STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation, interview and record review, the facility failed to provide privacy for 1 of 3 sampled residents (Resident 1) reviewed for dignity. This failure placed residents at risk for feelings of embarrassment, diminished self-worth, and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE]. The quarterly minimum data set, an assessment tool, dated 01/2/2025 documented the resident was cognitively intact and needed substantial to maximal assistance with showers and bathing. On 01/23/2025 at 10:23 AM, Resident 1 was observed being transported down the hallway in a shower chair with blankets draped over their abdomen only, exposing their left side and buttocks. On 01/23/2025 at 10:45 AM, Staff X, Certified Nursing Assistant, was asked about transporting Resident 1 down the hallway after their shower and Staff X said she did not see their bottom exposed. On 01/30/2025 at 12:32 PM, Staff B, Director of Nursing said her expectation was that residents be covered, when they were not clothed, to promote dignity when being transported down the hallway after a shower. 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to offer and/or honor bathing choices for 3 of 8 residents (Residents 124, 42 and 51) reviewed for choices. The failure to promote and facilitate resident choice related to type and frequency of bathing, placed residents at risk for poor hygiene, feelings of powerlessness, and diminished quality of life. Findings included . 1) Resident 124 admitted to the facility on [DATE]. In an interview on 02/05/2025 at 1:08 PM, the resident said staff had informed them that their shower days were Wednesdays and Saturdays, but reported staff didn't always show up. Resident 12 said they had only been provided one shower since admission. An activities of daily living (ADL) care plan, initiated 01/24/2025, documented Resident 124 required extensive assistance bathing, and would be showered on Wednesdays and Saturdays on evening shift. Review of the January and February 2025 bathing records showed there was no documentation to show the resident had been offered /provided bathing since admission. Resident 124 reported they were showered once in 13 days since admitting on 02/01/2025. The January 2025 Treatment Administration Record, directed nursing to shower resident on weekly shower days. Review of the documentation showed showers were not provided on Saturday 01/25/2025 or Wednesday 01/29/2025 as scheduled. 2) Resident 42 admitted to the facility on [DATE]. Review of the 01/12/2025 Quarterly Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, required substantial to maximal assistance with bathing and choices related to bathing were Somewhat Important. On 01/23/2025 at 10:11 AM, Resident 51 reported they were supposed to be bathed twice a week on Mondays and Thursdays but indicated they usually only get one a week on Monday. An ADL care plan, initiated 12/02/2024, directed staff to provide bathing once a week on Monday evening. Review of the electronic health record showed a 01/13/2025 order directing staff to shower the resident on their scheduled shower days of Monday and Thursday evening shift. Resident 42's bathing records showed since their shower frequency was increased from once a week to twice a week on 01/13/2025, staff failed to offer/provide bathing on the following scheduled shower days: -01/16/2025 -01/23/2025 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-01/30/2025 3) Resident 51 admitted to the facility on [DATE]. Review of the 11/29/2024 Quarterly MDS showed the resident was cognitively intact, and choices related to bathing were Very Important. On 01/23/2025 at 10:11 AM, Resident 51 reported they were told they could have two showers a week, but staff seldom came. The resident stated, They say I am independent, but I need someone to do my colostomy [A colostomy is a surgical procedure in which a portion of the large intestine, or colon, is brought through the abdominal wall to carry feces out of the body]. An ADL care plan, revised 08/04/2024, documented Resident 51 preferred showers on Thursdays, and was independent with bathing tasks after set-up, but still required oversight for safety. Resident 51's bathing schedule showed they were scheduled for showers twice a week on Mondays and Thursdays on day shift. Review of the December 2024 bathing record showed Resident 51 was offered/provided assistance with bathing on two of their residents eight scheduled days (12/05/2024 and 12/12/2024). No documentation was present to show staff offered/provided a shower from 12/13/2024 - 12/31/2024 (18 days). The January 2025 bathing record showed no documentation was present to show staff offered/assisted with bathing at all during the month. On 01/02/2025, 01/09/2025, 01/16/2025 and 01/20/2025, staff documented N/A (Not applicable). On 02/03/2025 at 9:27 AM, Resident 51 said they did not go several weeks without showering but confirmed staff did not offer bathing, assist with set up, and/or provide supervision unless they initiated it. On 02/05/2025 at 1:08 PM, Staff C, Resident Care Manager, said it was the expectation that residents be offered/assisted with bathing per their identified shower schedule. When asked if the above referenced residents were consistently offered/provided showers per their shower schedule Staff C stated, No. Reference WAC 388-97-0900(1)-(4)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 37044 Based on interview and record review, the facility failed to address, respond to and/or resolve concerns and/or suggestions brought forward by the resident council (RC) for 3 of 3 months (October, November and December 2024) of RC minutes reviewed. These failures resulted in the same unresolved/unaddressed concerns being brought forward for consecutive months without resolution, and resulted in RC members feeling frustrated, unheard and powerless to affect the care they receive and/or their environment. Findings included . Review of the facility's Resident Council policy, dated 2024, showed the purpose of RC was to provide a forum for residents and families to have input in the operation of the facility; to discuss concerns and make suggestions for improvement; and consensus building and improving communication between residents and staff. The council was encouraged to elect a president to act as a liaison and facilitate communication between the RC and the designated staff person chosen by the RC. A Resident Council Response Form would be utilized to track issues and their resolution. The facility department related to the issues would be responsible for addressing the item(s) of concern. During a meeting with the RC on 01/30/2025 at 10:00 AM, when asked if the facility considered the views of the RC and promptly acted upon concerns or suggestions brought forward by the group and provided a response, Resident 43, RC President, Resident 9, Resident 4, Resident 3 and Resident 41 said there was no follow-up, and the RC seldom heard anything back from the facility on concerns or suggestions brought up in the meeting. <October Resident Council> Review of RC minutes, dated 10/23/2024, showed the participants voiced the following group concerns and/or suggestions: a) Dietary staffs made constant errors on meal trays and were not paying attention to the information on residents' tray cards. b) Meals were being served to residents with dirty utensils/silverware. c) Resident clothing was not being returned from laundry. d) It was suggested the facility get a new brand of coffee, as RC participants agreed the current brand made them feel sick. <November Resident Council> Review of RC minutes, dated 11/20/2024, showed the participants voiced the following group concerns and/or suggestions: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Residents' clothes were still not being returned timely and/or were placed in the wrong closets (2nd consecutive month concern was reported). b) Dietary staff continued to make errors and were not following the instructions on residents' tray cards. (2nd consecutive month concern was reported). c) Residents continued to be served meals with dirty silverware or cups with lip stick on them (2nd consecutive month concern reported). d) Call lights were not being answered timely. Review showed concerns a, b and c were all reported by the RC in the October meeting and remained unresolved. <December Resident Council> Review of RC minutes, dated 12/28/2024, showed the participants voiced the following group concerns and/or suggestions: a) Dietary staff were not following instructions on resident tray cards (3rd consecutive month reported). b) Residents were served coffee cups that had chunks of cocoa or lipstick stain on them (3rd consecutive month concern was reported). The RC participants expressed that a meeting needed to be held to address the issue. c) Residents continue to have missing clothes. (3rd consecutive month concern was reported). d) Resident urinals were not being emptied. (Identified as an issue in two of the three months reviewed.) On 01/30/2025 at 10:52 AM, Resident 43, RC President, said the issues the RC identified in the October meeting remained unresolved, and the RC had not received any responses from the facility about the concerns. When asked if the facility utilized their Resident Council Response Form to track RC concerns and their resolution, Resident 43 said they had not heard of the form and reiterated with frustration, we never hear back on the things we bring up in the meeting. Resident 9 and Resident 4 expressed agreement with Resident 43's response On 02/05/2025 at 4:13 PM, Staff VV, Activities Director, explained they transcribed the RC meeting notes and then would go to the department head that a reported concern fell under (e.g. Dietary Service Manager) and would read the RC minutes to them. Staff VV said the department head would usually speak to their staff about the issue. Staff VV said they would follow up at the next RC meeting. When asked how they followed up at the next RC meeting Staff VV stated, we discuss old business before new business and hopefully the issue is fixed. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:24 PM, for clarification, Staff VV was asked if the department heads communicated with her and/or the RC President before the next RC meeting, to keep them apprised of the actions taken and/or to address the concern and/or to assess if the actions were effective in resolving the identified concern Staff VV indicated they did not but stated, They do if a grievance [form] was involved, but if not I find out at the next meeting if it fixed. Staff VV indicated they were unfamiliar with the facility's RC response form that was to be used to track RC concerns and their resolution. Reference WAC 388-97--0920(1-6)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to ensure residents with personal funds/resident trust accounts had ready access to their accounts during evenings and weekends for 12 of 12 residents reviewed for person funds accounts. This failure placed residents at risk of not having access to their accounts during non-banking hours, a decreased sense of autonomy and a diminished quality of life. Findings included . Resident 4 was admitted to the facility on [DATE]. The quarterly minimum data set, an assessment tool, dated 01/08/2025 documented the resident was cognitively intact. On 01/23/2025 at 9:33 AM, Resident 4 said they could not withdraw money from their account on the weekends. On 01/28/2025 at 12:24 PM, Staff K, Business Office Manager said residents could not withdraw money from their accounts after hours or on the weekends until a couple of weeks ago. Now if a resident wants to withdraw money the nurse will contact the administrator, and she will come in and help the residents make a withdrawal. On 01/28/2025 at 12:43 PM, Staff A, Administrator said residents have not been able to withdraw money from their accounts on the weekends or after hours until about 3 weeks ago. Reference: WAC 388-97-0340

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to ensure quarterly personal fund statements were provided to residents with personal fund accounts for 3 of 3 sampled residents (Residents 4, 32, and 5) reviewed for personal fund accounts. This failure placed residents at risk of not having an accurate accounting of their personal funds held in trust by the facility. Findings included . Resident 4 was admitted to the facility on [DATE]. The quarterly minimum data set, an assessment tool, dated 01/08/2025 documented the resident was cognitively intact. On 01/23/2025 at 9:33 AM, Resident 4 said they did not receive statements from their personal funds account, and would like a statement every month. On 01/28/2025 at 12:24 PM, Staff K, Business Office Manager said they were not sure if the residents received their statements before they started working in October 2024, but they would be receiving them now. Staff K showed a printed pile of statements sitting on the desk and said they would be distributing them to the residents today. A printed statement would be provided if the resident requested one. On 01/28/2025 at 12:43 PM, Staff A, Administrator said the trust fund account statements were not provided until I started working here 3 weeks ago and the residents would start receiving statements this week. Reference: WAC 388-97-0340

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to ensure the transfer of funds, from a resident trust account, was completed within 30 days following their discharge for 1 of 4 residents (Resident 177) reviewed for resident trust. This failure placed the resident and/or their representatives at risk for loss of funds and the interest accumulated. Findings included . A review of the electronic medical record showed Resident 177 deceased on [DATE] and a review of their account showed it contained a balance of $314.35. On [DATE] at 12:24 PM, Staff K, Business Office Manager confirmed Resident 177's account had not been closed within 30 days. On [DATE] at 12:43 PM, Staff A, Administrator said she was aware that Resident 177's account had not been closed and they had contacted the Department of Social and Health Services to close out the account properly. She said the expectation was that the accounts be closed within 30 days moving forward. Reference WAC [DATE]

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 46793 Based on observation and interview, the facility failed to ensure residents' medical information was maintained in a manner to ensure privacy and confidentiality when staff failed to properly secure medical records for 1 of 1 sampled resident (Resident 60) reviewed for privacy and confidentiality. These failures placed residents at risk for loss of confidential medical information and a diminished quality of life. Finding included . On 01/29/2025 at 2:03 PM, D Wing Medication cart had a laptop open and unsecured, displaying Resident 60's personal medical information. Seven feet away stood Staff L, Infection Preventionist, who was talking to contractor staff. Staff L then walked away a minute later. At 2:05 PM, Staff D, Resident Care Manager (RCM), walked past the open computer. At 2:07 PM, Staff M, Lead Restorative Nursing Assistant (RNA) walked past the open compute with a resident. At 2:08 PM, Staff N, Certified Nursing Assistant (CNA), walked past open computer. At 2:09 PM, Staff M, Lead RNA and Staff N, CNA walked by open computer. At 2:14 PM, Staff D, RCM, observed the open computer as they passed by, walked up to computer and locked it. When asked what should staff do when they walk away from the cart, Staff D said, lock the computer. Staff D said the computer should have been locked. On 02/04/2025 at 11:09 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services, Staff B said the expectation of staff was to lock the computer when they step away from the cart. Staff A and Staff B said the computer should have been locked. Reference WAC 388-97-0360

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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** 46793 Based on observation and interview the facility failed to maintain a safe, clean and comfortable homelike environment for 4 of 4 Wings (A Wing, B Wing, C Wing and D Wing) observed. The failure to ensure doorways were free from gouges, blue decorative coverings over resident doors were secured to doors, light fixtures and resident medical equipment and shower rooms were clean and in good condition, left residents at risk for a diminished quality of life and a less than homelike environment. Findings included . On 01/22/2025 at 10:14 AM and 01/30/2025 at 10:02 AM, room [ROOM NUMBER]'s overhead light was out. On 01/28/2025 at 12:18 PM, the overhead light in front of Nurses station had 10 dead bugs. room [ROOM NUMBER]'s door blue decorative covering was peeling off the door and there were multiple gouges ranging from 3 & 1/2 inch to and 1-inch gouges in the paint exposing wood beneath. On A Wing, the last overhead light at the emergency exit was broken and a section was missing out of the light covering. room [ROOM NUMBER]'s blue decorative covering was peeling off door. On A Wing, the fourth overhead light from the nurses station had 10 dead bugs sitting on the light covering. On 01/29/2025 at 1:51 PM, room [ROOM NUMBER]'s blue decorative covering was peeling off door. On B Wing, the second overhead light from the nursing station had 1 dead bug. The third overhead light had 6 dead bugs. The fourth overhead light had 4 dead bugs. room [ROOM NUMBER]'s doorway had 3 large 5-6 inch gouges in the door. At 1:56 PM, on C Wing outside room [ROOM NUMBER], the overhead light had 1 dead bug. The second overhead light had 2 dead bugs. The fourth overhead light had 7-8 light tan stains on the overhead light covering and around the overhead light. The fifth overhead light had a broken 1 inch wide section missing from the light. At 2:01 PM, on D Wing, the first overhead light had 2 dead bugs. room [ROOM NUMBER]'s blue decorative covering was peeling off the door. The fourth overhead light had 1 dead bug. The fifth overhead light had multiple tan stains including 6 on overhead light covering and 12 yellow pea sized stains next to the overhead light. On 01/30/2025 at 9:45 AM, observations of the Shower room on C Wing, included paint peeling from multiple tiles, moldy smell coming from room, stains on the ground and the air vent above the shower was covered in fuzzy dust. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/2025 9:31 AM, Staff O, Maintenance Director, said they has only been at this facility for four weeks. Staff O said they complete a walk through weekly, to identify facility maintenance issues. Staff O said every morning he would check the maintenance binder for maintenance issues reported the night before. He would also check the TELS communication system for updates. During a walk-through with Staff O, observations of blue covering, gouges in the door and dead bugs in the overhead lights were pointed out. Staff O said he was only made aware of the blue covering peeling off the doors yesterday. Staff O said the coverings should have been fixed. Staff O said the facility uses WA Pest Company. When shown the overhead lights with the dead bugs, Staff O said the dead bugs in the overhead lights should have been cleaned out. At 10:33 AM, Staff O, Maintenance Director, said they were aware of the overhead light in room [ROOM NUMBER] not working. Staff O said he had the new light but had not had a chance to replace it yet. Observation of C Wing Shower room, Staff O said the paint peeling off the shower tiles should have been addressed and the vent should have been cleaned. On 02/03/2025 at 10:19 AM and on 02/05/2025 at 9:47 AM, observation showed the base of Resident 61's tube feeding pole heavily soiled with multiple shades/layers of dried tube feeding solution(s). On 02/05/2025 at 10:57 AM, Staff C, Resident Care Manager, confirmed Resident 61's tube feeding pole was heavily soiled with dried tube feeding solution and needed to be cleaned. Reference WAC 388-97-0880 37044

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 37044 Based on interview and record review the facility failed to have a system in place that ensured grievances were initiated, logged, timely addressed, and resolved in response to residents' verbal conveyance of concerns during Resident Council for 3 of 3 months (October, November and December 2024) of resident council minutes reviewed. The failure to identify the initiate, log, investigate and timely resolve reported complaints/concerns, and inform residents of the findings and actions taken to correct the issues, placed residents at risk of feelings of frustration, unimportance, diminished self-worth, and quality of life. Findings included . Review of the facility's Resident and Family Grievance policy, dated 2024, showed the Grievance Officer was responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining confidentiality; and issuing written grievance decisions to residents. A resident or family member could voice a grievances in the following forums: a) Verbal complaint to a staff member or grievance official. b) Written complaint to a staff member or grievance official. c) Written complaint to an outside party. d) Verbal complaint during Resident/Family Council meetings. <October Resident Council> Review of the Resident Council minutes for October 2024 showed 9 residents were present and the following concerns were brought forward: Dietary concerns: a) The group complained of constant errors on meal trays, and that dietary staff were not paying attention to residents' tray cards. b) Resident 41 complained of receiving dirty utensils with meals. Concerned whether coffee canisters are being cleaned. c) Resident 14 also complained of receiving dirty silverware and complained of tasting peanut butter on their spoon when eating oatmeal. d) Resident 43, RC President, complained they were not receiving large portions. Maintenance/Laundry concerns: (continued on next page)

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	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Group complaint that clothes were not being returned from laundry. b) Resident 21 reported their clothes were not being returned. (What clothes were missing was not identified.) c) Resident 41 reported their favorite quilt was missing. The council minutes did not include the identity or number of residents whose diet orders were not being followed. The type of diet errors that occurred or what, if any, affect it had on the resident or potential risk it posed (e.g. choking risk due to being provided the wrong texture etc.) were not identified or addressed. Review of the October 2024 grievance log showed grievances were not initiated/logged for: - Resident 41 and 14's complaints of being dirty utensils with meals - Resident 43's complaint of dietary orders not being followed. - Resident 21's report of missing clothing. - Resident 41's missing quilt. <November Resident Council> Review of the Resident Council minutes for November 2024 showed 11 residents attended and the following concerns were brought forward: Old Business a) Group reported the still were not getting clothes back in a reasonable time, clothes were being put into the wrong closets. b) Dietary was still making errors, not following residents' tray cards. c) Residents still being served dirty silverware and cups with lipstick on them. d) Resident 43 reported they still were not receiving large portion meals. (repeat complaint) Nursing Concerns: a) Call lights were not being answered timely. The council minutes did not include the identity and/or number of residents who reported being served dirty dishware/utensils or who complained of long call light wait times. Nor did they identify how long residents had to wait, or what affect, if any, it had on them (e.g. due to prolonged call light response time, a continent resident was caused to have an incontinent episode or caused them to self-transfer in attempt to get to the bathroom and fall etc.). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the November 2025 grievance log showed no grievances were no grievances initiated for: - The unidentified residents who complained (for the second consecutive month) dietary staff were not following the instructions on their tray cards. - The unidentified residents who reported continued to report missing clothing. - The unidentified residents who complained for the second straight month that they were being served meals with dirty utensils/dishware. - Resident 43's complaint (for the second consecutive month) that they were not receiving large portions. <December Resident Council> Review of the Resident Council minutes for December 2024 showed 13 residents were present and the following concerns were brought forward: Old Business: a) Urinals are not being emptied. b) Residents report they still have clothes missing. c) Dietary staff are not reading residents' tray cards properly. d) large portions were not being provided for residents who are supposed to receive them. e) Coffee cups being served had lipstick or dried clumps of cocoa on them. The group stated that a meeting needed to be held to address the issues Nursing Concerns: a) Nurse aide(s) are telling residents no when they request to get out of bed, which is causing them to feel depressed. b) Nurse aides are taking their stress out on residents, causing them to feel stressed and down. Maintenance concerns: a) Resident 43 reported their bedroom smelled of mold. The council minutes did not include the identity or number of residents who alleged Nurse aide(s) had told them no when they request to get out of bed, which caused them to feel depressed; or the identity and number of residents who alleged Nurse aides were taking their stress out on residents, causing them to feel stressed and down. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the December 2024 grievance log showed no grievances were initiated/logged addressing the: - Unidentified resident complaints (for the third consecutive month) that meal cards were not being followed. - Unidentified resident complaints (for the third consecutive month) that clothing was not being returned from laundry. - Unidentified resident complaints (for the third consecutive month) that meals were being served on dirty dishware. - Unidentified resident(s) who alleged aides told them no when they requested to get out of bed causing them to feel depressed. - Unidentified resident(s) who alleged aides were taking their stress out on residents causing them to feel stressed and down. On 02/05/2025 at 4:13 PM, Staff VV, Activities Director, explained after transcribing the RC minutes, they would read the group and/or resident specific complaints that were identified to the associated department, and they would usually talk to their staff. When asked who and how it was determined if a residents' complaint warranted the initiation of a grievance and how the facility ruled out abuse and neglect if residents reporting concerns were not identified and/or asked follow up questions to determine what occurred, what effect, if any, it had on them (e.g. were the complaints of tray cards not being followed related to being served the wrong texture to a resident with swallowing issues etc.) Staff VV, stated, I see what you are saying. I have to be honest . Staff VV then reported the old activity director had recently left, and although they had been attending RC prior, they never participated in the follow-up after the meetings and were learning the process. Staff VV said grievances should have been initiated on the residents' behalf. Reference WAC 388-97-0460

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation, interview, and record review the facility failed to obtain assessments, orders, consent, and/or develop a care plan for the use of potential restraints for 4 of 5 residents (Resident 4, 1, 65, and 6) reviewed for physical restraints. This failure placed residents at risk for potential injury, potential restraint, unmet care needs, and a diminished quality of life. Findings included . Review of the facility policy, titled, Proper Use of Bed Rails, undated, showed the facility was to assess the resident's risk from using bed rails, risk of entrapment, and risk of potential restraint. The policy listed alternatives that were to be attempted prior to installing or using bed rails. 1) Resident 4 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS-an assessment tool), dated 01/08/2025, documented the resident was cognitively intact. On 01/27/2025 at 7:29 AM, Resident 4 was sitting up in bed watching TV and their bed was against the wall. On 02/03/2025 at 2:21 PM, Resident 4's bed was against the wall and they were sitting next to their bed in their wheel chair watching television. On 01/29/2025 at 12:16 PM, Staff D, Licensed Practical Nurse (LPN)/ Resident Care Manager (RCM), said there were four things needed when a resident has their bed against the wall: an evaluation, a consent, an order, and it must be care planned. She said Resident 4 did not have any of those items. On 01/29/2025 at 12:43 PM, Staff B, Director of Nursing Services (DNS) said they could not find a consent, order, assessment or care plan entry for Resident 4's bed against the wall and the expectation was for it to be in place and also be able to find them easily in the chart. 2) Resident 1 was admitted to the facility on [DATE] with a cerebral infarction affecting their right dominant side (a condition where blood flow to the brain is interrupted, causing brain tissue to die). The Quarterly MDS dated [DATE] documented the resident was cognitively intact. On 01/22/2025 at 11:32 AM, Resident 1 was observed in bed with the bed against the wall. On 01/27/2025 at 7:31 AM, Resident1 was in bed and appeared asleep, the lights were off, and the bed was observed against the wall. On 01/29/2025 at 12:16 PM, Staff D, LPN/RCM, said Resident 1 did not have a safety evaluation or a consent for their bed against the wall and it should be in place. On 01/29/2025 at 12:43 PM, Staff B, DNS, said they could not find an assessment or consent for Resident 1's bed against the wall and the expectation was for it to be in place and also be able to find them easily in the chart. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident 65 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction affecting left non-dominant side. The Quarterly MDS dated [DATE] documented the resident was moderately cognitively impaired. On 01/23/2025 at 3:02 PM, Resident 65 was observed in bed with the bed against the wall and window. On 01/27/2025 at 7:34 AM, Resident 65 was in bed and appeared asleep. The bed was observed against the wall and window. On 01/29/2025 at 12:16 PM, Staff D, LPN/RCM, said Resident 65 did not have an order, an evaluation, a consent nor was it care planned for their bed against the wall and those should be in place. On 01/29/2025 at 12:43 PM, Staff B, DNS, said they could not find those 4 pieces for Resident 65 for having her bed against the wall and the expectation was that they would be in place. On 01/29/2025 at 1:57 PM, Staff B, DNS, showed she compiled a list of residents with a bed against the wall, and said they know this was a problem. Staff B said they were working on putting all those pieces in place: a consent, evaluation, order and care plan entry for those residents. 50945 4) Resident 6 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 6 was cognitively intact and was dependent on staff regarding their lower body. During an observation on 01/23/2025 at 9:42 AM, Resident 6 was observed in bed with upper bilateral mobility bars. Resident 6 reported they used them for repositioning in bed. Review of the Electronic Health Record (EHR) showed Resident 6 did not have a safety assessment or care plan for mobility bars. During an interview on 02/04/2025 at 10:48 AM, Staff C, RCM, said Resident 6's consent on 02/22/2024 was the safety assessment. During an interview on 02/04/2025 at 11:18 AM, Staff B, DNS, said an evaluation, order, consent, and care plan should be in each resident's EHR for the use of side rails/mobility bars. When asked if there was an assessment done that showed it was safe for Resident 6 to use mobility bars, Staff B said the consent should say they had assessed Resident 6 and that it was appropriate to use/safe, but that the consent for Resident 6 did not say that. Staff B did not find any alternatives that were offered before the mobility bars were attempted. Staff B confirmed the mobility bars were not in the care plan. Reference WAC 388-97-0620(1)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure the documentation during transfer or discharge of the residents was complete with appropriate information provided to the receiving health care institution or provider, for 1 of 2 residents reviewed (Resident 11) for closed records. This failure placed residents at risk of unidentified and unmet medical needs, and a diminished qualify of life. Findings included . Resident 11 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD, a mental health condition triggered by an extremely stressful or terrifying event), depression, and anxiety. Review of the Electronic Health Record (EHR) showed Resident 11 was transferred and discharged to the hospital on 01/16/2025. The EHR showed it was a facility initiated discharge, as the facility called the police to transfer Resident 11 to the hospital for inappropriate behaviors. Review of the EHR showed the facility was missing documentation. The facility did not have documentation of the information provided to the receiving provider, to at a minimum have included: contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, or comprehensive care plan goals. During an interview on 02/05/2025 at 2:08 PM, Staff B, DNS, when asked for documentation of any communication with the hospital, Staff B said the admissions coordinator had contacted the hospital, and they would look into this. When asked for documentation of what was provided to the hospital, Staff B said they would look into this. During a follow up interview on 02/06/2025 at 10:50 AM, Staff B said they had followed up with the admission coordinator, the communication was minimal, and that the staff member had not documented anything. Staff B said they were unable to locate any documentation of what information was provided to the hospital. Reference F623 and F625 Reference WAC 388-97-0120

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident and/or their representative for 5 of 6 sampled resident (Residents 4, 11, 42, 57 & 58), failed to provide the Ombudsman notification for 6 of 6 sampled residents (Residents 3, 4, 11, 42, 57 & 58), and failed to update a resident representative for 1 of 6 sampled residents (Resident 11) reviewed for hospitalization . This failure placed the resident and/or their representative at risk for not having an opportunity to make informed decisions about transfers/discharges. Findings included . The facility policy titled, Transfer and Discharge, dated 2023, documented the facility's transfer/discharge notice would be provided to the resident and the resident's representative in a language and manner in which they could understand. The notice would include all of the following at the time it is provided that facility would maintain evidence that the notice was sent to the Ombudsman. <Transfer/discharge notice> Resident 4 was admitted to the facility on [DATE]. Resident 4 was transferred to the hospital on 11/23/2024. The electronic health record (EHR) documented no Transfer/Discharge notification was provided to Resident 4. Resident 11 was admitted to the facility on [DATE]. Resident 11 was transferred to the hospital on 01/16/2025. The EHR documented no Transfer/Discharge notification was provided to Resident 11 Resident 42 was admitted to the facility on [DATE]. Resident 42 was transferred to the hospital on 10/01/2024. The EHR documented no Transfer/Discharge notification was provided to Resident 42. Resident 57 was admitted to the facility on [DATE]. Resident 57 was transferred to the hospital on 01/17/2025. The EHR documented no Transfer/Discharge notification was provided to Resident 57. Resident 58 was admitted to the facility on [DATE]. Resident 58 was transferred to the hospital on 11/15/2024. The EHR documented no Transfer/Discharge notification was provided to Resident 58. <Ombudsman Notification> Resident 3 was admitted to the facility on [DATE]. Resident 3 was transferred to the hospital on 10/04/2024. The EHR documented no Ombudsman notification was provided. Resident 4 was admitted to the facility on [DATE]. Resident 4 was transferred to the hospital on 11/23/2024. The EHR documented no Ombudsman notification was provided. Resident 11 was admitted to the facility on [DATE]. Resident 11 was transferred to the hospital on 01/16/2025. The EHR documented no Ombudsman notification was provided. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 42 was admitted to the facility on [DATE]. Resident 42 was transferred to the hospital on 10/01/2024. The EHR documented no Ombudsman notification was provided. Resident 57 was admitted to the facility on [DATE]. Resident 57 was transferred to the hospital on 01/17/2025. The EHR documented no Ombudsman notification was provided. Resident 58 was admitted to the facility on [DATE]. Resident 58 was transferred to the hospital on 11/15/2024. The EHR documented no Ombudsman notification was provided. On 01/29/2025 at 9:01 AM, Staff A, Administrator, with Staff B, Director of Nursing Services present, said Transfer notification and Ombudsman notification had not been completed for residents. Staff A said the expectation was Transfer notification and Ombudsman notification would be completed moving forward. 50945 <Resident Representative Notification> Resident 11 was admitted to the facility on [DATE] and had diagnoses of post-traumatic stress disorder (PTSD, a mental health condition triggered by an extremely stressful or terrifying event), depression, and anxiety. Review of the (EHR) showed Resident 11 was transferred and discharged to the hospital on 01/16/2025. During an interview on 01/27/2025 at 4:29 PM, when asked about the circumstances surrounding Resident 11's discharge, Collateral Contact 1, Resident 11's medical and financial power of attorney (POA), said, when was he discharged ? Collateral Contact 1 said they were not notified Resident 11 had left the facility. During an interview on 01/28/2025 at 10:19 AM, Collateral Contact 1 said the facility would not tell them where Resident 11 went. At 10:28 AM, Collateral Contact 1 was given Resident 11's belongings on a cart (backpack, suitcase, mountain dew, red bull, root beer, filled Walmart totes, trash bag with items in it). At 10:30 AM, Staff C, RCM, updated Collateral Contact 1 on where Resident 11 had gone. During an interview on 02/05/2025 at 2:08 PM, Staff B, DNS, said their expectation was that the RCM or someone would notify the POA or emergency contact when a resident discharged . When asked why the facility did not send belongings with Resident 11, Staff B said it was emergent and that usually the family would come to pick them up. When asked about Resident 11's POA, Staff B said yes, the POA should have been contacted to pick up Resident 11's belongings. WAC 388-97- 0120 (2)(a-d) 37044 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42960 50488

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to provide written bed hold notices at the time of transfer to the hospital for 4 of 6 sampled residents (Resident 4, 11, 42 & 57) reviewed for hospitalization . This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . The facility policy, titled, Bed hold Notice Upon Transfer, dated 2023, documented, 1. Before a resident is transferred to the house or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies . 2. In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed hold policies, as stipulated in the State's plan . 5. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file. 1) Resident 4 was admitted to the facility on [DATE]. Resident 4 was transferred to the hospital on 11/23/2024. The electronic health record (EHR) documented no bed hold notification was provided to Resident 4. 2) Resident 11 was admitted to the facility on [DATE]. Resident 11 was transferred to the hospital on 01/16/2025. The EHR documented no bed hold notification was provided to Resident 11 3) Resident 42 was admitted to the facility on [DATE]. Resident 42 was transferred to the hospital on 10/01/2024. The EHR documented no bed hold notification was provided to Resident 42. 4) Resident 57 was admitted to the facility on [DATE]. Resident 57 was transferred to the hospital on 01/17/2025. The EHR documented no bed hold notification was provided to Resident 57. On 01/29/2025 at 11:09 AM, in a joint interview with Staff A, Administrator, and Staff B, Director of Nursing Services, Staff B said when a resident leaves the facility a bed hold should be offered to the resident. If the resident, wants a bed hold, the facility has the resident sign the bed hold notice. If the resident does not want a bed hold, they do not provide a copy of the bed hold. When asked if Resident 4, 11, 42 & 57 should have received a bed hold notification, Staff B said yes. WAC 388-97-0120 (4) 42960 50488 50945

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on record review and interview, the facility failed to ensure the Minimum Data Set Assessments (MDS) were complete and accurate for 9 of 23 sampled residents (Residents 27, 11, 12, 42, 1, 65, 16, 32 & 57). This failure placed the residents at risk of unmet and unidentified care needs, and a diminished quality of life. Findings included . Review of the October 2024 Resident Assessment Instrument (RAI, a manual that provides instruction on how to accurately code a MDS assessment) showed the following criteria must be met to code restorative services on the MDS: a) Measurable and objective interventions must be documented in the care plan. b) Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record, which should include reassessment of progress, goal, and duration/frequency of the program(s). c) Range of motion (ROM) exercise programs must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record. 1) Resident 27 was admitted to the facility on [DATE] with diagnoses of dementia and anxiety. Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment, and was taking an antipsychotic (decreases symptoms of a loss of contact with reality) medication. Resident 27's MDS had their last gradual dose reduction (GDR, a requirement of facilities to try to lower behavioral health drug doses) listed as 07/01/2024. A review of the Electronic Health Record (EHR) did not support the GDR date of 07/01/2024. Resident 27 was taking a medication called Seroquel (an antipsychotic), which, on 07/02/2024, the doses for morning and nighttime on the Medication Administration Record (MAR) were seen to have been swapped (this would not count as a GDR as the 24-hour dose remained the same). During an interview on 02/03/2025 at 12:52 PM, Staff G, MDS Director, said they should not have coded the GDR for 07/01/2024 and this date was incorrect. During an interview on 02/04/2025 at 11:26 AM, Staff B, Director of Nursing Services (DNS), said it did not meet expectation, that the MDS for Resident 27 was coded inaccurately for the last GDR date. 2) Resident 11 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD, a mental health condition triggered by an extremely stressful or terrifying event), depression, and anxiety. The Admission MDS, dated [DATE], showed Resident 11 did not have a Level II Preadmission Screening and Resident Review (PASRR) process completed. The EHR showed Resident 11 had a Level II PASRR uploaded in their record, dated 03/03/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/03/2025 at 1:01 PM, when asked if the Level II PASRR for Resident 11 should been included on the MDS, Staff G, MDS Director, said yes. During an interview on 02/04/2025 at 11:37AM, Staff B, DNS, said it did not meet expectations that Resident 11 did not have their Level II PASRR reflected on their MDS. 37044 3) Resident 12 admitted to the facility on [DATE] with orders for: venlafaxine (an antidepressant) for depression, mirtazapine (an antidepressant) for depression with decreased appetite, and buspirone (antianxiety medication.) The diagnosis for the use of buspirone was left blank. The 12/30/2024 Psychotropic Medication Therapy consent form for the use of buspirone, documented it was used to treat anxiety with a goal of decreasing anxiety symptoms. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact, had an active diagnosis of depression, no diagnosis of anxiety, but required the use of antidepressant and antianxiety medication. On 01/28/2025 at 3:09 PM, Staff DD, Social Service Director, confirmed Resident 12's diagnosis for the use of buspirone was anxiety disorder and anxiety should have been coded as an active diagnosis on the Admission MDS. 4) Resident 42's Quarterly MDS, dated [DATE], showed they received a restorative passive Range of Motion (ROM) program once and a bed mobility program twice during the assessment period. The 10/14/2024 Quarterly MDS showed they received a restorative passive ROM program and a bed mobility program five times each during the assessment period A restorative nursing care plan, initiated 12/01/2024, showed the resident was to participate in a passive ROM restorative nursing program (RNP) five to seven days a week to maintain upper extremity (UEs) strength, and an active ROM program five to seven days a week to maintain lower extremity (LEs) strength. The programs failed to identify what UE and LE joints would be ranged, through what planes of motion (e.g. flexion, extension, abduction, adduction, internal/external rotation) or how many sets/repetitions would be performed. The care plan did not identify a measurable objective, and the interventions were not personalized to Resident 42's needs. Additionally, there was not a bed mobility restorative program identified on the care plan. On 02/05/2025 at 11:56 PM, Staff G, MDS Director, said Resident 42's 10/14/2024 and 01/12/2025 quarterly MDS' needed to be corrected. Staff G acknowledged the resident was not on a bed mobility restorative /functional maintenance program and the passive ROM program did not identify a measurable objection or have interventions that were personalized to Resident 42's needs. 42960 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) A review of the Quarterly MDS, dated [DATE], shows Resident 1 was admitted to the facility on [DATE], with a diagnosis of a cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die) affecting their right dominant side. The MDS also showed Resident 1 was on a restorative nursing program documenting passive range of motion for five days and dressing and/or grooming for five days in the last seven calendar days for at least 15 minutes. On 02/05/2025 at 11:56 AM, Staff G, Licensed Practical Nurse (LPN)/MDS Director, acknowledged the information that was coded for restorative, on the most recent MDS, should not have been collected. 6) A review of the Quarterly MDS, dated [DATE], showed Resident 65 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (stroke) affecting left non-dominant side. The MDS also showed Resident 65 was on a restorative nursing program documenting passive range of motion for six days in the last seven calendar days for at least 15 minutes. On 02/05/2025 at 11:56AM, Staff G, LPN/MDS Director, acknowledged the information that was coded for restorative, on the most recent MDS, should not have been collected. 50488 7) Resident 16 admitted to the facility on [DATE] and was receiving dialysis. The MDS, dated [DATE], showed Resident 16 had a significant change and was no longer receiving dialysis but was receiving hospice services. The Quarterly MDS, dated [DATE], had dialysis marked and hospice was not marked. On 01/28/2025 at 10:26 AM, Staff G LPN/MDS Director, said that they had marked the MDS incorrectly and would submit a modification. 8) Resident 32 was admitted to the facility on [DATE] with hospice services. The Quarterly MDS, dated [DATE], showed Resident 32 was moderately cognitvely impaired and needed substantial assistance for most Activities of Daily Living (ADLs). A review of hospice records showed Resident 32 graduated from their services on 04/12/2024. The Significant Change MDS, dated [DATE] was marked for hospice. No further MDS assessments were completed until 07/12/2024. A review of provider notes dated 10/29/2024, 12/03/2024, 12/25/2024, all showed Resident 32 had a right hand contracture. The Quarterly MDS, dated [DATE], functional limitation in range of motion section, was marked no impairment for upper extremities (shoulder, elbow, wrist, hand). On 01/28/2025 at 2:48 PM, Staff G, LPN/MDS Director, said they triggered the Significant Change MDS to ensure staff would have reviewed and updated the care plan due to hospice being discontinued. Staff G said it had not been completed correctly and the care plan had not been updated accordingly. When asked if the right hand contracture should have been marked on the MDS to ensure the impairment and interventions were on the care plan, she said, yes. 9) Resident 57 was admitted to the facility on [DATE] with a diagnosis of end stage renal disease which required hemodialysis (treatment that removes waste products and excess fluids from the blood). The Admission MDS, dated [DATE], showed Resident 57 was cognitively intact and needed substantial assistance with most ADLs. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an order on the Medication Adminstration Record, dated 12/12/2024, showed nursing staff were to monitor a dialysis catheter to the left chest. Review of disharge hospital notes, dated 12/12/2024, showed Resident 57 had a left tunneled hemodyalisis catheter (a central venous access device specifically designed for kidney replacement therapy). Review of the Admission MDS, dated [DATE], showed the section for Special Treatments, Procedures, and Programs was marked no for intravenous access and was not marked for a central line. On 01/28/2025 at 10:29 AM, Staff G, MDS Director, said they missed marking the MDS for the intravenous access and central line. When asked if those omissions would have affected the accuracy of the care plan, she said it would have as the MDS drives the care plan. Reference WAC 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Reviews (PASRR) were complete and accurate for 2 of 7 sampled residents (Residents 11 & 12) reviewed for PASRR. This failure placed the residents at risk of unmet and unidentified care needs, and a diminished quality of life. Findings included . 1) Resident 11 was admitted to the facility on [DATE] with diagnoses of post-traumatic stress disorder (PTSD, a mental health condition triggered by an extremely stressful or terrifying event), depression, and anxiety. Review of the Electronic Health Record (EHR) showed Resident 11 had a Level II PASRR uploaded in their record, dated 03/03/2023, and a Level I PASRR, dated 05/02/2024. Resident 11's Level II PASRR was completed in 2023 and only addressed their diagnosis of PTSD. Resident 11's Level I PASRR, completed 05/02/2024 prior to their admission, only had PTSD selected. Resident 11's diagnosis list was updated on admission, 05/02/2024, with the addition of depression and anxiety. The EHR showed no additional Level I PASRRs were completed to account for the new diagnoses in Resident 11's chart. During an interview on 02/05/2025 at 1:51 PM, Staff DD, Social Services Director (SSD), said Resident 11's current Level II PASRR was uploaded on 02/24/2023. When asked if the referral needed to be redone due to Resident 11's mood management medications that were added since the Level II PASRR was completed, Staff DD said they had only been advised to redo a PASRR if diagnosis change, not medications. During an interview on 02/05/2025 at 2:08 PM, Staff B, Director of Nursing Services (DNS), when asked about Resident 11 only having a diagnosis of PTSD with the 2023 Level II PASRR, and with the most recent admission on 05/02/2024 now having additional diagnoses of anxiety and depression, if the Level I PASRR completed on 05/02/2024 was accurate, said they would look into this. During a follow up in interview on 02/06/2025 at 10:50 AM, Staff B, DNS, said they had looked into Resident 11's PASRRs and the Level II PASRR should have been redone. 37044 2) Resident 12 admitted to the facility on [DATE] with orders for: venlafaxine (an antidepressant) for depression, mirtazapine (an antidepressant) for depression with decreased appetite and buspirone (antianxiety medication) for anxiety. A Level I PASSR, dated 12/31/2024, showed the resident had a diagnosis of depressive disorder, but did not have a diagnosis of anxiety disorder. The assessment determined a Level II evaluation was required for indicators of serious mental illness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 12/30/2024 Psychotropic Medication Therapy consent form for the use of buspirone showed the reason for use was anxiety. The expected benefits were documented as Decrease Anxiety Symptoms. On 01/28/2025 at 3:09 PM, Staff DD, SSD, said the Level I PASRR was inaccurate and needed to be updated to reflect Resident 12's anxiety disorder. Reference WAC 388-97-1915 (1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation, interview and record review, the facility failed to review and revise a comprehensive plan of care to include resident specific interventions for 7 of 23 sampled residents (Residents 65, 4, 6, 11, 27, 12 and 61) reviewed for care plans. The failure to establish care plans that were individualized, accurately reflected assessed care needs and provided direction to staff, placed residents at risk to receive inappropriate and inadequate care to meet their individualized needs. Findings included . 1) Resident 65 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (stroke) affecting left non-dominant side. The quarterly Minimum Data Set (MDS/an assessment tool), dated 12/30/2024, documented the resident was moderately cognitively impaired. On 01/27/2025 at 7:34 AM, Resident 65 was in bed and appeared asleep. The bed was observed against the wall and window. On 02/03/2025 at 2:23 PM, Resident 65 was sitting up in bed watching TV. Their bed was observed against the wall. A Review of Resident 65's care plan did not show a focus or intervention listed about their bed being against the wall. 2) Resident 4 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident was cognitively intact. On 01/27/2025 at 7:29 AM, Resident 4 was sitting up in bed watching TV and their bed was observed against the wall. On 02/03/2025 at 2:21 PM, Resident 4's bed was observed against the wall and they were sitting next to their bed in their wheelchair watching television. A review of Resident 4's care plan did not show a focus or intervention listed about their bed being against the wall. On 01/29/2025 at 12:16 PM, Staff D said Resident 4 and Resident 65 did not have care plan, evaluation, consent or an order for their bed being against the wall. On 01/29/2025 at 1:57 PM Staff B, Director of Nursing (DNS) said she could not find a care plan, evaluation, consent or order for Resident 4 or Resident 65's bed being against the wall in their charts and it was her expectation that these things were in the chart. 50945 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident 6 was admitted to the facility on [DATE] and had a diagnosis that included kidney disease that required dialysis (treatment to filter blood and remove excess fluid and waste buildup). The Quarterly MDS, dated [DATE], showed Resident 6 was cognitively intact and was dependent on staff regarding their lower body. Review of Resident 6's care plans showed their care plan was missing information regarding details of dialysis, such as Resident 6's nephrologist information and their goal dialysis weight. Further review showed Resident 6's care plans showed they were missing information on mobility bars (bars on bed to help resident reposition themselves) being used. During an interview on 02/03/2025 at 11:51 AM, when asked who Resident 6's nephrologist was, Staff C, RCM said they did not know their specific name and that Resident 6 went to [NAME] for those services. When asked what Resident 6's goal weight was supposed to be, Staff C said it typically was put in the care plan, that it was not in Resident 6's care plans, and it should have been. During an interview on 02/04/2025 at 11:18 AM, Staff B, DNS, said a care plan should be in each resident's Electronic Health Record (EHR) for the use of side rails/mobility bars, and confirmed the mobility bars were not in Resident 6's care plans. When asked if Resident 6 should have had the name of their nephrologist or their dialysis goal weight, Staff B said yes, they should be in the care plan. 4) Resident 11 was admitted to the facility on [DATE] and had diagnoses of post-traumatic stress disorder (PTSD, a mental health condition triggered by an extremely stressful or terrifying event), depression, and anxiety. Review of the EHR showed Resident 11 had a Level II Preadmission Screening and Resident Review (PASRR) uploaded in their record, dated 03/03/2023. During an interview on 02/05/2025 at 1:51 PM, when asked if the Level II PASRR recommendations were on the care plan, Staff DD, Social Services Director said for the 05/02/2024 admission, it was not there and they did not know the reasoning it was not there, and that it should have been. 5) Resident 27 was admitted to the facility on [DATE] and had diagnoses of dementia and anxiety. Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment, was taking an opioid (strong pain reliever) and psychotropic medications (affect behavior, mood, thoughts or perceptions), and was receiving hospice services (end of life care). Review of Resident 27's care plans showed they did not have resident specific information in their care plan for their diagnosis of dementia, and did not have non-pharmacological (non-medication) interventions for staff on how to interact with Resident 27 to decrease anxiety or to handle behaviors. During an interview on 01/31/2025 at 10:53 AM, when asked if the care plan should include what Resident 27's anxiety or behaviors present like, Staff C said that the RCM or nurse would have to know about the behaviors and document them to care plan them. When asked if Resident 27's care plans included anything about opioid usage, Staff C said they did not see anything and that there should be. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/04/2025 at 11:26 AM, when asked what they expected in the care plan for Resident 27 regarding their diagnosis of dementia, Staff B, DNS, said all care needs, that there was a diagnosis of dementia, and interventions on how to care for Resident 27. When asked about Resident 27 being offered a standard alternative of yogurt and declining, after not eating any of their lunch, Staff B said that staff should have contacted family for information on what Resident 27 liked to eat and this should have been included on the care plan. Staff B said they would expect non-pharmacological interventions, specific to the resident, for dementia care or psychotropic medication usage to be in the care plans. After reviewing Resident 27's care plan, Staff B said they did not see in the care plan of what worked for Resident 27 related to non-pharmacological interventions. 37044 6) Resident 12 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of depression and required use of antianxiety and antidepressant medication during the assessment period Review of the Psychotropic Drug Use care area assessment (CAA), dated 01/06/2025, showed Resident 12 received psychotropic medications for anxiety and depression. It was documented in the CAA that the psychotropic drug use would be addressed in the care plan. An antidepressant medication for depression care plan, initiated 01/07/2025, directed staff to administer medications as ordered and to monitor for adverse side effects associated with antidepressant medication use. The care plan did not identify what antidepressant medications the resident received, identify the resident specific Target Behaviors (TB)s each medication was intended to treat or direct staff to monitor for and document when the behaviors were exhibited On 01/28/2025 at 3:09 PM, Staff DD, Social Services Director, said Resident 12's antianxiety and antidepressant care plans should have identified what medications the resident received, the specific TBs each medication was intended to treat and directed staff to monitor an document when the behaviors were exhibited. 7) Resident 61 admitted to the facility on [DATE]. Review of the 11/24/2024 Quarterly MDS showed the resident was cognitively intact, and identified being around animals such as pets, keeping up on the news, and getting fresh air when the weather was nice were somewhat important to them, while listening to music they liked was, very important. Review of Resident 61's activity care plan, with a target date of 05/15/2025, identified the resident liked to watch television, listen to music: would have opportunities to watch TV or listen to music and visit with family. The resident's other activity interests were identified on the 11/24/2024 MDS including being around animals/pets and going outside for fresh air when the weather was nice were not incorporated into their activity plan of care. On 02/05/2025 at 12:19 PM, Staff C said Residents 61's interest in being around pets/animals and going outside for fresh air when the weather was nice should have been included on their activity care plan. Reference F604 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1020(1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to ensure care plans were consistently reviewed and revised to meet residents' current needs for 7 of 23 sampled residents (Residents 65, 27, 58, 51, 7, 18 & 32) reviewed for care plans. This failure to revise care plans placed residents at risk for unmet care needs. Findings included . 1) Resident 65 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction affecting left non-dominant side. The quarterly MDS dated [DATE] documented the resident was moderately cognitively impaired and was on a pain medication regimen and the resident reported they had not had pain or hurting in the last 5 days. A review of Resident 65's care plan listed a focused intervention initiated on 09/27/2024 that said they have a history of chronic sores in their mouth making it painful to chew their food and they have an oral suspension for pain control. On 01/30/2025 at 12:42 PM Staff B, Director of Nursing (DNS), said I don't see that Resident 65 is on an oral analgesic. The care plan is not accurate and does not reflect the medication administration record. Staff B's expectation is for the nurse to notify the provider and review it with them. 50945 2) Resident 27 was admitted to the facility on [DATE] and had diagnoses of dementia and anxiety. Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment, was taking psychotropic medications (affect behavior, mood, thoughts or perceptions), and was receiving hospice services (end of life care). The EHR showed that in November of 2024, Resident 27 started to receive as needed antianxiety medication, lorazepam. Resident 27 was and had been taking an antipsychotic (decreases symptoms of a loss of contact with reality). Resident 27's care plans showed the psychotropic medication section was not updated to reflect two different classes of medication. Review of the care plans showed Resident 27 had a care plan, initiated on 10/19/2022, that said the Level I Preadmission Screening and Resident Review (PASRR) was negative. Review of the EHR showed Resident 27 had a Level II PASRR referral made on 04/24/2024. During an interview on 01/31/2025 at 10:53 AM, Staff C, RCM, said the lorazepam medication was not on the care plan and should have been. When asked if the care plan showed what class of drug (antianxiety vs. antipsychotic) the side effect monitoring was for, Staff C said the current care plan should have said antipsychotic, and they typically would create care plans with different classes of drugs being taken and would update the care plan to reflect this. When asked about Resident 27 having a care plan for a negative PASSR that was not updated until 01/27/2025, said it was not done timely and this did not meet expectations. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/04/2025 at 11:26 AM, Staff B, DNS, when asked when a resident had a diagnosis of dementia and was on psychotropic medication, what was your expectation for the care plan to include, said what medication Resident 27 was on, potential side effects, and behaviors associated with the medication. 37044 3) Resident 58 admitted to the facility on ,d+[DATE]. Review of the 11/30/2024 quarterly MDS showed the resident had moderate difficulty hearing with the use of a hearing appliance, adequate vision with use of corrective lenses, required set-up/clean-up assistance with oral care, was frequently incontinent of bowel and bladder and required substantial/maximal assistance with toileting, and moderate assistance with hygiene. On 01/22/2025 at 4:21 PM, Resident 58 reported their glasses prescription had not be good for the past few years and indicated they filled out a request for optometry services. A 12/24/2024 request for medical eye care was found in Residents 58's electronic health record. A vision care plan, initiated 11/26/2024, documented Resident 58 had prescription glasses, and listed one intervention Refer to optometrist as needed. The care plan did not address the resident's report tha the prescription had not been goor for a few years, their 12/24/2024 request for medical eye care, direct staff to ensure the glasses were within reach, were clean and in good repair, or provide any instruction to staff about the assistance, if any, the resident required with applying their glasses (e.g. cueing/reminders etc.) On 01/22/2025 at 4:16 PM, Resident 58 reported while they were hospitalized at the end of 2024, the facility had secured their belongings. Upon re-admitting to the facility, the resident said their items were returned but their hearing box was missing. A hearing care plan, initiated 11/26/2024, documented Resident 58 was deaf in the left ear, hard of hearing in the right ear, and utilized a voice amplifier to hear better. The care plan identified one intervention Refer to audiologist as needed. There was no direct to staff to approach from the right side when speaking, to ensure the resident's amplifier was within reach, or was present and functional. The care plan also failed to identify Resident 58's amplifier had been missing since their readmitted on [DATE]. A dental care plan, initiated 11/26/2024, documented the resident had natural teeth, identifed one intervention Refer to dentist as needed. There was no direction to staff to assist the resident or to set-up the resident for oral care, or documentation to show the amount assistance, if any, the resident required. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A potential for impaired skin integrity care plan, initiated on 11/22/2024, showed a goal of resident's skin would remain intact . The care plan identified three interventions: evaluate skin integrity, monitor nutritional status, and provide skin care per facility guidelines as needed. The facility's skin care guidelines were not identified or defined. The care plan did not insruct staff to assist with, or to cue the resident to turn and reposition, did not address the resident's frequent incontinence of bowel and bladder, that they required maximal assistance with toileting or direct staff to assist with incontinent care. Additonally, the risk factors the facility identifed to determine the resident was at risk for skin breakdown were not identified. On 01/29/2025 at 1:55 PM, Staff C, Resident Care Manager (RCM), said the above referenced care plans were incomplete, not personalized and needed to be reviewed and revised to accurately reflect Resident 58's care needs. 4) Resident 51 admitted to the facility on [DATE]. Review of the 11/09/2024 quarterly MDS showed the resident was cognitively intact and received chemotherapy while a resident. A Cancer care plan, initiated 08/04/2024, documented the resident was receiving chemotherapy and directed staff to gown and glove if there was a chance of contact with body fluids. A chemotherapy care plan, revised 08/04/2025, documented the resident was on contact isolation precautions due to receiving chemotherapy. On 01/30/2025 at 12:37PM, Resident 51 stated he had completed the previous cycle and would not start the next until after they had a hernia repair. On 01/29/2025 at 2:03 PM, Staff C, RCM, said the the above care plans were inaccurate and needed to be revised. 50392 5) Resident 7 admitted to the facility 02/03/2024. The Quarterly MDS, dated [DATE], indicated Resident 7 was cognitively intact. Review of resident 7's Physician Orders for Life-Sustaining Treatment (POLST, a medical document that outlines a patient's preferences for end-of-life care to ensure that the patient's wishes are followed in case of a medical emergency) document, dated 07/22/2024, indicated resident 7's preference was for Cardiopulmonary Resuscitation (a medical procedure performed in an attempt to restore blood circulation and breathing) was to be attempted if Resident 7 had no pulse or was not breathing. Review of Resident 7's care plan, documented Resident 7's POLST status was DNR (do not resuscitate), date initiated 7/22/2024. On 01/28/2025 at 11:57 AM, [NAME], Resident Care Manager, said Resident 7's care plan was incorrect and should have been updated to reflect Resident 7's POLST wishes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6)Resident 18 admitted to the facility on [DATE]. The Quarterly/5-day MDS, dated [DATE], indicated Resident 18 was cognitively intact and had depression (condition of persistent feelings of sadness, hopelessness, and loss of interest in activities). Resident 18's diagnosis included Major Depressive Disorder. A review of Resident 18's Care Plan documented that Resident 18 was taking the antidepressant medication Cymbalta, date initiated, 07/19/2024. A review of Resident 18's active Order Summary Report showed no current order for the antidepressant Cymbalta. A review of the medication order for Cymbalta showed it had been discontinued 01/06/2024. On 02/04/2025 at 10:22 AM, Staff B, Director of Nursing Services, said that Resident 18's care plan should have been updated when there were changes. 50488 7) Resident 32 admitted to the facility on [DATE] with hospice (end of life) services. The Quarterly MDS, dated [DATE], showed Resident 32 was moderately cognitively impaired and needed extensive assistance with most ADLs. Review of the records showed Resident 32 no longer qualified for hospice services as of 04/12/2024. A Significant Change MDS was triggered on 04/13/2024 which showed the resident still received hospice services. No assessment was created within 14 days indicating Resident 32 no longer received hospice services. On 01/22/2025 at 11:17 AM, Resident 32 was observed lying in a hospital gown in bed and was noted to have a significant right hand contracture. The skin to the palm of the hand was dry, flaking, yellow in color and thickened. When asked if staff offered range of motion exercises or any type of cleaning for the hand, Resident 32 said, no. When asked about getting out of bed, Resident 32 said the preference would be to get dressed and in the wheelchair for activities and meals. Resident 32 said they were getting, lazy feet from not being out of bed for so long. Review of provider notes dated 5/30/2024, 7/26/2024, 7/29/2024, 8/8/2024, 10/29/2024, and 12/25/2024 showed Resident 32 had a right hand contracture. It was not identified on the Significant Change MDS dated [DATE] or the Quarterly MDS dated [DATE]. There were no interventions regarding the contracture. On 1/22/2025 at 11:17 AM, Resident 32 said they had trouble with hearing at times due to wax build up. Resident 32 said drops had been placed in their ears at one point, but that it had been over a month since they could hear very well. A review of the orders for January 2025 showed ear drops were available every 12 hours as needed but none had been administered. A Social Services note dated 10/16/2024 indicated Resident 32 was happy with care and no changes needed to be made to the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan on 1/23/2025 showed several sections had not been updated since Resident 32 graduated from hospice on 4/12/2023. The care plan showed Resident 32 was still receiving hospice services. There was nothing on the care plan about hearing, the right hand contracture, preferences for being out of bed, or restorative programs. On 1/28/2025 at Staff G, MDS Director, said the Significant Change MDS triggered on 04/13/2024 should have been coded correctly to make sure the care plan was reassessed and revised. Staff G said the team should have evaulated Resident 32's change of condition, re-evaluated the care plan, and implemented needed interventions. On 1/28/2025 at 10:58 AM Staff J, Rehab Director, said their department did not know Resident 32 had graduated from hospice services. Staff J thought a splint had been trialed for the right hand but could not produce documentation verifying that. Staff J said they would initiate a restorative program right away and would work with nursing to address the right hand contracture. On 1/29/2025 at 3:07 PM Staff B, DNS, said the expectation was that care plans are reviewed and revised quarterly, with any significant change, and as needed. Reference WAC 388-97-1020(2)(c)(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 13 of 25 sample residents (Residents 65, 175, 3, 55, 42, 12, 71, 7, 40, 69, 1, 27 and 6) reviewed. Facility nurses' failure to obtain, accurately transcribe, follow, and clarify physicians' orders when indicated, and to only sign for tasks that were completed, placed residents at risk for medication errors, delays in treatment, unmet care needs and other potential negative outcomes. Findings included . 1) Resident 65 was admitted to the facility on [DATE] with multiple diagnosis including hypertension (a condition in which the blood pressure in the arteries is consistently too high). The quarterly minimum data set (MDS-an assessment tool), dated 12/30/2024, documented the resident was moderately cognitively impaired. A review of Resident 65's electronic medical record (EHR) showed an order for: -hydrochlorothiazide (a medication used to decrease blood pressure) 12.5 milligrams (mg-a unit of weight in the metric system) once a day with instructions to not give the medication for a Systolic Blood Pressure (SBP) less than 110. - Metoprolol (a medication used to decrease blood pressure) 25 MG twice a day with instructions to not give the medication for a SBP less than 110 or a heart rate (HR) less than 60. -Lisinopril (a medication used to decrease blood pressure) 5 MG once a day with instruction to not give the medication for SBP less than 110. A review of Medication Administration Record (MAR) for December 2024 showed Resident 65 had a blood pressure of 107/61 and a HR of 78. All three medications were documented as given on 12/08/2024. On 01/30/2025 at 10:31 AM, Staff D, Licensed Practical Nurse (LPN) and Resident Care manager (RCM), said Resident 65's blood pressure medications should have been held that day. On 01/30/2025 at 12:42 PM Staff B, Director of Nursing (DNS) said Resident 65's blood pressure medications should not have been given. 2) Resident 175 was admitted to the facility on [DATE] with multiple diagnosis. The admission MDS, dated [DATE], documented the resident was cognitively intact. A review of Resident 175's EHR showed an order, dated 01/16/2025, for Enzalutamide (a medication used to treat cancer) 80 mg to be given one time a day. A review of Resident 175's January 2025 MAR showed on 01/16/2025 and 01/18/2025 a 9 was documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/27/2025 at 2:33 PM Staff D, LPN/RCM said when a 9 was documented on a resident's MAR it meant the medication was not available. Staff D said the nurse should call the pharmacy to see what the holdup was and notify the doctor. On 01/28/2025 at 10:22 AM, Staff B, DNS, said when a medication was not available the nurse should document in a progress note that the doctor was notified. Staff B stated, I didn't see any documentation on the 16th or the 18th by the nursing staff. 46793 3) Resident 3 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 3 was cognitively intact. A physician's order, dated 10/08/2024, documented Resident 3 was ordered PRN (as needed) acetaminophen (Tylenol) Tablet 325 milligrams (times 2 tablets), by mouth every six hours as needed for elevated temperature, greater than 100.6 degrees. The MAR/Treatment Administration Record (TAR) documented Resident 3 was given acetaminophen on: 01/07/2025 with a temperature of 97.5/Pain level 3. 01/19/2025, no temperature taken/pain level 5. 01/23/2025, no temperature taken/pain level 5. On 01/29/2025 at 11:09 AM, in a joint interview with Staff A, Administrator, and Staff B, DNS, Staff B said when assessing a resident for pain, if the resident was alert and oriented, the facility used the pain numerical scale, if the resident was not alert and oriented the facility used nonverbal ques to indicated pain. Staff B said resident pain should be assessed every shift. When shown the acetaminophen order and the perimeters of the order, Staff B said the medication should not have been given per the perimeters of the order. When asked if nursing staff should have contacted the physician to provide the medication outside the perimeters of the order, Staff B, said yes, staff should have contacted the physician. 37044 4) Resident 55 had an order for lisinipril (blood pressure medication) daily, with direction to hold the medication for a systolic blood pressure (SBP) less than 100 or a pulse (P) less than 60. Review of the January 2025 MARs showed on the following dates facility nurses failed to hold the medication as ordered: - 01/13/2025- SBP 98; P 58 - 01/18/2025- P 58 A 01/09/2025 order for hydrochlorothiazide (hctz, a diuretic) daily, with direction to hold the medication for a SBP less than 100 or P less than 60. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2025 MARs showed on the following dates facility nurses failed to hold the medication as ordered: - 01/09/2025- SBP 98; P 43 - 01/13/2025- SBP 97; P 58 - 01/18/2025- P 58 On 02/03/2025 at 2:18 PM, Staff C, Resident Care Manager (RCM), said on the above referenced occasions facility nurses administered the hctz and lisinipril outside of the physician ordered parameters, when the medications should have been held. 5) Resident 42 had a 01/05/2025 order for oxygen (O2) at two liters per minute (2 L/min) via nasal cannula (NC) to maintain O2 saturation (SpO2) greater than 90%. On 01/23/2025 at 10:36 AM and 11:40 AM, Resident 42 was observed in bed receiving O2 at 4L/min via NC, which was confirmed by Staff L, Infection Preventionist, who was present for the 11:40 AM observation. On 01/27/2025 at 11:16 AM, Resident 42 was in bed receiving O2 via NC at 4L/min, which was confirmed at that time by Staff D, Resident Care Manager. On 01/27/2025 at 12:36 PM, when asked if the nurses administered Resident 42's O2 at the physician ordered rate of 2L/min Staff B, Director of Nursing Services (DNS), stated, No. Review of the January 2025 Medication Administration Record (MAR) showed Staff S, Registered Nurse (RN), signed on 01/23/2025 and 01/27/2025 they administered O2 at 2L/min via NC as ordered. There was no documentation that showed Resident 42 received O2 at 4L/min, the rate that was actually administered. On 01/27/2025 at 12:36 PM, Staff B, DNS, confirmed Staff S, RN, erroneously signed they administered O2 at 2L/min as ordered and failed to document the actual rate of 4L/min that they administered Staff B, said the MARs should accurately reflect the medication(s)/dose(s) that the nurse actually administered. Resident 42 had a 01/22/2025 order for Ondansetron (anti-nausea medication) as needed for nausea/vomiting. A 01/23/2025 nurse's note, written by Staff S, RN, documented Resident 42 did not eat well at breakfast due to nausea, and was administered 8 milligrams (mg) of as needed (PRN) zofran. Review of the January 2025 MAR showed Staff S did not sign that Resident 42's zofran was administered. On 01/27/2025 at 12:36 PM, Staff B, DNS, said all medications administered to residents were required to be documented on their MAR, but acknowledged on the above referenced occasion the nurse failed to do so. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 01/22/2025 provider note showed Resident 42 had experienced increased fatigue and difficulty breathing. The provider ordered the following: stat (immediately : without delay) chest x-ray (CXR), complete blood count (CBC, a blood test used to look at overall health and find a wide range of conditions, including anemia and infection), and basic metobolic panel (BMP, a blood test that measures eight substances in your blood, such as glucose, calcium and electrolytes), to continue intranasal O2 to keep sats [SpO2] 90% - 94%, and to monitor the resident closely for acute changes. Review of the facility's lab/radiology contract(s) showed stat labs and x-rays were available 24 hours a day, seven days a week. Results for stat orders, on average, would be available within 6-8 hours of the lab/radiology being notified of the order. Review of MAR showed Resident 42's O2 order still directed staff to administer O2 at 2L/min to maintaintain SpO2 greater than 90%, rather than to keep Spo2 at 90% - 94%, as ordered. On 01/27/2025 at 12:55 PM, Staff B, DNS, said the order to administer O2 to maintain Spo2 from 90% - 94 % Should have been [transcribed] but was not. The EHR showed Resident 42's CBC and BMP were not drawn until 01/23/2025 at 5:15 PM, and the CXR was not performed until 01/23/2025 at 4:15 PM. On 01/27/2025 at 1:07 PM, when asked if the nurse ordered the residents CBC, BMP and chest x-ray stat as directed by the provider Staff B, DNS, stated, No. A 12/10/2024 order directed nurses to change Resident O2 tubing weekly and date it. On 02/03/2025 at 10:02 AM, Resident 42's humidifier and O2 tubing were dated 01/22/2025. This was confirmed on 02/03/2025 at 2:32 PM by Staff C, Resident Care Manager (RCM). Review of the MAR showed Staff S, RN, signed they changed Resident 42's O2 tubing on 01/28/2025 as ordered. On 02/03/2025 at 2:52 PM, Staff C, RCM, said Staff S, RN, falsely/erroneously signed for a task they did not perform. 6) Resident 12 admitted to the facility on [DATE] with orders for a CBC, C- reactive protein (CRP, a blood test that checks for inflammation in the body), comprehensive metabolic panel (CMP, routine blood test that measures 14 different substances in a sample of your blood) and a erythrocyte sedimentation rate (ESR, a blood test that can show if you have inflammation in your body) to be drawn weekly while on intravenous (IV) antibiotics, with direction to fax the results to Infectious Disease practitioner. The January 2025 TAR showed the weekly labs were scheduled to be drawn on 01/06/2025, 01/13/2025, 01/20/2025 and 01/27/2025. Review of the documentation showed the following - 01/06/2025 weekly lab draw- the nurse signed that the labs were drawn as ordered. Review of the EHR showed no labs were present in the record for 01/06/2024. There was a CBC drawn on 01/08/2025 and a CMP, ESR and CRP drawn on 01/09/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/31/2025 at 3:00 PM, when asked why the stat UA had not been completed for Resident 71 as was ordered, Staff L, Infection Preventionist, said there was a supply shortage from their personal supplies at that time. When asked if it met her expectations that Resident 71's order for stat UA had not been completed, Staff L said, none of it meets my expectations. 8) Resident 7 admitted to the facility 02/03/2024. The Quarterly MDS, dated [DATE], indicated Resident 7 was cognitively intact. Review of the Treatment Administration Record (TAR), dated 01/01/2025-01/31/2025, showed an order for staff to monitor for constipation, delirium, over sedation, change in mental status, reduced respiration two times a day. This order had an area for staff to document Y/N (yes or no) daily on day shift and night shift. The order did not specify which sign/symptom (constipation, delirium, over sedation, change in mental status, reduced respirations) a Y would indicate. Further review of the TAR from 01/01/2025 - 01/26/2025 showed on the following dates/shifts staff had documented a Y to indicate that Resident 7 had one or more of the signs/symptoms (constipation, delirium, over sedation, change in mental status, reduced respiration) present. No associated progress note was found for any of the dates to clarify which signs or symptoms were present. 01/01/2025 AM shift- Y - no associated prog note located 01/01/2025 PM shift- Y - no associated prog note located 01/02/2025 AM shift- Y - no associated prog note located 01/03/2025 AM shift- Y - no associated prog note located 01/04/2025 AM shift- Y - no associated prog note located 01/05/2025 AM shift- Y - no associated prog note located 01/06/2025 AM shift- Y - no associated prog note located 01/07/2025 AM shift- Y - no associated prog note located 01/08/2025 AM shift- Y - no associated prog note located 01/08/2025 PM shift- Y - no associated prog note located 01/09/2025 AM shift- Y - no associated prog note located 01/09/2025 PM shift- Y - no associated prog note located 01/10/2025 AM shift- Y - no associated prog note located 01/11/2025 AM shift- Y - no associated prog note located 01/12/2025 AM shift- Y- no associated prog note located (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/12/2025 PM shift- Y- no associated prog note located 01/13/2025 AM shift- Y- no associated prog note located 01/14/2025 AM shift - Y- no associated prog note located 01/16/2025 AM shift - Y- no associated prog note located 01/16/2025 PM shift - Y- no associated prog note located 01/17/2025 AM shift - Y- no associated prog note located 01/17/2025 PM shift - Y- no associated prog note located 01/18/2025 AM shift - Y- no associated prog note located 01/18/2025 AM shift- Y- no associated prog note located 01/24/2025 AM shift- Y- no associated prog note located 01/26/2025 AM shift- Y- no associated prog note located On 01/31/2025 at 10:18 AM, Staff C, Resident Care Manager, after reviewing the TAR order said a Y indicated that Resident 7 was constipated. When it was pointed out that the order did not specify which of the listed signs/symptoms a Y answer indicated was present, Staff C said staff would put in a progress note for any of the positive signs (Y answers). On 02/04/2025 at 10:17 AM, Staff B, Director of Nursing Services, after reviewing the TAR order and asked what a Y indicated Staff B said, a Y would have indicated that staff had noted one or multiple of the symptoms. When asked what her expectation was if a Y was indicated, Staff B said, staff should make a progress note with a Y and document what symptoms they observed then notify the provider. When asked if she could locate any progress notes for the 27 Y's in January 2025, Staff B said she did not see any, and it did not meet her expectations. 50488 9) Resident 40 admitted to the facility on [DATE] with hospice services. The Admission MDS, dated [DATE], showed Resident 40 was severely cognitively impaired and needed extensive assistance for all ADL's. Review of the January 2025 MAR showed the following scheduled medications were not given as prescribed and nothing was documented as to rationale. The fields were left blank. Phenobarbital (medication for seizures) 30 mg tablet three times per day: 8 AM dose not given: 1/8/2025, 1/10/2025, 1/15/2025, 1/17/2025, 1/20/2025, 1/22/2025, and 1/25/2025 10 PM dose not given: 1/17/2025 (continued on next page)

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	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Morphine sulfate [narcotic pain medication] 20 mg/ml 1ml every 6 hours: 6 AM dose not given: 1/10/2025, 1/15/2025, and 1/25/2025 Trazadone 100 mg at night: not given on 1/17/2025. Risperdal 0.5 mg two times a day: not given on PM shift on 1/17/2025. On 01/29/2025 at 3:15 PM Staff B, DNS, said the expectation was that all medications were to be given as ordered. If medications were not given, a rationale should have been documented and the provider notified. 50945 10) Resident 69 was admitted to the facility on [DATE] and had a feeding tube (gastric tube, G-tube). During an observation of medication administration on 01/29/2025 at 9:21 AM, Staff V, RN, was observed to substitute a pill in place of the ordered liquid multivitamin. During an interview on 01/29/2025 at 10:12 AM, Staff V, RN, said the medication carts did not have the liquid multivitamin on them. When asked if the provider or pharmacist had been notified that they were using a pill in the place of a liquid, Staff V said they did not notify them. Review of the Medication Administration Record (MAR) for Resident 69 showed the nurses had documented Resident 69 received the liquid multivitamin from 01/01/2025 to 1/29/2025. During an interview on 01/29/2025 at 10:14 AM, Staff D, RCM, said staff should have talked to the pharmacist to get it ordered from them, or the doctor should have been notified that they did not have the liquid form. During a follow up interview on 01/30/2025 at 10:26 AM, Staff D, RCM, said they had now talked to the pharmacist and were told they could crush the multivitamin. When asked if the order should be updated, Staff D said yes, the order needed to be updated. 11) Resident 1 was admitted to the facility on [DATE]. During a medication administration observation on 01/30/2025 starting at 8:33 AM, Staff T, Licensed Practical Nurse (LPN), took Resident 1's blood pressure (BP) with an automatic vitals machine, the resident was shaking, and the BP read as 95/70. Staff T reported they would hold two medications due to the BP read, isosorbide (dilates blood vessels) and metoprolol (treats chest pain, heart failure and high blood pressure). During an interview on 01/30/2025 at 11:51 AM, when asked what they did with the information of the BP read, Staff T, LPN said they should have notified the provider (and did not). When asked when a manual BP should be obtained, Staff T said When its below 90? When asked if that BP was normal for the resident, Staff T said no and it should have been redone. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/31/2025 at 10:27 AM, Staff D, RCM, said they would want a nurse to recheck a BP when there was a discrepancy, if you are monitoring for BP effectiveness, or if the resident was sick. Staff D said the BP for Resident 1 was abnormally low for them, and if they were moving then the nurse should have checked manually to confirm the reading. Staff D said it did not meet expectations that there was no follow up after the low BP read for Resident 1. 12) Resident 27 was admitted to the facility on [DATE] and had diagnoses of hypertension (high blood pressure). Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment and was receiving hospice services (end of life care). Resident 27 was receiving a medication called nifedipine (treats high blood pressure and chest pain). The medication was to be held for SBP less than 110 (the top number on the blood pressure, BP) or heart rate (HR) less than 55. Resident 27's MAR for December 2024 and January 2025 (up to 01/29/2025) were reviewed and the following dates the nifedipine doses were held due to the HR: December: 5th: BP 152/51, HR 54 24th: BP 159/64, HR 52 31st: BP 157/95, HR 53 January: 8th: BP 185/94, HR 53 13th: BP181/65, HR 52 27th: BP 154/88, HR 54 28th: BP 170/63, HR 54 During an interview on 02/03/2025 at 11:41 AM, when asked what their expectation was for staff when a BP medication such as nifedipine was held and the resident still had a high BP, Staff C, RCM said they expected staff to tell the provider in order to figure out if the BP medication should still be given or not. Staff C reviewed the EHR and said they were unable to find any documentation of provider notification or that a conversation happened. 13) Resident 6 was admitted to the facility on [DATE] and had diagnoses that included kidney disease that required dialysis (treatment to filter blood and remove excess fluid and waste buildup), moderate malnutrition, and type 2 diabetes (high blood sugars). The Quarterly MDS, dated [DATE], showed Resident 6 was cognitively intact. Review of Resident 6's orders showed an active order, from 03/18/2024, for Refer to RD [Registered Dietician] for diabetic diet counseling. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/03/2025 at 11:51 AM, after looking in the EHR, Staff C, RCM said they could not find a RD visit for diabetic counseling for Resident 6. After looking at the order date, Staff C said it should have been done. During an interview on 02/04/2025 at 11:18 AM, when asked about the order for a RD diabetic counseling from 03/18/2024 not being documented, Staff B, DNS said it did not meet expectations and it should have happened. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) for 3 of 8 residents (Residents 124, 32 and 27) reviewed for ADLs. The failure to assist dependent residents with oral care, shaving and meals, placed residents at risk for decreased nutritional intake, weight loss, poor hygiene, feelings of embarrassment, diminished self-worth and a decreased quality of life. Findings included . 1) Resident 124 admitted to the facility on [DATE]. An Admit/Readmit Assessment, dated 01/24/2025, documented the resident required extensive assistance with personal hygiene. During a meeting with the Resident Council on 01/30/2025 at 10:00 AM, Resident 124 stated, I have not had my teeth brushed since I got here [7 days]. They reported a toothbrush was requested from staff on multiple occasions but had not been provided. On 01/30/2025 at 11:46 AM, Resident 124 opened their drawers and showed that there was not a toothbrush or toothpaste present in their room. Resident 124 indicated they were going to go request one again. On 01/30/2025 at 12:12 PM, an unopened toothbrush and tube of toothpaste were observed sitting on Resident 124's overbed table. On 02/03/2025 at 2:40 PM, Staff C, Resident Care Manager (RCM), said staff should have provided Resident 124 hygiene supplies the day they arrived and provided assistance with oral care the same day. 50488 2) Resident 32 admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS/an assessment tool), dated 01/08/2025, showed Resident 32 was moderately cognitively impaired and needed substantial to maximal assistance for most ADLs. On 01/22/2025 at 12:46 PM, Resident 32 was observed lying in bed. There was scruff on their face and their hair was past their shoulders, stringy, and tangled. On 01/23/2025 at 11:04 AM, Resident 32 was observed lying in bed, scruff still present and hair looked the same. Resident 32 said they had not been out of bed for a very long time and would like to get out of bed for meals and activities. Resident 32 said the facility had ordered a battery for a motorized wheelchair and was not aware what had happened with that. Resident 32 said they would prefer to get shaved at least once a week and had asked for a haircut at least 4 times. On 01/27/2025 at 2:45 PM, Staff C, RCM, said all residents should be assisted to be out of bed, if tolerated, and offered a shave daily. Staff C walked down the hall and observed several residents had not been shaved, including Resident 32. Staff C instructed the two aides working on D hallway to ensure all residents were shaved during their shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/28/2025 at 10:01 AM, Resident 32 was observed in bed with a shaved face but hair continued to be messy, long, and tangled. At 10:58 AM, Staff J, Therapy Director, said their department was unaware that Resident 32 was no longer on hospice. They said they would work with nursing to ensure Resident 32 was up in a tilt in space wheelchair for meals. At 10:06 AM, Staff I, Front Desk Receptionist, said the activities department handled hair cuts but was unable to recall the last time there was a beautician employed by the facility. They said there had been some recruitment efforts, but they had not been able to find someone . At 11:00 AM, Staff A, Administrator, said they were unaware of when the last time was the facility had a licensed beautician. She acknowledged the facility was responsible for providing those services. The Activity Director was unavailable for questioning. On 01/29/2025 at 3:07 PM, Staff B, Director of Nursing Services, said the expectation was that all residents received appropriate personal care on a daily basis. They said residents should be assessed for and assisted with safe transfers out of bed, as tolerated. 50945 3) Resident 27 was admitted to the facility on [DATE] and had diagnoses of dementia, anxiety, and malnutrition. Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment, was receiving hospice services (end of life care), and required supervision or touch assistance with eating. Review of Resident 27's care plans showed a focus on alteration in nutrition and hydration that listed an intervention/task, last revised 08/05/2023, of EATING ASSISTANCE: [Resident 27] can feed herself after setup of her meal tray. Provide supervision for intake and verbal cueing. Resident 27 also had an ADL focus that listed an intervention/task, last revised 07/16/2024, of EATING: [Resident 27] is able to hold cup, feed self with supervision, eat finger foods independently with set up/clean up assistance. During an observation on 01/24/2025 at 2:05 PM, Resident 27 was seen in their bed with their eyes and mouth open. Their meal of macaroni and cheese, veggies, chicken, bread roll, churro pieces, and yogurt were untouched. The lid from the plate was in Resident 27's bed next to them. At 2:13 PM, Staff NN, Certified Nursing Assistant (CNA), was observed to go into the room to interact with Resident 27. Staff NN said, The food is getting cold to Resident 27, left the milk and yogurt and took the rest of the meal away and then left the room. During an observation on 02/03/2025 at 1:27 PM, Resident 27 was seen with a food container on their bedside table. The door was cracked open, without any visibility to the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:28 PM, Resident 27 was observed to be unsuccessful at opening the food container, and then put their hands on their lap. Then Resident 27 picked up a food item in a paper bag, was unsuccessful with getting the food item out, and then put the paper bag back on the bedside table. Resident 27 again attempted to open the main food container, said, I can't open it and pushed the meal out of the way. At 1:32 PM, Resident 27 was able to open the paper bag, labeled mini chimis. Resident 27 said it was a sandwich and put it back on the bedside table. At 1:34 PM, Resident 27 again attempted to open the main food container, said, I can't open it, you push in the sections of the container to get it to open. Resident 27 was observed to be unsuccessful with opening the container, and then said out loud, I will wait until someone comes and opens it. Resident 27 did not make any other attempts to eat their lunch. At 2:06 PM, Staff KK, CNA, entered the room, opened the container and checked on how much was eaten. Staff KK offered to get a yogurt for Resident 27, but Resident 27 said no. Staff KK removed the food from Resident 27's bedside table. During an interview on 02/03/2025 at 4:00 PM, Staff KK, CNA, when asked what kind of supervision Resident 27 needed for meals, said they did not need any supervision, they were independent. When asked what kind of assistance was needed, Staff KK said Resident 27 needed assistance with opening items for meals. During an interview on 02/04/2025 at 11:26 AM, Staff B, DNS, said their expectation for staff when they bring the meal in, was for them to have lifted the container lid since Resident 27 required set up assistance. Staff B also said alternative foods specific to Resident 27's likes should have been care planned. Reference F656 Reference WAC 388-97-1060 (2)(c)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the facility failed to implement individualized activities for 3 of 3 sampled resident (Residents 69, 61 & 27) reviewed for activities. The failure to implement an activity plan of care that incorporated resident's stated interests, hobbies and preferences, placed the residents at risk for boredom, isolation, and a diminished quality of life. Findings included . 1) Resident 69 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool), dated 11/26/2024, documented Resident 69 had a Brief Mental Interview score of 00. Resident 69 does not speak English but was able to understand some English. Resident 69's communication and activities care plan documented Resident does not use call light, ask for assistant, but is able to make hand gestures and point to items to communicate. Resident 69 will need to be assisted to and from activities. Resident 69 enjoys music, watching TV, one on one visits from staff and being outdoors. An order, dated 01/14/2025, documented, Daily Skilled note required. Please enter detailed chart note on services provided i.e. PT [physical therapy]/OT [occupational therapy] participation, ADLs [activities of daily living], transfer status, new orders, and any concerns. everyday shift. No documentation found in electronic health record (EHR) related to the listed tasks above. An activities assessment, dated 11/30/2024, documented Resident 69 likes watching tv, scrolling online, listening to Christian & Marshallese music. Resident 69 also likes Bingo and Painting. The question Activities should be modified to address communication deficit? was marked yes. The question Does resident like independent activities (i.e. reading, puzzles etc.)? was marked yes. The EHR marked no documentation of activities provided to Resident 69. The Activities task documented Resident 69: Listened to music on 12/31/2024 and 01/20/2025. Watched TV on 12/31/2024, 01/01/2025, 01/04/2025, 01/06/2025, 01/11/2025, 01/20/2025 & 01/21/2025. Did I socialize during the 1:1 visit? On 12/31/2024, 01/01/2025 & 01/20/2025. Observations on 01/27/2025 at 8:39 AM until 10:54 AM, showed Resident 69 laid in bed in the dark, with no music, no TV, no games or individual activities. During this time, fifteen staff members entered the room and no one offered any activities to Resident 69. At 10:54 AM Staff CC, Certified Nursing Assistant (CNA) and Staff Y, CNA, entered the room and closed the door behind them. At 11: 02 AM Staff Y, CNA, brought in the hoyer (mechanical lift) and told Resident 69, they were getting her up for lunch. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 01/28/2025 at 9:01 AM until 11:22 AM, showed resident 69 sat in their wheelchair in the dark, with no music, no TV, no games or individual activities. During this time, twenty staff members entered the room and no one offered activities to Resident 69. At 12:48 PM, Resident 69 was brought their lunch meal tray. On 01/29/2025 at 10:12 AM, Staff DD, Social Services Director, said the activities assistant quit two weeks prior and the Activities Director was currently out sick. Staff AA said they had not had activities for the past week. On 01/30/2025 at 12:55 PM, Staff VV, Activities Director, said for dependent residents, activities included bringing the activities to them, things like, playdough (good for sensory), music, talking about family, conversations and busy book (open interactive book). Staff VV said the facility has two stuffed animal cats with brushes, playing with baby dolls and painting their fingernails. Staff VV said some residents don't care for some activities, but she makes a point to just sit with them. Staff VV said she will do spiritual readings/versus. Staff VV said there was also the independent cart; things like movies and popcorn, beading, coloring pages and coloring supplies, box puzzles and magnetic eraser writing tablets. When observations explained of Resident 69 sitting in the dark with no social interactions or activities offered, Staff VV said that was not accepted and staff should have offered/provided Resident 69 with individual activities. 37044 2) Resident 61 admitted to the facility on [DATE]. Review of the 11/24/2024 Quarterly MDS showed the resident was cognitively intact, and identified that being around animals such as pets, keeping up on the news, and getting fresh air when the weather was nice were somewhat important to them, while listening to music they liked was Very important. On 01/22/2025 at 9:40 AM, 01/23/2025 at 10:19 AM, 01/27/2025 at 02/03/2025 at 9:57 AM and 10:26 AM, and 02/05/2025 at 10:57 AM, Resident 61 was observed lying in bed without their television on or music playing. An activity care plan, revised 11/12/2024, documented the following goals: will have opportunities to watch TV or listen to music and will socialize in a one-to-one setting with a volunteer/visitor/activity staff two to three times a week. The care plan did not address getting fresh air or being around animals. Review of the Kardex showed under Activities it was documented one to one visits with family, one to one visits with staff and watching television. Review of the activities documentation for January 2025 showed on 01/01/2025 the resident passively participated in an activity one to one visit. There was no further documentation that activity staff offered or provided any further one to one visits. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/02/2025 at 4:17 PM, when asked why activity staff had not been providing one to one activity visits two to three times a week as care planned Staff VV, Activities Director, said the resident preferred to direct her own activities but acknowledged staff should have attempted one to one interaction two to three times a week in accordance with the plan of care. When asked why Resident 61 did not have music playing or their television on Staff VV indicated they had been out sick and explained that someone should have assisted the resident with their TV or to put music on. 50945 3) Resident 27 was admitted to the facility on [DATE] and had diagnoses of dementia and anxiety. Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment and was receiving hospice services (end of life care). The MDS showed Resident 27 found it very important that they had books, newspapers, and magazines to read, and that they had music to listen to. They found it somewhat important to do things with groups of people, to do favorite activities, to go outside to get fresh air when the weather was good, and to participate in religious services. Review of Resident 27's activities focus care plan, listed: -1:1 visits -Exercise -Family visits -Food activity -Grooming -Radio/television (TV) -Reading activities -Sensory Stim(ulation) -Staff will encourage Resident 27 to attend group activity, be provided with reading material, to receive two 1:1 visits a week to make sure she's happy with her routine -Sunshine therapy -Walking group Review of the care plan intervention of radio/TV showed it was initiated on 04/14/2021. During an observation on 01/27/2025 at 9:07 AM, Resident 27 was in bed, eyes closed. Resident 27 opened their eyes, answered a question, then closed them again. No activities were seen in their room, and no TV was on their side of the room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 2:22 PM, Resident 27 was in bed, supine, eyes closed. No activities seen in room. During an observation on 01/29/2025 at 3:16 PM, Resident 27 was in bed, supine, eyes closed, and mouth opened. During an observation on 01/30/2025 at 9:40 AM, Resident 27 was in bed, head of bed elevated, bedside table in front of them, eyes closed, mouth opened. No stimulation observed in the room. Blinds were shut. 02/03/25 01:34 PM Resident 27 was seen staring at roommate's TV. Resident 27's roommate had their sound off, as they were on the phone. At 1:44 PM, Resident 27 was seen staring in direction of roommate's TV. At 2:00 PM, Resident 27 continued to stare at roommates TV without sound. During an interview on 01/30/2025 12:10 PM, Staff KK, CNA, when asked what activities Resident 27 liked, said they liked watching TV, resident activities, and showering. During an interview on 01/30/2025 at 9:53 AM, Staff EE, Licensed Practical Nurse, when asked what activities Resident 27 liked, said they were unsure, then said bingo. During an interview on 01/31/2025 at 9:58 AM, Staff VV, Activities Director, said Resident 27 liked TV. When asked why they did not have their own TV, Staff VV said Resident 27 liked to watch their roommates. When asked if the curtain is pulled, if Resident 27 could still watch TV, Staff VV said, I see the issue. During an interview on 02/04/2025 at 11:26 AM, Staff B, DNS, when told about Resident 27 not having a TV, said yes, Resident 27 definitely should have their own entertainment. Reference WAC 388-97-0940 (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on interview and record review, the facility failed to ensure bowel management interventions were implemented for 3 of 8 residents (Residents 32, 65 & 3) reviewed for quality of care. This failure placed residents at risk for discomfort, further complications, and a diminished quality of life. Findings included . The facilities bowel protocol policy, undated, had the following instructions: FOR PATIENTS WITH CONSTIPATION; 1. If no bowel movement (BM) within 72hrs, may give MOM (Mild of Magnesia, a laxative) 30cc (cubic centimeter) po (by mouth). 2. If no results after MOM 30cc, may give Miralax (a laxative) 17gm (grams) po qd (daily) prn (as needed) or . 3. May add Bisacodyl (a laxative) 5mg (milligrams) i to ii (1 to 2) tablets po qd or suppository, NTE (not to exceed) 30mg in a 24hr period 4. May add Fleets (bowel stimulant) enema prn if constipation persists. 1) Resident 32 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 1/8/2025, showed Resident 32 was moderately cognitively impaired and needed substantial to maximal assistance with Activities of Daily Living (ADLs). On 1/23/2025 at 11:35 AM, Resident 32 was asked if they had regular BMs. Resident 32 said sometimes it was very hard to go and that there had been times when they weren't able to have a BM for several days. Review of the care plan revised on 5/1/2024 showed Resident 32 had a history of constipation related to decreased mobility. The goal for Resident 32 was that there would be a normal BM at least every three days. The staff were to follow facility bowel protocol. Review of the Medication Administration Record (MAR) for January 2025 showed Resident 32 received both scheduled and PRN opioids (medications used to treat pain with a side effect of constipation). Scheduled senna (bowel stimulant) was given twice a day. Available PRN bowel medications were as follows: Miralax 17 gm - as needed daily per hospice. Resident 32 was not receiving hospice services in January 2025. Bisacodyl 5mg - give 10mg by mouth as needed for five days without BM. Fleet oil enema - one application as needed. If no result, call physician. (continued on next page)

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	505254	A. Building B. Wing	02/06/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the aides documentation for January 2025, showed Resident 32 did not have a BM from 1/08/2025 to 1/14/2025, 6 days. No PRN medications were given. There was no documentation the physican had been notified. On 1/29/2025 at 3:07 PM, Staff B, Director of Nursing Servics, said there should have been pharmacological and non-pharmacological interventions implemented by day three of no BM. Staff B said the policy needed to be reviewed and revised. 42960 2) Resident 65 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented the resident was moderately cognitively impaired. Review of Resident 65's orders showed four medications for bowel management: 1). STEP 1: If no bowel movement in 72hrs may give 17g Miralax. If no results, go to step 2 of bowel protocol. 2). STEP 2: May give Senna 17.2gm by mouth once a day as needed, for day 4 without BM. If no results from step two, go to step three of bowel protocol. 3). STEP 3: Give Bisacodyl 10mg by mouth one time daily as needed for day 5 without BM. If no results from step three, go to step four. 4). STEP 4: Fleet Oil Enema Insert one application rectally and if not result from step four, call physician. Review of Resident 65's bowel record, showed they did not have a bowel movement on the following dates: 01/04/2025, 01/05/2025, 01/06/2025, 01/07/2025 (4 days) 01/19/2025, 01/20/2025, 01/21/2025, 01/22/2025 (4 days) Review of Resident 65's medication administration record (MAR) showed no bowel management medications were given on the dates listed above. On 01/30/2025 at 10:31 AM, Staff D, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) said Resident 65 did not receive a bowel medication and the bowel protocol should have been started. At 12:42 PM, Staff B, DNS said the expectation would be to start the bowel protocol on the third day. 46793 3) Resident 3 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 3 was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An order on 10/08/2024 documented Miralax to be given as needed after three days with no BM. If no BM after 24 hours go to step two. An order documented step two, may give Senna 17.2gm by mouth as needed. If no BM, go to step three. An order documented step three, give Bisacodyl 10 mg by mouth after five days with no BM. If no results, go to step four. An order documented Step four, Fleet enema, if no results from step four, call physician. Resident 3's Bowel Movement record documented Resident 3 had no BM from 01/16/2025 through 01/21/2025 (6 days). The electronic health record (EHR) documented the Bowel Protocol was never initiated for Resident 3. On 01/29/2025 at 11:09 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services, Staff B explained the facility's bowel protocol and when it should be initiated. When provided the dates of no BM's for Resident 3, Staff B said the bowel protocol should have been initiated for Resident 3. Reference WAC 388-97-1060 (1)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview, and record review, the facility failed to ensure Podiatry (the treatment of feet and their ailments) care and services were provided for 1 of 1 resident (Resident 27) reviewed for foot care. This failure placed the resident at risk for further skin impairment, discomfort, and a diminished quality of life. Findings included . Resident 61 admitted to the facility on [DATE]. Review of the 11/24/2024 Quarterly Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, and required substantial to maximal assistance with hygiene and lower body care. On 01/23/2025 at 9:40 AM, Resident 61's toenails were observed to long, yellow, thick and untrimmed. The second through fourth digits on the right foot and first, third and fifth digits on the left foot were starting to curve around the end of the resident's toes. At 10:35 AM, Resident 61 said that staff had not offered or provided toenail care since admission. The resident indicated they went to a podiatrist prior to hospitalization and placement at the facility. Review of the December 2024 and January 2025 Treatment Administration Records (TAR) showed nurses were directed to provide nail care weekly on Resident 61'a shower day. Review of the documentation showed the following: 12/04/2024 - Not provided 01/01/2025 - Not provided. 12/11/2024 - Blank 01/08/2025 - Not provided. 12/18/2024 - Blank 01/15/2025 - Not provided. 12/26/2024 - Not provided 01/22/2025 - Not provided. 01/29/2025 - Not provided. On 02/05/2025 at 10:57 AM, Staff C, Resident Care Manager (RCM), Resident 61's toenails were long, thick, yellow and untrimmed, with several on each foot beginning to curve around the end of the resident's toes. Staff C said they wouldn't feel comfortable trimming the resident's toenails and indicated the resident required a podiatry referral. Review of the facility's podiatry visits showed the podiatrist had been in the facility twice since the resident admitted . The podiatrist came on 11/12/2024 and 01/07/2025. Review of the podiatry referral list showed Resident 61 had not been referred or seen. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2025 at 2:14 PM, Staff C, RCM, confirmed Resident 61 was not referred or seen by the podiatry on 11/12/2024 or 01/07/2025. Staff C said Resident 61 should have already been referred/seen by the podiatrist. Reference WAC 388-97-1060 (3)(j)(viii)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to provide restorative services at the frequency residents were assessed to require for 5 of 6 sample residents (1, 42, 61, 69, and 32) reviewed with restorative nursing programs (RNPs). These failures placed residents at risk for decrease in Range of Motion (ROM/movement of a joint through the range of motion with no effort from the patient), increased dependance on staff for care needs and a diminished quality of life. Findings included . <Facility Policy> Review of the facilty's undated Restorative Nursing Documentation policy, showed the need for restorative nursing services would be documented in the medical record, and indicated on the resident's plan of care. Documentation would include: The problem, need, or strength that was being addressed. A measurable goal with target date. The specific interventions/treatments to be provided. The frequency and duration of interventions/treatments. Restorative aide documentation would include the treatment provided, specific distance or repetitions perfomed, use of assistive devices, endurance and tolerance level, and the amount of assistance provided and why. 1) Resident 1 was admitted to the facility on [DATE] with a cerebral infarction (stroke) affecting their right dominant side (a condition where blood flow to the brain is interrupted, causing brain tissue to die). The quarterly Minimum Data Set (MDS/an assessment tool), dated 01/02/2025, documented the resident was cognitively intact and on the RNP and receiving passive range of motion and dressing and/or grooming five days in the previous seven calendar days for at least 15 minutes. Resident 1's restorative nursing care plan, initiated 02/14/2024, showed they would receive restorative services five to seven days per week and record the number of minutes of services received. A review of restorative frequency for January 2025 for Resident 1 from 01/01/2025 - 01/14/2025 showed passive range of motion was documented as completed four times, refused one time, and two times was documented with an x. On 02/05/2025 at 12:05 PM, Staff C Licensed Practical Nurse(LPN), Resident Care Manager (RCM) said the x meant the resident was not seen by restorative that day. On 02/06/2025 at 8:27 AM, Staff B, Director of Nursing said Resident 1's frequency of restorative therapy was five to seven times per week and while looking at the restorative documentation said the resident did not receive therapy at that frequency. Staff B said if they had two restorative aids, they could get that accomplished. On 02/06/2025 at 8:27 AM, Staff A, Administrator said she was currently trying to hire a restorative aid. 37044 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident 42 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had impaired functional range of motion to both lower extremities, and received passive ROM and bed mobility RNPs on two of seven days during the assessment period. A restorative nursing care plan, initiated 12/01/2024, showed the resident was to participate in a passive ROM - RNP five to seven days a week to maintain upper extremity (UEs) strength. No explanation was provided related to how a passive ROM program would maintain the resident's UE strength, nor was there documentation that indicated what the resident's current upper extremity strength was. Resident 42 was also to participate in an active ROM program five to seven days a week to maintain lower extremity (LEs) strength. The care plan did not identify measurable goals; why the RNPs were necessary for this resident (resident specific risk factors); personalized interventions; which UE and LE joints would be ranged, through what planes of motion (e.g. flexion, extension, abduction, adduction, internal/external rotation); or how many sets/repetitions would be performed. Review of the January 2025 RNP flowsheets showed Resident 42's UE passive ROM program and LE active ROM programs were offered/provided twelve times during the month. 3) Resident 69 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident had severe cognitive impairment, impaired functional range of motion to both UEs and one LE and received skilled therapy services. A RNP care plan, initiated 01/22/2025, identified goals of maintaining ROM to both upper and lower extremities. The care plan did not identify whether Resident 69's ROM to both UE and LEs was currently limited or intact. The care plan did identify the resident was to participate in active and passive ROM programs to upper and lower extremities five to seven days per week. The care plan failed to identify which extremities (upper or lower) required passive ROM or why (e.g. right UE is flaccid secondary to stroke etc.), or which extremities the resident could perform active ROM with. The care plan failed to: identify measurable goals; why the RNPs were necessary for this resident; develop resident specicif interventions; and to identify UE and LE joints would be ranged, to what planes of motion; and identify the the number of repetitions and sets that were to be performed. Review of the January 2025 RNP flowsheets showed Resident 69's RNPs were offered/provided two times from 01/22/2025 (date initiated) - 01/31/2025 (9 days.) 4) Resident 61 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had no functional limitations to range of motion, and received passive and active ROM RNPs on four of seven days during the assessment period. A RNP care plan, revised 11/19/2024, documented the resident would participate in an active ROM program to both UEs, five to seven days a week to maintain ROM to UE joints and a passive ROM program to both LEs five to seven times a week with a goal of maintaining ROM to the residents lower extremity joints. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan did not indicate if the resident currently had functional limitations to their ROM, and if so what joints/extremities were affected. The care plan failed to identify: a measurable goal; why the RNPs were necessary for this resident; personalized interventions; which UE and LE joints would be ranged, through what planes of motion; or how many sets/repetitions would be performed. Additionally, there was no documentation indicating why the resident required passive ROM to both lower extremities; or how many ROM repetitions and sets would be performed. On 02/05/2025 at 10:31 AM, when asked who the Restorative Nurse was, Staff C, Resident Care Manager, said the facility's Restorative Nurse recently left and said Staff B, Director of Nursing Services (DNS) was currently performing the Restorative Nurse duties. On 02/05/2025 at 10:50 AM, Staff B, DNS, said they were not aware they had assumed the Restorative Nurse duties and were not familiar with the requirements for RNPs. On 02/05/2025 at 10:50 AM, when asked if there was anything prevented them from providing residents their RNPs at the frequency they had been assessed to require Staff M, Restorative Nursing Assistant (RNA), explained the facility usually had to two RNAs, but one had recently left and was not replaced yet. They also reported there were 35 residents currently on restorative services with two RNPs each (approximately16 hours of restorative programs per day). Staff M's schedule was Monday - Friday from 7:00 AM - 3:00 PM with a half an hour lunch. This provided Staff M with 7.5 hours to complete approximately 16 hours RNPs per day, which they acknowledged was not possible. Additionally, Staff M was pulled from restorative to provide direct resident care when the facility was short staffed. Reference WAC 388-97-1060 (3)(d), (j)(ix)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50945 Based on observation, interview, and record review the facility failed to consistently implement fall prevention interventions for 1 of 3 residents (Resident 27) reviewed for falls. This failure placed residents at risk of falling, injury, and a diminished quality of life. Findings included . Resident 27 was admitted to the facility on [DATE] with diagnoses of dementia and anxiety. Review of the Quarterly Minimum Data Set Assessment, dated 01/11/2025, showed Resident 27 had severe cognitive impairment, was receiving psychotropic medication (used for treating mental health conditions, can increase risk of falls), required staff assistance for using the restroom, and had a history of falls. Review of the Electronic Health Record showed that Resident 27's most recent fall was on 10/11/2024, which resulted in a broken nose. Review of Resident 27's fall and nutrition care plans, listed interventions that included: -Fall mat to the right side of bed to prevent injury -Keep call-light and things of interest within reach -Set-up assistance with all meals During an observation on 01/24/2025 at 2:10 PM, Resident 27's call light was draped over the head of the bed, outside of the resident's reach. It went above the pillow and went down over the headboard, and was touching the floor behind the bed. At 2:13 PM, Staff NN, Certified Nursing Assistant (CNA), was seen assisting Resident 27. At 2:15 PM, Staff NN left room. Resident 27, when asked if they were able to reach their call light, said I don't know. The call light was not adjusted since the 2:10 PM observation. During an observation on 01/27/2025 at 9:07 AM, Resident 27's call light was behind their mattress, went under their bed, and was observed on floor. During an observation on 01/30/2025 at 9:40 AM, Resident 27's call light went around the mattress, looped over the right upper mattress, and looped under the head of the bed, went under the bed on the left side, and was dangling just above the ground. The fall mat was seen on the ground, not lined up next to Resident 27. Resident 27 was sitting in bed with the head of the bed elevated, with a bedside table in front of them. The fall matt did not line up with the bed until the resident's shins and was angled to the wall (not in line with the resident). Resident 27 had their eyes closed, their mouth open, and there was no stimulation in room and the blinds were shut. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 01/30/2025 at 12:23 PM, Staff KK, Certified Nursing Assistnt (CNA), when asked where Resident 27's call light was, went into the room and confirmed the call light was behind Resident 27 and said they had forgotten to put it back on Resident 27 after cares. During an interview on 01/31/2025 at 10:53 AM, Staff C, Resident Care Manager, said it did not meet expectations a CNA had forgotten to put the call light back within reach for Resident 27, or that there were multiple observations of the call light being out of reach. During an observation on 02/03/2025 at 1:27 PM, Resident 27's fall mat was folded up, against a cabinet, not on the ground next to the right side of Resident 27's bed. Their call light was draped over their bed, dangling. Resident 27 had a food container at bedside, unopened. The door was slightly cracked, with no visibility to the resident. When asked if they knew where their call light was, Resident 27 replied no. During an observation at 2:06 PM, Staff KK, CNA, entered Resident 27's room, and removed the unopened meal. Staff KK left the room without adjusting the fall mat or call light. During an observation at 2:16 PM, Staff TT, CNA, said the call light was not in an obvious spot for Resident 27 and their matt was not put back down. Staff TT was observed to put the fall matt back down on the right side of Resident 27's bed. During an interview on 02/04/2025 at 11:26 AM, Staff B, Director of Nursing Services, when asked about Resident 27 having a history of falls and having interventions listed on the care plan, said it did not meet expectations that Resident 27 did not have their fall mat next to them on two observations or that their call light was not within reach. Staff B said when staff brought the meal in for Resident 27, they should have lifted the container lid since they required set up assistance with food. Reference F758 Reference WAC 388-97-1060 (3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure residents with indwelling catheters (a flexible tube inserted into the bladder through the urethra to drain urine) without a documented justification for use, were assessed for catheter removal as soon as possible, that catheter tubing properly positioned and secured to prevent trauma, and urology referrals were made when ordered for 1 of 3 residents (Resident 42) reviewed for urinary catheters. These failures placed residents at risk for unnecessary catheterization, urinary tract infections, decreased bladder tone, urethral erosion and a decreased quality of life. Findings included . Resident 42 admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had an indwelling urinary catheter but no diagnoses of neurogenic bladder, obstructive uropathy, urinary retention or kidney disease. An alteration in elimination related to indwelling catheter care plan, initiated 08/24/2024, failed to identify a diagnosis or condition to justify the need for continued catheterization. A 02/15/2024 provider documented Resident 42 had a prolonged hospitalization related to Fournier's gangrene (a severe and rapidly progressing form of necrotizing fasciitis affecting the genital, perineal, and abdominal regions, characterized by tissue death due to a polymicrobial infection), which required penile grafting. The note documented Resident 42's genital wounds were well healed at that time and use of a condom catheter would be appropriate to use per patients request to avoid skin breakdown. A 06/19/2024 nurse's note documented during removal of Resident 42's condom catheter large open sore was observed on the side of the penis. Resident 42 voided using a urinal while awaiting a response from the provider. A 06/20/2024 3:46 PM nurses note documented Resident 42 had an open sore on his penis related to condom catheter use and the resident refused it to be put back and said he wanted to use his urinal. A 06/20/2024 5:31 PM nurses note documented the provider was in house to see the resident and gave an order for an indwelling catheter to keep urine out of the wound. A 07/31/2024 nurses note documented the penile wound was resolved. A 08/29/2024 nurses note documented Resident 42 was to be referred to urology for follow up related to the indwelling catheter use. A 09/12/2024 nurses note documented that a call was made to a urology office to schedule Resident 42's urology appointment, but were informed the urology office was not contracted with Resident 42's insurance, so the facility would need to call another urologist. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the urology referral packet, dated 09/12/2024, showed a green sticky note was attached that read, Resident needs new referral to a different clinic. Review of the EHR showed no further documentation to show the facility made any further attempts to schedule Resident 42's urology appointment. On 02/03/2025 at 10:08 AM, Resident 42 said they could feel tugging on their catheter. When asked if they had a leg strap in place to secure the tubing Resident 42 stated, No, I need one put back on. I just worry about it. On 02/03/2025 at 11:03 AM, Staff C, Resident Care Manager, confirmed Resident 42's catheter tubing was not secured and said staff should have identified it when performing routine catheter care. On 02/03/2025 at 11:12 AM, when asked what the clinical justification for Resident 42's indwelling catheter was Staff C said Resident 42 did not have an appropriate diagnosis/clinical justification and explained the resident was supposed to be referred to urology but the office they were referred to didn't accept the resident's insurance. Staff C was uncertain if attempts were made to set up a urology appointment with other urology offices. Documentation of attempts to schedule the resident's urology appointment after the initial attempt on 09/12/2024 were requested. No further documentation was provided. Reference WAC 388-97--1060 (3)(c)

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	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on observation, interview and record review the facility failed to ensure their systems were in place to address and monitor weight loss experienced by 2 of 4 residents (Resident 71 and 65) reviewed for nutrition and failed to monitor and implement accurate fluid restrictions for 3 of 4 sampled residents (Residents 1, 6, and 12) reviewed for fluid restrictions. Resident 71 experienced harm when the facility failed to obtain weekly weights per their care plan, update the physician with the registered dietician's recommendations to add an appetite stimulant and calorie supplement and failed to offer supplemental food when the resident consumed less that fifty percent of their meal that resulted in a significant weight loss of 14.41 percent in 55 days. Resident 65 experienced harm when the facility failed to ensure adequate supplement intake or modify dietary interventions, that resulted in a significant weight loss of 16.64 percent in 113 days. These failures placed residents at risk of fluid imbalances, weight loss, medical complications and a decreased quality of life. Findings included . <Weight Loss> The facility policy titled, Weight Monitoring, undated, showed Residents with weight loss should have weekly monitoring of weight and defined a significant change in weight as a five percent change in weight in one month (30 days), 7.5 percent change in weight in three months (90 days), and a 10 percent change in weight in six months (180 days). The policy directed staff to inform the physician when residents had a significant change in weight. <Resident 71> Resident 71 admitted to the facility on [DATE]. According to the Admission Minimum Data Set (MDS, an assessment tool), dated 12/09/2024, Resident 71 was severely cognitively impaired with diagnoses of heart failure, cerebrovascular accident (stroke), and malnutrition or was at risk for malnutrition. Resident 71 had a mechanically altered diet (a change to food texture for individuals with difficulty chewing or swallowing), a feeding tube (a small tube that delivers nutrition, fluids, and medicine directly into the stomach) and did not have weight loss of five percent or more in the previous month or loss of ten percent or more in the previous six months. >Weights< Review of Resident 71's weight record showed: On 12/05/2024, upon admission to the facility, Resident weighed 118 pounds On 01/29/2025 (55 days later) Resident 71 weighed 101 pounds. This demonstrates a significant weight loss of 14.41%. On 02/04/2025 (6 days later and 61 days since admission), Resident 71 weighed 99.2 pounds, a 15.93% total weight loss in 61 days since admission. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 71's care plans, showed weight monitoring interventions of: 1. weigh on admission, daily and as indicated, revised on 12/06/2024 2. weekly weights, initiated on 12/05/2024 Review of Resident 71's weight record showed no weights were taken from 12/23/2024 to 01/14/2025, a period of 21 days. Although it was care planned, review of Resident 71's orders showed no orders for weekly weights. During an interview on 1/30/2025 at 11:57 AM, Staff C, Resident Care Manager (RCM), said residents who were at risk for malnutrition or were experiencing significant weight loss should be weighed weekly. When asked if Resident 71 had weekly weights ordered since they were experiencing significant weight loss, Staff C said no and that weekly weight orders should have been put in. Staff C said it was not acceptable that Resident 71 did not have a weight taken for 21 days while experiencing significant weight loss. >Dietician Recommendations< Review of a Significant Weight Loss Nutrition Progress Note, dated 12/16/2024, documented [Resident 71] had significant weight loss x7 days .Recommend consulting MD about need for an appetite stimulant. Recommend adding Benecalorie [supplement to add calories to food] to oatmeal or yogurt at breakfast. Review of a nutrition/dietary progress note, dated 01/25/2025, showed it took over five weeks after the significant weight loss was identified, before the facility documented provider notification and provider ordered interventions, provider updated and agrees with recommendations. Provider gave new order Mirtazapine [appetite stimulant], start Benecal [Benecalorie] daily via Gtube [feeding tube]. During an interview on 1/30/2025 at 1:27 PM, when asked if she could provide documentation that the physician was updated prior to documentation on 01/25/2025, based on the 12/16/2025 nutrition recommendations, Staff C could not provide documentation. Staff C said it was not acceptable that the provider was not updated for over five weeks on the recommendations. During an interview on 01/31/2025 at 11:38 AM, when asked about the Registered Dietician's 12/16/2024 recommendations for Resident 71 not being conveyed to the provider until over five weeks later, Staff B, Director of Nursing Services (DNS), said it did not meet expectations, it should have happened sooner. Staff B said there should have been weekly weights in place for Resident 71 while they were experiencing significant weight loss, that orders should have been put in for this, and it did not meet expectations that a weight had not been obtained for 21 days. During a phone interview on 02/06/2025 at 9:44 AM, when asked about her recommendation from 12/16/2024 for an appetite stimulant and Benecalorie supplement, Staff P, Registered Dietician said the provider not being notified of the recommendations until 01/25/2025 did not meet expectations. >Meal Monitoring and Alternative Food/Supplement< (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Certified Nursing Assistants (CNAs) were tasked in Point of Care, a computer program used mostly by NA to document resident care, to document and record percentage of each meal eaten for breakfast, lunch, and dinner, and if the resident ate 50 percent or less they were to offer an alternative food (alternative options included Boost (a supplemental drink), house shake, Mighty shake, sandwich, cottage cheese, yogurt, other), and to document what percentage of the alternative was eaten. During a 30-day lookback review, between 01/01/2025 to 01/30/2025, the following date/times were found to have not offered Resident 71 an alternative although they met the threshold, ate between 0% to 50% of their meal: 01/01/2025 at 10:16 AM, 25-50% of meal eaten - No alternative needed ate > 50% 01/03/2025 at 2:06 PM, 25-50% of meal eaten - No alternative needed ate > 50% 01/04/2025 at 10:19 AM, 25-50% of meal eaten - No alternative needed ate > 50% 01/04/2025 at 1:22 PM, 25-50% of meal eaten - No alternative needed ate > 50% 01/05/2025 at 1:52 PM, 25-50% of meal eaten - No alternative needed ate > 50% 01/06/2025 at 11:59 AM, 0-25% of meal eaten - Not applicable 01/12/2025 at 7:45 AM, 25-50% of meal eaten - Not applicable 01/12/2025 at 11:30 AM, 25-50% of meal eaten - Not applicable 01/13/2025 at 6:39 PM, 25-50% of meal eaten - No alternative needed ate > 50% 01/16/2025 at 10:26 AM, 0-25% of meal eaten - Not applicable 01/25/2025 at 2:23 PM, 25-50% of meal eaten - No alternative needed ate > 50% 01/28/2025 at 2:13 PM, 25-50% of meal eaten - Not applicable During an interview on 01/31/2025 at 11:38 AM, when asked about CNA documentation that Resident 71 ate 0% to 50% of meals and then documenting Resident 71 ate greater than 50% of meals resulting in no supplemental food being offered, Staff B said it did not meet expectations, and a supplement should have been offered. 42960 <Resident 65> (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident 65 was admitted to the facility on [DATE] with a diagnosis of severe protein-calorie malnutrition (a condition where the body doesn't get enough protein and energy) and muscle wasting and atrophy (loss of muscle mass and strength, typically caused by a lack of physical activity, injury, malnutrition, or certain medical conditions). The quarterly MDS, dated [DATE], showed Resident 65 was moderately cognitively impaired and had a loss of five percent or more in the previous month or loss of ten percent or more in the previous six months and was not on a doctors' prescribed weight loss plan. <Weight Loss> A review of the electronic health record (EHR) documented Resident 65 weighed 129.8 pounds on 09/27/2024 and weighed 109.5 pounds on 01/18/2025 which was a 15.64 percent loss in 113 days. On 01/27/2025 at 8:37 AM Observations of Resident 65 showed she has eaten the hot cereal but did not eat the other items on her breakfast tray. On 01/27/2025 at 12:48 PM Observations of Resident 65's lunch plate appears mostly full with 1-3 bites off her plate. Resident 65 did not touch her corn bread, pineapple and ate some of the roast beef and potatoes. On 01/28/2025 at 8:02 AM Observations of Resident 65 sitting in the dining room in her wheelchair eating her breakfast. Resident 65 ate all of her hot cereal and fruit, but did not eat the eggs, ham and toast. A review of the eating and meal intake sheet for 30 days from 12/31/2024 through 1/28/2025 showed on: 01/01/2025 at 6:35 PM, Resident 65 ate 0-25% and it was documented no alternative needed ate >50% 01/04/2025 at 2:10 PM, Resident 65 ate 0-25% and it was documented no alternative needed ate >50% 01/05/2025 at 9:53 AM and 1:11 PM, Resident 65 ate 25-50% and it was documented no alternative needed ate >50% 01/06/2025 - Resident 65 ate 25-50% for all three meals and it was documented no alternative needed ate >50% 01/21/2025 at 12:12 PM and 6:39 PM, Resident 65 ate 0-25% and it was documented no alternative needed ate >50% 01/22/2025 at 11:32 AM and 1:59 PM, Resident 65 ate 25-50% and it was documented no alternative needed ate >50% On 01/30/2025 at 12:42 PM, Staff B said while looking at the eating and meal intake sheet, the staff should have offered an alternative or supplement to Resident 65 when eating 0-25 percent and for 25-50 percent of their meals. Staff B said the resident was still losing weight and the interventions didn't seem to be effective from looking at the trending. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	<Interventions> A review of the EHR showed an order dated 11/05/2024 for a liquid nutritional supplement 120 milliliters (MLs - a measure of volume in the metric system) three times a day. A review of the medication administration record (MAR) showed blanks or a lack of documentation for 11/21/2024 and 12/22/2024 at bedtime. On 01/30/2025 at 12:42 PM, Staff B, DNS said while looking at the MAR there should not have been blanks and her expectation was for the nurse to document if the resident took it or refused it. A review of the January 2025 MAR showed the amount of total 120 MLs (approximately 4 ounces) of liquid nutritional supplement consumed was 30 MLs, 60 MLs or refused as follows: Morning: Refused 10 of 27 times 30 MLs was consumed 5 of 27 times 60 MLs was consumed 12 of 27 times Midday: Refused 11 of 25 times 30 MLs was consumed 3 of 25 times 60 MLs was consumed 11 of 25 times At bedtime: Refused 5 of 27 times 30 MLs was consumed 7 of 27 times 60 MLs was consumed 13 of 27 times On 01/30/2025 at 12:42 PM, while looking at the MAR, Staff B said Resident 65 was not drinking the full amount of the liquid nutritional supplement and her expectation would be for this to be in the Nutrition at Risk meeting and look at other interventions. <Resident 1> Resident 1 was admitted to the facility on [DATE] with a diagnosis of heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs) and chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products from the blood). The quarterly MDS, dated [DATE], documented Resident 1 was cognitively intact. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of the EHR showed an order, dated 01/13/2023, for a fluid restriction of two liters (a measure of volume in the metric system) per day to include 1600 MLs to be consumed with meals and 100 MLs for each med pass (for total of 400 MLs with medications per day) for hyponatremia (a condition where the sodium level in the blood is lower than normal). On 02/03/2025 at 2:15 PM, when asked if Resident 1 was on a fluid restriction, Staff F, CNA said, I will check with the nurse today. At 2:32 PM, when asked how the CNAs knew when a resident was on a fluid restriction, Staff E, Licensed Practical Nurse (LPN), said, the nurse should tell them to make sure they know. A review of the task documentation for 01/05/2025 - 02/03/2025 showed staff documented no for all entries when asked is resident on a fluid restriction? except on 01/15/2025, it was documented resident refused and on 01/21/2025 it was documented not applicable. A review of the task documentation for 01/05/2025 - 02/03/2025 showed the amount of fluid taken field on the document was left blank on the following dates: 1/14/2025, 1/19/2025, 1/20/2025, 1/23/2025, 1/24/2025, 1/25/2025, 1/28/2025, 1/30/2025, and 1/31/2025. On 02/04/2025 at 10:32 AM, Staff B said she would provide education to the CNAs and make sure they knew how to document when a resident was on a fluid restriction. A review of the MAR for January 2025 showed on 01/17/2025 at night and 01/23/2025 in the evening there were blanks with no documentation for MLs for each medication pass. On 02/04/2025 at 10:32 AM, Staff B, DNS said she would expect the nursing staff to document something there even if it was a refusal. When how they'd know when Resident 1 had reached their fluid restriction of two liters, Staff B said they would have to find out what dietary was documenting and what nursing was documenting and if the CNAs were also documenting and that she wasn't seeing any total amounts. 50945 <Resident 6> Resident 6 was admitted to the facility on [DATE] and had diagnoses including kidney disease that required dialysis (treatment to filter blood and remove excess fluid and waste buildup). Resident 6 had an order for a fluid restriction, initiated on 11/21/2023, for one liter per day. Resident 6's care plan also documented the resident was on a one liter fluid restriction. Further review of the EHR showed the CNA had a task that documented the fluid restriction as 1.5 liters. Review of the January 2025 records by licensed nurses (LNs) and task records inputted by CNAs showed: 01/03/2025: 500 MLs recorded by LN plus 735 MLs recorded by CNA for total of 1,235 MLs (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	01/11/2025: 440 MLs recorded by LN plus 840 MLs recorded by CNA for total of 1,280 MLs 01/24/2025: 600 MLs recorded by LN plus 960 MLs recorded by CNA for total of 1,560 MLs. The active order was for one liter which is 1,000 ML. The three sampled dates reviewed for all had totals exceeding 1000 MLs or one liter. During an interview on 01/31/2025 at 11:52 AM, Staff C, Resident Care Manager (RCM), after reviewing the above three days, said it did not meet expectations that Resident 6's fluid intake went over one liter. After the above interview, documentation was provided of a progress note from 04/19/2024, which showed the registered dietician documented Resident 6 was on a 1.5 liter per day fluid restriction. This was not consistent with the order and the order was not updated. The dietician noted that during their review of the past 30 days, the intake ranged from 270 ml to 1440 ml and requested to ensure staff is documenting all fluids accepted by residents (for meals and meds). During a follow up interview on 02/03/2025 at 11:51 AM, Staff C, RCM, said the point of a fluid restriction was to prevent fluid overload (when there is too much fluid in the body, causing increase in blood pressure, swelling, and possibly impact organ function) when kidneys were not functioning at full capacity. Staff C acknowledged that totaling the daily fluid intake was not occurring and was an issue. When asked about the conflicting fluid restriction information in the EHR, Staff C said they would contact the provider to clarify. After the above interview, Resident 6 had an updated fluid restriction order, initiated on 02/03/2025 at 12:18 PM, for a fluid restriction of 1.2 Liters per day. During an interview on 02/04/2025 at 11:18 AM, Staff B, Director of Nursing Services (DNS), said their expectation regarding fluid restrictions was that the orders, care plan, and everything else in the EHR would say the same thing and match. Staff B said it did not meet expectations staff were not totaling fluid intake, and that Resident 6 went over the one liter fluid restriction when it was the active order. 37044 <Resident 12> Resident 12 admitted to the facility on [DATE]. A 01/01/2025 physician's order showed the resident was placed on a two liter per day fluid restriction. The dietary department was to provide 1500 ML per day with meals, and nursing was to provide a total of 500 ML per day, or 250 ML per shift. On 01/22/2025 at 1:43 PM, Staff D, Resident Care Manager (RCM), said the facility placed stickers next to resident names outside their door to communicate specific care needs to staff. A sticker key was provided and showed a cactus was used to show a resident was on a fluid restriction. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 01/24/2025 at 1:13 PM and 01/28/2025 at 3:01 PM, observation showed a cactus sticker was not placed next to Resident 12's name outside their door. A nutrition problem care plan, initiated 01/01/2025, showed Resident 12 was on two liter per day fluid restriction, the kitchen provided 1500 MLs per day and nursing provided 500 ML per day for a total of two liters per day. Resident 12's EHR showed staff documented the resident's fluid intake in three separate locations. NA's charted: 1. In Point of Care, under 'meal monitor' for fluid intake with meals 2. In Point of Care, under 'additional fluids' Facility nurses charted: 3. under the MAR for fluids provided with medications The January 2025 meal monitor showed there was incomplete documentation of the resident's fluid intake with meals. Staff failed to document Resident 12's fluid intake for 21 of 93 meals. The second fluid intake with meals question asked staff is the resident on a Fluid restriction? Review of the documentation showed facility staff documented No or Not Applicable on 31 of 31 days. The January 2025 MAR showed each nurse recorded the amount of fluid they provided Resident 12 each shift, but there was no direction to, or place provided for nursing to reconcile the fluid intake recorded on the meal monitor, and under additional fluids, with the amount of fluids provided by nursing to calculate/evaluate the resident's 24-hour fluid intake. Resident 12's EHR showed no documentation was present to show facility nurses had calculated the resident's 24 hour fluid intake since admission to the facility. On 01/28/2025 at 3:08 PM, Staff D validated a cactus sticker was not placed next to Resident 12's name outside their door to alert staff the resident was on a fluid restriction. Staff D, RCM, explained that facility nurses were expected to assess/evaluate the resident's 24-hour fluid intake to determine if they were adherent or non-adherent with the fluid restriction. If Resident 12 was non-adherent, they would be educated about the risks/benefits of the non-adherence, and the physician would be notified. When asked if facility staff could determine if the resident was adherent with the fluid restriction without calculating the resident's 24-hour total fluid intake, Staff D stated, No. On 02/04/2025 at 3:12 PM, Staff D said Resident 12's fluid intake documentation on the meal monitor was incomplete; staff had erroneously documented on 31 of 31 days in January that the resident was not on a fluid restriction; staff failed to place a cactus sticker outside the resident's door next to their name to alert staff of the fluid restriction; and that facility nurses failed to reconcile the fluids provided by dietary with the fluids provided by nurses to calculate the resident's 24 hour fluid intake. Reference WAC 388-97-1060 (3)(i)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 .Based on interview and record review, the facility failed to ensure Peripherally Inserted Central Catheters (PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near the heart.), were assessed, maintained and monitored in accordance with professional standards of practice for 2 of 2 residents (Residents 55 & 12) reviewed for intravenous (IV) therapy. The failure to ensure IV orders included: the type and location of IV access, the method of delivery, the infusion rate and duration, monitoring of the insertion site, flush orders, changes of needleless injection caps, and initial and weekly external catheter measurements, placed residents at risk for loss of vascular access, infection, and other potential complications and negative outcomes. Findings included . <Facility Policy> Review of the facility's undated Care and Maintenance of Central Venous Catheter policy, showed nurses would: a) Document the indication for use, insertion date, and type of catheter in the resident's medical record. b) Obtain physician's orders for specific care and maintenance instructions. c) Assess the insertion site daily for signs of infection, redness, tenderness, pain, swelling, and ensure the PICC line dressing was clean dry and intact. d) Change needleless injection caps every 72 hours or in accordance with manufacturer recommendations. Review if the facility's undated Central Catheter, Flushing, Locking, Removal policy showed: a) The nurse would obtain and verify the physician's order for the type of solution or medication, dose, rate and length of treatment. b) PICC lines would be flushed before and after each infusion. If it was a multi-lumen catheter, all lumens must be flushed regularly. Review of the facility's undated PICC/Midline/CVAD [Central Venous Access Device] Dressing Change policy showed facility nurses would: a) Perform weekly dressing changes and as needed if the dressing is soiled, wet or dislodged. b) Measure and document the PICC external weekly with dressing changes, and as needed. c) Measure and document upper arm circumference (10 cm above antecubital fossa/elbow crook) upon (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Resident 55 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 12/01/2024, showed the resident was cognitively intact, had an infection of a internal right hip prosthetic, and required IV medication during the assessment period. An Admit/Readmit Assessment, dated 11/27/2024, documented Resident 55 admitted with a double lumen PICC to the right upper arm. A right hip infection care plan, initiated 12/14/2024, documented Resident 55 was receiving IV vancomycin (an antibiotic) and ampicillin (an antibiotic) for a right hip infection and required enhanced barrier precautions. Review of Resident 55's electronic health record (EHR) and January 2025 Medication and Treatment Administration Records (MAR/TAR) showed the following IV orders were in place: a) Unasyn (Ampicillin & Sulbactam Sodium) 3 grams intravenously every 6 hours for hip infection until 01/30/2025. b) Vancomycin HCl Intravenous Solution (Vancomycin HCl) Use 1250 mg intravenously in the morning for right hip infection until 01/30/2025. c) Monitor right upper arm PICC site for redness, swelling, pain, dislodgement of catheter every shift. If noted, notify the physician. d) Change the dressing to the right upper arm PICC site every seven days and as needed. The IV orders failed to identify the rate/duration of infusion and method of delivery (e.g. pump, dial-a-flow etc) for the IV medications. Additionally, there was no direction to or documentation to show, the facility did any of the following: a) Performed flushes on Resident 55's PICC with any solution at any time. b) Measured and documented the PICC line external length upon admission and weekly thereafter. c) Changed the PICC line needleless injection caps for each lumen at least weekly. On 01/28/2025 at 2:34 PM, Staff C, Resident Care Manager, said Resident 55's IV orders were incomplete and should have included flush orders, the rate and duration of the medication infusions, and the number of lumens for Resident 55's PICC and whether they were valved or non-valved. On 01/28/2025 at 2:43 PM, when asked if there was any documentation to show facility staff had measured external length of Resident 55's PICC or changed the needleless injection caps Staff C stated, No. 2) Resident 12 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of osteomyelitis (bone infection) and required IV medication during the assessment period. Review of Resident 12's EHR and January 2025 MAR/TARs showed the following 12/30/2024 IV orders: (continued on next page)

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	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Ceftriaxone (an antibiotic) two grams intravenously one time a day for 27 days, for osteomyelitis. b) Change administration set and IV tubing every 24 hours every night shift c) Change PICC line dressing every seven day and as needed, if soiled or dislodged. d) Flush PICC (each lumen) with 5 milliliters normal saline every 12 hours for IV maintenance, then clamp each lumen. The IV orders did not identify the rate/duration of infusion or method of delivery for the IV ceftriaxone. There also was no direction to or documentation to show, the facility: a) Performed PICC flushes before and after medication administration. b) Measured and documented the PICC line external length upon admission or weekly thereafter. c) Changed the PICC line needleless injection caps for each lumen at least weekly. On 01/28/2025 at 2:50 PM, when asked if there was any documentation to show facility staff had measured external length of Resident 12's PICC, changed the needleless injection caps or performed flushes before and after medication administration Staff D, Resident Care Manager, stated, No, not that I see. Reference WAC 388-97-1060 (3)(j)(ii)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview, and record review, the facility failed to ensure oxygen and nebulizer (a fine mist) medication therapy was administered in accordance with physician's orders, and respiratory equipment was monitored, routinely replaced and properly stored for 4 of 5 sampled residents (Resident 3, 42, 29 & 57) reviewed for respiratory care. Failure to follow provider's orders and properly store oxygen (O2) and nebulizer equipment placed residents at risk for unmet needs and potential negative outcomes. Findings included . Resident 3 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 11/03/2024, documented Resident 3 was cognitively intact. An order documented Resident 3 was to receive oxygen to maintain oxygen level above 90%. Resident 3 said she used the oxygen at night, but not during the day. On 01/27/2025 at 11:23 AM, Resident 3's oxygen tubing was laying on the ground, next to the bed, with a shoe on top of the nasal cannula (NC), the portion that inserts into the nose. When asked where she normally stores the oxygen tubing, Resident 3 said the staff have her hang it off her bed. At 11:30 AM, Staff S, Registered Nuse, was asked where the residents' store oxygen equipment like NC, when it was not in use. Staff S said residents store their oxygen equipment on the bedside table. Staff S was asked to observe Resident 3's NC. When shown Resident 3's NC laying on the floor and asked if that was an acceptable location for a NC, Staff S did not answer question, but questioned Resident 3, why she was not wearing the NC. Resident 3 said she did not wear it all the time, only at night. When asked again about the NC being on the floor, Staff S said it was not acceptable because it was on the floor under Resident 3's shoe. On 01/29/2025 at 11:09 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services, Staff B said oxygen equipment should be stored at the bedside, in plastic bag or on top of the oxygen concentrator. When the observation of the NC on the floor was explained, Staff B said it was not acceptable that the NC was on the floor and should have been exchanged. 37044 2) Resident 42 admitted to the facility on [DATE]. Review of the 01/12/2025 Quarterly MDS showed the resident was cognitively intact, had a diagnosis of lung disease and required supplemental oxygen during the assessment period. Review of Resident 42's orders showed a 01/05/2025 order for O2 at 2 Liters/minute (how much oxygen flowed in per minute) via NC to maintain O2 saturation (SpO2) above 90%. On 01/22/2025 at 10:05 AM, Resident 42 was lying in bed receiving 02 at 1.5L/min via NC. The O2 tubing and humidifier bottle were undated, and the humidifier bottle was empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/2025 at 10:36 AM, Resident 42 was in bed receiving O2 via NC at 4L/min. The humidifier bottle and O2 tubing had been replaced and were dated 01/22/2025. 01/23/2025 at 11:40 AM, Staff L, Infection Preventionist, observed Resident 42 and confirmed they were receiving O2 via NC at 4L/min. Review of the January 2025 Medication Administration Record (MAR) showed the nurse signed that they administered Resident 42 O2 at 2L/min as ordered. A 01/23/2025 provider note showed they gave an order to continue O2 via NC to maintain SpO2 90-94%. Review of the MAR showed the O2 order was still O2 at 2L/min to maintain SpO2 greater than 90%, not 90-94% as ordered. On 01/27/2025 at 11:16 AM, Resident 42 was in bed receiving O2 via NC at 4L/min, which was confirmed by Staff D, Resident Care Manager. Review of the MAR again showed the nurse signed they administered O2 at 2L/min as ordered. On 01/27/2025 at 12:36 PM, Staff B, Director of Nursing Services, confirmed Resident 42's O2 order was for 2L/min via NC to maintain SpO2 greater than 90%. When asked if facility nurses were administering the O2 in accordance with the physician's order Staff B stated, No. Staff B also confirmed that facility nurses on both days erroneously signed that they administered the resident O2 at 2L/min via NC as ordered and failed to transcribe the 01/23/2025 provider order that changed the O2 order from maintain SpO2 greater than 90% to maintain SpO2 90-94%. On 02/03/2025 at 10:02 AM, Resident 42's humidifier and O2 tubing was still dated 01/22/2025. Review of the January 2025 MAR showed a 12/10/2024 order directing nursing to change and date O2 tubing weekly. Further review showed Staff S, Registered Nurse, signed off they completed the task on 01/28/2025. On 02/03/2025 at 2:32 PM, Staff C, Resident Care Manager, observed Resident 42's O2 tubing was dated 01/22/2025. When asked if the tubing had been changed on 01/28/2025 as Staff S had documented Staff C stated, No. Staff C confirmed Staff S had signed for a task they had not completed. 50392 3) Resident 29 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed that Resident 29 did not use a Continuous Positive Airway Pressure device (CPAP device, a machine that uses mild air pressure to keep breathing airways open while you sleep). Review of Resident 29's active orders showed no order for CPAP. Review of Resident 29's care plan, showed no care plan for CPAP. On 02/03/2025 at 10:42 AM, an observation showed that Resident 29 had a CPAP machine on their bedside table. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:07 AM, Resident 29 said, I use my CPAP machine at night, every night. At 11:11 AM, when asked where in the Electronic Health Record (EHR) she would find the information that a resident uses a CPAP machine, Staff LL, Registered Nurse (RN) said it would be in their orders. When asked if Resident 29 used a CPAP machine, Staff LL said, yes. When asked if Resident 29 had orders for CPAP, Staff LL looked in the EHR and said, no, she did not see an order for CPAP. When asked if Resident 29 had CPAP on their care plan, Staff LL looked at the care plan and said she did not see it there. At 11:20 AM, when asked if Resident 29 used a CPAP machine, Staff N, Certified Nursing Assistant said, he does, I have seen him. At 11:26 AM, Staff LL was observed exiting the Resident Care Manager's (RCM) office, and said, Resident 29's orders for CPAP should be in now. At 11:36 AM, when asked what things should be in place for a Resident that uses a CPAP, Staff C, RCM, said orders for every night use, orders for settings, orders to clean the CPAP, orders to apply the CPAP at night and remove in the morning, orders to add distilled or sterile water if needed, instructions how to clean the CPAP on Wednesdays and how to clean the mask daily, cleaning schedule for the filters weekly, that should all be in the orders. When asked why orders were not in place for Resident 29 prior to that day, Staff C said, I would have to look back to see when [Resident 29] got their CPAP, it should have been put in right when he got it. At 12:05 AM, Staff C, RCM, said that for CPAP use, it should also be on Resident 29's care plan. At 1:03 PM, when asked how long they have used their CPAP machine, Resident 29 said, I have been using my CPAP machine for quite a while, a long time. At 1:08 PM, when asked if she had determined when Resident 29 had started using their CPAP, Staff C showed a referral document she found in the EHR and said, Resident 29 had gone to a neurology appointment and was diagnosed with sleep apnea on 05/20/2024 so Staff C was guessing that was when the neurologist gave the order for CPAP. When asked if the MDS, which did not code for CPAP, was accurately coded, Staff C said, probably not, most likely something got missed. On 02/04/2025 at 10:15 AM, when it was explained that Resident 29 and staff reported Resident 29 used CPAP therapy nightly, and Staff C, RCM, estimated that Resident 29 had been using CPAP since a neurology appointment in May 2024, that there were no orders in place for CPAP, no diagnosis on the diagnosis list for Sleep Apnea, CPAP was not indicated on the MDS, and there was no respiratory/CPAP care plan, Staff B DNS said it did not meet her expectations and it should have been in all of those areas. 50488 4) Resident 57 admitted to the facility on [DATE] with a diagnoses including chronic respiratory failure. The Admission MDS, dated [DATE], showed Resident 57 was cognitively intact and needed substantial assistance with most activities of daily living. Review of the Nebulizer Policy, dated 2023, showed the following instructions: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13. Keep nebulizer vertical during teatrnent. 14. Observe resident during the procedure for any change in condition. 15. When medication delivery wascomplete, turn the machine off. Treatment may be considered complete with the onset of nebulizer sputtering. 16. Disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry. Care of Equipment: 1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble parts after every teatnent. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 5. Shake off excess water. The Oxygen Policy, dated 2024, stated the following in regards to nebulizer equipment: e. Keep delivery devices covered in plastic bag when not in use. On 01/22/2025 at 10:30 AM, Resident 57 was observed lying in bed. A humming noise was heard and was found to be coming from a nebulizer machine (medical device used to deliver certain respiratory medications). The breathing treatment delivery set was lying on the right side of the bed, still delivering medication. The tubing was dated 01/08/2025. An oxygen concentrator was against the window with tubing that was also dated 01/08/2025. At 12:42 PM, the breathing treatment delivery set was observed intact and lying on the window seal. Staff BB, Registered Nurse, said the set should have been rinsed out after the treatment was completed and stored in a manner that would keep it clean. Staff BB said they worked as an agency nurse and was not sure what the facility policy was. The care plan, dated 1/24/2025, did not have oxygen therapy nor breathing treatments via nebulizer. There were no instructions regarding replacing tubing or maintenance/cleaning of equipment. On 1/27/2025 at 2:33 PM, Staff C, RCM, said the expectation would be that any respiratory tubing would be changed every week and would be documented on the MAR. The nebulizer equipment should have been rinsed, laid out to dry on a paper towel, and then stored in plastic bag. Both the oxygen and the breathing treatments should have been on the care plan. Refrence WAC 388-97-483.25(i)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on interview and record review, the facility failed to identify, plan, and implement interventions for the individual needs of 1 of 2 residents (Resident 57) reviewed for dialysis. This failure placed residents at risk for unmet care needs, rehospitalization s, and further medical complications. Findings included . The facility's Dialysis Policy, undated, stated the following, Residents receiving hemodialysis have a Plan of Care (POC) specific to meet their needs, which is developed by [facility] in conjunction with the dialysis center providing hemodialysis. It said the facility was responsible for completing/sending; and receiving back, the Dialysis Transfer Form which contained information about vitals, weights, medications, psychosocial changes/needs, and labs. In addition, the policy said the facility would provide ongoing monitoring and as needed interventions for the dialysis access site. Resident 57 initially admitted to the facility on [DATE], was hospitalized on [DATE], and was readmitted on [DATE]. They were hospitalized on [DATE] and readmitted on [DATE]. They were again hospitalized on [DATE]. Resident 57 had a diagnosis of end stage renal failure which required dialysis (a treatment that filters the blood when the kidneys aren't working properly) at an outside facility. The Admission Minimum Data Set (MDS, an assessment tool), dated 12/14/2024, showed Resident 57 was cognitively intact and needed substantial assistance for most activities of daily living. <Care Planning> Review of the care plan, dated 12/11/2024, showed Resident 57 was receiving dialysis. It did not specify what type, length of treatments, or assessment and monitoring needed prior to and after treatments. It did not address potential complications or/or who to notify. It did not list the nephrologist (a doctor specializing in kidney care) in charge of care or any contact information. Progress notes dated 10/21/2024 and 12/11/2024, said Resident 57 had chronic right arm swelling due to a past blood clot. The right arm was not to be used for blood pressures. A facility progress note, dated 10/24/2024, and a dialysis form, dated 10/22/2024, said blood pressure readings were taken from the right arm. The care plan did not address that blood pressures readings were not to be taken on the right arm. Review of the provider note dated 12/11/2024, showed Resident 57 had a left jugular vein tunneled hemodialysis catheter (a central line placed in the vein). There was nothing on the care plan regarding assessment, monitoring, and/or as needed interventions for the catheter, such as dressing changes (a sterile procedure for central lines). There were no instructions regarding lab draws. The care plan said to not draw blood in the arm with a graft. Resident 57 did not have a graft. On 01/28/25 at 10:29 AM, Staff G, MDS Director, said the central line was not coded on the admission MDS which would have helped to make sure it was on the care plan. Staff G stated, I missed it. <Dialysis Transfer Forms> (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the orders showed Resident 57 was to receive dialysis on Tuesdays, Thursday, and Saturdays. Staff were to send the Dialysis Transfer form with each treatment and to ensure the form was received back after treatment. Resident 57 had fourteen total treatment days while in the facility from 10/21/2024 to 01/23/2025. Of those days, two transfer forms were found, dated 10/22/2024 and 12/17/2024. <Psycosocial> Review of progress notes on 12/11/2024 and 12/16/2024, showed Resident 57 expressed wanting to be left alone and was irritable with staff. A note, dated 12/15/2024, showed Resident 57 made the statement, I don't want to live anymore. Progress notes dated 01/10/2025, 01/16/2025, 01/18/2025, and 01/21/2025 showed Resident 57 was annoyed with staff, yelling at staff, and/or disengaged and refusing to speak to staff. A progress note, dated 01/13/2025, said Resident 57 was placed on the mental health provider's list. An interview on 01/27/2025 at 2:16 PM with Staff C, Resident Care Manager, determined Resident 57 had not been seen during the provider's last rounds due to the resident being at dialysis. A collaborative psychoactive medication review form, dated 01/20/2025, showed Resident 57 was minimally depressed and was stable with both mood and behaviors. On 01/28/2025 at 10:53 AM, Staff FF, Registered Nurse, was asked how he would know how to provide individualized care for a dialysis resident. Staff FF said they would look at the care plan for directions on how to care for dialysis residents and their access sites. On 01/29/2025 at 3:07 PM, Staff B, Director of Nursing Services, said the facility's dialysis program needed to be reviewed and revised to ensure all components of care were addressed. Staff B said the care plan should have been individualized and created in collaboration from the dialysis clinic. When asked if Resident 57's psychosocial needs had been accurately assessed and addressed in a timely manner, Staff B said they had not. WAC Reference 388-97-1900(5)(c)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview, and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services as evidenced by information provided in Resident/Surveyor interviews for 4 residents (Residents 1, 7, 71 & 12) interviewed, and 5 staff (Staff T, X, OO, N & PP) interviewed. The facility had insufficient staff to ensure residents received assistance with activities of daily living, restorative services and staff documentation. Additionally, the aides from the Restorative Nursing Program (RNP) department were removed from restorative nursing duties to cover direct care staff absences resulting in the RNPs not being done for 3 of 4 residents (Residents 42, 1 & 32) reviewed for RNP. These failures placed residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident Interviews> On 01/22/2025 at 11:18 AM, Resident 1 said it took a long time to get help. At 2:16 PM, Resident 7 said it took a long time to get help. Resident 7 said they had currently been waiting an hour and a half or close to it to get changed. Resident 7 said it was their preference to have a female assist with bathing and if there were no female staff on shift, Resident 7 said they did not get bathed that day. On 01/23/2025 at 11:02 AM, Resident 71's representative said did not know if Resident 71 received the care she needed without waiting for a long time and said they had noticed that with all residents. Resident 71's representative said it had taken up to two hours for Resident 71 to be assisted back into bed. At 10:01 AM, Resident 12 said staff came into the room and they would tell staff what they need and staff would tell them they would be back but never come back. <Staff Interviews> On 02/04/2025 at 9:36 AM, Staff T, Licensed Practical Nurse (LPN), said on a normal shift, they were responsible for about 20 residents. Staff T said when they were completing wound care and other treatments, that other daily tasks, like assessments, were not often completed due to not having enough time. Staff T said on the weekends it was harder, because they did not have extra support from the administration. At 10:10 AM, Staff X, Certified Nursing Assistant (CNA), said on a normal shift they were responsible for 14-17 residents and usually had two CNA's per hall. Staff X said they could complete most of the daily tasks, but showers and documentation were always the hardest to complete within a normal shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 10:14 AM, Staff OO, Registered Nurse (RN) said, we need a shower aid, we have asked for a shower aid. At 10:15 AM, Staff X said they had been asked to come in early or work overtime more than once a week, due to call outs. Staff X said she was not able to help with Range of Motion (ROM) exercises with the resident, because she did not have time. At 10:25 AM, Staff N, CNA, said they were responsible for about 15-19 residents with two CNA's per hall. When asked about completing daily tasks, Staff N said it was getting harder to complete tasks, because lunch had been arriving later than normal. Staff N said it was always impossible to get to the second rounds of changing residents, after lunch and documentation before the end of the shift. Staff N said he would often stay 30-45 minutes every day, to finish documentation. Staff N said he did not complete ROM exercises with residents. At 10:32 AM, Staff PP, CNA, said they usually split the hall with another CNA, so they were responsible for about 11-12 residents each. Staff PP said if there were two CNA's on the hall, they could sometimes get all the daily activities completed, but if there was only one CNA on the hall, there was not enough time to get to all the residents and they did not get to take breaks. Staff PP said they usually stayed over about 45 minutes to complete documentation, because it was hard to complete during the day. Staff PP said they did not complete ROM exercises because they did not have time, most of the time they were lucky to get through second rounds before the end of the shift. Staff PP said they usually stayed over about 45 minutes to complete documentation they were not able to get to during the day. Documentation provided showed restorative nursing aide (RNA) was pulled to provide resident care on the floor on 12/03/2024, 12/26/2024, 12/17/2024, 12/18/2024, 12/23/2024, 01/02/2025, 01/03/2025, 01/04/2025, 01/09/2025, 01/10/2025, 01/12/2025, 01/14/2025, 01/19/2025, 01/26/2025, 01/29/2025, 01/30/2025, 01/31/2025, & 02/04/2025. On 02/04/2025 at 1:48 PM, Staff B, Director of Nursing Services, said she did not know how staffing levels were determined, that it was the responsibility of the Staffing Coordinator. When asked about hiring and retention interventions, Staff B said for hiring they were listing open positions on Indeed and did not know of any retention interventions being used. Review of the Staffing Pattern showed the facility was missing RN coverage on the following dates: 12/25/2024, 12/26/2024, 12/28/2024, 01/01/2025, 01/02/2025, 01/08/2025, 01/09/2025, 01/11/2025, 01/15/2025 & 01/16/2025. Staff B said they had not reviewed the staffing pattern. When asked about RN oversight for resident care, Staff B said, I'm always on call. When asked how RN coverage affected resident care, Staff B said it could potentially cause a delay in resident care needs being met. Staff B said the facility had one RNA, that had been pulled from restorative duties once or twice to provide resident care. When asked how pulling the RNA affected resident care, Staff B said Resident in the RNA program wouldn't get their RA program that day. When shown documentation that both the Infection Preventionist (IP) and the Resident Care Managers (RCM's) had been pulled to work the floor on 01/03/2025, 01/08/2025, 01/13/2025, 01/17/2025, 01/27/2025 & 02/04/2025, Staff B acknowledged the dates. Staff B said it made it challenging to get their job done because of oversight to the floor. When asked how this would affect resident care, Staff B said potential delays in care, untimely assessments/evaluation, and that it could have a [NAME] effect on resident care. Staff B acknowledged staffing has been a concern. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 1:56 PM, Staff A, Administrator, said the process for dealing with call outs/sick employees included, calling facility staff, agency staff and if they were not available, they would pull the DNS, RCM's or Infection Preventionist to work the floor. When asked what interventions had been implemented for hiring/retention, Staff A said she did not know, she was too new, hired on January 13th, 2025. Review of the Staffing Pattern showed the facility was missing RN coverage on the following dates: 12/25/2024, 12/26/2024, 12/28/2024, 01/01/2025, 01/02/2025, 01/08/2025, 01/09/2025, 01/11/2025, 01/15/2025 & 01/16/2025. Staff A acknowledged the missing RN coverage. When asked how this affected resident care, Staff A said LPN's can't do assessments or complete intravenous care for residents. Staff A said Staff B was always on call. Staff A said they would pull management; RCM or IP if needed. Review of facility records showed the IP and RCM's were pulled from job duties to provide resident care on 01/03/2025, 01/08/2025, 01/13/2025, 01/17/2025, 01/27/2025 & 02/04/2025. Staff A acknowledged IP and RCM's being pulled to cover the floor. When asked how this affected the RCM's and IP's job duties, Staff A said RCM's/IP can't do their paperwork when on the cart and patient care should be the priority. When asked how this affected resident care, Staff A said RCM's were slower on carts, orders and nurse reviews were delayed, charting was out of compliance and orders could be missed. Staff A acknowledged that staffing was a concern. On 02/05/2025 at 10:50 AM, when asked if there was anything preventing them from providing residents their RNPs at the frequency they had been assessed to require, Staff M, Restorative Nursing Assistant (RNA), said the facility used to have two RNAs, but one had recently left and had not been replaced yet. Staff M explained there were 35 residents with two RNPs each (approximately16 hours of restorative programs per day). Staff M's schedule was Monday - Friday from 7:00 AM - 3:00 PM with a half an hour lunch. This provided Staff M with 7.5 hours to complete approximately 16 hours of RNPs which they acknowledged was not possible. Additionally, if the facility was short staffed on the floor, Staff M indicated they would be pulled from restorative to provide direct resident care. Reference F688 Reference WAC 388-97 -1080 (1), 1090 (1) .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46793 Based on observation, interview and record review, the facility failed to ensure licensed nurses and nursing aides had the appropriate competencies/skill sets to provide nursing services that included appropriate transmission-based precaution (TBP) identification, staff correctly identifying which residents were on enhanced barrier precautions (EBP) and failed to implement correct usage of personal protective equipment (PPE) for residents on EBPs. The facility also failed to implement policies for orientation of agency/contracted staff, provide updated trainings for EBPs, ensure licensed staff were trained and competent in the management and monitoring of central venous catheters (centrally inserted access to veins), and to provide oversight of the Restorative Nursing Program (RNP). These failures placed residents at risk for facility acquired or healthcare-associated infections, related complications, unmet care needs and a decreased quality of life. Findings included . <Infection Control> Review of the facility policy titled Enhanced Barrier Precautions, undated, described that EBP should be implemented for preventing the transmission of multidrug-resistant organisms (MDROs). EBPs required the use of gown and gloves for high-contact resident care activities. Residents with wounds or indwelling (remaining in the body until removed) medical devices were considered at risk of MDRO acquisition. The policy stated, Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. Examples were provided of wounds that required EBP, including chronic wounds, pressure ulcers, foot ulcers, and unhealed surgical wounds. Examples of indwelling medical devices that required EBP were central lines, hemodialysis catheters, and feeding tubes. High-contact resident care activities included examples of dressing, bathing, transferring, and providing hygiene care. EBP findings included: A. Lack of consistent understanding by staff of understanding the orange sticker system for indicating EBP. No additional signage for EBP outside of sticker system. The facility did not follow its policy or CDC recommendations for appropriate signage. B. Residents were missing EBP stickers/signage when they should have been on EBP C. Lack of gown usage by staff during resident care activities for residents on EBP On 01/23/2025 at 1:49 PM, when asked how staff knew what the orange stickers (stickers that indicate a resident is on EBP) on the name plates by doors indicated, Staff L, Infection Preventionist (IP) said the facility had agency cards that explained the stickers that were on the doors, the stickers were present when she started her position and she did not know what they meant at the time so she had developed a card with explanation for agency nurses. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 2:18 PM, Staff AA, Certified Nursing Assistant (CNA), when asked what the orange sticker on a resident's name plate on the door indicated, Staff AA said, I am not sure. When asked if a resident had a catheter bag what type of precautions would she take when emptying the bag, Staff AA said she would wear gloves, and that was all. On 01/28/2025 at 9:16 AM, when asked how the facility manages residents who are colonized with MDROs, Staff L, IP said it would be classified under EBP and that any indwelling device or wound care required gowning, and if there was potential for splashing, then eyewear. Staff L, said a lot of the facility staff did not understand EBP, but the nurses and staff were educated on it because they recognized they had not been doing it. On 02/04/2025 at 11:13 AM, Staff B, Director of Nursing Services (DNS), said their expectation was for staff to implement precautions with EBP. <Orienting Agency Staff> On 02/04/2025 at 10:10 AM, Staff X, CNA, said they had only received training when they first started at orientation and had no other recent trainings. At 10:25 AM, Staff N, CNA, said they had completed the mandatory trainings in Relias (a computer based training system) and sometimes the facility would provide updates in team meetings, but had no other recent trainings. At 10:32 AM, Staff PP, CNA, said they had completed the required trainings in Relias, but had not received any other trainings in a while. On 02/05/2025 at 1:52 PM, in a joint interview with Staff A, Administrator and Staff B, DNS, Staff A said the facility did not have a written policy or a system in place to orient agency staff to facility policies or procedures. Staff B, nodded in agreement. <Intravenous therapy> Review of the facility's undated Care and Maintenance of Central Venous Catheter policy, showed direct care staff would receive training on the appropriate management of central lines, followed by a competency evaluation. Only competent staff would care for central lines within the individuals scope of practice. On 01/28/2025 at 11:03 AM, RN, Staff S' central line training and competency evaluation was requested from Staff B, DNS, but was not provided. <Restorative oversight> The facility policy titled, Restorative Nursing Programs, dated 2024, documented, The Restorative Nurse, or designated licensed nurse, will provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly and document accordingly. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/05/2025 at 10:31 AM, Staff C, Resident Care Manager, said the the facility's Restorative Nurse had left and indicated Staff B, DNS, had assumed the Restorative Nurse duties. At 10:50 AM, in a joint interview with Staff M, Restorative Nursing Assistant (RNA) and Staff B, DNS, Staff B said they were not aware that they had assumed the Resorative Nurse duties and were not well versed on the requirements for RNP. Staff M, RNA, then explained that the (RNAs) were suppose to meet with the Restorative Nurse monthly to review residents' RNPs but said it had not happened since November 2024. When asked who was overseeing the facility's restorative services and/or who they went to discuss any problems or concerns with residents', RNPs Staff M indicated they would go to the therapy department. Refer to F658, F688, F694, F759 and F880. Reference WAC 388-97 -1080 (1), 1090 (1) 37044

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review the facility failed to follow up on pharmacy recommendations for 1 of 5 sampled residents (Resident 65) reviewed for unnecessary medications. This failure placed residents at risk for medical complications and a diminished quality of life. Findings included . Resident 65 was admitted to the facility on [DATE] with multiple diagnoses including diabetes (a chronic metabolic disorder characterized by high blood sugar levels). The Quarterly Minimum Data Set, an assessment tool, dated 12/30/2024, documented the resident was moderately cognitively impaired. A review of the monthly pharmacy review (MMR) for Resident 65, dated 11/30/2024, showed the physician agreed with the pharmacist's recommendation to discontinue the blood sugar checks four times a day. The physician ordered Resident 65's blood sugar to be checked weekly and an A1C (a blood test that measures the average blood sugar level over the previous 2-3 months) in three months. The MMR was signed by the physician on 12/04/2024. A review of Resident 65's orders did not show an A1C laboratory test or the blood sugar being checked weekly. Resident 65 was still getting their blood sugar checked four times a day. On 01/29/2025 at 8:36 AM, Staff B, Director of Nursing Services said they did not see a canceled order for Resident 65 and new orders for an A1C and the resident's blood sugar to be checked weekly. Staff B said they did not see a signature from the resident care manager (RCM) indicating the MMR was reviewed. Staff B said the expectation was for the orders to be implemented and for the MMR paper to have the RCM's initials indicating it was reviewed and completed. Reference WAC 388-97- 1300 (1)(c)(iii)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to ensure freedom from unnecessary medications for 4 of 6 sampled residents (Resident 1, 32, 27, and 42) when reviewed for unnecessary medications. The failure to assess, monitor, and evaluate the need for medications ongoing use, and administration of medications without clinical indication resulted in residents receiving unnecessary medications and placed them at risk of experiencing avoidable adverse side affects to medications, and other potential negative health outcomes. Findings included . 1) Resident 1 was admitted to the facility on [DATE] with a cerebral infarction (stroke/a condition where blood flow to the brain is interrupted, causing brain tissue to die) affecting their right dominant side. The Quarterly Minimum Data Set, (MDS, an assesment tool) dated 01/02/2025, documented the resident was cognitively intact and they reported no pain or hurting at any time in the previous five days. A review of the electronic medical record (EHR) showed an order, dated 03/12/2024, for tramadol (a strong pain killer used to treat moderate to severe pain, for example after an operation or a serious injury) 25 milligrams (mg-a unit of measurement) two times a day. A review of Resident 1's January 2025 medication administration record (MAR) showed the staff documented 0 out of 10 pain score for both AM (used to indicate times in the first half of the day) and PM (used to indicate times in the second half of the day) medication times every day except on 01/27/2025 and it was documented in the PM as a score of 4/10. On 02/04/2025 at 10:32 AM, Staff B, Director of Nursing Services (DNS) said when a resident was receiving a pain medication and there were zeros across the board, another pain assessment should be completed, and the provider notified. The expecation was that the resident care managers (RCMs) were reviewing the MAR with the provider to develop a better plan. 50945 2) Resident 27 was admitted to the facility on [DATE] and had diagnoses of dementia and arthritis (joint pain and stiffness). Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment, was receiving opioids (strong pain medication), was receiving hospice services (end of life care) and had a history of falls. Review of Resident 27's pain medication orders showed they were receiving scheduled tramadol (an opioid) twice a day for pain, per hospice orders. Additionally, they had an as needed tramadol dose, that could be given every 4 hours, for Pain s/p [status post] fall, initiated on 06/20/2024. Resident 27 also had scheduled acetaminophen/Tylenol (non-opioid that treats mild to moderate pain), given three times a day. Review of the EHR showed Resident 27's most recent fall was on 10/11/2024, which resulted in a broken nose. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MARs for November 2024, December 2024, and January 2025 showed: 11/01/2024 to 11/30/2024: The scheduled tramadol was refused on five days (3rd, 17th, 19th, 20th, and 26th), and the documented pain scores were zero for 52 of 59 administrations reviewed. The scheduled acetaminophen was refused twice (12th and 13th), and the documented pain scores were zero for 82 of 86 administrations reviewed. The as needed tramadol dose was given only once, on the 1st of that month. 12/01/2024 to 12/31/2024: The scheduled tramadol was refused on four days (27th, 29th, 30th, and 31st), and the documented pain scores were zero for 51 of 53 administrations reviewed. The scheduled acetaminophen was refused twice (14th and 29th), and the documented pain scores were zero for 87 of 90 administrations reviewed. The as needed tramadol dose was not given at all. 01/01/2025 to 01/28/2025: The scheduled tramadol was refused on five days (3rd, 17th, 19th, 20th, and 26th), and the documented pain scores were zero for 50 of 51 administrations reviewed. The scheduled acetaminophen was given three times a day with nursing staff documenting that every pain score was a zero. The as needed tramadol dose was given three times (8th, 11th, and 21st). During an interview on 01/31/2025 at 10:53 AM, when asked about Resident 27's last fall being on 10/11/2024 and still having an as needed tramadol order for pain related to falls, Staff C, RCM, looked at the order in the EHR and said it should have had a stop date on it, and it did not. When asked how they reviewed the necessity for pain medication for a resident on hospice, Staff C said they looked at it if the resident was having increased pain or increased use of as needed pain medications. 50488 3) Resident 32 was admitted to the facility on [DATE] with a diagnosis of a right heel ulcer. The Quarterly MDS, dated [DATE], showed Resident 32 was moderately cognitively impaired and needed substantial to maximal assistance for most Activities of Daily Living. Review of the MAR, dated 01/29/2025, showed Resident 32 was receiving Bactrim DS (antibiotic) twice a day prophylactically (to prevent or guard against an infection) for a pressure ulcer to the right heel. The medication had been started on 10/25/2023. Review of the Treatment Administration Record, dated June of 2023, showed the right heel ulcer had healed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/04/2025 at 2:00 PM, Staff L, Infection Preventionist and Staff C, RCM, said they did not know why Resident 32 was still on the antibiotic. Documentation was requested from both Staff L and Staff C that would explain why Resident 32 had been on the antibiotic past the time the foot ulcer had healed. No documentation was provided. 37044 4) Resident 42 admitted to the facility on [DATE]. Review of the 01/12/2025 Quarterly MDS showed the resident was cognitively intact, had a diagnosis of lung disease and required supplemental oxygen during the assessment period. On 01/22/2025 at 10:05 AM, Resident 42 was lying in bed receiving oxygen (02) at 1.5Liters/minute (L/min the amount of O2 delivered in a minute) via nasal cannula (NC). The resident said O2 at 1-1.5L/min was their usual O2 flow rate. The resident had a 05/02/2025 order for O2 at 2L/min via NC to maintain O2 saturation (SpO2) above 90%. A 01/02/2025 provider note documented Resident 42 had a Spo2 of 95% with 02 on at 2L/min, thus should have their O2 flow rate titrated down. An order was given to decrease the resident's supplemental O2 from 2L/min via NC to 1L/min to maintain a SpO2 of 90-94%. Review of the EHR showed the 01/02/2025 order to decrease Resident 42's O2 rate to 1L/min to maintain a SpO2 of 90-94% was never transcribed and/or carried out. A 01/22/2025 provider note showed an order was given to continue intranasal O2 to keep sats [SpO2] 90% - 94%. Review of the EHR again, showed nursing staff failed to transcribe and/or implement the order. The January 2025 MAR showed nurses documented each shift that the resident received O2 at 2L/min to maintain a Spo2 greater than 90%. The MAR also showed nurses recorded the residents SpO2 each shift, but the documentation did not identify if the Spo2 was obtained while Resident 42 was receiving supplemental O2 or while on room air. Review showed the resident's SpO2 was 96% or higher for 37 of the 51 shifts and greater than 90% on all 51 shifts. Review of the vital sign flowsheet showed from 01/03/2025 - 02/02/2025 the residents SpO2 was taken on room [ROOM NUMBER] times and ranged from 91-96%. During the period of 01/25/2025 - 02/02/2025 the resident's SpO2 on room air were as follows: - 01/25/2025- SpO2= 96% on room air. - 01/26/2025- SpO2= 98% on room air - 01/29/2025- SpO2= 95% on room air - 01/30/2025- SpO2= 94% on room air (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 02/02/2025- SpO2= 96% on room air On 02/03/2025 at 2:52 PM, when asked how the facility monitored/ assessed a resident's need for continued supplemental O2 Staff C, Resident Care Manager, said residents' SpO2 would be taken on room air and if they could maintain the ordered SpO2 goal (e.g. maintain greater than 90% or 90-94%, as ordered) the nurse would contact the provider and titrate the O2 down or do a trial on room air. When asked if there was any documentation that occurred for Resident 42 Staff C, RCM, stated, No, not that I can see. Reference WAC 388-97--1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure that residents receiving psychotropic (used for treating mental health conditions) medications had specific target behaviors identified for there use, behavior and adverse side effect monitoring were in place, non-pharmacological (non-medication) interventions were identified and documented, informed consent was obtained prior to administering the medication, and resident specific care plans and interventions were developed and implemented for 4 of 5 sampled residents (Residents 12, 27, 3, & 40) reviewed for unnecessary medications. These failures detracted from staffs' ability to monitor the effectiveness and need for continued use of psychotropic medications and placed residents at risk of medication complications, unidentified adverse effects, unmet care needs, and a diminished quality of life. Findings included . 1) Resident 12 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had a diagnosis of depression and required use of antianxiety and antidepressant medication during the assessment period Review of Resident 12's Electronic Health Record (EHR) showed the resident had 12/30/2024 orders for: buspirone (an anxiolytic) twice daily for anxiety, venlafaxine (an antidepressant) daily for depression, and mirtazapine (an antidepressant) daily for depression with decreased appetitie. An antidepressant medication related to depression care plan, initiated 01/07/2025, directed staff to administer medications as ordered and to monitor for adverse side affects associated with antidepressant medication use. It did not identify what antidepressants the resident was receiving or what specific target behaviors (TB) each medication was intended to treat. An antianxiety medication related to diagnosis of anxiety care plan, initiated 01/07/2025, directed staff to administer medications as ordered, monitor for adverse side affects associated with antianxiety medications and to monitor the resident for safety. It did not identify the antianxiety medication the resident received or the TBs the medication was intended to treat. Review of thr January 2025 Medication and Treatment Administration Records (MAR/TAR) showed no behavior monitoring of TBs for the use of mirtazapine, buspirone or venlafaxine were in place. Review of the Certified Nursing Assistant (CNA) charting in Point of Care (a computer program where CNA's chart) showed they were instructed to monitor each shift for the following TBs: tearfullness, isolating self to room, and self depreciating statements. There was no documentation or indication what medication the TBs were for. (continued on next page)

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	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/28/2025 at 3:09 PM, Staff DD, Social Services Director, acknowledged that the facility failed to identify the resident specifc TBs that each medication (mirtazapine, buspirone and venlafaxine) were intended to treat. When asked if TBs for the use of buspirone were identified and whether behavior monitoring was in place Staff DD, stated, No and indicated they were not aware the resident had a diagnosis of anxiety. Additionally, Staff DD said Resident 42's antianxiety and antidepressant care plans should have identified what medications the resident received and the specific TBs each medication was intended to treat and required monitoring, but did not. 50945 2) Resident 27 was admitted to the facility on [DATE] and had diagnoses of dementia and anxiety. Review of the Quarterly MDS, dated [DATE], showed Resident 27 had severe cognitive impairment, was receiving psychotropic medications, was receiving hospice services (end of life care) and had a history of falls. Review of Resident 27's orders showed they were taking two psychotropic medications: 1. Seroquel, an antipsychotic, scheduled twice a day. 2. Lorazepam, an antianxiety medication, scheduled as needed (PRN). Review of the Electronic Health Record (EHR) showed consent for lorazepam was obtained on 11/19/2024. Review of the Medication Administration Record (MAR) showed Resident 27 had received two doses before consent was obtained, on 11/01/2024 and 11/18/2024. Review of Resident 27's care plans showed an intervention for orthostatic hypotension monitoring related to Seroquel usage, once per month, initiated 04/08/2024. Review of Resident 27's EHR blood pressure vitals, did not show that orthostatic blood pressures were being taken monthly. Review of Resident 27's MAR reviewed from 11/01/2024 to 1/28/2024 showed blanks (no documentation) for adverse side effect monitoring for Seroquel. There were blanks found on 11/20/2024, 11/28/2024, 01/14/2025, 01/16/2025, and 01/25/2025. Review of Resident 27's EHR showed no behavior monitoring was being done by licensed nursing (LN) staff. Behavior monitoring was found to be completed by CNAs but the behaviors were not clearly indicated for what they were being monitored for (antianxiety, antipsychotic, or dementia related). Review of Resident 27's EHR showed CNAs were monitoring behaviors of hallucinations, agitation related to delusional thoughts, negative statements, and delusional thoughts and statements. There was no anxiety behavior being monitored. From 01/01/2025 to 01/29/2025, there were only 10 dates with behaviors noted. Review of Resident 27's MAR from 01/01/2025 to 01/29/2025, showed LNs gave PRN lorazepam 24 times, on 17 different days. Review of Resident 27's EHR showed no documentation of non-pharmacological interventions offered with the PRN lorazepam doses. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/31/2025 at 10:53 AM, Staff C, Resident Care Manager (RCM), confirmed the blank adverse side effect monitoring dates and said their expectation was for staff to chart and sign off when they had monitored for adverse side effects. When asked of the four behaviors being monitored by the CNAs, what was each behavior associated with (antianxiety, antipsychotic, or dementia), Staff C said it was not clear. During this interview, Staff C reviewed the lorazepam consent and MAR and confirmed it was given before consent was signed. When asked what non-pharmacological interventions were documented before the PRN lorazepam doses were given, Staff C said they did not see any documentation, and they would have expected documentation of non-pharmacological interventions before each lorazepam dose. During this interview, Staff C said orthostatic blood pressures could be taken in the lying and sitting positions if the resident could not stand. When asked for documentation that orthostatic blood pressures were taken monthly, Staff C reviewed the blood pressure vitals for Resident 27 and said the blood pressures were not on the same date or around the same time, so they did not see any orthostatic blood pressures. Staff C said Resident 27 needed orthostatic blood pressures and they should have obtained them in the record. During an interview on 02/04/2025 at 11:26 AM, Staff B, Director of Nursing Services (DNS), said Resident 27 should have non-pharmacological interventions charted for their PRN lorazepam administrations. 46793 3) Resident 3 was admitted to the facility on [DATE], with diagnoses including depression (a common mental health condition characterized by persistent low mood, loss of interest, and other symptoms that significantly interfere with daily life), anxiety, Post Traumatic Stress Disorder (a mental health condition that can develop after experiencing or witnessing a traumatic event) and Obsessive Compulsive Disorder (a mental health condition characterized by intrusive, unwanted thoughts (obsessions) and repetitive behaviors (compulsions) that can cause significant distress and interfere with daily life). The Quarterly MDS, dated [DATE], documented Resident 3 was cognitively intact. The EHR documented Resident 3 was prescribed Abilify (antipsychotic) for major depressive disorder, Lexapro (Selective Serotonin Reuptake Inhibitor (SSRI), used to treat depression and generalized anxiety disorder) for depression and Wellbutrin (antidepressant) for major depressive disorder. The EHR documented no target behavior monitoring for any of the psychotropic medications. On 01/29/2025 at 11:09 AM, in a joint interview with Staff A, Administrator, and Staff B, DNS, Staff B said when administering any psychotropic medication consent, an order, updated care plan, side effect monitoring and target behavior monitoring were required. When asked to locate Resident 3's target behavior monitoring in the EHR, Staff B said she was unable to locate any target behavior monitoring for Resident 3. Staff B said target behavior monitoring should have been in the EHR for all psychotropic medications. 50488 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Resident 40 admitted to the facility on [DATE] with diagnoses of Schizophrenia (a mental condition that affects how people think, feel, and behave) and anxiety and was enrolled with hospice (end of life care). The Admission MDS, dated [DATE], showed Resident 40 was severely cognitively impaired and needed extensive assistance for all Activities of Daily Living. Review of the January 2025 MAR showed Resident 40 received Risperdal (antipsychotic) 0.5 milligram twice a day for anxiety and Schizophrenia. On 01/25/2025, the MAR showed a new order for as needed Zyprexa (antipsychotic) for anxiety and schizophrenia. Resident 40 received a dose on 01/25/2025 and 01/30/2025. Neither medication had behavioral monitoring. Zyprexa was given without a consent signed. On 01/27/2025 at 2:11 PM, Staff C, RCM, said staff should not have accepted an order for PRN Zyprexa and that they would need to call to fix that. Resident 40 received another dose on 02/02/2025 and 02/03/2025. On 01/29/2025 at 3:26 PM, Staff B, DNS, said both Risperdal and Zyprexa should have behavioral monitors. Zyprexa should not have been given without a consent and as a PRN, should have only beeen prescribed for a two week period. Reference WAC 388-97-1060 (3)(k)(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview and record review, the facility failed to ensure it was free from a medication error rate of 5% or greater, with an error rate of 16% with errors observed for 2 of 7 sampled residents (Residents 69 and 1) reviewed for medication administration observation. This failure placed residents at risk for medical device complications, delay in medication, and a diminished quality of life. Findings included . Review of the facility policy, titled Medication Administration via Enteral Tube, undated, showed staff were to administer each medication separately, not combined, and not add to a formula feed. The feeding tube was to be flushed with 15 milliliters (ml) of water after each medication. For medications substituted with pill form, they should have been crushed and mixed with water. 1) Resident 69 was admitted to the facility on [DATE] and had a feeding tube (gastric tube, G-tube). Resident 69 had four medications to be given: 1. A liquid Multivitamin 15 ml via G-tube AM 2. A stool softener, docusate oral liquid 50 milligrams (mg)/5ml, give 10 ml via G tube AM 3. A seizure medication, Keppra 100 mg/ml give 5 ml via G-tube AM 4. A beta-blocker (affects heart and circulation), metoprolol 37.5 mg 1 tablet via G-tube AM The docusate and Keppra medications were liquid and observed to be combined by Staff V, Registered Nurse. The metoprolol and multivitamin (substituted with a pill) medications were crushed together (no water added), then added to the Keppra/docusate mixture. During an interview on 01/29/2025 at 10:14 AM, Staff D, Resident Care Manager (RCM), was told about the medications being combined and said they would follow up with the pharmacist. During a follow up interview on 01/30/2025 at 10:26 AM, Staff D, RCM, said they had contacted the pharmacist, and the recommendation was to separate medication being given. Staff D said the pharmacist could not confirm the medications could be given together, because there were not any studies done to support it. Staff D said the current practice was to separate each medication. During an interview on 02/04/2025 at 11:38 AM, Staff B, Director of Nursing Services (DNS), said medications given through a G-tube should be given separately and it did not meet expectations the four medications were combined. 2) Resident 1 was admitted to the facility on [DATE]. The Electronic Health Record showed Resident 1 had a diagnosis of Parkinson's disease. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 had eight medications that were needing to be given, with one displaying red which indicated it was late: 1. Carbidopa-Levodopa (treats symptoms of Parkinson's disease such as stiffness or tremors) Tablet Extended Release (ER) 50-200 MG-Due at 7:30 AM Observation on 01/30/2025 at 8:45 AM, showed Staff T, Licensed Practical Nurse (LPN), gave the Carbidopa dose. During an interview on 01/30/2025 at 10:29 AM, Staff T, LPN, said they have one hour before and after a medications were due to give the medication, and that the Carbidopa dose was a little bit late. Review of Resident 1's Carbidopa orders showed the ER dose was due at 7:30 AM and 4:00 PM, and non-ER doses were due at 2:00 PM and 8:00 PM. During an interview on 02/04/2025 at 11:38 AM, Staff B, DNS, said their expectation for a resident with Carbidopa four times a day, with an extended release dose due at 7:30 AM, was that the resident could receive the dose within an hour either direction. Staff B said it did not meet expectations Resident 1's Carbidopa dose was given at 8:45 AM. Reference WAC 388-97-1060 (3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50945 Based on observation, interview and record review, the facility failed to ensure the medication storage room and medication carts were free from expired medication for 1 of 1 medication rooms (A and B Medication Nursing Station Room) and 2 of 2 medication storage carts (C Wing Cart & B Wing Cart) reviewed for medication storage and labeling. The facility failed to ensure that medications of different routes were safely stored in medication carts, that medication was appropriately labeled, that medication was not stored with possible items of contamination, and that controlled substances were appropriately stored, recorded, and wasted in a timely manner. The facility also failed to ensure that medication was stored inside the medication carts or with nursing present, for 1 of 3 medication carts (A Wing Cart) reviewed. This failure placed residents at risk for receiving expired medications, taking unattended medication, cross contamination, and a diminished quality of life. Findings included . <A and B Medication Nursing Station Room> During an observation and interview on 01/24/2025 at 11:10 AM, the medication room called A and B Medication Nursing Station Room was reviewed with Staff C, Resident Care Manager (RCM). Two doses of Vancomycin 900 milligrams (mg)/250 millilites (ml) NS (intravenous antibiotic) were found in the refrigerator with the expiration dates of 12/18/2024. Staff C confirmed the dates were expired and said they do not keep them if they were expired. <Medication Storage C Wing Cart> During an observation and interview on 01/24/2025 at 11:38 AM, the medication cart called C Wing Cart was reviewed with Staff EE, Licensed Practical Nurse (LPN). The top drawer of the cart had three medication cups that were uncovered and stacked on top of each other. Staff EE explained that they were for three different residents that had refused and would need to be offered again later. Ear and eye drops were noted to be stored in the same bin, without the use of a divider, in the medication cart. A box of ear drops said a room identifier, but did not say the resident's name. Staff EE said there should have been a name on the box and that they would fix it. Oral motion sickness medication was being stored with suppositories (rectal route). One resident specific anti-nausea medication was also found being stored with the suppositories. During this observation and interview, in the middle drawers, a resident specific medication, Bupropion HCL 75 mg tablet (oral antidepressant), was found to have an expiration date of 11/20/2024, confirmed by Staff EE. The bottom drawer was observed to have: A. six medication packets for six different residents B. Gauze and wound cleanser, gauze packet open (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Vaginal medications D. Laboratory tubes and urine cup E. Foam cleanser F. Nutritional Shakes G. Multiuse equipment (stethoscope, scissors) Staff EE said the medications came the prior night and needed to be put up in the drawers, that some did not belong to residents on this cart and needed to go to other carts. Staff EE, when asked if wound cleanser should be stored on the medication cart or the treatment cart, said it should be stored on the treatment cart. <Medication Storage B Wing Cart > During an observation and interview on 01/24/2025 at 12:11 PM, the medication cart called B Wing Cart was reviewed with Staff FF, Registered Nurse (RN). A resident specific medication, Symbicort (inhaler/breathing treatment), had a date listed of 11/25, no year listed. A pill cutter, unlabeled, had white powdery substance on it, with caking of white substance on the blade and around the edges. A resident specific medication, Naloxone (opioid reversal agent), expired 12/21/2024. Staff FF said the resident for the Naloxone medication was no longer at the facility and should have been taken off the medication cart. A resident specific medication, Duloxetine HCL (treats depression and anxiety), expired 01/08/2025, was confirmed to be expired by Staff FF. During this observation and interview on B Wing Cart, a controlled substance medication (for a randomly selected resident) was selected to be reviewed on the controlled substance book log. Staff FF remembered preparing the medication (Norco Oral Tablet 5-325 MG) and was unsure why the controlled substance book was not filled out. Staff FF then filled out the narcotic book and checked the Medication Administration Record (MAR). Staff FF was unsure why the MAR was not showing their administration. At 12:38 PM, after Staff FF investigated further, Staff FF reported they had attempted to give the medication to the resident earlier at 9:29 AM, but the resident refused. Staff FF was observed to have pulled out a medication cup with a white pill in it from the top drawer (not the controlled substance drawer) and there was no label. When asked if it should have been labeled, Staff FF said it did not need to be labeled as it was to be wasted. Staff FF asked the nurse next to them to waste the medication with them. <Medication Storage A Wing Cart> During an observation on 01/24/2025 at 2:20 PM, Cart A Wing medication cart was seen with no staff next to the cart and Culturelle tablets (probiotic) found on the medication cart. At 2:21 PM, Staff V, RN, when asked if the Culturelle tablets should be left on the cart, said no. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/28/2025 at 12:03 PM, Staff D, RCM, said the facility should not be storing expired medications in the medication carts or rooms, and they should have been disposed of. Staff D said their expectation was for wound care supplies to have been stored in the treatment cart and overstock to have been in the nurses' supply closet. Staff D said eye drops and ear drops needed to have been separated, and that suppositories should not have been stored in the same container as oral medications. When asked if a room number was sufficient for labeling a medication, Staff D said they need a resident's name on it. During this interview, Staff D, RCM, said their expectation when staff pulled a controlled substance was for staff to sign off the medication in the controlled substance book at the same time they pulled the medication. Staff D said their expectation for controlled substance disposal after resident refusal was for two nurses to be present to destroy, with both signing the controlled substance book that it was wasted, and this should have been done right way. If a second nurse was not found right away, then it would have been locked in the narcotic drawer until another nurse was available to waste the medication. Staff D said the controlled substance should not have been stored in the top drawer and should have been labeled. Staff D said it did not meet expectation that Staff FF reported the resident refused the medication at 9:29 AM, and at 12:38 PM it was not yet wasted. Reference WAC 388-97-1300 (1)(b)(ii), (c)(ii-iv)(2)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the facility failed to ensure that 2 of 10 sampled residents (Resident 12 & 51) received foods that accommodated the residents' preferences and allergies. This failure placed residents at risk for meal dissatisfaction, allergic reaction, and a diminished quality of life. Findings included . 1) Resident 12 was admitted to the facility on [DATE]. On 01/23/2025 at 10:03AM, Resident 12 said they did not like the food, it often gets stuck going down. Resident 12 said they did not like milk or apple juice but continual get it on the meal tray. Resident 12's ordered diet was CCHO (Controlled Carbohydrate Diet), Regular texture, thin liquids. The electronic health records (EHR) documented Resident 12 disliked the following foods/beverages: Cottage cheese, milk, Acidic foods, apple juice, seafood, fish, wild rice, pickles, and onions. The EHR documented Resident 12 was lactose intolerant. On 01/31/2025 at 8:16 AM, Resident 12 was laying in bed, with breakfast meal tray sitting on bedside table. Resident 12 provided meal ticket. Meal ticket documented Regular Carb controlled thin liquids; Dislikes: apple juice, high acid food, fish, seafood, onions, eggs, cereal and dairy products (cheddar cheese, lactose okay). Nothing was highlighted. Observation of apple juice 200 milliliters (ml) and 2 % milk 200 ml on breakfast cart, both untouched. Resident 12 said they get milk and apple juice every morning. On 02/05/2025 at 8:45 AM, Staff Y, Certified Nursing Assistant, said they look for resident preferences on the meal ticket card provided. When asked about how they identify allergies or intolerances, Staff Y said they look on the meal ticket, allergies or intolerances were highlighted, or they look on the Kardex. At 8:49 AM, Staff H, Dietary Manager, said the staff systems did not communicate with one another. Staff H said when he was hired 4 weeks ago, he had identified that residents were not getting the correct meals, to include dislikes, allergies and intolerances. Staff H said he started the beverage drink carts on each hall, for the CNA's to be able to read the meal ticket card and provide the residents with what they like or were allowed to have. Staff H said staff just need to read the meal ticket for residents dislikes and allergies/intolerance information. When observation was explained about beverages dislikes and intolerances, Staff H said the residents should not get things they were allergic/have intolerance to or dislike. 37044 2) Resident 51 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS, an assessment tool) showed the resident was cognitively intact and required a therapeutic diet. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 51's had a 03/29/2024 order for a regular diet with double portions and a mighty shake with each meal. On 01/23/2025 at 3:41 PM, Resident 51 returned to the facility and removed the lid on their lunch tray that was sitting on the bedside table. They then reported that the kitchen was not providing the diet that was ordered or honoring their food preferences and handed their tray card to this writer. Review of Resident 51's tray card showed the resident was to receive a health shake, two 1% milks, one cup of apple, one cup cranberry juice, 1/2 cup yogurt and large portions (1 and 1/2 servings) with every meal. Observation of their 01/23/2024 lunch tray showed dietary staff failed to provide the following: a) large portions. b) Two 1% milks (No milk was provided). c) A glass of cranberry juice. d) A glass of apple juice. e) A half cup of yogurt. f) A mighty/health shake On 01/30/2025 at 12:22 PM, observation of Resident 51's lunch tray showed the resident was not provided the following: a) large portions (provided one chicken breast) b) A glass of cranberry juice. c) A glass of apple juice. d) A half cup of yogurt. e) A mighty/health shake On 02/03/2025 at 2:53 PM, Staff C, Resident Care Manager, stated that residents should be served their ordered diet, and their identified preferences should be honored but acknowledged that was not occurring for Resident 51. Reference WC 388-97-1120 (2)(a)

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 50488 Based on observation, interview, and record review the facility failed to ensure residents who were prescribed therapeutic diets (as ordered by a physician or a dietician) received the correct foods/drinks that would fulfill the unique properties of each diet. This failure placed residents at risk for nutritional compromise and related negative health outcomes. On 01/28/2025 at 12:08 PM, staff began to plate the noon meal. The main meal consisted of roasted pork, cooked spinach, stuffing with apples, rolls, and pumpkin pie. Alternatives to the main meal were cold sandwiches, grilled cheese sandwiches, salads, and chicken noodle or tomato soup. Each plate was dished up the same way with the same food, unless the ticket said there was an allergy or a dislike. At 12:18 PM, a plate of food was placed on a tray with a ticket that said 'controlled carbohydrates.' Another plate of food was set on a tray with a ticket that said 'low calorie.' At 12:19 PM, Staff W, Cook, said the only therapeutic diet they served was Renal (for residents with kidney issues). They did not know what the other diets were or what kind of food to serve for them. At 12:20 PM, Staff H, Dietary Manager, said he had only started a few weeks prior. Staff H said there had not been a system in place that would enable the staff to cook and serve therapeutic diets. Staff H said the previous kitchen manager told staff that all residents could have whatever they wanted. Staff H said they were working with a company to implement a new system in the next few weeks that would direct specialy diets. Staff H said they had directions on the back wall for Renal diets as they knew how important those were from a previous job. Staff H acknowledged the facility was not in compliance with serving therapeutic diets. Reference WAC 388-97-1200 (1)

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	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview and record review, the governing body acted with disregard to the well-being of the residents of the facility by not ensuring adequate oversight and monitoring of appointed Administration and/or Directors of Nursing to ensure clinical systems were in place and followed and staffing levels were appropriate for the care required by the residents admitted to their facility. The governing body failed to ensure the facility was staffed sufficiently to meet the needs of the residents, so they received showers and other activities of daily living (ADLs) such as grooming and nailcare timely, that restorative programs were completed, and meals were delivered timely and accurately and that residents could access their personal funds. The governing body failed to ensure staff were adequately trained and had proper oversight for infection control practices, intravenous therapy and restorative nursing. The governing body's failure to provide oversight and support to ensure all policies and procedures were being followed and ensure the facility had an effectively functioning Quality Assurance and Performance Improvement (QAPI)/Quality Assessment and Assurance (QAA) program that consistently self-identified deficient practices. This placed residents at risk for injury, abuse and unmet needs that could negatively impact their physical function, psychosocial wellbeing, quality of life and quality of care. The failures also resulted in harm to residents and had the potential to place additional residents at risk for harm and negative outcomes. Findings included . Review of the facility's policy titled Governing Body, dated February 2023, documented, Policy Explanation and Compliance Guidelines: 1. The governing body will appoint an administrator who is: a. Licensed by the state where required. b. Responsible for management of the facility. c. Reports to and is accountable to the governing body. 2. The governing body is responsible and accountable for the QAPI program. 3. The governing body refers to individuals such as facility owner(s), Chief Executive Officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility. 4. The governing body will have a process in place by which the administrator: a. Reports to the governing body. b. Method of communication between administrator and governing body. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. How the governing body responds back to the administrator. d. What specific types of problems and information (i.e., survey results, allegations of abuse or neglect, complaints, etc.) are reported or not reported. e. How the administrator is held accountable and reports information about the facility's management and operation (i.e., audits, budgets, staffing supplies, etc.) f. How the administrator and the governing body are involved with the facility wide assessment. Refer to F565 Resident Council and F585 Grievances The governing body failed to ensure action or response was given to the resident council member concerns and to have a formal Grievance system in place. Refer to F604 Right to be Free from Restraints The governing body failed to ensure assessments, orders, consent and care plans were in place for residents with bed rails. Refer to F677 ADL Care Provided for Dependent Residents and F687 Foot Care The governing body failed to ensure systems were in place and staffing was adequate to provide residents with ADLs such as oral care, shaving, assistance with meals, grooming and nail care. Previously cited 02/2019, 08/2021, 05/2023, 03/2024 & 02/2025. Refer to F688 Increase/prevent Decrease In ROM (range of motion)/mobility The governing body failed to ensure staffing levels were appropriate to be able to provide restorative nursing and to ensure the program had sufficient oversight. Documentation provided showed Restorative Nursing Assistants (RNA) were pulled to provide resident care on the floor on 12/03/2024, 12/26/2024, 12/17/2024, 12/18/2024, 12/23/2024, 01/02/2025, 01/03/2025, 01/04/2025, 01/09/2025, 01/10/2025, 01/12/2025, 01/14/2025, 01/19/2025, 01/26/2025, 01/29/2025, 01/30/2025, 01/31/2025, & 02/04/2025. Refer to F692 Nutrition/hydration status maintenance The governing body failed to ensure systems were in place to monitor residents for weight loss and obtain and implement timely interventions that resulted in harm to two residents (Resident 71 and Resident 65). The governing body also failed to ensure systems were in place for monitoring and implementing fluid restrictions. Refer to F725 Sufficient Nursing Staff (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The governing body failed to ensure the facility had sufficient staff to ensure residents received assistance with activities of daily living, restorative services and staff documentation. Additionally, the aides from the Restorative Nursing Program (RNP) department were removed from restorative nursing duties to cover direct care staff absences resulting in the RNPs not being done. On 02/04/2025 at 1:48 PM, Staff B, DNS, said they did not know how staffing levels were determined, that was the responsibility of the Staffing Coordinator. When asked about hiring and retention interventions, Staff B said for hiring they were listing open positions on Indeed and did not know of any retention interventions being used. When shown the review of the Staffing Pattern, the facility was missing Registered Nurse (RN) coverage on the following dates: 12/25/2024, 12/26/2024, 12/28/2024, 01/01/2025, 01/02/2025, 01/08/2025, 01/09/2025, 01/11/2025, 01/15/2025 & 01/16/2025, Staff B said they had not reviewed the staffing pattern. When asked how RN coverage affected resident care, Staff B said it could potentially cause a delay in resident care needs being met. When asked how pulling the RNA affected resident care, Staff B said residents in RNA program did not get their Restorative Nursing Program (RNP) that day. Review of facility records showed the Infection Preventionist (IP) and Resident Care Managers (RCM)'s were pulled from job duties to provide resident care on 01/03/2025, 01/08/2025, 01/13/2025, 01/17/2025, 01/27/2025 & 02/04/2025. Staff B acknowledged the dates. Staff B said it made it challenging to get their job done because of oversight to the floor. When asked how this would affect resident care, Staff B said it could potentially cause delays in care, untimely assessments/evaluation, it could have a [NAME] effect on resident care. Staff B acknowledged staffing has been a concern. Refer to F726 Competent Nursing Staff The governing body failed to ensure the licensed nurses and nursing aides had the appropriate competencies/skill sets to provide nursing services that included appropriate infection control procedures. The facility also failed to implement policies for orientation of agency/contracted staff, provide updated trainings to ensure licensed staff were trained and competent in the management and monitoring of central venous catheters (centrally inserted access to veins), and to provide oversight of the Restorative Nursing Program (RNP). Refer to F865 QAPI Program/plan, Disclosure/good Faith Attempt The governing body failed to ensure the Quality Assessment and Performance Improvement (QAPI) program self-identified deficiencies and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Review of the facility's [NAME] report (a report with previous four years of cited deficiencies) documented the facility had repeated deficiencies cited including F550-Resident Rights/Exercise of Rights, F561-Self-Determination, F578-Request/Refuse/Discontinue Treatment; Formulate Adv Directives, F677-ADL Care Provided for Dependent Residents, F684-Quality of Care, F758-Free from Unnecessary Psychotropic Meds/PRN Use, F804-Nutritive Value/Appear, Palatable/Prefer Temp, F812-Food Procurement, Store/Prepare/Serve Sanitary and F880-Infection Prevention & Control for the previous four years. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/06/2025 at 10:05 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services (DNS) and Registered Nurse (RN), when asked if they had reviewed the [NAME] report to identify any repeat deficiencies that needed to be addressed, Staff A, Administrator, said no, they had only been in the facility since January 13th 2025, so they were unable to speak to previous years' results. Staff A reviewed the [NAME] report and acknowledged the repeated deficiencies and their concerns. Refer to F868 QAA Committee The governing body failed to maintain a Quality Assessment and Assurance (QAA) committee that included the Infection Preventionist (IP) and the Medical Director or his/her designee, to conduct required Quality Assurance and Performance Improvement (QAPI) and QAA activities. On 02/06/2025 at 10:05 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services, Staff A reviewed the QAPI/QAA required attendees for the past year of QAPI/QAA meetings. Staff A said she had not yet attended a QPAI meeting, only due to time frame. Staff A acknowledged the missing required QAPI/QAA committee members. QAPI meeting attendance sheet documented: May 24th, 2024: No IP in attendance. August 29th, 2024: No IP or Medical Director in attendance. September 11th, 2024: No IP or Medical Director in attendance. December 20th, 2024: No IP in attendance Refer to F880 Infection Prevention and Control The governing body failed to ensure systems were in place to operationalize an effective Infection Prevention and Control Program (IPCP) in accordance with facility policy, state, federal and or local infection control guidelines, regulations and practices when the facility failed to follow standard precautions (common sense practices to prevent the spread of infection in healthcare), enhanced barrier precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) and transmission based precautions (used when someone has confirmed or suspected infections) related to lack of prompt isolation and use of precautions when several residents and staff had vomiting and diarrhea and a suspected gastrointestinal outbreak. Previoussly cited 08/2021 with widespread harm, 05/2023, 03/2024 & 02/2025. Refer to F881 Antibiotic Stewardship Program The governing body failed to ensure systems and staff were in place to implement an effective Antibiotic Stewardship Program (ASP) for three of three months (October 2024, November 2024 and December 2023) reviewed. Refer to F887 Covid-19 Immunization (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The governing body failed to ensure a system was in place for tracking and documenting staff COVID-19 vaccination status. Reference WAC 388-97-1620 (2)(c)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure the facility's binding arbitration agreements (legal document that required the use of a third party to resolve disputes) included necessary wording of resident rights, and failed to explain to residents what a binding arbitration agreement was in a manner to allow them to understand, for 2 of 3 sampled residents (Residents 53 and 18) reviewed for binding arbitration agreements. This failure placed residents at risk for legal complications and a diminished quality of life. Findings included . The facility's blank Arbitration Agreement was reviewed on 01/27/2025 and found to be missing wording that: 1. The resident or their representative had the right to communicate with federal, state, or local officials such as federal or state surveyors, other federal or state health department employees and representative of the State Long Term Care Ombudsman 2. That a neutral arbitrator would be agreed upon by both parties 3. That the selection of a venue would be convenient to both parties During an interview on 01/27/2025 at 1:08 PM, Staff U, Human Resources/Payroll, was asked questions about the binding arbitration agreement and Staff A, Administrator, was present. When asked where in the agreement that it said the resident/representative could communicate with federal, state, or local officials such as federal surveyors, other federal or state health department employees or the office of the state long term care ombudsman, Staff U said they had looked at the form and it did not show any contact numbers. When asked how the resident would know their right on making a mutual neutral arbitrator, Staff U said they did not see in the document where it would say on how to select one. When asked if there was any wording for the selection of venue that was convenient to both parties, Staff U said they did not see any wording. At 01/27/2025 at 1:17 PM, Staff A, Administrator, when asked if the binding arbitration agreements were missing the wording just mentioned in the three above questions, said yes they should be listed. 1) Resident 53 was admitted to the facility on [DATE]. The Admission Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 53 was cognitively intact, was able to make themself understood and was able to understand others. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/27/2025 at 11:38 AM, Resident 53 said they were not sure they knew what a binding arbitration agreement was, they did not remember signing paperwork for this, and did not understand the arbitration process when disputes were to arise. When explained the arbitration process and asked if they had understood that they were giving up the right to litigation in a court proceeding, Resident 53 said they did not recall signing the agreement, that if they were aware or had read the fine print, that they would never have signed the agreement. Resident 53 went on to say as an American, they never would have willingly signed away their rights. 2) Resident 18 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 18 was cognitively intact, was able to make themself understood and was able to understand others. During an interview on 01/31/2025 at 2:06 PM, Resident 18 knew they had signed a binding arbitration agreement, but when asked about their understanding of what the process was when disputes were to arise, said they did not understand, the facility did not explain this, and they had signed the contract in good faith. Resident 18 said it was not explained to them that they could not sue the facility, that it was not explained that it was optional to sign the agreement (not as a condition of admission/remaining in facility), and did not know they could have terminated or withdrawn the agreement 30 days after signing. During an interview on 01/31/2025 at 2:26 PM, Staff A, Administrator, when asked if it met expectations that two residents reported they did not know they were signing away their right to be able to sue the facility, said no it did not meet expectations, and their expectation was for residents to be aware of their rights. No associated WAC .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 46793 Based on interview and record review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) program self-identified deficiencies and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Failure to have an effectively functioning QAPI program that consistently self-identified deficient practices led to repeated deficiencies, a pattern of deficiencies, widespread deficiencies, and a pattern of actual harm that placed residents at repeated risk for unmet needs that could negatively impact their safety, quality of life and quality of care. Findings included . On 02/06/2025 at 10:05 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services, when asked if they had reviewed the [NAME] report (a report with previously cited deficiencies) to identify any repeat deficiencies that needed to be addressed, Staff A, Administrator, said no, they had only been in the facility since January 13th 2025, so was unable to speak to last year's survey. Staff A said she had not yet attended a QAPI meeting, only due to being recently hired. Refer to the following citations identified during past 4 surveys which were identified and not addressed or had ineffective plans of correction to sustain correction by the QAPI program which led to repeated deficiencies, pattern or widespread of deficiencies, and a pattern of harm (D = Isolated, E = Pattern, F = Widespread, and H = Pattern of harm). Staff A reviewed the [NAME] report and acknowledged the following repeat deficiencies: Refer to F550-Resident Rights/Exercise of Rights. Previous survey deficiency dated 02/2019 (D), 08/2021 (E), 05/2023 (D) & 03/2024 (D) & 02/2025 (D). Refer to F561-Self-Determination. Previous survey deficiency dated 08/2021 (D), 05/2023 (D), 03/2024 (C) & 02/2025 (E). Refer to F578-Request/Refuse/Discontinue Treatment; Formulate Adv Dir. Previous survey deficiency dated 02/2019 (E), 08/2021 (E), 05/2023 (E) & 03/2024 (D). Refer to F677-ADL Care Provided for Dependent Residents. Previous survey deficiency dated 02/2019 (E), 08/2021(D), 05/2023 (D), 03/2024 (D) & 02/2025 (E). Refer to F684-Quality of Care. Previous survey deficiency dated 02/2019 (D), 08/2021 (E), 05/2023 (D), 03/2024 (E) & 02/2025 (E). Previous complaint investigation dated 08/2024: Substantiated: F684 Quality of Care (H). Refer to F758-Free from Unnecessary Psychotropic Meds/PRN Use. Previous survey deficiency dated 02/2019 (D), 08/2021 (E), 05/2023 (D), 03/2024 (E) & 02/2025 (E). Refer to F804-Nutritive Value/Appear, Palatable/Prefer Temp. Previous survey deficiency dated 02/2019 (D), 08/2021 (E), 05/2023 (E) & 03/2024 (E). (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer to F812-Food Procurement, Store/Prepare/Serve Sanitary. Previous survey deficiency dated 02/2019 (D), 08/2021 (E), 05/2023 (F) & 03/2024 (E). Previous complaint investigation dated 12/2024: Substantiated: F812 Food procurement, store, prepare, serve (E). Refer to F880-Infection Prevention & Control. Previous survey deficiency dated 08/2021 (H), 05/2023 (D), 03/2024 (E) & 02/2025 (F). Repeat deficiencies on current 01/2025 survey: Refer to F550-Resident Rights/Exercise of Rights Refer to F561-Self-Determination Refer to F677-ADL Care Provided for Dependent Residents Refer to F684-Quality of Care Refer to F758-Free from Unnecessary Psychotropic Meds/PRN Use Refer to F880-Infection Prevention & Control Reference WAC 388-97-1760(1)(2)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46793 Based on interview and record review, the facility failed to maintain a Quality Assessment and Assurance (QAA) committee that included the Infection Preventionist (IP) and the Medical Director or his/her designee, to conduct required Quality Assurance and Performance Improvement (QAPI) and QAA activities. This failure detracted from the effectiveness of the QAA committee and placed residents at risk for quality deficiencies, adverse events, and diminished quality of life. Findings included . On 02/06/2025 at 10:05 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services, Staff A reviewed the QAPI/QAA required attendees for the past year of QAPI/QAA meetings. QAPI meeting attendance sheet documented: May 24th, 2024: No IP in attendance. August 29th, 2024: No IP or Medical Director in attendance. September 11th, 2024: No IP or Medical Director in attendance. December 20th, 2024: No IP in attendance. Staff A, Administrator, said they had only been in the facility since January 13th, 2025, so was unable to speak to last year's QAPI/QAA attendees. Staff A said she had not yet attended a QPAI meeting, only due to time frame. Staff A acknowledged the missing required QAPI/QAA committee members. Reference F865. Reference WAC 388-97-1760 (1)(2)

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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** 50392 Based on observation, interview and record review, the facility failed to operationalize an effective Infection Prevention and Control Program (IPCP) in accordance with facility policy, state, federal and or local infection control guidelines, regulations and practices when the facility failed to follow standard precautions (common sense practices to prevent the spread of infection in healthcare), enhanced barrier precautions (a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) and transmission based precautions (used when someone has confirmed or suspected infections) related to lack of prompt isolation and use of precautions when several residents and staff had vomiting and diarrhea and a suspected gastrointestinal outbreak. The facility also failed to ensure the consitent hand hygiene, personal protective equipment (PPE) use and or cross contamination (the unintentional transfer of harmful bacteria, viruses, or allergens from one surface, person, or food to another) for 4 of 4 Halls (Hall A, Hall B, Hall C, & Hall D) reviewed for infection control practices. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications and a decreased quality of life. Findings included . Review of the facility policy titled, Standard Precautions Infection Control, undated, described standard precautions as practices applied to all residents, to prevent the spread of infection to residents, staff, and visitors. These precautions included hand hygiene, selection and use of personal protective equipment (PPE) as was appropriate, safe injection practices with the proper disposal of injection equipment in the sharp's container, environmental cleaning and disinfection, and the reprocessing of reusable resident medical equipment. Review of the Centers for Disease Control and Prevention (CDC) document titled, Clinical Safety: Hand Hygiene for Healthcare Workers, recommends hand hygiene be performed before touching a patient, before moving from a soiled body part to a clean body part on the same resident, after touching a resident or their surroundings, after any contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. <Standard Precautions> >Hall A< Observation of Hall A for the lunch meal on 01/22/2025 showed the following: At 12:21 PM, Staff PP, Certified Nursing Assistant (CNA), delivered a lunch tray to the resident in room [ROOM NUMBER]/Bed A. Staff PP assisted the resident with positioning and moved the overbed table before exiting the room without performing hand hygiene. (continued on next page)

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Roo Lan Health & Rehab	1505 Carpenter Road SE Lacey, WA 98503

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:23 PM, Staff PP retuned to the tray cart, and without performing hand hygiene obtained the tray for the resident in room [ROOM NUMBER]/Bed A and delivered it. Staff PP grabbed the bed control to elevate the head of the bed, handled the resident's bedding and then exited the room without performing hand hygiene. Staff PP proceeded to the beverage cart and poured a cup of milk and coffee and delivered them to room [ROOM NUMBER] and again exited without performing hand hygiene. At 12:25 PM, Staff PP and Staff Y, CNA, entered room [ROOM NUMBER] and approached Resident 69, who was on EBP. Without applying gloves or gowns, Staff PP and Staff Y proceeded to pull back the resident's bedding, grabbed the draw sheet and boosted the resident up in bed. They then used the bed control to elevate the head of the bed, touched the privacy curtains and positioned the overbed table. Once completed, both Staff PP and Y exited the room without performing hand hygiene. At 12:31 PM, Staff Y entered room [ROOM NUMBER] to pick up a breakfast tray and exited the room and placed the tray on the tray cart. Staff Y, without performing hand hygiene then entered room [ROOM NUMBER]. >Hall B< During a dining observation of Hall B on 01/22/2025, Staff Z was observed to miss several opportunities for hand hygiene as documented below: At 12:24 PM, Staff Z passed a lunch tray to the resident in room [ROOM NUMBER]/Bed B, touched the privacy curtain in the room, and did not use hand sanitizer before passing the next tray to bed A. At 12:27 PM, after Staff Z passed the lunch tray to the resident in room [ROOM NUMBER]/Bed A, staff Z touched their privacy curtain and did not use hand sanitizer when they walked out of the room. At 12:30 PM, Staff Z delivered a tray to resident in room [ROOM NUMBER]/Bed C, touched the resident's curtain, and did not hand sanitize. At 12:32 PM, Staff Z delivered a tray to room [ROOM NUMBER], helped set up the resident's tray, did not complete hand hygiene when leaving the room, and then went into room [ROOM NUMBER] to assist a resident. At 12:39 PM, Staff Z delivered a tray to room [ROOM NUMBER], did not complete hand hygiene afterwards, then went out of the room and got salt and pepper packets, went back into the room, and did not complete hand hygiene. >Hall C< During a dining observation of Hall C on 01/22/2025 from 12:33 PM to 12:42 PM, Staff KK, CNA, was observed to miss opportunities for hand hygiene, and did not wear PPE while in a contact precautions room (requiring gown and glove usage upon entry into room) as documented below: At 12:33 PM, Staff KK assisted room [ROOM NUMBER]/Bed B, (did not complete hand hygiene) then went and helped room [ROOM NUMBER]/Bed A, did not complete hand hygiene and then proceeded to go into the dining room area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:38 PM, Staff KK was observed leaving room [ROOM NUMBER], which had a contact room sign (signage did not indicate which resident it was for), Staff KK did not hand sanitize after opening/closing the door, then touched tea container on beverages cart in the hallway. At 12:39 PM, Staff KK knocked on room [ROOM NUMBER], entered with the tea, did not don (put on) any PPE (gloves, gown, etc.), did not hand sanitize after leaving room and then moved on to the next beverage on the hall cart. At 12:41 PM, Staff KK hand sanitized, poured coffee, knocked on room [ROOM NUMBER]s' door, assisted Bed 21A without PPE, and hand sanitized on the way out. At 12:42 PM, Staff KK knocked on door for room [ROOM NUMBER]/Bed B, did not don PPE, brought in the meal tray and then left the room. Staff KK did not hand sanitize and then touched items on the beverage cart, poured milk into a cup, put lids on cups and brought them into room [ROOM NUMBER] without donning PPE. >Hall D< During a dining observation of Hall D on 01/23/2025 at 12:43 PM, Staff AA, CNA, was seen passing food trays to residents on Hall D with the following missed opportunities for hand hygiene: Staff AA took a tray from the food cart and brought it to room [ROOM NUMBER], put the tray on tray table, moved pillows off of the tray table and dropped a pillow on the floor, picked the pillow off of the floor and put it on a nearby walker seat, exited the room without performing hand hygiene and went back to the food cart and picked up a tray to take to room [ROOM NUMBER]. Staff AA then went to room [ROOM NUMBER] and put a food tray on the tray table, moved a cup that was already on the table and was half empty with a clear fluid in it and exited the room without performing hand hygiene. Staff AA then went back to the food cart and took a food tray out of the cart and took it to room [ROOM NUMBER] and put the food tray on a side table, moved a bedside table closer to the resident, and opened a drawer on a side table. Staff AA then exited the room without performing hand hygiene and went to hydration station in the hallway where they poured juice into cup and took it back to room [ROOM NUMBER] where Staff AA entered the room without performing hand hygiene and then removed the paper from drinking straw, touched the straw and put in the resident's cup, assisted resident with drinking from straw, touched side table, put a sandwich on the tray, moved a table closer to resident and then exited the room without completing hand hygiene. Staff AA then went back to food cart and shut the door to the food cart, went back to hydration station, poured juice, and then brought the juice to the food cart and put juice on a food tray. Staff AA then took the tray to room [ROOM NUMBER] and delivered to the bedside table, no hand hygiene noted upon exiting the room and then went back to hydration station to retrieve two milk cartons, went back to room [ROOM NUMBER] to deliver milk, no hand hygiene upon entering or exiting the room, then went back to hydration cart and poured juice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 1:02 PM, Staff AA was observed getting a food tray from the food cart and bringing it to room [ROOM NUMBER], and put the food tray on the tray table, then rubbed a resident's shoulder, and exited the room without performing hand hygiene. Staff AA then shut the food cart door and then pulled gloves from a personal protective equipment cart outside of room [ROOM NUMBER], no hand hygiene was observed before Staff AA put on one glove, picked up a water bottle from the floor with the ungloved hand, no hand hygiene, and put on second glove and went into room [ROOM NUMBER] again and pushed a resident in a wheelchair into the bathroom. During an interview on 01/31/2025 at 3:00 PM, when asked about multiple observations of lack of hand hygiene while staff provided care and delivered meal trays, Staff L, Infection Preventionist (IP) said her expectation was for staff to perform hand hygiene during food tray pass and that not doing so did not meet her expectations. <Enhanced Barrier Precautions> Review of the facility policy titled, Enhanced Barrier Precautions, undated, described EBP should be implemented for preventing the transmission of multidrug-resistant organisms (MDROs). EBPs were the use of gown and gloves for high-contact resident care activities. Residents with wounds or indwelling (remaining in the body until removed) medical devices were considered at risk of MDRO acquisition. This policy stated, Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. Examples were provided of wounds that required EBP, including chronic wounds, pressure ulcers, foot ulcers, and unhealed surgical wounds. Examples of indwelling medical devices that required EBP were central lines, hemodialysis catheters, and feeding tubes. High-contact resident care activities included examples of dressing, bathing, transferring, and providing hygiene care. Review of the CDC document titled, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, provided guidance for isolation signage, Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of Precautions and the recommended PPE to be worn when caring for the resident. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure Precautions are followed. EBP findings included: A. Lack of consistent understanding by staff of understanding the orange sticker system for indicating EBP. No additional signage for EBP outside of sticker system. The facility did not follow its policy or CDC recommendations for appropriate signage. B. Residents were missing EBP stickers/signage when they should have been on EBP C. Lack of gown usage by staff during resident care activities for residents on EBP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/23/2025 at 1:49 PM, when asked how staff knew what the orange stickers (stickers that were on the name plates outside residents' doors) indicated, Staff L said the orange stickers identified residents that required EBP. Staff L said the facility had cards with a key that explained the stickers that were on the doors. Staff L said the stickers were present when she started her position as the Infection Preventionist, and she did not know what they meant at the time, so she developed a card with explanation for agency nurses. At 2:18 PM, Staff AA, CNA, when asked what the orange sticker on a resident' s name plate on the door indicated, Staff AA said, I am not sure. When asked if a resident had a catheter bag what type of precautions would she take when emptying the bag, Staff AA said she would wear gloves, and that was all. During a phone interview on 01/28/2025 at 9:16 AM, when asked how the facility manages residents who were colonized with MDROs, Staff L, IP said it would be classified under EBP and any indwelling device or wound care required staff to gown and if there were a potential for splashing then staff would be required to wear eyewear. Staff L said a lot of the facility staff did not understand EBP, but nurses and staff were being re-educated on it. 1) Hall A staff were interviewed on residents on EBP. On 01/22/2025 at 10:58 AM, when asked if any residents were on any type of TBPs, Staff S, Registered Nurse (RN), stated, No. When asked why there were three personal protective equipment (PPE) kits in the hallway but no signage indicating what residents the kits were for, Staff S, RN, explained they were there just in case someone needed access to PPE and there was no signage because no current residents were on precautions. At 12:22 PM, a key for the facility's sticker system was requested and provided. Review of the key showed an orange dot next to a resident's name meant they were on EBP. On 01/22/2025 at 12:25 PM, observation of the name plates on Hall A showed the following residents had an orange dot sticker next to their name indicating they were on EBP: -Resident 64 -Resident 61 -Resident 69 -Resident 55 -Resident 42 -Resident 324 -Resident 12 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/23/2025 at 12:45 PM, when asked if there were any residents on the hall that were on precautions, Staff QQ, CNA, stated, No, not on this hall. When asked what the orange dot next to Resident 42's name (who's room was on Hall A) meant, Staff QQ stated, It means [Resident 42] is on thickened liquids. 2) Hall C staff were interviewed on residents on EBP. During an observation 01/23/2025 at 12:22 PM, room [ROOM NUMBER] had three listed residents outside of the door. Resident 71 was observed to have an orange dot next to their name, no orange dot was observed next to the other resident names (Resident 45 was missing an orange dot). At 12:38 PM, Staff BB, RN, said this was their first day on the unit. When asked who was on EBP and for what, Staff BB pointed at an orange dot for Resident 71 and said it was for a feeding tube. No other residents on the hall were identified. When asked when a resident should be placed on EBP, Staff BB said it should be initiated on admission, when the resident has a suprapubic catheter, feeding tube, or any opening/body cavity. At12:52 PM, Staff HH, CNA, said they were very familiar with Hall C. When asked who was on EBP precautions, Staff HH said Resident 45 possibly was, because of their wound on their back. Staff HH said no one else was on EBP. When asked when EBP should be implemented, Staff HH said for catheters, colostomies, and wounds. Staff HH said you should wear PPE for residents on EBP anytime you provide care to the resident. 3) Resident 45 should have been on EBP for a wound. No signage or sticker for EBP was noted on the door during an observation on 01/23/2025 at 12:22 PM. Staff HH, CNA, had identified Resident 45, in the above interview, as possibly being on EBP for a wound. During an observation on 01/23/2025 at 1:09 PM, Staff BB, RN, and Staff HH, CNA, turned Resident 45 to examine their back wound. The dressing that was lifted off was observed to have drainage on the inside of the dressing, with the site appearing reddened and raw. Neither staff wore gowns for this high contact resident care activity. During an observation on 01/24/2025 at 1:53 PM, no EBP sticker or signage was seen next to Resident 45's name outside of their door. During an interview on 01/28/2025 at 12:29 PM, Staff JJ, LPN, said Resident 45 recently had a wound that opened back up, that they should have had the resident on EBP, and they would put Resident 45 on EBP. 4) Resident 324 was observed on 01/27/2025 at 7:47 AM, with an orange sticker (indicating EBP) next to their name outside of their door, with no PPE cart located immediately outside of their door. At 7:49 AM, Staff II, a contracted phlebotomy technician was observed entering Resident 324's room. Staff II did not wear a gown while caring for Resident 324. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/31/2025 at 3:00 PM, when asked what her expectations were for when staff should wear PPE Staff L, IP said for any medical indwelling device they should wear gown, gloves, and potentially a mask. Staff L said during any close contact related to the care for the reason for which they were on EBP, staff should both glove and gown. When it was explained to Staff L, that there were multiple observations such as wound care, catheter care and medications being given through a feeding tube without staff wearing gowns for residents on EBP, along with interviews showing that staff and outside contractors did not know what the orange stickers indicated and staff/contractors were observed not following EBP precautions with orange stickers on the door, Staff L said, none of these issues met her expectations. When reviewing the facility EBP policy with Staff L, which documents that signage should be posted outside of the room indicating type of precautions, required PPE, and high-contact resident care activities that require use of gown and gloves, Staff L said, that the orange sticker system currently in use did not meet the facilities policy standards. During an interview on 02/04/2025 at 11:13 AM, Staff B, DNS, said their expectation was for staff to implement precautions with EBP. <Outbreak Surveillance/Transmission Based Precautions> Review of the facility policy titled, Infection Outbreak Response and Investigation, dated 04/27/2023, described Outbreak as the occurrence of more cases of a communicable disease than expected in a given area or among a specific group of people over a particular period of time. The policy further documented, Implementation of infection control measures: a. Symptomatic residents will be considered potentially infected, assessed for immediate needs, and placed on empiric precautions while awaiting physician orders d. Standard precautions will be emphasized. Transmission-based precautions will be implemented as indicated for the particular organism. Review of the Case Report Worksheet (a tracking worksheet used for communicable disease tracking) for the GI outbreak showed staff first had symptoms of vomiting and/or diarrhea on 01/09/2025, and residents became symptomatic with vomiting and/or diarrhea starting on 01/13/2025, the majority of the symptomatic residents were on Hall D. On 01/23/2025 at 3:06 PM, Staff L, IP said, the outbreak monitoring ends tomorrow, (01/24/2025), that is was officially 4 days as of tomorrow. Review of a new GI outbreak worksheet, received 02/05/2025, showed symptom onset date was 01/24/2025 through 02/04/2025. The 3 residents reviewed were all from Hall C. 1) Resident 53 was admitted to the facility on [DATE], and was on Hall C. During an observation on 01/22/2025 at 10:11 AM, Resident 53 said, I have the flu. Resident 53 was observed with their arm draped over their face, and said they were not feeling good and did not want to talk. There was no signage outside of Resident 53's room for any kind of TBP. During an interview on 01/23/2025 at 10:45 AM, Staff SS, CNA, said Resident 53 had been saying they were sick and did not have an appetite. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/03/2025 at 2:20 PM, Staff MM, Housekeeping was observed coming to the threshold of Resident 455's door and announced to Staff NN, CNA, that Resident 455 was throwing up again. Observation of the door showed there was no signage to indicate Transmission Based Precautions (TBP) were in place. Staff NN then entered the room with mask and gloves, but no gown or face shield. At 2:30 PM, Staff EE, LPN, said Resident 455 had started vomiting that day, after lunch time. Staff EE said she was told by a CNA that the resident was throwing up, and that Staff EE had given the resident a medication for dizziness at that time. Staff EE said she would check the resident's vital signs again because there was an infection going around Hall C and she would put the resident on TBP. Staff EE said she would check with the Infection Preventionist about implementing TBP for Resident 455. At 3:49 PM, Staff NN, CNA said when a resident was vomiting, she would use gown, gloves and mask. When asked why she didn't wear a gown when going into the room where Resident 455 was vomiting, she said she didn't wear a gown because the room wasn't on special precautions (TBP), and she didn't see a sign, so she didn't put a gown on. At 3:54 PM, when asked why Resident 455 did not have a TBP sign up, Staff EE, LPN said the RCM said to not put Resident 455 on precautions (TBP) until the roommate started having symptoms, then to put up the precautions sign, because Resident 455 had a history of nausea and vomiting. On 02/05/2025 at 2:09 PM, Staff L, IP said in regards to Resident 455 vomiting and her room being on Hall C, where many residents were experiencing gastrointestinal (GI) outbreak symptoms (vomiting and/or diarrhea), yet Resident 455 was not put on TBP said, the RCM had assessed Resident 455 and since Resident 455 had admitted with the same symptoms, it was ruled out to not be part of the GI outbreak symptoms, and Resident 455's roommate had not exhibited any symptoms to indicate otherwise. At 2:40 PM, Staff B, DNS, said for a resident who was vomiting, that anyone entering the room should have gown and gloves, and since it was coming out of the mouth, a face shield as well. Staff B said if a resident was vomiting, TBP should be put in place. When asked about Hall C having a GI outbreak, and Resident 455 experiencing a vomiting episode but not being placed on TBP due to a history of vomiting, Staff B said she would still expect resident 455 to have been placed on TBP. <Cross Contamination> >Wound Care< Resident 7 admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 7 was cognitively intact, and had one Stage 2 pressure ulcer (PU, injury to the skin and underlying tissue resulting from prolonged pressure on the skin), one Stage 4 PU, and had Moisture Associated Skin Damage. Resident 7 was on EBP for wounds, a suprapubic indwelling catheter, and for a MDRO. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505254	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of wound care on 01/22/2025 at 2:48 PM, Staff BB, RN, was observed providing wound care to Resident 7 without a gown. Staff BB cleansed a wound perimeter with gauze, adjusted Resident 7's body with the same gloves on, pulled out a pad that was under Resident 7's body, then rolled the pad up and tucked it under the resident. Staff BB then adjusted Resident 7 in bed, removed their gloves without performing hand hygiene, and put on new gloves. Staff BB then grabbed gauze and a bottle of wound cleanser, sprayed the gauze with wound cleanser, and put the gauze and wound cleanser on bedside table. Staff BB then remov

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 50392 Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program (ASP) for three of three months (October 2024, November 2024 and December 2023) reviewed. This failure placed residents at risk for adverse outcomes associated with inappropriate and/or unnecessary use of antibiotics, including for Multi Drug Resistant Organisms (MDRO: germs that are resistant to many antibiotics), and a diminished quality of life. Findings included . On 02/05/2025 at 2:09 PM, when asked which residents should be included in the Antibiotic Line Listing (a list that tracks antibiotic use, patterns, or infection cases to track trends and identify inappropriate use of antibiotics) Staff L, Infection Preventionist, said any resident who was on antibiotics should be on the Antibiotic Line Listing. When Staff L was made aware that Resident 32, who had been taking antibiotics since 10/2023 but was not found on the 10/2024, 11/2024, or 12/2024 Antibiotic Line Listing, Staff L said she did not track indefinite antibiotics (antibiotics that are prescribed for long term use, without an estimated end date) on the Antibiotic Line Listing. At 2:40 PM, Staff B, Director of Nursing Services, said for antibiotic stewardship her expectation was that someone who was taking antibiotics indefinitely, would be reviewed by the provider on a regular basis to make sure the antibiotics were used appropriately. Staff B said the whole case should be reviewed to rule out anything that would indicate need for discontinuation of the antibiotics or need for changes. When asked if residents that were taking antibiotics indefinitely should still be placed on the Antibiotic Line Listing, Staff B said to continue to monitor them, they should be included on the Antibiotic Line Listing. Reference F757 No Associated WAC .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 50392 Based on interview and record review, the facility failed to maintain documentation of staff COVID 19 (an infectious respiratory disease caused by a virus) vaccination status. This failure placed residents at risk of contracting COVID 19, medical complications and a decreased quality of life. Findings included . On 01/28/2025 at 9:16 AM, when asked if there was documentation of staffs COVID-19 vaccination status, Staff L, Infection Preventionist (IP) and Registered Nurse said it's was not a requirement, it was not part their hiring process and it was not being done. On 01/29/2025 at 2:07 PM, when clarifying that keeping documentation of staff COVID-19 vaccination was a requirement Staff L, IP, said, I was told that it was not a requirement, that it is not mandated. I was keeping a record when it was a mandated requirement. Staff L said, I don't yet have a staff list of vaccination status. No associated WAC