| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505230 | A. Building<br>B. Wing | 06/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fir Lane Care | 2430 North 13th Street<br>Shelton, WA 98584 |

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to honor resident rights related to medical appointments for 1 of 1 resident (Resident 70) reviewed for resident rights. This failure placed residents at risk of delay in care, emotional upset, and a diminished quality of life.<br><br>Findings included .<br><br>Resident 70 was admitted to the facility on [DATE]. The admission Minimum Data Set Assessment, dated 04/29/2025, showed Resident 70 was understood and understands, and was cognitively intact.<br><br>Review of an email dated 05/16/2025 at 11:25 AM, by Staff L, Transportation, showed Resident 70 had an appointment scheduled for 06/04/2025 with Neurology.<br><br>During an interview on 06/06/2025 at 12:54 PM, Resident 70 said they were promised diagnostic testing when they came to the facility, as they were unsure of why they were no longer able to walk. Resident 70 reported they were supposed to have a nerve conduction test done on their lower spine, but transportation was not arranged and the appointment was canceled. Resident 70 said they had not been informed by the facility, and had only found out because they looked at their email and discovered the appointment had been canceled. Resident 70 said the appointment was rescheduled for 07/09/2025, and they did not want to wait another month (to get possible answers).<br><br>During an interview on 06/06/2025 at 1:38 PM, Staff L, Transportation, said they had made an error and had not scheduled transportation for Resident 70, and the appointment was canceled due to the lack of transportation.<br><br>During an interview on 06/06/2025 at 2:09 PM, Resident 70 said they had been waiting for that appointment for a month, and were upset that it was canceled. Resident 70 stated, I can't wait another month, someone needs to get on the phone and raise hell to get me an earlier appointment. I want to find out what the heck is wrong with me.<br><br>During an interview on 06/09/2025 at 9:42 AM, Staff B, Director of Nursing Services, when asked if it met expectations that Resident 70 had missed an appointment because of a lack of transportation, said no.<br><br>Reference WAC 388-97-0180(1-4)<br><br>(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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | . |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Resident 52 was admitted to the facility on [DATE] and has a diagnosis of depression. Resident 52's Quarterly MDS, dated [DATE] documented the resident was cognitively intact and was dependent to moderate assist with activities of daily living.<br><br>Resident 52's EHR documented Sertraline, an antidepressant, was ordered on 02/24/2025 and the consent was signed on 03/21/2025.<br><br>On 06/09/2025 at 9:49 AM Staff C, RCM/RN said we should have had a consent done when the order was placed. I am not sure why this was missed.<br><br>On 06/09/2025 at 11:07 AM Staff B, Director of Nursing Service said the expectation was for the resident provide consent before the medication was given.<br><br>Reference WAC 388-97-0300 (3)(a)<br><br>Based on interview and record review the facility failed to ensure residents and/or resident representatives were informed and provided consent before administering psychotropic (mind altering) medication for 2 of 6 sampled residents (Residents 52 and 283) reviewed for right to be informed about treatment decisions. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about medications and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 283 admitted to the facility on [DATE]. The admission Minimum Data Set, (MDS, an assessment tool), dated 05/27/2025, documented Resident 283 was severely cognitively impaired. Resident 283 had a court appointed guardian (appointed legal representative who makes decisions).<br><br>A review of consents in the Electronic Health Record (EHR) showed there were consents for the medications Mirtazapine, Risperidone and Lorazepam, all psychotropic medications. All three consents documented Resident 283's guardian had given verbal consent for these medications on 05/23/2025.<br><br>The May 2025 Medication Administration Record documented both Mirtazapine and Risperidone had been administered to Resident 283 on 05/22/2025.<br><br>On 06/06/2025 at 8:55 AM, in a phone interview, Resident 283's guardian said facility staff had not alerted them to Resident 283's arrival on 05/22/2025 and consents were not obtained for medications until 05/23/2025. Resident 283's guardian said the facility did not fax them the medication consents until 05/23/2025, at which point she crossed out the date on the consents (05/22/2025) and inserted the date of 05/23/2025 noting on the consents that verbal consent was not obtained on 05/22/2025. Resident 283's guardian said they then faxed the corrected consents back to the facility. Resident 283's guardian provided copies of the corrected consents with the fax date of 05/23/2025.<br><br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/06/2025 at 11:19 AM, Staff C, Resident Care Manager(RCM)/Registered Nurse(RN), said the expectation was for consents of psychotropic medications to be obtained prior to the first dose being given. Staff C said the evening nurse had not called Resident 283's guardian on 05/22/2025 when Resident 283 arrived at the facility and that she herself had faxed the consents the next day (05/23/2025) and believed they had already been filled out by the evening nurse. When asked if it met her expectations that Resident 283 received medications prior to their guardian giving consent, Staff C said consents should be obtained prior to medication administration. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) Resident 75 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively moderately impaired.<br><br>Review of Resident 75's EHR documented them as Responsible Party. A progress note by Staff F, SSD, dated 06/03/2025, documented he provided the family with paperwork and contact information so they could begin the process of becoming Resident 75's legal representative.<br><br>On 06/06/2025 at 10:49 AM, Staff F said Resident 75 did not have an advanced directive. Staff F said he did not offer information to Resident 75 or their family about establishing a POA during the initial care conference, and said the information was not provided until recently in June 2025.<br><br>On 06/09/2025 at 11:07 AM, Staff B, DNS, said her expectation was that advanced directives be addressed on admission, including offering information about formulating a POA.<br><br>Reference WAC 388-97-0300 (1)(b), (3)(a-c)<br><br>Based on interview and record review, the facility failed to ensure they informed and provided written information to residents on their right to formulate an advance directive (written instruction for the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney (POA) for health care) for 3 of 4 residents (Residents 70, 333, & 75) reviewed for advance directives. This failure placed residents at risk for not having their choice of who to care for them when incapacitated, of not having their health care wishes honored, and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 70 was admitted to the facility on [DATE]. The admission Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 70 was understood and understands, and was cognitively intact.<br><br>Review of the electronic health record (EHR) on 06/03/2025, showed Resident 70 was considered their own decision maker, but there was no documentation of them having been offered or declining the formulation of an advance directive.<br><br>During an interview on 06/04/2025 at 8:29 AM, Staff K, Social Services Assistant, said advance directives should be reviewed on admission, with any evaluation, or if something happens. At 8:31 AM, Staff F, Social Services Director (SSD), joined the interview. Staff F said if a resident was their own person, this was care planned. Staff K said that for Resident 70, there was not documentation of them being offered an advance directive and they should put this in a progress note. Staff K said that they ask residents if they have a POA. When asked if they had offered residents the opportunity to formulate an advance directive, both Staff F and Staff K indicated they understood they had not met this requirement.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of a progress note, dated 06/04/2025 at 8:39 AM, showed social work had brought POA paperwork to Resident 70, and Resident 70 had stated, I don't want anyone to have power to make decisions, I just want them to be able to get information.<br><br>During an interview on 06/04/2025 at 12:18 PM, Resident 70 was asked about advance directives. Resident 70 said the facility had not talked to them about designating a decision maker if they were to become incapacitated, they would want their son or daughter to make the decisions, and if they were provided a form to elect their son or daughter to make decisions when incapacitated, that yes they would be interested in that.<br><br>During a joint interview on 06/04/2025 at 3:12 PM, Staff A, Administrator, and Staff B, Director of Nursing Services (DNS), were both interviewed. Staff B said advance directives should be reviewed on admission, quarterly, and should be care planned. When asked if it met expectations that social work reported they did not always document conversations asking if residents wanted a POA, Staff A and B said no. When asked about their expectation for residents who were their own decision makers, not being offered the right to formulate an advance directive, Staff B said they should be offered.<br><br>2) Resident 333 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed Resident 333 was cognitively intact.<br><br>Review of the EHR on 06/03/2025, showed Resident 333 was considered their own decision maker, but there was no documentation Resident 333 was offered or declined the formulation of an advance directive.<br><br>During a joint interview on 06/04/2025 at 8:31 AM, Staff F, SSD, and Staff K, Social Services Assistant, were asked about Resident 333. Staff F said Resident 333 was their own person (decision maker) and there was no documentation of them being offered the opportunity to formulate an advance directive.<br><br>During an interview on 06/04/2025 at 9:54 AM, Resident 333 was asked if the facility went over formulating an advance directive and if they had declined. Resident 333 said they did not remember declining and their husband would make decisions. After getting an explanation of an advance directive, Resident 333 said if they became unable to make their own decisions, they would want their husband to make decisions. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>.<br><br>Based on interview and record review the facility failed to have a system in place that ensured grievances were initiated, logged, addressed, and timely resolved in response to residents' complaints verbalized during Resident Council (RC) meeting for 4 of 6 months (December 2024, January, February and April 2025) The failure to initiate, log, investigate verbalized concerns, inform residents of their findings and actions taken, if any, prevented the facility from identifying care trends and determining if actions taken were effective in resolving the reported issues. These failures resulted in residents verbalizing the same complaints for multiple months without resolution, and placed residents at risk of feeling frustrated, unimportant and unheard, and a decreased quality of life.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of the facility's Resident Council policy, revised 01/23/2023, showed the staff member who recorded the RC meeting minutes would report concerns/grievances to the Administrator and/or the department head responsible. A response would be provided in writing to concerns/grievances brought up in RC in accordance with the facility's grievance policy and procedure.<br><br>Review of the Facility's Grievances policy, revised February 2024, showed it was staff's responsibility to encourage residents/resident representatives to discuss all grievances so issues may be resolved. Staff would initiate a resident grievance report for all concerns and forward them to the grievance officer. If grievance was an allegation of abuse, neglect or misappropriation it would be immediately investigated. If it was not an allegation of abuse, neglect or misappropriation, the grievance would be read at the daily stand-up meeting, logged in the grievance log and forwarded to the appropriate department for resolution. The department head would then communicate with the resident/resident representative within five days and attempt to resolve the issue. Once resolved, the grievance would be discussed in the daily stand-up and the grievance report would be provided to Social Work. The grievance officer would then follow up with the resident/resident representative to ascertain if they were satisfied with the resolution of the reported concern.<br><br>Review of the RC minutes from December 2024 - May 2025 (6 months) showed the following concerns were verbalized by residents in the RC meetings.<br><br>The December (12/04/2024) RC minutes showed residents reported the following concerns:<br><br>a) When not eating in the dining room liquids are not always provided with residents' meals and when liquids are requested from staff they are not brought right away.<br><br>The minutes did not identify who or how many residents had verbalized the concern about the provision of beverages with meals.<br><br>Review of the grievance log showed no grievances related to the provision of beverages/liquids with meals were logged.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The January (01/01/2025) RC minutes showed residents reported the following concerns:<br><br>a) TVs are too loud and keep others awake.<br><br>b) Privacy curtains are not being closed when they should be.<br><br>c) Staff were not getting drinks for residents on room trays right away. (repeat complaint, 2nd month)<br><br>The RC minutes did not identify:<br><br>a) How many or which residents verbalized concerns about not being provided drinks with meals right away.<br><br>b) Which TVs were too loud or which residents were being kept awake.<br><br>c) Who and/or how many residents expressed concern about privacy curtains not being closed or the specific circumstance(s) related to the concern. (e.g. was the resident(s) exposed when the privacy curtain was left open and in view of others, if so, what effect, if any, did it have on the resident etc.)<br><br>Review of the grievance log showed no grievances were logged addressing the above reported concerns.<br><br>The February (02/12/2025) RC minutes showed residents reported the following concerns:<br><br>a) If a drink is on the tray card, then it should be on the tray. (repeat complaint, third month)<br><br>b) Still having issues with TVs being too loud. (Repeat complaint, 2nd month)<br><br>The RC minutes did not identify:<br><br>a) Who or how many residents were not receiving drinks that were documented on their tray cards to receive, or whether it was a physician ordered beverage (e.g. protein shake for wound healing) or a resident preference (e.g. prefers cranberry juice with lunch).<br><br>b) Which TVs were too loud or which residents were kept awake.<br><br>Review of the grievance log showed no grievances were logged addressing the above reported concerns.<br><br>The March (03/05/2025) RC minutes showed no specific complaints were verbalized.<br><br>The April (04/02/2025) RC minutes showed residents reported the following concerns:<br><br>a) Under Old Business it was documented that call light response time was too long (although this was not recorded in March 2025 RC minutes)<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b) Call light response time needs to be improved.<br><br>c) Residents need haircuts (facility did not currently have a visiting barber/stylist).<br><br>The RC minutes did not identify:<br><br>a) Who or how many residents complained about call light response time, how long they waited, what the resident need was, or what outcome, if any, there was for the resident (e.g. a continent resident needed to void, because assistance did not come for 45 minutes, the resident was incontinent etc.)<br><br>b) Who and/how many residents were requesting haircuts.<br><br>Review of the grievance log showed no grievances were logged addressing the above reported concerns.<br><br>The following residents were in attendance during a meeting with RC on 06/04/2025 at 3:30 PM:<br><br>Resident 52, President; Resident 2; Resident 54; Resident 39; Resident 72; and Resident 58.<br><br>During the meeting residents said staff did not act promptly upon grievances brought forward in the meetings, and did not follow up with them individually or as a group to inform them how they planned to correct the issue(s) or to find out if the action taken was effective. Residents 52, President, 39 and 54 said beverages with meals was still an issue that had not been resolved, but indicated they just stopped bringing it up every month. Resident 54 indicated call light response time was still a problem although improved. Resident 52, President, nodded in agreement but expressed the RC tried to keep the meeting positive and give staff credit for incremental improvement, even if the issue is not fully resolved.<br><br>On 06/06/2025 at 1:33 PM, Staff B, Director of Nursing, said the residents with complaints about beverages with meals, tray cards not being followed, privacy curtains not being closed, and poor call light response time should have been identified so abuse/neglect could be ruled outn with follow-up questioning, and grievances should have been generated and logged on their behalf. When asked if that had occurred Staff B stated, No.<br><br>Reference WAC 388-97-0460<br><br>. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure psychotropic medications (any drug that affects the brain activities associated with mental processes and behavior) were regularly monitored, documented on and/or monthly pharmacist recommendations were acted upon timely, for 2 of 5 residents (Residents 54 &19) reviewed for unnecessary medication. This failure placed residents at risk of unnecessary medication usage, increase in side effects without intervention, and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 54 was admitted to the facility on [DATE] with diagnoses of depression, anxiety disorder, dementia with psychotic disturbance, and psychosis (disconnection from reality). The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 54 was cognitively intact.<br><br>Review of the electronic health record (EHR), showed Resident 54 was taking scheduled psychotropic medications including antipsychotic (a class of psychotropic medication primarily used to manage psychosis) and antidepressant (a class of medications used to treat major depressive disorder, anxiety disorders, chronic pain, and addiction) medications.<br><br>Review of Resident 54's May 2025 Medication Administration Record (MAR), showed missing documentation for the behavior monitor of delusions, hallucinations, and paranoia on 05/07/2025, 05/13/2025, 05/14/2025, and 05/23/2025. Resident 54's side effect monitor for antipsychotic medications had missing documentation on 05/07/2025, 05/13/2025, 05/14/2025, and 05/23/2025. Resident 54's antidepressant side effect monitor had no documentation found for May or June 2025.<br><br>During an interview on 06/05/2025 at 12:40 PM, Staff C, Resident Care Manager (RCM)/Registered Nurse, said psychotropic medications should have side effect monitoring done, and their expectation was for it to be documented. When asked about Resident 54's antidepressant side effect monitor and no documentation for May or June 2025, Staff C said this did not meet expectations. When asked about Resident 54's antipsychotic side effect monitor having missing documentation in May 2025, Staff C said this did not meet expectations. Regarding Resident 54's behavior monitor for delusions, hallucinations, paranoia having missing documentation in May 2025, said this did not meet expectations.<br><br>During an interview on 06/09/2025 at 9:42 AM, Staff B, Director of Nursing Services, was asked what their expectation was for psychotropic medications being monitored for adverse side effects. Staff B said they should be monitored daily, every shift. When asked about behavior monitors, said they should be monitored daily, every shift.<br><br>2) Resident 19 was admitted to the facility on [DATE] with diagnoses of bipolar disorder (episodes of extreme mood swings) and depression. Review of the Medicare 5 Day MDS, dated [DATE], showed Resident 19 was understood and understands, and was cognitively intact. Review of the EHR showed Resident 19 was taking two antidepressants, one antipsychotic, and one mood stabilizer medication.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 19's orders showed they were taking a mood stabilizer called lamotrigine, which is an anticonvulsant medication, once a day for bipolar disorder. Review of Resident 19's EHR showed no adverse side effects monitoring for this medication.<br><br>Review of Resident 19's EHR showed they were taking an antipsychotic medication for bipolar disorder, which required the use of the Abnormal Involuntary Movement Scale (AIMS, tool used to monitor for drug induced movement disorder) for monitoring. AIMS testing was completed on 10/07/2024 and 04/16/2025.<br><br>Review of the Monthly Pharmacist Recommendation Binder, showed Resident 19 restarted an antipsychotic medication in February, and there was a recommendation signed on 02/20/2025 for staff to make sure the AIMS had been done.<br><br>During an interview on 06/06/2025 at 10:30 AM, Staff D, RCM/Licensed Practical Nurse, after looking in the EHR, said they did not see any side effect monitoring done for Resident 19's lamotrigine medication and they would expect there to be. When asked about the recommendation signed off on 02/20/2025 for an AIMS, said it looked like it was not done, and the 04/16/2025 AIMS test would not be considered timely. Staff D said their expectations was for recommendations to be followed through on and done timely.<br><br>Reference WAC 388-97-0620 (1)(a) ,1060 (3)(k)(i)<br><br>. |

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|---|---|---|---|
| | 505230 | A. Building<br>B. Wing | 06/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fir Lane Care | 2430 North 13th Street<br>Shelton, WA 98584 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the State Agency within 24 hours for 1 of 2 resident (Resident 3) reviewed for abuse. This failure placed residents at risk of incidents not being reported and at risk for abuse and neglect.<br><br>Findings included .<br><br>Resident 3 admitted to the facility on [DATE]. The admission Minimum Data Set (an assessment tool), dated 03/21/2025, documented Resident 3 was severely cognitively impaired.<br><br>A social services progress note, dated 05/16/2025, documented that Resident 3 had stated, they hit me.<br><br>Review of the facility investigation logs showed the allegation was not reported to the State Agency until 05/19/2025, 3 days after the allegation.<br><br>On 06/04/2025 at 2:15 PM, Staff B, Director of Nursing Services, said an allegation of abuse should be reported to the State Agency within two 2 hours. Regarding Resident 3's allegation on 05/16/2025 not being reported to the State Agency until 05/19/2025, Staff B said it did not meet her expectations.<br><br>Reference WAC 388-97-0640 (5)(a)<br><br>. |

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|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure notification to the Office of the State Long-Term Care Ombudsman (resident advocates) occurred for residents transferred to the hospital, for 2 of 2 residents (Residents 19 & 25) reviewed for hospitalization. This failure placed residents at risk of a lack of advocacy and possible unidentified or unmet care needs.<br><br>Findings included .<br><br>Resident 19 was admitted to the facility on [DATE]. They were transferred to the hospital on [DATE] and again on 04/05/2025.<br><br>Resident 25 was admitted to the facility on [DATE]. They were transferred to the hospital on [DATE].<br><br>On 06/04/2025 at 9:14 AM, a request was made with the social services department for documentation of ombudsman notifications for Resident 19's hospitalizations on 02/07/2025 and 04/05/2025, and Resident 25's hospitalization on 05/29/2025.<br><br>During an interview on 06/04/2025 at 2:20 PM, Staff F, Social Services Director, said they had not provided the ombudsman with any notifications of residents being hospitalized since February.<br><br>During an interview on 06/04/2025 at 3:10 PM, Staff A, Administrator, said their expectation was for monthly ombudsman notifications with resident hospitalization.<br><br>During an interview on 06/05/2025 at 11:45 AM, Staff F showed they had now sent the ombudsman notifications for hospitalizations and confirmed this was not done before.<br><br>Reference WAC 388-97-0120<br><br>. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review the facility failed to ensure Pre-admission Screening and Resident Reviews (PASRR, a screening tool used to identify behavioral healthcare needs) were completed prior to admission and/or accurately reflected residents' mental health diagnoses for 7 of 8 residents (Residents 67, 53, 69, 78, 44, 54, & 19) reviewed for PASRR. These failure placed residents at risk for inappropriate placement, unmet behavioral healthcare needs and diminished quality of life.<br><br>Findings included .<br><br>1) Resident 67 was admitted to the facility on [DATE]. Review of the 02/26/2025 admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had a diagnosis of anxiety disorder and received antianxiety medication on seven of seven days during assessment period.<br><br>Review of the 02/19/2025 admission/transfer orders showed an order for lorazepam (an antianxiety medication) every six hours as needed (PRN), for anxiety for 14 days.<br><br>Review of the electronic health record (EHR) showed the 14-day PRN lorazepam order had been repeatedly renewed and was still in use.<br><br>A Level I PASRR, dated 02/18/2025, showed Resident 67 had mental health diagnoses, and determined a Level II PASRR referral (in depth evaluation used to determine residents' need for nursing facility services, and whether specialized services are needed) was not required.<br><br>On 06/06/2025 at 2:43 PM, Staff F, Social Services Director (SSD), said Resident 67's 02/18/2025 Level I PASRR was inaccurate and should have identified the resident's diagnosis of anxiety disorder and referral for a Level II PASRR evaluation.<br><br>2) Resident 53 was admitted to the facility on [DATE] with a diagnosis of schizophrenia, depression and anxiety. The Quarterly MDS, dated [DATE], documented the resident was cognitively intact.<br><br>A review of the EHR showed a Level I PASRR, dated 01/22/2025, was triggered for schizophrenia, depression and anxiety and was referred for Level 2 for Serious Mental Illness (SMI). Additionally, the review showed progress notes, dated 01/22/2025, written by social services, said Level II referral sent due to new guidance.<br><br>On 06/06/2025 at 10:49 AM Staff F, SSD, provided an email he sent to follow-up on the Level 2 referrals within the facility, but it did not list Resident 53 specifically.<br><br>3) Resident 69 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact.<br><br>A review of the EHR showed a Level I PASRR, dated 03/03/2025, which listed no SMI Indicators.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident 69's medications showed an order for Risperidone (an antipsychotic), dated 05/05/2025, related to delusional disorder (a mental illness where individuals hold firm, false beliefs despite evidence to the contrary).<br><br>On 06/06/2025 at 10:49 AM, Staff F, Social Services Director, said the PASRR should be updated for a new diagnosis. Staff F said the PASRR had not been updated for Resident 69's new diagnosis of delusional disorder but he would update it.<br><br>4) Resident 78 was admitted to the facility on [DATE] with diagnoses that included delusional disorder and hallucinations unspecified (the experience of perceiving things that are not real, without a clear cause being identified).<br><br>The PASRR Level I, dated 05/09/2025, documented no SMI indicators.<br><br>5) Resident 44 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, delusional disorder, depression, dementia and unspecified psychosis.<br><br>The PASRR Level I, dated 02/15/2024 and 02/23/2024, documented Resident 45 required a Level II referral due to SMI.<br><br>The EHR showed no documentation a Level II evaluation referral had been made, or a Level II invalidation had been completed.<br><br>On 06/06/2025 at 9:24 AM, Staff P, Registered Nurse Unit Manager, said Social Services oversees PASRR's evaluations and making sure they were competed correctly. Staff P was asked to look up Resident 78's PASRR Level I and mental health diagnoses. Staff P said the mental health diagnoses were not on the PASRR Level I and this should have been caught.<br><br>On 06/06/2025 at 9:59 AM, Staff F, SSD, said it was their duty to review all Level I evaluations for accuracy and to refer Level I's as needed to the PASRR evaluators. Staff F said Resident 78's PASRR Level I was incorrect, should have been corrected and referred for a Level II. Staff F reviewed Resident 44's Level I and said they could not confirm if a Level I evaluation was referred or if the facility had received a Level II invalidation/recommendation.<br><br>On 06/06/2025 at 10:22 AM, Staff B, DNS, said Resident 78's Level I should have been corrected and Resident 44's Level I should have been referred to the PASRR evaluators for a Level II.<br><br>Surveyor: Stoneway, [NAME]<br><br>6) Resident 54 was admitted to the facility on [DATE] with diagnoses including depression, anxiety, psychosis, and dementia with psychotic disturbance. The Quarterly MDS, dated [DATE], showed Resident 54 was able to be understood and understands, and was cognitively intact. Review of the EHR showed Resident 54 was taking two antidepressants and one antipsychotic medications.<br><br>Review of Resident 54's Level 1 PASRR from 11/27/2024 showed psychotic disorder was not selected. The form did not select that a Level 2 PASRR evaluation was required. The form was not redone until 06/03/2025. Review of the EHR showed the diagnosis of psychosis was added to Resident 54's diagnosis list on 12/07/2024.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/05/2025 at 1:13 PM, Staff F, SSD, when asked if Resident 54's Level 1 PASRR, dated 11/27/2024, was accurate said no it was not accurate. Staff F said a Level 1 PASRR should be updated if there was a change in diagnosis. When asked about a diagnosis of psychosis having been added to Resident 54's chart on 12/07/2024, Staff F said yes, the Level 1 PASRR should have been redone. When asked if it met expectations that the Level 1 PASRR, from 11/27/2024 to 06/03/2025, had not referred for a Level 2 PASRR, Staff F said no this did not meet expectations.<br><br>7) Resident 19 was admitted to the facility on [DATE] with diagnoses of depression, bipolar disorder, and post-traumatic stress disorder (PTSD). Review of the Medicare 5 Day MDS, dated [DATE], showed Resident 19 was understood and understands, and was cognitively intact. Review of the EHR showed Resident 19 was taking two antidepressants, one antipsychotic, and one mood stabilizer medication.<br><br>Review of Resident 19's Level 1 PASRR, dated 01/22/2025, showed they had SMI indicators selected, specifically Mood Disorders-Depressive or Bipolar. That specific section had listed diagnostic codes (shows what the resident had a diagnosis of, since they may or may not have one or both diagnoses, or have another mood disorder not listed), with only depression listed (bipolar was not listed).<br><br>During an interview on 06/05/2025 at 1:13 PM, Staff F, SSD, reviewed Resident 19's Level 1 PASRR, dated 01/22/2025, and said they did not see indication for PTSD on the form.<br><br>During an interview on 06/05/2025 at 10:30 AM, Staff D, Resident Care Manager/Licensed Practical Nurse, was asked to review Resident 19's Level 1 PASRR from 01/22/2025. Staff D said the box for mood disorder or depression was selected, with depression bolded. When asked what mental health diagnoses Resident 19 had, Staff D said bipolar, PTSD, and depression.<br><br>Reference WAC 388-97-1915 (1)(2)(a-c)<br><br>. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Resident 67 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact, had Stage 3 (Full-thickness skin loss in which fat is visible in the ulcer) and Stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure injuries, required substantial to maximal assistance with bed mobility, and had an indwelling urinary catheter.<br><br>A Urinary Incontinence and Indwelling Catheter care area assessment, completed 03/04/2025, documented Resident 67 required an indwelling catheter secondary to Stage 3 and Stage 4 pressure injuries to the sacrum and right buttock.<br><br>Review of the urinary catheter care plan, revised 04/17/2025, showed there was no indication or justification for use documented. The goals were identified as: will remain free from urinary tract infections and other catheter related complications; and will have the catheter removed in the absence of indications for use.<br><br>On 06/05/2025 at 10:32 AM, Staff S, Resident Care Manager, said Resident 67's care plan should have identified the purpose of the indwelling catheter was to prevent contamination of the resident's Stage 3 and 4 pressure ulcers to promote wound healing, but acknowledged it did not.<br><br>Based on interview and record review, the facility failed to ensure person centered care plans were completed to address all aspects of resident care for 3 of 24 sampled residents (Resident 69, 67, and 19) reviewed for comprehensive care plans. These failures placed residents at risk for inconsistent and/or inadequate care and treatment and a diminished quality of care.<br><br>Findings included .<br><br>1) Resident 69 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool) dated 03/20/2025 documented the resident was cognitively intact.<br><br>A review of the Electronic Heath Record (EHR) showed Resident 69 had a focus of therapeutic nutritional risk care plan with a goal and interventions initiated on 03/05/2025.<br><br>On 06/09/2025 at 10:07 AM, Staff W, Dietician, said while looking at the Resident 69's theraputic nutrition care plan that it needed to be updated and said, thank you for pointing that out. Staff S said she would add information such as a history of refusal, encourage food and fluid intake, provide a supplement as ordered, inadequate nutrition and weight loss may be unavoidable, inability to consume adequate nutrition, refusal of purposed interventions, psych provider to assessed, and honor their wishes as a [age of resident in years] old.<br><br>On 06/09/2025 11:07 AM, Staff B, Director of Nursing, said her expectation would be that the care plan be patient specific based on their needs.3) Resident 19 was admitted to the facility on [DATE] and had a diagnosis of anemia (low levels of red blood cells or hemoglobin). The Medicare 5 Day MDS, dated [DATE], showed Resident 19 was cognitively intact, and wore corrective lenses for moderately impaired vision.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the EHR showed Resident 19 was hospitalized from [DATE] to 04/14/2025.<br><br>Review of Resident 19's care plans showed their anemia diagnosis was listed as a potential cause for risk for falls and risk for nutrition, but there was not a specific care plan for anemia with goals and interventions to prevent rehospitalization. There was no information related to anemia on risk factors, signs/symptoms or monitoring considerations, and it did not include any information on the recent blood transfusions. Review of Resident 19's alteration in sensory/communication related to visual disturbance care plan did not mention any information on them wearing glasses or their needs related to wearing glasses.<br><br>During an interview on 06/02/2025 at 10:50 AM, Resident 19 reported they wore glasses, had trouble reading even with their glasses on, and needed assistance by staff to read. Resident 19 said their last hospitalization was for a blood transfusion.<br><br>Review of a provider note from 05/28/2025 documented Resident 19 was hospitalized on [DATE] for multiple concerns including acute-chronic anemia receiving blood transfusion.<br><br>Review of other progress note from 05/29/2025 at 4:32 PM, showed Resident 19 had a blood transfusion that day and documented, Resident just returned from clinic, he states it went well and he feels great. Will continue to monitor for adverse effects of transfusion and Nurse reported that he tolerated well, two units packed RBC's [red blood cells] received, 6.6 hgb [hemoglobin], 18.9 hct [hematocrit] pre-infusion. Will call back once post-infusion labs are received.<br><br>During an interview on 06/06/2025 at 10:30 AM, Staff D, RCM/Licensed Practical Nurse, reviewed Resident 19's EHR and said there was not a specific care plan for anemia (with goals and interventions) or blood transfusions, and there should be.<br><br>During an interview on 06/09/2025 at 9:42 AM, Staff B, DNS, said they expected care plans to be updated with changes, quarterly with MDS assessments, and on admission with baseline. When asked about Resident 19's care plans and anemia diagnosis, Staff B did agree that blood transfusions were not included in the care plan. When asked how the facility updated care plans to prevent future hospitalizations, Staff B said they should be reviewing the care plan on return from the hospital. When asked if blood transfusions should be added to the care plan, Staff B said they would add a history of blood transfusions. When asked if Resident 19's glasses usage should have been added to the care plan, Staff B said yes.<br><br>Reference WAC 388-97 -1020(2)(c)(d), (5)(b)<br><br>. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) On 06/05/2025 at 8:06 AM, during a medication administration observation and record review, it was noted that Resident 450 had a current order for Aspirin 81 mg tablet, in a chewable form.<br><br>On 06/05/2025 at 8:15 AM, Staff Q, LPN, provided Resident 450 with a small plastic cup with multiple medications in it, including the chewable Aspirin. Resident 450 was observed taking all the medications with a drink of water, including the chewable medication.<br><br>On 06/05/2025 at 8:36 AM, Staff Q, regarding the chewable medication being swallowed and not chewed, said Resident 450 requests to take them all together. Staff Q said she had to give them the chewable form of the medication, rather than the non-chewable form, because that was how it was ordered.<br><br>On 06/09/2025 at 10:48 AM, Staff C, RCM/RN, when asked what the process was if a resident preferred a medication in a different form, said staff could get orders from the doctor to change it to the right form, such as with chewable aspirin, and staff could contact the doctor. When it was explained staff had reported Resident 450 preferred their tablets be taken in non-chewable forms and had been given their chewable tablet with other medications, Staff C said her expectation was that staff would get the order changed.<br><br>4) On 06/04/2025 at 12:20 PM, during a medication cart observation, when looking at the controlled substance book (book for documenting quantity of control substances) it was noted that a small clear plastic bag with a white pill in it was pinned to the book with a paper clip. The bag had writing on it with a resident's name, Oxy and 2.5 written on it. When asked about the pill, Staff J, RN, said a nurse failed to waste (destroy) it appropriately.<br><br>On 06/04/2025 at 12:55 PM, Staff C, RCM/RN, when asked when staff should waste a controlled substance not being used, said immediately. After being informed of the assumed controlled substance pill that was found paper clipped to the narcotic book, Staff C said her expectation was this would not happen.<br><br>On 06/04/2025 at 1:00 PM, Staff C went to the medication cart to talk with Staff J. Staff J told Staff C that the night shift nurse did not know what had happened with the pill, and Staff J had told the night nurse she would take care of it on her shift. Staff J said she wasn't sure what happened but assumed because the order was for ½ a tablet of the controlled substance, the medication was provided by pharmacy as a whole tablet, this was possibly the half leftover, and it should have been wasted. Staff C said it looked as though they didn't have ½ tablets of this medication to provide to the resident and the leftover medication should have been destroyed.<br><br>Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)<br><br>Based on interview and record review, the facility failed to meet professional standards of practice by failing to follow medication administration times, to follow up with the provider, to waste controlled substances timely, and/or to ensure medications were in an appropriate form for 3 of 21 sampled residents (Residents 54, 333, & 450) and 1 of 3 medication carts (Medication Cart A3) reviewed. This failure placed residents at risk of medication complications and a diminished quality of life.<br><br>(continued on next page) |

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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Findings included .<br><br>1) Resident 54 was admitted to the facility on [DATE] with a diagnosis of hypothyroidism (thyroid gland does not produce enough hormones). The Quarterly Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 54 was cognitively intact.<br><br>Resident 54's electronic health record (EHR) had an order for levothyroxine for thyroid disorder, to be given in the morning scheduled for 6:00 AM.<br><br>Resident 54's hallway was scheduled to receive breakfast at approximately 8:15 AM daily.<br><br>Resident 54's 6:00 AM levothyroxine medication administration times were reviewed, from 05/01/2025 through 06/04/2025, and showed the following dates with administration times over 1 hour past 6:00 AM:<br><br>05/01/2025- 12:41 PM<br><br>05/02/2025- 10:20 AM<br><br>05/05/2025- 11:03 AM<br><br>05/06/2025- 8:42 AM<br><br>05/07/2025- 11:14 AM<br><br>05/08/2025- 11:13 AM<br><br>05/09/2025- 9:08 AM<br><br>05/12/2025- 10:47 AM<br><br>05/13/2025- 12:56 PM<br><br>05/14/2025- 1:58 PM<br><br>05/15/2025- 10:58 AM<br><br>05/16/2025- 10:57 AM<br><br>05/19/2025- 11:04 AM<br><br>05/20/2025- 7:23 AM<br><br>05/21/2025- 9:29 AM<br><br>05/22/2025- 9:57 AM<br><br>05/23/2025- 10:41 AM<br><br>(continued on next page) |

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| | 505230 | A. Building<br>B. Wing | 06/09/2025 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 05/24/2025- 7:33 AM<br><br>05/26/2025- 10:17 AM<br><br>05/27/2025- 8:49 AM<br><br>05/28/2025- 9:13 AM<br><br>05/29/2025- 12:58 PM<br><br>05/30/2025- 8:41 AM<br><br>06/02/2025- 7:13 AM<br><br>06/03/2025- 10:02 AM<br><br>06/05/2025- 8:26 AM<br><br>06/04/2025- 9:17 AM<br><br>During an interview on 06/04/2025 at 3:41 PM, Resident 54 said they were getting their thyroid medication after breakfast and it was supposed to be given before breakfast on an empty stomach, scheduled for 6:00 AM.<br><br>During an interview on 06/05/2025 at 12:40 PM, Staff C, Resident Care Manager/Registered Nurse (RCM/RN), when asked if levothyroxine had specific timing, said it should be given on an empty stomach, at the same time every day, and for Resident 54 at 6:00 AM. When asked about levothyroxine being given greater than one hour after 6:00 AM, for 27 of 36 days reviewed, Staff C said it should be given within an hour.<br><br>During an interview on 06/09/2025 at 9:42 AM, Staff B, Director of Nursing Services (DNS), when asked about levothyroxine being given over one hour past 6:00 AM, for 27 of 36 days reviewed, said it did not meet expectations if it was given after meals. When administration times of 12:00 PM and 1:00 PM were brought up, Staff B said this did not meet expectations.<br><br>2) Resident 333 was admitted to the facility on [DATE] with a diagnosis of hypertension (high blood pressure). The admission MDS, dated [DATE], showed Resident 333 was cognitively intact.<br><br>Review of Resident 333's EHR showed they had an order for lisinopril (blood pressure medication), ordered on 05/22/2025, for 20 milligrams (mg) by mouth two times a day for hypertension, with hold parameters for a systolic blood pressure (top number) less than 100.<br><br>Review of Resident 333's May MAR, from 05/22/2025 through 05/31/2025, showed on 05/27/2025 the evening dose was held for a blood pressure (BP) of 97/49 and the evening dose was held 05/31/2025 for a BP of 89/64.<br><br>Review of a progress note, dated 05/31/2025, showed a nurse had documented, BP 89/64. Resident states she was taking lisinopril 20 mg once a day while at home, and would like to go back to doing so.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 333's June MAR, from 06/01/2025 through 06/04/2025 morning, showed the following BP readings connected to the lisinopril order:<br><br>06/01/2025, AM BP 103/59 (medication held); PM BP 108/67<br><br>06/02/2025, AM BP 118/82, PM BP 102/62<br><br>06/03/2025, AM BP 110/68, PM BP 106/66<br><br>06/04/2025, AM BP 116/70<br><br>During an interview on 06/03/2025 at 8:37 AM, Resident 333 said they had been given too much of their blood pressure medication at this facility, and at home they only took 20 mg a day and now were receiving that dose twice a day.<br><br>During an interview on 06/04/2025 at 9:58 AM, Resident 333 said their blood pressure readings were still low, and their blood pressure had never been this low. When asked if they were still getting the medication twice a day, said they did not know if they were as the staff did not tell them what they were giving.<br><br>During an interview on 06/06/2025 at 10:30 AM, Staff D, RCM/Licensed Practical Nurse (LPN), reviewed Resident 333's EHR and confirmed there was a progress note on 05/31/2025 about Resident 333 reporting they were receiving the wrong dose. Staff D said this was not communication with the provider, there was no follow up seen in the EHR, and there should have been. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure routine assessment and monitoring of skin conditions and implementation of interventions for 1 of 2 residents (Resident 67) reviewed for non-pressure skin, to provide bowel care in accordance with physicians' orders and facility protocol for 4 of 8 residents (Residents 67, 41, 45 & 283) reviewed for bowel management, and to effectively communicate, collaborate, and implement coordinated hospice plans of care for 2 of 2 (Residents 26 & 11) reviewed for Hospice services. These failures placed residents at risk for unidentified decline and/or delayed treatment and healing of non-pressure skin conditions, abdominal pain, decreased appetite, other negative outcomes related to untreated constipation, and unmet end of life care needs related to hospice services.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of the facility's Management of Constipation policy, revised November 2023, showed<br><br>constipation was defined as three or more days without a bowel movement (BM). When a resident was identified with no BM for eight shifts or 64 hours, the LN would assess the resident and determine if the bowel protocol would be initiated. The protocol to relieve constipation was as follows:<br><br>a) Administer Milk of Magnesia (MOM) after eight shifts of no BM.<br><br>b) Administer a bisacodyl suppository, if no results from MOM.<br><br>c) Administer a fleet enema, if no results from the bisacodyl suppository.<br><br><Bowel Management><br><br><Resident 67><br><br>Resident 67 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool) showed the resident was cognitively intact and was constipated during the assessment period.<br><br>On 06/03/2025 at 8:55 AM, Resident 67 complained that they occasionally suffered from constipation.<br><br>Review of the Electronic Health Record (EHR), showed Resident 67 had the following 02/19/2025 bowel care orders:<br><br>a) Administer MOM if there is no BM on the third day.<br><br>b) Bisacodyl suppository as needed for Constipation if no results from MOM after 12 hours.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | c) Fleet enema as needed for Constipation if no results from bisacodyl suppository in 4-6 hours. If there are no results from the enema, notify MD.<br><br>Review of the March and April 2025 bowel records and Medication Administration Records (MARs), showed Resident 67 went the following periods without a BM, and was not administered as needed bowel medication as ordered:<br><br>a) No BM from 03/15/2025 - 03/18/2025 (11 shifts); No PRN bowel medication was administered.<br><br>b) No BM from 03/20/2025 - 03/24/2025 (12 shifts); No PRN bowel medication was administered.<br><br>c) No BM from 04/19/2025 - 04/22/2025 (12 shifts); No PRN bowel medication was administered.<br><br>On 06/05/2025 at 10:22 AM, Staff S, Resident Care Manager, confirmed Resident 67 went the above-mentioned periods without a BM. When asked if facility nurses administered the resident's as needed bowel medication after three days without a BM as ordered Staff S stated, No.<br><br><Resident 41><br><br>Resident 41was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact and did not have constipation during the assessment period.<br><br>On 06/03/2025 at 11:49 AM, Resident 41 said they would occasionally get constipated.<br><br>Review of the EHR, showed Resident 41 had the following 12/15/2023 bowel care orders:<br><br>a) Lactulose, administer if no BM on third day.<br><br>b) Bisacodyl suppository as needed for Constipation if no results from MOM after 12 hours.<br><br>Review of the February and May 2025 bowel records and MARs, showed Resident 41 went the following periods without a BM and was not administered as needed bowel medication as ordered:<br><br>a) No BM from 02/26/2025 - 02/29/2025 (12 shifts); No PRN bowel medication was administered.<br><br>b) No BM from 05/17/2025 - 05/20/2025 (12 shifts); No PRN bowel medication was administered.<br><br>On 06/09/2025 at 3:14 PM, Staff B, Director of Nursing, confirmed Resident 41 went to the above-mentioned periods without a BM. When asked if facility nurses administered the resident as needed bowel medication after three days without a BM as ordered Staff B stated, No.<br><br><Resident 45><br><br>Resident 45 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 45 was severely cognitively impaired.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 45 had no documented bowel movement on 05/05/2025-05/08/2025 (4 days), 05/17/2025-05/20/2025 (4 days), 05/22/2025-05/25/2025 (4 days), or 05/29/2025-06/02/2025 (5 days). The EHR documented no initiation of the bowel protocol for the 05/05/2025-05/08/2025, 05/17/2025-05/20/2025, or 05/22/2025-05/25/2025. A progress note, dated 06/02/2025, documented the bowel protocol was initiated on 06/02/2025, 5 days after no bowel movement (greater than 64 hours).<br><br>The MAR/TAR for May and June 2025 documented Milk of Magnesia had been administered once on 05/22/2025, noted first day of no bowel movement as 06/02/2025, 5 days after no bowel movement.<br><br>On 06/06/2025 at 9:24 AM, Staff P, Registered Nurse Unit Manager, said the dashboard in the EHR, would alert staff if a resident had gone more than 64 hours without a bowel movement. On the third day (72 hours) without a bowel movement, staff would offer/administer Milk of Magnesia. If it produced no result, 24 hours later they would offer/administer a suppository. If no result after another 24 hours, staff would offer/administer a fleet enema. Staff P reviewed all dates with no bowel movement and said the bowel protocol should have initiated for all the dates.<br><br>At 10:22 AM, after being provided with all the dates with no bowel movement for Resident 45, Staff B, DNS, said the bowel protocol should have been started and should have been documented for all episodes.<br><br><Resident 283><br><br>Resident 283 admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 283 was severely cognitively impaired. Resident 283 was a Hospice patient.<br><br>Review of Resident 283's care plan showed alteration in bowel elimination, constipation related to decreased mobility, medication side effects with the goal of a normal bowel movement at least every third day.<br><br>Review of Resident 283's orders showed the following bowel medication orders to treat constipation:<br><br>Order dated 05/22/2025, Bisacodyl Rectal Suppository, insert one suppository rectally every 24 hours as needed for constipation.<br><br>Order dated 05/23/2025, Fleet Enema, insert one application rectally every 24 hours as needed for constipation if no results from Dulcolax in 4-6 hours. If there were no results from enema, notify MD.<br><br>No order for Dulcolax was found.<br><br>Review of Resident 283's bowel records documented no bowel movement from 05/28/2025 through 06/03/2025, 7 days. Further record review showed Resident 283 did not have a suppository administered until 06/03/2025.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 06/06/2025 at 11:19 AM, Staff C, Resident Care Manager/Registered Nurse, said the ordered bowel medications came from the Hospice provider. When asked if it met expectations that a suppository was not administered until the seventh day of no bowel movement, Staff C said it was difficult when someone was passing away and not eating or moving much. Staff C said usually bowel meds were given on the third day of no bowel movement, and staff should have checked with Hospice to see when they should have given the suppository.<br><br><Hospice Services><br><br><Resident 26><br><br>Resident 26 was admitted to the facility on [DATE]. Review of the Significant change MDS, dated [DATE], showed the resident had severe cognitive impairment, a terminal diagnosis and was on Hospice services.<br><br>Review of the EHR showed Resident 26's Hospice intake, terminal diagnosis, current coordinated Hospice plan of care or any hospice visit notes were not present in the resident's record. There was also no indication or documentation what disciplines Hospice was to provide (e.g. Registered Nurse, home health aide, Chaplain, Master Social Worker, music therapy etc.,) and at what frequency.<br><br>On 09/06/2025 at 11:10AM, when asked how do staff knew what disciplines Hospice was providing and at what frequency Staff B, Director of Nursing, said the information should be documented in the Hospice plan of care. When asked if they could find a Hospice plan of care in the resident's record Staff B stated, No. When asked if they knew what disciplines had visited Resident 26, when, and what was done during the visit from the information in Resident 26's EHR Staff B, said no.<br><br><Resident 11><br><br>Resident 11 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 11 was rarely/never understood, severely cognitively impaired, was on hospice and had a terminal diagnosis. Resident 11 was placed on hospice services on 01/13/2025.<br><br>The EHR had minimum hospice documentation, which included uploaded files on:<br><br>02/06/2025 Hospice Physician Order- Hospice MD prescribed Paxlovid (COVID-19 treatment)<br><br>02/07/2025 Hospice Physician Order- Hospice MD prescribed Paxlovid<br><br>02/07/2025 Medication Review<br><br>03/17/2025 Medication Review<br><br>03/31/2025 Medication review.<br><br>05/29/2025 Hospice Physician Order- increase in Lorazepam (an antianxiety medication).<br><br>Progress notes documented dated:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 02/11/2025 Resident 11's bathing would discontinue Mondays but would continue on Wednesdays and Saturdays.<br><br>02/19/2025 Ativan (an antianxiety) was stopped for comfort measures.<br><br>05/30/2025 Per hospice order and increase in Lorazepam.<br><br>No other hospice documentation was found including the most recent individualized hospice plan of care, hospice election form, the Physician certification/recertification of the terminal illness, visitation notes (log in sheets), or progress notes stating care provided to the resident.<br><br>On 06/09/2025 at 9:27 AM, Staff R, Registered Nurse, said they used to have binders located at the nurse's station with all hospice information. Staff R said all contact information for hospice wass located in the EHR and staff could send referrals to hospice via the EHR. Staff R looked through all the binders located at the nurse's station and could not locate a hospice binder for Resident 11.<br><br>At 9:37 AM, Staff S, Licensed Practical Nurse, said all hospice information was kept in the EHR of the resident's hospice binder. Staff S provided a hospice binder. Upon review of the hospice binder the only information found was a resident Facesheet (demographics), POLST (Physician Orders for Life-Sustaining Treatment, is a portable medical order that helps people with serious illnesses communicate their wishes for end-of-life care to medical providers) and Advance Directive (legal documents that allow individuals to outline their preferences for healthcare decisions). No hospice care plan, hospice election form, Physician certification, visitation notes or progress notes were found.<br><br>At 11:10AM, Staff B, DNS, said the point of contact for all hospice residents were the assigned unit managers. When asked how RCM's knew what disciplines were required and at what frequency for hospice services, Staff B said it should be documented in the hospice plan of care. When asked how that information was provided to the floor staff, Staff B said it should be loaded into the EHR. Staff B said all hospice documentation including plan of care, visit notes, and progress notes should be in EHR. When asked to review Resident 11 and Resident 26's hospice documentation, Staff B said they could not locate any hospice documentation for Resident 11 or Resident 26, including hospice plan of care, hospice election form, the Physician certification/recertification of the terminal illness, visitation notes (log in sheets), or progress notes stating care provided to the resident.<br><br><Non-pressure Skin Monitoring><br><br><Resident 67><br><br>During an interview on 06/04/2025 at 12:07 AM, Resident 67 began vigorously scratching her right shoulder and right and left hips. Observation showed a palm sized area with linear abrasions with a scant amount of blood present at each location. Resident 67 indicated there was another area on their back and explained that their antibiotic had been making them itchy for a few months. The resident said they used to receive Benadryl, but the nurse informed them the order was no longer in place.<br><br>A generalized rash to bilateral (both) arms and trunk care plan, initiated 03/31/2025, directed staff to apply moisturizer to dry flaky skin, cue resident to avoid scratching, and monitor for spreading of the rash.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A 03/04/2025 wound consultant note documented Resident 67 had a significant rash and recommended discontinuing their Keflex (an antibiotic) and starting the resident on doxycycline (an antibiotic). The consultant also recommended administering Benadryl every six hours as needed for itching.<br><br>A 03/11/2025 wound care consult documented Resident 67 complained of a pruritis (the sensation of an unpleasant urge to scratch the skin) and identified a rash to the resident's back. The wound care consultant recommended applying hydrocortisone (anti-inflammatory cream) 1% to the residents back for seven days and to administer Benadryl (an antihistamine) every six hours as needed for itching.<br><br>Review of the March 2025 MAR and Treatment Administration Record (TAR) showed the 03/11/2025 recommendation for Benadryl and hydrocortisone were not implemented. Nor was there direction to staff to monitor the abrasions to the residents left lower back.<br><br>A 04/30/2025 nurses note documented the resident had a six-centimeter (cm) x 11 cm area of scattered scabs to their left lower back which was self-inflicted due to scratching. The physician was notified and an order to apply hydrocortisone cream to the area twice daily for seven days was given.<br><br>Nurses' notes, dated 05/01/2025 and 05/02/2025, documented Resident 67 was on alert for self-inflicted abrasions.<br><br>Nurses' notes, 05/03/2025 and 05/04/2025 documented Resident 67 had self-inflicted abrasions to their buttocks.<br><br>Review of the April and May 2025 MAR/TAR showed staff were not monitoring Resident 67's abrasions to the buttocks or left lower back.<br><br>Review of the EHR showed there was no documentation about the abrasions Resident 67's on left shoulder, right flank, left flank, left lower back or buttocks.<br><br>On 06/04/2025 at 12:40 AM, when asked if they were aware of Resident 67's complaints of pruritis and the self-inflicted abrasions to the left shoulder and right and left flanks Staff S, Licensed Practical Nurse, indicated they were and had just received an order to start hydroxyzine (an antihistamine) every six hours as needed for itching.<br><br>Review of the EHR on 06/09/2025 showed an order for hydroxyzine was obtained on 06/04/2025, but no documentation about Resident 67's self-inflicted abrasions to the left shoulder or right and left flanks was found.<br><br>On 06/09/2025 at 11:27 AM, Staff B, Director of Nursing, said when abrasions or other skin issues are identified, they should be placed on the TAR to monitor until resolved. When asked if that occurred for the abrasions noted to the resident left lower back, buttocks, left shoulder or right and left flanks Staff B, stated, Not that I can see.<br><br>Reference WAC 388-97-1060(1)<br><br>. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to ensure pressure injuries (PIs) were consistently assessed, and ordered pressure redistribution measures and equipment were in place and functional for 1 of 4 residents (Resident 67) reviewed for PIs. The failure to ensure an ordered low air loss mattress was in place and functional and to routinely assess identified PIs, detracted from the ability to determine if current treatments and interventions were effective and appropriate. This failure placed residents at risk for prolonged wound healing, unidentified decline, and development of avoidable PIs.<br><br>Findings included .<br><br>The National Pressure Injury Advisory Panel (NPUIP) provided the following PI stage descriptions:<br><br>- PI- localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device, because of intense and/or prolonged pressure or pressure in combination with shear.<br><br>- Stage 1 Pressure Injury: Non-blanchable erythema (redness) of intact skin.<br><br>- Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.<br><br>- Stage 3 Pressure Injury: Full-thickness skin loss in which adipose (fat) is visible in the ulcer.<br><br>- Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia (connective tissue), muscle, tendon, ligament, cartilage or bone in the ulcer.<br><br>- Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (tissue death).<br><br>Resident 67 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 02/26/2025, showed the resident was cognitively intact, required substantial to maximal assistance with bed mobility, was at risk for PI formation and had two Stage 3 and one Stage 4 PI present on admission. During the assessment period, Resident 67 also received PI care, and had pressure reducing devices in place to their bed and wheelchair.<br><br><Monitoring Function of Pressure Redistribution Devices><br><br>Resident 67 had an order, dated 04/02/2025, for an alternating low air loss (LAL) mattress for pressure redistribution.<br><br>(continued on next page) |

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| | 505230 | A. Building<br>B. Wing | 06/09/2025 |

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| Fir Lane Care | 2430 North 13th Street<br>Shelton, WA 98584 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/03/2025 at 10:46 AM, Resident 67 was observed lying on a LAL mattress with pillows under both hips, both thighs and one pillow under their back. When asked why there were pillows, Resident 67 explained they were there to hold them up, because without the pillows in place they could feel the bed frame and it caused their tailbone to be sore. Observation of the LAL mattress pump showed two red flashing lights were activated. One was for low pressure and the other for power failure. When asked how long they had been able to feel the bed frame through the LAL mattress, Resident 67 stated, Since I got here.<br><br>On 06/04/2025 at 12:16 AM, Resident 67 was observed lying in bed with pillows positioned under both hips and thighs. There was no pillow positioned behind their back. Resident 67 said nothing had changed and staff had not noticed the red flashing lights or taken any action to fix the LAL mattress. Observation of the LAL mattress pump display panel showed both red flashing lights were still activated for low pressure and power failure.<br><br>On 06/04/2025 at 12:34 PM, Staff S, Licensed Practical Nurse, observed Resident 67 in bed and confirmed there were pillows positioned under the resident's bilateral hips and thighs. Resident 67 stated, I need the pillows to boost me up off the bed, otherwise my tailbone gets sore because it hits the frame. When asked to look at the LAL mattress pump display panel, Staff S confirmed the presence of two red flashing alert lights indicating the mattress had low pressure and a power failure. Staff S said they would notify maintenance.<br><br>On 06/05/2025 at 2:37 AM, Resident 67 was observed with a new and functional LAL mattress in place.<br><br><Assessment and Monitoring of PIs><br><br>Review of the admission Evaluation, dated 02/19/2025, showed Resident 67 was assessed with the following skin conditions:<br><br>a) A 5.5-centimeter (cm) x 6 cm unstageable PI to the right heel.<br><br>b) Moisture-Associated Skin Damage (MASD, damage caused by prolonged exposure to moisture) to the left heel.<br><br>c) A 5.8 cm x 4.5 cm unstageable eschar to the bottom of the left foot.<br><br>d) A 5.5 cm x 4 cm Stage 3 PI to the right buttock.<br><br>e) MASD to the left gluteal cleft.<br><br>A 02/19/2025 progress note documented Resident 67 had PIs to both heels.<br><br>A 02/20/2025 progress note documented the resident reported the pain related to PIs on both heels was well controlled.<br><br>A 02/24/2025 provider note documented Resident 67 had unstageable PIs to the right and left heels.<br><br>During an interview on 06/04/2025 at 12:39 PM, Staff S, Resident Care Manager, said Resident 67's weekly wound measurements/assessments were being performed by a consulting wound care company.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the initial wound care consult, dated 02/25/2025, showed they assessed Resident 67 as having a Stage 4 PI to the left lateral heel, a Stage 3 PI to the sacrum, and a Stage 3 PI to the right buttock. There was no mention or assessment of the PI to the resident's right heel.<br><br>Review of subsequent wound care consults, dated 03/04/2025, 03/11/2025, and 03/18/2025, showed no mention or assessment of Resident 67's right heel PI.<br><br>A 03/02/2025 progress note documented Resident 67 was on antibiotic therapy for heel wounds.<br><br>A 03/03/2025 progress note documented wound care was provided for bilateral (both right and left foot) heel pressure ulcers.<br><br>A 03/04/2025 progress note documented wound care was provided to bilateral heels and the dressings were changed.<br><br>A 03/09/2025 progress note documented that Resident 67's heel dressings were changed.<br><br>A 03/09/2025 progress note documented that the resident's bilateral heel pressure ulcer dressings were clean, dry, and intact.<br><br>A 03/14/2025 progress note documented Resident 67 received antibiotic therapy for bilateral heel wounds.<br><br>A wound care consult, dated 04/01/2025 documented Right heel was not a PU [pressure ulcer], it is hyperkeratosis (abnormal thickening of the outer layer of skin).<br><br>Review of the hospital wound care notes, dated 02/17/2025, showed Resident 67 was assessed with unstageable PIs to the right and left heel (with associated photographs) and a deep tissue injury to the left gluteal cleft/coccyx.<br><br>During an interview on 06/09/2025 at 11:44 AM, Staff B, Director of Nursing Services, and Staff A, Administrator, confirmed Resident 67 was assessed upon admission to have PIs to their bilateral heels, which was consistent with the discharging hospitals assessments. Additionally, Staff A and B confirmed facility staff documented the presence of heel wounds to both heels, through 03/14/2025. When asked if there was any documentation to show Resident 67's right heel PI had been measured/assessed/monitored since admission Staff B said No, not that I can see.<br><br>Reference WAC 388-97-1060 (3)(b)<br><br>. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to ensure residents admitted with indwelling catheters (a flexible tube inserted into the bladder through the urethra to drain urine) were assessed for catheter removal as soon as possible, and to ensure clinical condition/ justification existed for continued use for 1 of 1 resident (Resident 67) reviewed for urinary catheters. These failures placed residents at risk for unnecessary catheterization, urinary tract infections, and a decreased quality of life.<br><br>Findings included .<br><br>Review of the facility's Indwelling Catheters policy, revised December 2024, showed all residents with indwelling catheters required a medical justification for their initiation and continued use. A Bladder Data Collection/Evaluation and/or the Catheter Justification Evaluation was required for all residents with an indwelling catheter. The assessment would determine the reason/ justification for use, if any factors were reversible, and a plan of care developed to document the justification of continued catheterization beyond 14 days. The interdisciplinary team would discuss the appropriateness of catheterization with the provider and obtain an order including a justification for continued use or to discontinue the catheter.<br><br>Resident 67 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 02/26/2025, showed the resident was cognitively intact, had Stage 3 (Full-thickness skin loss in which fat is visible in the ulcer) and Stage 4 (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) pressure injuries, required substantial to maximal assistance with bed mobility, was dependent on staff for toileting and had an indwelling urinary catheter.<br><br>On 06/03/2025 at 9:01 AM, Resident 67 said they did not have a urinary catheter prior to their recent hospitalization. When asked why the catheter was still in place, Resident 67 said they believed it was because they were difficult to get out of bed, and they preferred not to use a bed pan because they were uncomfortable.<br><br>A urinary catheter care plan, revised 04/17/2025, had an identified goal of removing the resident's catheter in the absence of indications for continued use.<br><br>Review of the electronic health record showed no diagnosis of obstructive uropathy (blockage of urine flow anywhere in the urinary system), neurogenic bladder (a condition where nerve damage disrupts the normal function of the bladder, leading to problems with urination), benign prostate hyperplasia (enlarged prostate) or urinary retention.<br><br>A 02/25/2025 wound care consult documented Resident 67 had Stage 3 pressure injuries to the sacrum and right buttock.<br><br>A 04/01/2025 wound care consult documented Resident 67's right buttock pressure injury was resolved and Stage 3 to the sacrum was 0.5 x 0.4 x 0.1 centimeters and healing.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A 04/22/2025 wound care consult documented Resident 67's sacrum pressure injury was closed.<br><br>A Bladder Data Collection and Evaluation, dated 05/28/2025, showed residents with a catheter were required to have at least one of the following conditions:<br><br>a) A terminal illness or severe impairment and movement that caused intractable pain.<br><br>b) Stage 3 or 4 pressure injuries in an area affected by incontinence that would prevent ulcer(s) from healing.<br><br>c) Untreatable urethral blockage causing urinary retention (documented post void residual of greater than 200 milliliters) and staff were unable to perform intermittent catheterization.<br><br>d) A documented medical justification for catheterization.<br><br>Review of the evaluation showed none of the above conditions were identified/documented.<br><br>On 06/05/2025 at 10:32 AM, Staff C, Resident Care Manager/Registered Nurse, indicated the initial justification for continued catheter use was the presence of Stage 3 pressure injuries to the right buttock and sacrum, but confirmed both had resolved as of 04/22/2025. Staff C stated, We should have contacted the doctor and asked for orders to do a trial discontinuation [of the catheter]. Staff C then confirmed that this had not occurred.<br><br>Reference WAC 388-97-1060 (3)(c)<br><br>. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Fluid Intake><br><br>Resident 41 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of end stage renal disease, and required dialysis during the assessment period.<br><br>An end stage renal disease care plan, revised 05/01/2025, had a goal that the resident would not have any signs and symptoms (s/sx) of fluid volume overload or fluid volume deficit through the next review. Interventions included dialysis three times a week, monitoring for s/sx of hypervolemia (excessive fluid in the body) and hypovolemia (low levels of fluid in the body caused by various factors including dehydration.)<br><br>A nutritional risk care plan, revised 05/01/2025, documented the resident was on a 1500 milliliter (ml)/day fluid restriction and directed staff to record food and fluid intake.<br><br>Review of the resident's physician's orders, showed a 04/15/2025 order for a 1500 ml per day fluid restriction. Dietary was to provide 1080 ml per day, or 360 ml per meal and nursing was to provide 420 ml per day, or 210 ml per shift (12 hour (hr) shifts) for a 24 hour total of 1500 ml.<br><br>Review of the June 2025 Medication Administration Record (MAR) showed nurses were directed to document the fluids provided on their shift (day/night shift) and night shift was to reconcile the fluids provided by nursing, with the fluids provided with meals, and calculate the resident's 24 hour fuid intake. Review of documentation from 05/23/2025 -06/05/2025 (14 days) showed facility staff failed to consistently document fluid intake for all meals and failed to accurately calculate the residents 24 hour fluid intake on 14 of 15 days reviewed, as follows:<br><br>- 05/23/2025- meal monitor- 1718 ml; Nursing- 330 ml for a total of 2048 ml; staff documented 1500 ml<br><br>- 05/24/2025- meal monitor- 480 ml (dinner not recorded); Nursing- 820, 24hr total=1360; staff documented N/A<br><br>- 05/25/2025- meal monitor- 990 ml; Nursing- 360 ml, 24 hr. total=1350 ml; staff documented 1420 ml<br><br>- 05/26/2025- meal monitor- 480 ml (lunch not recorded); Nursing- 360 ml, 24 hr total=840 ml; staff documented 1420 ml<br><br>- 05/27/2025- meal monitor- 20 ml (lunch/dinner not recorded); Nursing- 360 ml, 24 hr total= 380 staff documented 1420 ml<br><br>- 05/28/2025- meal monitor- 240 ml (lunch/dinner not recorded); Nursing- 570 ml, 24 hr total= 810 staff documented 1420 ml<br><br>- 05/292025- meal monitor- 720ml; Nursing- 560 ml, 24 hr. total= 1280 staff documented 0 ml<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - 05/302025- meal monitor- 640 ml (lunch not recorded); Nursing- 570 ml, 24 hr total= 1210 staff documented 210 ml<br><br>- 05/31/2025- meal monitor- 720 ml (lunch not recorded); Nursing- 410 ml, 24 hr total= 1130 staff documented 1500 ml<br><br>- 06/02/2025- meal monitor- 900 ml (one missing meal; Nursing- 690 ml, 24 hr total= 1590 ml; staff documented 1500 ml<br><br>- 06/03/2025- meal monitor- 1200 ml; Nursing- 420 ml, 24 hr. total= 1590 ml; staff documented 350 ml<br><br>- 06/04/2025- meal monitor- 360 (breakfast/lunch not recorded); Nursing-570 ml, 24 hr total= 930ml; staff documented 240 ml<br><br>- 06/05/2025- meal monitor- 1200 ml (breakfast/ not recorded); Nursing-570 ml, 24 hr total= 1770ml; staff documented 0 ml.<br><br>On 06/011/2025 at 3:37 PM, Staff A, Administrator, confirmed Resident 41's fluid intake was incomplete and inaccurate. Staff A indicated the orders had been input in in a confusing manner, which likely contributed to the inaccurate tabulation.<br><br>Reference WAC 388-97 -1060 (3)(h)<br><br>Based on observation, interview and record review, the facility failed to ensure significant weight loss was identified, and nutritional interventions were implemented and evaluated for effectiveness for 1 of 2 sampled residents (Residents 45) reviewed for nutrition. Additionally, the facility failed to have a system in place that ensured fluid intake was accurately monitored, documented, and 24-hour intake totals were calculated and evaluated for 1 of 1 resident (Resident 41) reviewed with a fluid restriction. These failures placed residents at risk for continued weight loss, malnutrition, fluid volume overload, fluid and electrolyte imbalances and other medical complications.<br><br>Findings included .<br><br><Nutrition><br><br>Resident 45 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS, an assessment tool), dated 04/06/2025, documented Resident 45 was severely cognitively impaired. On 12/03/2024, the resident weighed 131 lbs. On 05/12/2025, the resident weighed 112 pounds which was a -14. 50 % Loss.<br><br>Resident 45 was prescribed a CCHO diet Regular (Level 7-RG7) (controlled carbohydrate diet in conjunction with the International Dysphagia Diet Standardisation Initiative (IDDSI) Level 7 for Regular foods. This suggests a diet planned for individuals who need consistent carbohydrate intake for blood sugar management (like in diabetes) and can safely consume regular textured foods).<br><br>A physician's order, dated 09/06/2023, documented resident was to have a health snack at night.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 45's Nutrition Care Plan, documented Resident did not have unplanned significant weight changes through the next 90 days as evidenced by their weight record.<br><br>A Nutritional Evaluation, dated 02/16/2025, documented Resident's intake was excellent, they ate independently and consumed greater than 75% of their meals. Resident was noted with weight stability without unplanned significant changes over 90 and 180 days.<br><br>On 06/06/2025 at 9:24 AM, Staff P, Registered Nurse Unit Manager, said if a resident was identified as losing weight, staff would make a referral to the Registered Dietitian for a case review with the Nutrition At Risk (NAR) team do be done weekly. Staff P said the NAR team would discuss appropriate interventions and notify the family. When asked about Resident 45's weight loss, Staff P said they were unaware of any weight loss for Resident 45. When shown the weights under the vitals tab in the Electronic Health Record (EHR), Staff confirmed Resident 45 had lost weight, resulting in a 14.50% weight loss. Staff P reviewed the EHR and confirmed no further weight loss interventions had been implemented.<br><br>At 10:22 AM, Staff B, Director of Nursing Services, said when a resident had lost weight, staff were able to make a Nursing to Nutrition note that went directly to the Registered Dietitian (RD). The RD would review the resident's nutritional status before they attended the Nutrition At Risk meeting, where the residents' case would be discussed and interventions would be implemented. When asked about Resident 45's weight loss, Staff B said they were unaware of any weight loss for Resident 45. Staff B was shown Resident's 45's 14. 50% weight loss. Staff B said they would look in the interventions and respond back with any new information found. No response or new information was provided. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide restorative nursing services for 2 of 2 residents (Residents 8 and 61) reviewed for limited range of motion. The failure to have sufficient qualified staff to provide restorative nursing services resulted in the therapy department not referring residents for restorative nursing programs, who they acknowledged were at risk for declines in range of motion (ROM), contracture formation/progression, and would have been referred for and benefited from restorative services, had sufficient staff been available to provide them. This failure placed residents at risk for decreased ROM, contractures, impaired skin integrity, increased dependence on staff for care needs and a diminished quality of life.<br><br>Findings included .<br><br><Restorative Services><br><br>1) Resident 61 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively impaired, required maximal/substantial assistance with most activities of daily living (ADLs), had limited functional rom to both lower extremities, and did not receive restorative nursing services.<br><br>An Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 8/23/2025, documented the reason for therapy was impaired balance, mobility, gross motor coordination and problem solving, resulting in limitations in the areas of mobility and self-care. It was assessed that due to the residents documented physical impairments and associated functional deficits, Resident 61 was at risk for further decline in function and mobility.<br><br>An OT Discharge Summary, dated 09/11/2024, showed under Discharge Recommendations and Status staff documented restorative nursing programs were not indicated at this time.<br><br>An OT Evaluation and Plan of Treatment, dated 01/02/2025, documented the reason for the current referral was due to new onset of decrease in functional mobility, decrease in strength, falls/fall risk, functional limitation with ambulation, and limited and painful movement.<br><br>An OT Discharge Summary, dated 01/15/2025, showed under Discharge Recommendations and Status, staff documented restorative nursing programs were not indicated at this time.<br><br>A bilateral knee contracture care plan, initiated on 07/15/2024, showed on 4/29/2025 the resident was to start a passive ROM restorative nursing program which directed the restorative aide to perform passive ROM to both lower extremities for three sets, then apply splints to both lower extremities for four to six hours, seven days a week.<br><br>Review of the electronic health record (EHR) showed the restorative nursing program was never implemented.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the May 2025 Treatment Administration Record (TAR) showed the splints were placed on the TAR with direction to apply for four to six hours from 2:00 PM - 6:00 PM, and to check skin integrity when removed.<br><br>On 06/06/2025 at 12:50 PM, Staff AA, Director of Rehabilitation, was asked why Resident 61, who was assessed to be at risk for further decline in function and mobility, was not referred to restorative nursing to maintain gains made with therapy and/or prevent further decline in the 09/11/2024 and 01/15/2025 OT discharge summaries. Staff AA acknowledged Resident 61 would have benefited from restorative nursing services, but explained OT did not refer the resident to restorative nursing because the facility did not have staff to provide the services.<br><br>2) Resident 8 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively impaired, was dependent on staff for ADLs, had impaired functional ROM to both upper and lower extremities and did not receive restorative nursing services.<br><br>A Physical Therapy (PT) Evaluation and Plan of Treatment, dated 07/07/2021, documented Resident 8 was referred to therapy for a decline in ROM, strength and ability to perform functional activities without physical assistance.<br><br>A PT Discharge Summary, dated 10/05/2021, showed the therapist had documented under Discharge Recommendations and Status the resident was referred for a restorative splint and brace program.<br><br>A PT Discharge Summary, dated 05/12/2022, showed the therapist had documented under Discharge Recommendations and Status the resident was referred to restorative nursing for a bilateral lower extremity ROM program.<br><br>Review of the EHR showed there was no documentation to show the 10/05/2021 referral for a restorative splint and brace program or the 05/12/2022 referral for a bilateral lower extremity rom program were ever initiated.<br><br>On 06/09/2025 at 1:43 PM, Staff AA, Director of Rehabilitation, confirmed that there had been a lot of residents that would have benefited from restorative nursing services and would have typically been referred, but were not due to the lack of restorative staff to provide the programs.<br><br>On 06/09/2025 at 2:18 PM, Staff A, Administrator, and Staff B, Director of Nursing, both confirmed the facility did not currently provide restorative nursing services due to a lack of sufficient and qualified staff.<br><br>Reference WAC 388-97-1080 (1), 1090 (1)<br><br>. |

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| | 505230 | A. Building<br>B. Wing | 06/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Fir Lane Care | 2430 North 13th Street<br>Shelton, WA 98584 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) Resident 283 admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 283 was severely cognitively impaired. Resident 283 was on hospice services (end of life care).<br><br>Resident 283 had orders for morphine (pain reliever) oral solution, by mouth every 1 hours as needed for breakthrough pain; dyspnea (shortness of breath).<br><br>Review of Resident 283's MAR, from 05/22/2025 through 06/05/2025, showed morphine was administered with documented pain on 05/24/2025, 05/26/2025, 05/27/2025, 05/28/2025, 05/29/2025, 05/30/2025, 06/01/2025, 06/02/2025 and 06/05/2025.<br><br>Resident 283's May 2025 and June 2025 MARs also showed staff were ordered to provide NPI to reduce pain and document the effectiveness. Interventions included repositioning, relaxation, diversional activities and redirection. Staff were instructed to document the NPI intervention and effectiveness as needed. There was no documentation NPIs had been attempted.<br><br>On 06/06/2025 at 11:19 AM, Staff C, RCM/RN, said NPIs should be implemented any time a resident complains of pain, and staff should always try NPIs before medication. When asked if NPIs for Resident 283 had been attempted with morphine given for pain management, Staff C reviewed the EHR and said that NPIs were not documented, and staff should have tried and documented NPIs. Staff C said staff could also document attempted NPIs in progress notes but was unable to locate documentation that NPIs had been attempted.<br><br>Reference WAC 388-97-1060 (3)(k)(i)<br><br>Based on interview and record review, the facility failed to ensure medications were necessary by providing residents with non-pharmacological interventions (NPIs, non-medication interventions) for pain management, documenting side effect monitors, and/or to reassess the necessity of medication on admission for 3 of 7 residents (Residents 333, 54, & 283) reviewed for unnecessary medication and pain. This failure placed residents at risk of receiving medication not clinically indicated, increased pain, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Pain Management, dated with a revision date of 06/2024, showed staff were to determine the appropriate interventions to manage the pain and side effects, and appropriate interventions should include pharmacological as well as non-pharmacological interventions. Staff should evaluate and document effectiveness of pain management interventions in the medical record.<br><br>1) Resident 333 was admitted to the facility on [DATE] with a diagnosis of fracture of the pubis (pelvic fracture). The Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 333 was cognitively intact and had constant pain.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the electronic health record (EHR), showed Resident 333 had an order for omeprazole daily, for gastroesophageal reflux disease (GERD). Review of Resident 333's diagnosis list showed this was not an active diagnosis.<br><br>Review of the Medication Administration Record (MAR), from 05/22/2025 through 06/03/2025, showed Resident 333 had as needed acetaminophen (non-opioid pain medication) given for pain on 05/25/2025, 05/28/2025, 05/30/2025, and 06/02/2025. Resident 333 had as needed morphine (opioid pain medication) given for pain from 05/22/2025 through 06/03/2025. Resident 333's NPI order had no documentation for 05/22/2025 through 06/03/2025. Additionally, Resident 333's side effect monitor order was as needed for pain medication, and had no documentation on the MAR from 05/22/2025 through 06/03/2025, despite receiving as needed pain medication daily.<br><br>During an interview on 06/03/2025 at 8:37 AM, Resident 333, when asked about NPI and pain management, said they had pain and it was only addressed at the facility with medication.<br><br>During an interview on 06/04/2025 at 9:58 AM, Resident 333 said they were not told what they had been getting with medication administration and found out they were being given something for acid reflux (GERD), despite not having this condition.<br><br>During an interview on 06/06/2025 at 10:30 AM, Staff D, Resident Care Manager/ Licensed Practical Nurse (RCM/LPN), said NPI should be offered as a first line of defense. Staff D reviewed Resident 333's MAR for May and June 2025, and confirmed Resident 333 did not have any documented NPI. When asked if there should be documented NPI usage, Staff D said yes. Staff D reviewed Resident 333's diagnosis list and confirmed there was no diagnosis of GERD. When asked how the facility reviews medications for residents on admission who do not have a diagnosis for the medication ordered, to ensure it is necessary, Staff D said they could ask the provider if it was necessary or talk to the resident about it.<br><br>During an interview on 06/09/2025 at 9:42 AM, Staff B, Director of Nursing Services (DNS), when asked their expectation for NPI usage with pain medication, said NPIs should be offered prior to administration of as needed medications and documented on whether effective or not. When asked if it met expectations that Resident 333 did not have documented NPIs with pain medication given, said no.<br><br>2) Resident 54 was admitted to the facility on [DATE] with diagnoses of healed traumatic fracture and left hip pain. The Quarterly MDS, dated [DATE], showed Resident 54 was cognitively intact.<br><br>Review of Resident 54's May 2025 MAR, showed as needed acetaminophen was given on 05/02/2025, 05/04/2025, 05/06/2025, 05/08/2025, 05/09/2025, 05/14/2025, 05/15/2025, 05/16/2025, 05/17/2025, 05/18/2025, 05/20/2025, 05/21/2025, 05/22/2025, 05/24/2025, 05/26/2025, 05/27/2025, 05/28/2025, and 05/30/2025. Resident 54's order for NPI showed no documentation for all of May 2025.<br><br>During an interview on 06/05/2025 at 12:40 PM, Staff C, RCM/ Registered Nurse (RN), said their expectation was for NPI to be in place and for other things to be tried besides just giving medication. Staff C said pain interventions were ordered for residents. Staff C reviewed the EHR and confirmed that Resident 54 received as needed acetaminophen in May 2025 and there was no documentation of NPI usage.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/09/2025 at 9:42 AM, Staff B, DNS, when asked if it met expectations that Resident 54 did not have documented NPIs with pain medication given, said no. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>.<br><br>Based on observation and interview, the facility failed to store and label medications appropriately and discard expired medications for 2 of 5 medication carts (Medication Carts A2 & A3) reviewed. These failures placed residents at risk of receiving expired or less effective medications, and inappropriate access to medication.<br><br>Findings included .<br><br>1) Observation of Medication Cart A2 on 06/04/2025 at 11:57 AM, showed an unattended bottle of Tylenol on top of the cart. In addition, a bottle of Day Time Cold and Flu Relief was located within the cart with an expiration date of 12/2024. Located within the cart drawers, were a nystatin (antifungal) cream and clotrimazole (antifungal) cream, both without resident names and labels.<br><br>Staff I, Licensed Practical Nurse, said the bottle of Tylenol on top of the cart came from central supply, and the employee that delivered it had left it unattended and it was a new staff member. Staff C, Resident Care Manager/Registered Nurse (RCM/RN), looked at the bottle of Day Time Cold and Flu medication and confirmed it was expired.<br><br>2) Observation of Medication Cart A3 on 06/04/2025 at 12:20 PM, showed 4 opened bottles of nystatin powder without resident names or labels. Staff J, RN, confirmed the lack of identifiers and threw the bottles in the garbage.<br><br>On 06/04/2025 at 12:55 PM, Staff C, RCM/RN, said her expectation was that expired medications in the medication cart would be taken out of the cart and destroyed. Regarding Tylenol being left unattended on the medication cart, Staff C said it did not meet her expectations. Regarding the medications found without resident names and labels, Staff C said it did not meet her expectations, medications should have residents names and be labeled.<br><br>Reference WAC 388-97-1300(2) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>.<br><br>Based on interview and record review the facility failed to store food for residents in accordance with professional standards for 5 of 5 refrigeration/freezer units (A1/A2, A3, B3, Walk in Cooler and Walk in Freezer) reviewed for food service safety. The failure to maintain documented refrigerator temperature logs placed residents at risk of foodborne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and diminished quality of life.<br><br>Findings included .<br><br>Review of the following refrigerator temperature logs located on A1/A2 hall, A3 hall, B3 hall, Walk in Cooler and Walk in Freezer in the kitchen, documented missing refrigerator/freezer temperatures:<br><br>Snack Refrigerator since February 25th, 2025 (logs started on 02/25/2025):<br><br>02/25/2025 Hall A1 & A2- no temperatures recorded.<br><br>02/26/2025 Hall A1, A2, A3 & B3- no temperatures recorded.<br><br>02/27/2025 Hall A1 & A2- no temperatures recorded.<br><br>02/28/2025 Hall A1 & A2- no temperatures recorded.<br><br>A3 Hall no temperatures recorded on: 03/06/2025, 03/23/2025, 03/29/2025, 04/03/2025, 04/10/2025, 04/11/2025, 04/13/2025, 04/17/2025, 04/18/2025, 04/24/2025, 04/25/2025, 04/26/2025 & 05/11/2025<br><br>A1 and A2 Hall no temperature records on: 03/22/2025, 03/23/2025, 03/26/2025, 03/29/2025, 04/03/2025, 04/04/2025, 04/10/2025, 04/11/2025, 04/13/2025, 04/24/2025,04/25/2025, 04/26/2025, 05/11/2025 & 04/22/2025.<br><br>B Hall no temperatures recorded on: 03/23/2025, 03/26/2025, 03/29/2025, 04/04/2025, 04/04/2025, 04/09/2025, 04/10/2025, 04/11/2025, 04/13/2025, 04/17/2025, 04/18/2025, 04/24/2025, 04/25/2025, 04/26/2025 & 05/25/2025.<br><br>Walk in Cooler Temperature Log March 2025 through May 2025-no temperatures recorded on temp log on:<br><br>03/01/2025 Mid time and PM time.<br><br>03/02/2025 Mid time and PM time.<br><br>03/03/2025 Mid time and PM time.<br><br>03/08/2025 Mid time and PM time.<br><br>03/09/2025 Mid time and PM time.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 03/10/2025 Mid time and PM time.<br><br>03/15/2025 Mid time and PM time.<br><br>03/17/2025 Mid time and PM time.<br><br>03/18/2025 Mid time and PM time.<br><br>03/19/2025 Mid time and PM time.<br><br>03/23/2025 Mid time.<br><br>03/24/2025 Mid time and PM time.<br><br>03/25/2025 Mid time and PM time.<br><br>03/26/2025 Mid time and PM time.<br><br>03/27/2025 Mid time and PM time.<br><br>03/28/2025 PM time.<br><br>03/29/2025 PM time.<br><br>03/30/2025 Mid time and PM time.<br><br>Walk in Freezer Temperature Log March 2025 through May 2025-no temperatures recorded on temp log on:<br><br>03/01/2025 Mid time and PM time.<br><br>03/02/2025 Mid time and PM time.<br><br>03/03/2025 Mid time and PM time.<br><br>03/08/2025 Mid time and PM time.<br><br>03/09/2025 Mid time and PM time.<br><br>03/10/2025 Mid time and PM time.<br><br>03/15/2025 Mid time and PM time.<br><br>03/17/2025 Mid time and PM time.<br><br>03/18/2025 Mid time and PM time.<br><br>03/19/2025 Mid time and PM time.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 03/23/2025 Mid time.<br><br>03/24/2025 Mid time and PM time.<br><br>03/25/2025 Mid time and PM time.<br><br>03/26/2025 Mid time and PM time.<br><br>03/27/2025 Mid time and PM time.<br><br>03/28/2025 PM time.<br><br>03/29/2025 PM time.<br><br>03/30/2025 Mid time and PM time.<br><br>On 06/04/2025 at 12:59 PM, Staff N, Dietary Manager, said the kitchen refrigerators and the unit/snack refrigerators were the responsibility of the kitchen staff. Staff N said all refrigerators should have been checked daily. When shown the missing dates on the temperature logs, Staff N said they were hired in March 2025 and the missing temperature dates were a problem that was identified immediately. Staff N said there were a lot of holes (missing temperatures) and the missing dates should have been filled in.<br><br>Reference WAC 388-97-1100 (3), 2980.<br><br>. |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure the facility's binding arbitration agreements (legal document that required the use of a third party to resolve disputes) was reviewed and explained in a form, manner, and/or language understood by the resident and/or their legal representative for 3 of 3 sampled residents (Residents 39, 70, & 28) reviewed for binding arbitration agreements. This failure placed residents at risk for lacking understanding of the legal document signed, forfeiture (loss or giving up of something) of the right to a jury or court, and a diminished quality of life.<br><br>Findings included .<br><br>The facility's blank Arbitration Agreement, dated 07/2024, was reviewed on 06/06/2025, and documented:<br><br>A. Resident and Resident's Representative ARE NOT required to sign the Agreement as a condition of admission to or as a requirement to continue to receive care at the Center.<br><br>C. This agreement waives the right to a trail by judge or Jury.<br><br>1. Disputes to be Arbitrated. The Parties shall submit for binding arbitration pursuant to this Agreement, any and all claims or controversies arising out of or in any way relating to: (i) the Center's admission Agreement; (ii) the Resident's stay at the Center, including all prior stays at the Center; and (iii) disputes regarding interpretation or enforceability, or both, of this Agreement, whether such claims or controversies described in (i)-(iii): (x) arise out of state or federal law, whether existing now or arising in the future; (y) include statutory, compensatory, or punitive damages; or (z) sound in breach of contract, negligence, tort, or breach of statutory duties (including, without limitation, claims based on personal injury or death), regardless of the basis for any duty or of the legal theories upon which the claim is asserted.<br><br>2. Waiver of Judge or [NAME] Trial. By signing this Agreement, the Parties expressly and irrevocably waive any right to trial by judge or jury.<br><br>3. Right to Revoke. Resident or Resident's Representative may revoke this Agreement by providing written notice to the Center within thirty (30) calendar days of signing the Agreement. If any alleged dispute arises before the Center receives such notice, this Agreement shall be binding with respect to such dispute.<br><br><Resident 39><br><br>Resident 39 was admitted to the facility on [DATE]. The admission Minimum Data Set, (MDS, an assessment tool), dated 04/16/2025, documented Resident 39 was cognitively intact.<br><br>(continued on next page) |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 06/06/2025 at 11:51 AM, when asked what their understanding was of an arbitration agreement, Resident 39 stated, I don't know what an arbitration agreement is. Resident 39 said they vaguely remember the facility saying something about an arbitration agreement, but they did not know what it was. When asked if they understood they were giving up their right to a court proceeding, Resident 39 said no. When asked if it was explained they did not have to sign the agreement as a term of admission to the facility, Resident 39 said no. When asked if it was explained that the resident only had 30 days to revoke the arbitration, Resident 30 said no. When asked if the arbitration agreement was explained in a way that they understood, Resident 39 stated, no, not like you're explaining it to me. Resident 39 said they would not have signed it, if they did not have too.<br><br><Resident 70><br><br>Resident 70 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 70 was cognitively intact.<br><br>On 06/06/2025 at 12:54 PM, when asked what their understanding was of the facility's arbitration agreement, Resident 70 stated, I don't know, I don't know what I signed. I signed what ever they put in front of me. I don't know what I was signing. When asked if the arbitration agreement was explained in a manner they understood, Resident 70, said they did not recall. Resident 70 said they were at the hospital, then the next thing they were at the facility, and they did not know why they were sent here. Resident 70 said nothing was explained to them.<br><br><Resident 28><br><br>Resident 28 was admitted to the facility on [DATE]. The 5 Day MDS, dated [DATE], documented Resident 28 was severely cognitively impaired and had an active Power of Attorney (POA, a legal document that allows one person to grant another person the power to act on their behalf).<br><br>On 06/09/2025 at 9:50 AM, when asked what their understanding was of the facility's arbitration agreement, Resident 28's POA, stated, It wasn't explained by the facility, they just sent it over. Resident 28's POA said the facility emailed them the packet and said sign it, nothing was explained and there were no directions with the admission packet. Resident 28's POA said there was no discussion about the rights they were giving up. Resident 28's POA said they would have liked the facility to explain the arbitration agreement to them.<br><br>(continued on next page) |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 06/09/2025 at 10:14 AM, Staff G, Business Office Manager (BOM), said no residents were currently entered into a dispute or had any resolved disputes. Staff G said the arbitration agreement was provided to the resident at the time of admission or within 72 hours. The resident was able to agree or disagree with the arbitration agreement. Staff G said they go over the arbitration agreement with every resident, it was explained that it was a legal voluntary document. Staff G stated, let me give you, my [NAME]. This is a voluntary agreement, if you are considering suing us, we ask you come to us first, before going to court. If you don't want to, then you can rescind the decision, I ask for it in writing and provide it to me. Staff G repeated the [NAME] twice. No explanation was provided that included this was not a term of admission, no timelines were provided (30 days to rescind) or that the resident was giving up right to a court hearing. When asked about the timeline (30 day to rescind), Staff G stated, I do not give timeline, there are no timelines. When asked how they assess a resident with cognitive delays, Staff G said they asked resident basic questions to see if the resident was cognitively aware and abale to sign. Staff G said if there were concerns with cognitive abilities, they would reach out to Social Services to acquire about Brief Interview for Mental Status (BIMS, performance-based cognitive assessment tool used to screen for cognitive impairment). Staff G said if a resident did not have the cognitive ability to understand then the facility would reach out to the family or next of kin and would provide the admission packet with the arbitration agreement to them. When asked about family or next of kin not being able to sign in person, Staff G said the facility used DocuSign (electronic signature system) and they would have a conversation via phone call with the family/next of kin.<br><br>On 06/09/2025 at 10:52 AM, when asked about the arbitration agreement process, Staff A, Administrator, with Staff H, Regional Clinic Manager, present, said the arbitration agreement was given to residents upon admission, they agree or decline to sign it and it was stored in the resident's file under the document manage tab. When asked their understand of the arbitration agreement, Staff H said it was explained that it was a basic admission agreement that the resident and the facility would go to mediation first, instead of going to court or jury. Staff H said the resident has the choice to sign the agreement and can change their mind at any time, as many times as they want. Staff H said there is no grace time and it was not a requirement for admission. It was explained to Staff A and Staff H, that the information provided by Staff G (BOM), did not include that it was not a term of admission, no timelines were provided (30 days to rescind) or that the resident was giving up right to a court/jury hearing. When asked does it meet expectation that residents were lead to believe they still have court options, were not informed of 30 days timeline requirement for revocation and were no not provided information that signing Arbitration agreement was not a term of admission to the facility, Staff A and Staff H did not answer the question. When asked again if this met their expectation, Staff A asked to review the Arbitration Agreement. Staff reviewed the electronical copy of the Arbitration agreement. Staff H said the residents were told that it was a voluntary agreement. When asked a third time, if this met their expectation, Staff H asked to again hear Staff G' explanation of the arbitration agreement. Staff G's [NAME] was recited to Staff A and Staff H again. When asked again, if giving the resident false information or incorrect information met their expectation, Staff H stated, her verbalizing needs to be worked on, but the implication is there. When asked again, if this met their expectation, Staff H said no and Staff A did not respond.<br><br>No associated WAC. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505230 | A. Building<br>B. Wing | 06/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fir Lane Care | 2430 North 13th Street<br>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) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to ensure staff-maintained infection control practices during dressing changes for 1 of 3 wound cares observed, during meal tray delivery for 1 of 5 meal tray observations, and that regular temperature checks of the washing machines were complete for washing machines for for 1 of 1 laundry room reviewed for infection control. This failure placed residents at risk for the spread of infection and a diminished quality of life.<br><br>Findings included .<br><br><Logs for Washer Temperatures><br><br>A Review of the Washer Temperature Logs showed no documentation on:<br><br>-February 2025 blanks on the 1st, 2nd, 16th and 29th - 31st<br><br>-May 2025 a blank on the 26th<br><br>On 06/04/2025 at 1:03 PM Staff X, Housekeeping and Laundry Manager said the washer temperatures were checked to ensure proper standards for equipment, to make sure the laundry was sanitized, and it killed the germs. Staff X said she would in-service the staff and make sure the temperatures were done in the future.<br><br>On 06/05/2025 at 12:19 PM Staff A, Administrator said her expectation for the blanks on the temperature logs were that they should have been done.<br><br><Hand hyigene during meal tray delivery><br><br>On 06/02/2025 at 11:46 AM, the lunch meal cart arrived on the unit. The dining room was served first.<br><br>On 06/02/2025 at 11:58 AM, Staff O, Certified Nursing Assistant (CNA), started delivering meal trays to resident rooms. Staff O entered room [ROOM NUMBER], set meal tray on bedside table, removed the lid from the plate and then touched the resident's bed, sheets and bed remote control. Staff O left the room and did not complete hand hygiene.<br><br>On 06/02/2025 at 11:58 AM, Staff O entered room [ROOM NUMBER], set meal tray on bedside table, removed the lid from the plate and cup, and then touched the resident (assisting resident with sitting up) and the resident's bed, sheets and bedside table. Staff O left the room and did not complete hand hygiene.<br><br>On 06/02/2025 at 12:00 PM, Staff O entered room [ROOM NUMBER], set meal tray on bedside table, removed the lid from the plate. Staff O picked up the bed remote control off the floor and placed it on resident's bed, next to the resident. Staff O then touched the resident (assisting resident with sitting up) and the resident's blanket. Staff O left the room and did not complete hand hygiene.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505230 | A. Building<br>B. Wing | 06/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fir Lane Care | 2430 North 13th Street<br>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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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/02/2025 at 12:03 PM, Staff O entered room [ROOM NUMBER], set meal tray on bedside table. Staff O touched the bedside table, the resident's blanket and then the hand crank at the end of the bed. Staff O then went to the bedside table and took off the plate cover, lid cover, picked up the resident's utensils and handed them to the resident. Staff O left the room and did not complete hand hygiene.<br><br>On 06/02/2025 at 12:05 PM, when asked when should hand hygiene be completed, Staff O said every two passes. Staff O said they only completed hand hygiene once during the whole pass.<br><br>On 06/06/2025 at 9:24 AM, Staff P, Registered Nurse Unit Manager, said staff should be washing their hands before grabbing a meal tray and when staff leave the residents room or helping another resident before delivering the next tray. Observation of Staff O's, CNA, lack of hand hygiene was explained. Staff P said they had heard the conversation and did not know where the two pass hand hygiene requirement came from. Staff P said staff should have completed hand hygiene before and after every meal tray pass.<br><br>On 06/06/2025 at 10:22 AM, Staff B, Director of Nursing Services, said hand hygiene should be completed before and after every meal tray delivery. When observations of Staff O's, CNA, lack of hand hygiene was explained, Staff B said it did not meet expectation for hand hygiene.<br><br><Wound Care Observation><br><br>An observation of wound care on 06/05/2025 at 1:53 PM, showed Staff I, Licensed Practical Nurse, put on a gown and mask, then opened a medication cart with keys, removed gloves, then entered a resident's room. Staff I then put a plastic cup of medication on the bedside table and put gloves on (no hand hygiene observed prior to putting gloves on). Staff I then took the resident's sock off their foot and used a tube of normal saline to soak off the dressing that was in place, removed dirty dressing and placed in a garbage bag. Staff I then wiped the wound with gauze, removed gloves, washed hands at the sink and put on new gloves. Staff M, CNA, held the resident's leg up in the air, and Staff I with gloved hands took over holding resident's leg, Staff M then took resident's leg back and Staff I resumed wound care (No glove change and hand hygiene was observed after holding residents' leg and before they resumed wound care).<br><br>On 06/06/2025 at 11:09 AM, Staff C, Resident Care Manager/Registered Nurse, said the expectation was that staff perform hand hygiene before putting gloves on and after removing gloves. Regarding staff holding the resident's leg then continuing with wound care, Staff C said staff should have changed gloves and performed hand hygiene and put on new gloves before proceeding with wound care.<br><br>Reference WAC 388-97-1320(1)(a)(c)(3)<br><br>. |