STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505239	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Rose Care Center	3919 South 19th Street Tacoma, WA 98405

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview and record review, the facility failed to thoroughly investigate allegations of abuse or neglect for 3 of 5 sampled residents (Residents 33, 101 and 87) reviewed for abuse. This failure prevented the facility from identifying the extent and nature of the occurrence of abuse/neglect in a timely manner and placed residents at risk for unidentified abuse and/or neglect, and a decreased quality of life. Findings included . Resident 33 Review of the electronic health record (EHR) showed Resident 33 admitted to the facility on [DATE] with diagnosis of acute and chronic respiratory failure with a tracheostomy (an opening into the neck for breathing) and was dependent on staff for all activities of daily living (ADLs). The resident was usually able to make needs known. During an observation and interview on 09/13/2024 at 11:24 AM, Resident 33 laid in bed and was alert and responding to yes or no questions. The resident was able to answer questions regarding care and other yes or no questions during the interview. During an interview on 09/13/2024 at 4:40 PM, Collateral Contact 1 (CC1), stated Resident 33 had been at the facility for several years and recently had been having problems with staff not providing care timely. CC1 stated the resident could communicate with yes/no answers and was able to spell out sentences using the ABCs. Review of an incident investigation dated 08/27/2024 showed the facility had received a report from a family member that on the nightshift of 08/24/2024 Resident 33 had been changed only once at 5:00 AM, and was covered in poop and pee, and on the nightshift of 08/25/2024 they had requested to be changed at 8:00 PM and the staff member did not change them until 12:30 AM. The staff member was very aggressive when moving the resident around and talking to them. Review of the incident investigation dated 08/27/2024 showed no documentation that Resident 33 was interviewed regarding the incident and no documentation that other staff or other residents were interviewed. Review showed no documentation that the allegation of staff being aggressive was investigated. Interventions included to educate the involved staff on changing residents in a timely manner. There was no documentation that the identified staff member who worked on 08/24/2024 was educated. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/18/2024 at 12:01 PM, Staff B, Director of Nursing Services (DNS), stated the facility followed the purple book for allegations of abuse or neglect, the statement the staff was aggressive should have been investigated as potential abuse and that the resident, staff and other residents should have been interviewed. Staff B stated the incident dated 08/27/2024 for Resident 33 was not investigated thoroughly. 49926 Resident 101 Review of the EHR showed Resident 101 was admitted to the facility on [DATE] with diagnoses of amputation of toe and diabetes. The admission minimum data set assessment (MDS), an assessment tool, dated 08/11/2024, showed Resident 101 was able to make needs known. During an interview on 09/12/2024 at 9:35 AM, Resident 101 stated their wheelchair got in the way of the door, but that was the only way for them to get in and out of bed. Resident 101 stated, Last Sunday the night nurse was having a meeting in the hall and was too loud and me and my roommate woke up. My roommate got upset with me about not being able to close the door of the room. That continued in the morning. I was eating breakfast, and [they] wanted me to get up and move the wheelchair from the doorway. I asked to wait, but they didn't listen. Resident 101 stated their roommate was moved to a different room and Resident 101 was told that the roommate felt threatened with a butter knife. Observations of Resident 101 from 09/12/2024 - 09/18/2024 showed Resident 101 laid in bed and the wheelchair was behind the curtain and partially blocked the exit of the room. Review of Resident 101's incident investigation, dated 09/02/2024, showed no interviews or statements from other residents and staff to determine the root cause of the argument between the two roommates. During an interview on 09/17/2024 at 1:14 PM, Staff B, DNS, stated, Typically we do have statements, but this time we didn't. 50945 Resident 87 Review of the EHR showed Resident 87 was admitted to the facility on [DATE] with diagnoses of cognitive communication deficit (problem with communication due to cognitive problems), developmental delay of speech and language, and an intracranial injury (a brain injury). During an interview on 09/12/2024 at 1:08 PM, Resident 87 made an allegation of physical abuse by staff. The incident was investigated by the facility, starting on 09/12/2024. Review of Resident 87's incident investigation, dated 09/12/2024, showed the facility was unable to determine who the alleged perpetrator was. Review showed the facility did not conduct staff or resident interviews. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/18/2024 at 12:20 PM, Staff B, DNS, stated staff and residents were not interviewed and this did not meet expectations. Reference WAC 388-97-0640 (6)(a)(b)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide written notification of the reason for transfer to the hospital to resident or responsible party for 1 of 2 sampled residents (Resident 256) reviewed for hospitalization . This failure placed the resident at risk for not knowing rights regarding transfer and discharge from the facility, and diminished protection from been inappropriately discharged . Findings included . Review of the electronic health record (EHR) showed Resident 256 admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, asthma and dependence on respirator. Resident 256 was able to make needs known. Review of Resident 256's EHR showed a hospitalization on [DATE], and readmission to the facility on [DATE]. There was no documentation about transfer notice. During an interview on 09/17/2024 at 10:27 AM, Staff B, Director of Nursing Services, stated the expectation was that residents were provided with written documentation regarding reason for transfer and a transfer form completed. Reference WAC 388-91-0120(2) (a-d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to accurately assess 3 of 22 sample residents (Residents 95, 36 and 90) whose minimum data set (MDS, a required assessment tool) were reviewed. This failure placed the residents at risk of not receiving the care and services required to meet the residents' needs and inaccuracies in their care planning. Findings included . Resident 95 Resident 95 admitted to the facility on [DATE] with diagnoses of quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso), anxiety, depression and had a psychotic disorder. The MDS showed the resident was able to make their needs known. Review of quarterly MDS dated [DATE] showed Resident 95 was marked with a diagnosis of dementia (non-Alzheimer's dementia). Review of Resident 96's electronic health record (EHR) on 09/17/2024 showed no diagnosis of dementia (non-Alzheimer's dementia) within the resident documented diagnoses listing. During an interview on 09/17/2024 at 11:42 AM, Staff T, Registered Nurse/Minimum Data Set Coordinator (RN/MDSC), stated they did not see a diagnosis of dementia and did not know why the resident was coded with that wrong diagnosis. 46148 Resident 36 Resident 36 admitted to the facility on [DATE] with diagnosis of chronic respiratory failure and had a tracheostomy (an opening in the neck for breathing). Observation on 09/12/2024 at 11:24 AM showed Resident 36 was receiving oxygen through a tube attached at the neck. Review of the EHR showed an order for oxygen to be adjusted as needed and documentation showed Resident 36 had received 2 - 4 liters per minute (LPM) daily from 08/01/2024 through 08/04/2024. Review of the admission MDS, dated [DATE], showed Resident 36 was marked as not receiving oxygen during the prior 5 days. During an interview on 09/17/2024 at 12:25 PM, Staff G, Regional Nurse, stated the resident was receiving oxygen during the assessment period and the MDS was coded incorrectly. 50945 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 90 Review of the EHR showed Resident 90 was admitted [DATE], had a tracheostomy and was dependent on staff for repositioning. The admission MDS, dated [DATE], showed Resident 90 had four pressure ulcers on admission, had moisture associated skin damage (MASD), and did not have any assessment done of their teeth. Review of the EHR showed that Resident 90 had two pressure wounds and two hematoma wounds (abnormal pooling of blood under the skin from a broken or ruptured blood vessel) present on admission. During an interview on 09/17/2024 at 11:45 AM, Staff F, Licensed Practical Nurse, stated the MDS was incorrect, Resident 90 did not have MASD and did not have four pressure ulcers on admission. During an interview on 09/17/2024 at 12:07 PM, Staff G, Regional Nurse, stated the facility had new wound care nurses, and updating the MDS nurse was probably missed due to a lack of communication. During an interview on 09/18/2024 at 9:44 AM, Staff C, Assistant DNS, was unable to find documentation in the EHR of MASD for Resident 90. Staff C was unsure why dental care was not assessed for the MDS. Staff C stated the admission MDS for Resident 90 did not meet expectations. During an interview on 09/18/2024 at 12:18 PM, Staff B, DNS, stated the admission MDS for Resident 90 was not accurate, did not meet expectations, and that their expectation was for the MDS to be accurate. Reference WAC 388-97 -1000 (1)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to ensure bathing/showers and personal hygiene were consistently provided according to the plan of care for 2 of 3 sample residents (Residents 33 and 87), reviewed for Activities of Daily Living (ADL). This failure placed the resident at risk for poor hygiene, decreased self-esteem, and a diminished quality of life. Findings included . Resident 33 Review of the electronic health record (EHR) showed Resident 33 admitted to the facility on [DATE] with diagnosis of acute and chronic respiratory failure with a tracheostomy (an opening into the neck for breathing) and was dependent on staff for all activities of daily living (ADLs). The resident was usually able to make needs known. During an interview on 09/12/2024 at 4:46 PM, Collateral Contact 1 stated Resident 33 preferred showers twice a week but they had not had a shower for a couple weeks. During an interview on 09/13/2024 at 11:58 AM, Resident 33 shook their head no when asked if they had a shower this week and shook their head yes when asked if they wanted a shower. Review of the EHR showed a total of three showers and one bed bath between the dates of 08/14/2024 and 09/13/2024 (prior 30 days). During an interview on 09/16/2024 at 10:47 AM, Staff O, Certified Nursing Assistant (CNA), stated that the facility had an assigned shower aid for Resident 33 who normally worked Monday through Friday, but they had not seen them this day. Staff O stated if a shower or bed bath was missed the shower aides made up for it on another day. Staff O stated the aides working the halls did not give showers if the shower aide was not there. During an interview on 09/16/2024 at 10:56 AM, Staff B, Director of Nursing Services (DNS) stated that the assigned bath aide for Resident 33 was not at work this day. During an interview on 09/16/2024 at 11:51 AM, Staff C, Assistant Director of Nursing (ADON), stated they would assign another aide to give showers and if they did not, the aides working the halls do their own showers. Staff C stated Resident 33 should have received a shower 2 times a week. During an interview on 09/16/2024 at 12:43 PM, Staff B, DNS stated it was their expectation residents received two showers a week, but this did not happen for Resident 33 and should have. 50945 Resident 87 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR showed Resident 87 admitted to the facility on [DATE] with diagnoses of need for assistance with personal care and reduced mobility. The admission MDS, dated [DATE], showed Resident 87 needed partial or moderate assistance for a shower or bath. During an interview on 09/12/2024, Resident 87 stated they had previously gone eight days without a shower and were unaware of what days of the week showers were scheduled for. During an interview on 09/16/2024 at 08:57, Resident 87 reported their shirt had been on for three days. The EHR showed the resident was scheduled for showers on Mondays and Wednesdays. Resident 87 was due for a shower on 9/16/2024. During an observation on 09/17/2024, Resident 87 was seen to be wearing the same shirt as they were wearing the previous day. During an interview on 09/18/2024 at 08:28 AM, Staff D, CNA, stated Resident 87 was scheduled for showers on Mondays and Wednesdays, and preferred showers later in the day after physical therapy (PT), which could be after the bath aide's shift. Staff D stated that if the bath aide was not present, CNAs will give residents showers only if they have time. Staff D stated that the bath aide was not in the facility on Monday. During an interview on 09/18/2024 at 08:55 AM, Staff C, Assistant DNS, was only able to provide one documented shower in the past 30 days. Staff C stated the facility should address Resident 87's preference for a shower, to be after receiving PT. During an interview on 09/18/2024 at 10:11 AM, Staff B, DNS, stated that it did not meet expectations that Resident 87 did not receive a shower on Monday (09/16/2024) or that Resident 87 had reported going eight days without a shower. Reference WAC 388-97-1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview and record review, the facility failed to monitor and implement interventions for bowel or diabetic care for 2 of 6 sample residents (Residents 38 and 156) reviewed for unnecessary medications and failed to ensure care and monitoring for edema (a condition caused by too much fluid trapped in the body's tissues) or activities of daily living (ADLs) were provided for 2 of 22 sample residents (Resident 156 and 87) when reviewed for showers and skin care. These failures placed the residents at risk for worsening condition, discomfort and a decreased quality of life. Findings included . Resident 38 Review of the electronic health record (EHR) showed Resident 38 was admitted to the facility on [DATE] with diagnoses of kidney and lung disease, diabetes, depression and anxiety. Resident 38 was able to make needs known and required assistance with ADLs. During an interview on 09/12/2024 at 11:40 AM, Resident 38 stated they had diarrhea for the last two weeks, and that they had an order for Imodium (a medication used to treat diarrhea) but it had not been administered by the licensed nurses (LNs). Review of Resident 38's focus care plan dated 08/02/2024 showed documentation that the resident had bowel incontinence, and the goal was for the resident to have less than two episodes of incontinence per day through the review period. Review of Resident 38's medication administration record (MAR) showed a provider's order for Imodium to be administered by the LN every 4 hours as needed for diarrhea; however, review of the residents Task section documentation showed multiple days that the resident had diarrhea/loose stool from 09/07/2024 to 09/10/2024 and 09/12/2024 but the MAR showed no documentation that the Imodium was administered or offered to the resident. During an interview on 09/17/2024 at 10:14 AM, Staff U, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the resident who had diarrhea or loose stool should appear on the alert roster and that it was their expectation Certified Nurse Aides (CNAs) informed the LNs so that they could administer the diarrhea medication as ordered. During an interview on 09/17/2024 at 10:40 AM, Staff B, Director of Nursing Services (DNS), stated it would be their expectation that if a resident had multiple days of diarrhea or loose stools then it should have been addressed. Staff B stated the LN should have administered the Imodium medication as ordered by the provider. Resident 156 <Diabetic Care> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 156's EHR showed they were admitted to the facility on [DATE] and was discharged on [DATE] with diagnoses of stoke, hemiplegia (a loss of function to one side of the body), Parkinsons disease (a progressive nervous system disorder that causes cells in the brain to weaken, damage and die), diabetes, heart and kidney disease and was legally blind. In addition, Resident 156 was able to make needs known and was dependent on facility staff for ADLs. Review of Resident 156's August 2024 MAR, showed a provider's order for the LN to administer Semaglutide (a medication that helps control blood sugar and appetite and used for the treatment of diabetes) once a week, dated 08/28/2024; however, the MAR showed the medication was not administered and a progress note in the EHR showed it was unavailable. Another provider's order, dated 08/28/2024, was for the LN to administer glargine (insulin, used for the treatment of diabetes) once a day and to monitor the resident's blood glucose prior to administration. The MAR showed the LN had documented the administration of the glargine on the 28th, 29th, 30th and 31st of August 2024; however, the resident's blood glucose was documented in the EHR on 08/31/2024 (once for four administrations of glargine). A provider's order dated 08/27/2024 showed the resident wore a Freestyle Libre 3 Plus Sensor (a continuous glucose system sensor inserted intradermally [just below the skin layer]). The August 2024 MAR showed that an LN had documented their initials on 08/28/2024 that the device was replaced. Review of a focus care plan for Resident 156 showed the resident had an altered health condition related to diabetes. Multiple interventions included for the LNs to monitor blood glucose levels, signs and symptoms of hypoglycemia/hyperglycemia (a low or high blood glucose level within the body) and to administer the medications as ordered by the provider. Review of Resident 156's progress note showed that a LN had documented the Semaglutide was unavailable and f/u (follow-up) with pharmacy about delivery. The resident's progress notes had no additional documentation of whether the LN had f/u with the pharmacy regarding the unavailable medication in the progress notes or if the provider, resident / resident representative or Director of Nursing was contacted. During an interview on 09/16/2024 at 8:35 AM, Staff P, RCM/LPN, stated it would be their expectation if the Semaglutide was unavailable then the provider, resident or their representative should have been made aware and further follow up (additional progress notes) of the status of the unavailable medication. Staff P stated the residents blood glucose should have been monitored daily since they were on insulin and that the Libre device the resident wore required an app (an application, downloaded by the user to a mobile device) and the facility did not have access to that device app that was required to transmit and read the resident's blood glucose. Staff P stated LNs should not have signed off the Libre order in the MAR if they did not change the device or transmit the continuous glucose result. Staff P stated their expectation was the staff would document either refused or unavailable and not document not applicable on the EHR (Task) sheet. During an interview on 09/16/2024 at 9:29 AM, Staff C, Assistant Director of Nursing, stated Resident 156 should have had their Semaglutide retrieved from the Omni cell (a central storage machine that dispenses medication in a nursing home) or continued to follow up with the pharmacy, inform the resident's representative and provider regarding the unavailable medication and documented in the resident's EHR (progress notes). Staff C, stated the resident's blood glucose should have been monitored and documented (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<ADL Care> Review of Resident 156's EHR showed an order in the (Task) section which showed the resident to have a shower every Monday and Thursday and when necessary and that the resident required 1-person maximal assistance. The document showed staff had documented a checkmark as not applicable on Thursday 08/29/2024 at 1:17 PM for whether the resident received a shower or bath. During an interview on 09/16/2024 at 8:35 AM, Staff P, RCM/LPN, stated staff should re-offer the resident a shower or bath at the next available opportunity. During an interview with on 09/16/2024 at 9:26 AM, Staff BB, CNA, stated Resident 156 was supposed to have their shower changed to the following day; however, it did not appear the resident received their shower since the EHR (Task) was not signed off that next day. During an interview on 09/16/2024 at 9:29 AM, Staff C, Assistant Director of Nursing, stated a shower should have been provided to the resident as directed. 50945 Resident 87 Review of the EHR showed Resident 87 was admitted to the facility on [DATE] with diagnoses of generalized muscle weakness, reduced mobility, and deep vein thrombosis (blood clot of a deep vein). Resident 87 was able to make needs known. Review of the EHR showed Resident 87 had a care plan for altered cardiovascular status, initiated 08/05/2024, with interventions to monitor, document, and report any dependent edema (swelling in the lower body related to gravity, can change based on positioning). Multiple observations between 09/12/2024 - 09/17/2024 showed Resident 87's lower left extremity (leg, ankle, and foot) was larger in size than the right lower extremity. During an interview on 09/13/2024 at 11:19 AM, Resident 87 stated they had decreased sensation to their feet, their left leg had been more swollen than the right for about five years, and no interventions had been offered to help with the swelling. Resident 87 stated they would like something to wrap around their leg. During an interview on 09/17/2024 at 11:05 AM, Staff E, Registered Nurse, stated edema was assessed once a shift. Staff E stated although they had just put lotion on Resident 87's feet, they had not done a head-to-toe assessment yet, so they could not say if Resident 87 had edema. Staff E was unable to find any interventions for edema in the EHR. During a follow-up interview on 09/17/2024 at 1:41 PM, Staff E stated they assessed edema present on the legs and feet and would notify the provider. During an interview on 09/18/2024 at 8:05 AM, Staff C, Assistant Director of Nursing, stated there were no documented assessments of edema being present for Resident 87 prior to 09/17/2024. Staff C stated based on the observations, edema was not being monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/2024 at 10:10 AM, Staff B, DNS, stated it did not meet expectations that staff did not identify edema for Resident 87 until 09/17/2024. Reference WAC 388-97-1060 (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview, and record review, the facility failed to provide pressure ulcer care consistent with professional standards of practice to prevent and treat pressure ulcers for 1 of 2 sampled residents (Resident 90) reviewed for pressure ulcers. This failure placed residents at risk for developing pressure ulcers, worsening pressure ulcers, increased pain, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 90 was admitted [DATE], had a tracheostomy (a tube for breathing that goes through an opening in the neck) and was dependent on staff for repositioning. Resident 90 was not able to make needs known. Review of the EHR showed Resident 90 had three pressure ulcers: one on the left lower leg, one on the sacrum (the bone at the base of the spine), and one on the left ear. The left lower leg pressure ulcer was identified on arrival, with an initial documentation of the wound, but with no follow up assessments documented in the EHR. Documentation of this wound was not included in the progress notes by an outside wound provider, as they stated in a progress note on 08/21/2024 they were only requested to consult on the thighs and sacrum. The left ear pressure ulcer was not present on arrival, as it was first identified on 09/08/2024. During an interview on 09/17/2024 at 11:28 AM, Staff F, Licensed Practical Nurse, stated they had not been documenting assessments on the left lower leg pressure ulcer, and there should have been weekly assessments of all Resident 90's pressure ulcers and wounds. Review of a provider's order, dated 09/08/2024, showed for Resident 90's left ear pressure ulcer to be cleaned with wound cleanser, patted dry, and skin prep (a skin protectant) applied with the ear left open to air. Observation of wound care for Resident 90's pressure ulcers on 09/17/2024 from12:29 PM - 1:16 PM showed Staff F put a dressing on the sacral wound, with redness noted to the uncovered skin on the right and left sides dressing. Observation showed Staff F did not apply wound cleanser to the left ear pressure ulcer, applied skin prep and then repositioned Resident 90 with their entire left ear against the pillow. During an interview on 09/17/2024 at 1:20 PM, Staff F stated they missed applying wound cleanser to the left ear pressure ulcer and did not offload the left ear. Staff F stated based on the redness noted to the skin to the right and left sides of the dressing, a bigger sacral dressing could have been used, or a modified dressing. During an interview on 09/18/2024 at 9:00 AM, Staff C, Assistant Director of Nursing, stated wound care for Resident 90 could have been better, dressings should have been big enough to cover the entire pressure ulcer, and pressure ulcer care did not meet expectations. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/2024 at 10:13 AM, Staff B, Director of Nursing Services, stated their expectation for wound care was that orders were followed, and the observation during wound care on 09/17/2024 did not meet expectations. Reference WAC [PHONE NUMBER] (3)(b)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview, and record review, the facility failed to provide consistent indwelling urinary catheter (a tube inserted into the bladder to provide urinary drainage) care and management for 3 of 3 sampled residents (Residents 7, 90, and 77) reviewed for urinary catheter. This failed practice placed the residents at increased risk of complications, catheter associated urinary tract infections, including the potential development of sepsis, and a decreased quality of life. Findings included . Review of the facility's policy titled Indwelling Urinary Catheters, revised 04/2018, showed residents with indwelling urinary catheters were to have interventions in place that included placing the drainage bags below the level of the resident's bladder, avoiding kinking of the drainage tubing, keeping the drainage tubing as straight as possible from the catheter to the drainage bag, and to secure the catheter with a catheter strap or tape. Resident 7 Review of the electronic health record (EHR) showed Resident 7 was admitted on [DATE] and had diagnoses of neuromuscular dysfunction of the bladder (the muscles in the bladder wall do no contract and relax correctly), sepsis (infection of the blood stream), and urinary tract infection (UTI). Resident 7 was not able to make needs known and had a urinary catheter. Review of a provider progress note dated 06/18/2024 stated the urine sample from 06/13/2024 indicated a UTI, but the cultures were still pending. Review of Resident 7's urine sample, collected on 06/13/2024, showed the culture was unable to be ran as there were three or more organisms present, and thus considered mixed. Review of Resident 7's administration record for June 2024 did not have documentation of the catheter being removed and replaced on the date of the urine sample. Review of the EHR showed that Resident 7 was admitted to the hospital from 08/23/2024 -08/29/2024 and did not have any orders after hospitalization for catheter care or changing out the catheter. There was no record of catheter care in the administration record when reviewed for the dates of 09/01/2024 to 09/14/2024. Review of the catheter justification forms, dated 08/29/2024 and 08/30/2024, stated Resident 7 had a suprapubic catheter (a tube that goes through the abdomen to drain urine from the bladder). Observation on 09/13/2024 at 9:50 AM showed Resident 7 had a urinary catheter that entered from the urethra, not the abdomen. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/13/2024 at 11:48 AM showed Resident 7's catheter tubing looped down which created a dependent section of the tubing, then looped back up before connecting to the catheter bag. The dependent part of the tubing had bright yellow urine with sediment in it. Observation on 09/13/2024 at 12:05 PM showed two certified nursing assistants (CNAs) entered the room to care for Resident 7, and the urine in the catheter tubing was not drained into the catheter bag. Review of a progress note, dated 09/12/2024 at 9:50 PM, showed that Resident 7 had suspected blood in the catheter bag. Review of the EHR showed a urine sample was collected on 09/13/2024 and was positive for a UTI. Observation on 09/16/2024 at 9:57 AM showed Resident 7 was repositioned by two CNAs. Resident 7 was positioned with their right side up (left side down), the catheter tubing positioned over the resident's right side (up above the level of the bladder), and then the catheter bag was positioned to hang on the right side of the resident's bed. The urine from the catheter tubing was not drained into the catheter bag at any time during this observation. Observation on 09/17/2024 at 11:26 AM showed the catheter bag was touching the floor. During an interview on 09/17/2024, Staff E, Registered Nurse (RN), stated Resident 7's catheter bag was on the floor and it needed to be fixed. During an interview on 09/18/2024 at 9:07 AM, Staff C, Assistant Director of Nursing (ADON), stated it should be documented how a urine sample was collected, and their expectation was if the sample was contaminated to notify the provider to redo the sample, to notify the family member, and to chart. Staff C stated for Resident 7 it did not meet expectations that there was documentation of a suprapubic catheter when the resident had an indwelling catheter. Staff C stated there should have been indwelling catheter orders for Resident 7 on admission and after the hospitalization . Staff C was unable to provide documentation of catheter care for Resident 7 since returning from the hospital, and stated this did not meet expectations. During an interview on 09/18/2024 at 10:15 AM, Staff B, Director of Nursing Services (DNS), stated the urine sample from 06/13/2024 for Resident 7 did not meet expectations. Staff B stated it did not meet expectations that there were observations that the catheter tubing was not emptied into the catheter bag, that the catheter bag was moved above the bladder of Resident 7, the catheter tubing crossed up and over Resident 7's body, or that Resident 7's catheter bag was touching the floor. Resident 90 Review of the EHR showed Resident 90 was admitted on [DATE] with diagnoses of muscle weakness and neuromuscular dysfunction of the bladder. Resident 90 was not able to make needs known. Review of the EHR showed that on 08/20/2024 Resident 90 had a urine sample that was positive for a UTI, and there was no documentation of how the urine sample was collected. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the administration records for Resident 90 for September 2024, showed no documentation of catheter care being provided on 09/04/2024 in the morning or 09/10/2024 in the evening. Observation on 09/17/2024 at 12:29 PM showed Resident 90 had urine in the catheter tubing, and without emptying the urine from the tubing into the catheter bag, the catheter bag was lifted above the bladder of the resident, and then put on the bed. At 12:40 PM, urine was observed in the catheter tubing. At 1:09 PM, the catheter bag was again lifted above the bladder of Resident 90, before going back to its original position. At 1:14 PM urine was observed to be present in the tubing from the urinary catheter to where the tubing looped over the Resident 90's shin, and the tubing was not emptied into the catheter bag before staff left the room. During this observation period, Resident 90 did not have a securement device in place to secure the urinary catheter, usually seen on the thigh. The catheter tubing's clip was observed to not be attached to anything. During an interview on 09/18/2024 at 10:15 AM, Staff B, DNS, stated the missing catheter care documentation in September for Resident 90 did not meet expectations. Staff B stated it did not meet expectations that the catheter bag was lifted above the bladder of Resident 90 without ensuring the urine in the tubing was drained into the catheter bag, or that the catheter tubing was unsecured. 46148 Resident 77 Review of the EHR showed Resident 7 admitted to the facility on [DATE] with diagnoses of persistent vegetative state (non-responsive) and respiratory failure. Observation on 09/12/2024 at 10:38 AM showed Resident 7 laid in bed and there was a urinary catheter attached to the side of the bed with a clear tube which contained dark yellow urine. Review of the EHR on 09/13/2024 at 2:14 PM showed no current provider's orders or qualifying diagnosis for a urinary catheter. No documentation was found that catheter care had been provided from 08/24/2024 through 09/13/2024. During an interview on 09/16/2024 at 11:33 AM, Staff C, ADON, stated residents with a catheter should have orders in place which included the related diagnosis. During an interview on 09/16/2024 at 12:45 PM, Staff B, DNS, stated it was their expectation that Resident 7 had orders in place which included the type, size and catheter care instructions. Refer to F880 for additional information. Reference WAC 388-97-1060 (3)(c)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was managed in accordance with provider's orders and professional standards of practice to ensure correct placement prior to administering medications, manage the amount of fluids received and implement as needed (PRN) provider's orders for 4 of 4 sampled residents (Residents 33, 73, 77, and 7) reviewed for enteral nutrition. Resident 33 experienced harm when there was no evaluation of whether staff was administering the as needed medication to prevent clogging of a feeding tube or whether additional interventions were needed to prevent the resident from being transferred to the local emergency department four times between 08/04/2024 to 09/10/2024. These failures placed residents at risk for receiving inadequate nutrition and hydration, weight loss, hospitalization , and a decreased quality of life. Findings included . Review of an industry accepted resource for professional standards, Lippincott Manual of Nursing Practice, 11th edition showed the following three recommendations for enteral feeding tube obstruction: flush tube every four hours with 30 milliliters (ml,cc) of water and after administration of medications, administer medications in liquid form if possible; crush medications finely, and attempt to declog by administering water first. If unsuccessful, then administer pancreatic enzyme. Resident 33 Review of the electronic health record (EHR) showed Resident 33 admitted to the facility on [DATE] with a diagnosis of acute and chronic respiratory failure with a tracheostomy (an opening into the neck for breathing) and was receiving nutrition through a jejunostomy tube (J-tube, a tube inserted through the abdomen and stomach into the small intestine). During an interview on 09/12/2024 at 4:45 PM, Collateral Contact 1 (CC1) stated Resident 33 had been to the hospital three times in August because the J-Jube was clogged and needed to be replaced. CC1 stated the facility staff were not providing care to prevent it from clogging. Review of the feeding tube care plan dated 04/25/2023 showed an intervention to administer Viokace (a pancreatic enzyme that helps dissolve clogs) as needed for de-clogging. Review of a provider's order dated 05/26/2024 showed staff were to check placement of the J-tube prior to administering medications, fluids and food by listening during a 20 milliliter (mL, cc) instilled puff of air using a 60 cc syringe or check residual (a practice of checking for extra formula in the stomach, not traditionally used in j-tubes) every shift. Review of the provider's orders showed an order dated 05/26/2023 for Viokace tablet every 24 hours as needed for clogged feeding tube. Review of the medication administration record for August and September 2024 showed no documented PRN administrations. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Review of the EHR showed Resident 33 had been transported to the hospital for J-tube replacement related to a clogged J-tube on 08/04/2024, 08/15/2024, 08/27/2024 and 09/10/2024. The EHR did not show documentation of implemented interventions to unclog the tube prior to transport. Observation on 09/17/2024 at 10:46 AM showed Staff S, Registered Nurse, entered Resident 33's room with a clear cup with multiple crushed medications in liquid. There was visible particles in the bottom of the cup. Staff S flushed the J-tube with 30 cc of clear water using a 60 cc syringe. They did not check for residual or instill 20 cc of air to check placement prior to administering the crushed medications. Staff S stated when the tube got clogged, they used a manual de-clogging device. During an interview on 09/18/2024 at 11:09 AM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that staff checked placement of enteral feeding tubes prior to administering medications and implement PRN interventions per provider's orders. During an interview on 09/23/2024 at 1:21 PM, Staff C, Assistant Director of Nursing (ADON), stated it was their expectation that staff administered PRN medications to prevent complications per provider's orders. Staff C stated staff not attempting to use Viokace prior to sending the resident out to the emergency room did not meet expectations. Staff C stated that the order for Viokace should have been clarified with the pharmacy, and staff made aware of the intervention, and it was possible that Resident 33 may not have needed to be sent to the emergency roiagnom on [DATE], 08/15/2024, 08/27/2024 and 09/10/2024 if they had followed the provider's order. 50945 Resident 7 Review of the EHR showed that Resident 7 was admitted on [DATE] with diagnoses of brain damage and vegetative state. The Medicare 5-day minimum data set assessment, dated 09/05/2024, showed Resident 7 was dependent on staff for care and required a gastric tube for nutrition. Review of Resident 7's provider's orders showed an order, dated 08/29/2024, for staff to administer 30 cc of water before and after medication administration. Review showed Resident 7 had an order for a goal intake of 1500 cc formula and 600 cc water. Observation on 09/16/2024 at 9:28 AM showed a licensed nurse paused and disconnected the tube feed for Resident 7, provided a 30 cc flush, administered medications, then reconnected and resumed the tube feed. No flush was observed after the medications were given. Review of Resident 7's administration record for formula and water showed, from 09/03/2024 - 09/13/2024, Resident 7 did not reach their goal for formula and only once met their goal for water. On 09/09/2024, Resident 7 was recorded to receive 631 ml of formula and 335 ml of water. During an interview on 09/18/2024 at 8:37 AM, Staff C, ADON, stated staff should have charted why Resident 7 did not receive the full amount of their ordered formula and water, notified the provider, and notified the family member. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/18/2024 at 10:06 AM, Staff B, DNS, stated it did not meet expectations that Resident 7 was observed to be given medications without a flush given afterwards, nor did the recorded intake of formula/fluids for September 2024 meet expectations. 49926 Resident 73 Review of the EHR showed Resident 73 admitted to the facility on [DATE] with a diagnosis of acute and chronic respiratory failure with a tracheostomy and was receiving nutrition through a gastric tube (a tube inserted through the abdomen and stomach). Observation on 09/16/2024 at 8:46 AM showed Staff AA, Licensed Practical Nurse, prepared multiple crushed medications in liquid. There were visible particles in the bottom of the cup. Staff AA flushed the gastric tube with 10 cc of water using a 60 cc syringe. They did not check for residual or instill 20 cc of air to check placement. Staff AA then administered the crushed medications using the 60 cc syringe, flushed with 30 cc of water and reconnected the tube to the pump. Resident 77 Review of the EHR showed Resident 77 admitted to the facility on [DATE] with diagnoses of persistent vegetative state and respiratory failure and received nutrition through a gastric tube. Observation on 09/16/2024 at 9:12 AM showed Staff V, Registered Nurse, prepared two crushed medications for Resident 77. During the attempt to flush the gastric tube, fluids sprayed in the air onto the nurse and resident. Staff V obtained assistance from a different nurse and a physical declogger (device used to declog gastric tubes) was used to open the gastric tube. Staff V then flushed the gastric tube with 60 cc of water, administer the crushed medications, and flushed with 30 cc of water using the 60 cc syringe. Staff V did not check for residual or instill 20 cc of air to check placement. During an interview on 09/17/2024 at 10:23 AM, Staff B, Director of Nursing Services, stated it was their expectation that staff checked placement of enteral feeding tubes prior to administering medications and implemented PRN interventions per provider's orders. During a follow-up interview on 09/18/2024 at 10:51 AM, Staff B stated nurses checked placement by checking residuals of the gastric tubes. Reference WAC 388-97-1060 (3)(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview and record review, the facility failed to ensure residents were provided tracheostomy (an opening surgically created through the neck for breathing) care in accordance with professional standards of practice for 1 of 5 sampled residents (Resident 7) reviewed for respiratory care. This failure placed residents at risk for unmet care needs and potential negative outcomes. Findings included . 50945 Resident 7 Review of the EHR showed that Resident 7 was admitted on [DATE] with diagnoses that included brain damage, tracheostomy, and chronic respiratory failure. The Medicare 5 day minimum data set assessment (MDS), dated [DATE], showed Resident 7 was dependent on staff for all care, required oxygen, and required a ventilator (machine used to assist in breathing). Observation on 09/13/2024 at 11:56 AM showed two certified nursing assistants (CNA) entered Resident 7's room to provide care. The blue tubing connected to the ventilator was observed to have approximately six inches of yellow fluids lining the tubing. The CNAs saw the fluids and paged the respiratory therapist (RT). The CNAs then turned Resident 7 fully onto their right side, causing (via gravity) the fluid to move from the ventilator tubing into the tracheostomy. Resident 7 was observed to cough and have fluids spilling out of the mouth, and the ventilator audibly alarmed for the high pressure. A CNA dabbed the outside of Resident 7's mouth, to remove some of the fluids, and both CNAs left the room before the RT had arrived. Observation and interview on 09/13/2024 showed Staff J, RT, entered the room to provide respiratory care to Resident 7. Staff J described removing a lot of fluids from the resident. Staff J stated it was not appropriate staff turned the resident onto their right side when there were fluids in the ventilator tubing next to the tracheostomy. Multiple observations on 09/16/2024 from 8:40 AM - 12:52 PM, showed Resident 7 had yellow fluids saturating the gauze around the tracheostomy site, and fluids pooled onto the hand towel positioned on Resident 7's chest. Resident 7 was observed to cough, grimace, and have the ventilator alarm briefly. Resident 7 was observed to be turned twice during this observation period, both times there were fluids saturating the gauze around the tracheostomy tube, and there were fluids in the blue tubing of the ventilator. During an interview on 09/15/2024 at 1:16 PM, Staff K, RT, stated they had just removed moderate to large amounts of fluids from Resident 7, had needed to change the gauze around the tracheostomy site, and had needed to change out a part of the ventilator tubing (the heat and moisture exchanger filter) due to there being a lot of fluids in the ventilator tubing. Staff K stated they had not received any pages by staff to come suction or care for Resident 7. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/2024 at 10:20 AM, Staff B, DNS, stated it did not meet expectations that staff called the RT and did not wait for the RT to be present before turning Resident 7 on 09/13/2024. Staff B stated it did not meet expectations that on 09/16/2024 Resident 7 was turned twice without the RT being paged, and that RT had not received any pages during the observation. Staff B stated their expectation was for the RT to be notified and respond. Reference WAC 388-97-1060(3)(j)(iv)(v)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34567 Based on observation, interview and record review, the facility failed to post the actual nursing staffing hours daily. This failure prevented the residents, family members, and visitors from exercising their rights to know the actual numbers of available nursing staff in the facility. Findings included . Observation and record review on 09/18/2024 at 8:45 AM showed that the nursing staff posting, located in the facility's entrance hallway and dated 09/18/2024, did not have the actual adjustments documented to reflect the nursing staff absences on each shift due to call-offs or illness nor show that it was being reconciled to show actual hours worked. During an interview on 09/18/2024 at 2:01 PM, Staff N, Staffing Coordinator (SC), stated they were unaware that they needed to post the actual hours worked for the nursing staff daily. During an interview on 09/18/2024 at 2:37 PM, Staff A, Administrator, stated it was their expectation that the staffing coordinator post the nursing staff actual hours worked on the document. No reference WAC

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview and record review, the facility failed to monitor adverse side effects and implement provider recommendations for psychotropic medications (medications that affect the mind) for 2 of 5 sampled residents (Residents 43 and 456) reviewed for unnecessary medications. This failure placed residents at risk of adverse side effects, medical complications and a diminished quality of life. Findings included . Resident 43 Review of the electronic health record (EHR) showed Resident 43 admitted to the facility on [DATE] with diagnoses that included aphasia (a comprehension and communication disorder resulting from damage or injury to the specific area in the brain), unspecified psychosis (detachment from reality) and dementia (loss of memory, problem-solving and thinking abilities). Resident 43 was sometimes understood and sometimes able to understand others. Review of the EHR showed an order for Seroquel (an antipsychotic) to be given 12.5 milligrams by mouth one time a day for paranoia/psychosis secondary to vascular dementia and give 25 milligrams by mouth two times a day for paranoia/psychosis secondary to vascular dementia. Review of a provider encounter note dated 08/30/2024 showed Would recommend gradual dose reduction (GDR) as the patient is stable currently with mood and behaviors. Decrease Seroquel to 25 milligrams twice daily, continue to monitor mood and behaviors, continue supportive measures. Review of the September 2024 medication administration record (MAR) showed Resident 43 received the Seroquel 12.5 milligrams by mouth one time a day and 25 milligrams by mouth two times from September 1, 2024, through September 17, 2024. During an interview on 09/17/2024 at 12:26 PM, Staff U, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the GDR should have been implemented within a week but was not due to miscommunication. During an interview on 09/17/2024 at 12:48 PM, Staff B, Director of Nursing (DNS), stated the expectation that provider recommendations were implemented as soon as possible was not met. 49926 Resident 456 Resident 456 admitted to the facility on [DATE] with diagnoses that included dementia, chronic obstructive pulmonary disease (a breathing disease), and diabetes. The admission minimum data set (MDS, an assessment tool), dated 09/08/2024, showed Resident 456 was with moderate cognitive impairment. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/12/2024 at 12:52 PM showed Resident 456 sitting in wheelchair in the room with a bruise on their forehead. Resident 456 described how they fell when trying to get in bed and hit their head. Review of the EHR showed Resident 456 had fallen on 09/05/2024 and was evaluated in the local emergency room . Continued review showed that Resident 456 was prescribed and administered quetiapine (an antipsychotic medication that affects the mind) in the evening time, with a black box warning that showed an increase in mortality in elderly patients with dementia. Additional review showed an AIMS test (a test that assesses the severity of involuntary movements) was not performed and ordered orthostatic blood pressure (condition that causes a sudden drop in blood pressure when standing up from a sitting or lying don position), scheduled for 09/13/2024, was not completed. During an interview on 09/17/2024 at 9:33 AM, Staff P, RCM/LPN, stated AIMS tests and orthostatic blood pressure should have been done for Resident 456. During an interview on 09/17/2024 at 1:18 PM, Staff B, DNS, stated the expectation was for nurses to complete AIMS testing and orthostatic blood pressure on residents that were receiving an antipsychotic medication. Reference WAC 388-97-1060(3)(k)(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49926 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of two errors were made in twenty-five opportunities during a medication administration for 1 of 5 sampled residents (Resident 77) reviewed for medication administration. This placed the residents at risk for receiving medications that were not effective or less effective and a diminished quality of life. Findings included . Observation of medication administration on 09/16/2024 at 9:12 AM showed Staff V, Registered Nurse, prepared and administered the medications baclofen and tizanidine (medications for muscle spasms) via artificial tube to Resident 77. Review of a provider's orders for Resident 77 showed orders for baclofen and tizanidine with a specific time of administration to be administered at 8:00 AM. During an interview on 09/17/2024 at 10:23 AM, Staff B, Director of Nursing Services, stated the expectation was for nurses to follow orders including the correct time of administration and this did not meet expectations. Reference WAC 388-97-1060(3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 49926 Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 3 of 3 medication carts (400 front, 400 back, and 300 back) and 2 of 2 medication rooms (300 and 100 halls) when reviewed for medication storage. This failure placed residents at risk for receiving expired medications, and ineffective treatment, and diminished quality of life. Findings included . Observation of 300 hall medication room on 09/17/2024 at 9:20 AM with Staff P, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), showed the contents of the refrigerator to have an open vial of Tubersol solution (used in testing for tuberculosis) with no opened date. Observation of the 100 hall medication room on 09/17/2024 at 9:35 AM with Staff P, showed content of refrigerator to have an open vial of Tubersol solution without an open date. During an interview on 09/17/2024 at 9:40 AM, Staff P stated the Tubersol solution should be dated when opened as it would expire based on the opened date. Observation of the 400 front medication cart on 09/17/2024 at 10:55 AM with Staff X, LPN, showed Timolol eye drops with an opened date of 06/25/2024 and expiration date of 07/23/2024. Observation of the 300 back medication cart on 09/17/2024 at 1:31 PM with Staff Z, LPN, showed atropine 1% eye drops that were opened but not dated, Admelog Insulin pen with open date of 08/13/2024 good for 28 days till 09/10/2024, and a Basaglar Insulin pen with opened date of 08/13/2024 good for 28 days till 09/10/2024. Review of the scheduled narcotics records with Staff Z showed missing nurse's signatures on 09/03/2024,09/06/2024, 09/07/2024, 09/08/2024, 09/09/2024, 09/11/2024, 09/12/2024, 09/13/2024, 09/14/2024, 09/15/2024 and 09/17/2024. Observation of the 400 back medication cart on 09/18/2024 at 8:42 AM with Staff Y, LPN, showed three house supply eye drops with no opened dates. During an interview on 09/17/2024 at 10:23 AM, Staff B, Director of Nursing Services, stated that multidose medications should be dated when opened. Narcotic medications should be double signed for at the end of each shift by nurses, and this did not meet expectations. Reference WAC 388-97-1300(2)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to provide routine dental care for 1 of 3 sampled residents (Resident 55) when reviewed for dental. This failure placed residents at risk of avoidable dental pain, difficulty eating, unintended weight loss, and a diminished quality of life. Findings included . Review of the electronic health record showed Resident 55 admitted to the facility on [DATE] with diagnoses of type two diabetes, dependence on renal dialysis (process of removing waste from the blood), and depression. Observation and interview on 09/12/2024 at 12:13 PM showed Resident 55 had multiple missing teeth and was not wearing a denture. Resident 55 stated they did not have a denture. Review of the admission minimum data set assessment, dated 01/10/2023, showed Resident 55 had obvious or likely cavity or broken natural teeth. Review of the care plan, dated 02/03/2023, showed Resident 55 had no care plan for missing teeth or use of a denture. Review of a dental consultation, dated 08/25/2023, showed Resident 55 had multiple dental issues and was referred for x-ray, extraction of teeth, and evaluation for denture. Review of a dental consultation, dated 08/19/2024, showed Resident 55 had multiple dental issues and was referred for x-ray, extraction of teeth, and evaluation for denture. During an interview on 09/17/2024 at 12:35 PM, Staff P, Resident Care Manager/Licensed Practical Nurse, stated an outside dental provider would assess resident's dental needs and any further dental needs would be scheduled within a week. Staff P stated Resident 55 had been evaluated on 08/25/2023 and 08/19/2024 and no follow-up had been provided. Staff P stated Resident 55 had dental needs per evaluation and the lack of follow-up did not meet expectation. During an interview on 09/17/2024 at 12:54 PM, Staff B, Director of Nursing Services, stated an outside provider would come to the facility to assess resident dental needs and follow-up would be provided as soon as possible. Staff B stated Resident 55's lack of follow-up on dental recommendations on 08/25/2023 and 08/19/2024 did not meet expectation. Reference WAC 388-97-1060 (3)(j)(vii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview and record review the facility failed to implement infection control and prevention measures to include transmission based precautions for 3 of 22 sampled residents (Residents 74, 324 and 14), during wound care for 1 of 4 residents (Resident 90) and catheter care for 1 of 3 residents (Resident 7). These failures placed residents at increased risk for healthcare associated infections, related complications and a decreased quality of life. Findings included . Resident 74 Review of Resident 74's electronic health record (EHR) showed the resident readmitted on [DATE] with a diagnosis of respiratory failure with a tracheostomy (an opening into the neck for breathing), required mechanical ventilation (a machine that helps the resident breath) and had a feeding tube for nutrition (a tube that is inserted through the abdomen into the stomach for nutrition). The resident was receiving inhaled antibiotics for an multi drug resistant organism (MDRO, infection an infection with a bacterium that resists most antibiotics). During an observation on 09/15/2024 at 10:44 PM, Resident 74 sat on the side of the bed, there was a sign posted by the room door which showed the resident required Contact Precautions and staff were to perform hand hygiene and put on an isolation gown and gloves prior to entering the room. During an observation on 09/15/2024 at 10:51 PM, an unidentified nursing staff entered Resident 74's room, put on gloves and assisted the resident with adjusting the PEG tube and pump. They did not put on an isolation gown or perform hand hygiene. During an observation and interview on 09/16/2024 at 10:45 AM, Staff V, Registered Nurse, was observed entering Resident 74's room and assisting the resident with feeding tube care, Staff V did not put on a gown or perform hand hygiene when entering the room. When asked what type of precautions Resident 74 had and what was required when providing care, they stated it is the same precautions as everyone else with a tracheostomy. After reviewing the EHR, Staff V was not able to determine why the resident required contact precautions. Resident 456 Review of the EHR showed Resident 456 admitted to the facility on [DATE] with a diagnosis of bladder cancer and required an indwelling urinary catheter. Review showed a care plan intervention dated 09/05/2024 for Implement Enhanced Barrier Precautions during high contact care activities Observation on 09/13/2024 at 12:00 PM showed no enhanced barrier precautions sign posted at Resident 456's door. Observation on 09/16/2024 at 11:37 AM showed no enhanced barrier precautions sign posted at Resident 456's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 14 Review of the EHR showed Resident 14 readmitted to the facility on [DATE] with diagnosis of ventilator associated pneumonia (lung infection) with a history of an MDRO and urinary tract infection. The resident required enhanced barrier precautions. During an observation on 09/17/2024 at 10:04 AM, Staff DD, Certified Nursing Assistant entered Resident 14s room, did not perform hand hygiene upon entering and did not put on an isolation gown. Staff DD put on gloves and provided direct resident care to resident 14 and was observed to place soiled linens on the floor. Staff DD exited the room and went to the clean linen cart across the hall. Staff DD opened the linen cart flap with soiled gloves on and grabbed an absorbent pad with the dirty gloves. Staff DD then went back into Resident 14s room, assisted the resident again, did not wash their hands or put on clean gloves, exited the room again with the dirty gloves on and obtained more linens from the linen cart. Staff DD exited the room with a bag of soiled linens, put them into the soiled utility and did not wash their hands. During an interview on 09/17/2024 at 10:16 AM, Staff DD stated they should have worn a gown and gloves for enhanced barrier precautions and not worn dirty gloves to obtain linens. During an interview on 09/18/2024 at 10:21 AM, Staff H, Infection Preventionist/Licensed Practical Nurse (IP/LPN) stated Resident 456 should have had an order for enhanced barrier precautions and they should have been in place for staff to follow. Staff H further stated that it was their expectation that staff follow the posted precautions signs and should remove soiled gloves and perform hand hygiene prior to exiting a resident's room. During an interview on 09/16/2024 at 12:52 PM, Staff B, Director of Nursing Services stated it was their expectation that any resident with a catheter be on enhanced barrier precautions, the staff should be able to tell you what the infection was and why the resident was on contact precautions and the staff should follow the directions on the posted precautions signs. 50945 Resident 90 Review of the EHR showed Resident 90 was admitted on [DATE] and had diagnoses of urinary tract infection (UTI) and osteomyelitis (bone infection) to the sacrum (bone at the base of the spine). Resident 90 was not able to make needs known and had five wounds. Observation of wound care on 09/17/2024 from 12:29 PM - 1:14 PM showed Staff F, Licensed Practical Nurse, performed care to five wounds on Resident 90. An absorbent bed pad was placed on the bed for a clean surface for items. At 12:37 PM the catheter bag was observed to touch this absorbent pad. It was moved off the pad by the assisting certified nursing assistant (CNA), but then the catheter tubing was observed to touch the pad before it was moved off. The pad was not replaced and was used throughout the observation. Multiple observations showed Staff F use wound cleanser and then put the wound cleanser back on the bed next to Resident 90. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:54 PM, Staff F was observed to remove the old dressing from the lower leg, then moved to the sacral wound with the same gloves and removed the dressing and the packing from in the wound. Then Staff F performed hand hygiene and changed their gloves. At 12:57 PM Staff F was observed to spray the leg wound with wound cleanser, and then moved to the sacral wound with wound cleanser with the same gloves on. Staff F used gauze to clean the sacrum and sprayed more wound cleanser. Then, Staff F performed hand hygiene and changed their gloves. At 12:59 PM Staff F applied skin prep (skin protectant) to the outer skin around the sacral wound, then moved to the leg wound and applied skin prep with the same gloves on. With the same gloves, Staff F put padding into the wound of the sacrum. Then Staff F performed hand hygiene and changed their gloves. At 1:03 PM Staff F put a padded dressing on the sacrum, did not change gloves or provide hand hygiene, then took a Q tip and measured the left lower leg wound. A dressing was applied, and then Staff F changed their gloves and performed hand hygiene. During an interview on 09/17/2024 at 1:20 PM, Staff F stated that clean surfaces should not have anything put on them to contaminate them, and that the wound care should be done one at a time. During an interview on 09/18/2024 at 10:13 AM, Staff B, DNS, stated that it did not meet expectations that Resident 90's wound care involved using an absorbent pad that had been touched by the catheter bag and tubing, that the wound spray was being put down next to the Resident 90 on the bed, or that staff moved from one wound to another without changing gloves or performing hand hygiene. Resident 7 Review of the EHR showed that Resident 7 was admitted on [DATE] and had diagnoses of sepsis (infection of the blood stream) and UTI. Resident 7 was not able to make needs known. Resident 7 had a urinary catheter and a tracheostomy (a tube for breathing that goes through an opening in the neck). Resident 7 was on enhanced barrier precautions. Observation on 09/13/2024 at 12:05 PM showed two CNAs turned and changed Resident 7. Then catheter care was provided without changing gloves. Observation on 09/16/2024 at 12:45 PM showed Staff R, CNA, entered the room with another CNA. Staff R was observed to touch the catheter tubing to drain the tubing into the catheter bag. Both CNAs removed wedges from beneath Resident 7 and repositioned the resident. Staff R opened the brief to check for waste and was observed to touch the catheter that had been covered by the brief with the same gloves they had been wearing. No catheter care was performed. During an interview on 09/16/2024 at 2:01 PM, Staff R stated it was not okay to touch the catheter with gloves that previously touched other items. During an interview on 09/18/2024 at 9:07 AM, Staff C, Assistant Director of Nursing, stated catheter care should have been done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/18/2024 at 10:15 AM, Staff B, DNS, stated that both the observations on 09/13/2024 and 09/16/2024 for Resident 7 did not meet expectations. Reference WAC 388-97-1320 (1)(a)(c), (2)(b)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to provide pneumococcal vaccines for 1 of 5 residents (Residents 97) reviewed for vaccinations. This failure placed the resident at a higher risk for contracting pneumococcal infections, related complications, and a decreased quality of life. Findings included . Resident 97 Review of the electronic health record (EHR) showed Resident 97 admitted to the facility on [DATE] with diagnosis of diabetes and surgical amputation of the legs. Review of the EHR showed Resident 97 consented to receiving the Pneumococcal Vaccine on 06/03/2024. Continued review on 09/17/2024 showed no documentation of Resident 97 receiving the pneumococcal vaccine. During an interview on 09/18/2024 at 10:19 AM, Staff H, Infection preventionist/Licensed Practical Nurse stated Resident 97 should have received the pneumococcal vaccine and that they did not have a process in place for screening residents and administering vaccines to residents who requested them. During an interview on 09/16/2024 at 12:52 PM, Staff B, Director of Nursing Services stated it was their expectation that residents be educated, offered and administered the pneumococcal vaccine if requested. Reference WAC 388-97-1340 (1), (2), (3).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 40817 Based on observation, interview, and record review, the facility failed to maintain the mechanical lifts (used to help residents move from one surface to another) for 3 of 3 sampled halls (100, 300, and 400 Halls) when reviewed for safety. This failure placed residents at risk for falls, avoidable injury, and a diminished quality of life. Findings included . Review of a document titled Mechanical Lift Checklist, dated 01/2024, showed Swivel bar: Check bolts and sling hooks are they free from damage, bends, or deflections. Observation on 09/17/2024 showed the mechanical lifts on 100, 300, and 400 Halls had no safety clips attached to the sling hooks. During an interview on 09/17/2024 at 12:12 AM, Staff W, Maintenance Director, stated the facility ensured that mechanical lifts were safe to use by performing an audit of the lifts quarterly. Staff W stated the mechanical lifts should have safety clips attached to the sling hooks. Staff W inspected the mechanical lifts on 100, 300 and 400 Halls and stated there were no safety clips on any of the lifts and this did not meet expectation. During an interview on 09/17/2024 at 2:13 PM, Staff A, Administrator, stated the facility ensured mechanical lifts were safe to use by auditing them using the Mechanical Lift Checklist. Staff A stated Mechanical lifts could pose a safety risk if they did not have safety clips and staff should immediately correct missing safety clips once noticed. Staff A stated the mechanical lifts in100, 300, and 400 Halls missing safety clips did not meet expectation. Reference WAC 388-97-2100