STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505257	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Manor	3600 East Hartson Avenue Spokane, WA 99202

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure psychotropic medication consents were accurate and obtained prior to their administration (Residents 3, 13, 39) and failed to ensure a consent for treatment and admission were signed by someone able to make those decisions (Resident 27) for 4 of 5 sampled residents reviewed for unnecessary medications. This failure placed the residents or their representative at risk of not being fully informed of the potential risks and benefits of taking the medications and care being provided at the facility. Findings included . <Resident 3> Review of Resident 3's medical record showed the provider ordered the medication sertraline on 07/01/2024 for depression. Review of the October 2024 Medication Administration Record showed the staff administered the sertraline to Resident 3 at bedtime. Review of Resident 3's care plan showed the resident used sertraline related to depression. Review of a 07/02/2024 Medication Informed Consent showed Resident 3 and a facility staff signed the form and the reason for the use of the sertraline was somatization, contrary to the physician order and the care plan. Somatic symptom disorder is diagnosed when a person has a significant focus on physical symptoms, such as pain, weakness or shortness of breath, to a level that results in major distress and/or problems functioning. On 10/28/2024 at 1:46 PM, Staff A, Administrator, acknowledged the inaccurate consent and stated that it should have been clarified. 46033 <Resident 13> A quarterly assessment dated [DATE] documented Resident 13 had diagnoses including end-stage kidney disease dependent on dialysis (a mechanical way of removing waste from the body when the kidneys no longer work), dementia and anxiety. Resident 13 was moderately cognitively impaired and took medications for anxiety and depression. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 01/19/2024 care plan documented Resident 13 used anti-anxiety medication related to anxiety with dialysis. Staff were instructed to administer the medication as ordered, observe for and report any adverse reactions which could be associated with an increased risk of confusion, amnesia, loss of balance and cognitive impairment that looked like dementia. On 12/04/2023, a provider order was given to administer lorazepam (a medication used to treat anxiety that worked by slowing activity in the brain to allow relaxation), 0.5 milligrams every Monday, Wednesday and Friday prior to leaving for the resident's dialysis appointment. On 01/31/2024, a consent was signed by Resident 13's representative that agreed to the use of lorazepam to treat the resident's anxiety related to their dialysis treatment. The consent included why the medication was prescribed, risks and benefits, and non-drug approaches that had been ineffective. A consent dated prior to the initiation of the lorazepam on 12/04/2023 was requested. On 10/29/2024 at 3:27 PM, an email from Staff B, Director of Nursing, confirmed that there was no consent completed prior to the consent dated 01/31/2024. 46115 <Resident 27> A 07/26/2024 admission assessment documented Resident 27 had diagnoses including dementia, depression and agitation. Resident 27 was severely cognitively impaired and took medications for agitation and depression. The 07/26/2024 care plan documented Resident 27 used antidepressant medication related to depression and anxiety and antipsychotic medication for agitation. Staff were instructed to administer the medication as ordered, observe for and report any adverse reactions and to educate the resident/family/caregivers about the risks, benefits and the side effects of the medication. On 07/23/2024, a provider order was given to administer Lexapro (a medication used to treat depression and anxiety) and Zyprexa (an antipsychotic medication used to regulate mood and behaviors). On 07/23/2024, a consent was signed by Resident 27's representative that agreed to the use of Lexapro and Zyprexa. Resident 27's representative had moderate cognitive impairments and was also a resident of the facility. During an interview on 10/28/2024, Resident 27's representative stated they did not know what medications their family member was receiving and was unaware of the risks and benefits when asked about the Lexapro and Zyprexa. On 07/23/2024, Resident 27's representative signed Resident 27's admission packet, which included financial agreements, consent for treatment, rules and regulations, immunizations, pharmacy authorization and resident records. In an interview on 10/28/2024 at 2:28 PM, Staff B, Director of Nursing, stated consents needed to be signed by cognitively intact representatives and this was important, so they understood what they were signing. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 39> A 10/10/2024 admission assessment documented Resident 39 had diagnoses including depression and insomnia. Resident 39 was cognitively intact and took medications for insomnia. The 10/08/2024 care plan documented Resident 39 used antidepressant medication related to insomnia. Staff were instructed to administer the medication as ordered, observe for and report any adverse reactions. On 10/10/2024, a provider order was given to administer Trazodone (a medication used to treat depression and insomnia). On 10/11/2024, a consent was signed by Resident 39 that agreed to the use of Trazodone. Per the October 2024 medication administration record, Resident 39 received their first dose of Trazodone on 10/10/2024, prior to the consent being signed. In an interview on 10/28/2024 at 10:08 AM, Staff M, Resident Care Manager, stated the consent for the Trazodone needed to be obtained prior to Resident 39 receiving their first dose. During an interview on 10/28/2024 at 10:10 AM, Staff B, Director of Nursing, stated the consent should have been signed prior to the administration of the medication and this was important because the resident needed education on what they were taking. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b).

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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. 40297 Based on interview and record review, the facility failed to accommodate preferences for bedtime routine for 1 of 2 sampled residents (Resident 44) reviewed for choices. This failure placed the resident at risk for a diminished quality of life. Findings included . Review of a 08/16/2022 facility policy titled Person Centered Planning, showed the facility would develop a person-centered care plan that addressed the goals, preferences, values, and practices of the resident. This policy showed it would include the resident's participation and reflect the resident's right to make informed choices. In an interview on 10/22/2024 at 8:36 AM, Resident 44 stated, I would prefer to be woken up at or before 6:00 AM to remove the bi pap [respiratory equipment] off as early as possible. Resident 44 stated their preferred bedtime hours was around 8:00 PM. Review of a 10/17/2024 quarterly assessment showed the staff identified it was very important for Resident 44 to choose their own bedtime. Review of a 04/15/2024 Activities Evaluation showed Resident 44's preferred wake up time in the morning was 8:00 AM to 8:30 AM and preferred time to retire was between 11:00 PM to 11:30 PM. Review of Resident 44's care plan showed no instruction to the staff of Resident 44's preferences for their waking or bedtime hours, or that it was very important for Resident 44 to choose their bedtime hours. In an interview on 10/29/2024 at 10:37 AM, Staff L, Activities Coordinator, confirmed they helped identify the residents' preferences for activities and preferred routines in daily life by completing Section F in the Minimum Data Set (an assessment tool) and the Activities Evaluation. Staff L stated that once they gathered information on the resident's preferences, it is then added to the care plan. Staff L acknowledged Resident 44's plan of care did not instruct the staff in the resident's preferences for bedtime or waking hours. Reference WAC 388-97-0900(1)-(4).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46033 Based on observation, interview and record review, the facility failed to provide a secure place for residents to store their valuables for 1 of 2 sampled residents (Resident 13) reviewed for personal property. This failure placed residents at risk for their property to be lost or stolen, and decreased quality of life. Findings included . The Life Care Centers of America Inventory of Personal Belongings policy revised 06/12/2024 documented on admission, a resident or their representative would bring in personal clothing and it was to be marked with the resident's name by the laundry department then returned to the resident after labeled or washed. This was done to ensure all of the resident's clothing was returned once it had been laundered. The policy did not describe how other belongings were to be secured or safeguarded. A review of the 08/20/2024 quarterly assessment documented Resident 13 had diagnoses including dementia and depression. Resident 13 was moderately impaired cognitively, and it was somewhat important to the resident to have a place to lock their belongings to keep them safe. During an interview on 10/22/2024 at 11:57 AM, Resident 13 stated they had a wedding ring and two diamond bracelets come up missing from their room. The resident stated they had removed their bracelets to clean them and then was unable to find them. They stated it was possible they had lost them at dialysis, but they did not know what had become of the jewelry. Resident 13 stated they would like a lock for their belongings but they had not been asked. Review of the personal belonging inventory sheets kept in a binder at the [NAME] Unit nursing station documented that when admitted on [DATE], Resident 13 had 1 nightgown, 1 suitcase for dialysis, 1 sweatshirt, and 1 tablet (type not listed). There was no jewelry documented on the inventory sheet. Grievance logs dated from May 2024 through October 2024 were reviewed. There were no entries on the logs related to missing jewelry belonging to Resident 13. During an interview on 10/29/2024 at 12:22 PM, Staff D, Registered Nurse, Resident Care Manager, stated when a resident was admitted , any clothing or durable items were added to a personal belonging sheet. Resident 13 had reported earlier that they were missing a ring and it had been located; the resident's spouse had taken the ring home. Staff D stated Resident 13 had not mentioned they were missing bracelets. At this time, Resident 13's room was observed. The nightstands and dressers were observed with the resident's permission. There was no lock box in any of the drawers, and none of the drawers had a locking mechanism on them for the resident to secure their belongings if desired. Resident 13 stated they would use a lock if they had one and Staff D notified the resident this would be arranged. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 12:50 PM, Staff C, Assistant Director of Nursing, stated newer residents were asked on admission if they wanted a lock box for their belongings. Some of the rooms on the [NAME] Unit had locked drawers but not all. Staff C stated it was possible that residents that had lived at the facility longer had not known they could have a place to lock up their belongings and they would recheck with the residents. Reference: WAC 388-97-0880

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to implement their Abuse and Neglect Prohibition Policies and Procedures to include, not reporting allegations of abuse to the State Agency (SA) within the required timeframe and completing thorough investigations for 1 of 4 sampled residents (Resident 25) reviewed for abuse. This failure placed the resident and other residents at risk for repeated abuse. Findings included . Review of an October 2022 facility policy titled Abuse - Prevention showed the facility prevented and prohibited all types of abuse, neglect, misappropriation of resident property, and exploitation. This policy showed the facility would identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, to include verbally or physically aggressive behavior. Review of a 06/27/2024 facility policy titled Abuse - Reporting and Response- Suspicion of a Crime showed it instructed the staff to report immediately to the SA, but no later than 2 hours after an allegation involving abuse or neglect was made, if the events that caused the allegation resulted in serious bodily injury, and no later than 24 hours if the events that caused the allegation did not involve abuse or result in serious bodily injury. Review of Appendix D in the October 2015 Nursing Home Guidelines The Purple Book, showed it instructed the facility to log the incident in the SA Log within 5 days of event discovery and report it to SA Hotline if psychological or physical harm occurred. The guideline additionally instructed the facility to report events to the local law enforcement in cases of sexual abuse or misappropriation/exploitation. Where there was no harm associated with mental or physical abuse allegations, the guideline instructed the facility to log the incident in the SA log within 5 days of discovery. A 06/17/2024 facility policy titled Abuse - Conducting an Investigation showed that all allegations of abuse were promptly and thoroughly investigated by the facility. The policy showed the facility would prevent abuse while the investigation was in progress, and take appropriate corrective action based on the investigation findings. When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, misappropriation or resident property was reported, the Administrator or designee would investigate the occurrence and provide protection to the alleged victim and other residents. Review of a 10/11/2024 assessment showed Resident 25 readmitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff identified Resident 25 as cognitively intact, used a wheelchair, and was independent with mobility throughout the facility. This assessment showed Resident 25 displayed verbal behavioral symptoms directed toward others, like threatening, screaming and/or cursing and other behavioral symptoms not directed toward others, like hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/30/2024 at 9:21 AM, Staff G, Nursing Assistant, described Resident 25's behavior. Staff G stated, Some days it's yelling out at residents non-specifically, then at staff. Sometimes goes into mania, like very high mania, thinking [they're] invincible. Staff G stated that Resident 25 vocalized loudly and made threats to the staff, yells and accuses the staff, hollers at other residents get out of my way. Review of the medical record showed a 05/13/2024 progress note. This progress note showed Resident 25, had a hard morning, shouting loudly, and angrily in the hall, playing the music and TV [television] loudly, upsetting the res [resident] across the hall. Res settled down after a while. Review of the medical record showed no information the facility investigated the extent of how Resident 25's behaviors upset the resident across the hall or other residents, to include ruling out psychological harm, and implementing protective measures to prevent recurrence. Review of a 05/29/2024 progress note showed Resident 25, had some verbal aggression toward another resident . Review of the SA Log showed no documentation the facility logged the incident in the log within 5 days of discovery. Review of a 05/31/2024 note showed the staff identified Resident 25 engaged in, 1 episode of verbal aggression noted today with another resident at approx. [approximately] 11pm today. Res stated to resident to 'shut your mouth! Review of the SA Log showed no documentation the facility logged the incident within 5 days of discovery, completed an investigation, and put measures in place to prevent recurrence of verbal aggression towards another resident. Review of a 06/02/2024 progress notes showed the staff witnessed Resident 25, was talking loudly to another male. Record review showed no documentation the facility ruled out a resident-to-resident event occurred, to include psychological harm, and measures to prevent recurrence. Review of a 10/06/2024 progress note showed Resident 25 was, agitated today. Was going down the hall saying, 'everyone better stay out of my way!' This note showed Resident 25 moved towards a female resident coming down the hall, but this nurse intercepted [Resident 25]. Record review showed no documentation the facility ruled out a resident-to-resident event occurred, to include psychological harm, and develop and implement measures to prevent recurrence. The above findings were shared with Staff A, Administrator, on 10/30/2024 at 8:41 AM. Staff A acknowledged the facility did not follow its abuse and neglect policies and procedures. No further information was provided. Reference WAC 388-97-0640(2).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37544 Based on interview and record review, the facility failed to ensure the Office of the State Long-Term Care Ombudsman received written notification of a hospital transfer, for 1 of 2 sampled residents (Resident 51), reviewed for hospitalization /discharge. This failure placed the resident at risk of not having access to additional advocacy services from the State Long-Term Care Ombudsman. Findings included . The 08/29/2024 discharge assessment documented Resident 51 was cognitively intact to make decisions regarding their care and had diagnoses which included anxiety and opioid dependence. Review of Resident 51's record showed a nursing progress note documented in the early morning hours of 08/29/2024, the resident was observed to be pulling their hair and experiencing severe jerking movements of their body. The resident was assessed, and per direction of the on-call provider, the resident was sent to the hospital for evaluation. Additional record review found no documentation that showed the State Long-Term Care Ombudsman had been notified of the resident's transfer to the hospital. In an interview on 10/29/2024 at 12:05 PM, Staff E, Medical Records, stated the Notice of Transfer or Discharge form was filled out when a resident discharged from the facility or was transferred to the hospital, and Staff F, Receptionist, sent the form to the Ombudsman's office. Staff E reviewed Resident 51's record and confirmed the form was not present. In an interview on 10/29/2024 at 12:20 PM, Staff F, stated once they received the Notice of Transfer or Discharge form from the Resident Care Managers, the form was sent to the Ombudsman's Office. Staff F stated once the form had been sent, it was given to Medical Records to be placed in the resident's record. After review of Resident 51's record, Staff F confirmed the form was not present. Reference (WAC) 388-97-1020 (2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 37544 Based on interview and record review, the facility failed to provide a bed-hold notice, a notice that informed the resident of their right to pay the facility to hold their room/bed while they are hospitalized , to the resident and/or their representative at the time of discharge, or within 24 hours of transfer to the hospital, for 1 of 2 sampled residents (Resident 51), reviewed for hospitalization . This failure placed the resident at risk for a lack of knowledge regarding the right to a bed-hold, while they were hospitalized . Findings included The 08/29/2024 discharge assessment documented Resident 51 was cognitively intact to make decisions regarding their care and had diagnoses which included anxiety and opioid dependence. Review of Resident 51's record showed a nursing progress note documented in the early morning hours of 08/29/2024, the resident was observed to be pulling their hair and experiencing severe jerking movements of their body. The resident was assessed, and per direction of the on-call provider, the resident was sent to the hospital for evaluation. Additional record review found no documentation that showed the resident had been provided a bed-hold notice as required. In an interview on 10/29/2024 at 11:31 AM, Staff B, Director of Nursing, stated bed hold notices were done upon admission and again when a resident was transferred to the hospital. Per Staff B, the bed hold was completed by Medical Records and should have been in the resident's record. In an interview on 10/29/2024 at 12:05 PM, Staff E, Medical Records, stated the bed hold notice was an electronic form and was part of the resident's record, if the form was not in the resident's record, then it was not done. After review of Resident 51's record, Staff E confirmed no bed hold notice was done. Reference (WAC) 388-97-1020 (4)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to identify and incorporate specific recommendations made by the PASARR Level 2 evaluator for 1 of 3 sampled residents (Resident 25) reviewed for pre admission screening. A PASARR (Preadmission Screening and Resident Review) Level 2 Evaluation is a person-centered evaluation that is completed for anyone identified as having or suspected of having a serious mental illness, intellectual disability, developmental disability, or related condition. This failure placed Resident 25 at risk for unmet mental health care needs. Findings included . Review of a 10/11/2024 assessment showed Resident 25 admitted to the facility on [DATE] with medically complex conditions and assessed as cognitively intact. The assessment showed the diagnoses of depression and bipolar disorder. Bipolar disorder is a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior. These shifts can make it difficult to do daily tasks and maintain relationships. In an interview on 10/30/2024 at 9:21 AM, Staff G (Nursing Assistant) was asked about Resident 25's behavior. Staff G stated, I know there's been times [the resident] has heard a lot of noise early in the morning and it may irritate [them]. I'm unsure what really sets [the resident] off. Some days none [behavior], some days it's yelling out. Staff G described Resident 25 as impulsive and stated, sometimes goes into mania, like very high mania, thinking [they are] invincible. Review of Resident 25's medical record showed a 05/04/2024 PASARR Level 2 that recommended to the facility to keep Resident 25's room free of obstacles that could make it difficult for them to maneuver their wheelchair, encourage bedroom to be well-lit during the day and gradually decreasing amount of light in the room as bedtime approaches. Keep room quiet, dark and cool at night to encourage improved sleep. Encourage powering down all electronic devices at least 30 minutes prior to bedtime. Keep calendar, clock, and daily schedule in an easily visible location. The evaluation also recommended to the facility to be clear in communication with Resident 25, limiting direction to 1-2 steps at a time. Be consistent with information conveyed and refrain from making multiple changes to a plan if at all possible. Especially last-minute changes. Monitor for small changes in speech patterns, decreased need for sleep, or increased distractibility or disorganized thoughts and alert mental health prescriber as rapidly as possible - early intervention can assist in avoiding a full blown manic episode. Mania is the most intense and extreme phase of bipolar disorder and can interfere with daily functioning and impair judgment. It can also lead to psychosis (the person loses touch with reality). Review of Resident 25's care plan showed no documentation the facility incorporated the PASARR Level 2 recommendations to help support Resident 25's mental health care needs. An observation of Resident 25's room on 10/30/2024 at 9:19 AM showed no clock or daily schedule in an easily visible location as recommended by the PASARR Level 2. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above information was shared with Staff A, Administrator, on 10/30/2024 at 9:02 AM. Staff A acknowledged the PASRR Level 2 recommendations were not and should be in the care plan. You get the Level 2 and incorporate those recommendations. Reference WAC 388-97-1915 (4).

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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** 40297 Based on interview and record review, the facility failed to ensure a PASARR Level 1 [preadmission screening for individuals with a mental disorder and/or intellectual disabilities] was completed as required for 2 of 5 residents (Residents 3 and 27) reviewed for pre admission screening. This failure placed the residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . <Resident 3> Review of a 10/25/2024 comprehensive assessment showed Resident 3 readmitted to the facility on [DATE] from the hospital with medically complex conditions, to include depression and anxiety disorder. Review of Resident 3's diagnoses list also included somatization disorder (when a person has a significant focus on physical symptoms, such as pain, weakness or shortness of breath, to a level that results in major distress and/or problems functioning). Review of the medical record showed no presence of a PASARR Level 1. The above findings were shared with Staff A, Administrator, and Staff B, Director of Nursing, in a joint interview on 10/28/2024 at 1:23 PM. Staff A acknowledged the medical record showed no presence of a PASARR Level 1. Staff B presented a paper copy of a PASARR Level 1 dated 03/25/2020. Review of the PASARR Level 1 showed no recognition of anxiety, depression, or somatization disorder diagnoses. Staff A acknowledged the PASARR Level 1 was not accurate, should have been updated, and stated, Right now there is nothing marked. I see things [diagnoses] that should have been marked. <Resident 27> The 07/26/2024 admission assessment documented Resident 27 had diagnoses which included depression, anxiety, and dementia. Review of Resident 27's record documented a PASARR was completed on 07/18/2024 prior to the resident's admission to the facility, Section 1A documented the resident had anxiety and a mood disorder, but the box for a Level II evaluation as required was unchecked. Further record review found no documentation that the PASARR had been redone to attain a Level II evaluation. In an interview on 10/29/2024 at 9:36 AM, Staff A stated that the PASARR should have been redone and a Level II referral should have been made and this was important to meet the care needs of the resident. Reference: WAC 388-97-1915 (1)(2)(a-c) 46115

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 40297 Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs) related to cleanliness and grooming for 4 of 6 sampled residents (Residents 44, 37, 9, and 19) reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with shaving (Resident 37), nail care (Resident 9), and bathing (Resident 44 and 19), placed the residents at risk for poor hygiene, embarrassment, and a diminished quality of life. Findings included . <Resident 44> Review of a 10/17/2024 assessment showed Resident 44 admitted with medically complex conditions. This assessment showed the staff assessed the resident to be cognitively intact and dependent on the staff for bathing. In an interview on 10/22/2024 at 8:36 AM, Resident 44 stated, Bathing dwindled down to once a week. Resident 44 stated that they preferred a bed bath twice a week. Review of the electronic medical record under Tasks showed an instruction to the staff to provide bathing to Resident 44 twice a week on Mondays and Thursdays. Review of the medical record from 09/27/2024 to 10/26/2024, showed no documentation the staff provided assistance to complete Resident 44's bathing twice a week on 09/30/2024, 10/10/2024, 10/17/2024, and 10/24/2024. Review of a bathing sheets binder maintained on the East Hall of the facility was reviewed with Staff M, Licensed Practical Nurse/ Resident Care Manager on 10/28/2024 at 11:26 AM. Staff M confirmed the binder showed no documentation the staff provided Resident 44 bathing twice a week for the month of October 2024. The above information was shared with Staff B, Director of Nursing, on 10/29/2024 at 10:27 AM. No further information was provided. 46033 <Resident 37> A review of the 07/16/2024 quarterly assessment documented Resident 37 had diagnoses including dementia and paralysis on one side of the body after a stroke. Resident 37 was severely cognitively impaired and required moderate assistance for personal hygiene and extensive assistance for showering. The 10/21/2022 ADL self-care deficit care plan documented Resident 37 was dependent on staff for bathing/showering and was to be given showers twice weekly on Wednesdays and Sundays. The care plan did not provide instructions for staff regarding shaving preferences. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower binder documentation from 09/25/2024 to 10/24/2024 showed Resident 37 was provided showers on 09/25/2024, 10/02/2024, 10/09/2024, 10/16/2024, 10/20/2024, and 10/23/2024; weekly, not twice weekly as care planned. There was no documentation Resident 37 refused showers. The documentation showed Resident 37 was shaved on 10/09/2024. On 10/22/2024 at 9:10 AM, Resident 37 was observed scooting in the hall in their wheelchair. The resident had several days of whisker growth on their face and neck, and they had a full mustache. Their hair was unkempt. Additional observations of Resident 37 being unshaven were made on 10/23/2024 at 2:05 PM, 10/24/2024 at 8:15 AM, 10/25/2024 at 10:42 AM, and 10/28/2024 at 9:46 AM. During an interview on 10/24/2024 at 8:15 AM, Resident 37 stated they liked their hair kept short so that it was not hanging on their ears. They preferred to be clean shaven but liked to keep their mustache. Resident 37 was unable to recall when they had been showered last. During an interview on 10/28/2024 at 10:38 AM, Staff N, Nursing Assistant/Shower Aide, stated residents were to be showered twice weekly, but showers were not completed on Sundays. If they were care planned to have a shower on Sundays, it would be made up on a Saturday instead. Shaving was completed during showers. Staff N stated Resident 37 was asked when they wanted to be shaved and if the resident refused, other staff offered at a different time. Staff N stated showers were important to keep residents skin intact. This was especially important for Resident 37 because they had frequent periods of incontinence and their skin needed to be kept clean. During an interview on 10/29/2024 at 2:12 PM, Staff C, Assistant Director of Nursing, stated ideally the care plan would have instructions for shaving written out specifically. Each unit had a shower aide, and if unable to be completed on the day shift, the evening shift staff could make them up. Staff C stated they expected the staff to complete the showers as care planned. 46115 <Resident 9> According to the 07/29/2024 quarterly assessment, Resident 9 had moderate cognitive impairments and needed substantial assistance from staff for ADL's, such as personal hygiene. Per the 04/29/2021 care plan, Resident 9 was to have nail care completed twice weekly during bathing and as necessary. Review of the bathing documentation from 10/03/2024 to 10/28/2024 showed the resident had not refused to be bathed. In an observation on 10/22/2024 at 10:27 AM, Resident 9 was sitting in their wheelchair in their room. Resident 9's nails were unclean with a brown substance underneath them. Subsequent observations of Resident 9's nails being unclean with a brown substance underneath them were made on 10/23/2024 at 8:16 AM and 3:21 PM, 10/24/2024 at 10:07 AM and 12:36 PM, and 10/25/2024 at 8:42 AM and 10/25/2024 at 2:04 PM. In addition, Resident 9's nasal hair was protruding past their nose on 10/23/2024 at 3:21 PM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/2024 at 3:21 PM, Resident 9 was unaware their nasal hair protruded past their nose. The resident stated the staff had not offered to trim it and they would have accepted because they liked to be well kept. <Resident 19> According to the 10/01/2024 admission assessment, Resident 19 was cognitively intact and needed substantial assistance from staff for ADL's, such as bathing. In an interview on 10/22/2024 at 2:10 PM, Resident 19 stated they were supposed to have two showers per week and sometimes they only had one per week. Per the 09/11/2023 care plan, Resident 19 was to be assisted with showers twice weekly. Review of the bathing documentation from 09/28/2024 to 10/23/2024 documented Resident 19 had been given showers on 09/28/2024, 10/02/2024, 10/05/2024, 10/09/2024, 10/16/2024, 10/20/2024 and 10/23/2024. In addition, the documentation showed the resident had not refused to be bathed. In an interview on 10/28/2024 at 10:47 AM, Staff H, Nursing Assistant, stated showers were to be given twice weekly and this was important for hygiene and skin. During an interview on 10/28/2024 at 10:32 AM, Staff B, Director of Nursing, stated nasal hair was removed as needed during showers and showers were to be given twice weekly. Staff B added this was important because it would be a dignity issue for the residents. Reference: WAC 388-97-1060 (2)(c).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure the provider was notified when a resident had possible seizure activity for 1 of 2 sampled residents (Resident 37) reviewed for quality of care. This failure placed residents at risk of not being assessed for possible decline by their provider, unintended health consequences, and decreased quality of life. Findings included . A review of the annual assessment dated [DATE] documented Resident 37 had diagnoses including dementia, and paralysis on one side of their body from a stroke. The resident was severely cognitively impaired and had not had a previous diagnosis of having seizures. A nursing progress note dated 10/19/2024 at 3:16 PM documented Resident 37 was in the dining room with their family when the resident had what looked like an absence seizure, (a short period of staring blankly in to space). The resident's hand and foot were having seizure like movements for about 10 minutes. The resident was aware and speaking during the time and held their affected hand. When asked, the resident stated they did not want to go anywhere. The provider was notified via binder. The note documented Resident 37's vital signs (measurements of the resident's blood pressure, heart rate, respirations, and oxygen saturations) were within normal limits. A review of the vitals section of the electronic medical record (EMR) had no vital signs documented for 10/19/2024. Further review of nursing progress notes from 10/20/2024 to 10/26/2024 documented the resident was on alert charting due to a seizure and had not had any further seizure activity. There were no provider progress notes in the EMR after 10/03/2024. On 10/29/2024 at 10:43 AM, the Provider communication binder (a binder kept at the nurse's station that notified providers on paper of non-emergent resident situations) was reviewed with Staff C, Assistant Director of Nursing. There was no entry for Resident 37 on 10/19/2024 regarding possible seizure activity. Staff C stated once the provider had reviewed the information in the binder, they initialed the document, possibly wrote new orders or instructed staff to continue to monitor a resident. Staff C stated recent notifications in the binder had been removed by Staff B, Director of Nursing, and a copy of the 10/19/2024 provider notification regarding Resident 37's possible seizure was requested. During an interview on 10/29/2024 at 12:39 PM, with Staff C and Staff D, Resident Care Manager, Staff D stated without the notification document, it was difficult to know if the provider had been aware of Resident 37's possible seizure. Staff D stated they had to assume Resident 37 had a seizure until there was something from the provider that documented it was something else. Staff D stated if the resident had a seizure, this was a change of condition and the provider needed to be notified. Staff C stated they expected staff to obtain a resident's vital signs and notify the provider, especially for a resident who had no previous diagnosis of seizures. Staff C stated staff would be educated on what needed to be reported to the provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an email correspondence dated 10/29/2024 at 2:37 PM, Staff B, Director of Nursing, documented the provider notification sheet regarding Resident 37's possible seizure was unable to be located. Staff B documented the provider was going to evaluate Resident 37 on that day, 10/29/2024, 10 days after the initial event. Reference: WAC 388-97-1060(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46033 Based on observation, interview and record review, the facility failed to identify and monitor a pressure ulcer for 1 of 2 sampled residents (Resident 24) reviewed for pressure ulcers. This failure put the resident at risk for worsening breakdown of their skin, infection, and unintended health consequences. Findings included . A review of the 08/19/2024 admission assessment documented Resident 24 had diagnoses including paralysis of one upper extremity following a stroke and left fractured femur (thigh bone). Resident 24 was cognitively intact and was at risk for development of pressure ulcers but had none when admitted . On 09/16/2024, a significant change assessment was completed that documented Resident 24 rejected care and had one unstageable (the ulcer was covered by a layer of dead tissue that may have been green, brown, or black and made it unable to determine the extent of the wound underneath) pressure ulcer not present on admission. The 08/23/2024 care plan documented Resident 24 was at risk for break in skin integrity related to decreased mobility. Staff were to provide a pressure relieving mattress and wheelchair cushion, provide treatments as ordered, and conduct weekly skin checks and notify Social Services or the Director of Nursing if the resident refused. On 09/19/2024, the care plan was updated to show Resident 24 had an unstageable pressure ulcer to their left heel related to immobility and resistance to skin checks. Staff were to administer medications and treatments as ordered, assess wound healing, measure length, width and depth where possible, assess and document status of the wound perimeter, wound bed and healing progress, report improvement and decline to the provider. If the resident refused, staff were to confer with the resident and the interdisciplinary team to try alternate methods. The provider gave the following orders for the resident's care: -08/13/2024 check under brace to left lower extremity twice daily for skin breakdown. Resident has to be in bed with the brace open but not removed. -08/18/2024 weekly skin assessment on Sunday, document new and chronic skin impairments. -09/11/2024 Consult the wound care provider group. A review of hospital records documented on 08/06/2024 on the daily flow sheet, the resident had wounds on both heels. The wound on the right heel was not named and the wound on the left heel was called pressure. The left heel wound was described as redness. A registered dietician note dated 08/10/2024 documented the resident had a stage 1 pressure ulcer on their heel (redness that did not turn white when pressed, skin still intact.), but did not state which heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A photograph of Resident 24's left heel was included in the hospital documentation. It showed the outer aspect of the resident's heel had a dark purple area similar in diameter to a golf ball. The skin surrounding the area was red. There were no measurements of the area on the heel. A review of the treatment administration records (TAR) for August, September 2024 showed the skin under Resident 24's brace was checked twice daily as ordered (with only one omission) beginning on 08/13/2024 until the order was discontinued on 09/19/2024. Weekly skin checks were completed as ordered beginning 08/18/2024. There were no omissions, and no refusals were documented. Weekly Skin Evaluations form documented in the assessment area of the electronic medical record (EMR) documented on 08/18/2024, the resident's skin was normal and there were no new findings. On 08/25/2024, the resident refused to have their skin evaluated and agreed to have their skin checked once they were in bed. On 09/01/2024, there were no new issues. On 09/08/2024, there was an abrasion to the left lower extremity, a skin tear to the right forearm, and no new skin issues were seen or reported. All skin evaluations were reviewed, and the only refusal documented was on 08/25/2024. A review of the Skin Integrity Update forms in the assessment area of the EMR documented on 09/11/2024, Resident 24 had an unstageable pressure ulcer on their left heel, the resident was resistant to skin checks, and often refused to allow staff to see full skin on assessment. The ulcer on the heel was unstable, and the Director of Nursing was notified immediately. All of the Skin Integrity Update forms that were part of the EMR were reviewed and there was no documentation the resident had refused skin assessments. A 09/12/2024 physician assistant (PA) progress note from the consulting wound care provider documented Resident 24 had a wound to their heel, the wound had been noted in the resident's hospitalization notes on 08/10/2024, but the resident had refused evaluations of their extremities multiple times. Last week, a nurse noticed the dark area on the heel. The wound was described as pressure, measured 3.5 centimeters (cm) by 4.4 cm by 0, unstageable, all eschar (dead tissue), and treatments were ordered. On 10/22/2024 at 10:19 AM, Resident 24 was observed in their room scooting in their wheelchair. The resident was wearing a pressure relieving boot on their left foot. Resident 24 stated they had a pressure ulcer on their left heel. They stated it had gotten worse after they got to the facility, but it was being treated, and the wound was improving. On 10/24/2024 at 9:49 AM, Resident 24 stated they had been seen by the wound care PA that morning, and some dead tissue had been removed from their wound. On 10/30/2024 at 10:52 AM, the treatment for Resident 24's heel was observed with Staff D, Resident Care Manager. After removal of the old dressings, the left heel was observed. The outer aspect of the heel had an area of injury similar in diameter to a fifty-cent piece. The area was covered with a dark scab-like tissue in the center of the wound. There was slough (dead moist yellowish tissue) around the perimeter from 9 o'clock to 12 o'clock. The skin surrounding the wound was red. There was minimal drainage present. The area was redressed according to the orders. There was no concern with the infection control practices during the observation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 12:01 PM, Staff H, Nursing Assistant, stated when Resident 24 was first admitted , they wore a firm brace on their left leg that kept their leg straight. Staff H stated when Resident 24 went to bed, they were unable to sleep because of the brace. They also had padded foam boots they were supposed to wear, but complained the boots also interrupted their sleep because they made their feet hot. Resident 24 refused to keep the boots on at night. Staff H stated the resident then developed a wound on their calf, so the brace was discontinued. After the wound care company began working with the resident's heel, Resident 24 then got better about keeping a boot on their left foot. Staff H stated the resident was angry when they were admitted and refused care, but that got better as time went on. During a follow-up interview with Resident 24 on 10/30/2024 at 12:25 PM, they stated they were told in the hospital that a pressure sore was building. They wore the leg brace but had no foot rests on their wheelchair at the hospital so they propped their left leg on top of their right so they could scoot around and this position caused the sore on the back of their calf. They stated they were provided foam boots for their heels right from when they got to the facility, but they did not wear them because they were unable to sleep with them on. Staff gave the resident a pillow instead to put under their legs to prop them up off the mattress. Resident 24 stated the hospital was not doing treatments on their heels; those started after they went to the facility. During an interview on 10/30/2024 at 1:24 PM, Staff M, Resident Care Manager, stated when Resident 24 first arrived at the facility, they refused to have their skin checked so it was several days before they were allowed to look. Staff M reviewed the hospital photographs and stated they had not seen the hospital pictures of Resident 24's heel before then and the wound in the picture looked like a suspected deep tissue injury. They were unable to say what the heel looked like when the resident was admitted . Staff M stated had they known of the heel wound, they would have done more monitoring, and would have had staff measure it to make sure it was improving. Staff M stated the resident was given the foam boots and all residents have pressure relieving mattresses, but there were still a few other interventions they could have tried to help keep the resident's heel from further breakdown. During an interview on 10/30/2024 at 3:56 PM, Staff B, Director of Nursing, stated Resident 24 had not allowed staff to look at their skin from the waist down initially, but agreed that those refusals had not been documented. Staff B stated once the wound was identified, they did a full skin assessment on all residents to ensure there were none that had been overlooked and so they could put interventions in place. Staff B stated they had nurses sign statements that the resident had refused skin observations, but those were not completed until 10/16/2024. Staff B agreed there had been no documentation of the wound until 09/11/2024. Reference: WAC 388-97-1060(3)(b)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 40297 Based on observation, interview, and record review, the facility failed to demonstrate orthotic devices (devices to help support muscles, tendons and ligaments in the wrist and hands) were implemented and monitored to prevent contractures for 1 of 3 sampled residents (Resident 10) reviewed for Position/Mobility. This failure placed the resident at risk for deterioration in Range of Motion (ROM) abilities and development of contractures. Findings included . On 10/22/2024 at 12:03 PM, Resident 10 stated that they participated in a Restorative Nursing Program for, arms and legs, hands and feet. On 10/23/2024 at 9:31 AM, Resident 10 was observed sitting in their wheelchair, with their legs propped on a pillow, and a rolled washcloth to each hand grip. On 10/24/2024 at 2:21 PM, Resident 10 was observed with a rolled washcloth to each hand grip and they stated, They gave me a splint for both hands. But it hurt my hands so now I have washcloths. The observation showed the washcloth to the right hand grip was out of Resident 10's hand. Resident 10 stated that they had the rolled washcloths on yesterday and all the time. On 10/25/2024 at 9:39 AM, Resident 10 was again observed to have rolled washcloths to their hand grips, and stated, The right hand [washcloth] it falls out, but the left hand [grip] is good. In an interview on 10/25/2024 at 9:14 AM, Staff O, Restorative Nursing Assistant, stated, We use wash cloths to keep [the resident's] hands open. Staff O described Resident 10's hands as stiff. In an interview on 10/25/2024 at 3:18 PM, Staff P, Nursing Assistant, stated that the rolled washcloths were used because Resident 10 does not want their nails digging in the palm and will tell us to readjust it every so often. In an interview on 10/25/2024 at 8:16 AM, Staff Q, Nursing Assistant, stated Resident 10 used the rolled washcloths to the hands to, help cushion their arms and that the staff put them in place every morning. Review of an 08/06/2024 quarterly assessment showed Resident 10 was assessed to be cognitively intact, and with the diagnosis of a progressive neurological condition. The assessment showed Resident 10 had functional limitation (which interfered with daily functions or placed resident at risk of injury) to both arms and legs. This assessment showed the staff provided a Range of Motion program but no splint or brace assistance. Review of a care plan showed Resident 10 has limited physical mobility related to a progressive neurological condition, with risk for contractures. The care plan showed a 02/27/2024 instruction to the staff to apply orthotics to both hands, to be worn by the resident up to 6 hours a day and off at night, and to check the skin each shift. A 10/25/2024 addendum to the instruction showed, Often refuses orthotics. If refused, offer rolled up washcloths and place in resident's grip. Review of the medical record showed no documentation the staff applied the hand orthotics, monitored its application or tolerance, identified refusals, and how it managed the refusals. (continued on next page)

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Alderwood Manor	3600 East Hartson Avenue Spokane, WA 99202

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above information was shared with Staff B, Director of Nursing, on 10/28/2024 at 2:17 PM. Staff B acknowledge the lack of monitoring of the orthotics and stated, I do not see an order for this [orthotics] to be in the [treatment administration record] to ensure it is in place for six hours during the daytime. I do not see it is being complied with, how often [the resident] is refusing, why [the resident] is refusing, and the use of the washcloth and tolerance to it. 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 - Some	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** 40297 AMMENDED ON 11/18/2024. Based on observation, interview and record review, the facility failed to ensure residents identified at risk for elopement were accurately assessed and interventions implemented to prevent elopement for 4 of 5 sampled residents (Residents 7, 27, 25 and 254) reviewed for elopement. The facility failed to ensure 1 of 3 sampled residents (Resident 41) had adequate and prompt interventions and supervision to prevent falls. Also, the facility failed to ensure 2 of 2 sampled residents (Residents 24 and 41) reviewed for smoking were adequately supervised, to include safe keeping of smoking materials. These failures placed the residents at risk for injuries related to elopement, falls, and smoking. Findings included . <ELOPEMENT> <Resident 25> Review of a 09/25/2024 facility policy titled Unsafe Wandering and Elopement Prevention showed the facility would assess residents to determine their risk for elopement and implement interventions as appropriate to mitigate risks identified. The policy defined elopement when a resident left the premises or safe area without authorization or without the necessary supervision to do so. The policy identified some of the risks associated with an elopement included heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. The policy showed that a system to help identify residents with the potential for unsafe wandering and elopement included a current photograph of residents and responsible party contact information. The policy instructed the staff to complete an elopement assessment upon admission, re-admission, change in condition, quarterly, and with any unsafe wandering or elopement event. Review of a 10/11/2024 quarterly assessment showed Resident 25 readmitted to the facility on [DATE]. This assessment showed the staff identified Resident 25 wandered 1 to 3 days of the assessment reference period, did not place the resident at risk of getting to a potentially dangerous place, but significantly intruded on the privacy or activities of others. The assessment showed the wandering behavior worsened from the previous assessment. Review of 05/07/2024, 07/15/2024, and 09/10/2024 Elopement Risk Evaluations showed the staff did not find Resident 25 was at risk for elopement. A 10/23/2024 care plan showed the staff identified Resident 25 was, At risk for elopement. Impaired safety awareness, contrary to the evaluations, and instructed the staff to, Add resident to the Elopement Book. Review of the Elopement Books at the Receptionist Desk and the [NAME] Hall where Resident 25 resided showed no information that alerted the staff the resident was at risk for elopement. The facility provided the Surveyor a list of residents At risk for elopement the morning of 10/30/2024. Along with Resident 25, the list also included 4 other residents: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 254 - Review of a 10/24/2024 Elopement Risk evaluation showed the staff identified the resident was at risk for elopement. The 10/22/2024 care plan instructed the staff to, Add Resident to Elopement Book. Review of the Elopement Book at the receptionist area and the East Hall where Resident 254 resided showed no information to alert the staff the resident was at risk for elopement. Resident 27 - Review of a 10/23/2024 Elopement Risk evaluation showed the staff assessed the resident not at risk for elopement and, Pt [patient] wonders [sic] and tries to exit seek occasionally, Pt is easily redirected. The 10/23/2024 care plan showed Resident 27 was, At risk for elopement. Disoriented to place, Resident wanders aimlessly and Add Resident to Elopement Book. Review of the Elopement Book at the receptionist area and the East Hall where Resident 27 resided showed no information to alert the staff the resident was identified at risk for elopement. Resident 7 - Review of a 08/30/2024 Elopement Risk evaluation showed the staff assessed Resident 7 not at risk for elopement. The 10/23/2024 care plan showed the resident was At risk for elopement. Impaired Safety Awareness and Add Resident to Elopement Book. Review of the Elopement Book at the receptionist area and the [NAME] Hall where the resident resided showed no information to alert the staff the resident was identified at risk for elopement. In an interview on 10/30/2024 at 12:47 PM, Staff I, Registered Nurse on East Hall, identified only Resident 253 should be in the Elopement Book, contrary to the care plan instructions for Residents 27 and 254. In an interview on 10/30/2024 at 12:51 PM with three Nursing Assistants on the [NAME] Hall present, Staff Q stated that they knew which residents were at risk for elopement by checking in the Kardex (abbreviated instructions from the care plan) and we also have alarms on the doors. Staff G stated, There's a binder. Staff T answered, Don't we have wrist bands? The Nursing Assistants then brought out two Elopement Books from the [NAME] Hall. The black Elopement Book had a photo of a female resident. Review of the neon green Elopement Book showed the same photo of the female resident and a male resident. In an interview on 10/30/2024 around 12:55 PM, Staff C, Assistant Director of Nursing, confirmed that the female resident had recently passed and the male resident had recently discharged . Neither binder included resident information on Residents 7 and 25, as instructed by the care plan. The above information was shared with Staff A, Administrator, on 10/30/2024 at 9:02 AM. Staff A stated that an Elopement Book is used to help the staff, understand who is at risk for elopement and if we do have a missing resident, it's a reference for when we make the call to 911. Staff A stated that not including a resident who is at risk for elopement in the Elopement Book, could make it less likely for staff to be aware of the elopement. The above information was shared in a joint interview with Staff B, Director of Nursing, and Staff U, Corporate Nurse, on 10/30/2024 at 1:38 PM. Staff B acknowledged the inconsistencies between the Elopement Risk Evaluations, care plan instructions, and information in the Elopement Books. Staff U stated, We need to update it. <SMOKING> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an 11/30/2023 facility policy titled, Area of Focus: Smoking vs [versus] Non-Smoking documented that smoking was not allowed, at any time, inside or outside the building or on the facility property. <Resident 24> An admission assessment dated [DATE] documented Resident 24 had diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung conditions that cause inflammation and difficult breathing) and stroke with paralysis of one upper extremity. Resident 24 was cognitively intact and used tobacco. The 08/12/2024 comprehensive care plan documented Resident 24 was a smoker. Staff were instructed to complete a smoking safety evaluation, provide the resident education on the facility non-smoking policy, instruct the resident on the hazards of smoking and smoking cessation aids that were available, and notify the charge nurse immediately if it is suspected the resident has violated the facility smoking policy. The 08/13/2024 and 09/15/2024 Smoking Safety Evaluations documented Resident 24 was able to appropriately use an ashtray, had demonstrated the ability to safely smoke with supervision and was compliant with the smoking regulations in the facility. On 10/22/2024 at 10:21 AM, Resident 24 was observed in their wheelchair in their room. Resident 24 had a pressure reducing boot on their left foot, their left hand rested in their lap and the resident was unable to move it purposefully. The resident used their right foot to scoot and position their wheelchair. A strong odor of cigarettes could be smelled when standing next to Resident 24. Resident 24 stated when they smoked, they left the facility property because smoking was not allowed on the facility property. Staff did not accompany them. The resident stated they did not have smoking materials; a friend that lived close by met them outside and brought cigarettes and a lighter to them. Resident 24 stated the staff had educated them about the smoking policy. On 10/24/2024 at 3:37 PM, Resident 24 was observed scooting down the hall towards the exit. Resident 24 was met at the exit by Resident 41, and they exited the building, and scooted their wheelchairs directly behind the facility transport van next to the bumper. The van was parked directly outside the exit in the driveway. Resident 41 handed Resident 24 a lighter and cigarette, which Resident 24 lit with their right hand and handed the lighter back to Resident 41. Resident 24 took several long puffs off the cigarette and was observed flicking ashes on to the driveway where they landed on the ground just behind the tailpipe area of the van. Resident 24 extinguished their cigarette when it was half gone, but had their back to the facility entrance, so was unable to see where the cigarette was extinguished. There was no cigarette receptacle next to the resident. Resident 24 handed the half-smoked cigarette back to Resident 41, who put it in their front shirt pocket. Resident 24 went back in the facility and Resident 41 stayed in the driveway and continued to smoke. There were no staff present during the observation. Resident 24 was also observed smoking in the same area on 10/29/2024 at 8:10 AM. There were no staff present, and the resident did not put their cigarette butt in the receptacle by the entrance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/2024 at 1:36 PM, Staff M, Resident Care Manager, stated the facility was a non-smoking facility. Residents were offered smoking cessation aids when they were admitted and a safety evaluation was completed. Staff M stated they assumed someone watched Resident 24 smoke to see if they were safe when smoking. Staff did not accompany residents when they left the facility to smoke. Staff M was unaware Resident 24 smoked in the driveway behind the facility van and was unaware they got their cigarettes from Resident 41. Staff M stated there was no designated smoking area on the property; they were unsure how to honor the resident's preference to smoke without violating the facility policy. <Resident 41> Review of a 09/03/2024 quarterly assessment showed Resident 41 admitted to the facility on [DATE] with medically complex conditions, to include a stroke with one sided paralysis or weakness, and an amputation of the left leg above the knee. This assessment showed the resident was homeless, cognitively intact, had limitation in their range of motion to both upper and lower extremities, used a wheelchair independently, and required supervision or touching assistance for transfers. The assessment showed Resident 41 was dependent on nicotine. In an interview on 10/22/2024 at 12:33 PM, Resident 41 stated that they, can't get back [in the building] in the middle of the night when they go outside to smoke. Resident 41 stated that they got cigarettes and in my pocket and nobody holds it for me, and I smoke on the sidewalk. Resident 41 stated that there was another door they used to access entry to the facility after hours with a code and, Am not supposed to. I knock on the door, and they have to stop and come and get me in. Some guy gave me the code to get back in. An observation on 10/22/2024 at 1:33 PM showed Resident 41 in his room sitting in their wheelchair, with a cigarette lighter in their shirt pocket. Resident 41 stated that they liked to go out and smoke after meals and at bedtime. An observation on 10/25/2024 at 4:05 PM showed Resident 41 outside of the facility in a wheelchair on the sidewalk. The resident leaned over and looked like he picked up something off the sidewalk, then wheeled themselves on to the main road around a black SUV. Cars were observed going around the resident and the SUV. Resident 41 was on the driver's side of the parked SUV. Resident 41 again leaned over a few times as if picking up something off the pavement. An observation on 10/29/2024 at 8:05 AM showed Resident 41 in his wheelchair and on the main road, going past a bulldozer parked next to the sidewalk. There was construction in progress next to the facility with heavy equipment. Traffic was observed going both ways on the road. Resident 41 wheeled himself on the edge of the facility entry way, faced the facility parking lot, and started smoking. Resident 41 put out his cigarette on the wheel of the wheelchair, licked the cigarette, then placed the cigarette in his shirt pocket. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and record review on 10/29/2024 at 12:33 PM at the receptionist area showed a binder with alphabetically listed forms titled, Release of Responsibility for Leave of Absence. Record review showed Resident 41 last signed out of the facility on 7/8 at 1PM. This record showed Resident 41 signed out a total of 13 times between 06/21/2024 and 07/08/2024. Review showed no documentation the resident signed back in to the facility. In an interview on 10/29/2024 at 2:04 PM, Staff F, Receptionist, stated that they observed Resident 41 and 2 other male residents, usually go out [to smoke] on the side walk throughout the day. Review of a 09/04/2024 Smoking Safety Evaluation showed the nurse answered Yes to Is resident non-compliant with smoking regulations in the facility? The Summary of Findings showed the nurse answered Yes to Resident has demonstrated ability to safely smoke with supervision. Additionally, the nurse was instructed to answer Yes to Resident exhibits poor safety awareness when smoking and interventions must be put in place to promote smoking safety but the nurse answered No. Under Smoking Cessation the nurse answered, Undecided at this time. In an interview on 10/29/2024 at 1:30 PM, when asked to clarify if Resident 41 required supervision while smoking and was noncompliant with smoking regulations in the facility, Staff C stated, This is not my favorite assessment. The interpretation of what they're asking could be different between nurses. Review of a 10/24/2024 Risks and Benefits forms showed the facility offered Resident 41 a smoking cessation program with identified health benefits and risks contingent on choice. This form was signed by both the resident and a facility staff. Review of a 05/30/2024 care plan showed, Resident is a smoker. The care plan showed no instruction on where Resident 41's smoking materials would be safely stored, or the level of supervision Resident 41 required during smoking. The care plan instructed the staff to, Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. The care plan showed no instruction to the staff on when Resident 41 would go outside to smoke or to encourage the use of the Sign In/Sign out book to account for Resident 41's whereabouts when they left the building to smoke. In an interview on 10/29/2024 at 12:10 PM, Staff G confirmed that Resident 41 smoked. When asked what interventions were in place to ensure safe smoking Staff G stated, I don't know. I know they have to be off premises 'cause it's a non-smoking facility. Staff G stated that Resident 41 had to let staff know when they are going outside to smoke but was unsure if the resident told others when they went outside. Staff G stated that Resident 41 went to smoke outside, all day. Different times, as soon as the door opens, with time outside of the facility between 20 to 30 minutes at a time. When asked where Resident 41 kept their smoking supplies, like the cigarettes or a lighter, Staff G said, I have no idea. I believe it's with the nurses I've never seen them with it, and that they did not know if the resident shared smoking materials with other residents. In an interview on 10/29/2024 at 12:28 PM, Staff V, Registered Nurse, assigned to the [NAME] Hall where Resident 41 resided stated, None of my residents smoke right now. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview on 10/29/2024 at 12:49 PM, with Staff C and Staff D, Registered Nurse/Resident Care Manager, Staff D stated that they educated the resident about the dangers of smoking in general and offered smoking cessation assistance after a recent fall Resident 41 experienced outside. Staff D stated that Resident 41 does not want to quit smoking and, doesn't want to stop going outside to smoke. Staff D was asked if they knew where Resident 41 kept their smoking supplies and stated, I don't know that [the resident] has any personal smoking belongings. Staff D stated a Risks and Benefits form was completed with Resident 41 because the resident, goes out there to smoke. Staff D stated that Resident 41 told them they did not smoke that much and did not ask Resident 41 where the cigarettes and a lighter were obtained from and kept. Staff D stated that as long as Resident 41 signs out of the facility, they can go outside. During after hours, Staff D described how Resident 41 would go to the employee access door at the East Nurses station, even though [the resident] is not supposed to go there, and knock on the door and staff will let [them] in. On 10/29/2024 at 1:32 PM, Staff C stated that Resident 41 did not have access to money and might be getting their cigarettes by, maybe bumming from construction workers. I never witnessed it, just a theory. In the joint interview, Staff D stated, I don't know, when asked where Resident 41 obtained cigarettes from. Staff D acknowledged the care plan did not reflect Resident 41's current smoking patterns, the level of supervision required, or instructions on how to keep smoking materials in safe keeping when not in use. The above information was shared with Staff B on 10/29/2024 at 2:41 PM. No further information was provided. <FALLS> Review of a 12/04/2023 facility policy titled Fall Management, showed the facility would promote resident safety and reduce falls by proactively identifying, care planning, and monitoring a resident's fall indicators. The policy showed that with each fall event or change in condition, it would identify appropriate interventions to minimize the risk of injury related to falls, and update the care plan, if indicated, upon a fall event and as needed thereafter. Review of progress notes showed the staff identified Resident 41 had poor balance and transferred self independently, despite reminders by staff to use the call light for assistance (05/31/2024, 06/01/2024, 06/01/2024, 06/02/2024, 06/02/2024, and 06/23/2024). Review of a 05/30/2024 Fall Risk Evaluation showed Resident 41 required assistance with toileting needs, was not able to attempt a balance test without physical help and had 3 or more health conditions and one to two medications that contributed to risk for falls. This evaluation showed a score of 18 and that for a score of 10 or above, interventions should be initiated by the staff. Review of the care plan showed Resident 41 required supervision for transfers, was independent with wheelchair locomotion, and was at risk for falls due to above knee amputation, left arm paralysis, incontinence and medication use. The interventions to prevent falls were dated 06/06/2024. The interventions instructed the staff to anticipate and meet the resident's needs, assist with Activities of Daily Living as needed, keep the call light within reach, complete a fall risk assessment, provide adaptive equipment or devices as needed, and refer to therapy to evaluate and treat as ordered or as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 09/05/2024 progress note showed that Resident 41, was found outside of facility laying on the ground next to a bush. The facility was alerted of the resident's fall when a bystander told a Nursing Assistant who was outside at the time that someone was on the ground outside of the facility. The note showed the resident told the staff that they were wheeling backwards in their wheelchair and had toppled over landing on the ground. Review of a 09/05/2024 Fall Risk Evaluation showed a score of 12. The evaluation instructed the staff to initiate interventions for a score of 10 or above. Review of a facility 09/07/2024 Incident Report (IR) associated with the 09/05/2024 fall, showed Resident 41 told the staff that they were attempting to move onto the sidewalk and their wheelchair got caught and fell out of the wheelchair. The IR showed the staff identified Resident 41 often went outside and self-propelled in their wheelchair in the parking lot and sidewalks around the building. The IR showed the facility completed education with Resident 41 and the resident, continues to state, 'I don't care if I get hurt'. The IR concluded Resident 41 often refused to abide by medical recommendations and has no safety awareness and very impulsive. The IR showed the facility reviewed the care plan and encouraged the staff to round frequently and monitor the resident's location. Review of the care plan interventions showed no change or addition to prevent fall recurrence after the 06/06/2024 interventions. Record review showed no documentation the facility referred Resident 41 to therapy services to help ascertain why the resident chose to wheel themselves backwards and if the resident was cleared for safe navigation on uneven terrain. The care plan showed no direction to the staff on how to compensate for the resident's poor safety awareness and impulsivity they identified since 05/31/2024, how to anticipate their needs, or what round frequently should look like to the staff. Review of a 10/20/2024 progress note showed Resident 41 fell out of their wheelchair. Review of a 10/21/2024 associated IR showed the resident fell during the morning hours outside the facility and with no injury. The IR showed that someone driving by let staff know the resident was outside on the cement. Resident 41 told the staff that while they were going up the facility ramp backwards in their wheelchair, the bottom of the ramp caught the wheelchair tire and flipped over the resident, dumping them on their back. The IR showed that the staff identified Resident 41, knows how to get outside . encouraged not to go out the ramp way, but still does. This IR showed the resident was seen at a grocery store half a mile away shortly after they ate their breakfast. The IR showed no conclusion to the investigation or changes to prevent recurrence of falls and associated injury, whether the facility referred the resident to therapy to assess safe wheelchair mobility on out of facility terrain, ascertain why the resident chose to continued to wheel themselves backwards, or how the facility compensated for the resident's poor safety awareness and impulsivity to prevent fall recurrence. Review of a 10/20/2024 Fall Risk Evaluation showed a score of 14. The evaluation instructed the staff to initiate interventions for a score of 10 or above. Review of the care plan interventions showed no change or addition to prevent fall recurrence after 06/06/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Occupational and Physical Therapy Discharge Summaries dated 06/07/2024 showed no documentation therapy services assessed and cleared Resident 41 for safe navigation on out of facility or uneven terrain, like the sidewalk or propelling self via wheel hair half a mile to the grocery store, or identified and addressed why Resident 41 would wheel themselves backwards when outside of the facility. In an interview on 10/29/2024 at 2:02 PM, Staff W, Therapist, stated that Resident 41 was not receiving therapy services and, hasn't been on therapy for quite a while. I don't know if there's anyone here who knows [the resident] really well. Review of a 10/20/2024 progress note showed the staff were aware Resident 41 continued to go outside of the facility multiple times a day. The above findings were shared with Staff B on 10/29/2024 at 2:25 PM. Staff B stated Resident 41 started going outside shortly after their admission to the facility. Staff B stated that both of Resident 41's falls were related to the resident hitting something when propelling backwards in their wheelchair outside and the reason the resident propelled backwards in the wheelchair is because they, only got one leg so it's easier to navigate backwards with the one leg. Staff B stated that Resident 41 was referred to therapy services verbally but showed no documentation the facility followed through to ensure closure with the referral, to include recommendations to prevent fall recurrence or their associated injuries. Staff B was asked if the care plan was updated with interventions to prevent fall recurrence as instructed by the Fall Risk Evaluations and stated, I felt all the interventions were already there. Reference WAC 388-97-1060 (3)(g). 46033

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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** 40297 Based on observation, interview and record review, the facility failed to ensure 1 of 2 residents (Resident 18)reviewed for incontinence, received the care and services necessary to maintain and avoid loss of bowel and bladder functions. This failure placed the resident at risk for continued decline in bowel and bladder function, skin issues, and feelings of frustration and embarrassment. Findings included . Review of a 10/15/2024 quarterly assessment showed Resident 18 readmitted to the facility on [DATE]. This assessment showed the resident admitted to the facility with a stroke and assessed to have moderate cognitive impairment. The assessment showed the resident required substantial/maximal assistance to transfer to the toilet, was frequently incontinent of bowel and bladder, and no toileting program in place to manage the resident's incontinence. An observation on 10/22/2024 at 9:40 AM showed Resident 18 in bed. When asked if they required assistance to use the bathroom for bowel and bladder elimination, Resident 18 stated, I go right in my britches. I unfortunately have a problem, so I end up going in my pants. Resident 18 stated that they mainly experienced bladder incontinence. Resident 18 was unaware if they were on a bowel and bladder toileting program. On 10/28/2024 at 2:41 PM, Resident 18 was observed again in bed and stated, I prefer using the bathroom, but I can't make it. My walker is behind the door. I call but if the staff is not on time I do it on my own. They don't come in out of the blue and ask if I need to use the bathroom. Review of a 01/11/2024 Urinary Incontinence Tool showed the staff identified Resident 18 experienced urge incontinence (a sudden and intense need to urinate that can't be delayed), required stand-by assistance with toileting, and used a wheelchair and a walker. This tool showed Resident 18 could understand and follow directions, recognize urinary urge sensation, and learn to control the urge to void. No referral needs to specialists or other disciplines were indicated. The tool showed no documentation on what the facility did to help the resident gain their continence. Review of results for an 01/11/2024 Evaluation for Bowel and Bladder Training showed the staff assessed Resident 18 met criteria for a timed or scheduled voiding program. Review of a 02/04/2024 Urinary Incontinence Tool showed Resident 18 experienced functional incontinence (a person is usually aware of the need to urinate, but for one or more physical or mental reasons they are unable to get to a bathroom) required total physical assistance for toileting, no Post Void Residual (PVR, a test which measures urine volume and can help evaluate incontinence and other urinary symptoms) was completed, and the resident did not recognize or learn to control the urge to void. The tool showed the staff referred Resident 18 to Occupational Therapy (OT) and Physical Therapy (PT). Review of results for an 04/11/2024 Evaluation for Bowel and Bladder Training showed the staff assessed Resident 18 met criteria for a timed or scheduled voiding program. (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 a 05/01/2024 Urinary Incontinence Tool showed the staff identified Resident 18 experienced stress incontinence (when movement or activity puts pressure on the bladder, causing urine to leak, like coughing, laughing, sneezing, running or heavy lifting). This tool showed Resident 18 was able to sense the urge to void, required physical assistance for toileting, and no PVR was completed. The tool showed that even though the resident refused to be toileted prior to a recent hospitalization , the resident now stated that they desired to get out of bed more often. The tool showed Resident 18 recognized and learned to control the urge to urinate. The tool showed the staff referred Resident 18 to OT and PT. Review of results for a 05/01/2024 Evaluation for Bowel and Bladder Training showed the staff assessed Resident 18 was a poor candidate for scheduling or retraining bowel and bladder program. Review of 05/29/2024 OT and PT Discharge Summaries and a 08/06/2024 PT Discharge Summary showed no documentation therapy evaluated Resident 18 for bowel and bladder incontinence. No further OT or PT records were provided by the facility to show the resident was evaluated by therapy to address their incontinence. Review of results for a 07/11/2024 and 10/11/2024 Evaluation for Bowel and Bladder Training showed the staff assessed Resident 18 met criteria for a timed or scheduled voiding program. Review of the bowel and bladder flow sheets from 09/28/2024 to 10/26/2024 showed Resident 18 was incontinent of bowel and bladder at a minimum of two times a day and sometimes up to three times a day. Review of Resident 18's care plan showed a 10/18/2024 care plan that showed the resident required substantial assistance by one staff for toileting hygiene and the resident chose to be incontinent all the time of bowel and bladder and not use the toilet. There were no interventions to show a timed or scheduled program as indicated in the 07/11/2024 and 10/11/2024 Evaluation for Bowel and Bladder Training. The above information was shared with Staff B, Director of Nursing, on 10/29/2024 at 8:54 AM. Staff B acknowledged the conflicting results of the Urinary Incontinence Tools and no interventions in the care plan to instruct the staff on how to decrease or avoid loss of bowel and bladder functions. Staff B stated that they expected to see interventions that encouraged the resident to use the bathroom and clearly show the staff how to manage the resident's incontinence. Reference WAC 388-97-1060 (3)(c).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46115 Based on observation, interview, and record review, the facility failed to ensure oxygen delivery equipment was maintained in a clean manner for 2 of 4 sampled residents (Resident 19 and 38) reviewed for respiratory care. These failures placed the residents at risk for respiratory complications and infection. Findings included . <Resident 19> Per the 10/01/2024 admission assessment, Resident 19 had diagnoses which included heart failure and obstructive sleep apnea (OSA, when you can't breathe while asleep because of a blockage of your windpipe) and needed a CPAP (a machine that uses mild air pressure to keep breathing airways open) due to those conditions. The 09/27/2024 physician order instructed nursing staff to cleanse the CPAP mask with warm soapy water, rinse and air dry daily and as needed. The 02/28/2024 care plan documented Resident 19 used a CPAP for OSA. In an observation and interview on 10/22/2024 at 2:19 PM, Resident 19's CPAP was unclean with white splatter inside of the mask. Resident 19 stated staff had not cleaned their mask, and they cleaned it twice weekly by rinsing it off and running water through the hose. Subsequent observations of Resident 19's CPAP being unclean with white splatter inside of the mask were made on 10/23/2024 at 3:30 PM, 10/24/2024 at 8:11 AM, and 10/25/2024 at 1:28 PM. On 01/28/2024 at 1:28 PM, the CPAP was stored in Resident 19's drawer that was full of crumbs. <Resident 38> Per the 09/20/2024 admission assessment, Resident 38 had diagnoses which included chronic respiratory failure with hypoxia (a condition in which the lungs do not supply enough oxygen to the blood) and asthma and required oxygen due to those conditions. The 09/20/2024 physician order instructed nursing staff to clean the oxygen concentrator filter with soap and water every Sunday. The 10/01/2024 care plan documented Resident 38 needed oxygen related to shortness of breath and asthma. In an observation on 10/22/2024 at 9:51 AM, Resident 38 was sitting in their wheelchair in their room. The resident's oxygen concentrator filter was unclean with thick dust debris. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/28/2024 at 2:32 PM, Staff B, Director of Nursing, stated oxygen filters were to be cleaned weekly, and this was important because the amount of oxygen flowing could be interrupted and cause breathing difficulties. During an interview on 10/29/2024 at 2:34 PM, Staff B stated CPAP machines were to be cleaned daily and as needed and this was important for infection control. Reference: WAC 388-97-1060 (3)(j)(vi)

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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** 46033 Based on observation, interview and record review, the facility failed to ensure dialysis care was provided consistently with professional standards for 2 of 2 sampled residents (Residents 13 and 19) reviewed. Specifically, Resident 13 was not consistently evaluated post-dialysis treatments, and Resident 19 was not given their morning medications on dialysis treatment days. This failure placed residents at risk for unintended health consequences, deterioration of their chronic diseases and decreased quality of life. Findings included . The Life Care Centers of America, Area of Focus: Dialysis policy revised 11/29/2023 documented on the day of dialysis, staff were to check medications the resident was taking and follow physician orders regarding medication administration and complete the Pre/Post Dialysis Communication form before and after treatment. Post-dialysis, staff were instructed to obtain vital signs, transcribe any orders received from the dialysis facility and maintain the communication form in the resident's medical record. <Resident 13> A review of the quarterly assessment dated [DATE] documented Resident 13 had diagnoses including paralysis on one side of their body after a stroke, and end-stage kidney disease dependent on dialysis (a mechanical way of removing waste from the body when the kidneys no longer work). The 05/23/2023 comprehensive care plan documented Resident 13 was dependent on dialysis and had dialysis sessions every Monday, Wednesday and Friday. Staff were instructed to assess the resident's access site daily and upon return from dialysis, check vital signs (a person's blood pressure, heart rate, respiratory rate, temperature, and oxygen saturation) daily, as needed and upon return from each dialysis session. Staff were to notify the provider of any abnormalities, and document the resident's status in the Dialysis Communication Binder pre and post-dialysis sessions. On 10/22/2024 at 11:45 AM, Resident 13 was observed in their room scooting in their wheelchair. Resident 13 stated they went to dialysis three times a week. Resident 13 stated they took a bag lunch with them to their session, then ate dinner when they returned. They stated staff did not always check on them when they got back from dialysis, just brought them their meal then left their room without checking their vital signs. A review of Resident 13's Dialysis Communication binder for the months of September and October 2024 revealed 9 times the post-dialysis evaluation was not completed: 09/06/2024, 09/11/2024, 09/13/2024, 09/20/2024, 10/02/2024, 10/04/2024, 10/11/2024, 10/18/2024, and 10/25/2024. During an interview on 10/30/2024 at 2:42 PM, Staff D, Resident Care Manager, stated they expected staff to evaluate the resident and document it in the Dialysis Communication binder after the resident returned from their dialysis sessions. Staff D stated this ensured Resident 13 was not having any adverse reactions to their treatments, and the communication binder was one of the ways the facility communicated with the dialysis center so it was important for those evaluations to be documented. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 19> A review of the 10/01/2024 admission assessment documented Resident 19 had diagnoses including heart failure, and end-stage kidney disease dependent on dialysis, The 09/27/2024 comprehensive care plan documented Resident 19 was dependent on dialysis and had dialysis sessions every Monday, Wednesday and Friday and dietary was to provide an early breakfast for them. A 09/27/2024 provider order stated medications orders reflected appropriate times around dialysis (at least two hours prior to or after return). Resident 19 was prescribed insulin before meals, and the provider was to be notified if their blood sugar was greater than 400 or less than 70. In an interview on 10/22/2024 at 2:15 PM, Resident 19 stated they went to dialysis on Monday, Wednesdays and Fridays and ate a bowl of cereal before they left and was unsure if they received their medications before dialysis. Review of the October 2024 medication administration record documented Resident 19 had no blood sugar checks prior to going to dialysis and had not consistently received their scheduled medications on dialysis days. In an interview on 10/29/2024 at 10:27 AM, Staff B, Director of Nursing, stated blood sugars should be monitored prior to the resident leaving for dialysis and this was important to ensure the resident was within the correct parameters. Staff B added Resident 19 should have received their medications when they returned from dialysis unless it was appropriate to give them before they left. During an interview on 10/29/2024 at 9:10 AM with the dialysis clinic, they stated they did not check Resident 19's blood sugar unless they were symptomatic, and they did not administer any medications that were prescribed at the facility. They further added the only medications that could not be received prior to dialysis were blood pressure medications and antibiotics, all other medications could have been given. Reference: WAC 388-97-1900(1), (6)(a-c) 46115

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure that 2 of 2 sampled residents (Resident 3 and 25) reviewed for trauma informed care, received culturally competent, trauma-informed care in accordance with professional standards of practice. The failure of the facility to adequately assess, identify potential triggers (a psychological stimulus that prompts recall of a previous traumatic event), and develop and implement a Trauma Informed Care Plan to help limit the residents' exposure to potential trauma triggers, placed the residents at risk for re-traumatization and a diminished quality of life. Findings included . <Resident 3> Review of a 09/06/2024 facility policy titled Trauma-Informed Care showed that residents who have a history of trauma and or post-traumatic stress disorder will receive appropriate treatment and services to correct the assessed problem. Trigger-specific interventions would identify ways to decrease the resident's exposure to triggers which re-traumatize the resident and identify ways to mitigate or decrease the effect of the trigger on the resident. The policy showed the facility should collaborate with the resident's family, friends, or any other health care professional, to develop and implement an individualized plan of care with interventions. Review of Resident 3's medical record showed they readmitted to the facility on [DATE]. The review showed the diagnoses of several mental health disorders. Review of a 01/03/2024 Trauma Informed Care Evaluation (TIC) showed, Resident 3 personally experienced physical assault and severe human suffering. The evaluation listed no triggers that could possibly re-traumatize the resident. The evaluation showed that in the past month, Resident 3 experienced a little bit of repeated and disturbing dreams of the stressful experience, suddenly feeling or acting as if the stressful experience were actually happening again, had strong physical reactions when something reminded them of the stressful experience, trouble remembering important parts of the stressful experience, had strong negative beliefs about themselves, other people, or the world, and blamed themselves or someone else for the stressful experience or what happened after it. Review of a 07/19/2024 progress note showed, Monitor for psychosocial harm after intimidating staff event. Review of the incident log showed the facility reported the event to the State Agency on 07/17/2024. The associated facility incident report showed Resident 3 reported to the facility that they, had some 'rough' experiences' with a male staff. The resident described the staff appeared to be very agitated and witnessed him throwing his gloves down and aggressively saying he was taking a break, and when the staff returned from break and helped the resident get into bed, was still agitated. The report showed Resident 3 told the facility that they had, had a history of behaviors like this from a male family member and it was very triggering for [the resident]. The resident shared with the facility that the male staff still seemed stressed out days later even with simple tasks and heard some yelling next door between the male staff and another resident. The resident stated that they did not feel comfortable having him as a caregiver and feels somewhat intimidated when they see the male staff in the halls. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes showed no documentation the facility monitored Resident 3 for latent or adverse reaction to the triggering event which occurred on 07/17/2024, until 07/19/2024. The following unrelated progress note was dated 08/07/2024. On 10/28/2024 at 10:27 AM, Staff N, Nursing Assistant (NA)/Shower Aide, stated that they were familiar with Resident 3's care and unaware of any behaviors the resident could exhibit that could impact their care. Staff N stated, I know [the resident] has some trauma from the past but nothing that has made [them] flip out. Staff N shared her knowledge of Resident 3's traumatic childhood events at length. Staff N was unaware of what could trigger Resident 3's re-traumatization. On 10/28/2024 at 10:43 AM, Staff Q, NA, stated that they were familiar with Resident 3's care and unaware of any behaviors the resident could exhibit that could impact their care. When asked if they had knowledge Resident 3 had a history of past trauma, or if there were events or environmental factors that could trigger it, Staff Q stated, Nothing comes to mind. Review of a 07/22/2024 care plan showed Resident 3, has a potential for a psychosocial well-being problem r/t [related to] history of trauma in childhood. The resident will identify coping mechanisms (new and old) by the review date. Review of the care plan showed no documentation what the coping mechanisms were. Additionally, the care plan showed that, When conflict arises, remove residents to a calm safe environment and allow to vent/share feelings, but did not describe what could trigger the conflict. The care plan showed no interventions that instructed the staff on how to prevent re-traumatization and what to do if it occurred. The above findings were shared with Staff A, Administrator, and Staff B, Director of Nursing, on 10/28/2024 at 1:46 PM. Staff A acknowledged the lack of interventions to prevent re-traumatization of Resident 3, to include identification of the triggers, coping mechanisms, and how to de-escalate or manage re-traumatization. Staff A stated that they expected the staff to monitor the resident every shift for latent effects of re-traumatization for a minimum of 72 hours after the event. <Resident 25> Review of a 10/11/2024 quarterly assessment showed Resident 25 readmitted to the facility on [DATE] with medically complex conditions and diagnoses of mental illness. The staff assessed Resident 25 as cognitively intact. Review of a 02/26/2024 progress note showed, Resident 25 was, getting loud, and yelling around, bringing up [their] past of all different years, and situations. Res consumed with [their] [NAME] Beret time and marriage. Res wants to be 'heard.' The [NAME] Berets are the United States Army Special Forces, a special operations branch of the military, known for their distinctive green berets and for conducting quiet, guerilla-style missions in foreign countries. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 05/04/2024 Preadmission Screening and Resident Review (an evaluation completed for anyone identified as having or suspected of having a serious mental illness, intellectual disability, developmental disability, or related condition) showed, family may have information about what [the resident] looks like at baseline with mood disorder and help provide information on whether the resident has shown a decline in cognitive function. This evaluation showed the resident was a Nursing Assistant in a hospital during the Vietnam Era. The evaluation showed the resident stated, There were body bag [sic] everywhere and They made me wrap up the corpse and get it down for autopsy. The evaluation showed the resident stated, They gave me shock treatment. I went into seizures from it. Review of Resident 25's progress notes (03/10/2024, 04/11/2024, 04/21/2024, 04/26/2024, 05/13/2024, 05/29/2024, 10/14/2024, and 10/21/2024) showed several disruptive behaviors like banging and yelling in the middle of the night, punching the door leading to downstairs, sexually inappropriate behaviors towards the staff, talking aloud in the hallways sometimes to other residents or themselves, playing the music and TV loudly, verbal aggression toward other residents, yelling at staff, kicking a chair toward a dining room wall heater, and becoming angry at a passing male resident because Resident 25 thought the other resident was looking into their room. A review of a 02/14/2024 TIC showed the staff identified Resident 25 experienced personally a very stressful event or experience but showed no documentation what the event was. The evaluation showed that in the past month Resident 25 felt at a moderate intensity very upset when something reminded [them] of the stressful event, had strong negative beliefs about themselves, other people, or the world, blamed themselves or someone else for the stressful experience or what happened after it, and irritable behavior, angry outbursts, or acting aggressively. The TIC showed only the resident participated in the interview. A review of a 09/17/2024 TIC showed again that the staff identified Resident 25 experienced personally a very stressful event or experience but showed no documentation what the event was. The evaluation asked the staff to list the triggers, but the staff documented feelings of losing control, fearful, etc. The evaluation showed the staff failed to identify triggers that could possibly retraumatize Resident 25. The evaluation showed that the resident experienced 15 out of the 19 possible reactions indicative of a response to a triggering event that ranged in intensity from, A little bit, Moderately, to Quite a bit. The TIC showed only the resident participated in the interview. Review of Resident 25's care plan showed no indication the facility identified the very stressful event or experience the facility assessed in the 02/14/2024 and 09/17/2024 TIC. The care plan showed no Trigger-specific interventions to help prevent re-traumatization and address the 15 out of the 19 possible reactions Resident 25 experienced. The above information was shared with Staff A, Administrator, on 10/30/2024 at 8:56 AM. Staff A acknowledged the facility did not evaluate Resident 25's very stressful event or experience adequately, to include participation of family members or representative. Staff A acknowledged Resident 25's plan of care lacked guidance to the staff to help prevent re-traumatization and stated, I don't see anything documented. No Associated WAC.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 40297 Based on interview and record review, the facility failed to ensure blood pressures and heart rates were monitored and medications were held when parameters required it for 2 of 5 sampled residents (Residents 10 & 22) reviewed for unnecessary medications. This failure placed the residents at risk for unintended health consequences and decreased quality of life. Findings included . <Resident 10> Review of Resident 10's September and October 2024 Medication Administration Records (MAR) showed an order that instructed the staff to administer metoprolol (a medication used to treat high blood pressure and heart failure) by mouth at bedtime. The order also instructed the staff to hold the metoprolol if the resident's pulse was less than 60 beats per minute. Review of the September and October 2024 MAR showed the staff administered the metoprolol at bedtime even though they assessed Resident 10's pulse was below 60 on 09/01/2024, 09/05/2024, 09/07/2024, 09/13/2024, 10/01/2024, 10/02/2024, 10/03/2024, 10/08/2024, 10/10/2024, 10/15/2024 and 10/29/2024. The above findings were shared with Staff D, Registered Nurse/Resident Care Manager on 10/30/2024 at 10:29 AM. Staff D acknowledged the metoprolol was not required on the days the staff assessed Resident 10's pulse was below 60 and that it, should have been held. <Resident 22> A review of the 07/23/2024 quarterly assessment documented Resident 22 had diagnoses including hypertensive kidney disease (when long term high blood pressure causes kidney damage) and dementia. Resident 22 was severely cognitively impaired and required assistance with their activities of daily living (ADLs) including medication administration. On 06/03/2024, an order was given by the provider to give Resident 22 Carvedilol (to treat high blood pressure) 3.125 milligrams (mg) twice daily for high blood pressure. Staff were instructed to hold the medication for a systolic blood pressure (the top number in a blood pressure reading) less than 110 or for a heart rate less than 60 beats per minute. A review of the October 2024 administration record (MAR) through 10/24/2024 documented Resident 22 received their Carvedilol twice daily with no omissions. Further review of the MAR showed there were no areas on the MAR for staff to document Resident 22's heart rate and blood pressure when their medications were administered. A review of the vital signs area of the electronic medical record (EMR) for October 2024 showed Resident 22 did not have their heart rate or blood pressure documented twice daily, if monitored prior to the administration of their Carvedilol. On 10/16/2024, the systolic blood pressure was less than 110, and on 10/07/2024, 10/08/2024 and 10/20/2024, the resident had heart rates documented of less than 60 beats per minute. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 11:46 AM, Staff J, Licensed Practical Nurse, stated they administered medications to Resident 22. Staff J stated they checked the resident's heart rate and blood pressure, but there was nowhere to document the results on the MAR. Staff J stated Residents had their vital signs taken every other day. Residents in even numbered rooms had theirs taken on even calendar days, and residents in odd numbered rooms had their taken on odd numbered days. During an interview on 10/29/2024 at 12:11 PM, Staff D, Resident Care Manager, stated Resident 22 was to have their heart rate and blood pressure monitored and medication held if indicated, but this had slipped through the cracks. If Resident 22 had a low heart rate or blood pressure, giving the medication opened it up to make those values even lower. Staff D stated if the parameters were not added to the MAR when the order was given, there was nowhere to document the vital signs on the MAR to demonstrate they had been reviewed prior to administration of the medication. Staff D stated this had been corrected. Vital signs had to be taken and entered on the MAR before staff could sign that the medication was given. Reference: WAC 388-97-1060(3)(k)(i) 46033

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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. 46115 Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed of timely, in accordance with currently accepted professional standards, in 2 of 2 medication carts, and needles and lab supplies were securely stored that were in a bistro. The facility failed to maintain temperatures to ensure medications were properly stored in 2 of 2 medication storage rooms. The facility further failed to ensure anti-anxiety medications were stored behind two locks as required and nursing staff were signing the narcotic logs verifying all medications were accounted for at shift change. This failure placed residents at risk for receiving compromised or ineffective medication, placed the facility at risk for potential diversion or misappropriation of psychotropic medications and potential for needlestick injuries. Findings included . On 10/22/2024 at 10:34 AM, an observation was made of a room called The Bistro. The room contained a kitchenette and had multiple cabinets and drawers. The lower unlocked cabinet contained two bottles of red liquid that was used to transport stool samples to assess for pathogens and the bottles were not sealed. The unlocked top drawer contained 8 intravenous (by vein) needles. A lower unlocked cabinet contained sanitizing wipes that stated to keep out of reach of children. There were 2 bottles of a solution that was used to fit test staff for a respirator (a mask) sitting on a stand. There were no residents wandering around the area. During an interview on 10/22/2024 at 11:26 AM, Staff B, Director of Nursing, stated The Bistro was used for family visits, staff breaks, interviews and corporate visits. Staff B stated the lab supplies were stored in that room for quick and easy access by the staff. In an interview at 11:44 AM, Staff B was asked if they were aware there were unsecured needles stored in the drawer and they stated yes. Staff B acknowledged this could be a potential for injury and stated the supplies should be locked up for resident safety. Staff B stated they were unaware there were vials that contained liquid in them. Staff B added the vials, fit testing solution and sanitizing wipes should have been locked up. Staff B stated they were going to remove the items to a locked room. On 10/30/2024 at 10:10 AM, the medication room on the east unit was observed with Staff I, Registered Nurse. The refrigerator contained 2 vials of hepatitis vaccine, 11 vials of influenza vaccine, and 1 vial of covid vaccine which must be stored between 35-46 degrees Fahrenheit. The temperature logs for October 2024 were sitting on the counter and had multiple omissions. In an interview on 10/30/2024 at 10:11 AM, Staff I stated the refrigerator temperatures needed to be monitored because if the vaccines were not in the correct temperature range it would impact the vaccines effectiveness. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The unlocked refrigerator contained 2 vials of house stock Ativan (a medication used to treat anxiety) that were contained in an unlocked black box, not behind two locks as required. The only lock was the door leading into the medication room. In an interview on 10/30/2024 at 10:18 AM, Staff I stated they were aware the Ativan needed to be stored behind 2 locks, and this was important to prevent someone from taking the medication. During an interview on 10/30/2024 at 10:24 AM, Staff B stated the refrigerator temperatures needed to be monitored to ensure the viability of the vaccines, and the Ativan needed to be locked behind two locks for security. On 10/30/2024 at 10:31 AM, the medication room on the west unit was observed with Staff B, Director of Nursing. The refrigerator contained 20 vials of influenza vaccines and 3 vials of pneumonia vaccines. The temperature logs for October 2024 were sitting on the counter and had multiple omissions. On 10/30/2024 at 10:37 AM, the west medication cart 3 was observed with Staff J, Licensed Practical Nurse. There was an insulin pen dated 09/04/2024, that was not discarded after 28 days as required, two insulin pens and an Ozempic pen that had no date that had been used, and a bottle of allergy nasal spray that had expired 12/2023. Staff J stated the medication needed to be discarded because it may not be effective after the required timeframe. Review of the narcotic books on west cart 3 showed the nursing staff was not consistently signing at the change of each shift, which verified the narcotic count was accurate. In an interview on 10/30/2024 at 10:50 AM, Staff J stated it was important to count the narcotics to ensure the count was accurate and who was accountable. On 10/30/2024 at 10:59 AM, the west medication cart 1 was observed with Staff K, Registered Nurse. There was an inhaler used for asthma that expired on 04/2024, sodium chloride tablets that expired on 08/2024, calcium tablets that expired on 09/2024, an insulin pen dated 08/25/2024, an insulin pen dated 09/21/2024, an insulin pen dated 09/28/2024, and four insulin pens with no date that had been used. Review of the narcotic books on west cart 1 showed the nursing staff was not consistently signing at the change of each shift. In an interview on 10/30/2024 at 10:59 AM, Staff K stated the narcotic books needed to be signed every shift to ensure that the count was accurate, and drug diversion had not occurred. During an interview on 10/30/2024 at 11:24 AM, Staff B stated the narcotic books needed to be signed to verify who was on shift and who was responsible. Staff B added it was important that insulin and expired medications not be used outside of the required timeframe to ensure the viability of the medication. Reference: WAC 388-97-1300(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40297 Based on observation and interview, the facility failed to ensure proper hand hygiene and hair coverings were worn and implemented during food service. This failure placed the residents at risk for foodborne illness. Findings included . A 04/30/2024 facility policy titled Associate Conduct and Dress Code showed hair and beard coverings were used when cooking, preparing or assembling food, but not required when distributing foods to the residents at the dining tables or when assisting the residents to dine. An observation on 10/22/2024 at 8:08 AM showed Staff Z, a Dietary Aide, participated in the breakfast tray line. Staff Z had visible facial hair and no beard covering. An observation on 10/25/2024 from 11:30 AM to 11:53 AM showed Staff Y, a Cook, standing in front of the food prep counter. The kitchen staff were getting ready to start lunch tray line. Staff Y wore a pink bandana. About three inches of hair was observed flowing down Staff Y's forehead. The bandana failed to contain Staff Y's hair, with visible hair observed coming out of the bandana around the sides and the back of Staff Y's head. At 11:42 AM, Staff Y stood next to the food prep counter, hands were gloved. Staff Y moved towards the garbage can where they threw in a small indiscernible object, then wiped the right side of their head with their gloves, took a paper napkin and wiped off their gloves, then adjusted their shirt. Staff Y took the temperature of food items on the steamer table with the same gloves on. Staff Y then removed their gloves and tossed them in the garbage can, walked over to the sink where they washed their hands for seven seconds, wiped their hands with a paper towel, and with the same paper towel proceeded to wipe down the steamer table where food items were kept hot for the upcoming lunch. Staff Y then crunched the paper towel into a ball with their left hand and threw it in the garbage can. The above information was shared with Staff X, Dietary Manager, on 10/25/2024 at 12:30 PM. Staff X stated that the kitchen staff was required to always wear head and beard coverings, no matter what they're doing. Someone can be prepping food, and hair can come drifting over. Staff X stated, You gotta' wash your hands and change your gloves. Staff X stated that Staff Y should, wash [their] hands completely 30 seconds at least. Staff X stated that Staff Y should have thrown the paper towel in the garbage can after they dried their hands instead of using it to wipe down the steamer table. An observation on 10/28/2024 at 11:47 AM showed Staff Y with a hairnet. The hair net was placed above the ears exposing Staff Y's hair below the hair net line, with anywhere from one to four inches of hair hanging out, to include a tuft of hair hanging down the staff's forehead. Reference WAC 388-97-1100 (3), -2980.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37544 Based on observation, interview and record review, the facility failed to develop a complete water management plan, to mitigate the facility's risk factors associated with Legionnaire's Disease (a serious condition, caused by exposure to water sources infected with the Legionella pathogen), failed to ensure soiled linens were transported properly, and failed to ensure oxygen was administered in a sanitary manner and equipment was clean and maintained for 1 of 3 sampled residents (Resident 38) reviewed for respiratory care. These failures placed all residents at risk for exposure to Legionella, infections, respiratory complications, and diminished quality of life. Findings included . <Water Management Program> Review of the facility's water management plan showed it was last reviewed on 03/11/2024. Review of the plan showed it had not been fully developed and, aside from identifying the facility's water source, the facility's contacts, and the facility's characteristics, the rest of the program was either not fully completed or blank. On 10/30/2024 at 12:51 PM, Staff A, Administrator, confirmed the plan was incomplete and needed to include more information. 46115 <Improper Handling of Soiled Linen> In an observation on 10/25/2024 at 10:53 AM, Staff R, Nursing Assistant, left a resident's room carrying a bag with a soiled brief and in the other hand a soiled gown, and walked down the hall with the items towards the soiled utility room. The soiled gown had not been placed in a bag or other container. At 10:58 AM, when asked if there was anything that had to be done prior to transporting soiled linen/items to the soiled utility room, Staff R stated they should have put the soiled items in a bag to prevent the potential spread of germs. In an interview on 10/29/2024 at 10:25 AM, Staff C, Infection Preventionist, stated all soiled linen were to be placed in bags prior to being removed from a resident's room to prevent the spread of bacteria. <Oxygen Administration> The 09/25/2024 admission assessment documented Resident 38 was able to make decisions regarding their care, had diagnoses which included chronic respiratory failure, and utilized oxygen. Review of Resident 38's records showed on 09/20/2024 the physician had prescribed oxygen to be administered continuously at the rate of two to three liters a minute. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/2024 at 9:51 AM, Resident 38 was observed in their room sitting in their wheelchair without their oxygen in place. Observation showed the oxygen concentrator was running, and the nasal cannula (tubing that was placed in the nose to deliver oxygen) was lying on the floor near the resident. When asked how they were doing, the resident stated they felt short of breath. At 10/03/2024 AM, Staff S, Nursing Assistant, entered Resident 38's room, picked the nasal cannula off the floor and placed it in the resident's nose. When asked if the nasal cannula being on the floor was an infection control concern, Staff S stated they should have cleaned the cannula or replaced it. In an interview on 10/22/2024 at 10:13 AM, Staff C, Infection Preventionist, stated Staff S should have gotten a new nasal cannula as the floor was not sanitary and using the nasal cannula that had been lying on the floor could introduce bacteria. Reference (WAC): 388-97-1320 (1)(a), (3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46115 Based on observation and interview the facility failed to ensure wheelchairs were maintained in a clean manner for 2 of 4 sampled residents (Residents 14 and 19) reviewed for physical environment. This failure placed residents at risk for lack of dignity and diminished quality of life. Findings included . <Resident 14> Per the 10/16/2024 quarterly assessment, Resident 14 had diagnoses which included a stroke and hemiplegia (paralysis on one side of the body), had moderate cognitive impairments and required substantial to total assist for all cares. Review of the 01/25/2023 comprehensive care plan documented Resident 14 was wheelchair bound. During an observation on 10/22/2024 at 10:22 AM, Resident 14 was sitting in their wheelchair in their room. The left armrest of their wheelchair was covered with sheepskin and a netting was placed over it. The sheepskin and netting were unclean and had a brown and red substance on it. In an observation on 10/23/2024 at 8:14 AM, Resident 14 was sitting in the dining room. The sheepskin and netting were unclean with a red and brown substance on it. During an observation on 10/23/2024 at 10:51 AM, Resident 14 was sitting in their room. Their wheelchair was unclean with food debris crusted on the cushion and bottom of the chair. Subsequent observations of the wheelchair and armrest being unclean were made on 10/23/2024 at 2:04 PM and 3:18 PM, 10/24/2024 at 8:05 AM, 10:10 AM, 12:35 PM, and 2:31 PM, 10/25/2024 at 8:43 AM, 10:51 AM and 12:23 PM. <Resident 19> Per the 10/01/2024 admission assessment, Resident 14 had diagnoses which included heart failure and diabetes, was cognitively intact and required substantial to total assist with cares. Review of the 02/28/2024 comprehensive care plan documented Resident 14 was wheelchair bound. In an observation on 10/23/2024 at 2:09 PM, Resident 19 was asleep in bed. Their wheelchair was unclean with food debris. Subsequent observations of the wheelchair being unclean were made on 10/23/2024 at 3:30 PM, 10/24/2024 at 8:11 AM and 2:28 PM, and 10/25/2024 at 1:28 PM. In an interview on 10/28/2024 at 2:24 PM, Staff B, Director of Nursing, stated wheelchairs were to be cleaned weekly and if they were not, it would be a dignity issue for the resident. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97- 3220 (1)