STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505251	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colfax of Cascadia, LLC	1150 West Fairview Road Colfax, WA 99111

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46115 Based on observation, interview and record review, the facility failed to ensure catheter care was provided in a dignified manner for 1 of 2 sampled residents (Resident 13), reviewed for use and care of a urinary catheter (a flexible tube that passes through the urethra and into the bladder to drain urine). This failure placed the resident at risk for diminished quality of life. Findings included . Per review of the 05/27/2024 quarterly assessment, Resident 13 had diagnoses which included neurogenic bladder, (a condition in which one lacked bladder control due to a brain, spinal cord, or nerve problem), and utilized a urinary catheter. On 07/08/2024 at 09:03 AM, Resident 13 was observed asleep in their bed. The urine collection bag of their catheter was attached to the bed, not covered by a privacy bag. Additional observations of the collection bag without a privacy bag were observed on 07/08/2024 at 2:38 PM, 07/10/2024 at 4:52 PM, 07/11/2024 at 9:06 AM AND 11:31AM, 07/12/2024 at 9:11 AM, 07/15/2024 at 4:26 AM AND 7:33 AM, and 07/16/2024 at 10:41 AM, 11:48 AM, 12:36 PM and 1:50 PM. In an interview on 07/16/2024 at 2:12 PM, Staff B, Director of Nursing, stated the urine collection bag should have been placed in a privacy bag and it was a dignity issue. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview, and record review, the facility failed to ensure 1 of 1 sampled resident (Resident 24) reviewed for accommodation of need, was provided a bariatric commode. This failure to ensure the resident received appropriate toileting equipment in their room placed them at risk for diminished independent functioning, and a loss of dignity and comfort. Findings included . Review of the resident's medical record showed the resident was admitted to the facility on [DATE] (age 39) with diagnoses to include obesity and a history of falls. The 07/03/2024 comprehensive assessment showed the resident required stand by to partial assist with activities of daily living and used a mechanical lift as needed for transfers. The assessment showed the resident was oriented and able to make their needs known and used a motorized wheelchair for mobility. During an interview on 07/08/2024 at 3:30pm, Resident 24 stated that they needed a large bedside commode because the bathroom in their room was too small and there was no way they could use the toilet in the bathroom. For toileting the resident stated they used a urinal and a bedpan but, stated that a commode would increase their quality of life and feel more dignified. During an interview on 07/11/2024 at 8:55am, Staff NN, Physical Therapy, stated Resident 24 was walking more over the past couple of months. They had been receiving physical therapy two times per week. Staff NN reported Resident 24 is very motived, and encourages other clients. They are an excellent candidate for assisted living or group home. When asked about a bathroom in the facility able to accommodate the resident, staff NN stated, Functionally, he can do stand pivot transfers with a front wheel walker. When asked If a bariatric commode was available, would Resident 24 be able to use it, Staff NN stated Yes, they would. On 07/12/2024 at 11:30am, Resident 24 was observed walking 25 feet with physical therapy. He required stand by assistance. During an interview on 07/12/2024 At 2:30pm, Staff PP ,Nursing Assistant, stated, resident 24 Never had a problem with incontinence with him. He uses a urinal and a bed pan. He can tell us when he needs to go. On 07/16/2024 at 10:58am, Staff B, Director of Nursing, stated Resident 24 seems to be making great progress, we have watched him walk. When asked what staff is doing for bowel and bladder care. Staff B stated, He needs assistance, he is aware of when he needs to go. He asks staff for assistance. He does not fit into the bathroom in his room. We talked about getting a bariatric toilet into his room. This is something more recently where he can use a commode, I believe it has been ordered for him. Therapy will work with staff on the best way to safely transfer him. We should promote independence for highest level of function. I also believe it will aide him into getting into a group home. When asked for documentation of bariatric commode order, none was provided. Reference: (WAC) 388-97-0860 (2)

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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 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** 46115 Based on record review and interview, the facility failed to inform and provide written information concerning the right of their residents to formulate an advance directive for 2 of 3 sampled residents (Resident 17, 33) reviewed. This failure placed residents at risk of not being able to exercise their rights and not having their wishes honored. Findings included . <Resident 17> A review of the record documented Resident 17 admitted to the facility on [DATE]. A 04/29/2024 quarterly assessment documented Resident 17 had diagnoses which included a stroke, lung disease and depression. Resident 17's record did not contain documentation that they had been informed of their right to form an advance directive or if they had accepted assistance in forming one until 06/02/2024, more than four months after admission to the facility. <Resident 33> A review of the record documented Resident 33 admitted to the facility on [DATE]. A 07/25/24 quarterly assessment documented Resident 33 had diagnoses which included heart disease, high blood pressure and chronic pain. Resident 33's record did not contain documentation that they had been informed of their right to form an advanced directive or if they had accepted assistance in forming one. During an interview on 07/18/2024 at 11:09 AM, Staff B, Director of Nursing, stated the advanced directives were offered upon admission and during the initial care conference. Reference: WAC 388-97-0300(1)(b), (3)(a-c) 50027

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview and record review, the facility failed to ensure a safe, sanitary, homelike environment was maintained at the facility for 3 of 3 hallways reviewed. Failure to provide necessary maintenance and repairs in resident rooms and bathrooms, clean dirty carpets, flooring and wheelchairs and address odoriferous non transient odors throughout the building. placed residents at risk for accidents, injuries, unsanitary living conditions and diminished quality of care and life. Findings included . On 07/08/2024, during initial rounds of the building and throughout the survey period (07/08/2024 - 07/12/2024, 07/15/2024 -07/19/2024, and 07/22/2024) multiple resident rooms were observed with gouged walls, chipped paint, holes in the walls, nails on resident room walls with nothing hanging, un-sanded wall patches, cracked damaged blinds with missing slats, hazy windows, window screens clogged with dirt particles, damaged baseboards in resident rooms and bathrooms, and toilets and bathroom sinks stained and scratched. The facility had non-transitory odors of urine and fecal matter throughout the building. On 07/12/2024, at 09:04am. Observation of resident rooms, 101, 103, 105, 107, 202,203, 208,210, 212, 214, 218, all had blinds with missing slats or that were bowed and could not be opened or closed. The blinds were plastic and appeared to be melted. The windows in these rooms were dirty and the screens clogged with dirt and debris. On 07/08/2024 at 11:00am, and throughout the survey period (07/08/24- 07/12/2024, 07/15/2024 -07/19/2024, and 07/22/2024) observation of the dark brown carpet in the 100, 200 and 300 hallways had over 50 stains (combined on the three carpets in each hallway) which ranged in size from approximately 5-6 inches to over 3 feet in length and width. The carpet in each of these hallways was approximated 75 ft. wide by 15 feet across. On 07/08/2024 at 11:30am, and throughout the survey period (07/08/24- 07/12/2024, 07/15/2024 -07/19/2024, and 07/22/2024) observation of the toilets and sinks in resident rooms were scratched and stained brown,102, 103, 111, 114, 210, 216, 218. There were gouges in the walls, chipped paint, unused nails on the walls, unpatched nail holes, and resident room thresholds were in disrepair. The nursing station counter had multiple chips and sharp edges from the broken laminate. room [ROOM NUMBER] had strong urine and feces odors. On 07/15/2024 at 9:38am. Staff O, Nurse, was observed cleaning a resident electric wheelchair. The wheelchair on 07/11/2024 at 3:30pm, had been observed in the hallway to be caked with what appeared to be dried food, dust, and debris. When asked if cleaning the wheelchairs were a part of the nurse's typical routine, she stated, No, when asked about a wheelchair cleaning schedule, Staff O referred surveyor to Staff B, Director of nursing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/15/2024 at 9:45am. Staff P, Housekeeper, stated there were 2 housekeepers for the building, the house keepers weekly work 4 days together and 3 days independently. When asked about the cleaning regimen in the building, Staff P stated, Some of the problem is things just can't get clean, like floors. When asked specifically, Staff P stated, the facility canceled a contract with the carpet cleaners 2 years ago, so they have not been deep cleaned since. When asked about the blinds, Staff P stated, They have been talking about getting new ones forever and ever since. Staff P had worked at the facility for [AGE] years. Staff P stated the facility was not homelike. When asked about the toilets some of them have no caulking and the bathrooms are odorous, Staff P stated, All the bathrooms need to be redone the toilets are old, they came with the building 35-[AGE] years ago. When asked about the holes and nails in the walls Staff P stated, Sometimes they move them (residents) around so fast, we have no notice when a new person come in. On 07/15/2024 at 9:59am. Staff G, Maintenance Director, reported, The last CEO had a plan to replace all the blinds in resident rooms. When they are broken and sagging, they need to be replaced. We have a couple right now that need to be replaced. I have replaced ones where residents have said something, they express they want new blinds, prefer to see the wooden colored blinds, gives them a more homely appearance. What we have are the wooden ones in stock. When asked why they are not replacing them, Staff G stated, I don't know I don't have an excuse. Staff G stated he monitors the window washing schedule, Windows should be done every 2-3 weeks. Staff G stated he is Starting the window cleaning schedule again, but there is no manpower to get it done. We started doing it last week we have been very short staffed. Staff G stated Carpet cleaning has not been done in 6-8 months. Time consuming, not conducive to being cleaned. I would love to see the carpet replaced. Staff G did not have a systematic schedule for maintenance repairs. I feel like we have done better in that regard in the past. I am not sure what it is, lack of staffing or culture piece. We have improvements to make, the last Administrator was supportive, I feel a little unsupported at the moment. We have been very short staffed. I have two housekeepers, one laundry person, and an assistant who main job is transportation, so he is not always available. It is absolutely not enough. Staff G reported Currently we have no sanitizing scheduled for wheelchairs. Does not exist. Talked about many times. On 07/16/2024 at 10:58am. Staff B, stated Cleaning and sanitizing of wheelchairs happens on the night shift. The Staff N, CNA Staffing Coordinator, is responsible for making the schedule. On 07/16/2024 at 11:15am Staff N stated, It (wheelchair cleaning and stocking of supplies) is something we are going to be implementing now on nightshift. On 07/16/2024 at 11:26am Staff A, Interim Administrator, stated, Every building I go into needs some love, it's the nature of the building, I really have not had time to see the building, I was brought in as the interim the day the survey team walked in. I do not think there is anything critical that is wrong like electric or plumbing issues. When asked about the overall condition of the facility, to include, cleanliness and maintenance concerns, Staff A stated, Over time, they will be taken care. I am the fifth administrator in a year, they have not had the consistent leadership they deserve. Someone new is going to come August 1st, a new administrator. They are going to be the permanent administrator. Reference WAC 388-97-0880 (1)(2)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview, and record review the facility failed to protect a resident's right to be free from physical and psychological abuse by another resident for 1 of 2 sampled residents (Resident 28) reviewed for abuse. Resident 28 experienced psychological as evidenced by a change in behaviors, being up at night, pacing and fear. This failure placed residents at risk for physical and psychological abuse, and a diminished quality of life. Findings included . Review of the facility policy Abuse Prevention, Identification and Reporting and Investigating, dated 10/31/2017, directed protocol for Protection of a Patient during an investigation if resident to resident abuse occurred. The policy stated . Residents are separated and supervised to prevent additional contact until the investigation is completed and an intervention plan implemented. Examine of the alleged victim for any signs of injury, including a physical examination and psychosocial assessment as needed. Protect the alleged victim from retaliation . Statements are collected immediately from those with knowledge of the event. The investigation starts immediately, maintains integrity . Review of Resident 28 comprehensive Minimum Data Set Assessment (MDS) dated [DATE], showed Resident 28 was cognitively intact. Diagnosis included mental illness with delusions of grandeur (impressive, especially of appearance). During an observation on 07/08/2024 at 8:45 am, Resident 28 was observed sitting in the hallway by the nursing station, not engaged with other residents talking incoherently to themself. During an interview on 07/08/2024 at 9:37am, Resident 28 stated staff and clients mock me. A resident slapped me on the a** [butt] I filed a police report. Resident 28 reported Resident 14 who slapped them lived two doors down the hallway. Resident 28 had the last room at the end of the hallway. Resident 28 stated they would have to pass by Resident 14's room every time they left their own room. During an interview on 07/16/2024 at 2:00 pm, Staff J stated Resident 28 was talking to me about her television and they walked into the hallway. Staff J observed Resident 28 walking by Resident 14's room and Resident 14 reached out and smacked Resident 28 on the butt. Staff J said they were in shock. Staff J said Resident 14 can be nasty, but never thought they would put their hands on Resident 28. Staff J said they believed Resident 14 was planning as they were behind the door and when Resident 28 walked by [NAME] it was quite shocking. Staff J added that they reported the incident of Resident 14 smacking Resident 28 to Staff N, Staffing coordinator. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/11/2024 at 2:30 pm, Staff B, Director of Nursing (DNS), stated Staff J, Maintenance Person, witnessed Resident 14 slap Resident 28 on the butt on 07/01/2024. Staff B stated there was no investigation initiated, no physical or psychosocial assessment completed. Staff B stated they came to the facility on [DATE] and saw the police at the facility. Staff B asked Staff M, Charge Nurse, to make a report, but that did not happen. Staff B thought Staff M would initiate the abuse protocols. Staff B stated to investigate allegations of abuse in the facility, guidelines from the Center for Medicare and Medicare would be followed, the Purple Book (DSHS abuse protocol guidance) and the policies and procedures of the facility corporation. Staff B stated none of this was done at the time. The abuse was not called in and an investigation needed to have been done and is being done now. Staff B stated Resident 14 was being moved to a different room on a different hall today [ten days after the physical abuse]. Staff B acknowledged Resident 28 would probably feel vulnerable, anxious, fearful, and probably would be upset if another resident slapped them on the butt. Review of progress note from 07/01/2024 to 07/03/2024 showed: - Staff B arrived at the facility and noted the presence of a police cruiser in the parking lot. After speaking with Staff M, Licensed Nurse, regarding the police presence, Staff B was aware Resident 28 called them due to a male resident smacking her bottom yesterday. Police took her statement and did speak to the male resident accused of smacking Resident 28's bottom. - Resident appeared to become more manic in her behaviors the last two days. - Resident 28 was placed on alert due to changes in behavior. - Resident 28 decided to go down the hall and yell at another female resident in a wheelchair. - Resident 28 was upset that the other resident said hello to the activity director. She was quick to become agitated over what she perceives others to be doing. - Resident 28 has been to the kitchen over 10 times since lunch requesting multiple food items. - Staff B discussed whether there was a possibility of resident having a Urinary Tract Infection (UTI.) Resident would not agree to having a Urinary Analysis (UA) with her increased mania at this point in time. - Resident tested negative for Covid-19 (infectious virus causing respiratory illness that may cause difficulty breathing and could lead to severe impairment or death) test yesterday. Continued review of 07/02/2024 progress noted, Resident 28 was out in the hallway at the nurses station mostly all shift. Made rude comments to other pts [Residents]. Pt [Resident] became agitated when other people talk or talk over her. Stomping her feet and wailing her arms around. Is constantly asking staff for things. Resident wanted to talk with Staff A, Administrator. Review of progress note dated 07/02/2024, showed Resident 28 came out onto the 200 hallway at approximately 2000 [08:00 PM], demanding all the televisions to be turned down and the rooms that had televisions on to have their doors shut. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of progress note dated 07/03/2024, showed Resident 28 was up three times during the night, pacing, looking around like she was counting the staff, nodding her head then walking away, no contact with others resident on this shift. Per record review over three days (7/01/2024-07/03/2024). It revealed Resident 28's increased agitation was documented. There was no documentation of the resident being assed for psychosocial well-being to rule out behaviors that may have been related to the abuse. There was no documentation of interventions or investigation regarding the incident that occurred on 07/01/2024. During a follow up interview on 07/10/2024 at 11:00 am, when asked if they were feeling safe in the facility, Resident 28 stated, Everyone knows (in reference to the abuse) everyone who has been here is aware of it, they laugh and I feel preyed upon, that's preyed with an e in the facility. Reference WAC 388-97-0640 (1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50846 Based on interview and record review the facility failed to ensure allegations of abuse were identified as such and reported to the State Survey Agency as required for 2 of 4 sampled residents (Resident 28, 40) reviewed for abuse. Failure to report an allegation of abuse by Resident 14 towards Resident 28, and failure to identify and report resident to resident altercations involving Resident 40 as potential abuse, placed the residents at risk for additional abuse, unmet care needs and diminished quality of life. Findings included . Review of the facility Abuse Prevention, Identification and Reported facility procedures revised 10/31/17 showed the facility procedures for reporting abuse: All staff members in all departments are required to immediately report any allegation of abuse to their direct supervisor and the State Survey Agency If their direct supervisor is not available report to the floor supervisor, CNO or CEO. You must speak with someone Facilities have two hours to notify state agencies and law enforcement if indicated so report to your supervisor immediately. Staff are mandatory reporters and required to fulfill the responsibility of reporting the must notify the state Survey Agency/law enforcement directly unless they have full confidence that the facility internal system for notification is effective. <Resident 28> During an interview on 07/08/2024 at 9:37am, Resident 28 stated staff and clients mock me. A resident slapped me on the a** [butt] I filed a police report. During an interview on 07/16/2024 at 2:00 pm, Staff J stated Resident 28 was talking to me about her television and they walked into the hallway. Staff J observed Resident 28 walking by Resident 14's room and Resident 14 reached out and smacked Resident 28 on the butt. Staff J added that they reported the incident of Resident 14 smacking Resident 28 to Staff N, Staffing coordinator. During an observation and interview on 07/08/2024 at 10:22 AM, Resident 14 was sitting in their wheelchair in their room. Their left arm was lying on their armrest demonstrated their inability to open and close their left hand. Resident 14 maneuvered in their wheelchair with their right hand, using their left leg primarily for mobility. The resident stated they were in a verbal and physical altercation with Resident 28 (currently residing on the same hall as them) about two weeks ago and the police were called to the facility. Resident 14 stated, I hit her on the butt. Per record review on 07/08/2024, there was no documentation regarding the incident of abuse that occurred on 07/02/2024 in Resident 14's medical chart, the facility Accident and Incident Report Log, the facility Grievance Log and the Washington State Secure Tracking and Reporting System (STARS, the state incident reporting platform). When interviewed on 07/22/2024 at 07:25 PM, Staff B, Director of Nursing Services, confirmed the facility should have reported and investigated the incident of abuse to the State Agency at the time. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50027 37544 <Resident 40> The 05/28/2024 admission assessment documented Resident 40 was able to make their needs known to staff, and had diagnoses which included anxiety, insomnia, restlessness, agitation, and a attention/concentration deficit. In addition, the assessment documented the resident had physical and verbal behavioral symptoms, and wandering behavior during the assessment period. A nursing progress note on 05/30/2024 at 11:52 PM by Staff KK, Registered Nurse, documented staff responded to another resident yelling and swearing. When staff responded, they found Resident 40 sitting in the other resident's recliner watching television. Resident 40 was then re-directed back to their room. A nursing progress note On 06/17/2024 at 8:57 PM by Staff M, Registered Nurse, documented Resident 40 walked into another resident's (6) and pushed them to down to the ground. The resident then walked out of the room and continued to wander down the hallway. Review of the facility investigation dated 06/17/2024 documented Resident 40 was found in another resident's room. A verbal altercation occurred between Resident 40 and the other resident. The other resident was alert and oriented, but unable to verbalize. The incident was not witnessed, but raised voices were heard and when staff arrived, the resident started to stumble and fall to the floor. No injuries were sustained, and when asked if Resident 40 had pushed them, the resident signaled yes. It could not be determined if Resident 40 intended to push the other resident. A note was added on 06/23/2024 to document the investigation into physical aggression against another resident was completed and it was determined Resident 40 had no intention of harming the other resident. A nursing progress note on 06/25/2024 at 6:34 AM by Staff JJ, Licensed Practical Nurse, documented staff responded to loud yelling, and found Resident 40 in another resident's (8) room. The resident told staff that Resident 40 had stated, I want to kill you. Resident 40 was difficult to redirect, but staff were able to redirect the resident to leave the room. A nursing progress note 0n 06/29/2024 at 5:19 AM by Staff TT, Licensed Practical Nurse, documented a resident (25) reported to staff that Resident 40 had gone into their room, took a bag of chips, threw them at the resident, and then Resident 40 hit them with their left hand. Review of the facility investigation dated 06/29/2024 documented Resident 40 had wandered into another resident's room, became upset and threw a bag of chips at the other resident, then left the room. The incident was not witnessed. A note was added on 07/02/2024 to document the investigation into physical aggression against another resident had been completed and it was concluded the behavior was not intentional. Review of the State Survey Agency's reporting database (STARS) found none of the above resident-to-resident incidents had been reported to the State Agency as required. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/22/2024 at 12:45 PM, the resident-to-resident altercations involving Resident 40 were discussed. With regards to the incidents on 05/30/2024 it was felt the incident did not need to be reported due to being a verbal outburst, and with the incident on 06/17/2024, staff did not witness the incident, and assumed the Resident 40 pushed the other resident. Staff B was not aware of the incident on 06/25/2024. After discussion and review of the progress notes, when asked if the incident should have been reported to the State Agency, Staff B stated no, the staff were able to redirect the resident and no further incident occurred. Per Staff B, the incident on 06/29/2024 was not reportable as there were no lasting effect to the Resident 25. At 12:47, when asked when an incident would be called into the State Agency, Staff B stated when a verbal altercation was aggressive, or a resident was aggressive, then a call to the State Agency would be made. Refer to F-600 and F-610 Reference (WAC): 388-97-0640 (5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50846 Based on observation, interview and record review, the facility failed to thoroughly investigate allegations of abuse for 2 of 4 sampled residents (Resident 28, 40) reviewed for abuse. This failure placed residents at risk for not being adequately protected from additional episodes of abuse, unmet care needs and diminished quality of life. Findings included . Review of the facility Abuse Prevention, Identification & Reporting procedure dated 10/31/2017, directed staff to initiate investigations as soon as a report of abuse was received to rule out or identify abuse. Investigations would be completed within five days. On 07/08/24 at 9:37am. Resident 28 stated .A resident slapped me on the a** I filed a police report . During an interview on 07/08/2024 at 10:22 AM, Resident 14 stated, I hit her on the butt. and identified Staff J, Maintenance/Transportation, witnessed it. The resident stated after the incident, they were directed by the police not to do that again, and by staff, not to inflame the situation with Resident 28. Per record review on 07/08/2024, there was no documentation regarding the incident of abuse that occurred on 07/02/2024 in Resident 14's medical chart, the facility Accident and Incident Report Log, the facility Grievance Log and the Washington State Secure Tracking and Reporting System (STARS, the state incident reporting platform). During an interview on 07/19/2024 at 02:13 PM, Staff KK, Registered nurse, stated when a resident is being abused, staff should follow the facility policies and procedures, which included reporting to the State Agency within two hours, notifying the administrator, adding the incident to the alert charting log and modify their care plan to ensure that it does not happen again. Staff KK also stated that they would intervene and separate the residents at the time of the incident to ensure their safety and prevent an altercation from happening again. Staff KK verified that there was no documentation in Resident's 14's medical chart stating that the resident-to-resident incident of abuse occurred to date, only that Resident 14 was moved to another hall on 07/11/2024. Staff KK confirmed that immediate intervention should have been implemented to ensure the safety of the residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/2024 at 2:30 pm, Staff B, Director of Nursing (DNS), stated Staff J, Maintenance Person, witnessed Resident 14 slap Resident 28 on the butt on 07/01/2024. Staff B stated there was no investigation initiated. Staff B stated they came to the facility on [DATE] and saw the police at the facility. Staff B asked Staff M, Charge Nurse, to make a report, but that did not happen. Staff B thought Staff M would initiate the abuse protocols. Staff B stated to investigate allegations of abuse in the facility, guidelines from the Center for Medicare and Medicare would be followed, the Purple Book (DSHS abuse protocol guidance) and the policies and procedures of the facility corporation. Staff B stated none of this was done at the time. The abuse was not called in and an investigation needed to have been done and is being done now. 50027 37544 <Resident 40> The 05/28/2024 admission assessment documented Resident 40 was able to make their needs known to staff, and had diagnoses which included anxiety, insomnia, restlessness, agitation, and a attention/concentration deficit. In addition, the assessment documented the resident had physical and verbal behavioral symptoms, and wandering behavior during the assessment period. A nursing progress note on 05/30/2024 at 11:52 PM by Staff KK, Registered Nurse, documented staff responded to another resident yelling and swearing. When staff responded, they found Resident 40 sitting in the other resident's recliner watching television. Resident 40 was then re-directed back to their room. A nursing progress note on 06/25/2024 at 6:34 AM by Staff JJ, Licensed Practical Nurse, documented staff responded to loud yelling, and found Resident 40 in another resident's (8) room. The resident told staff that Resident 40 had stated, I want to kill you. Resident 40 was difficult to redirect, but staff were able to redirect the resident to leave the room. Review of the facility reporting log for May and June 2024 showed no incidents had been logged related to the above resident-to resident incidents for Resident 40. Further record review found no documentation that showed the facility did an investigation to determine if abuse had occurred. In an interview on 07/22/2024 at 12:45 PM, the resident-to-resident altercations involving Resident 40 were discussed. With regards to the incident on 05/30/2024 it was felt the incident did not need to be logged into the facility reporting log or investigated as it was just a verbal outburst. When asked about the incident on 06/25/2024, Staff B stated they were not aware of the incident. When asked if the incident should have been entered into the facility reporting log and an investigation completed, Staff B stated, no since staff had been able to redirect the resident and no further incident occurred. Refer to F-600 and F-609 Reference WAC 388-97-0640 (1)(2)(3)(a) Reference (WAC) 388-97-0640 (6)(a)(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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to ensure 4 of 6 sample residents (28, 35, 40, 14) reviewed for Pre-Admission Screening and Resident Review (PASARR, an assessment completed prior to admission into a skilled nursing facility to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services) was completed prior to admission, accurately, and if indicated, a referral for a PASARR Level II (a more in-depth screening assessment) had been made. this faliure placed residents at risk on unmet care needs. Findings included <Resident 35> The 04/23/2024 quarterly assessment documented Resident 35 had diagnoses which included depression, psychotic disorder, a severe mental illness that caused abnormal thinking, delusions and hallucinations. Review of Resident 35's record showed a PASSAR was completed on 12/28/2023 prior to the resident's admission to the facility, but Section 1A documented the resident had no serious mental illness indicators and the boxes for psychotic disorder and delusional disorder were unchecked. Further record review found no documentation that the PASARR had been redone to correct the omission of the psychotic disorder and delusional disorder. <Resident 40> The 05/31/2024 admission assessment documented Resident 40 had diagnoses which included anxiety disorder, agitation, and attention/concentration deficits. Review of Resident 40's record showed a PASARR had been completed on 05/28/2024 prior to admission as required, but under Section 1A, the assessment documented the resident had no serious mental illness indicators and the box for Anxiety disorders was unchecked. Additional record review found no documentation that the PASARR had been redone to correct the omission of the anxiety disorder. In an interview on 07/19/2024 at 12:45 PM, Staff E, Social Services Manager, stated the PASSAR needed to be done prior to admission to the facility and during admission, it was checked to ensure it had been done, but had not been checked to ensure it was completed correctly. <Resident 14> A review of the record documented Resident 14 was admitted to the facility on [DATE] and had diagnoses including major depressive disorder (a chronic, severe mental disorder that affects the way a person feels, thinks and behaves and can lead to a variety of emotional and physical problems). (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A further review of Resident 14's record documented a Level I PASARR was completed on 03/20/2024, ninety-eight days after the resident admitted to the facility. On 07/18/24 at 4:42 PM, a request was made for a PASARR dated prior to the resident's admission on 01/10/2024, and none was provided. In an interview on 07/19/24 at 10:26 AM, Staff C, Corporate Registered Nurse, stated they did not have an earlier PASARR for Resident 14. Staff C stated they had done a mock survey in March 2024 and had identified at that time that there were residents who did not have PASSARRs completed. Resident 14 had one completed at that time. This was a process the facility was now monitoring. 46033 50846 <Resident 28> Resident 28 admitted to the facility on [DATE]. Admitting diagnosis of serious mental illness included, schizoaffective disorder, bipolar type, post-traumatic stress disorder, acute, major depressive disorder, recurrent, unspecified, schizophrenia, unspecified. Resident 2 was assessed as cognitively intact. On 05/12/2023 a care plan was initiated addressing residents' mood and behavior potential to exhibit behaviors r/t paranoia, whimsical tough process, schizophrenia and bipolar disorder as evidenced by believing she is GOD and making odd magical statements. Review of the residents comprehensive Minimum Data Set Assessment (MDS) dated [DATE] documented are delusions and psychosis. On 07/08/2024 at 8:45am, Resident 28 observed sitting in the hallway by the nursing station. Not engaged with other residents talking incoherently to themself. When approached Resident asked surveyor to address them as GOD. Review of Resident 28's July 2024 Medication Administration Records (MARs) showed Resident 28 had refused medication for mental health diagnosis since admission. A PASRR form was completed by the hospital 05/12/2024, indicating no need for a mental health level 2 PASRR review. An additional PASRR form (undated) was initiated but not completed by the Staff E, Social Services. On 07/11/2024 at 8:24 am, Staff E when asked what the facilities process was for identifying residents with a mental illness or intellectual disabilities and how does the facility ensure the psychosocial needs these residents are met? Staff E stated, I am still in the learning process. Reviewed of the medical records with Staff E confirmed no level 2 PASRR was requested or completed as required by state law. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFERENCE: WAC 388-97-1915 (1).

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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. 37544 Based on observation, interview and record review, the facility failed to ensure care plan interventions were implemented for 1 of 5 sampled residents (Resident 1) reviewed for care planning. Failure to ensure fall interventions for Resident 1 were followed. this failure placed the residents at risk for injury, and decreased quality of life. Findings included . <Resident 1> The 5/10/2024 quarterly assessment documented Resident 1 had diagnoses which included dementia, and was dependent on nursing staff for transferring to/from the wheelchair to bed. The assessment also documented the resident had weakness, was unsteady on their feet, and had a history of falling. On 07/08/2024 at 2:49 PM, Resident 1 was observed sleeping in bed in their room. A sign on the wall above the bed instructed staff, DO NOT leave resident alone in room. Transfer immediately or leave in common area. Thanks! Review of Resident 1's fall/safety care plan documented the resident was at high risk for falls and interventions were implemented on 11/21/2019. A revision of the care plan on 10/25/2023 informed staff that the resident was not to be left alone in their room when they were up in their wheelchair. On 07/09/2024 at 9:45 AM, Resident 1 was observed alone in their room. The resident was sitting in their wheelchair, leaned over, with their upper body lying on the bed. At 9:48 AM, an unidentified female staff member was heard telling Staff C, Clinical Resource Nurse, that the resident didn't want to lay down earlier, so they just left her alone. On 07/10/2024 at 4:13 PM, Resident 1 was observed sitting in their wheelchair, alone in their room. On 07/11/2024 at 9:51 AM, Resident 1 was again observed alone in their room. The resident was sitting in their wheelchair next to the bed, leaned over with their upper body on the bed and a blanket covering their back/shoulders. In an interview on 07/19/2024 at 11:54 AM, Staff Q, Nursing Assistant, stated Resident 1 was a fall risk and for safety reasons, was not to be left alone in their room if they were up in their wheelchair. During an interview on 07/19/2024 at 2:25 PM, when informed of multiple observations of Resident 1 being left alone in their room while up in their wheelchair, Staff B, Director of Nursing, stated staff were not to leave the resident alone in the room and should transfer them to bed or move to the nurse's station or other area where they would be visible. 50846

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47728 Based on interviews and observations, during the medication cart review, the facility failed to provide timely administration of prepared medications according to accepted standards of clinical practice for 1 of 2 medication carts reviewed. This failure placed residents at risk of medication errors and decreased quality of life. According to the Institute for Safe Medication Practices, a delay between preparation and administration of a medication or the preparation of multiple medications for different clients is a contributing factor to medication errors and a risk to patient safety. (ISMP Canada Safety Bulletin - Volume 23 o Issue 12 o December 19, 2023, Pre-pouring Medications: A Risky Approach) Findings included: During an inspection of the 100-hall medication cart on 07/22/2024 at 4:28 PM with Staff R, Medication Technician, eight medication cups, each labeled with a different resident's name, and containing medications and were observed in the top drawer of the cart. In an interview on 07/22/2024 at 4:28 PM Staff R, said they prepared the 2:00pm medications but could not administer the medications because the residents were unavailable at the time. Staff R stated they had been told by Staff B, Director of Nursing (DON), if a resident was unavailable to take the medication once it had been prepared, they should label the medication cup with the resident name and store it in the medication cart drawer. In an interview on 7/22/2024 at 4:42PM, Staff B, DON, stated medications should be prepared and immediately be administered to the resident. When asked what the procedure was if a medication could not be given once it was prepared, they stated the cup needed to be labeled with the resident name and put in the top drawer of the medication cart until it could be administered to the resident. Staff B stated it was improbable to have eight separate occurrences, within the same time frame, of residents unavailable to take their prepared medications. Reference WAC 388-97-1620(2)(b)(ii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 37544 Based on observation, interview, and record review, the facility failed to consistently provide bathing and/or grooming for 13 of 16 sampled residents (17, 18, 8, 1, 16, 13, 36, 39, 294, 33, 22, 14, 34) reviewed for activities of daily living. This failure placed the residents at risk for poor personal hygiene, diminished quality of life and unmet care needs. Findings included . <Resident 1> The 05/10/2024 quarterly assessment documented Resident 1 had bladder and bowel incontinence and needed assistance from nursing staff to complete activities of daily living (ADL) for bathing and shaving. On 07/08/2024 at 12:36 PM, Resident 1 was observed sitting in their wheelchair. The resident had long facial hair on the chin and upper lip. Review of the 06/18/2020 ADL care plan documented Resident 1 needed assistance for bathing, and preferred to have two showers a week. Instructions to nursing staff were added on 02/28/2023 to inform staff that Resident 1 needed assistance with shaving of facial hair and to reapproach if they refused. Additional observations of Resident 1 with facial hair on the chin and upper lip were made on the following: 07/09/2024 at 9:45 AM and 10:55 AM; 07/11/2024 at 9:33 AM, 9:40 AM, 10:30 AM, 11:19 AM, 2:03 PM, and 2:56 PM; and 07/12/2024 at 8:43 AM. Review of the bathing/grooming record from 06/19/2024 through 07/17/2024 documented Resident 1 received a shower on 06/19/2024 and the next shower provided was on 06/27/2024, a period of seven days. Per the documentation, the resident refused to bathe on 07/03/2024, but no documentation was found in the resident's record to show a shower/bath had been re-offered. On 07/05/2024, Resident 1 received another shower, which was eight days after the shower on 06/27/2024. Additional review of Resident 1's record found no documentation that the resident had refused assistance with shaving of facial hair. In an interview on 07/22/2024 at 12:12 PM, Staff B, Director of Nursing was informed of the observations of Resident 1. Staff B stated it was the expectation that residents were bathed and groomed according to their preferences and care plans. <Resident 36> The 05/17/2024 quarterly assessment documented Resident 36 needed assistance from nursing staff to complete activities of daily living for personal hygiene such as shaving and washing the face. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/2024 at 11:34 AM, Resident 36 was observed sitting in their wheelchair in their room, facial stubble was present on the resident's cheeks, chin and upper lip, and the upper eyelashes of both eyes had yellow, crusty matter. The facial stubble and yellow matter to the eyelashes was still present when the resident was again observed at 2:47 PM that day. Additional observations of Resident 36 with facial stubble and yellow, crusty matter to both eyelashes were made on the following: 07/09/2024 at 9:08 AM, 9:50 AM, and 10:56 AM, 7/10/2024 at 4:51 PM, and 07/11/2024 at 9:07 AM, and 2:57 PM. Review of the 02/14/2024 ADL care plan for Resident 36 documented the nursing staff were to assist and provide cues to complete personal hygiene tasks. Review of Resident 36's record. which included the grooming record from 06/25/2024 through 07/17/2024, found no documentation that the resident had refused to be shaved. On 07/12/2024 at 9:30 AM, Resident 36 was observed sitting in their wheelchair, no facial hair was present. When asked how often they shaved, the resident stated, usually every day, was able to do once staff set up the supplies. Resident 36 then said it was good to be shaved, since they were starting to look scraggly. In an interview on 07/17/2024 at 8:58 AM, Staff T, Nursing Assistant, stated shaving was done when the resident got up for the day. When asked about Resident 36, Staff T stated the resident was able to do their shaving once the staff set up the supplies. In an interview on 07/22/2024 at 9:09 AM, Staff B, Director of Nursing, stated shaving was offered when the residents got up for the day, as needed and when they were bathed. 46115 <Resident 8> According to the 05/03/2024 quarterly assessment, Resident 8 had severe cognitive impairments and needed assistance from staff for activities of daily living, such as bathing. Per the 11/08/2022 care plan, Resident 8 was to be showered twice weekly. Review of the bathing documentation from 05/22/2023 to 06/28/2023 documented Resident 8 had been bathed once a week, and not twice a week as preferred or scheduled. In addition, the documentation showed the resident had not refused to be bathed. <Resident 13> According to the 05/27/2024 quarterly assessment, Resident 13 was cognitively intact and able to make their needs known and needed assistance from staff for activities of daily living, such as bathing. Per the 10/31/2023 care plan, Resident 13 was to be bathed once a week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the bathing documentation from 06/11/2024 to 07/16/2024 documentated Resident 13 had not been bathed once a week as preferred or scheduled. In addition, the documentation showed the resident had not refused to be bathed. <Resident 14> According to the 04/07/2024 quarterly assessment, Resident 14 was cognitively intact and able to make their needs known and needed assistance from staff for activities of daily living, such as bathing. Per the 01/10/2024 care plan, Resident 14 was to be showered twice weekly. Review of the bathing documentation from 06/03/2024 to 07/15/2024 documentated Resident 14 had been bathed once a week, and not twice a week as preferred or scheduled. In addition, the documentation showed the resident had not refused to be bathed. <Resident 17> According to the 04/29/2024 quarterly assessment, Resident 17 had cognitive impairments and was able to make their needs known and needed assistance from staff for activities of daily living, such as bathing. Per the 01/25/2024 care plan, Resident 17 was to be showered twice weekly. Review of the bathing documentation from 06/04/2024 to 07/17/2024 documented Resident 17 had been showered twice in June on 06/04/2024 and 06/26/2024 and had refused on 06/12/2024. For the month of July, the resident received showers once a week, and not twice a week as preferred or scheduled and had not refused. <Resident 18> According to the 04/18/2024 admission assessment, Resident 18 was cognitively intact and able to make their needs known and needed assistance from staff for activities of daily living, such as bathing. Per the 04/13/2024 care plan, Resident 18 was to be showered twice weekly. Review of the bathing documentation from 06/01/2024 to 07/17/2024 documented Resident 18 had been bathed twice in June on 06/01/2024 and 06/27/2024 and had refused on 06/05/2024 and 06/06/2024. In July the resident received a shower on 07/17/2024, not twice a week as preferred or scheduled and had not refused to be bathed. <Resident 33> According to the 04/09/2024 admission assessment, Resident 33 was cognitively intact and able to make their needs known and needed assistance from staff for activities of daily living, such as bathing. (continued on next page)

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Colfax of Cascadia, LLC	1150 West Fairview Road Colfax, WA 99111

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the 04/05/2024 care plan, Resident 33 was to be showered twice weekly. Review of the bathing documentation from 06/01/2024 to 07/18/2024 documented Resident 8 had been bathed once a week, and not twice a week as preferred or scheduled. In addition, the documentation showed the resident had not refused to be bathed. <Resident 39> According to the 06/20/2024 quarterly assessment, Resident 39 was cognitively impaired and able to make their needs known and needed assistance from staff for activities of daily living, such as bathing. Per the 03/23/2024 care plan, Resident 39 was to be showered twice weekly. Review of the bathing documentation from 06/01/2024 to 07/16/2024 documented Resident 39 had been bathed once a week, and not twice a week as preferred or scheduled in June. Iin July the resident received a shower on 07/01/2024 and 07/16/2024. In addition, the documentation showed the resident had not refused to be bathed. <Resident 294> According to the 06/25/2024 admission assessment, Resident 294 was cognitively intact and able to make their needs known and needed assistance from staff for activities of daily living, such as bathing. Per the 06/28/2024 care plan, Resident 294 was to be showered twice weekly. Review of the bathing documentation from 06/25/2024 to 07/14/2024 documented Resident 294 had been bathed once a week, and not twice a week as preferred or scheduled. In addition, the documentation showed the resident had not refused to be bathed. 47728 <Resident 16> Per the 06/11/2024 assessment Resident 16 was cognitively intact, was incontinent of bowel and bladder, was dependent on staff for activities of daily living (ADLs) such as bathing, personal hygiene, and transfers, and had diagnoses including diabetes, depression, and a pressure wound. According to the care plan dated 04/20/2024, resident 16 required extensive assistance for bathing and was to be bathed twice weekly and as necessary. Per review of the record, Resident 16 was bathed twice weekly, as care planned, for only four of seven consecutive weeks from 06/02/2024 - 07/20/2024. During an interview on 07/19/2024 at 2:14 PM, resident 16 stated, they get showered only one time per week, more often than not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Staff R, Medication Technician, on 07/16/2024 at 2:02PM, they stated missed showers were always offered to residents the next day. During an interview on 07/18/2024 at 2:18 PM, Staff Q, nursing assistant, stated residents' showers were sometimes missed and moved to the next day as a priority. In an interview with Staff Y, Licensed Practical Nurse (LPN), on 07/18/2024 at 10:09 AM, they stated showers were given to residents twice per week and occasionally missed, though they tried to catch up the next day. In an interview with Staff B, Director of Nursing (DON), on 07/18/2024 at 12:10 PM they stated residents' showers were occasionally missed and were then offered the next day. During an additional interview on 07/22/2024 at 9:09 AM Staff B, DON stated the expectation for bathing was for the aides to follow the care plans to ensure the residents were clean and presentable. They stated showers were offered anytime the residents wanted one, as needed, and there was a shower schedule which was audited by the staffing coordinator. Staff B stated if there was no specific shower aide, then it was each aide's responsibility to provide the showers for the residents they were assigned to that shift. Staff B continued to state showers given and refusals of showers were documented and if a resident refused a shower they had to sign a refusal sheet that was placed in the resident's record. Additionally, Staff B stated, the nurse was to be notified of refusals and a shower offered on a different day. Staff B stated showers were important because it helped the residents to feel better, decreased odor and chance for infection, and allowed the staff to check for skin issues. <Resident 22> Per the 07/09/2024 assessment Resident 22 was cognitively intact, was incontinent of bowel and bladder, was dependent on staff for activities of daily living (ADLs) such as bathing, personal hygiene, and transfers, and had diagnoses including stroke. Hemiplegia (one-sided weakness or paralysis), and depression. According to the care plan dated 03/272024, resident 22 required extensive assistance for bathing and was to be bathed twice weekly. Per review of the record, Resident 22 was bathed twice weekly, as care planned, for only two of eight consecutive weeks from 05/26/2024 - 07/20/2024. During an interview on 07/08/2024 at 11:30AM, resident 22 stated, they were getting maybe one shower a week and they would prefer 2 showers weekly. At this point resident 22 cried and stated they went to a doctor appointment the prior week and were embarrassed because they felt they smelled bad. In an interview with Staff R, Medication Technician, on 07/16/2024 at 2:02PM, they stated Resident 22 was scheduled to be showered on Wednesdays and Saturdays, showers for this resident were rarely missed, and missed showers were always offered to the resident the next day. During an interview on 07/18/2024 at 2:18 PM, Staff Q, nursing assistant, stated residents' showers were sometimes missed and moved to the next day as a priority. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Staff Y, LPN, on 07/18/2024 at 10:09 AM, they stated showers were given to residents twice per week and occasionally missed, though they tried to catch up the next day. In an interview with Staff B, Director of Nursing (DON), on 07/18/2024 at 12:10 PM they stated resident 22's showers were occasionally missed and were then offered the next day. Staff B also stated Resident 22 had wanted different shower days several times and the care plan was updated with their preferences. During an additional interview on 07/22/2024 at 9:09 AM Staff B, DON stated the expectation for bathing was for the aides to follow the care plans to ensure the residents were clean and presentable. They stated showers were offered anytime the residents wanted one, as needed, and there was a shower schedule which was audited by the staffing coordinator. Staff B stated if there was no specific shower aide, then it was each aide's responsibility to provide the showers for the residents they were assigned to that shift. Staff B continued to state showers given and refusals of showers were documented and if a resident refused a shower they had to sign a refusal sheet that was placed in the resident's record. Additionally, Staff B stated, the nurse was to be notified of refusals and a shower offered on a different day. Staff B stated showers were important because it helped the residents to feel better, decreased odor and chance for infection, and allowed the staff to check for skin issues. <Resident 34> The 05/01/2024 quarterly assessment documented Resident 34 had diagnosis to include a progressive neurological disorder and needed assistance from nursing staff to complete all activities of daily living (ADL) tasks 07/09/24 at 09:44 am, 11:00am and 2:30pm, Resident 34 was observed with crusted food debris around his face, moustache and beard. Their teeth were visible with plaque, gums were white with food coating his teeth. Their nose was running with thick mucus. Additionally, the resident was observed to have, smudged glasses, he was unshaven with a long facial hair, and had long fingernails. During an interview on 07/09/2024 at 09:44am, Resident 34 stated he would like assistance to shave. On 07/10/2024 at 2:48pm, and 4:30pm Resident 34 was observed with crusted food debris around his face, moustache and beard. Their teeth were visible with plaque, gums were white with food coating his teeth. Additionally, the resident was observed to have, smudged glasses, he was unshaven with a long facial hair, and had long fingernails. Review of the 01/23/2024 ADL care plan documented Resident 34 was dependent on staff for assistance with bladder and bowel incontinence care, bathing, oral care, and shaving. The care plan stated resident 34 had a specialized build up toothbrush and an electric razor they preferred to use. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/11/24 at 9:30am during an interview with Nursing Assistant, Staff V, stated, Resident 34 needed assistance of one person to assist with dressing and personal care. When asked for the way instructions for care are made known, staff V stated, We have on Kardex and in Point Click Care (electronic medical records) or just asking, most people know. I don't think I ever helped him with teeth brushing or shaving. When asked about Resident 34 preferences for ADL cares, Staff V stated, If he wants something he will come and tell you, I have never shaved him, He has an electric razor, I believe he has this. Not entirely sure what it looks like, never done it before. On 07/12/2024 at 10:00am Nursing Assistant, Staff PP was observed assisting resident to get out of bed. At 10:16am, the sink in Resident 34's room was observed dry, there was no water used for ADL cares. Staff PP stated he had worked at the facility 10 months, and frequently worked with Resident 34. When asked about oral care Staff PP stated, he had not assisted Resident 34 with oral care today. When asked about shaving Staff PP stated, I use a single trim razor, the shower aide takes care shaving, I am not involved in that. On 07/12/2024, Nursing Assistant (shower aide) Staff T, stated, I think Resident 34 may have an electric razor, or the facility trimmer can be used. I have not given him a shave recently or trimmed his nails. On 0/7/12/24 at 11:00am, Charge Nurse Staff AA stated the charge nurse oversee the cares for residents. When asked if resident 34s ADL care was supervised, staff AA stated yes, absolutely, the expectation is the nursing assistants, offer care, residents have a right to refuse care. On 07/12/2024 at 11:15am, observed with staff AA, clients room. Toothbrush (electric) dry not used, razors in package not used. Per review of the electronic medical record there was no documentation that resident 34 had refused ADL care for the month of July 2024. Reference: 483.24(a)(2) -1060 (2)(c) 50027 50846

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47728 Based on interview and record review the facility failed to implement bowel management protocol when indicated for 1 of 2 sampled residents (Resident 26), reviewed for constipation. These failures placed residents at risk for complications, worsening conditions, and diminished quality of life. Findings included: Review of the undated facility policy titled, Bowel Protocol, instructed nursing staff to implement the bowel program if a resident did not have a bowel movement (BM) for 72 hours. The policy documented nursing staff was to administer Milk of Magnesia (MOM) or Miralax on the evening shift of 72 hours with no BM, a suppository on the following night shift, and an enema on the following day shift. Per the 05/24/2024 assessment, Resident 26 was cognitively intact, required maximum assistance for moving in bed, transfers, and toileting, and had diagnoses including multiple sclerosis (a disease that affects the brain and spinal cord and causes nerve damage and communication problems), hemiplegia (weakness or paralysis affecting one side of the body), and depression. Review of Resident 26's provider orders documented active orders for: -8/23/2023 Polyethylene Glycol (powder laxative mixed with water) to be given every 12 hours as needed for constipation, -8/23/2023 Senna (stimulant laxative) to be given every 24 hours as needed for constipation, -8/23/2023 MOM (liquid laxative) to be given as needed on day two of no BM. -8/23/2023 Dulcolax Suppository (stimulant laxative) to be given as needed if no results from MOM, -8/23/2023 Fleet Enema (stimulate laxative) to be given as needed if no results from MOM and subsequent dulcolax suppository Review of Resident 26's 06/01/2024 through 07/10/2024 bowel record documented resident had no BMs on the following days: 06/04/2024 through 06/08/2024 (five days) 06/13/2024 through 06/15/2024 (three days) 06/23/2024 through 06/26/2024 (four days) 07/08/2024 through 07/10/2024 (three days) Review of Resident 26's 06/01/2024 through 7/10/2024 Medication Administration Record (MAR) documented bowel medications were not administered when needed for constipation, as ordered. Nor was there any documentation found that bowel medications were offered and/or refused (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/2024 at 01:57 PM Staff R, medication technician stated resident 26 had no problems with constipation. They stated the bowel protocol was to give MOM after a resident had gone 3 days without a BM, administer a suppository the next day, then administer an enema on the subsequent day. During an interview on 07/18/2024 at 10:00 AM, Staff Y, Licensed Practical Nurse (LPN), stated Resident 26 had occasional constipation and should have been offered bowel medications when no BM had occurred for 48-72 hours. They stated this was important in preventing the resident from developing a blockage. In an interview on 07/18/2024 at 11:45 AM, Staff B, Director of Nursing (DON) stated the nursing assistants documented resident BMs and the nurses received an alert when a resident had gone 48 and 72 hours without a BM. Staff B stated there were standing orders for MOM, Miralax, suppositories, and enemas. Staff B reviewed Resident 26's bowel pattern and stated the resident should have been given the as needed bowel medications to assist with their constipation. When asked, Staff B stated a small size BM did not count for Resident 26. REFERENCE: WAC 388-97-1060 (1).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728 Based on observation, interview and record review, the facility failed to ensure that 4 of 4 residents who were assessed to smoke independently (Resident 30, 31, 24, and 20) had a designated safe location to smoke, fire-safe receptacle for disposal of cigarette butts, and a system in place to ensure smoking supplies were stored safely. In addition, the facility failed to ensure smoking evaluations were done timely for 1 of 1 sampled resident (Resident 22) reviewed for smoking. These failures, which were exacerbated by hotter than normal temperatures during fire season, placed the facility at risk for fire and all residents at risk for serious injury, harm or death and constituted an immediate Jeapordy (IJ). On 07/10/2024 at 1:58 PM, the facility was notified IJ was identified related to F689 CFR S483.25 Free of Accident Hazards/Supervision/Devices. The facility removed the immediacy on 07/10/2024 with an onsite verification by surveyours ensuring all residents that smoked had a smoking assessment completed, education was provided on the safe disposal of cigarette butts to staff and residents, and a receptacle for the disposal of the cigarette butts were provided. Findings included . According to the facility policy titled Smoking Campus Policy, dated 11/28/2017 and updated 7/10/2024, residents were unable to smoke on the facility premises. It documented at the time the facility went tobacco free, if there were current residents still smoking, the current residents were allowed to use tobacco or tobacco products in a designated area outside, weather permitting. These residents were required to have a smoking assessment completed to determine the level of supervision to be provided and interventions to mitigate the risk of injury. Additionally, a smoking assessment was not required if a resident did not smoke and the policy would be enforced by asking residents to immediately comply, assessing for distress, and storing any tobacco products or lighting material at the nursing station with the resident's consent. During the entrance conference meeting on 07/08/2024 at 9:04 AM, with Staff A, Interim Administrator, and Staff B, Director of Nursing (DON), when asked if the facility had residents who smoked, Staff B stated the facility was a non-smoking campus and residents who smoked were assessed on admission to ensure they were safe to smoke independently, and there were no designated smoking areas or times, since residents had to be independent to smoke. The facility had four residents who smoked (30, 31, 24, and 20). Record review showed the following residents all had smoking assessments completed on 05/30/2024. Additional information is as follows: *Resident 30, admitted [DATE], no admission smoking assessment completed, the only smoking assessment found was the assessment on 05/30/2024 *Resident 31, admitted [DATE], first smoking evaluation 01/03/2024 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	*Resident 24, admitted [DATE], no admission smoking assessment completed, the only smoking assessment found was the assessment on 05/30/2024 *Resident 20, admitted [DATE], no admission smoking assessment completed, first smoking assessment completed on 01/03/2024. <Observations> On 07/10/2024 at 8:28 AM, Resident 31 was observed leaning up against the telephone pole at the top of the facility driveway smoking. On 07/10/2024 at 11:15 AM, dry vegetation was observed at the end of the facility asphalt driveway, multiple cigarette butts were on the ground around the area, and a plastic garbage bin located by the facility front door contained paper, surgical masks, and approximately 50 cigarette butts. At 12:18 AM, discarded cigarette butts were observed lying in brown, brittle, dry grass in the facility front yard. At 12:18 PM, 3 cigarette butts were observed lying in brown, dry, grass by the facility sign, 2 cigarette butts were lying on the ground by the fence along the facility driveway (where resident 31 was observed smoking), and 5 cigarette butts were lying on the ground under a facility window in the garden area parking lot. Resident 20 was also observed at this time sitting on their walker on the sidewalk at the end of the facility driveway smoking. Review of the AccuWeather Forecast showed the outside temperature was 97 degrees Fahrenheit on 07/10/2024 and an extreme heat warning was in place. In addition, the Washington State Department of Natural Resources website, (https://fortress.wa.gov/dnr/protection/firedanger/) advised the risk of fire was high. In an interview on 07/10/2024 at 1:58 PM, with Staff A, Staff B, Staff C (Clinical Resource Nurse), and Staff O, Corporate Nurse, when asked about the lack of safe disposal of cigarette butts and potential risk for fire, Staff B stated residents needed to dispose of cigarettes safely and stated they did not have a means to do that. <Resident 22> Per the 07/09/2024 assessment Resident 22 was cognitively intact and able to direct their own care. They required assistance for transfers, and supervision when using their wheelchair, and had diagnoses which included stroke, and hemiplegia (one-sided weakness or paralysis). Review of Resident22's current physician orders, dated 01/23/2024, showed Varenicline Tartrate daily to decrease tobacco craving. Review of the care plan dated 7/10/2024, showed Resident 22 wished to smoke, was determined to be dependent and unsafe to smoke, and could not smoke while at the facility. A smoking evaluation dated 07/10/2024 by Staff B, documented Resident 22 had no independent smoking privileges allowed off premises due to safety concerns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A Progress note by Staff E, Social Services Director, dated 3/11/2024 documented Resident 22 was found outside smoking a cigarette and had already been advised by Staff B that smoking wasn't allow on the property. Additionally, the note documented Resident 22 wouldn't give their lighter to Staff E for safe keeping. A progress note by Staff B, dated 03/12/2024, documented on 3/11/24 Resident 22 was provided education regarding smoking. Staff B explained to Resident 22 the facility policy at that time, informed them they were not safe to take themself off the property to smoke, and that they would need to be evaluated to make sure were safe to smoke independently. Staff B then let Staff E know Resident 22 was not safe to have a lighter in their possession. Additional review of Resident 22's care plan found no documentation that a smoking evaluation had been completed. During an interview on 07/10/2024 at 9:55 AM, when asked if they smoked Resident 22 stated the last time, they smoked was about one month ago at a doctor's appointment. They stated they kept their cigarettes and lighter in their bag and proceeded to remove a lighter and sealed pack of cigarettes from their bag. During an interview on 07/16/2024 at 03:50 PM with Staff A, Staff O, and Staff C, Staff C stated they talked to Resident 22 about surrendering their cigarettes the prior week and Resident 22 became upset and stated they would keep them in their purse. When asked what process was place in ensure safety since the resident refused to give the facility their cigarettes and lighter Staff O stated it should have been added to the care plan for nurses to check each shift. In an interview on 07/22/2024 at 04:49 PM, Staff B stated a smoking evaluation and safety plan for Resident 22 should have been completed on 03/11/2024 when Resident 22 was identified as a smoker. Reference (WAC): 388-97-1060 3(g)

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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. 37544 Based on observation, interview, and record review, the facility failed to ensure staff obtained accurate and timely weights 1 of 3 sampled residents (Resident 1) reviewed for nutrition. In addition, the facility failed to ensure the physician was notified of a change in a resident's condition (Resident 17) that impacted their nutrition. These failures placed the residents at risk for unrecognized, unplanned, significant weight loss, and nutritional complications. Findings included . <Resident 1> The 05/10/2024 quarterly assessment documented Resident 1 had diagnoses which included dementia, malnutrition, depression, vascular dementia, nutritional deficiency, mild protein-calorie malnutrition. Review of Resident 1's nutritional care plan documented the resident had an increased nutritional risk and interventions were implemented on 11/14/2019. A revision on 12/04/2023 instructed nursing staff to weigh the resident weekly. On 02/22/2024, a nutrition progress note by Staff RR documented the resident weighed 129.4 pounds which was a significant weight gain of 19.4 pounds (lbs.) in 16 days, and a reweigh was requested as the weight was believed to be an error. On 03/05/2024, a second nutrition progress note by Staff RR again stated a requested a reweigh as the weight was up significantly from the resident's usual weight range. Review of Resident 1's record showed the resident's weigh on 02/19/2024 was 129.4 lbs. No documentation was found to show the resident had been reweighed as requested by Staff RR until 03/19/2024, almost a month after the initial request. The resident's weight at that time was 105.6 lbs. which was within their normal weight range. Additional review found the next documented weight was on 05/04/2024, 46 days after the last weight on 03/19/2024. The resident weight was 94 lbs., which was within their normal weight range. Following the weight on 05/04/2024, Resident 1 was being weighed weekly as care planned. In an interview on 07/19/24 at 2:24 PM, Staff B, Director of Nursing, stated residents are weighed weekly for three days when admitted , then weekly for four weeks and then monthly as a facility standard. Staff B further stated that if there were concerns identified or the resident was on certain medications, the physician may order additional weighs to be taken. After review of Resident 1 record, Staff B acknowledged, the resident had not been weighed consistently, and weekly as instructed in the nutritional care plan. 46115 <Resident 17> (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 04/29/2024 quarterly assessment, Resident 17 had diagnoses including malnutrition, depression and a stroke, was moderately cognitively impaired and was able to feed self. A review of the weights showed the following weights for Resident 17: -07/17/2024 135.2 pounds (lbs.), -06/11/2024 143 lbs., -04/17/2024 146.2 lbs., -01/27/2024 155.2 lbs., a 12.89% loss in 6 months, -7.52% in 3 months and -5.45% loss in 1 month According to the 01/25/24 care plan, Resident 17 had nutritional risks related to their stroke and swallowing difficulties and the goal for the resident was not to have any unplanned significant weight loss. The 02/19/2024 Nutritional evaluation documented Resident 17's average intake was 26-50% of meals and recommended that 1-3 teaspoons of margarine or sugar be added to each meal to promote adequate intake until Resident 17's intake improved. Further record review showed no documentation that the recommendation had been followed up on. A 06/25/2024 progress note documented Resident 17 had an 8.4% weight loss in 2 weeks related to recent acute changes in the resident's health. The resident had increased nausea that had started on 06/13/2024 and had been refusing meals and dietary supplements. Resident 17 had tested positive for COVID-19 (an acute respiratory illness caused by a virus, capable of producing severe symptoms and in some cases death, especially in older people and those with underlying health conditions) on 06/17/2024 and had been sent to the hospital for weakness and nausea. In an interview on 07/18/2024 at 11:09 AM, Staff B, Director of Nursing, stated interventions for weight loss were added based off the recommendations from the dietician. Staff B confirmed the recommendation to add margarine or sugar to Resident 17's diet order had not occurred. Staff B added if Resident 17 would have been offered and accepted the recommendation it may have helped their weight. During an interview on 07/17/2024 at 2:55 PM, Staff MM, Doctor, stated they were unaware Resident 17 had experienced nausea and was sent to the hospital. Staff MM stated if they would have been notified, they would have ordered labs and possibly changed the resident's medications. Staff MM added they were supposed to be notified of changes in the resident's condition by nursing staff and felt the nausea had impacted the resident's weight. In an interview on 07/19/2024 at 10:20 AM, Staff SS, Dietician, stated the butter and sugar was not enough to have impacted Resident 17's weight and felt the weight loss was related to COVID-19 and nausea. Reference: WAC 388-97-1060(3)(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46115 Based on observation, interview and record review, the facility failed to ensure that residents had current and complete oxygen orders and failed to ensure that oxygen equipment was maintained in a clean manner for 4 of 4 sampled residents (Resident 16, 39, 14, 27) reviewed for respiratory care. These failures placed the residents at risk for respiratory complications and infection. Findings included . A facility policy, dated 08/04/2023, titled Oxygen Therapy documented orders for oxygen were to be verified prior to initiating oxygen therapy. In addition, the policy documented to change disposable oxygen equipment routinely per manufacturer directives and PRN (as needed) soiling. <Resident 39> Per the 06/20/2024 quarterly assessment, Resident 39 had diagnoses which included COPD (a group of lung diseases that block airflow and make it difficult to breathe), chronic respiratory failure and needed oxygen due to those conditions. Review of the physician orders documented on 07/01/2024, the resident had been prescribed oxygen to maintain oxygen saturations between 88 and 98 percent, due to the diagnoses listed above, but did not contain the number of liters needed. The orders also documented to clean the oxygen concentrator filter weekly. On 07/08/2024 at 10:00 AM, Resident 39 was observed asleep in bed. An inspection of the oxygen concentrator in the resident's room showed the concentrator was unclean with thick dust. In an observation on 07/11/2024 at 10:28 AM, the cover of the oxygen filter was lying on the floor. The filter and inside where the filter was stored was covered in thick dust. During an interview on 07/11/2024 at 11:37AM, Staff U, Registered Nurse confirmed the filter was unclean with dust and needed to be cleaned. Staff U, added it was important to keep the filters cleaned as uncleaned filters can contribute to respiratory infections. During an observation and interview on 07/12/2024 at 8:47 AM, Resident 39's personal oxygen concentrator was in the red zone, meaning it was empty. The resident stated they could not feel any air and stated the tank needed to be changed and denied shortness of breath. In an observation on 07/16/2024 at 9:05 AM, the filter on the oxygen concentrator was clean but the area where the filter was stored was full of dust. During an observation on 07/17/2024 at 4:33 PM, Resident 39 was sitting in the hall and their personal concentrator was empty. The resident did not feel any air and denied being short of breath. The medication technician was asked to check the resident's oxygen concentration and it was 93 percent and they filled the tank. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/16/2024 at 12:24 PM, Staff B, Director of Nursing, stated the nurses would adjust the oxygen to keep it between the ordered levels and document what liters were used. Staff B added that oxygen filters were to be cleaned weekly and this was important as this was a risk for respiratory illnesses or an exacerbation of an underlying condition. 47728 <Resident 16> Per the 06/11/2024 assessment Resident 16 was cognitively intact, able to make their needs known, and had diagnoses including heart failure (a condition where the heart cannot pump blood as well as it should), asthma, and sleep apnea (a sleep disorder where breathing repeatedly stops and starts during sleep). A review of Resident 16's medical record documented no physician order or care planned interventions for oxygen, oxygen therapy, or maintenance and cleaning of the oxygen tubing and filters prior to 07/11/2024. During an observation/interview 07/09/2024 at 9:48AM, Resident 16 stated they had been using oxygen at night for about two weeks. In a concurrent observation, there was no label on the oxygen tubing, that indicated when it was last changed. Resident 16 stated they did not know if the tubing had been changed. The external filter of the oxygen concentrator (a medical device which provides extra oxygen by filter the surrounding air) was dusty with a visible thick whitish powder/residue. During an observation/interview on 07/11/2024 at 8:57AM Resident 16 stated the oxygen tubing was changed a couple days ago. Observation of the oxygen tubing showed it was not labeled with the date it was changed and the external filter on the oxygen concentrator was covered in heavy dust. During an interview on 07/11/2024 at 11:38 AM, Staff Z medication technician, stated they thought the aides changed the oxygen tubing if it needed to be changed but there was no set schedule, and the filters on the oxygen concentrators were cleaned every 2 weeks by the aides. In an observation/interview on 07/11/2024 at 11:42 AM, Staff Z, and Staff C, corporate Registered Nurse (RN) looked at the external filter on the oxygen concentrator and confirmed it was dirty then Staff C opened the filter compartment and removed the filter, which was covered in a thick layer of gray dust, and stated they were going to clean it In an observation on 07/11/2024 at 2:15PM the external filter on the oxygen concentrator had been changed but the filter compartment remained coated with dust. During an interview on 07/11/2024 at 2:03PM, Staff C stated the standard for the facility, for a resident using oxygen, was to have an order for weekly tubing and filter changes. Staff C also stated Resident 16 did not have a current order for oxygen and no order for changing the tubing and filter. In an interview on 07/16/2024 at 1:52PM, Staff R, Medication Technician stated resident 16 had been getting oxygen at night since they returned from a hospital stay, 06/06/2024. Staff R then accessed the resident chart and displayed the order for oxygen dated 7/11/2024. There were no other oxygen orders documented. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/22/2024 at 4:49PM, Staff B, director of Nursing stated the facility did not have an order for oxygen for Resident 16 when they initiated it. They stated the facility should have obtained an order for the oxygen before initiating it because it was important in ensuring all staff had the same instructions and to avoid complications <Resident 14> Per the 04/16/2024 comprehensive assessment, Resident 14 had diagnoses which included Post-Polio Syndrome (a neurological condition that causes gradual muscle weakness and loss of muscle tissue) circulation problems, lung disease, and needed oxygen due to those conditions. Review of the physician orders on the Medication Administration Records (MARS) from April 2024 to July 2024, documented Resident 14 was prescribed oxygen on 01/10/2024 to be used as needed, due to the lung conditions listed above. Another physician's order was documented for the resident's oxygen tubing, humidifier bottle and oxygen filter to be cleaned weekly. On 07/09/2024 at 11:10 AM, Resident 14 was observed wearing oxygen while in sitting in their chair during an interview. On 07/09/2024 at 11:37 AM, an inspection of the oxygen concentrator conducted in the resident's room showed the concentrator foam filter was unclean with visible thick and heavy dust. An observation of the Resident 14 wearing oxygen while in bed was made on 07/10/24 at 05:08 PM. A subsequent inspection of the oxygen concentrator on 07/11/2024 at 11:32 AM showed the foam and capsule filters were unclean with thick heavy dust and debris, as well as in the surrounding compartments. During an observation and interview on 7/11/2024 at 11:39 AM, Staff U, Registered Nurse, verified that the oxygen foam and capsule filters were unclean, coated with thick heavy dust and debris, as well as in surrounding compartmental areas. Staff U stated that the concentrator needed to be cleaned. On 07/11/2024 at 2:10 PM, another inspection of the concentrator was conducted showing new replacements of the foam and capsule filters, but the compartmental areas remained coated with heavy dust and debris. On 07/11/2024 at 2:22 PM, Staff U confirmed that that the oxygen concentrators are to be cleaned, including changing the filters every week as stated in the physician's order. Another observation of the resident wearing oxygen while in bed was made on 07/12/2024 at 01:31 PM. On 07/18/2024 at 11:28 AM, an observation and interview with Resident 14 was conducted. The resident was observed wearing oxygen while lying in bed. Resident 14 stated they were feeling short of breath and recently applied the oxygen. The foam filter on the concentrator was covered with thick heavy dust patches of frayed particle pieces. <Residents 27> (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the 07/01/2024 comprehensive assessment, Resident 27 had diagnoses which included acute respiratory failure (when the level of oxygen in the blood becomes dangerously low or the level of carbon dioxide becomes dangerously high) and needed oxygen due to that condition. Review of the Medication Administration Record (MAR) for July 2024 showed no documentation of physician orders for oxygen and routine oxygen tube changing. The care plan completed on 05/27/2024 had no documentation to provide interventions for respiratory care. On 07/09/2024 at 09:04 AM, Resident 27 was observed wearing oxygen while in their bed supplied by a concentrator. Per review of the progress notes, it was documented that Resident 27 was administered three liters of oxygen continuously on 07/01/2024 and 07/02/2024. On 7/11/2024 at 11:44 AM, an observation and interview were conducted. The concentrator was in Resident 27's room plugged in. The resident stated they were told by staff that they were no longer on oxygen. Subsequent observations were made of the Resident 27 with a portable oxygen tank on the back of their wheelchair on 7/11/2024 at 01:58 PM and 7/11/2024 at 04:49 PM. On 7/15/2024 at 7:06 AM, an observation of a portable oxygen tank was in the resident's room. On 7/15/2024 at 09:53 AM there was signage on Resident 27 door stating, Oxygen in Use. In an interview on 07/17/24 at 01:23 PM, Staff AA, Registered Nurse, stated that Resident 27 became short of breath approximately three weeks ago, in which they required oxygen. Reference: WAC 388-97-1060 (3)(j)(vi) 50027

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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. 50027 Based on observation, interview and record review, the facility failed to provide person-centered pain management for 1 of 2 sampled resident (Resident 294). Resident 294 was not offered pain medication and non-pharmacological pain interventions, non-pharmacological interventions were not documented when they were administered and failed to notify the physician and request additional pain management interventions. These failures placed the resident at risk for increased pain and decreased quality of life. Findings included . Per the 06/25/2024 comprehensive assessment, Resident 294 had diagnoses which included a stroke, sacral ulcer (pressure sore near the lower back and spine) and quadriplegia (paralysis of the arms and legs) due to a motor vehicle accident. In addition, the assessment showed the resident was cognitively intact to make decisions regarding their care, exhibited verbal and physical aggressive behaviors and was dependent for all cares. Review of the June 2024 and July 2024 Medication Administration Record (MAR) showed physician orders to administer scheduled Gabapentin (a seizure medication sometimes used for pain) 300 (milligrams) mg once a day in the morning. In addition, the physician also ordered Oxycodone (a narcotic used for moderate pain) 5 mg every six hours as needed and Baclofen (a medication that reduces pain and discomfort caused by muscle spasms) 5 mg every eight hours as needed. There was also a physician's order to document the resident's level of pain on a scale of 0 (no pain) to 10 (excruciating pain) at the beginning of every day and night shift. Review of the care plan completed on 06/18/2024 addressed Resident 294's chronic pain and documented pain medication interventions and non-pharmacological intervention, such as repositioning. Per record review on 07/11/2024, Resident 294's pain level was documented in the MARS to be generally higher (a pain level of 7 [severe] and above) during the night. There was no documentation found that showed the provider was contacted and what attempts were made to contact them. During an observation and interview on 07/08/24 10:45 AM, Resident 294 was observed sitting in their wheelchair, leaning to their right side with their head turned mostly to the right. When asked about their pain, the resident stated their pain was a 7 out of 10. Resident 294 stated that they were always in pain and stated their pain was not being managed at the facility. They stated that their bed was uncomfortable, and their feet pushed into the foot of the bed. During an interview on 07/11/24 09:43 AM, Resident 294 stated that their pain level was 7 out of 10. An observation was made of a new bed with a larger mattress. The resident stated that they received a new bed on 07/09/2024 and staff left them in the bed last night without assisting with repositioning. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview were conducted with Resident 294 on 07/12/2024 at 09:19 AM. They were covered in a blanket sitting in their wheelchair. The resident was short-tempered in their responses throughout the interview. The resident stated that they were not repositioned during the night. Resident 294 stated their pain level was currently 7 out of 10 and they were waiting for their next dose of pain medications. Their location of pain was in their back, neck, and buttocks. The resident stated within the first two hours after taking pain medications, their pain level is a 5/10 increasing to 7/10. The resident stated there was no response from the staff when they informed them that the pain medications were not lasting. During an interview on 07/12/24 at 01:33 PM, Resident 294 stated that their pain level was an 8 out of 10. They stated that they take Baclofen for pain, but it does not help. During an interview with Resident 294 on 07/16/2024 at 02:43 PM, they stated, I'm not doing good today, and that their pain level was at an 8 out of 10. The resident stated they told the staff and physician this date that they remain in constant pain. Per record review of a 30-day look back at the nursing bed repositioning monitoring task, from 06/18/24 to 07/18/2024, required staff to document the level of assistance for bed rolling. The resident was dependent on the staff to roll in bed every day, except for two days. There was no documentation of bed repositioning after 8:00pm for 13 days and before 7:00am for 15 days. During an observation and interview on 07/18/2024 at 3:01 PM, Resident 294 was sitting upright in their wheelchair and showed intense facial grimacing and arched their head back pressing into the headrest of their wheelchair. The resident stated that his pain level was 9 out of 10 and stated, Sometimes it [pain medication] works and sometimes it doesn't. Resident 294 indicated that they would desire to be at least at a pain level of 4 out of 10. During an interview on 07/18/24 at 4:10 PM, RN, Staff M, Registered Nurse, stated that Resident 294 constantly complained of pain. Staff M stated they consulted with the physician regarding changing the resident's prescription for Oxycodone to be a routine order instead of as needed. Staff M stated non-pharmacological interventions for pain included getting the resident a bariatric bed and air mattress and were not available within the facility until recently. On 07/19/24 at 09:37 AM, an observation and interview were conducted with Resident 294. The resident was sitting in their wheelchair dozing off listening to music. They stated their pain level was 7 out of 10 and did not remember when they had last taken their pain medication. Resident 294 stated that the staff usually tells them when their pain medications are due. During an interview on 07/22/2024 at 10:19 AM with Staff B, Director of Nursing Services and Infection Prevention, stated that the process for residents that have uncontrolled pain includes offering pain medications for control, monitoring changes in their medical condition, and conducting pain evaluations (including an assessment completed by the facility physician). Staff B stated they were aware that Resident 294 had a diagnosis of chronic pain, which is an indicator that their pain needs to be managed per the care plan. Staff B confirmed there was no documentation by the physician addressing Resident 294's pain. Staff B also confirmed nursing should have documented that Resident 294's pain was not being managed and notified the physician. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per review of the Physician's Communication Book on 07/22/2024 at 10:44 AM, an undated entry documented after 07/20/2024 requested the provider to review Resident 294's pain. Reference WAC 388-97-1060 (1)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 46115 Based on observation, interview, and record review, the facility failed to ensure 2 of 3 nursing assistants (Staff V,W) met competency requirements defined under State Law, for license and certification. This failure placed residents at risk to receive care from incompetent and unlicensed staff. Findings included: Record review of employee files on 07/22/2024 documented Staff V was hired as a nursing assistant on 04/01/2024. Documentation in the file revealed that Staff V had a nursing assistant license that was pending. Staff V was observed in the facility on 07/09/2024, 07/11/2024 and 07/16/2024 providing care and services to the residents. Record review of employee files on 07/22/2024 documented Staff W was hired as a nursing assistant on 05/01/2024. Documentation in the file revealed that Staff W had a nursing assistant license that was pending. Staff W was observed in the facility on 07/08/2024, 07/09/2024, 07/11/2024, 07/12/2024, and 07/13/2024 providing care and services to the residents. In an interview on 07/22/2024 at 2:30 PM, Staff X, Administrator from a sister facility, stated staff must have a nursing assistant certification before providing direct patient care. Reference: WAC 388-97-1660 (3)(a)(i)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 46115 Based on interviews and record review, the facility failed to ensure 5 of 8 sampled staff received mandated training on dementia and behavioral health. This failure placed the residents at risk for having unmet care needs and a diminished quality of life. Findings included . Review of competency training records for Staff W, Nursing Assistant, Staff BB, Cook, Staff JJ, Licensed Practical Nurse, Staff KK, Registered Nurse and Staff LL, Registered Nurse revealed they had not received any training on dementia and behaviors. During an interview on 07/22/2024 at 3:54 PM, Staff C, Clinical Resource Nurse, stated dementia and behavior training was important so that staff could meet the needs of the residents and should be offered to new employees and annually thereafter. Review of the 2024 Facility Assessment Tool provided by the facility documented training requirements included full time, part time and contracted staff. No Associated WAC

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 50846 Based on interview, observation and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 3 residents (Resident 28) Failure to assist with discharge planning placed resident at risk for a decreased quality of life. Findings included: The resident admitted to the facility in May 2023. Review of the Minimum Data Set (MDS) assessment, dated 04/30/2024, revealed they did not have any cognitive impairment. The MDS indicated resident 28 had behaviors, the facility coded her behaviors did not significantly intrude on the privacy or activity of others, and that the behaviors did not significantly disrupt care or living environment. The MDS indicated she was independent with Activities of Daily Living (ADL's) to include, bed mobility, transfers, locomotion on/off unit, dressing, toilet use and personal hygiene. On 07/08/2024 at 2:42pm, Resident 28 stated she would like to be living somewhere else. When asked if she was getting assistance with finding alternate placement, Resident 28 stated No. On 07/10/24 at 10:00am, Resident 28, observed walking in the facility hallways independently. She dropped off her laundry in front of the facilities laundry room door, went to the kitchen, got the food she requested and walked back to her room. On 07/11/2024 at 11:00am, Interview with Social Services, staff E, regarding discharge planning for Resident 28. Staff E stated, She does talk with her about discharging every day. She would like to discharge to the hotel. Resident has also requested to be discharged to the street. Functionally, she is independent with ADL's mental health issues interferes with her ability to live independently. Like an Adult family home she would be OK. I think she would be OK there. When asked for inquiries for alternate living arrangements, there was no documentation. When asked if the State Social Worker had been contacted to assist with discharge planning, Staff E, stated No, she had not talked with the State Social Worker about Resident 28's discharge. There was no level 2 PASRR completed to ascertain if specialized mental health services would be beneficial to ensure appropriate placement of Resident 28. On 07/16/2024, at 4:15pm, staff II, nursing assistant, stated resident is independent with her ADL's, except for bathing. On 07/16/2024 at 4:30pm, staff B, Director of Nursing, stated a Less restrictive environment, most definitely, she has not pushed for going anywhere else. A group home would be a good place for her. She is independent with a lot of her cares in her room. Reference WAC 388-97-0960(1)

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	505251	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colfax of Cascadia, LLC	1150 West Fairview Road Colfax, WA 99111

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46115 Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of timely, in accordance with currently accepted professional standards, in 1 of 1 medication storage rooms. The facility further failed to ensure narcotics were locked in a permanently affixed narcotic container in 1 of 1 medication storage room refrigerators. These failures placed residents at risk for receiving compromised or ineffective medication and placed the facility at risk for potential diversion or misappropriation of narcotic medications. Findings included . During an observation of the medication storage room on 07/15/2024 at 7:45 AM with Staff, AA, Registered Nurse (RN), the refrigerator contained influenza vaccines that had expired on 06/30/2024 and Tuberculin (used to check for tuberculosis) that was opened on 04/27/2024 and not discarded after 30 days as required. The medication refrigerator held a white box, which was used to store narcotic medication, and was not locked as required. During an interview on 07/22/2024 at 5:49 PM, Staff B, Director of Nursing, stated the vaccines and the Tuberculin should have been discarded as the effectiveness of the medications could have been altered. Staff B added the Ativan should have been in a locked container. <Undated Insulin> According to the American Diabetes Association, insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59 F and 86 F for up to 28 days and continue to work. During an audit of the 100-hall medication cart on 7/22/2024 at 4:28pm with Staff R, Medication Technician, an insulin pen (an injection device used to deliver preloaded insulin into the body) was observed to have been opened and it was not dated with the date it was opened or the discard date. In a concurrent interview Staff R stated they did not know when the insulin pen had been opened. In an interview on 07/22/2024 at 5:47 PM, Staff M, Registered Nurse (RN) stated insulin should be dated when opened and discarded after 30 days. They stated this was important because the insulin could be less effective after 30 days of being opened. Reference: WAC 388-97-1300 (2), 2340 47728

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728 Based on observation and interview the facility failed to ensure food was labeled, dated and covered, and expired food was discarded on or before the expiration date for 1 of 1 kitchen reviewed. Additionally, the facility failed to ensure staff wore beard covering while preparing and serving food. These failures resulted in risk of food borne illness and diminished quality of life for all residents. In an observation of the facility kitchen on [DATE] at 8:50 AM the following foods were noted in the refrigerators/freezers that were expired and/or past the use by date: -tortillas use by [DATE] -macaroni salad use by [DATE] -salsa use by [DATE] -strawberry yogurt with expiration date of [DATE] In addition, there were open packages of various berries that were not dated, uncovered celery in the refrigerator, and an open undated package of cooked eggs. During an observation of the resident nourishment freezer/refrigerator on [DATE] at 5:00 AM multiple open food packages were observed that were not labeled with a resident name and/or the date opened or use by date. In addition, the shelves in the refrigerator were dirty with debris on the bottom shelf, and standing liquid was present on the top shelf where food containers were placed. The seals on the freezer and refrigerator doors were both dirty with debris and spilled food/liquid. In an observation on [DATE] at 11:31 AM during lunch tray-line service, Staff BB, Cook, was serving food onto plates for residents and was not wearing a beard net. When asked, Staff BB, and Staff CC, Dietary Manager both stated they were told by the former dietician that Staff BB's beard was short enough that they did not need a beard net. Staff BB had a full beard approx. two inches long. At 11:41AM on [DATE], during lunch tray-line an observation was made of uncovered cottage cheese and pudding cups placed on lunch trays to be delivered to resident rooms. During an interview on [DATE] at 11:54 AM, Staff CC (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 1:14 PM Staff CC, Dietary Manager, stated the dietary manager was responsible for cleaning the resident's nourishment refrigerator and discarding expired food. Staff CC stated the nourishment refrigerator was cleaned once per week and checked Monday-Friday by the dietary manager and checked on weekends by the weekend dietary aide. They stated the refrigerator/freezer should not have spilled food or debris in them because it was not sanitary. When asked why the cottage cheese and pudding cups were not covered when placed on the meal trays, Staff CC stated they did not normally cover them and asked if they should. They then stated it was important to cover the food to prevent contamination. When asked how opened food should be stored Staff CC stated in a container with a lid, labeled with what the item was, the date it was opened and the date it should be used by. Reference: WAC [DATE](3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on observation, interview, and record review, the facility failed to ensure personal protective equipment (PPE) was implemented timely in accordance with the guidelines of the Centers for Disease Control (CDC) and the Local Health Department for the use of facial coverings after Resident 18 tested positive for COVID-19. This failure placed all residents and staff at risk for contracting COVID-19 (an acute respiratory illness caused by a virus, capable of producing severe symptoms and in some cases death, especially in older people and those with underlying health conditions). In addition, failure to ensure PPE was implemented for 2 of 4 sampled residents (Resident 13, 16) reviewed for Enhanced Barrier Precautions (EBP), failure to ensure resident 13's urinary catheter (a tube placed in the bladder to drain urine into a collection bag outside the body) was maintained in a sanitary manner, and failure to ensure hand hygiene was performed during the dining observation placed residents at risk for infection and diminished quality of life. Findings included . <Facial Coverings> According to the 06/24/2024 CDC publication, Infection Control Guidance: SARS-CoV-2, a barrier face covering, such as a surgical mask, and/or an N95 respirator, a particle filtering device worn over the mouth and nose, was recommended to be worn by healthcare providers when there were suspected or confirmed cases of SAR-CoV-2 (COVID-19), when other respiratory infections symptoms such as runny nose, cough or sneeze were present, or when there had been close contact or a high risk exposure to someone infected with COVID-19. In an interview on 07/17/2024 at 10:02 AM, Resident 41 stated their roommate, Resident 18, tested positive for COVID-19 at the hospital and tested negative here. Resident 41 stated the nursing staff would be testing them today. On 07/17/2024 at 10:04 AM, Staff AA, Registered Nurse, stated they were informed Resident 18 tested positive yesterday at an outside doctor appointment. Staff AA stated they retested the resident when they returned to the facility, and the test was negative, the resident had no symptoms, and the facility was monitoring (test) the resident on days three and five. On 07/17/2024 at 10:39 AM, a telephone call was placed to [NAME] County Public Health Department to inquire if the facility had notified them of Resident 18 testing positive for COVID-19 on 07/16/2024, while at an outside doctor appointment. Collateral Contact (CC1), Communicable Disease Registered Nurse, stated the facility had just had a COVID-19 outbreak recently, and they had not notified of any new positive cases. When asked what PPE and precautions the staff should be using, CC1 stated Resident 18 should be placed in isolation, retested on days one, three, and five, staff needed to wear an N95 and PPE when providing care for Resident 18, surgical masks should be worn by all staff while in the building, and the resident's room mate needed to be monitored for symptoms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 07/17/2024 at 10:53 AM found Resident 18 had not been placed in isolation, no signage was present on the door to inform staff of any PPE that was needed, nor had a PPE cart been placed with supplies outside the resident's door. In addition, none of the staff in the building were wearing surgical masks. In an interview on 07/17/2024 at 11:21, Staff B, Director of Nursing was asked about Resident 18's positive COVID status. Staff B stated because they did not know what type of test the clinic had done and the test done at the facility when the resident returned was negative, they considered the resident's COVID status as unknown. They were treating the resident as if they had been exposed, and Resident 18 would not be placed on precautions until direction was received from the Health Department. When asked if the facility had notified the Health Department, Staff B stated no. In an interview on 07/17/2024 at 11:56 AM, CC2, Charge Nurse Tri-State Same Day Procedure Unit, confirmed Resident 18 had tested positive for COVID-19 on 07/16/2024 while at the clinic and they had called the facility and informed Staff AA, Registered Nurse. Observations on 07/17/2024 at 1:05 PM, 1:48 PM, and 3:16 PM showed staff were still not wearing surgical masks, nor had Resident 18 been placed on isolation, or precautions implemented. In a follow-up interview on 07/17/2024 at 3:17 PM, CC1 stated the facility had notified them of Resident 18's positive COVID test, and the facility was told Resident 18 should be on isolation, retested on days one, three, and five, staff needed to wear an N95 and PPE when providing care for Resident 18, surgical masks should be worn by all staff while in the building, and the resident's roommate needed to be monitored for symptoms. A follow-up observation on 07/17/2024 at 3:17 PM found Resident 18 had been placed on isolation, a PPE cart was at the room entrance, and a sign had been posted to inform staff of the PPE needed, but staff working the building were not wearing surgical masks. On 07/18/2024 at 9:03 AM, observations showed staff were not wearing surgical masks while in the building. On 07/18/2024 at 9:27 AM, a telephone call was received from CC3, Director [NAME] County Public Health Department, to clarify to the survey team that they had recommended the facility implement the use of surgical masks for their staff after Resident 18 tested positive on Monday. Review of the email correspondence between CC3 and Staff B, showed on 07/18/2024, Staff B had communicated with the [NAME] County Health Department and at 9:57 AM, CC3 responded with the following Department of Health and CDC guidance related to Resident 18's positive COVID-19 status: - Isolate the resident and have them wear a surgical mask. - The resident needed to be retested at days one, three, and five, and with negative results was to be taken out of isolation. - The proper state signage needed to be placed on the resident's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- For the resident's roommate, it was recommended that they wear a surgical mask. They do not need to be tested unless they develop symptoms. - All staff entering the resident's room must wear an N95 mask and gloves. - It was a CDC recommendation that all staff in the building wear surgical masks as part of spread prevention. In an observation on 07/18/2024 at 10:06 AM, staff working in the building were now wearing surgical masks, two days after Resident 18 tested positive for COVID-19. 46115 <Enhanced Barrier Precautions> According to the 04/02/2024 Centers of Disease Control publication, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care areas and indicated for residents with urinary catheters. On 07/11/2024 at 2:49 PM, Staff AA, Registered Nurse, observed Resident 13's colostomy bag and removed the dependent loop from their catheter and was not wearing a gown. On 07/11/2024 at 3:13 PM, Resident 13 did not have an enhanced barrier precautions sign on the door and did not have personal protective equipment (PPE) that was accessible near the room. During an observation on 07/15/2024 at 9:51 AM, Staff Z, Nursing Assistant and Staff GG, Nursing Assistant entered room [ROOM NUMBER] to assist the resident with repositioning, neither of them had worn a gown. In an interview on 07/16/2024 at 2:50 PM, Staff Z stated if a resident was on precautions there would be a sign on the outside of their door and a gown and gloves would needed to be worn during cares. Staff Z added that Resident 13 had wounds and a urinary catheter. Staff Z was unsure if they should have worn a gown to reposition and move the resident's catheter to the opposite side of the bed. During an interview on 07/16/2024 at 2:54 PM, Staff C, Clinical Resource Nurse, stated Resident 13 should have had a sign on their door for enhanced barrier precautions and a gown should have been worn during cares. Staff C added this was important to prevent the potential for increased risk of bacterial infections related to open wounds and the urinary catheter. In an interview on 07/18/2024 at 12:16 PM, Staff B, Director of Nursing, stated Resident 13 should have had enhanced barrier precautions in place and staff should have worn a gown when cares were provided. <Resident 16> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per the 06/11/2024 assessment Resident 16 was cognitively intact, was incontinent of bowel and bladder, was dependent on staff for activities of daily living (ADLs) such as bathing, personal hygiene, and transfers, and had diagnoses including diabetes, and a pressure wound. During an observation on 07/15/2024 at 09:41 AM, Staff AA, Registered Nurse (RN) performed wound care for Resident 22 on open wounds on the resident's buttocks and back of the left thigh. Staff AA was not wearing a gown while performing wound care. On 7/15/2024 at 10:00 AM Resident 22 did not have an enhanced barrier precautions sign on the door and did not have personal protective equipment (PPE) that was accessible near the room. In an interview on 07/18/2024 at 2:08 PM, Staff Q, Nursing Assistant, stated they had received Enhanced Barrier Precautions (EBP) education and EBP consisted of wearing a gown, gloves, and mask, and should have been implemented when a resident had a catheter, and/or open wounds. During an interview on 07/18/2024 at 12:16 PM, Staff B, Director of Nursing, stated the expectation for a resident with a wound was to have EBP implemented and if staff was performing wound care they should have worn a gown, gloves, and mask to protect the resident and themself. <Urinary Catheter> According to the 05/27/2024 quarterly assessment, Resident 13 had diagnoses which included neurogenic bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems) and was moderately cognitively intact and able to direct their care. The resident required total assistance for activities of daily living such as toileting and had a catheter. During an observation on 07/08/2024 at 2:38 PM, Resident 13 was observed lying in bed, and their catheter was lying on the floor without a cover over it. In an observation on 07/15/2024 at 4:26 AM, the resident was observed lying in bed, and their catheter was lying on the floor without a cover over it. During an observation on 07/17/2024 at 8:53 AM, the resident was lying in bed and the catheter was on the bed, the same level as the bladder, which prevents the urine from draining into the collection bag and can cause a urinary tract infection. During an interview on 07/16/2024 at 2:12 PM, Staff B, Director of Nursing, stated the catheter needed to be changed if it was on the floor. In an interview on 07/17/2024 at 8:56 AM, Staff B confirmed the catheter was at the same level as the bladder and needed to be lowered. 47728 <Hand Hygiene> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per the 07/09/2024 assessment Resident 22 was cognitively intact, was incontinent of bowel and bladder, was dependent on staff for activities of daily living (ADLs) such as bathing, toileting, and personal hygiene and had diagnoses including stroke, and hemiplegia (one-sided weakness or paralysis). During an observation of personal care on 07/22/2024 at 12:54 PM, Staff II, Nursing Assistant (NA), and Staff Z, Medication Technician (MT), provided perineal care (cleaning of the genitals and anal area) for Resident 22. While Resident 22 was lying on their back on the bed, Staff II donned gloves and using a wet wipe performed perineal care then rolled the resident onto their left side. Staff Z then, wearing gloves and using wet wipes, proceeded to carry out the perineal care for the resident. Staff II, after removing their gloves and before performing hand hygiene, proceeded to touch their surgical mask, and Staff Z, after removing their gloves and before performing hand hygiene, proceeded to adjust the bed and place pillows under and around the resident In an interview on 07/22/2024 at 1:07 PM, Staff II (NA) stated hand hygiene should have been done between glove changes and acknowledged they should have performed it after removing their gloves and before touching anything else to prevent infection. During an interview on 07/22/24 at 1:39 PM, Staff Z, MT stated hand hygiene should be performed before putting on gloves, after removing gloves, and between gloves changes, to prevent the spread of bacteria. They stated they should have performed hand hygiene after removing their gloves and before adjusting the resident's bed. Reference (WAC): 388-97-1320 (2)(b),(c)