depth tool to evaluate psychosocial and psychiatric need) Level II, for 1 of 2 residents (Resident 30) reviewed for PASARR. This failure placed residents at risk of not receiving necessary services to meet their mental health and intellectual disability care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 30's quarterly Minimum Data Set (MDS, an assessment tool), dated 03/27/2024, showed the resident admitted to the facility on [DATE] with multiple diagnoses including anxiety, unspecified lack of expected normal physiological development in childhood, and colon/liver and lung cancers. Resident 30 was moderately cognitively impaired.</p> <p>Resident 30 had a Level II PASARR determinations on 12/27/2023, conducted by the state contracted PASARR evaluator. The determinations stated, The Individual is determined to have RC (Related Condition). The box under specialized services needed was filled in with Yes. It was stated under the comment section, she could benefit from services during this tough time.</p> <p>On 05/06/2024 at 10:12AM, Staff F, Social Services Assistant, said the PASARR assessor that completed the form would refer the resident to services. Resident 30's medical record documentation did not show any follow up was made to ensure the resident was referred to and received services.</p> <p>On 05/08/2024 at 10:16 AM, Staff F said she was unable to find any documentation that Resident 30 had received or would receive services. She said she would be reaching out to the PASARR evaluator to coordinate.</p> <p>Reference WAC 388-97-1915 (4)</p> <p>.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37044</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan (CP), within 48 hours of admission, that provided the minimum healthcare information necessary to meet residents' immediate care needs for 1 of 6 residents (Resident 129) reviewed, who recently admitted to the facility. This failure placed residents at risk for medical complications, unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility's Baseline Care Plan Policy, dated 02/01/2023, showed the facility would develop and implement a baseline care plan on new residents within 48 hours of admission. The baseline care plan would include the minimum healthcare information necessary to properly care for a resident, such as:</p> <ul style="list-style-type: none"> <li>a. Initial goals based on admission orders</li> <li>b. Physician orders</li> <li>c. Dietary orders</li> <li>d. Therapy orders</li> <li>e. Social Services and PASRR recommendations if applicable.</li> </ul> <p>Resident 129 admitted to the facility on [DATE] after hospitalization for respiratory failure secondary to chronic lung disease. Review of the Admission Evaluation, dated 05/03/2024, showed the resident admitted on oxygen at four liters per minute via nasal cannula, received anticonvulsant medication for the treatment of seizures, required the use of an indwelling urinary catheter, and was on a 1500 milliliter (ml) per day fluid restriction.</p> <p>Review of the electronic health record showed a baseline CP was not developed or implemented for Resident 129 until 05/06/2024.</p> <p>On 05/08/2024 at 1:18 PM, when asked if a baseline CP had been developed and implemented within 48 hours of admission as required, Staff B, Director of Nursing, stated, no.</p> <p>Reference WAC 388-97-1020 (3)</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</b></p> <p>Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 2 of 32 sample residents (Residents 129 &amp; 69) reviewed. Facility nurses failed to obtain, accurately transcribe, follow, and/or clarify physician's orders when indicated. The facility failed ensure nurses only signed for tasks that were completed. These failures placed residents at risk for medication errors, delays in treatment, unmet care needs and potential negative outcomes.</p> <p>Findings included .</p> <p>&lt;Resident 129&gt;</p> <p>Resident 129 admitted to the facility on [DATE] with care needs related to heart and lung disease.</p> <p>&lt;pain medication&gt;</p> <p>Review of the Resident 129's May 2024 Medication and Treatment Administration Records (MAR/TAR) showed 05/03/2024 orders for oxycodone (narcotic pain medication) 2.5 milligrams (mg) every four hours as needed for pain, and oxycodone 5 mg every four hours as needed for pain. The orders did not provide instruction or the assessment method a nurse should have used to determine if oxycodone 5 mg or 2.5 mg should have been administered.</p> <p>On 05/08/2024 at 1:11 PM, Staff B, Director of Nursing (DNS), said the oxycodone order should have included parameters for use like a pain scale (e.g. pain scale 1-5, give 2.5 mg and 6-10, give 5 mg). Staff B indicated facility nurses should have identified the orders were inappropriately written and corrected and/or clarified them.</p> <p>&lt;oxygen&gt;</p> <p>Review of Resident 129's 05/03/2024 hospital transfer orders showed an order for oxygen therapy at four liters per minute, wean as tolerated. The order did not identify the method of delivery to be used.</p> <p>Review of Resident 129's electronic health record showed the resident did not have an order for administration of oxygen.</p> <p>Review of the facility's 05/03/2024 admission orders showed the oxygen order was never transcribed.</p> <p>On 05/05/2024 at 1:28 PM, 05/06/2024 at 10:54 AM and 05/08/2024 at 11:18 AM, Resident 129 was observed in their room, receiving oxygen at four liters per minute via nasal cannula. Observation of the oxygen concentrator revealed no humidifier bottle was in use and the oxygen tubing was undated.</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>On 05/08/2024 at 1:11 PM, Staff B, DNS, said facility nurses should not have administered Resident 129 oxygen without an order. Additionally, Staff B said each nurse who worked the cart since the resident admitted, should have identified there was not an order for oxygen administration when they attempted to validate the oxygen flow rate was correct, and should have obtained and or clarified the order.</p> <p>On 05/08/2024 at 1:22 PM, Staff B, DNS, said the reason Resident 129 did not have a current oxygen administration order was due to a transcription error during the admission process.</p> <p>50488</p> <p>&lt;Resident 69&gt;</p> <p>Resident 69 was admitted to the facility on [DATE] with multiple diagnoses including depression, pneumonia (an infection in the lungs) and anxiety. The Admission Minimum Data Set (MDS, an assessment tool), dated 01/30/2024, indicated Resident 69 was moderately cognitively impaired.</p> <p>On 05/05/2024 at 10:12 AM, Resident 69 said she had a chest x-ray completed on 04/11/2024 due to feeling short of breath. A seven day course of Levaquin (an antibiotic) was started on 04/18/2024. The MAR showed Levaquin was not given on the 20 th or 21 st. Resident 69 stated, I was told the nurse couldn't find it.</p> <p>On 05/08/2024 at 10:14 AM, Staff G, Licensed Practical Nurse, said some antibiotics were available in the Pyxis (an automated medication distribution system) if needed. When asked if Levaquin would be in the Pyxis, she stated, yes, most likely. She said if the medication was not in the Pyxis, she would call the pharmacy. Staff G stated, any resident that starts an antibiotic is put on alert for side effects and effectiveness for the duration of the medication. Staff G said the nurses complete the alert charting under the progress notes in PCC (Point Click Care, a healthcare documentation system). There was no alert charting completed for Resident 69's antibiotic therapy.</p> <p>On 05/08/2024 at 10:26 AM, Staff B, DNS, stated, there are options if a medication isn't available. The nurse should have tried to pull it from the Pyxis, called the pharmacy to had it satellited, or reached out to management for direction. Staff B said the nurse that approved the antibiotic put in the wrong type of note so the alert charting wasn't triggered.</p> <p>Reference WAC 388-97-1060 (3)</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on interview and record review, the facility failed to provide services to maintain vision for 2 of 2 sampled residents (Residents 50 and 69) reviewed for vision/hearing. This failure placed residents at risk of inability to complete activities of daily living, a heightened risk of accidents and a diminished quality of life.</p> <p>Findings included .</p> <p>1) Resident 50 admitted to the facility on [DATE] with diagnoses including diabetes and kidney failure. Review of Resident 50's admission Minimum Data Set (MDS, a required assessment tool) showed that the resident's vision was assessed to be moderately impaired.</p> <p>During an interview on 05/06/2024 at 9:27 AM, Resident 50 said they were having issues with their vision and they had been waiting for several months to be seen by the eye doctor.</p> <p>During an interview on 05/09/2024 at 11:39 AM, Staff F, Social Service Assistant, said the eye doctor conducts exams at the facility every three months. Staff F said they had recently found multiple appointments that were never made which had included Resident 50's eye exam. Staff F said the resident would be seen within the next month but should have been seen in March 2024.</p> <p>During an interview on 05/09/2024 at 12:37 PM, Staff A, Administrator, said it was the expectation as soon as the resident need was identified, an appointment should have been scheduled.</p> <p>50488</p> <p>2) Resident 69 was admitted to the facility on [DATE] with multiple diagnoses including depression, acute MI (Myocardial Infarction, heart attack), and anxiety. The MDS, dated [DATE], indicated Resident 69 had mild cognitive impairment and impaired vision.</p> <p>On 05/05/2024 at 12:19 PM, Resident 69 said she has had difficulty with nerve pain since the MI. She said it affected the right side of her tongue, her right leg, and her right eye. She stated, I have gray splatters in my right eye. I have to cover my right eye with my hand to be able to watch TV. She said she asked the Social Services Director about an eye appointment when she first admitted but she hadn't heard anything since.</p> <p>On 05/06/2024 at 10:14 AM, Staff F, Social Services Assistant, said the company the facility used for eye exams comes in every six months. Staff F stated, community appointments can be made if a resident needs to be seen sooner. Staff F did not know if Resident 69 had been seen by the eye exam company or if she had been seen in the community.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Fir Lane Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  2430 North 13th Street Shelton, WA 98584	
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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 05/08/2024 at 10:00 AM, Staff F showed documentation that the eye exam company had been in the facility on March 15th 2024, but Resident 69 was not seen due to a COVID infection. Staff F was not able to determine why Resident 69 was not seen in the community. Staff F stated, I only work five hours a month, the social services director quit last week, and the communication has never been very good. Staff F said the eye exam company was due back in the facility on June 7th 2024 and she would make sure Resident 69 was seen.</p> <p>Reference WAC 388-97-1060(3)(a)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</b></p> <p>Based on interview, and record review, the facility failed to ensure fluid intake was accurately monitored, documented, and assessed for 1 of 1 resident (Resident 129) reviewed with a fluid restriction. The failure to accurately record fluid intake and to calculate the resident's total 24-hour fluid intake, precluded staff from determining if Resident 129 was adherent with or was exceeding the ordered fluid restriction. This placed residents at risk for fluid volume overload, fluid and electrolyte imbalances, unidentified education needs and other medical complications.</p> <p>Findings included .</p> <p>Resident 129 admitted to the facility on [DATE]. Review of the Admission Evaluation, dated 05/03/2024, showed the resident admitted with a diagnosis of heart disease and an order for a 1500 milliliter (ml) per day fluid restriction. The kitchen would provide 360 ml with meals and nursing would provide 210 ml on day and evening shift, for a total of 1500 ml/day.</p> <p>A nutrition/hydration at risk care plan, initiated 05/07/2024, showed Resident 129 was on a fluid restriction, and directed staff to monitor and record fluid intake.</p> <p>The electronic health record showed fluid intake with meals was recorded on the meal monitor and the Medication Administration Record (MAR), and fluids provided by nursing were recorded on the MAR.</p> <p>Review of the May 2024 MAR showed nurses were recording the amount of fluid they provided each shift, as well as the resident's fluid intake with each meal. When the fluid intake with meals documentation on the MAR was reconciled with the documentation on the meal monitor, it showed for the meals between 05/04/2024- 05/07/2024, the MAR and meal monitor had conflicting values on 10 of 12 meals:</p> <p>MAR Meal Monitor</p> <p>05/04/2024 05/04/2024</p> <p>Breakfast (B) - Blank B- 350 ml</p> <p>Lunch (L) - Blank L- 350 ml</p> <p>Dinner (D) - 360 ml D- 240 ml</p> <p>05/05/2024 05/05/2024</p> <p>B- Blank B- 220 ml</p> <p>L- Blank L- 240 ml</p> <p>D- 360 ml D- 240 ml</p> <p>05/06/2024 05/06/2024</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B- 360 ml B- 360 ml</p> <p>L- 360 ml L- 360 ml</p> <p>D- 240 ml D- 360 ml</p> <p>05/07/2024 05/07/2024</p> <p>B- 360 ml B- 240 ml</p> <p>L- 360 ml L- 240 ml</p> <p>D- unknown D- 360 ml</p> <p>Review of the May 2024 meal monitor and MAR showed there was no direction to staff to calculate Resident 129's 24-hour intake total, or documentation that it had occurred.</p> <p>On 05/08/2024 at 1:03 PM, Staff B, Director of Nursing, said Resident 129's fluid restriction orders were incomplete, and the documentation was both incomplete and inaccurate.</p> <p>Reference WAC 388-97-1060 (3)(i)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044</b></p> <p>Based on observation, interview, and record review the facility failed to ensure oxygen therapy was provided in accordance with physician's orders and accepted professional standards of practice for 1 of 2 residents (Resident 129) reviewed for respiratory care. Facility staffs' administration of oxygen without an order for oxygen, placed residents at risk for side effects related to oxygen therapy, respiratory compromise and/or unmet respiratory needs.</p> <p>Findings included .</p> <p>Resident 129 admitted to the facility on [DATE], after hospitalization for chronic lung disease, hypoxemia (low blood oxygen levels) and respiratory failure. Review of the Admission Evaluation, dated 05/03/2024, showed the resident admitted to the facility on four liters of oxygen per minute (4L/min) via nasal cannula (NC).</p> <p>On 05/05/2024 at 1:28 PM, 05/06/2024 at 10:54 AM and 05/08/2024 at 11:18 AM, Resident 129 was observed in their room, receiving oxygen at 4L/min via NC. The oxygen tubing was undated and no humidifier bottle was in use.</p> <p>An oxygen therapy care plan, initiated 05/06/2024, showed Resident 129 received oxygen at 2-3L/min for chronic obstructive pulmonary disease. The interventions included direction to monitor for signs and symptoms of respiratory distress and to administer oxygen as ordered.</p> <p>Review of Resident 129's physician's orders on 05/08/2024, showed there was no order for the administration of oxygen, to change and the oxygen tubing and/or humidifier bottle routinely.</p> <p>On 05/08/2024 at 1:11 PM, when asked if Resident 129 had any oxygen maintenance and monitoring orders in place or an order to administer oxygen Staff B, Director of Nursing, stated, No. Staff B explained Resident 129's hospital transfer orders included an order for supplemental oxygen, but it was erroneously omitted when the orders were transcribed.</p> <p>Reference WAC 388-97-1060 (3)(j)(iv)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46793</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services as evidenced by information provided in Resident/Surveyor interviews for 4 residents (Residents 24, 63, 128 &amp; 67) interviewed, and 2 staff (Staff C &amp; Staff D) interviewed. The facility had insufficient staff to ensure residents received assistance with Activities of Daily Living (ADLs) including showers, nail care and shaving. These failures placed residents at risk for unmet care needs and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Resident Interviews/Observations&gt;</p> <p>On 05/05/2024 at 11:25 AM, Resident 24 said sometimes aides didn't have time to give showers.</p> <p>On 05/05/2024 at 1:04 PM, Resident 63 said there was not enough staff and they were real busy.</p> <p>On 05/06/2024 at 11:36 AM, Resident 128 stated, I have had to wait four hours after requesting my pain pill, the excuse or what I was told was, 'I will tell the nurse again', or 'the nurse was on their rounds,' so I had to wait my turn.</p> <p>On 05/10/2024 at 11:41 AM, Resident 67 said wait times were 45 minutes, sometimes longer. Resident 67 said when the Certified Nursing Assistant's (CNA) were asked by residents for help, the CNA's would frequently respond with Not my run, which means they were told to stay on their hall. Resident 67 said agency aides would also not assist with answering call lights.</p> <p>&lt;Staff Interviews&gt;</p> <p>On 05/09/2024 at 12:02 PM, Staff C, CNA, said when they were not able to complete tasks due to not enough staff it is was usually showers that didn't get done.</p> <p>At 12:13 PM, when asked if they had enough time to complete all the daily tasks, Staff D, CNA, stated, sometimes. When asked what tasks they were not able to complete, Staff D said showers, nail care, shaving and Range of Motion exercises and this happened at least twice a week.</p> <p>&lt;Resident Council Minutes&gt;</p> <p>On 11/01/2023 Resident Council Meeting Minutes documented under Department issues: Nursing: Grievances put in.</p> <p>On 01/03/2024 Resident Council Meeting Minutes documented under Department issues: Nursing: No entry.</p> <p>On 02/07/2024 Resident Council Meeting Minutes documented under Department issues: Nursing: Resident not being checked when suppose to.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/06/2024 Resident Council Meeting Minutes documented under Department issues: Nursing: No entry.</p> <p>On 04/04/2024 Resident Council Meeting Minutes documented under Department issues: Nursing: Nurse didn't want to come in Resident's rm (room) when Resident having chest . (page cut off).</p> <p>On 05/01/2024 Resident Council Meeting Minutes documented under Department issues: Nursing: Call lights not being answered. No soaking feet when supposed to.</p> <p>On 05/10/2024 at 10:00 AM, Staff B, Director of Nursing Services, said she knew the facility was having staffing issues, they were cited prior for shortage of staff. When asked about the missing Registered Nurse (RN) coverage, Staff B, said it was an issue and acknowledged the missing RN coverage dates.</p> <p>At 10:48 AM, Staff A, Administrator, said they were having staffing issues, they had been cited prior for lack of RN coverage and acknowledged the multiple missing days without an RN on duty.</p> <p>Reference F561</p> <p>Reference WAC 388-97-1080</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50488</p> <p>Based on interview and record review, the facility failed to provide medically related social services for 1 of 3 residents (Resident 30) reviewed for mood and behavior. The facility failed to monitor for mental health needs and coordinate necessary psychiatric consult/services. These failures placed residents at risk for unmet psychosocial needs, an increase in anxiety, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 30 admitted to the facility on [DATE] with diagnoses including anxiety and Unspecified Lack of Expected Normal Physiological Development in Childhood. The Admission Minimum Data Set (an assessment tool), dated 12/26/2023, showed Resident 30 was severely cognitively impaired.</p> <p>A Preadmission Screening and Resident Review (PASARR) Level II (an in-depth tool to evaluate psychosocial and psychiatric needs), dated 12/27/2023, showed, she could benefit from services during this tough time. The box under Specialized Services needed was filled in with yes.</p> <p>A provider note, dated, 12/20/2023, showed, will have psych provider follow up with patient.</p> <p>A provider note, dated 04/01/2024, showed, F/U [follow up] with Daiya psych provider.</p> <p>A provider note, dated 04/21/2024, showed, Daiya psych as needed.</p> <p>A Quarterly social services assessment, dated 03/25/2024, showed Resident 30 was having, increased anxiety, goal to return to community. Intervention - talking on phone with boyfriend.</p> <p>Multiple nursing notes from 03/12/2024 through 05/05/2024, documented an increase in anxiety with tearfulness, requests for as needed medications, screaming, throwing things, restlessness, and refusal of blood draws. The behaviors were documented to escalate when Resident 30 was unable to reach her partner by phone. The care plan was not updated with these behaviors or resident centered interventions.</p> <p>A nursing note, dated 03/13/2024, showed, resident continued to have behavioral episodes, such as crying, whining, and asking to sleep on the couch in the TV room.</p> <p>A nursing note, dated 03/14/2024, showed, resident refused blood draw again today. Resident believes if she refuses her blood draws that she will be taken to the hospital for her blood draw then discharge into a facility closer to her boyfriend. Provider notified of behaviors.</p> <p>A nursing note, dated 04/11/2024, showed Resident 30 would use the call light and when staff would respond Resident 30 would refuse to communicate with staff.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note, dated 04/13/2024, showed, Resident came back again stating her stomach hurt, I replied she has had something already and that she needs to give it time to work. Resident then went to her room slammed the door and started making herself sick. LN entered the door and saw what she was doing and told her to quit making herself sick. Resident started screaming and throwing stuff in her room.</p> <p>Resident 30's Behavioral Care Plan, revised 04/23/2023, showed, has a behavior problem r/t [related to] dry heave holding stomach when boyfriend will not answer phone. Care Plan interventions included having fewer episodes of attention seeking behaviors, approaching resident in a calm manner, diverting attention, removal from triggering situation/take to an alternate location, and allowing resident to talk on phone without speaker on decrease amount of time on phone.</p> <p>On 05/05/2024 at 9:45 AM, Staff F, Social Services Assistant, said she was not sure what the plan was for Resident 30. A care conference was scheduled for 04/18/2024 but the resident's family member did not come or answer their phone. When asked if a referral was made based on the recommendation of the PASARR Level II, Staff F said the PASSAR assessor would have made the referral. When asked if Daiya psych had seen Resident 30, Staff F said she didn't know.</p> <p>On 05/09/2024 at 1:32 PM, Staff M, Resident Care Manager, stated, I don't know if she has seen anyone from the Daiya psych team, but I will make another referral.</p> <p>Reference WAC 388-97-0960 (1)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>42960</p> <p>Based on observation, interview, and record review, the facility failed to ensure refrigerator temperatures were recorded for 1 of 2 refrigerators in the locked medication rooms. This failure placed residents at risk for receiving medications that were not properly stored.</p> <p>Findings included .</p> <p>On 05/08/2024 10:03 AM, Staff E, Registered Nurse (RN) went into the medication room by the nurse station that was near the front entrance of the facility and they could not find a temperature log for the locked refrigerator. When asked if there was a temperature log, Staff E said, not that I see. When asked if there should have been a temperature log, Staff E said, yes and it is recorded by the staff on the night shift.</p> <p>On 05/08/2024 10:13 AM, Staff B, RN and Director of Nursing Services (DNS), went into the medication room at the nurse station near the entrance to the facility and she could not locate the log for the locked refrigerator temperatures. When asked if there should have been a temperature log, Staff B said, yes and it is usually placed on top of the refrigerator.</p> <p>On 05/10/2024 at 10:59 AM, Staff B, RN and DNS said the refrigerator temperatures should be monitored and documented and if the night shift nurse could not find the log, they should start a new log.</p> <p>Reference WAC 388-97-1300 (2)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067</b></p> <p>Based on observation, interview and record review, the facility failed to prepare and deliver food in a manner that conserved the nutritive value, palatability, an appetizing appearance, and that ensured meal temperatures were maintained for 6 of 6 residents (Residents 10, 54, 13, 23, 39 &amp; 60) reviewed with pureed diets, and for 1 of 6 residents (Resident 46) reviewed for food quality. Dietary staffs' failure to follow written recipes when preparing pureed diets, to test and record holding temperatures including the time the food temperature was checked, and to ensure foods were not overcooked, placed residents at risk for decreased satisfaction with meals, poor intake, weight loss and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Brief Initial Tour&gt;</p> <p>Observation on 05/05/2024 at 10:22 AM during the initial kitchen tour showed incomplete temperature logs. The logs had missing temperatures and there was no documentation of when the temperatures were taken.</p> <p>&lt;Lunch Service&gt;</p> <p>Observation of the lunch meal preparation on 05/07/2024 at 10:59 AM showed Staff K, Cook, was observed using a food processor to puree. Staff K was observed pouring unmeasured amounts of water into the food processor multiple times and checking the consistency with a spatula.</p> <p>During an interview on 05/07/2024 at 11:05 AM, Staff K said they did not document the time the food temperatures were taken because there was no designated area on the form. Staff K said they did not reference any recipe when making puree, they just poured water until the consistency looked good.</p> <p>During an interview on 05/07/2024 at 1:45 PM, Staff J, Dietary Manager, said it was the expectation that staff documented the time and temperatures on the Temp Log prior to and throughout each meal service. Staff J said the cooks should be following recipes for all the meals, every day, including pureed meals.</p> <p>37044</p> <p>&lt;Resident Complaint&gt;</p> <p>Resident 46 admitted to the facility on [DATE].</p> <p>On 05/06/2024 at 10:17 AM, Resident 46 complained about facility food quality and stated, the meat is pretty tough. You have to saw on it a while to take a bite, then chew on it a while .it's tough.</p> <p>On 05/07/2024 the lunch was beef tips in gravy, rice, and carrots. At 1:03 PM a test tray was provided. The beef tips were gristly and difficult to chew, and the rice was over cooked with a mashed potato like texture.</p> <p>(continued on next page)</p>		

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F 0804  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Reference WAC 388-97-1100 (1) (2)

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46067</p> <p>Based on observation, interview and record review, the facility failed to ensure that 2 of 2 sampled residents (Residents 24 and 50) received foods that accommodated the residents' preferences and allergies. This failure placed the resident at risk for meal dissatisfaction, allergic reaction and diminished quality of life.</p> <p>Findings included .</p> <p>1) Resident 24 admitted to the facility on [DATE] with a neurological condition (condition that affects the brain, spinal cord, and nerves).</p> <p>Observation during the lunch meal on 05/06/2024 at 12:02 PM showed Resident 24 eating lunch in the dining room with another resident. Resident 24 was observed scraping their broccoli onto a separate plate. Resident 24 said they continued to get items on their dislike list, especially broccoli, which they also received the night before in a stir fry.</p> <p>During an observation and interview on 05/06/2024 at 12:13 PM, Staff J, Dietary Manager (DM) observed Resident 24's plate and tray card and said, it must have been an oversight by the cook again. Staff J said they had recently done an in-service on resident preferences related to food.</p> <p>Observation during the lunch tray line service on 05/07/2024 showed Staff K, Cook, plated beef tips with cooked tomatoes on Resident 24's plate which was loaded into the food cart for delivery to the unit. Review of the tray card showed cooked tomatoes under the dislikes lists.</p> <p>2) Resident 50 admitted to the facility on [DATE] with diagnoses including diabetes and kidney failure.</p> <p>Observation during the lunch tray line service on 05/07/2024 showed Staff K, Cook, plated beef tips with cooked tomatoes on Resident 50's plate which was loaded into the food cart for delivery to the unit. When requested for the tray to be pulled and reviewed Staff K, Cook, reviewed the tray card which showed beef as an allergy.</p> <p>During an interview on 05/07/2024 at 1:49 PM, Staff J, DM, said the expectation was for staff to follow the tray cards related to preferences and allergies.</p> <p>During an interview on 05/09/2024 at 12:52 PM, Staff A, Administrator, said their expectation was not met, as staff should have paid special attention to resident allergies and preferences by highlighting the tray card each meal.</p> <p>Reference WAC 388-97-1100 (1)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Fir Lane Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  2430 North 13th Street Shelton, WA 98584	
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>46067</p> <p>Based on observation, interview, and record review, the facility failed to appropriately provide specialized diets for 3 randomly observed residents (Resident 18, 69 and 428) during meal service. This failure placed the residents at risk for complications of their medical conditions, weight loss/gain and diminished quality of life.</p> <p>Findings included .</p> <p>Review of general diet lunch menu for 05/07/2024 showed the following:</p> <p>Beef tips, rice, seasoned carrots, dinner roll, chilled pears, juice and milk.</p> <p>Review of the diet spreadsheet provided showed the 05/07/2024 lunch meal for cardiac diet residents were to receive a wheat roll instead of a dinner roll.</p> <p>Observation on 05/07/2024 between 11:35 AM and 12:45 PM, showed Staff K, Cook, serving a general diet to include a dinner roll to all residents including Residents 18, 69 and 428 with tray cards that indicated a cardiac diet.</p> <p>Review of the diet spreadsheet showed cardiac diets and low cholesterol diets were to receive skim milk instead of 2% milk.</p> <p>Observation on 05/07/2024 between 11:35 AM and 12:45 PM, showed dietary staff providing all residents with 2% milk.</p> <p>During an interview on 05/07/2024 at 12:22 PM Staff K, Cook, said the facility only had dinner rolls and 2% milk.</p> <p>During an interview on 05/07/2024 at 1:49 PM Staff J, Dietary Manager said they did not have any skim milk on hand however the expectation was that tray cards were followed, or the dietician would be notified to determine if an alternative could be substituted.</p> <p>Reference WAC 388-97-1200(1)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/10/2024
NAME OF PROVIDER OR SUPPLIER  Fir Lane Health and Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2430 North 13th Street Shelton, WA 98584	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46067</p> <p>Based on observation and interview, the facility failed to ensure food was stored and served under safe and sanitary conditions in one of one kitchen. These failures placed residents at potential risk for cross contamination, food borne illnesses and diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Brief Initial Tour&gt;</p> <p>Observation of the industrial refrigerator on 05/05/2024 at 10:10 AM, showed several uncovered cups of juice on a rolling cart. Additional observation showed several bowls of uncovered pudding on a separate rolling cart in the path of a fan blowing with visible dust/debris blowing.</p> <p>Observation of the industrial freezer on 05/05/2024 at 10:14 AM, showed a package of hot dogs, chicken patties and manicotti unsealed and undated. The chicken patties and manicotti had a thick layer of frost on them.</p> <p>Observation on 05/05/2024 at 10:11 AM, showed three plastic containers of used spices without a date.</p> <p>&lt;Follow-up kitchen observation&gt;</p> <p>Observation of the industrial refrigerator during the lunch meal preparation on 05/07/2024 at 10:10 AM, showed uncovered desserts in the path of a fan with visible dust/debris blowing.</p> <p>During an interview on 05/07/2024 at 10:19 AM, Staff J, Dietary Manager, said the desserts should not have been in the path of the fan and the DM disposed of them. Staff J said they needed to find out if staff were required to cover the desserts because they were being transported via a food cart. Staff J said the evening staff was responsible for pouring the juices the night before and that they should have been covered and labeled. Staff J said all food should have been dated when opened and sealed properly to preserve food quality.</p> <p>During an interview on 05/09/2024 at 12:52 PM, Staff A, Administrator, said the expectation was that food would be stored, prepared and served according to required guidelines.</p> <p>Reference WAC 388-97-1100 (3)</p>		