

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Burien		STREET ADDRESS, CITY, STATE, ZIP CODE 1031 Southwest 130th Street Burien, WA 98146	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &lt;Resident 78&gt;</p> <p>According to the [DATE] admission MDS Resident 78 had intact memory and admitted to the facility on [DATE].</p> <p>Record review showed no AD documentation in Resident 78's chart. There was no documentation to demonstrate the facility offered Resident 78 assistance to formulate an AD.</p> <p>In an interview on [DATE] at 12:43 PM Staff F stated there should be a signed acknowledgement form on file showing Resident 78 was offered AD formulation assistance. Staff F stated they would look into the matter and provide whatever documentation they found. No further documentation was provided.</p> <p>REFERENCE: WAC 388-97-0280(3)(c)(i-ii).</p> <p>Based on interview and record review the facility failed to obtain and/or renew guardianship papers, and/or failed to provide assistance in the formulation of an Advanced Directive (AD - a document describing a resident's wishes for care if they became incapacitated) for 4 of 7 residents (Residents 42, 78, 3, & 27) reviewed for guardianship/advance directives. This failure left residents at risk for losing the right to have their preferences and choices honored during emergent and end-of-life care.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 2001 AD policy, when a resident admitted the facility would inquire as to their AD status. The policy showed if the resident did not have an AD, the facility would offer assistance to formulate one. If the resident had one or more ADs, the facility would obtain copies to place in the resident's record. The policy did not address the maintenance of guardianship papers.</p> <p>&lt;Resident 42&gt;</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to a [DATE] Significant Change Minimum Data Set (MDS - an assessment tool), Resident 42 had severe memory impairment and multiple medically complex diagnoses including a stroke, dementia (a progressive impairment of memory and abstract thinking), and end-stage kidney disease. This MDS showed Resident 42 had a life expectancy of less than six months and required hospice (specialized care for individuals with a life expectancy of six months or less) services.</p> <p>Review of Resident 42's revised [DATE] AD Care Plan (CP) showed the resident had a legal guardian and indicated Resident 42 did not have the capacity for decision making regarding their healthcare. This CP gave directions to staff to review the ADs with the resident/family and legal guardian quarterly and as needed.</p> <p>Record review showed [DATE] guardianship court papers on file. These papers indicated they were only effective until [DATE], almost one year prior. No further guardianship paperwork was present in Resident 42's records.</p> <p>In an interview on [DATE] at 11:00 AM, Staff F (Social Services Director) stated it was their expectation guardianship papers were uploaded timely and not expired. Staff F stated it was important for ADs to be in place, in case something happened, and a resident could no longer make decisions on their own behalf. Staff F reviewed Resident 42's records and stated their guardianship papers were expired.</p> <p>&lt;Resident 3&gt;</p> <p>According to the [DATE] Quarterly MDS Resident 3 had severely impaired memory.</p> <p>Review of Resident 3's record showed the provider signed a Capacity for Medical Decision form on [DATE] indicating Resident 3 was not capable of making their own medical decisions.</p> <p>Review of Resident 3's record showed an [DATE] letter of guardianship. This letter showed it was effective until [DATE]. There was no current guardianship documentation.</p> <p>In an interview on [DATE] at 8:09 AM, Staff F reviewed Resident 3's record and stated their guardianship papers were expired. Staff F stated the facility did not have current guardianship papers on file for Resident 3.</p> <p>&lt;Resident 27&gt;</p> <p>According to the [DATE] Annual MDS Resident 27 had impaired memory.</p> <p>Review of Resident 27's record showed a provider signed a Capacity for Medical Decision form on [DATE] showing Resident 27 was not capable of making their own medical decisions.</p> <p>Review of the revised [DATE] AD CP showed Resident 27 did not have the capacity for decision making. This CP showed Resident 27's legal guardianship documentation expired and instructed staff to keep copies of guardianship documents in Resident 27's record.</p> <p>Review of Resident 27's record showed a [DATE] letter of guardianship that expired on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 27's 2024 and 2025 clinical record showed no current guardianship paperwork.</p> <p>In an interview on [DATE] at 8:15 AM Staff F stated they did not have any current guardian paperwork for Resident 27.</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide required liability notices for 1 of 3 residents (Resident 83) reviewed for liability notices. Failure of the facility to issue a Notification of Medicare Non-Coverage (NOMNC - a notification informing Medicare beneficiaries that their covered services will be terminated and provides information on their appeal rights) before Resident 83 was discharged from the facility, placed the resident at risk for not fully understanding their Medicare benefits and appeal rights.</p> <p>Findings included .</p> <p>&lt;Resident 83&gt;</p> <p>Record review showed Resident 83 was admitted to the facility on [DATE] and was discharged home on [DATE]. Resident 83's record showed the facility did not document they provided a NOMNC letter to Resident 83.</p> <p>Resident 83's record showed the facility provided a Nursing Home Transfer or Discharge notice to the resident on 01/25/2025. This notice showed the reason for the discharge was Resident 83's health was improved and they no longer needed the services provided by the facility.</p> <p>The 01/26/2025 Nursing progress note showed the facility's social service department arranged for Resident 83 to discharge home with home health, including physical and occupational therapy. The nursing note showed the facility provided medications and discharge papers to Resident 83 to go home with. There was no documentation showing that the facility provided a NOMNC letter to the resident.</p> <p>In an interview on 05/15/2025 at 2:59 PM, Staff F (Social Services Director) reviewed Resident 83's record and stated they did not provide a NOMNC letter to Resident 83. Staff F confirmed Resident 83 did not leave the facility against medical advice. Resident 83 was not available for the interview at this time.</p> <p>Reference: WAC 388-97-0300(1)(e),(5),(6).</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a homelike environment for 5 of 5 units. The failure to ensure residents' windows were free of missing blind panels, resident rooms were free of wall scrapes, and handrails in hallways were in good repair left residents at risk for a diminished sense of privacy, and a less than homelike environment.</p> <p>Findings included .</p> <p>&lt;Handrails&gt;</p> <p>Observation of the facility's hallways on 05/13/2025 from 12:51 PM through 12:54 PM showed the handrail in the central hallway was missing the end piece. This left a sharp edge on the rail and not looked homelike rail. The handrail outside room [ROOM NUMBER] and room [ROOM NUMBER] were also missing their end pieces, were with sharp edges and did not look homelike handrails .</p> <p>&lt;Wall Gouges&gt;</p> <p>Observation on 05/12/2025 at 8:47 AM showed the wall behind the resident's bed in room [ROOM NUMBER]-2 had deep gouges that exposed drywall.</p> <p>Observation on 05/13/2025 at 9:52 AM showed the walls of room [ROOM NUMBER]-2 were scuffed, with gouges that exposed drywall.</p> <p>Observation of room [ROOM NUMBER]-2 on 05/13/2025 at 1:52 PM showed the wall by the window had significant gouging that removed paint and exposed drywall.</p> <p>Observation of room [ROOM NUMBER]-2 on 05/13/2025 12:54 PM showed several areas of the wall were not painted, including around the window.</p> <p>Observation of room [ROOM NUMBER]-2 on 05/13/2025 at 12:39 PM showed the wall was scuffed under window, leaving exposed drywall. The material cover of the chair in the room was torn.</p> <p>&lt;Blinds&gt;</p> <p>In an interview on 05/13/2025 at 12:45 PM Resident 74 expressed frustration the blinds of their window were missing vertical panels. Resident 74 stated this affected their sense of privacy. Resident 74's blinds were noted to miss several panels.</p> <p>Observations on 05/19/2025 from 9:21 AM to 9:28 AM showed vertical blind panels were missing in Rooms 21, 25, 48, and 50. In room [ROOM NUMBER] one vertical panel was broken. In room [ROOM NUMBER] one vertical panel was 3-4 inches shorter than the others and did not look homelike.</p> <p>&lt;Interview&gt;</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During environmental round on 05/23/2025 at 3:04 PM, Staff H (Maintenance Director) stated it was important to maintain a homelike environment for the facility's residents. Staff H stated keeping the facility clean and in good repair was important and confirmed the handrails, walls, and blinds needed to be repaired.</p> <p>REFERENCE: WAC 388-97-0880.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on observation, interview, and record review the facility failed to initiate, investigate, and resolve a grievance for 1 of 1 sampled residents (Resident 44) reviewed for grievances. This failure placed residents at risk for emotional distress and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's January 2017 Grievance Policy, informal concerns should be forwarded verbally to the Grievance Official or a department supervisor. This person should then contact the resident with the concern, and the concerned resident had the right to obtain a written decision on the grievance if they chose. This policy showed immediate action would be taken to prevent any potential violations of resident rights.</p> <p>&lt;Resident 44&gt;</p> <p>According to the 02/25/2025 Annual Minimum Data Set (MDS - an assessment tool) Resident 44 had clear speech and was able to make themselves understood. The MDS showed Resident 44 had a moderate memory impairment and demonstrated no behavior.</p> <p>In an interview on 05/14/2025 at 12:51 PM Resident 44 stated they were having a bad day. Resident 44 stated they told their caregiver someone took their personal gallon bottle of hand soap and replaced the soap with a pack of wipes only. Resident 44 stated they did not feel clean with using the wipes for hygiene and was upset. Resident 44 stated someone took their soap a couple of days ago and no staff offered to help them fill out a grievance form. No gallon bottle of hand soap was observed in the room at this time.</p> <p>During observations on 05/14/2025 at 1:05 PM, Resident 44 was heard reporting their missing soap concerns to Staff P (Licensed Practical Nurse), who told the resident they could offer them wipes. Resident 44 stated they wanted the soap to wash their hands and stated for two days I have had dirty hands. Resident 44 stated they wanted to know who took the soap.</p> <p>In an interview on 05/16/2025 at 10:41 AM Resident 44 stated they were irritated because staff now took their washcloth, and they still did not hear back regarding their hand soap. Resident 44 stated a family member bought the soap and would be looking for it when they visited.</p> <p>In an interview on 05/16/2025 at 11:00 AM, Staff F (Social Services Director) stated paper grievances were stored in a binder in the administrator's office. Staff F stated if they heard of a resident grievance (including a missing item) they completed a form and took it to the administrator. Staff F said if the issue was not resolved the facility needed to replace the item. Staff F stated they expected a grievance form to be completed by facility staff if a resident raised a concern verbally. Staff F stated missing property should be resolved timely.</p> <p>In an interview on 05/19/2025 at 12:36 PM Resident 44 stated their soap was still not returned to them and they had not received any updates.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/19/2025 at 1:08 PM Staff D (Resident Care Manager) stated when staff learned of a missing item for a resident they should immediately start a grievance form. Staff D stated they were unaware of Resident 44's missing bottle of hand soap.</p> <p>In an interview on 05/19/2025 at 1:40 PM Staff P stated when a resident reported a missing item, they verify with the resident what was missing, when it was last seen, and inform the laundry department, they let the Social Services department know and complete a grievance form. Staff P stated they knew a bottle of sanitizer was removed from Resident 44's room, but they were unsure by whom. Staff P stated they explained to Resident 44 they could not keep sanitizer in their room, offered wipes as an alternative, and did not know Resident 44 had further concerns. Staff P stated they regarded this a safety issue rather than a grievance, so they did not process it as a grievance.</p> <p>In an interview on 05/19/2025 at 1:4 PM Staff D stated they would expect a nurse to begin the grievance process when a resident complained of a missing item.</p> <p>Review of an updated grievance log on 05/19/2025 showed no grievance was documented for Resident 44.</p> <p>In an interview on 05/19/2025 at 2:37 PM, Staff A (Administrator) stated they were the facility's Grievance Officer. Staff A stated their expectation when a resident brought forward a concern or grievance was for a resolution within five days. Staff A stated they expected staff to report to their manager when they learned of a grievance and offer to start a grievance form. If the resident stated a formal grievance process was not necessary, that would be documented. Staff A stated it was important to resolve grievances timely so the facility felt homelike to its residents.</p> <p>REFERENCE: WAC 388-97-0460.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure level I Preadmission Screening and Resident Reviews (PASRRs - a mental health screening required to be completed prior to admission to a skilled nursing facility) were accurate prior to admission for 2 of 7 residents (Residents 50 & 133). These failures placed residents at risk for inappropriate placement, unmet mental health needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's July 2024 PASRR policy, all newly admitting residents would have a Level I PASRR screening prior to admission to the facility. The policy showed all potential admissions identified with a positive Level I PASRR must be evaluated by the state authority through the Level II process and be approved for admission prior to admitting.</p> <p>&lt;Resident 50&gt;</p> <p>According to a 01/23/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 50 had multiple medically complex diagnoses including anxiety, depression, and Post Traumatic Stress Disorder (PTSD), and required the use of psychotropics (medications that affect mental function, mood, and behavior).</p> <p>Record review showed Resident 50 admitted to the facility on [DATE] from the hospital with a 01/14/2025 Level I PASRR. Section 1 of this PASSR showed the resident was marked as having no Serious Mental Illness (SMI) indicators. The last section of the form showed Resident 50 did not require a level II evaluation as they did not show indicators of an SMI. Review of the 01/17/2025 Clinical Summary hospital record showed Resident 50 actively received psychotropic medications and had SMI indicators prior to and upon admission to the facility.</p> <p>In an interview on 05/19/2025 at 12:11 PM, Staff F (Social Services Director) stated accurate Level 1 PASRRs were important as they defined what mental health services a resident would be provided based on the resident's mental health. Staff F stated it was their expectation a Level 1 PASRR would be accurate upon admission to the facility and stated the admissions coordinator was responsible for obtaining them prior to admission.</p> <p>In an interview on 05/22/2025 at 12:00 PM, Staff L (Admissions Coordinator) stated they were responsible for checking and obtaining the Level 1 PASRR prior to a resident's admission to the facility. Staff L stated it was their expectation a Level 1 PASRR was accurate, and if the resident had an SMI, a Level 2 evaluation would be completed prior to admission to the facility. Staff L reviewed Resident 50's admission Level 1 PASRR and stated it was inaccurate.</p> <p>&lt;Resident 133&gt;</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the 05/07/2025 admission MDS, Resident 133 had a moderate memory impairment and admitted to the facility on [DATE]. The MDS showed Resident 133 had a diagnosis of depression and took an antidepressant medication.</p> <p>Review of the 05/01/2025 Level I PASRR showed Resident 133 had no Serious Mental Health (SMI) indicators. This PASRR did not include Resident 133's depression diagnosis.</p> <p>In an interview on 05/19/2025 at 12:22 PM Staff F stated it was the facility's responsibility to review the Level I PASRR completed by the hospital for accuracy. Staff L stated the 05/01/2025 Level I PASRR lacked Resident 133's depression diagnosis and was inaccurate.</p> <p>REFERENCE: WAC 388-97-1915 (1)(2)(a-c).</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure residents were offered the opportunity to participate in a care conference for 2 (Residents 24 & 183) of 21 sample residents whose Care Plans (CPs) were reviewed, and failed to ensure resident CPs were updated as needed for 2 (Residents 22 & 48) of 21 sample residents. These failures placed residents at risk for unmet care needs, and frustration.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 2001 comprehensive, person-centered CP policy, the facility would, in conjunction with the resident and their family or legal representative, develop a comprehensive CP for each resident. The policy showed residents would be informed of their right to, and be provided with, advanced notice of care planning conferences. The policy showed assessment of residents was ongoing and CPs should be revised as needed with changes.</p> <p>&lt;Care Conferences&gt;</p> <p>&lt;Resident 24&gt;</p> <p>According to a 03/27/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 24 had no memory impairment, clear speech, was able to understand and be understood by others.</p> <p>In an interview on 05/12/2025 at 9:04 AM, Resident 24 stated they did not recall having any recent care conferences with staff to discuss their CP and goals.</p> <p>Record review showed a 01/07/2025 care conference evaluation signed as complete on 01/24/2025. No other care conference documentation was found after that date in Resident 24's records.</p> <p>In an interview on 05/19/2025 at 12:00 PM, Staff F (Social Services Director) reviewed Resident 24's records and confirmed Resident 24 should have, but did not have a care conference around the end of March 2025 when their MDS and CP were updated.</p> <p>&lt;Resident 183&gt;</p> <p>According to a 05/06/2025 admission MDS, Resident 183 was admitted to the facility on [DATE] with clear speech, and was able to understand, and be understood by others.</p> <p>In an interview on 05/13/2025 at 11:09 AM, Resident 183 stated they were frustrated and felt they were dumped at the facility and staff started feeding them pills. Resident 183 did not remember meeting with staff for a care conference after admission.</p> <p>Record review showed no care conference documentation in Resident 183's records.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/16/2025 at 6:55 AM, Staff D (Resident Care Manager - RCM) stated the process for care conferences was to include residents and/or their family in the care planning process and were to be completed within the first three days of admission and then quarterly thereafter, or as needed with changes.</p> <p>In an interview on 05/19/2025 at 12:00 PM, Staff F reviewed Resident 183's records and confirmed the resident should have, but did not have a care conference after their admission as required.</p> <p>&lt;Care Plan Revision&gt;</p> <p>&lt;Resident 22&gt;</p> <p>According to a 04/23/2025 Quarterly MDS, Resident 22 used a walker and a wheelchair for mobility and required partial assistance from staff to transfer to a chair. This MDS showed Resident 22 only received splint or brace assistance once during the seven-day assessment period.</p> <p>Review of a 04/24/2025 restorative progress note showed staff documented Resident 22's splint was discontinued due to the resident's continued removal of, and refusals to wear the splint.</p> <p>Record review showed the revised 12/12/2024 restorative program CP still identified a goal for Resident 22 to continue to wear their splints comfortably and without complication. Staff did not identify Resident 22's refusals to wear the splints or update and revise the goal after the splints were discontinued.</p> <p>In an interview on 05/19/2025 at 1:08 PM, Staff D stated their expectation was for staff to update and revise CPs with changes to make sure the CP reflected the resident's current condition. Staff D stated Resident 22's CP should have been but was not updated to reflect the resident's splint refusals&lt;Resident 48&gt;</p> <p>According to the 05/01/2025 Significant Change MDS, Resident 48 was admitted to the facility on [DATE], had diagnoses including an enlarged prostate and had an indwelling catheter (a small flexible tube inserted into the bladder through the urethra to drain urine).</p> <p>Observations on 05/12/2025 at 10:23 AM, 05/13/2025 at 1:17 PM, and on 05/15/2025 at 9:34 AM showed Resident 48 was lying in their bed with an indwelling urinary catheter in place. In an interview on 05/15/2025 at 9:34 AM, Resident 48 stated they had an indwelling catheter in for a long time because they could not urinate on their own.</p> <p>Review of the physician orders showed a 04/25/2025 order directing the nursing staff to provide indwelling catheter care every shift to Resident 48 and change the catheter as needed.</p> <p>Review of the revised 05/08/2025 Alteration in Elimination CP showed Resident 48 had a suprapubic catheter (a different type of catheter that drains urine through a whole in the lower abdomen rather than the urethra) and instructed staff to provide suprapubic catheter care per facility protocol, rather than an indwelling catheter.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/19/2025 at 12:42 PM, Staff D (RCM) reviewed Resident 48's record and confirmed Resident 48 had an indwelling catheter. Staff D stated the CP was not accurate. Staff D stated they expected CPs to be accurate so the staff could provide better care for the residents.</p> <p>REFERENCE: WAC 388-97-1020 (2)(f), (4)(b), -1020 (5)(b).</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** &lt;Resident 44&gt;</p> <p>According to a 02/25/2025 Annual MDS, Resident 44 had clear speech and was able to understand, and be understood by others. This MDS showed Resident 44 required substantial assistance from staff to stand, needed set up assistance for personal hygiene, and had no rejection of care during the assessment period.</p> <p>Review of a revised 09/20/2024 Self Care Performance CP showed Resident 44 had limited mobility related to weakness and impaired balance. This CP gave directions to staff to provide physical assistance with shaving.</p> <p>Observations on 05/12/2025 at 1:58 PM showed Resident 44 with a patch of long hairs on their chin. In an interview at this time, Resident 44 stated they liked to have their chin shaved so it felt smooth. Resident 44 stated they could tell when their chin hair grew out and indicated in the past staff assisted them to shave. Resident 44 was observed two days later, on 05/14/2025 at 12:51 PM with the same unshaven chin hair.</p> <p>Review of Resident 44's May 2025 ADL documentation from 05/01/2025-05/19/2025, showed staff documented they provided shaving daily during that time.</p> <p>In an interview on 05/19/2025 at 10:41 AM, Staff N (CNA) stated they were expected to provide assistance with shaving, if required, any time a resident was observed with hair growth. Staff N stated shaving should not only be done on shower days. Staff N stated they did not notice Resident 44 had hair growth during the current shift and did not offer to assist with shaving.</p> <p>Observation on 05/19/2025 at 12:36 PM showed Resident 44 with new hair growth on their chin. In an interview at that time, Resident 44 stated they were shaved once but not shaved once but their chin hairs regrew as they did not get assistance to shave since.</p> <p>In an interview on 05/19/2025 at 1:08 PM, Staff D (Resident Care Manager) stated it was their expectation staff provide shaving assistance as needed every shift when they saw hair growth. Staff D stated personal hygiene was important for residents to feel good about themselves and how they look. Staff D stated Resident 44 should have but was not provided shaving assistance daily as directed on their ADL records.</p> <p>REFERENCE: WAC 388-97-1060(2)(c).</p> <p>Based on observation, interview, and record review the facility failed to assist residents with Activities of Daily Living (ADLs - personal hygiene, grooming, bathing, eating etc.) for 2 of 6 residents (Residents 70 & 44) reviewed who were assessed to be dependent on staff for ADLs. The failure to provide ADL assistance to dependent residents as required left residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's 03/2018 revised Supporting ADLs policy showed residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. This policy showed if residents with an impaired ability to think or memory loss disorders resisted care, staff should attempt to identify the underlying cause of the problem and not assume the resident rejected care. This policy showed staff should reapproach the resident or have another staff member offer the care needed.</p> <p>&lt;Resident 70&gt;</p> <p>According to the 04/22/2025 Significant Change Minimum Data Set (MDS - an assessment tool) Resident 70 readmitted to the facility on [DATE] after a fall with a right arm fracture. The MDS showed Resident 70 did not reject care during the assessment period. The MDS showed Resident 70 was dependent on staff for toileting, transferring, personal hygiene including shaving, oral care and bathing.</p> <p>According to the 04/21/2025 revised ADL Self Care Deficit Care Plan (CP) Resident 70 was non-weight-bearing on their right arm and required one-person physical assistance for dressing, transferring from the bed to a wheelchair, and personal hygiene including brushing hair, brushing teeth, and shaving. The CP directed staff to assist the resident to get up in their wheelchair for all meals and report refusals to a licensed nurse.</p> <p>Observations on 05/12/2025 at 2:09 PM and on 05/14/2025 at 8:40 AM showed Resident 70 lying in their bed, dressed, and with facial hair.</p> <p>In an observation and interview on 05/14/2025 at 10:47 AM, Resident 70 was in their wheelchair in front of the nursing station,with obvious facial hair. When asked if staff offered them assistance to shave their facial hair, Resident 70 stated, No. I used to do everything but not anymore since I broke my arm</p> <p>In multiple observations on 05/15/2025 at 8:21 AM, 10:50 AM, and at 12:51 PM, Resident 70 was in their bed in a hospital gown. Resident 70 stated they waited for staff to dress them and get them in their wheelchair for lunch, but it did not happen.</p> <p>In an interview on 05/15/2025 at 1:07 PM, Staff P (Licensed Practical Nurse) stated Resident 70 needed assistance with all ADLs including getting out of bed. Staff P stated they did not get a report from staff that Resident 70 refused care that morning.</p> <p>In an interview on 05/15/2025 at 1:13 PM, Staff O (Certified Nursing Assistant - CNA) stated they did not shave Resident 70 that morning or dress them. Staff O stated they should provide morning care to Resident 70 and get them up in their wheelchair for meals, but they did not.</p> <p>In an interview on 05/16/2025 at 12:02 PM, Staff B (Director of Nursing) stated they expected staff to provide morning care to every resident including oral care, shaving, dressing, and getting them in their wheelchair as residents allowed, but did not.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>Based on observation, interview, and record review the facility failed to ensure 1 of 2 residents (Resident 24) reviewed for vision and hearing services received the care and services they required to maintain their vision. The failure to provide follow through with a needed follow up appointment placed Resident 24 at risk for worsening vision, and frustration.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 2001 Sensory Impairment policy, the physician would identify and order the appropriate consultations needed to help manage the causes, complications, and risks for residents with sensory impairments.</p> <p>&lt;Resident 24&gt;</p> <p>According to a 03/27/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 24 had multiple medically complex diagnoses including a stroke with cortical blindness (a condition with loss of vision due to damage in the visual processing areas of the brain). This MDS showed Resident 24 had highly impaired vision.</p> <p>Review of the 05/17/2024 and 01/08/2025 visual function Care Area Assessments showed staff documented Resident 24 had highly impaired vision and was at risk for safety issues, distress, and isolation related to their impaired vision. Staff documented they would address this concern in Resident 24's Care Plan (CP) to ensure plans were in place to decrease the identified risks.</p> <p>Review of a revised 01/03/2025 impaired vision CP showed directions were provided to staff to arrange for consultation with eye care practitioners as required.</p> <p>In an interview on 05/12/2025 at 9:00 AM, Resident 24 stated they lost their eyesight about a year ago after they had a stroke. Resident 24 stated the last time they went to the eye doctor was over six months ago when they were informed they were blind.</p> <p>Review of a 04/26/2024 nursing progress note showed staff documented Resident 24 had an appointment for an eye exam that day, had a follow up appointment, and would let the next shift and scheduler know.</p> <p>Record review showed a 05/15/2025 records request form was sent from the facility to the eye specialist clinic requesting the after-visit summary from Resident 24's 04/26/2024 appointment. On 05/22/2024 the clinic responded and sent the documents to the facility, which included information showing Resident 24 needed a six-month follow-up visit. The documents were added to Resident 24's records on 05/30/2024.</p> <p>In an interview on 05/27/2024 at 11:05 AM, the eye specialist clinic stated Resident 24 did not return since their 04/26/2024 appointment. The specialist stated Resident 24 was scheduled for their six month follow up visit on 10/25/2024, but did not show up. No documentation was found in Resident 24's records regarding the missed appointment.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/19/2025 at 1:08 PM, Staff D (Resident Care Manager) stated follow-up appointments were important for continuation of care. Staff D reviewed Resident 24's records and was unable to find further information regarding the missed six-month vision follow-up appointment.</p> <p>REFERENCE: WAC 388-97-1060(3)(a).</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure mechanical lifts (lift devices used to help transfer residents who cannot bear their own weight from surface to surface) were maintained in safe working order for 2 of 2 mechanical lifts. The failure left residents at risk for unsafe transfers, falls, and injury.</p> <p>Failures included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's undated Equipment Safety and Functionality Expectations policy, staff must inspect all equipment prior to use. The policy showed for mechanical lifts, safety clips must be present and attached securely prior to use, and wheels function and can lock.</p> <p>&lt;Resident Council&gt;</p> <p>During a Resident Council meeting on 05/16/2025 at 1:08 PM, Resident 35 expressed a concern with the facility's mechanical lifts. Resident 35 stated some of the pins (spring-loaded locking clips on the hooks of the lift where the sling in which the resident is seated for transfer is connected - a safety clip. These spring-loaded locking clips helped ensure the sling does not disconnect when the resident is not suspended.) were missing. Resident 35 stated some of the other spring-loaded locking clips no longer worked as they should because the spring mechanism did not work. Resident 35 stated they needed a mechanical lift for transfers and seeing the missing or non-functional pins made them feel unsafe.</p> <p>Observation on 05/16/2025 at 1:55 PM showed the mechanical lift nearest Resident 35's room (located outside room [ROOM NUMBER]) was missing one of the six spring-loaded locking clips. Additionally, this mechanical lift had two spring-loaded locking clips that did not spring shut, confirming the concern Resident 35 raised at Resident Council. The brake of the left rear wheel of the lift was missing the rubber mechanism that allowed the brake to be deployed with the use of a foot. The brake would not engage.</p> <p>Observation on 05/16/2025 at 2:01 PM showed the mechanical lift on East wing hallway near room [ROOM NUMBER] was missing two spring-loaded locking clips.</p> <p>In an interview on 05/16/2025 at 2:34 PM, Staff A (Administrator) stated they would provide the user manual for the facility's mechanical lifts. Staff A reached out to Staff H (Maintenance Director) to obtain it.</p> <p>On 05/16/2025 at 2:46 PM Staff H joined the interview. Staff H stated they checked the mechanical lifts monthly. Staff H stated sometimes the spring-loaded locking clips failed and needed replacement. Staff H showed the checklist they used to check the mechanical lifts monthly. Staff H stated they received no reports residents had a safety concern related to the lifts. Staff A stated both lifts would be removed from the floor until they were in full working order.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and observation on 05/16/2025 at 3:10 PM, Staff A noted the missing pins and brake panel from a lift still located in the resident hallway, over an hour after the lift safety concern was identified, and stated the lift would be removed from the floor until repaired.</p> <p>Observation on 05/19/2025 at 9:47 AM showed a rented mechanical lift being used on the floor.</p> <p>REFERENCE: WAC 388-97-1060(3)(g).</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to reassess the resident for bowel and bladder needs or provide the necessary care and services to ensure bowel and bladder continence was improved for 1 of 2 residents (Resident 47) reviewed for bowel and bladder needs. This failure left the resident at risk for unmet care needs, avoidable incontinence, and embarrassment.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's April 2018 Urinary Incontinence policy, nursing staff would assess residents and document the circumstances related to incontinence. The physician would identify potentially treatable medical conditions and address causes related to urinary incontinence. The policy showed facility staff would identify environmental interventions and assistive devices such as grab bars, urinals (bottles male residents can urinate in), bedside commodes, and walkers to facilitate toileting. Based on the assessment and causes of the incontinence, staff would provide scheduled toileting, prompted voiding, or other interventions to try to improve the resident's continence status.</p> <p>&lt;Resident 47&gt;</p> <p>According to the 04/08/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 47 admitted to the facility on [DATE], had no memory impairment, and was able to make their own decisions. This MDS showed Resident 47 was always incontinent of bowel and bladder during the assessment period and was dependent on staff for toileting needs.</p> <p>Observation on 05/12/2025 at 11:12 AM and on 05/13/2025 at 1:23 PM showed Resident 47 lying in bed.</p> <p>In an interview on 05/13/2025 at 1:23 PM, Resident 47 stated they used incontinence briefs for bowel and bladder needs since admitting to the facility. Resident 47 stated when they were in the hospital they successfully used a urinal to urinate. Resident 47 stated they knew when they needed to urinate but they could not walk to the bathroom.</p> <p>Record review showed the 01/08/2025 Urinary incontinence Care Plan (CP) directed staff to assist Resident 47 with the toilet upon rising, before and after meals, at bedtime, and as needed. The CP instructed the staff to keep a urinal within reach because Resident 47 used a urinal in bed.</p> <p>In a joint interview on 05/14/2025 at 11:00 AM, Staff C (Assistant Director of Nursing), Staff E (Resident Care Manager), and Staff M (Resource Nurse) stated Resident 47 was alert and able to make their needs known. Staff E stated Resident 47 was always incontinent of bowel and bladder. Staff E stated staff should assess the resident's bowel and bladder needs and initiate interventions like a urinal or a bedside commode to facilitate toileting.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview and observation on 05/14/2025 at 11:15 AM, Staff M confirmed there was no urinal in Resident 47's room. Staff M discussed urinal use with Resident 47. Resident 47 stated they would use a urinal while in bed.</p> <p>On 05/14/2025 at 11:33 AM, Staff C stated they should have reassessed Resident 47's bowel and bladder status and start a scheduled toileting program, but they did not.</p> <p>In an interview on 05/16/2025 2:32 PM, Staff B (Director of Nursing) stated staff should reassess to ensure Resident 47 received the necessary care they required.</p> <p>REFERENCE: WAC 483.25-1060 (3)(c).</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review the facility failed to ensure medications were stored, returned, and/or discarded when expired for 1 of 3 medication carts (Middle Medication Cart) and 1 of 1 medication rooms observed. The failure to ensure unneeded medications were returned to the pharmacy upon resident discharge and to ensure medications carts were secured when not in use by a nurse placed the residents at risk for receiving unauthorized, compromised, and/or ineffective medications.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's revised November 2020 Storage of Medications policy, discontinued, outdated, and deteriorated drugs and biologicals must be returned to the dispensing pharmacy or destroyed. The policy showed compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) that contained drugs and biologicals must be locked when not in use and unlocked medication carts must not be left unattended.</p> <p>&lt;Medication Room&gt;</p> <p>Observations of the medication room on 05/12/2025 at 9:41 AM with Staff P (Licensed Practical Nurse) showed a vial of Tuberculosis (TB - a highly contagious respiratory disease) testing solution in the refrigerator. The vial had an open date of 04/11/2025 and more than 30 days passed since the vial was opened. Staff P stated staff should have, but did not remove and discard the TB vial once it expired.</p> <p>The following observations in the medication room were made with Staff P on 05/12/2025 at 9:45 AM:</p> <ul style="list-style-type: none"> - five vials of a blood thinning medication that expired 04/30/2025 - two containers of blood collection needles that expired 10/31/2024 - two containers of blood collection needles that expired 11/30/2024 - one box of oil-based dressings that expired 10/2024 - one tube of a wound gel that expired 04/2025 - two one-gram boxes of protein wound powder dressings that expired 06/2024 - one one-gram box of protein wound powder dressings that expired 09/2024 <p>In an interview at this time, Staff P stated the expired medications and supplies should have been but were not discarded and removed from the supply area in the medication room.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the contents of a filing cabinet in the medication room were made with Staff P on 05/12/2025 at 10:05 AM. This filing cabinet contained:</p> <ul style="list-style-type: none"> - a bag with at least 12 bottles of medications for a resident who discharged on 07/11/2024, 10 months previously. - nine bottles of medication for a resident who discharged on 10/13/2024, seven months previously. - eight medication cards for a resident who discharged on 12/10/2024, five months previously. <p>In an interview at this time, Staff P stated it was their expectation the medications would be removed promptly and either returned or destroyed upon a resident's discharge. Staff P stated the medication found in the filing cabinet should be removed.</p> <p>&lt;Middle Medication Cart&gt;</p> <p>&lt;Unsecured Medication Cart Keys&gt;</p> <p>Observation on 05/12/2025 at 9:36 AM showed the keys of the middle medication cart were left hanging in the lock of the narcotic drawer with no staff in the area. At 9:37 AM, Staff Q came to the cart and realized they left the keys in the cart. Staff Q stated I should have locked that. When asked if the keys should be left in the cart, Staff Q stated, at least you were there.</p> <p>&lt;Expired Medications&gt;</p> <p>Observations of the middle medication cart on 05/12/2025 at 10:22 AM with Staff Q (Registered Nurse) showed a long-acting insulin pen (medication used to manage blood sugar levels) with an open date of 04/12/2025. In an interview at this time, Staff Q stated the insulin pen expired 28 days after opening and should have been removed from the cart on 05/10/2025, two days previously.</p> <p>In an interview on 05/19/2025 at 11:08 AM, Staff B (Director of Nursing) stated it was their expectation for expired medications and supplies to be removed from the medication room and carts. Staff B stated the nursing staff should not be using them. Staff B stated discharged residents' medications should be discarded or returned to the pharmacy within the first week of discharge to decrease the risk for possible medication errors and to avoid possible financial burdens for the residents.</p> <p>WAC: REFERENCE 399-97-1300(2),-2340.</p>		

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NAME OF PROVIDER OR SUPPLIER Avamere Rehabilitation of Burien		STREET ADDRESS, CITY, STATE, ZIP CODE 1031 Southwest 130th Street Burien, WA 98146	
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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain dental services for each resident.</p> <p>Based on observation, interview, and record review the facility failed to ensure 3 (Resident 21, 24, & 64) of 4 residents reviewed for dental services received the care and services they required to preserve their dental health. This failure placed the residents at risk for unmet dental needs and a diminished quality of life.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>According to the facility's 2001 Dental Services policy, the facility provided routine and emergency dental services to residents via a contract agreement with a licensed dentist, referral to a resident's personal dentist, referral to a community dentist, or other dental providers. The policy showed the facility's social services department would assist residents with dental appointments.</p> <p>&lt;Resident 21&gt;</p> <p>According to the 04/14/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 21 had clear speech with no memory loss, was understood, and able to understand others.</p> <p>In an interview on 05/13/2025 at 2:23 PM, Resident 21 stated they had some broken teeth for quite a while, recently with occasional pain. Resident 21 stated they were finally scheduled for a dental appointment on 05/14/2025.</p> <p>Record review showed a 02/03/2025 in-house dental consult for Resident 21 with recommendations for a referral for x-rays, evaluation, extractions, and upper and lower dentures. This consult was acknowledged by staff and uploaded into Resident 21's records on 03/07/2025. No further documentation was found regarding staff following up on the dental referral until 04/14/2025, over two months after the consult.</p> <p>In an interview on 05/19/2025 at 12:00 PM, Staff F (Social Services Director) stated it was their expectation follow up for dental referrals would occur as soon as possible to avoid worsening issues. Staff F stated they would expect staff to document when the referrals were made and attempt to schedule appointments promptly. Staff F reviewed Resident 21's records and was unable to locate documentation to indicate why the dental referral was not completed timely.</p> <p>&lt;Resident 24&gt;</p> <p>According to a 01/02/2025 Significant Change MDS, Resident 24 had clear speech with no memory loss, was understood, and able to understand others. This MDS showed staff assessed Resident 24 with obvious or likely decayed or broken natural teeth.</p> <p>Review of a 01/08/2025 dental Care Area Assessment (CAA) staff documented Resident 24 had broken, missing teeth, and required assistance with oral care needs. Staff documented they would proceed to the CP to ensure plans were in place to decrease risks.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a revised 04/09/2025 dental health CP showed directions to staff from 09/10/2024 to coordinate arrangements for dental care, transportation as needed/as ordered.</p> <p>In an interview on 05/12/2025 at 9:10 AM, Resident 24 stated they had one progressively worsening tooth, broken teeth, and missing teeth. Resident 24 stated they needed to go to the dentist for a long time.</p> <p>Review of a 10/28/2024 progress note showed Resident 24 was scheduled for an 11/18/2024 consult to address their outstanding dental concerns.</p> <p>Record review showed an 11/18/2024 in-house dental consult for Resident 24 with recommendations for a referral for x-rays and evaluation, and a note indicating the resident would like their teeth evaluated. The consult was uploaded to Resident 24's records on 12/01/2024. No further documentation was found regarding the dental referral until 04/08/2025, almost five months later, when Resident 24 was seen again by the in-house dentist with the referral requested a second time.</p> <p>In an interview on 05/19/2025 at 12:00 PM, Staff F stated their department had some turn-over with staff and some appointment referrals were not followed up on. Staff F reviewed Resident 24's records and stated their dental referral was not followed up timely.</p> <p>&lt;Resident 64&gt;</p> <p>According to a 07/11/2024 admission MDS, staff assessed Resident 64 with obvious or likely decayed or broken natural teeth.</p> <p>Review of a 07/18/2024 dental CAA showed staff documented Resident 64 had broken, missing teeth, and was at risk for a decline in oral health. Staff documented they would proceed to the CP to ensure plans were in place to decrease the risk.</p> <p>Review of a revised 07/24/2024 oral health CP showed directions to staff to coordinate arrangements for dental care and transportation as needed/as ordered.</p> <p>Record review showed a 11/18/2024 in-house dental consult for Resident 64 with recommendations for a referral for x-rays, evaluation, extractions due to broken, loose, and rotting teeth.</p> <p>Review of the provider progress notes showed on 12/09/2024, 01/02/2025, 01/12/2025, and 02/23/2025, the provider wrote directions for a dental referral for Resident 64.</p> <p>Review of a progress note on 05/07/2025 showed staff documented Resident 64 handed half of a broken tooth to staff during lunch.</p> <p>Record review showed no documentation the dental referral for x-rays, evaluations, and extractions for Resident 64 were followed up on by staff until staff followed up on the broken tooth on 05/08/2025, almost six months later.</p> <p>In an interpreted interview on 05/13/2025 at 1:52 PM, Resident 64 stated they had a broken tooth and had a hard time eating.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 05/15/2025 at 12:31 PM, Staff T (Medical Records Assistant) stated they were in that position since December 2024 and were responsible for making resident information packets when residents were scheduled for appointments. Staff T stated they did not hear of any dental concerns or appointments scheduled for Resident 64.</p> <p>In an interview on 05/19/2025 at 12:00 PM, Staff F stated in November 2024 a different staff member was assigned to follow up on appointments and things were missed. Staff F stated it was their expectation the dental referral for Resident 64 should have been but was not completed timely.</p> <p>REFERENCE: WAC 388-97-1060(1), (3)(j)(vii).</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: ensure staff followed contact precautions (a type of isolation precaution used to prevent the spread of infections transmitted by direct or indirect contact) for 1 resident (Resident 183) of 1 reviewed for contact precautions; ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear and gowns used to prevent exposure to infectious materials) for one supplemental Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms in long-term care settings) room (room [ROOM NUMBER]); ensure staff used appropriate Hand Hygiene (Staff R); ensure the facility was free of uncleanable surfaces; ensure urinals (plastic bottles used to pass urine for resident with mobility issues) were sanitary. These failures placed residents at risk for exposure to and development of infectious diseases.</p> <p>Findings included .</p> <p>&lt;Facility Policy&gt;</p> <p>Review of a revised August 2019 facility, Isolation- Initiating Transmission-Based Precautions [TBP - a set of infection control measures designed to prevent the spread of infectious diseases] policy, showed TBPs would be initiated when a resident was at risk of transmitting an infection to other residents. This policy showed when TBP precautions were implemented, the infection preventionist would provide and oversee the process.</p> <p>&lt;Contact Precautions&gt;</p> <p>&lt;Resident 183&gt;</p> <p>According to the 05/06/2025 admission Minimum Data Set (an assessment tool), Resident 183 had diagnoses including an acute bone infection in their left ankle and foot, amputation of their left toes, and a skin infection to their left leg. This MDS showed Resident 183 required antibiotic medication during the assessment period.</p> <p>Record review showed Resident 183 had a 05/02/2025 order for contact precautions due to a multidrug-resistant organism wound infection to their left leg. The order showed staff must follow the posted signage outside of the room.</p> <p>Observation on 05/12/2025 at 8:34 AM showed Resident 183's room (room [ROOM NUMBER]) had a Contact Precautions sign at the door directing anyone entering the room to perform Hand Hygiene (HH) upon entry and before leaving. This sign showed that in addition to HH, all staff entering the room must also put on gloves and a gown prior to entering the room. The sign showed staff should remove the gown and gloves and perform HH again before exiting the room. At that time, Staff Q (Registered Nurse) was observed to be in the room wearing a surgical mask but no gown or gloves. This nurse stood at the resident's bed as they gave the resident their morning medications.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations on 05/12/2025 at 8:39 AM showed Staff Q exit Resident 183's room, without performing HH, went into the kitchen, and returned with a cup of coffee to deliver to the resident. Staff K (Infection Preventionist) stopped Staff Q and told them to use PPE. Staff Q then grabbed a gown and took it with them into the room and put it on while walking to the resident's bedside.</p> <p>Observations during meal service on 05/12/2025 at 11:57 AM showed Staff U (Certified Nursing Assistant) enter Resident 183's room to deliver their lunch tray. Staff U did not use the required PPE as directed on the door for contact precautions. Once inside the room, Staff U put on gloves, did not put on a gown, and emptied Resident 183's urinal. After emptying the urinal, Staff U removed their gloves, washed their hands, and began moving items on Resident 183's bedside table. Staff U then used the remote control to adjust the bed and then left the room without performing HH. Staff U picked up another lunch tray and delivered it to room [ROOM NUMBER] and touched their bedside table, moved their television, came out and closed the door, and then performed HH.</p> <p>Observations on 05/12/2025 at 12:10 PM showed Staff S (Dietary Manager) entered room [ROOM NUMBER] without putting on a gown or gloves or performing HH as directed by the contact precautions sign posted at the door. Staff S was observed to touch Resident 183's tray ticket while in the room. Staff S was then observed leaving the room, without performing HH, entered the main dining room, and moved a meal cart. Staff S then adjusted the menus in their plastic holders in the dining room. Upon exiting the dining room, Staff S was noted to touch the handrail and go into the kitchen.</p> <p>&lt;EBP&gt;</p> <p>Observations during meal service on 05/12/2025 at 11:54 PM showed room [ROOM NUMBER] had an EBP sign placed outside the door. This sign directed everyone entering the room to perform HH before entering and when leaving the room and directed staff to wear gloves and gowns before close contact with the resident. Staff U delivered a lunch tray to the resident in room [ROOM NUMBER], moved up their bed, and physically assisted the resident with positioning, without wearing a gown or gloves. Staff U then exited the room, and without performing HH, took a cup from the food cart, used the main coffee pot to fill the cup, and reentered room [ROOM NUMBER].</p> <p>In an interview on 05/16/2025 at 11:28 AM, Staff K stated it was their expectation that staff follow the directions posted on the precaution signs at resident doors. Staff K stated the required PPE was an important part of reducing the risk of disease transmission. Staff K stated for a resident on contact precautions, staff were required to put on a gown and gloves at the door, prior to entering a resident's room. Staff K stated staff should not go in a room to drop things off, without putting on the proper PPE first if a resident was on contact precautions. Staff K stated for EBP, staff were expected to put on a gown and gloves prior to providing any close contact with residents. Staff K stated all staff should perform HH before entering, providing care, after care, touching resident items, and upon exiting a room. Staff K stated HH was important to reduce and prevent disease transmission.</p> <p>&lt;Uncleanable Surfaces&gt;</p> <p>Observations on 05/13/2025 at 12:39 PM showed a chair with a leather-like cover near the window in room [ROOM NUMBER]. The leather-like fabric cover of the chair was peeled and torn with uncleanable material showing through.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/29/2025 at 3:04 PM, Staff H (Maintenance Director) stated they removed the chair from the resident's room because it was not cleanable and did not look homelike.</p> <p>&lt;Hand Hygiene&gt;</p> <p>Observation on 05/14/2025 at 1:22 PM showed Staff R (Housekeeping) placed their housekeeping cart in the hallway outside a nurse's station, entered the nursing station, took a nail clipper from their pocket and clipped their fingernails at the nurse's station. They put the nail clipper in their pocket, went out in the hallway, and moved their housekeeping cart to the janitor room in east wing hallway. Staff R came back to the nursing station, blew their nose, threw the tissue in a trash can, and went to clock out for the day. Staff R did not perform HH.</p> <p>Observation on 05/15/2025 at 10:45 AM showed Staff R walking in the east wing hallway and filing their fingernails.</p> <p>In an interview on 05/19/2025 at 12:43 PM, Staff K stated Staff R should not clip their fingernails at the nursing station. Staff K stated Staff R should wash their hands after they placed their housekeeping cart in the janitor room and before touching the time clock as it was an infection control issue.</p> <p>&lt;Urinals in Trash Cans&gt;</p> <p>Observation in room [ROOM NUMBER]-1 on 05/12/2025 at 10:45 AM and 12:46 PM showed Resident's urinal was hanging inside a trash can.</p> <p>Observations in room [ROOM NUMBER]-1 on 05/12/2025 at 10:54 AM and on 05/13/2025 at 12:35 PM showed Resident's urinal was hanging inside a trash can next to the resident's bed.</p> <p>In an interview on 05/19/2025 at 12:47 PM, Staff K stated residents' urinals should not be placed inside the trash cans, that was infection control issue. Staff K stated the facility staff should keep resident's urinals clean, and in a bag, but not in the trash cans.</p> <p>REFERENCE: WAC 388-97-1320 (1)(c), (2)(b), (5)(c).</p>		