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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505240	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Bay Care	140 South Marion Avenue Bremerton, WA 98312

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50488 Based on observation and interviews, the facility failed to ensure dining services were provided in a respectful and dignified manner for 5 of 14 residents (Residents 54, 33, 15, 60, and 22) eating in the dining room. This failure placed residents at risk for feelings of dehumanization and a diminished quality of life. Findings included . The facility's Admissions Packet, undated, documented, You have the right to be treated with respect. On 06/10/24 at 12:22 PM, 14 residents were seated in the dining room at six different tables. Table 1 had one resident, Table 2 had two residents, Table 3 had one resident, Table 4 had two residents, Table 5 had two residents, Table 6 had six residents. Staff EE, restorative aide, and Staff FF, restorative aide, began passing out trays at 12:32 PM. Nine of the 14 residents were served at various tables at that time. At 12:35 PM, Staff FF said they pass trays from the cart according to how they were loaded. Staff FF stated, we can't pull a tray out and set it to the side to pull out the one behind it. At 12:43 PM, Residents 54, 33, 15, 60, and 22 had not received trays while others at their tables had finished eating. At 12:44 PM, residents at Table 6 questioned Staff EE as to why other residents at their table had not received their tray yet and Staff EE responded, yea, we are looking for your food. At 1:15 PM Staff D said each table should have been served at the same time to ensure the best dining experience. Reference WAC 388-97-0180(1-4)

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 46067 Based on interview and record review, the facility failed to ensure quarterly personal fund statements were provided to residents with personal fund accounts for 4 of 4 sampled residents (Residents 11, 37, 43 and 46) reviewed for personal funds. This failure placed residents at risk of not having an accurate accounting of their personal funds held in a trust account by the facility. Findings included . During a resident council meeting on 06/17/2024 at 2:56 PM, when asked about quarterly statements, Residents 11, 37 and 43 said they had never received a quarterly statement for their trust account balance. Resident 46 stated, I didn't even know I had a trust account. Review of a document provided by the facility titled, Trial Balance, dated 06/10/2024, showed Residents 11, 43, and 46 all had a balance in their trust fund. Resident 37 had a trust fund with a balance of zero dollars. On 06/17/2024 at 3:16 PM, Staff F, Business Office Manager, said they provided quarterly statements to residents with trust accounts every three months. Staff F said the most recent documentation they could provide was from December 2023 and stated, if I don't have the documentation, I probably didn't do them for those months. On 06/17/2024 at 4:05 PM, Staff A, Administrator,said the expectation was that residents or resident representatives should have been receiving quarterly statements consistently. Reference WAC 388-97-0340(3)(a)(b)(c)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 46067 Based on interview and record review the facility failed to ensure mail was delivered unopened for 4 of 7 residents (Residents 25, 30, 43 and 46) reviewed for resident rights. This failure placed the residents at risk for lack of privacy and a diminished quality of life. Findings included . Review of the Resident Rights policy, dated 08/2022, showed centers will comply with resident rights under Federal law at 42 U.S.C 483.10 (Resident Rights) and communicate those rights to patients in language/and or by a means of communication that ensures understanding. Review of 42 U.S.C 483.10 section (h)(2) (Privacy and Confidentiality) showed the facility must respect the residents' right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. During the resident council interview on 06/17/2024 at 2:56 PM, Resident 43 stated, the office manager opens envelopes that look like there is a check inside. Resident 46 commented, I've received my mail opened in the past and it wasn't a check. On 06/17/2024 at 3:16 PM, Staff F, Business Office Manager, said they do open some residents' mail, however, they are usually the social security checks for Residents 30 and 25. Staff F said they had been doing this for a long time and did not see an issue with it. On 06/18/2024 at 2:45 PM, Resident 30 stated, I'm not happy that I was just made aware that my social security check was being opened and deposited. Resident 30 said they were approached that morning and asked to sign a form giving Staff F permission to open all future checks. On 06/17/2024 at 4:05 PM, Staff A, Administrator, said they were unaware that mail was being opened and that staff would be educated immediately that the expectation was for mail to be opened at bedside with the resident's permission. Reference WAC: 388-97-0500 (1)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on interview and record review the facility failed to provide an Advanced Directive (AD, a written instruction of health care directions) for 2 of 9 residents (Residents 59 and 62) reviewed for ADs. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . <Resident 59> Resident 59 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS), an assessment tool, dated 05/15/2024, documented the resident was mildly cognitively impaired. A review of the Electronic Health Record (EHR) showed a document titled, Resident Rights-Advanced Directives, which was signed by Resident 59 on 05/08/2024, and indicated the resident had an AD. No record of the AD was in the EHR. A copy of the AD was requested from the facility on 06/12/2024, 06/13/2024, and 06/14/2024. On 06/17/2024 at 2:47 PM, Staff B, Director of Nursing Services (DNS), said they did not see the AD in the EHR and stated, we don't have the documentation. Staff B said a copy of the AD should be in the EHR. 42960 <Resident 62> Resident 62 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented the resident was cognitively intact. A review of the EHR showed a document titled, Resident Rights-Advanced Directives, which was signed by Resident 63 on 01/09/2024, and indicated the resident had an AD. No record of the AD was in the EHR. On 06/17/2024 at 11:44 AM Staff B, DNS said she did not see an AD in Resident 62's EHR and she said her expectation would be to follow-up with the resident and see if the family can bring it in. Reference WAC 388-97-0300 (3)(b-c)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to file a grievance and to make a prompt effort to resolve the resident's grievance for 1 of 3 sampled residents (Resident 18) reviewed for personal property. This failure placed residents at risk for a diminished quality of life. Findings included . Resident 18 was admitted to the facility on [DATE] with diagnoses including depression and psychosis (a mental disorder characterized by a disconnection from reality). The Significant Change Minimum Data Set (MDS), an assessment tool, dated 05/10/2024, showed the resident was cognitively intact and was able to recall. On 06/11/2024 at 8:57 AM, Resident 18 said they came to the facility with two phones, that the one that worked better and was pretty was the phone that went missing. Resident 18 recalled multiple staff members had helped the resident look for the phone, but they were unable to locate it. Resident 18 said a grievance was filed with the activity person, and that there had been no follow up or information given to the resident about the grievance. Resident 18 was upset about the phone had gone missing and stated the missing property made them feel upset and flabbergasted. On 06/18/2024 at 9:53 AM, Resident 18 said the phone that went missing was a Motorola G turquoise blue phone, that there had still not been follow up from the facility, and that they still had only their black phone. Resident 18 again said they remembered filing a grievance with the activity person. On 06/17/2024 at 1:50 PM, Staff G, Activities Director said they had filed a missing item report with social services. A Missing Property Report was filed on 05/21/2024 for Resident 18. The report was filled out by Staff G, Activities Director. The form reported, found no missing phone resident is using a phone. Per Resident 18, the missing item was a second phone, which the Missing Property Report did not address. Review of the Grievance Log, dated 01/10/2024 to 06/10/2024, did not show a grievance was listed for Resident 18 for missing property. Review of the Incident Log, dated 01/10/2024 to 06/10/2024, did not show an incident was recorded for Resident 18 for missing property. On 06/18/2024 at 10:15 AM, when asked about the missing phone for Resident 18, Staff H, Social Services Director said there should have been a missing property report, but that if the resident was upset or thought that it was theft, that it should then have been filed as a grievance. On 06/18/2024 at 12:40 AM, Staff A, Administrator, said a grievance should have been resolved in two days. Reference WAC 388-97-0460

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50945 Based on interview and record review, the facility failed to provide residents/resident representatives a written notice detailing the reasons for discharge/transfer and/or to provide a copy of the notice to the state Ombudsman office as required, for 6 of 8 residents (Residents 18, 19, 73, 16, 67 and 30) reviewed for hospitalization s. This failure placed residents at risk for inappropriate transfers and a lack of information regarding their rights and options related to bed-holds. Findings included . <Resident 18> Resident 18 was admitted on [DATE]. The Significant Change Minimum Data Set (MDS), an assessment tool, dated 05/10/2024, showed the resident was cognitively intact. Resident 18 was hospitalized from 04/27/2024 to 05/03/2024 due to a fall. The Electronic Health Record (EHR) showed no documentation of Ombudsman notification. On 06/17/2024 at 10:37 AM, Staff B, Director of Nursing Services (DNS), said social services was responsible for contacting the Ombudsman and to ask social services for any documentation. On 06/18/2024 at 10:15 AM, Staff H, Social Services Director confirmed there was no Ombudsman notification. <Resident 19> Resident 19 was admitted on [DATE]. The Quarterly MDS, dated [DATE], showed resident was moderately cognitively impaired. Resident 19 was hospitalized three times: 02/18/2024 to 02/19/2024, 03/06/2024 to 03/14/2024, and 04/15/2024 to 04/19/2024. The EHR showed no documentation of Ombudsman notification. On 06/18/2024 at 10:15 AM, Staff H, Social Services Director confirmed there were no Ombudsman notifications for the three hospitalization s. 46793 <Resident 67> Resident 67 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 67 was cognitively intact. Resident 67 was admitted to the hospital on 05/13/2024-05/16/2024 and 05/31/2024-06/05/2024. The EHR showed no documentation of Ombudsman notification for either hospital transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 30> Resident 30 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented Resident 30 was cognitively intact. Resident 30 was admitted to the hospital on 03/17/2024-03/20/2024. The EHR showed no documentation of Ombudsman notification. On 06/17/2024 at 11:30 AM, Staff B, DNS, said they did not have the notices and knew it was an issue. 42960 <Resident 16> Resident 16 was admitted to the facility on [DATE] with a diagnosis of multiple sclerosis (a long lasting disease of the central nervous system) and chronic kidney disease (damage to the kidneys where they cannot filter blood the way they should). The Quarterly MDS, dated [DATE], documented the resident was cognitively intact. Resident 16 was admitted to the hospital on 02/08/2024 and discharged on [DATE]. The EHR showed no documentation of Ombudsman notification. On 06/17/2024 at 9:27 AM, Staff H, Social Services Director stated, I was not aware I had to do this. She said while looking in the EHR she did not see any notes that stated the Ombudsman was notified. At 11:00 AM, Staff A, Administrator, said if the Ombudsman was notified, they would be contacted by Social Services. 37044 <Resident 72> Resident 73 admitted to the facility on [DATE]. Review of a Discharge MDS, dated [DATE], showed Resident 73 was transferred to an acute care hospital. No documentation was found in Resident 73's EHR that showed the facility provided Resident 73 or their representative written notification detailing the reasons for the transfer or that a copy of the notice was provided to the state Ombudsman' office as required. On 06/18/2024 at 12:27 PM, when asked if they had documentation to show the facility provided Resident 73 and State Ombudsman office written notification detailing the reasons for the resident's transfer to the hospital, Staff B, DNS, stated, I don't see either. Reference WAC 388-97-0120 (2)(a-d) ,0140 (1)(a)(b)(c)(i-iii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to provide the resident and/or resident representative, a written notice of the facility's bed-hold policy at the time of transfer for 4 of 8 residents (Residents 18, 19, 30, and 73) reviewed for hospitalization s. This failure placed residents at risk for emotional distress and a diminished quality of life. Findings included . <Resident 18> Resident 18 was admitted on [DATE]. The Significant Change Minimum Data Set (MDS), an assessment tool, dated 05/10/2024, showed the resident was cognitively intact. A review of the Electronic Health Record (EHR) showed Resident 18 was hospitalized from 04/27/2024 to 05/03/2024 due to a fall. The bed hold was filled out on 04/27/2024 at 7:57 PM, after the patient had already left the building at 6:40 PM. The registered nurse signed as the nursing home administrator/designee that the notice was presented 04/27/2024. The section of the bed hold for the 'notice provided to resident or resident representative' was blank. The registered nurse electronically signed the bed hold document on 04/27/2024. There was no documented notification of bed hold to the resident or resident representative within 24 hours of transfer. <Resident 19> Resident 19 was admitted on [DATE]. The Quarterly MDS, dated [DATE], showed the resident was moderately cognitively impaired. Resident 19 was hospitalized three times: 02/18/2024 to 02/19/2024, 03/06/2024 to 03/14/2024, and 04/15/2024 to 04/19/2024. No bed hold was present for the first two hospitalization s. For the third hospitalization , two bed hold forms were present in the chart, both without a signature by the resident or resident representative. A review of the EHR showed Resident 19 was sent to the emergency roiagnom on [DATE]. On 04/15/2024 at 6:53 PM, Staff R, Licensed Practical Nurse (LPN), completed a bed hold that included a date the bed hold was given (04/15/2024), but had no other information on who the bed hold was given to. On 04/15/2024 at 7:08 PM, a registered nurse filled out a bed hold and under who the notice was provided to, resident or resident representative, the registered nurse's name was written and it was dated 04/15/2024. The bed hold notification also stated the delivery method of the bed hold was given at time of transfer. Staff R electronically signed the bed hold document on 04/16/2024. On 06/14/2024 at 11:54 AM, when asked who was responsible for signing a bed hold, Staff R, Licensed Practical Nurse (LPN) said that they filled out the bed hold because they were not sure who was responsible for signing. When asked if they had reviewed the bed hold with the patient, Staff R said the patient was gone before it was signed. When asked what information was on the bed hold, Staff R said they did not know. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/17/2024 at 10:37 AM, when asked who was esponsible for signing a bed hold, Staff B, Director of Nursing Services (DNS) said the nurse initiating the discharge was responsible. Staff B, said there was no current process for training staff on what a bed hold was. 46793 <Resident 3> Resident 30 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 30 was cognitively intact. A review of the EHR showed Resident 30 was admitted to the hospital from 03/17/2024-03/20/2024 and no documentation of a transfer notice was found. On 06/17/2024 at 11:30 AM, Staff B said they did not have the notices and they knew it was an issue. 37044 <Resident 73> Resident 73 admitted to the facility on [DATE]. Review of a Discharge MDS, dated [DATE], showed the resident was transferred to an acute care hospital. Review of the EHR showed no documentation that a written notice of the bed-hold policy was provided at the time of transfer. On 06/18/2024 at 12:01 PM, when asked if there was documentation to show a written notice of the bed-hold policy was provided to the resident/resident representative at the time of discharge, Staff Z, Regional Director of Operations, said no. Reference WAC 388-97 -0120 (4) .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on interview and record review, the facility failed to complete a Significant Change Minimum Data Set (MDS), an assessment tool, for 1 of 2 residents (Resident 10) reviewed for hospice and end of life. This failure placed residents at risk for unidentified and unmet care needs and a diminished quality of life. Findings included . According to the Resident Assessment Instrument manual (a document directing staff when assessments of resident status are required), a Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains a resident at the nursing home. Resident 10 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed the resident was severely cognitively impaired. The Electronic Health Record (EHR) showed Resident 10 was admitted to hospice on 05/11/2024, requiring a Significant Change MDS assessment within 14 days. The EHR showed an admission MDS was completed on 04/24/2024. No further MDS assessments were found. On 06/18/2024 at 8:55 AM, Staff B, Director of Nursing Services, said there should have been an MDS assessment completed within 14 days of Resident 10's admission to hospice. Reference WAC 388-97-1000 (3)(b)

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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** 37044 Based on interview and record review, the facility failed to ensure Minimum Data Sets (MDS), an assessment tool, accurately reflected residents' health status and/or care needs for 2 of 28 sampled residents (Residents 73 and 18) reviewed for MDS accuracy. The failure to accurately assess if residents had a terminal diagnosis or fall with major injury, placed residents at risk for unidentified and/or unmet care needs. Findings included . <Resident 73> Resident 73 readmitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident was cognitively intact, received hospice services, but did not have a physician documented condition or chronic disease that may result in a life expectancy of less than six months. A Hospice Comprehensive Assessment and Plan of Care Update Report, revised 12/28/2023, showed the hospice physician documented that Resident 73 remained eligible for hospice services, with a prognosis of six months or less to live, if the terminal diagnosis continued to run its usual course. On 06/17/2024 at 12:31 PM, Staff CC, MDS Nurse, said Resident 73's MDS was inaccurate and should have reflected the resident's terminal diagnosis. 50945 <Resident 18> Resident 18 was admitted on [DATE]. Review of the Electronic Health Record showed Resident 18 was hospitalized from 04/27/2024 to 05/03/2024 for a fall resulting in a right femoral (thigh bone) fracture, requiring surgical intervention. The Significant Change MDS, dated [DATE], under section J, regarding falls, was coded as one fall with no injury and one fall with injury (except major). Major injury was coded as no falls. Under major injury, the MDS stated, bone fracture, joint dislocations, closed head injuries with altered consciousness, subdural hematoma [bleeding near the brain]. On 06/17/2024 at 3:59 PM when asked if the MDS for Resident 18, under section J, major injury should say zero, Staff B, Director of Nursing Services, said no, it should not say zero. Reference WAC 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) assessment accurately reflected the resident's mental health diagnoses for 1 of 7 residents (Resident 73) reviewed for PASRR. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary mental health services to meet their individualized mental health needs. Findings included . Resident 73 readmitted to the facility on [DATE]. Review of the 01/04/2024 Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had a diagnoses of anxiety and depressive disorders, and received antidepressant, antianxiety, and antipsychotic medication during the assessment period. Review of Resident 73's electronic health record showed the following 12/27/2023 physicians orders: duloxetine (an antidepressant medication) daily for depression; lorazepam (an antianxiety medication) every four hours as needed for anxiety; and quetiapine (an antipsychotic) twice daily, no diagnosis listed. Review of Resident 73's Level I PASRR, dated 12/27/2023, showed the resident had no indicators of serious mental illness (SMI), to include depressive and anxiety disorders, which the resident was actively being treated for. On 06/18/2024 at 12:07 PM, Staff B, Director of Nursing, said Resident 73's Level I PASRR was inaccurate and needed to be redone. Reference: WAC 388-97-1915 (1)(2) (a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to develop and implement a care plan that was comprehensive and individualized, with measurable objectives, interventions and timeframes for how staff would meet the residents' needs related to opioids, for 1 of 4 sampled residents (Resident 18) reviewed for pain. This failure placed residents at risk for possible side effects of opioids, lack of follow up interventions related to opioids, for no reevaluation of care area, or of unidentified and unmet care needs and of a diminished quality of life. Findings included . Resident 18 was admitted on [DATE] with diagnoses including fall and fracture of the right femur (large thigh bone), requiring surgical intervention during hospitalization from [DATE] to 05/03/2024. The Significant Change Minimum Data Set (MDS), an assessment tool, dated 05/10/2024, showed Resident 18 was cognitively intact, was on a scheduled pain medication regimen with as needed (PRN) pain medications and non-medication interventions for pain. Resident 18's comprehensive care plan, reviewed on 06/15/2024, documented a care area for acute/chronic pain and included interventions to monitor for signs and symptoms of pain medication but did not specify or mention opioids or opioid specific interventions. On 06/17/2024 at 9:30 AM, when asked if a care plan should include an opioid specific section, Staff R, Licensed Practical Nurse (LPN) said that it should. At 3:29 PM, when asked if a care plan should include a specific section on opioids, including signs and symptoms specific to opioids, Staff S, Advanced Registered Nurse Practitioner, stated, yes, and there typically is. Reference WAC 388-97-1020(1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on record review and interview, the facility failed to provide a Care Conference (a conference where staff and residents/families talk about life in the facility, review the progress of each patient and make adjustments, as needed, to the care plan), for 2 of 2 sampled residents (Resident 10 and 38) reviewed for care plan timing and revision. This failure placed residents at risk for unmet needs, diminished quality of care and a decreased quality of life. Findings included . <Resident 10> Resident 10 was admitted to facility 04/17/2024. The Admission Minimum Data Set (MDS), an assessment tool, dated 04/24/2024, showed the resident was severely cognitively impaired. The medical conditions of the resident included Crohn's disease (a condition of the stomach and digestive tract) and cellulitis (a skin infection) of the buttocks. The Electronic Health Record (EHR) showed there was no documentation of a care conference being done after admission to facility. On 06/12/2024 at 9:31 AM, Staff H, Social Services Director said they and Staff O, Social Services Assistant, were responsible for care conferences being arranged and documented when it was completed. Staff H said an initial care conference was not done within 48 hours of the resident's admission. At 10:05 AM, Staff H, Social Services Director, said an initial care conference should have been done following Resident 10's admission. 50488 <Resident 38> Resident 38 admitted to the facility on [DATE], with diagnoses including Major Depressive Disorder (persistent feeling of sadness and loss of interest), Muscle Weakness, Pressure Ulcer (bedsore), and Unspecified Severe Protein-Calorie Malnutrition (lack of proper nutrition). The Significant Change MDS, dated [DATE], documented Resident 38 was referred to hospice (end of life care). Resident 38 required maximum assistance with most activities of daily living (ADLs) and was moderately cognitively impaired. Resident 38's hospice [updated by non-facility staff] care plan, dated 04/12/2024, indicated the resident was completely dependent for activities of daily living, was bed bound, and had a urinary catheter in place. The hospice care plan, updated 05/15/2024, showed, foley [urinary catheter] is no longer in place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 38's care plan completed by the facility on 06/10/2024 showed resident, has an alteration in urinary elimination r/t [related to] indwelling catheter related to stage 3 pressure area to coccyx [bedsore into soft tissue]. Interventions included emptying and changing the drainage bag, changing the catheter per physician order, and keeping the catheter anchored to prevent tension or trauma. On 06/12/2024 at 9:08 AM, Resident 38 was observed on their right side in bed. No drainage bag or catheter tubing was observed. At 9:15 AM, Staff W, Certified Nursing Assistant (CNA), said the resident had not had a foley catheter for several weeks. On 06/14/2024 at 8:32 AM, Staff B, Director of Nursing Services, stated, care plans should be updated as care needs change but right now they are done quarterly at best. When asked who was responsible for updating the care plans, Staff B said the facility did not have an MDS nurse on site so it would have been herself or the care managers. Reference WAC 388-97-1020(2)(c)(d)

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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 treatment and services in accordance with professional standards for 2 of 7 sampled residents (Residents 10 and 40) reviewed for pressure ulcers. This failure placed residents at risk for untreated pressure ulcers, pain, and a diminished quality of life. Findings included . <Resident 69> Resident 69 was admitted to the facility on [DATE] with diagnoses including infection of the left knee and malnutrition. The Admission Minimum Data Set (MDS), an assessment tool, dated 05/24/2024, showed the resident was cognitively intact, had a stage 2 pressure ulcer (bedsore), was at risk for developing pressure ulcers, was impaired on one side of their lower extremity, required substantial/maximum assistance with lower body dressing, and required partial/moderate assistance with rolling from left to right. Resident 69's orders for wound care to their coccyx (tailbone), in the Electronic Health Record, included to Cleanse the wound with cleanser and pat dry with gauze. Apply oil emulsion gauze to the wound bed. Apply skin prep [helps protect skin and aids in helping the dressing stick] to the periwound [around the wound]. Cover with absorbent pad dressing 3 x [times] weekly and PRN [as needed] for soiled or loose dressing. Secure dressing with tape as needed. On 06/10/2024 at 11:53 AM, Resident 69 said they had a pressure ulcer, it was painful all the time, and that staff did not help with turning unless the resident asked. On 06/12/2024 at 11:05 AM, Resident 69 reported the dressing over the wound had been changed the day prior but the dressing had become soiled before bedtime during the 3 PM to 11 PM shift, and a Nursing Assistant (NA) had taken the dressing off during their brief change. At 11:40 AM, during observation of Resident 69's wound care with Staff P, Licensed Practical Nurse (LPN), the resident was found without a dressing and Staff P said the bandage was not going to stick well and they would follow up with the care team. The Incontinence Log for Resident 69 showed documentation on 06/11/2024 at 10:38 PM and 06/12/2024 at 1:07 AM, 3:35 AM, and 5:36 AM. Resident 69's Medication Adminstration Record (MAR) and Treatment Administration Record (TAR) regarding wound care showed the dressing had last bee changed on 06/11/2024 during its scheduled time in the evening, and no as needed (PRN) dressing changes had been recorded from 06/01/2024 through 06/12/2024 at 11:40 AM, at the time of review. On 06/13/2024 at 4:24 PM, Resident 69 said their pressure ulcer once went five to seven days without a dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/14/2024 at 9:04 AM, Staff Q, NA, said the nurse should be the one to remove and replace a pressure dressing, and if a nurse was unavailable that a manager should be told. When asked if it was acceptable for briefs to be changed without replacing a dressing, Staff Q, said no. At 11:54 AM, Staff R, LPN, said a pressure dressing change should be documented in the TAR every time, that the dressing on a pressure ulcer should be checked every shift, and that if a resident's brief was changed, the NA should get the nurse to replace the dressing. On 06/17/2024 at 10:37 AM, Staff B, Director of Nursing Services (DNS), said a pressure dressing change should have been documented in the TAR or MAR, should have been recorded every time, and then stated, I would expect nursing to follow up after brief change, with the expectation that the NA would notify the nurse. Resident 69's comprehensive Care Plan showed the pressure ulcer dressing should have been monitored every shift to ensure it was intact and adhering and that any loose dressing should have been reported to the treatment nurse. 42960 <Resident 40> Resident 40 was admitted to the facility on [DATE] and had a diagnosis of stage 4 pressure ulcer (bed sore). The MDS, an assessment tool, dated 04/20/2024, showed the resident was cognitively intact and was dependent to substantial maximum assist with activities of daily living. On 06/13/2024 at 2:03 PM, no dressing was observed prior to wound care by Staff P, LPN. Resident 40 said, they did not know when it fell off and Staff P said the NAs do not tell her when the dressing is not on. A review of Resident 40's care plan stated monitor dressing to ensure it is intact and adhering. Report loose dressing to Treatment Nurse. On 06/13/2024 at 2:51 PM, Staff B, DNS, said her expectation was to monitor the dressing and when a resident did not have a dressing in place, she expected the nursing staff to put one on the resident. Reference WAC 388-97-1060 (3)(b)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview and record review, the facility failed to timely identify, assess, and address the nutrition of residents with significant and/or trendable weight loss for 2 of 6 residents (Residents 69 and 61) reviewed for nutrition. The facility failed to ensure resident weights were consistently and accurately obtained, to honor residents' diet preferences, and to implement nutritional intervention recommended by the Registered Dietician (RD). These failures placed residents at risk for continued and/or unidentified weight loss, delayed nutritional intervention, and unmet nutritional needs. Findings included . <Resident 69> Resident 69 was admitted to the facility on [DATE] with diagnoses including post (after) bariatric surgery status (a surgery that removed part of the stomach and decreased it's size), severe sepsis with septic shock (infection of the blood causing organ failure and low blood pressure), infection of left knee, chronic iron deficiency anemia (not enough iron in the blood), and severe protein-calorie malnutrition. The Admission Minimum Data Set (MDS), an assessment tool, dated 05/24/2024, showed the resident was cognitively intact, had no difficulty swallowing, had no recent or unknown weight loss or gain, and was on a mechanically altered diet. The Electronic Health Record (EHR) showed prior to admission to the facility, Resident 69 had been admitted to the hospital on 04/28/2024 with a weight of 138 pounds. On 05/17/2024, date of admission to the facility, it was documented Resident 69 weighed 160 pounds. The EHR showed a weight for Resident 69 recorded on 06/08/2024 of 122 pounds, which was a 23.75 percent loss. The Admission Nutrition Evaluation, dated 05/20/2024, showed the resident was at moderate risk for weightloss and malnutrition and laboratory values included in evaluation had a note attached that showed concern for malabsorption related to history of gastric bypass (surgery makes stomach smaller and eliminates a section of small intestine). On 06/10/2024 at 11:37 AM, Resident 69 said she was unsure if she had lost weight. On 06/12/2024 at 10:31 AM, when asked about the weight loss, Resident 69 said they weren't often hungry and were a picky eater, had weighted 127 pounds in April, and the week prior had been the first weight taken at the facility. Resident 69 denied being 160 pounds on admission. On 06/13/24 at 4:20 PM, Resident 69 stated, the concern is, I don't want to lose any more weight. Resident 69 had weekly weights ordered for every Saturday day shift. Weights found for Resident 69 in the EHR: On 05/17/24, 160 pounds (in a wheelchair) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/2024, 122 pounds (in a wheelchair) On 06/08/2024, 122 pounds (sitting) In the EHR on the dates of 05/18/2024, 05/25/2024, and 06/01/2024, Resident 69 did not have their ordered Saturday weights done. On 06/14/2024 at 9:08 AM, Staff Q, Certified Nursing Assistant (CNA), said the hospital would send weights on forms, but the facility was still responsible to obtain a weight. At 12:07 PM, when asked if they should follow up when an admission weight matched the last weight in the hospital documentation, that was taken prior to oliguria (low urine output) and dialysis completion (a treatment that helps to remove extra fluid and waste products from the blood), Staff R, Licensed Practical Nurse (LPN) said that staff should always double check. Staff R, LPN, said it would be concerning if a patient with a prior gastric bypass was losing weight. During review of the EHR, on 06/06/2024 Staff B, DNS, documented a response to a weight loss warning alert with the note of Rt [related to] had gastric bypass surgery. Wt [weight] loss anticipated/planned. The facility's Alert Charting Policy, revised 05/2023, showed the interdisciplinary team was to notify the physician and was to document the date and time the physician was notified and any orders that were obtained. On 06/17/2024 at 10:37 AM, Staff B, Director of Nursing Services (DNS), said a resident with a weight loss alert would have been documented by nursing, registered dietician, or physician. When asked if it is appropriate that a resident, that was hospitalized with oliguria and fluid overload (too much fluid in the body), did not have a weight for about 20 days after the admission weight, Staff B, DNS said it was not appropriate and they should have had at least weekly weights. At 12:24 PM, Staff B, DNS, said she could not obtain the documentation from the dietician in regard to provider notification of weight loss. Staff B, DNS stated, you can go ahead and cite. At 3:29 PM, when asked if provider was aware of a significant weight loss for Resident 69, Staff S, Advanced Registered Nurse Practitioner (ARNP) said yes and that it was inaccurate. When asked if provider was aware of the weight warning with the attached explanation, Rt [related to] had gastric bypass surgery. Wt [weight] loss anticipated/planned, Staff S, ARNP said there was no recent surgery, that there was no provider notification, and that they were unaware of the attached explanation. 37044 <Resident 61> Resident 61 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had no swallowing issues, and had not had any significant weight loss in the past six months. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nutrition care plan, revised 01/23/2024, identified a goal to maintain adequate nutritional status as evidenced by maintaining their weight. Staff were directed to monitor Resident 61's weight weekly, provide and serve supplements and diet as ordered On 02/12/2024, a dietary referral form was completed requesting the dietary manager obtain Resident 61's dietary preferences. There was no documentation found in the EHR to show this occurred. Resident 61 continued to report a poor appetite for lunch and dinner due to the kitchen continuing to send food they did not like as evidenced by the following progress notes: 02/05/2024 social services note showed resident not eating due to food dislikes. 02/12/2024 social services note showed, a dietary referral is required for the following reasons: food preferences. 02/19/2024 social services note showed Resident 61 was not eating due to food dislikes. 02/26/2024 social services note showed Resident 61 was not eating due to food dislikes. 03/28/2024 nurse's note showed Resident 61 said they believed their appetite was fine and they were not eating because they didn't care for the food the facility was provided. Review of Resident 61's weight record showed on 03/11/2024 the resident weighed 121 pounds (lbs.) On 04/04/2024 they weighed 115 lbs., a loss of 4.8% in 24 days. Review of the EHR showed no documentation or indication the facility identified the weight loss until 04/14/2024 (10 days later) when a nurse's note documented Resident 61 was on alert for weight loss and had reported it was due to not liking the food the facility provided. A nutrition evaluation, dated 04/22/2024, documented Resident 61 had lost 6.5 percent of total body weight over the previous 90 days, which was not planned or desired. A goal was established to stop weight loss by improving meal intake and total calorie consumption. The RD recommended the resident the resident receive large portions of protein and two carton of milk three times a day. On 06/11/2024 at 2:23 PM, Resident 61 reported they had lost weight since admitting to the facility. They reported eating well at breakfast but had poor intake for lunch and dinner because the facility primarily served vegetables and some form of pasta for those meals, which they did not like. Resident 61 said they had informed Staff H, Social Services Director (SSD), and multiple other staff members on multiple occasions about his dislike of pasta and vegetables and had completed a food preference form, but the kitchen continued to frequently serve pasta and vegetables for lunch and dinner. Review of the EHR showed the RD's recommendations were never implemented. Additionally, review of Resident 61's tray card on 06/17/2024, showed the likes/dislikes sections remained blank. On 06/17/2024 at 2:27 PM, when asked if Resident 61's food preferences had been input into the dietary computer Staff N, Regional RD, stated, No. On 06/18/2024 at 12:12 PM, when asked if they implemented the RD's 04/22/2024 recommendations, Staff B, DNS, stated, Not that I see. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97 -1060 (3)(h)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview and record review, the facility failed to provide pain management that met professional standards including the failure to monitor or reassess effectiveness of pain medication, to use non-pharmacological interventions when indicated, and to work with the practitioner to taper analgesics (pain relieving medications) when medically indicated, for 1 of 4 sampled residents (Resident 18) reviewed for pain. This failure placed residents at risk for side effects of medications for pain, unidentified and unmet care needs, and a diminished quality of life. Findings included . Resident 18 was admitted on [DATE] with diagnoses including fall and fracture of the right femur (thigh bone), requiring surgical intervention during hospitalization from [DATE] to 05/03/2024. The Significant Change Minimum Data Set (MDS), an assessment tool, dated 05/10/2024, showed resident was cognitively intact, was on a scheduled pain medication regimen with as needed (PRN) pain medications and non-medication interventions for pain. During the pain assessment included in the MDS that reviews pain over the past five days, Resident 18 reported that pain was only occasional, rarely or not at all effecting sleep, rarely or not at all interfering with therapy activities, rarely or not at all interfering with day-to-day activities, and the worst pain was an 8/10. On 06/11/2024 between 8:49 AM and 10:18 AM, Resident 18 was observed to be talking, then would stop talking and have their eyes closed. Resident 18 had to loudly have their name said to them, between and during questions, to continue the interview. At 9:55 AM, Resident 18 reported they were taking scheduled pain medication, had no significant pain, but were super tired and would nod off. When asked when the nodding off started, Resident 18 reported it started with the pain medication. Resident 18 said they were thinking about asking the team to back off on the pain medication. From 06/01/2024 to 06/15/2024, 34 of 45 pain assessments recorded on the Medication Administration Record (MAR), showed Resident 18 had reported zero pain and still received the scheduled pain medication. Resident 18's scheduled pain medication, ordered on 05/13/2024, was one hydrocodone-acetaminophen oral tablet 5-325 milligram at 8 AM, 12 PM, and 8 PM. Resident 18 also had an as needed (PRN) dose, with the last dose given on 05/22/2024. From 06/01/2024 to 06/15/2024, non-pharmacological interventions were documented in the MAR for eight of fifteen days, with seven days having no documented interventions. Non-pharmacological interventions include repositioning, relaxation, diversional activities, and redirection. No non-pharmacological interventions were listed on 06/11/2024 for 4/10 pain or 06/14/2024 for 2/10 pain. From 06/01/2024 to 06/15/2024, no documentation of any as needed (PRN) acetaminophen doses for pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/2024 at 9:30 AM, Staff R, Licensed Practical Nurse (LPN), said that the MAR only had them document a reassessment score for PRN opioids, but that for scheduled pain medication there was no place to document the reassessment score. Staff R, LPN said the pain regimen should have been reassessed every day, and that opioids should have been held if the patient was too sleepy or medicated. When asked if the nurse should have notified the provider if a patient was having zero out of ten pain and was receiving scheduled opioid pain medication, Staff R, LPN said they would not have called the provider, but would have mentioned it when the provider was rounding. When asked if it was appropriate to not provide a non-pharmacological intervention for 4/10 pain, Staff R, LPN said it was never okay. On 06/17/2024 at 3:29 PM, when asked if they had been notified of any symptoms of oversedation for Resident 18, or if they were aware that Resident 18 had not had any as needed (PRN) doses of opioid pain medication since 05/22/2024, Staff S, Advanced Registered Nurse Practitioner, said no to both questions. 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37044 Based on interview and record review the facility failed to implement a system in place that ensured periodic reconciliation and accounting for all controlled medications, for 2 of 2 medication carts (C cart & A cart) reviewed. Facility nurses' failure to consistently reconcile controlled medications at shift change and to co-sign the ledger to show both nurses validated the accuracy of the controlled medication count, placed residents at risk for misappropriation of their medication and detracted from the facility's ability to promptly identify potential diversion. Findings included . Review of the C-cart controlled medication ledgers for May and June 2024, showed facility nurses failed to count controlled medication at shift change, and/or failed to sign the ledger to validate the count was accurate, for one or both shifts, on the following dates: May-5/02/2024, 5/04/2024, 5/06/2024, 5/09/2024, 5/10/2024, 5/18/2024, 5/20/2024, 5/25/2024, 5/26/2024, and 5/31/2024. June- 06/03/2023, 06/09/2023, 06/03/2023, 06/14/2023, 06/15/2023, 06/16/2023, 06/17/2023, and 06/18/2023. Review of the A-cart controlled medication ledger for June 2024 showed facility nurses failed to co-sign the controlled medication ledger for one or both shift changes, on the following dates in June- 06/01/2023, 06/02/2023, 06/04/2023, 06/08/2023, 06/09/2023, 06/10/2023, 06/11/2023, 06/12/2023, 06/16/2023, 06/17/2023, and 06/18/2023. On 06/18/2024 at 9:46 AM, Staff GG, Regional Director of Operations, said it was their expectation that both nurses performed a controlled medication count and co-sign on the ledger that the count was correct. When asked if that was consistently occurring Staff GG stated, no. Reference WAC 388-97-1300(1)(b)(ii), (c)(ii-iv)

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NAME OF PROVIDER OR SUPPLIER: Emerald Bay Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 140 South Marion Avenue Bremerton, WA 98312	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50392 Based on interview and record review the facility failed to monitor 5 of 5 residents (Residents 10,18, 38, 62, and 68) reviewed for unnecessary medications for adverse (negative) side effects and/or target behaviors (an evaluation for the effectiveness of medication). This failure placed residents at risk for adverse side effects, lack of monitoring for effectiveness of medications, and decreased quality of life. Findings included . <Resident 10> Resident 10 was admitted to the facility 04/17/2024. The Admission Minimum Data Set (MDS), an assessment tool, dated 04/24/2024, documented the resident was severely cognitively impaired. Resident 10 was prescribed trazadone (an antidepressant) for insomnia (a sleep disorder), lorazepam (a benzodiazepine, a medication that slows brain activity to allow for relaxation) for anxiety, and diazepam (a benzodiazepine) for anxiety. Resident 10's Electronic Health Record (EHR) showed no orders for monitoring of target behaviors for the antidepressant or for the antianxiety medications. On 06/14/2024 at 12:38 PM, Staff B, Director of Nursing Services, said there should have been target behaviors documented in the EHR to understand if the medication was working. 46793 <Resident 68> Resident 68 was admitted to the facility on [DATE]. The admission MDS, an assessment tool, dated 05/21/2024, documented Resident 68 was moderately cognitively impaired. Resident 68 was prescribed quetiapine (atypical antipsychotic, mind altering substance) for dementia and psychosis (a mental disorder characterized by a disconnection from reality). Resident 68's EHR showed no orders for monitoring of target behaviors for the antipsychotic medication. On 06/17/2024 at 11:30 AM, Staff B, DNS, said when administering any psychotropic medication it required a physician's order, resident consent and it must be in the resident's care plan. When asked what type of monitoring was required with antipsychotic medication, Staff B said adverse side effects and target behavior monitoring. When shown no target behavior monitoring for the antipsychotic, Staff B said there should have been side effect and target behavior monitoring. 50488 <Resident 38> (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 38 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 38 was moderately cognitively impaired. Resident 38 was prescribed lorazepam (benzodiazepine, slows down nervous system) for anxiety and citalopram (anti-depressant) for major depressive disorder. Resident 38's EHR showed no documentation of monitoring target behaviors or for side effects for lorazepam. There was no documentation of monitoring for adverse side effects for the citalopram. On 06/17/2024 at 1130 AM, Staff B, DNS, said adverse side effects and target behavior monitoring for benzodiazepines and anti-depressants should be documented in the EHR. 42960 <Resident 62> Resident 62 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented the resident was cognitively intact. Resident 62 was prescribed mirtazapine for depression (a constant feeling of sadness or loss if interest) and to increase their appetite. Resident 62's EHR showed no orders for monitoring of target behaviors or side effects for the antipsychotic medication. On 06/17/2024 at 11:44 AM, Staff B, DNS, said she did not see orders for behavior or side effect monitoring for Resident 62 and her expectations is for there to be monitoring orders in the EHR. 50945 <Resident 18> Resident 18 was admitted to the facility on [DATE] with diagnoses including depression and psychosis. The Significant Change MDS, dated [DATE], showed the resident was cognitively intact, with frequent mood disturbances such as feeling down, depressed, or hopeless. Resident 18 was prescribed Abilify, an antipsychotic for psychosis. No monitoring orders for adverse side effects were found in the EHR. Resident 18 was prescribed sertraline, an antidepressant for depression. No behavior monitoring orders were found in the EHR. On 06/17/2024 at 0359 PM, Staff B, DNS, confirmed that there were no adverse side effect monitoring orders for the antipsychotic (Abilify) and no behavior monitoring orders for the antidepressant (sertraline), for Resident 18, and said there should have been. 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. 37044 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent when 1 of 2 nurses (Staff P) incorrectly administered 3 of 25 medications in accordance with physician orders and/or manufacturer's guidelines for 1 of 3 residents (Resident 39) observed during medication pass. This resulted in a medication error rate of 8 percent. These failures placed residents at risk for ineffective treatment of underlying medical conditions and/or adverse side effects. Findings included . <Resident 39> On 06/18/2024 at 7:41 AM, Staff P, Licensed Practical Nurse (LPN), prepared to administer cyclosporine ophthalmic emulsion (used for allergic eye conditions.) Staff P administered three drops into Resident 39's left eye and two drops into the right eye. After waiting 33 seconds, Staff P then administered two drops of Refresh ophthalmic solution (lubricating eye drops) into the resident's right eye and four drops into the left eye. Review of the June 2024 Medication Administration Record (MAR) showed an order for cyclosporine ophthalmic emulsion, instill one drop in both eyes three times a day, and an order for Refresh plus ophthalmic solution, instill one drop into both eyes four times a day. Review of cyclosporine manufacturer's guidelines showed if it was being administered with another lubricating eye drop, you must wait 15 minutes before administering. The manufacturer's guidelines for Refresh ophthalmic eye drops, showed it needed to be administered at least 5 minutes after the administration of other eye drops. On 06/18/2024 at 7:50 AM, Staff P, LPN, confirmed they administered more than one drop of the cyclosporine and Refresh, to each eye. Staff P stated, hat happens a lot with those [eye drops]. When informed that the manufacturer's guidelines for cyclosporine ophthalmic emulsion eye drops, said they should be separated by 15 minutes from administration of other lubricating eye drops Staff P, LPN, indicated they did not know that the eye drops should be separated. 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 - Some	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. 37044 Based on observation and interview, the facility failed to ensure drugs and biologicals were labeled and dated in accordance with accepted professional standards of practice, and expired medications were discarded for 1 of 1 medication room and 2 of 3 medication carts (C1 & C2) that were observed. These failures placed residents at risk to receive expired medications and negative health outcomes. Findings included . <Medication Room> Observation of the Medication room on 06/13/2024 at 1:47 PM, with Staff T, Registered Nurse, revealed the following expired and/or undated medications: 1) Resident 26- An opened Byetta pen, dated 3/13/2024. Per manufacturer should have been discarded 30 days after opening. 2) Resident 30- an opened vial of Humulin R insulin, dated 08/26/2023. 3) Resident 69- five bags of intravenous (IV) ceftriaxone (antibiotic), which were brown and discolored. On 06/13/2024 at 1:53 PM, Staff T, Registered Nurse, confirmed Resident 26's Byetta pen was opened greater than 30 days prior, Resident 30's vial of Humulin R insulin was opened greater than 28 days prior, and both medications needed to be disposed of. Staff T also confirmed Resident 69's five bags of IV ceftriaxone were brown and discolored, and needed to be discarded. <C1 Medication Cart> Observation of the C1 medication cart on 06/13/2024 at 2:10 PM with Staff T, Registered Nurse, revealed the following expired and/or undated medications: 1) An opened and undated Lispro insulin pen for Resident 18. 2) An opened Aspart insulin pen, dated 04/28/2024, for Resident 65. On 06/13/2204 at 2:22 PM, Staff T, confirmed the insulin pens should have been discarded 28 days after opening. <C2 Medication Cart> Observation of the C2 medication cart on 06/13/2024 at 2:23 PM with Staff T, Registered Nurse, revealed the following expired and/or undated medications: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Resident 64 - a three milliliter (ml) syringe sitting in a transparent plastic cup, contained a red syrup like solution. The syringe was not labeled with the medication name, date opened/prepared or expiration date. On 06/13/2204 at 2:32 PM, Staff T, said they did not know what medication was in the 3 ml syringe or when it was opened/prepared, and discarded the syringe. Reference WAC 388-97-1300(1)(b)(ii), (c)(ii-v), 1300 (2)

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview, and record review, the facility failed to ensure the quality and timeliness of laboratory services for 1 of 8 sampled residents (Resident 19) reviewed for urinary catheter or Urinary Tract Infection (UTI). This failure placed residents at risk for delay in diagnosis of infection, of sepsis, of potential complications, of increased length of stay, and of a diminished quality of life. Findings included . Resident 19 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 05/25/2024, showed the resident was cognitively moderately impaired and had an indwelling urinary catheter. Timeline of Events: 4/30/2024 Complete Blood Cell Count (CBC) collected, 05/01/2024 received by lab, 05/01/2024 reported to facility - elevated white blood cell count (WBC) at 11.1. 05/03/2024 Urinalysis with culture (UA) ordered, 05/06/2024 no successful completion of UA was documented by provider. 05/06/2024 UA ordered STAT (quickly), no record of any results. 05/14/2024 UA ordered, 05/14/2024 sample collected, 05/15/2024 frozen urine specimen received by the laboratory, 05/15/2024 reported to facility . 05/23/2024 Comprehensive Metabolic Panel (CMP) and CBC ordered, 05/24/2024 samples taken, 05/27/2024 facility notified of elevated WBC count at 17.3. 05/27/2024 1 gram ceftriaxone (antibiotic) intramuscular ordered one time (for elevated WBC), 05/28/2024 was given. 05/27/2024 UA ordered, 05/28/204 UA collected, 05/29/2024 laboratory received frozen urine specimen, 05/30/2024 facility notified of frozen specimen. 05/30/2024 UA ordered, 05/31/2024 collected, 06/02/2024 received by the laboratory, 6/04/2024 results reported to facility - results indicated a UTI. 06/06/2024 2 grams ceftazidime (antibiotic) intravenous started, ordered every 8 hours for 7 days for a complicated UTI. (continued on next page)

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Progress Notes in the Electronic Health Record (EHR) for Resident 19, dated 05/06/2024, showed the urine specimen was collected and placed in fridge, and a call was placed for STAT pick up. There was no record of results from the sample and the STAT order from 05/06/2024 was still active at time of review. Nursing Progress Notes for Resident 19, signed and dated 05/14/2024 at 12:13 PM by Staff R, Licensed Practical Nurse (LPN), stated, 20Fr/30cc Foley changed. New drainage bag as well. UA collected and placed in lab box on ice. This sample was received frozen by the laboratory on 05/15/2024. On 06/14/2024 at 11:54 AM, when asked what the process was for collecting urine samples, Staff R, LPN, said they filled out a paper, immediately put the sample on ice, and then put the sample in the laboratory box located next to the nursing station. Staff R, LPN, then added that sometimes they put ice packs into the laboratory box with the specimen, instead of putting the sample on ice. When asked if it was appropriate that the two urine samples for a resident were both rejected due to the sample being frozen, Staff R, LPN, said it was not okay. When asked if it was acceptable that a urine sample was not sent to lab unfrozen, until after an antibiotic had already been started, Staff R, LPN, said no. On 06/17/2024 at 10:37 AM, when asked about the process for urine samples after collection, Staff B, Director of Nursing Services (DNS), said they recently switched the laboratory that they use, that they no longer send urine in cups, that urine needed to be put in the correct tubing and then stored in the urine refrigerator. When asked to show the refrigerator that urine was being kept in, Staff B, DNS, was unable to locate a thermometer. When asked if they were aware of the frozen urine samples, Staff B, DNS, said they were aware, and this was why they switched to the urine fridge. When asked if it was acceptable that two urine samples for a resident were rejected due to the sample being frozen, Staff B, DNS, said it was not appropriate for the first sample to be frozen. At 3:29 PM, when asked if there were any lab results from the orders on 05/03/2024 or 05/06/2024, Staff S, Advanced Registered Nurse Practitioner (ARNP), said there was no suitable result for the sample on 05/03/2024 and they had not received any results for the STAT 05/06/2024 sample. When asked if staff had followed up with the provider, over the STAT sample on 05/06/2024 not having any results, Staff S, ARNP stated, no, I have to be persistent. Reference WAC 388-97-1620 (6)(b)(i)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to promptly notify the provider of laboratory results that fell outside of normal ranges for 1 of 8 sampled residents (Resident 19) reviewed for urinary catheter or Urinary Tract Infection (UTI). This failure placed residents at risk for potential complications, of increased length of stay, and of a diminished quality of life. Findings included . Resident 19 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 05/25/2024, showed the resident was cognitively moderately impaired and had an indwelling urinary catheter. On 05/30/2024, a urinalysis and culture were ordered, on 05/31/2024 collected, on 06/02/2024 received by lab, and on 06/04/2024 at 9:29 AM, reported to facility. Laboratory/Diagnostic Test Values-Monitoring Policy, undated, reported that the nurse was responsible for documenting a nurse note that included receipt of lab/diagnostic test result, provider notification, resident representative (if indicated), and new orders received. The policy also said that for general laboratory test values, for non-critical abnormal labs, the provider should be called with the results and called again in 24 hours if no answer. For critical laboratory test values, asymptomatic, the provider should be called and repeat calls should occur every 30 minutes if no response. Nursing progress notes in the Electronic Health Record were reviewed and no provider notification was noted from the date of facility notification on 06/04/2024, to the date the provider first documented the positive UTI on 06/05/2024. On 06/17/2024 at 3:29 PM, when asked when they were notified of the UTI, Staff S, Advanced Registered Nurse Practitioner, said they had to look up the result themselves and that there was no notification of the UTI by staff to the provider. On 06/18/2024 at 12:52 PM, when asked if they could provide documentation that the provider was notified of Resident 19's lab results of a UTI, Staff B, Director of Nursing Services (DNS), provided a provider progress note which showed the provider discussed results of the urinalysis with the patient on 06/05/2024. No documentation of provider notification by staff was provided. Reference WAC 388-97 -1260 (3)(a), (4)(b),-0320 (1)(b)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview, and record review, the facility failed to ensure sufficient dietary staff were trained and competent in the preparation and provision of puree (food made to consistency of pudding) diets for 2 of 2 residents (Residents 35 & 125) reviewed for pureed diets. The failure to have sufficient staff available to ensure dietary staff were supervised until they were trained and competent in their duties, resulted in residents being provided the incorrect diet texture, and placed residents at risk for aspiration, choking risk and for food borne illness. Findings included . Resident 35 admitted to the facility on [DATE] and had a 04/04/2024 order for a regular, pureed diet, with thin liquids. Resident 125 admitted to the facility on [DATE], with an order for a regular, pureed diet, with thin liquids. Observation of the breakfast meal on 06/14/2024 from 8:18 AM - 8:50 AM, showed Resident 35 and 125 were served regular texture scrambled eggs, chopped sausage, with pureed pancakes. On 06/14/2024 at 9:59 AM, Staff D, Head Cook/Dietary Manager in Training, said the facility had a process in place to ensure residents received the correct diet type and texture. Staff D explained residents' meal trays were triple checked for accuracy prior to delivery to the resident. The first check was performed by the cook who read the tray card to identify the diet type and texture and prepared the tray accordingly. The tray then went to the dietary aide to place cold food and beverages on the tray. The dietary aide then checked the prepared diet type and texture against the type and texture on the resident's tray card to validate accuracy. The tray was then placed on a tray cart for delivery. The third check occurred by the direct care staff removing the tray from the tray cart before delivery it to the resident. At 10:03 AM, when asked how the regular textured scrambled eggs and chopped sausage made it through the facility's triple checks without it being identified and were served to Residents 35 and 125, Staff D said the facility had a new cook who was scheduled to train on how to read resident tray cards that day (06/14/2024), but the dietary aide called off. Staff D explained she assumed the duties of the dietary aide and prepared the cold dishes and beverages for the meal, thus was unable to provide the new cook the level of oversight that they normally would. Additionally, Staff D said Staff X, Certified Dietary Manager (CDM), a CDM from another facility who was training Staff D for the Dietary Manager position, had not arrived for the day. Staff D confirmed staffing issues resulted in the new cook not being trained to read tray cards as scheduled, Staff D's inability to provide the level of oversight they normally would contributed to the diet texture errors. Refer to F803 Reference WAC 388-97-1020(1)

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F 0803

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37044

Based on observation, interview, and record review, the facility failed to ensure menus were followed and modified diet textures were prepared in accordance with established guidelines and physicians' orders for 2 of 2 residents (Residents 35 & 125) reviewed for diet textures who were at serious risk for aspiration (inhalation of foods/fluids into the lungs), pneumonia, and choking. The facility's lack of an effective system to ensure residents at risk received the correct food texture represented a potential serious outcome including death and constituted an Immediate Jeopardy (IJ). Additionally, the facility failed to make a reasonable effort to honor food preferences for 1 of 7 residents (Resident 61) reviewed for food quality, placing the residents at risk for decreased intake, weight loss and a diminished quality of life.

On 06/14/2024 at 1:08 PM, the facility was notified of an IJ at CFR S483.60 F803, Menus meet Resident Needs/Prep in Advance/Followed, related to the facility's failure to follow the menu for residents on pureed diets, and the residents were served and assisted with eating the wrong diet texture. The facility removed the immediacy on 06/17/2024 with onsite verification from surveyors by conducting interviews of staff and reviewing the updated puree recipes.

Findings included .

<Resident 35>

Resident 35 admitted to the facility on [DATE]. Review of the 04/03/2024 Minimum Data Set (MDS, an assessment tool), showed the resident had severe cognitive impairment, was on a mechanically altered diet, and required substantial to maximal assistance with eating.

Review of a diet order, dated 04/04/2024, showed Resident 35 was on a pureed diet (food that has been blended, mixed, or processed into a smooth and uniform texture)

Review of a progress note, dated 05/13/2024, showed Resident 35 had an episode of choking at breakfast, requiring staff to intervene and perform the Heimlich maneuver to clear the airway.

Review of a swallowing problem care plan (CP), dated 05/21/2024, showed Resident 35 had intermittent episodes of coughing and choking with meals and staff were directed to alternate small bites and sips, check the resident's mouth after meals for pocketed food and debris, keep the head of bed elevated 45 degrees during meals and for at least thirty minutes afterwards, instruct the resident to eat slowly, and to chew each bite thoroughly and provide the diet as ordered.

Review of a progress note, dated 05/21/2024, showed the nurse was called to Resident 35's room due to the resident coughing and having difficulty swallowing during the lunch meal. The nurse alternated providing small bites of food followed by small sips of fluid, but the resident's coughing with attempts to swallow persisted.

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/14/2024 at 8:19 AM, Staff V, Certified Nursing Assistant (CNA), delivered Resident 35's breakfast tray. Staff V elevated the resident's head of bed to approximately 60 degrees, sat down and began assisting the resident with their meal. At 8:36 AM, Resident 35's breakfast tray was observed, and the tray card identified the resident's diet as dysphagia [difficulty swallowing] pureed. When asked to describe the foods and textures on the tray, Staff V, who was assisting Resident 35 to eat, said there were regular textured scrambled eggs, chopped sausage, and pureed pancakes. <Resident 125> Resident 125 admitted to the facility on [DATE]. Review of the 06/18/2024 admission MDS showed the resident had severe cognitive impairment, received hospice services, and required an altered texture diet. Review of the physicians' orders, (date order was written unknown) but order was current on 06/14/2024, showed Resident 125 was on a regular, pureed diet, with thin liquids. On 06/14/2024 at 8:34 AM, Staff Q, CNA, was observed delivering Resident 125's breakfast tray. Staff W, CNA, who was already in the resident's room began setting up the meal as Staff Q exited the room. At 8:36 AM, Resident 125's breakfast tray was observed. The tray card identified the resident's diet as dysphagia pureed. When asked to describe the foods and textures on the tray, Staff W, who was assisting the resident with the meal, identified regular texture scrambled eggs, chopped sausage and pureed pancakes. When asked what diet was on the resident's tray card, Staff W stated, pureed. On 06/14/2024 at 8:50 AM, Staff Z, Regional Nurse Consultant (RNC), confirmed Resident 35's tray card showed the resident was on a dysphagia pureed diet. When asked to describe the food and associated texture Staff Z, RNC, said there was chopped sausage and pureed pancakes. No scrambled eggs remained on the tray at that time. Resident 125's tray had already been removed from the floor. On 06/14/2024 at 9:59 AM, Staff D, Head Cook/ Dietary Manager in Training, indicated residents' meal trays were triple checked for accuracy prior to being delivered to ensure the diet type and texture were correct. Staff D explained the triple check process as follows: First check- the cook read the tray card, identify the diet type and texture, and plated the meal; Second check- the tray then went to the dietary aide to add the cold dishes and beverages. The dietary aide would review the tray card, validate that what was on the tray was correct, and then place the tray in the tray cart for delivery; Third check- when direct care staff removed a meal tray from the tray cart, they would check the tray card against the diet type and texture present on the tray and validate accuracy prior to delivering it to the resident. (continued on next page)

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F 0803

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

At 10:03 AM, when asked how regular scrambled eggs and chopped sausage made it through the triple check and were served to Resident 35 and 125 without staff identifying the wrong texture diet was provided, Staff D said they were scheduled to train the new cook on how to read tray cards that day, 06/14/2024, but the dietary aide had called off, so they could not provide the level of oversight of the new cook that they normally did because they had to work as the dietary aide, preparing the cold dishes and beverages for the meal. Staff D said Staff X, Certified Dietary Manager (CDM), a CDM from another facility who was training Staff D for the Dietary Manager position, hadn't yet arrived for the day. Staff D confirmed staffing and their inability to provide oversight of the new cook contributed to the diet texture errors.

At 11:41 AM, when asked if dietary staff had access to and utilized a recipe when preparing pureed diets, Staff D stated, no.

On 06/17/2024 at 1:53 PM, Staff N, Regional Registered Dietitian, said that kitchen staff were to follow recipes when making pureed food. Staff N said recipes for pureed meals were reviewed and updated and dietary staff had been educated in their use.

<Resident 61>

Resident 61 admitted to the facility on [DATE]. Review of the 01/25/2024 admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had diagnoses of stroke and malnutrition and had significant weight loss of greater than 5% in a month or 10% in six months.

On 06/11/2024 at 2:23 PM, Resident 61 said they ate well at breakfast but had not had lunch and dinner because the facility primarily served vegetables and some form of pasta for those meals. Resident 61 said they had informed Staff H, Social Services Director (SSD), and multiple other staff members on multiple occasions about his dislike of pasta and vegetables and had completed a food preference form where they listed their likes and dislikes. The resident indicated despite the above, the kitchen continued to frequently serve pasta and vegetables for lunch and dinner.

Review of the electronic health record (EHR) showed a Nursing to Nutrition Referral Communication form was completed on 02/12/2024 for food preferences.

Review of Resident 61's progress notes showed the following documentation:

01/29/2024- social services note Resident not eating due to food dislikes.

02/05/2024- social services note Resident not eating due to food dislikes.

02/12/2024- social services note documented, a dietary referral is required for the following reasons: Food preferences.

02/19/2024- social services note documented Resident 61was not eating due to food dislikes.

02/26/2024- social services note documented Resident 61was not eating due to food dislikes.

03/28/2024- nurse's note documented Resident 61 said they believed their appetite was fine. They were not eating because they didn't care for the food the facility was provided.

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	04/14/2024- nurse's note documented Resident 61 was on alert for weight loss and indicated it was due to not liking the food the facility provided. Review of the EHR showed Staff H, SSD, completed a Food Preference Record on 06/07/2024, which identified Resident 61 did not want pasta for lunch or dinner, did not want applesauce or broccoli and little rice. On 06/17/2024 at 11:59 AM, Staff H, SSD, said they spoke directly to Staff Y, former Dietary Service Manager, about Resident 61's food preferences at the end of May 2024, and Staff Y was supposed to have input them into the dietary computer. Staff H indicated when they followed up one to two weeks later, the resident's preferences still had not been input into the dietary system. Staff H said they completed a second Food Preference Record on 06/07/2024, again delivering it directly to Staff Y, the former DSM. Staff H reported a CNA, whose name they did not recall, had also informed Staff Y of Resident 61's food preferences, but Staff Y failed to enter them into the dietary computer. Review of the tray card on 06/14/2024 and 06/17/2024, showed Resident 61's likes/dislikes still had not been input into the dietary computer, thus were not reflected on the tray card. On 06/17/2024 at 2:27 PM, when asked if Resident 61's food preferences had been input into the dietary computer Staff N, Regional RD, stated, No. Refer to F802. Reference WAC 388-97-1100(1) 50488

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the facility failed to ensure that 1 of 3 sampled residents (Resident 67) received foods that accommodated the residents' preferences and allergies. This failure placed residents at risk for meal dissatisfaction, allergic reaction, and a diminished quality of life. Findings included . Resident 67 was admitted to the facility on [DATE]. The Admission Minimum Data Set, dated dated [DATE], documented Resident 67 was cognitively intact. On 06/11/2024 at 9:07 AM, Resident 67 was observed with three unopened apple juice containers on the bedside table. Resident 67 said they were on a cardiac diet and had allergies to apples but still received apple juice every day with breakfast. On 06/12/2024 at 3:09 PM, Resident 67 was observed with two unopened containers of apple juice sitting on the bedside table. On 06/14/2024 at 7:39 AM, Resident 67 was observed with one unopened container of apple juice on the breakfast tray. A Life Enrichment Evaluation, dated 05/03/2024, showed Resident 67 had a known allergy to apples. No other documentation in the electronic health record documented the apple allergy. On 06/17/2024 at 10:38 AM, in a joint interview with Staff D, Dietary Manager/Cook and Staff N, Regional Registered Dietitian, both staff said they are informed of resident preference/allergies when the resident is admitted to the facility either by evaluation or word of mouth from other staff members. Staff D said she had just been informed about Resident 67's apple allergy that morning. Reference WAC 388-97-1120 (2)(a)

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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** 37044 Based on observation, interview, and record review, the facility failed to establish and maintain effective infection prevention and control practices to prevent the spread of infections and communicable diseases. Facility staff failed to follow accepted infection control practices during the provision of wound care for 3 of 3 residents (Residents 62, 40 & 69) reviewed for wound care, failed to perform hand hygiene after contact with residents and/or their environmental surfaces (Staff AA), and failed to wear required personal protective equipment (PPE) when providing care to residents on transmission based precautions for 3 of 3 residents (Residents 324, 53 & 10) reviewed for transmission based precautions. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . Review of the facility's Handwashing/Hand Hygiene policy, revised 08/2019, showed all facility personnel would be trained, regularly in-serviced, and shall follow handwashing/hand hygiene procedures to prevent the spread of infections. Hand hygiene should be performed when coming on duty, before preparing and handling medications, before and after direct contact with residents or resident environmental surfaces, before and after entering an isolation room, before and after assisting residents with meals, before applying gloves and after glove removal. The use of gloves does not replace hand washing/hand hygiene. Review of the facility's Enhanced Barrier Precautions (EBP) policy, revised 08/2022, showed EBP expanded the use of personal protective equipment and referred to the use of gown and gloves during high-contact resident care activities that provide opportunities for multi-drug resistant organisms (MDRO) to staff hands and clothing. High-contact resident care activities included dressing; Bathing/showering; transferring; providing hygiene; changing briefs or toileting; changing linens; wound care; and device care like catheters intravenous access devices etc. Transmission Based Precautions <Resident 324> Resident 324 had a Contact Precautions sign posted outside their door that directed staff to perform hand hygiene, gown , and glove prior to entering the room. On 06/11/2024 at 12:46 PM, Staff JJ, Physical Therapy Assistant (PTA), was observed working with Resident 324 at bedside, without wearing gloves or a gown. <Resident 53> Resident 53 had an EBP sign outside of their door, which directed staff to wear a gown and gloves for high-contact resident activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/10/2024 at 1:12 PM, Staff II, Nursing Assistant (NA), entered Resident 53's room and placed a meal tray on the overbed table. Staff II then placed their arms around the resident, lifting and boosting the resident up in bed. Staff II then utilized the bed control to elevate the head of the bed. <Resident 10> Resident 10 had an EBP sign outside of their door, which directed staff to wear a gown and gloves for high-contact resident activities. On 06/11/2024 at 11:16 AM, Staff AA, CNA, was observed without a gown or gloves on, positioning Resident 10 in bed. After boosting Resident 10 up in bed, Staff AA tucked pillows under the resident's back and backside to assist with positioning. On 06/17/2024 at 1:46 PM, when informed of the above observations Staff E, Infection Preventionist, said if Staff II and Staff AA provided care that required direct contact, they should have gowned and gloved. Staff E then said Staff JJ should have gowned and gloved prior to entering the room, just as the sign directed. 42960 <Meal Tray Delivery> On 06/10/2024 at 1:33 PM, Staff AA, (NA), delivered a meal tray to room [ROOM NUMBER] and did not use hand sanitizer when coming out of the room. At 1:34 PM, Staff AA delivered a meal tray to room [ROOM NUMBER] and did not use hand sanitizer when coming out of the room. At 1:36 PM, Staff AA, delivered a meal tray to room [ROOM NUMBER] and brought the tray back out to the cart and did not use hand sanitizer. At 1:36 PM, Staff AA, delivered a meal tray to room [ROOM NUMBER] and did not use hand sanitizer when coming out of the room. On 06/17/2024 at 2:19 PM, Staff AA said when they deliver meal trays they should have used hand sanitizer after every tray when before going into the room and then when they came out of a resident's room. <Wound Care> <Resident 62> Resident 62 was admitted to the facility on [DATE] and had a diagnosis of Venous Stasis Ulceration (caused by damaged valves inside the leg veins). The Quarterly Minimum Data Set (MDS), an assessment tool, dated 04/17/2024 documented the resident was cognitively intact and needed maximum to partial assistance with activities of daily living (ADLs). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/13/2024 at 1:31 PM, Staff P, Lincensed Practical Nurse (LPN), was observerd completing a dressing change and wound care for Resident 62 and changed her gloves multiple times but did not use hand sanitizer or wash her hands between changing her gloves. <Resident 40> Resident 40 was admitted to the facility on [DATE] and had a diagnosis of stage 4 pressure ulcer (bed sore). The MDS, dated [DATE], documented the resident was cognitively intact and was dependent to substantial maximum assist with ADLs. On 06/13/2024 at 2:03 PM, Staff P was observed completing a dressing change and wound care for Resident 40 and Staff P entered Resident 40's room with the same box of medium gloves that were in the previous room with Resident 62. Staff P changed gloves multiple times and did not use hand sanitizer or wash her hands between changing gloves when performing the dressing change. At 2:31 PM, Staff P stated when I was in school we were told to use hand sanitizer when changing gloves but I don't know if you noticed there is no hand sanitizer in the rooms and there are not medium gloves in the room, I typically put them in my pocket and did not today. At 2:51 PM, Staff B, Director of Nursing (DNS), said her expectation would be for staff to wash their hands when changing gloves during a dressing change and to not take a box of gloves from one resident's room to another resident's room. 50945 <Resident 69> Resident 69 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed the resident was cognitively intact and had a stage 2 pressure ulcer (bedsore). On 06/12/2024 at 11:51 AM, Staff P was observed performing wound care. Outside of Resident 69's room, Staff P put on a gown for Enhanced Barrier Precautions, put down supplies on a tray in the room, then came back outside of the room to put on gloves without using any hand sanitizer or washing her hands. Staff P touched Resident 69's tray, then went and grabbed more gloves, placed extra gloves on the resident's bed, touched the trash can, put on additional gloves (double gloved), and then helped the resident turn to left side. Staff P removed her gloves and put on new gloves from the pile on the resident's bed, without using any hand sanitizer. Wound cleanser was sprayed on a gauze stack, gauze was then used to wipe the resident's skin, was then thrown away, and additional gauze was used for cleaning. Staff P removed sticky residue from Resident 69's skin from a previous dressing. Staff P removed their gloves and then put on new gloves from pile of gloves on Resident 69's bed, no hand sanitizer was used, then patted the wound area dry with gauze, and an oil emulsion dressing was cut to size and placed on wound. Staff P, LPN, tucked the resident's brief further under them, did not change gloves or use hand sanitizer, then applied skin barrier film on the skin around the wound, an abdominal (ABD) pad was applied with paper tape along the edges, gloves were changed without any hand santizer, and then the resident's brief was changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/17/2024 at 10:27 AM, Staff P was interviewed on wound care. When asked what should be done when entering a room with enhanced barrier precautions, Staff P said you should wash your hands when you enter and exit, and that you should wear gloves and a gown with patient care. When asked when hand sanitizer should be used, Staff P said before gloves, before entering room, between glove changes, after any task, going from patient to patient, and for many instances. When asked if it was appropriate to add a glove after you have been using another glove (without changing prior gloves), Staff P said no. When asked if you can take your gloves off and put new gloves on, without using hand sanitizer, Staff P responded, you should not. Staff P stated, this facility does not have hand sanitizer inside the room. Reference WAC 388-97-1320 (1)(c), -1320 (2)(b)