STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505261	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Ridge Center	817 East Plum Street Moses Lake, WA 98837

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to honor the resident's authority to exercise their right to not designate a representative to act on their behalf for 1 of 1 resident (Resident 16) reviewed for resident rights. This failure placed the resident at risk for violation of their rights as a resident to make their own health care and financial decisions. Findings included . Review of the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, Rev. 211, dated 02/03/2023, showed Code of Federal Regulations 483.10(b)(3)(ii): the resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State Law. Review of a policy titled, Resident Rights Under Federal Law, showed the resident had the right to designate a representative, but the resident retained the right to exercise those rights not delegated to a resident representative. <Resident 16> Review of the medical record showed Resident 16 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and kidney disease. The 06/03/2024 comprehensive assessment showed Resident 16 was dependent on one to two staff members for activities of daily living. The assessment also showed Resident 16 had a moderately impaired cognition. An observation on 06/10/2024 at 2:53 PM, showed Resident 16 lying in bed on their right side. Resident 16's eyes were teary and stated their family did not come to visit them. Review of a provider progress note (PN) dated 02/11/2024, showed Resident 16 had recent significant losses in their life and had increased fatigue and withdrawn mood/affect. The provider ordered trazodone (a medication used to treat depression) nightly. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing PN dated 02/11/2024, showed spoke with POA (son-in-law) .POA does not give verbal consent for trazodone because they did not believe in sedating or giving medications that would cause the resident to become drowsy. The son-in-law stated the resident had experienced recent losses of their daughter, son, and husband, and needed time to [NAME], and that crying was a natural process. Record review of a social services PN dated 05/02/2024 at 2:47 PM, showed the Washington State Long Term Care Ombudsman (an advocate for residents of nursing homes that protects and promotes the Resident Rights guaranteed to residents under Federal and State law and regulations) had met with Resident 16 regarding their issues with their Power of Attorney [(POA), a written authorization to represent or act on another's behalf). The PN showed Resident 16 had requested an antidepressant medication (a type of medication used to treat depression, anxiety, and chronic pain) due to increased feelings of sadness since the recent passing of their daughter. The PN showed Resident 16 stated they did not know how their POA could deny medications when they (Resident 16) had requested them. The PN also showed Resident 16 was cognitively intact at that time and was able to make their own decisions. During an interview on 06/17/2024 at 8:24 AM, Resident 16 stated their son-in-law was not their POA. They stated they had never signed any paperwork allowing the son-in-law to make decisions for them. During an interview on 06/17/2024 at 9:59 AM, Staff D, Admissions Coordinator, stated the process for verifying POA for a resident started when they received a referral from their receiving facility, or they would ask the family if there was a POA. They stated if a POA was identified, they would ask them to provide the legal paperwork for the medical record. Staff D stated they did all of Resident 16's admission paperwork with their son-in-law, but their son-in-law was not the POA. Staff D stated Resident 16's son-in-law was their representative and speaks for them. Staff D stated Resident 16 was able to speak for themself at the time of their admission, but they did not speak to Resident 16; they had completed the admission paperwork with their son-in-law through electronic mail and electronic signatures. Staff D stated since they (the son-in-law) were doing all the paperwork, I just took him as the representative. Review of Resident 16's admission agreement, dated 02/05/2024, showed a form titled, Resident Representative Designation, that had a box checked next to Resident/Patient only, no Representative Designated. There was no documentation on the form that showed Resident 16 had a POA. During an interview on 06/17/2024 at 10:45 AM, Staff A, Administrator, stated if a resident was deemed cognitively intact, they should retain their rights, including the right to designate and/or not designate a representative. Reference: WAC 388-97-0240(1-9)

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to issue a Notice of Medicare Non-Coverage [(NOMNC) a notice that indicates when your care is set to end from a skilled nursing facility] as required for 1 of 3 residents (Resident 37) reviewed for beneficiary notification. Additionally, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice [(SNFABN) a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare; beneficiaries may choose to continue services but may be financially liable] for 2 of 3 residents (Residents 37 and 162) reviewed for SNFABN requirements. These failures placed the residents at risk for the inability to make informed financial and care decisions related to their continued stay. Findings included . Review of an undated facility policy titled, Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, showed the NOMNC must be delivered at least two calendar days before the resident's Medicare coverage ended. Review of an undated facility policy titled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) CMS-10055, showed the facility was required to issue an SNFABN to Medicare beneficiaries prior to providing care that Medicare usually covered but may not pay for because the care was either not medically reasonable or necessary. Additionally, the SNFABN provided information to the beneficiary so they could decide whether or not they wished to receive the care that would not be paid for by Medicare and would assume the financial responsibility for that care received. <Resident 37> Review of the medical record showed Resident 37 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Review of the 03/11/2024 comprehensive assessment showed Resident 37 required maximum/dependent assistance of one to two staff members for activities of daily living (ADLs, daily actions like dressing, transferring and toileting). The assessment also showed Resident 37 had a severely impaired cognition. Review of the medical record showed Resident 37's skilled services began on 12/04/2023 and their last covered day was 01/06/2024. Resident 37 had not exhausted their Medicare Part A benefits and remained in the facility. A NOMNC was issued on 01/08/2024, providing the resident with less than the required two days notice prior to the end of their Medicare Part A stay. Additionally, there was no documentation that Resident 37 was issued the required SNFABN. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2024 at 12:54 PM, Staff H, Business Office Manager (BOM), stated their process was to place a call to the resident's power of attorney or representative to explain that the resident was losing their Medicare coverage. They stated they were required to provide the communication at least 48 hours prior to the last day of the residents covered services. Staff BOM stated they did not issue Resident 37's NOMNC in the required time frame. <Resident 162> Review of the medical record showed Resident 162 was admitted to the facility on [DATE] with diagnoses including a broken right hip, broken tailbone, and a history of falling. The comprehensive assessment dated [DATE], showed Resident 162 was independent with ADLs. The assessment also showed Resident 162 had a severely impaired cognition. Review of the medical record showed Resident 162's skilled services began on 01/24/2024 and their last covered day was 02/27/2024. There was no documentation that the required SNFABN had been issued. During an interview on 06/11/2024 at 2:31 PM, Staff J, Minimum Data Set [(MDS) a standardized assessment tool that measures health status in nursing home residents] Coordinator (a nurse that assesses and evaluates the quality of care provided to long-term care residents), stated that their process was to issue the SNFABN at least 48 hours before residents had come off of the services. Staff J stated both Resident 37 and Resident 162 should have received a SNFABN. During an interview on 06/17/2024 at 10:46 AM, Staff A, Administrator stated the required NOMNC's and SNFABN's needed to be completed and delivered timely according to the regulation. Reference: WAC 388-97-0300(1)(e)(5)(6)

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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** 46722 Based on observation and interview, the facility failed to ensure a sanitary and homelike environment for 1 of 3 hallways (Hall C), 1 of 1 shower room (Hall C shower room), and 3 of 9 resident rooms (rooms [ROOM NUMBER]) reviewed for environment. Hall C smelled of urine, Hall C shower room was dimly lit, the ceiling fan was coated with lint, and the walls were missing tile that left exposed concrete. The resident rooms smelled of urine and had furniture/walls in disrepair. These failures placed the residents at risk for unpleasant living conditions, exposure to foul odors, and diminished self-worth. Finding included . Review of the facility's 02/01/2023 revised policy, Resident Rights Under Federal Law, showed residents had the right to a safe, clean, comfortable, and homelike environment and the facility must maintain a sanitary, orderly, and comfortable interior. <Hall C> <Odors> Observations from 06/10/2024 to 06/17/2024, showed strong odors of urine upon entrance to Hall C from the Main Hall as follows: 06/10/2024 at 9:27 AM; 06/11/2024 at 8:22 AM; 06/12/2024 at 8:15 AM; 06/13/2024 at 8:37 AM and 11:08 AM; 06/17/2024 at 8:00 AM. During an interview on 06/10/2024 at 11:50 AM, Resident 310's representative stated Hall C smelled strongly of urine. During an interview on 06/13/2024 at 11:08 AM, Staff BB, Maintenance Director, stated Hall C's urine odor was like a punch in the face, and they were unsure where the odor was originating from. <Furniture> An observation on 06/11/2024 at 8:22 AM, showed the entrance to C Hall had a green leather chair which had leather peeling off the arms, seat, and base of the chair. The wooden legs had multiple gouges and scrapes. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 06/14/2024 at 10:52 AM, showed the entrance to C Hall had two fabric covered chairs with brown, black, red, and white smears on the arms and seat of the chairs. The same green leather chair had peeling leather on the arms, seat, and base of the chair. The green leather chair had a white dried liquid down the sides of the chair. An observation on 06/17/2024 at 9:35 AM, showed the entrance to C Hall had fecal matter on the green leather chair and the floor beneath the chair. <Shower room> An observation on 06/13/2024 at 10:36 AM, showed the shower room on Hall C in the following state of disrepair: The shower room was dim with one light bulb for lighting; The shower wall behind the shower chair was missing a 4-foot-long (ft, a unit of measure) section of tile with exposed concrete; The wall to the left of the entrance to the shower room had an 8-ft-long section of missing tile with exposed concrete.; The wall in front of the shower chair was missing a 4-ft-long section of tile with exposed concrete; Shower tiles above the exposed concrete showed yellow, black, and reddish-brown substance in the grout lines; The ceiling fan had thick lint fibers that flaked off and fell to the shower floor; The inside of the shower door had multiple paint scrapes and smears of a brown and black substance. <Resident rooms> <room [ROOM NUMBER]> An observation on 06/10/2024 at 11:31 AM, showed a dresser with multiple areas of worn, bubbled, and peeled layers on top. The drawers and edges of the dresser had multiple scrapes and scratches to the wood. The drawers and knobs were loose and unable to close completely. The leather recliner showed a worn two-inch (a unit of measure) area in the seat of the chair that exposed the fabric underneath the leather. <room [ROOM NUMBER]> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 06/10/2024 at 10:08 AM, showed two nightstands with multiple scratches and missing wood stain. The bathroom had an odor or urine, a protective panel missing from the door, the entrance door had a 12-inch piece of missing trim, and scratched paint. The bathroom floor was sticky, had a one-inch hole in the floor, and an exposed one-inch pipe stub with a three plate that was rusty under the soap dispenser. <room [ROOM NUMBER]> An observation on 06/10/2024 at 10:16 AM, showed three 2-ft by 2s-ft pictures leaned up against the wall and bookshelf. The six dresser drawers were worn with multiple scrapes and scratches, three mis-matched drawer handles and two drawers without handles. The bathroom had a strong urine odor, sticky floor, and missing paint from the bottom 12-inches of the door frame. During an interview on 06/17/2024 at 8:10 AM, Staff CC, Housekeeping Supervisor, stated the furniture did not have cleanable surfaces, shower room had minor repairs and the cove base (trim along the base of a wall that meets the floor) was not reinstalled. Staff CC stated they did not know if the substance in the tile grout was and that it could be mold or rust. Staff CC stated the urine odor in room [ROOM NUMBER] was within the flooring of the bathroom and they had been unsuccessful on removing the odor. During an interview on 06/17/2024 at 8:22 AM, Staff B, Director of Nursing Services, stated the dresser in room [ROOM NUMBER] was not a cleanable surface and needed to be disposed of. Staff B stated the furniture in Hall C was not able to be cleaned or sanitized and they were unaware of the urine odor in room [ROOM NUMBER]. Staff B stated maintenance works throughout the building and room [ROOM NUMBER] needed to be a priority. Reference WAC: 388-97-0880(1)(2) 45117

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interviews and record review, the facility failed to ensure an allegation of abuse/neglect was reported to the State Agency in a timely manner as required for 2 of 4 residents (Resident 38 and 5) reviewed for abuse/neglect. Failure to report the allegation physical and verbal abuse to the State Agency placed the residents at risk for unidentified and ongoing abuse/neglect. Findings included . Review of the policy titled, Abuse Prohibition, dated 10/24/2022, showed external abuse report requirements needed to be reported to the State Agency immediately, but not later then two hours after forming the suspicion for allegations with serious bodily harm; immediately but no later than 24 hours after forming the suspicion for allegations with no serious bodily injury, and reported to the State Agency the results of all investigation within five days. The policy showed the Administrator or Director of Nursing (DNS) was responsible for reporting to State Agencies. <Resident 38> Review of the medical record showed Resident 38 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (a specific progressive disease that destroys memory and other important mental functions). The 04/26/2024 comprehensive assessment showed Resident 38 was dependent on one to two staff for activities of daily living. The assessment also showed Resident 38 had a severely impaired cognition. <Resident 5> Review of the medical record showed Resident 5 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity level, and concentration). The 04/17/2024 comprehensive assessment showed Resident 5 required partial/maximum assistance for ADLs. The assessment showed Resident 5 had a severely impaired cognition. During an interview on 06/13/2024 at 8:25 AM, Staff B, Director of Nursing Services (DNS), stated a nursing assistant (NA) reported an allegation of abuse/neglect towards Resident 38 and Resident 5 that occurred on 06/07/2024. The allegation showed a staff member had pushed and yelled at Resident 38 and Resident 5. The allegation also showed the staff member had kicked Resident 5's walker. Staff B stated the NA informed Staff B that a report had already been completed regarding the allegation of abuse/neglect to the State Agency by the NA as an anonymous reporter. Staff B stated they did not report the allegation to the State Agency because the NA was a mandated reporter and had already reported the incident. Staff B stated they thought that the NA's report would cover the facility for the requirement to report to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/17/2024 at 10:48 AM, Staff A, Administrator, stated the normal process for allegations of abuse/neglect involved ensuring the resident was safe/protected, the facility suspended the staff member pending the investigation, reported the allegation to the appropriate agencies, and completed a thorough investigation. Staff A stated they understood the allegation should have been reported because the NA reported it anonymously and not as a facility reporter. Reference: WAC 388-97-0640(5)(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to provide a written notice of transfer/discharge to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a person that advocates for residents in nursing homes) for 2 of 4 residents (Residents 2 and 59) reviewed for transfer/discharge notice requirements. This failure placed the residents at risk for diminished protection, lack of access to an advocate that could inform them of their options and rights, and to ensure the resident advocacy agency was aware of the facility practices and activities related to a transfer or discharge. Review of the policy titled, Discharge and Transfer, revised 11/15/2022, showed a written notice of transfer/discharge must be provided to the Ombudsman when the facility initiated a discharge of a resident that had been transferred to the hospital or other acute care setting, including transfers for therapeutic leaves. <Resident 38> Review of the medical record showed Resident 38 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a specific progressive disease that destroys memory and other important mental functions) and dementia (a progressive disease that destroys memory and other important mental functions). The 04/26/2024 comprehensive assessment showed Resident 38 was dependent on one to two staff for activities of daily living (daily actions like dressing, transferring and toileting). The assessment also showed Resident 38 had a severely impaired cognition. Review of a nursing progress note (PN) dated 10/18/2023, showed Resident 38 experienced a change in their health condition. Resident 38's primary care provider was notified and recommended the resident transfer to the emergency department for evaluation and treatment. Review of the medical record showed no documentation that a notice of transfer/discharge to the Ombudsman had been completed. During an interview on 06/17/2024 at 8:20 AM, Staff L, Social Services Director, stated their process for notifying the Ombudsman was to complete the notice of transfer, scan it to their computer, and send it to the Ombudsman. They stated they also do a snip of the email and upload that to the resident's chart. Staff L stated they did not see any documentation of notification to the Ombudsman in Resident 38's medical record. <Resident 59> Review of the medical record showed Resident 59 was admitted to the facility on [DATE] with diagnoses including a right leg fracture and depression. A 03/22/2024 nursing PN showed Resident 59 had a moderately impaired cognition. Review of a 03/22/2024 nursing PN showed Resident 59 was transferred to the hospital on 03/22/2024 and did not return to the facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/14/2024 at 12:39 PM, Staff L stated they were unsure if a notice of transfer/discharge was sent to the Ombudsman for Resident 59. During a follow-up interview on 06/17/2024 at 10:37 AM, Staff L stated they were unable to locate any documentation that a notice of transfer/discharge had been sent to the Ombudsman when Resident 59 left the facility. During an interview on 06/14/2024 at 1:15 PM, Staff A, Administrator, stated the process for notifying the Ombudsman for a resident's transfer/discharge was for the Social Services Director to email the Ombudsman, take a screenshot and upload it into the resident's chart. During a follow up interview on 06/17/2024 at 10:54 AM, Staff A stated there should have been a notification of the transfers/discharges to the Ombudsman according to the regulation. Reference: WAC 388-97-0120 (2)(a-d) 46722

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of hospital transfer for 2 of 4 residents (Residents 16 and 38) reviewed for hospital transfers. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold while in the hospital. Findings included . Review of a policy titled, Bed Holds, revised 01/16/2023, showed when a resident was transferred out of the facility to a hospital or on therapeutic leave, the facility designee would provide the resident and/or their representative with the written Bed Hold Notice Policy & Authorization form. <Resident 16> Review of the medical record showed Resident 16 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and kidney disease. The 06/03/2024 comprehensive assessment showed Resident 16 was dependent on one to two staff members for activities of daily living (ADLs, daily actions like dressing, transferring and toileting). The assessment also showed Resident 16 had a moderately impaired cognition. Review of a hospital transfer form dated 05/22/2024 showed Resident 16 was transferred to a local hospital for evaluation and treatment for shortness of breath. Review of a Bed Hold Notice Policy and Authorization form, dated 05/22/2024, showed Resident 16's name and medical record number. There was an illegible (a state of being unreadable) handwritten note at the bottom of the form and a facility representative signature that was also Illegible. The form was not completed, including no monetary rate for the per day charge to hold the bed, nor a resident signature. <Resident 38> Review of the medical record showed Resident 38 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). The 04/26/2024 comprehensive assessment showed Resident 38 was dependent on one to two staff for ADLs. The assessment also showed Resident 38 had a severely impaired cognition. Review of a Change in Condition Evaluation form dated 10/18/2023, showed Resident 38 was transferred to the emergency department for evaluation and treatment for blood in their urine and painful urination. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Bed Hold Notice Policy and Authorization form, illegible date, showed the Resident 38's name printed at the top and the resident's representative and facility representative's name printed at the bottom. There were no other areas completed on the form, including the daily monetary amount to hold the bed. There was no documentation that showed Resident 38 and/or their representative wanted to hold the bed or refused the bed hold. During an interview on 06/17/2024 at 8:16 AM, Staff A, Administrator, stated they expected the basic information on the bed hold notice policy and authorization form to have been completed by facility staff, especially the dollar amount. Staff A stated they had posted the daily rate at each nurse's station so they (facility staff) should be doing that. During an interview on 06/17/2024 at 10:28 AM, Staff B, Director of Nursing Services, stated the process for bed hold included the nursing staff completing the bed hold form, whether the resident and/or their representative accepted or declined the bed hold. The nursing staff should send the form with the resident, or if it was emergent, they would save the form for signatures when they return to the facility. Staff B stated the nursing staff should be completing the form with the required information and should not require the resident and/or their representative to sign a blank form. Reference: WAC 388-97-0120(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** 45117 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review [(PASARR) - a federally required form that is used to help ensure individuals are not inappropriately placed in nursing homes for long term care] was accurate for 2 of 7 residents (Residents 16 and 52) reviewed for PASARR accuracy. This failed practice placed the residents at risk of not receiving specialized mental health services. Findings included . Review of the policy titled, Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients, revised 02/16/2024 showed social services would coordinate and/or inform the appropriate agency to conduct an evaluation and obtain results if there was a significant change in health status of a resident that resulted in new evidence of a possible mental disorder, intellectual disability, or related condition. <Resident 16> Review of the medical record showed Resident 16 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), kidney disease, and depression. The 06/03/2024 comprehensive assessment showed Resident 16 was dependent on one to two staff members for activities of daily living (ADLs, daily actions like dressing, transferring and toileting). The assessment also showed Resident 16 had a moderately impaired cognition. Record review of Resident 16's admission PASARR, dated 01/04/2024, showed they had no diagnoses related to a serious mental illness, intellectual disability, or related condition. Review of a provider progress note (PN) dated 01/16/2024, showed Resident 16 had a diagnosis of depression. Review of Resident 16's diagnosis list showed the diagnosis of depression was added to the resident's Admission Record on 02/13/2024. There was no documentation of an updated PASARR for the addition of the depression diagnosis. <Resident 52> Review of the medical record showed Resident 52 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity level, and concentration), difficulty swallowing, and weakness. The 04/05/2024 comprehensive assessment showed Resident 52 was dependent on one to two staff members for ADL's. The assessment also showed Resident 52 had an intact cognition. Resident 52's diagnosis information showed showed they had a new diagnosis of anxiety dated 08/11/2023. Review of Resident 52's admission PASARR, dated 06/29/2023, showed they had a serious mental illness indicator of mood disorder. There were no other indicators selected on the PASARR form. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 52's Admission Record showed a new diagnosis of anxiety was added to the diagnosis list on 08/24/2023, and dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding) was added to their diagnosis list on 10/01/2023. Review of Resident 52's medical record showed no documentation that an updated PASARR was completed for the addition of the 08/24/2023 anxiety diagnosis or the 10/01/2023 dementia with behavioral disturbance diagnosis as required. During an interview on 06/14/2024 at 1:28 PM, Staff B, Director of Nursing Services, stated the process for adding diagnoses included the Minimum Data Set (a standardized assessment tool that measures health status in nursing home residents) Coordinator (a nurse that assesses and evaluates the quality of care provided to long-term care residents) or Medical Records entering in the new diagnoses. They would then tell the Social Services Director of the new diagnoses and an updated PASARR would be completed for accuracy on those residents. Staff B stated they were not sure why the process had failed for Residents 16 and 52. During an interview on 06/17/2024 at 10:30 AM, Staff A, Administrator, stated any time there was an addition of a new mental health related diagnosis, a second, updated PASARR would be completed, with a level two referral if needed. Reference: WAC 388-97-1915(1)(2)(a-c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure residents dependent on staff received consistent oral care for 1 of 3 residents (Resident 2) reviewed for activities of daily living (ADL). The failure to receive adequate oral hygiene according to the resident' Physician orders and care plan placed the residents at risk for unmet care needs, and diminished quality of life. Findings include . Review of the facility's policy titled Activities of Daily Living (ADLs) revised date 05/01/2023 showed a patient who was unable to carry out ADLs would receive the necessary level of ADL assistance to maintain good nutrition, grooming, personal and oral hygiene. <Resident 2> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including dementia, dysphagia, muscle weakness, and contractures (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become stiff, often leading to a deformity) of their left and right hands. Further review of Resident 2's medical records showed a physician order dated 06/16/2023 that the resident was to receive oral care every shift. Review of Resident 2's most recent comprehensive assessment dated [DATE], showed the resident's cognition was severely impaired and dependent on staff for all transfers, nutrition, grooming, personal and oral hygiene. During multiple observations on 06/10/2024 at 9:51 AM, 12:30 PM, and 1:58 PM, showed Resident 2's teeth had a thick white film to the front of their front teeth. Their bottom lip and tongue were dry and had a thick patch of white film on their tongue. An observation on 06/11/2024 at 8:24 AM, showed Resident 2 lying in a hospital gown in their bed with the head of the bed elevated. Resident 2's mouth was open, dry, and their front teeth were covered with a thick white film. During an observation on 06/11/2024 at 3:06 PM, Resident 2 was sitting in a tilt wheelchair, clean and well dressed. The resident's mouth was open, and their teeth and tongue were coated with a white film. During two different observations on 06/13/2024 at 8:36 AM and 1:45 PM, Resident 2 was lying in bed in a hospital gown, making grunting noises. Their mouth was open with a thick white matter stuck to their front teeth and around their lips and their tongue was white in color and dry. In an interview on 06/12/2024 at 11:03 AM, Staff M, Nursing Assistant (NA), stated Resident 2 was fully dependent on staff for their ADL's. Staff M stated that staff were responsible for their oral care. Staff M stated that they were unsure if the resident's oral hygiene had been done that day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/14/2024 at 8:54 AM, Staff J, Registered Nurse (RN), stated that their expectation of the NAs was to do all personal care, oral care and assist those all the are dependent. Staff J stated they do walk rounds to ensure care was done and was unsure if resident 2's oral hygiene had been done. In an interview on 06/14/2024 at 9:27 AM, Staff N, NA, stated for a dependent resident, before we move the resident to the dining room we will wash their face, comb their hair, and bring them to the dining area. Staff N stated they attempted to use the sponges for Resident 2's oral care and were unsure if the oral hygiene had been done. In an interview on 06/17/2024 at 9:03 AM, Staff B, Director of Nursing Services, agreed that it looked like oral care had not been done for Resident 2. Staff B stated they had a system in place with the restorative aides to assist with resident's oral care. It doesn't look like that system is working. Reference WAC: 388-97-1060 (2)(c)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review the facility failed to implement resident preferences for outdoor activities for 5 of 6 residents (Residents 56, 7, 13, 14, and 25) reviewed for activities. This failure placed residents at risk of frustration, boredom, and meaningful enjoyment. Findings included . Review of the facility policy titled Resident Rights Under Federal Law, dated 02/01/2023, showed the facility was to care for each resident in an environment that promotes maintenance and enhancement of their self-worth by incorporating the resident's preferences and choices. <Resident 56> Review of the medical record showed Resident 56 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe) dementia (a progressive disease that causes memory loss) and heart failure. The 05/23/2024 comprehensive assessment showed Resident 56 required moderate assistance of one staff member for activities of daily living (ADLs) and had a moderately impaired cognition. The assessment also showed that it was very important for them to go outside and get fresh air when the weather was good. An observation and interview on 06/12/2024 at 8:26 AM, showed Resident 56 sitting in their bed eating breakfast no television on. Resident 56 stated they would like to go outside and enjoy some fresh air. Resident 56 stated they rarely had the opportunity to go outside, the staff were too busy. An observation on 06/12/2024 at 1:13 PM, showed Resident 56 lying in their bed awake, room dim, the privacy curtain was pulled so the resident was unable to view out the bedroom window and no television was on. During an interview on 06/14/2024 at 8:35 AM, Resident 56 stated they were not going to be doing anything today. Resident 56 stated if the staff would ever ask them to go outside, they would welcome the opportunity, as they wanted to enjoy the weather. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (lack of oxygen to the brain that causes cognitive deficits), dementia and depression. The 04/25/2024 comprehensive assessment showed Resident 7 required supervision assistance of one staff member for ADLs and was independent for mobility. The assessment also showed Resident 7 had severely impaired cognition and it was very important for them to go outside when the weather was nice. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's 05/13/2024 care plan, showed it was important for the resident to have the opportunity to have meaningful routines for their preferences. One of the listed important preferences was to go outside when the weather was good and enjoy sitting, walking, and watching the birds and wildlife. An observation and interview on 06/14/2024 at 8:47 AM, showed Resident 7 was seated in a chair on Hall C alone. Resident 7 stated they were bored. During an interview on 06/17/2024 at 9:35 AM, Resident 7 stated they did not get to go outside, and staff do not invite them to go outdoors. Resident 7 stated this is [NAME] Lake, and it would be nice to see. <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility on [DATE] with diagnoses including anxiety and a history of falls. The 05/27/2024 comprehensive assessment showed Resident 13 was independent with all ADLs and had an intact cognition. The assessment also showed Resident 13 had no wandering behaviors and it was very important for them to go outside and get fresh air when the weather was good. <Resident 14> Review of the medical record showed Resident 14 was admitted to the facility on [DATE] with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and depression. The 05/07/2024 comprehensive assessment showed Resident 14 was independent with ADLs and had an intact cognition. The assessment also showed the resident felt it was very important for them to go outside and get fresh air when the weather was good and had no wandering behaviors. <Resident 25> Review of the medical record showed Resident 25 was admitted to the facility on [DATE] with diagnoses including a stroke and heart disease. The 03/28/2024 comprehensive assessment showed Resident 25 was independent with transfers and walking, had a moderately impaired cognition, and did not have wandering behaviors. The assessment also showed it was very important for Resident 25 to go outside when the weather was good. During concurrent interviews on 06/11/2024 at 1:39 PM, Resident 13 stated they were allowed to go outside once. Resident 13 stated it was like a prison in here. Resident 14 stated they liked to go outside but did not get to. Resident 25 stated going outside would be nice. During an interview on 06/13/2024 at 1:42 PM, Staff FF, Activities Director, stated they did provide outdoor group activities when the weather was good in the months of July, August, and September. Staff FF stated the weather was not usually good until these months and the staff would need to offer the residents an opportunity to go outside as their memory was impaired. During an interview on 06/14/2024 at 12:26 PM, Staff DD, Nursing Assistant (NA), stated they only care for the residents on the floor, and they did not offer to take residents outside. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/14/2024 at 12:31 PM, Staff EE, NA, stated they only assisted residents on the floor and did not take them outside. Staff EE stated they would like to take residents outdoors but were informed they could not. During an interview on 06/14/2024 at 1:15 PM, Staff A, Administrator, stated residents would need to request to go outdoors and be assisted by staff. Staff A stated residents would need to be assessed to be able to wander freely in the courtyards and believed some residents would be allowed to do so. Reference WAC: 388-97-0940(1)(2) 46722

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review the facility failed to provide services to prevent a potential reduction in range of motion for 2 of 3 residents (Residents 2 and 15) reviewed for range of motion and/or use of splints. This failure placed the residents at risk for decreased mobility and loss of independence. Findings included . Review of the facility's policy titled Restorative Nursing revision date 08/07/2023 showed the purpose was to help the patient attain and maintain optimal physical, mental, and psychosocial functioning. <Resident 2> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including dementia, dysphagia, muscle weakness, and contractures to their left and right hands. Review of Resident 2's most recent comprehensive assessment dated [DATE], showed the resident's cognition was severely impaired and was dependent on staff for daily care. Review of a physician order dated 05/19/2023, showed Resident 2 had an order for daily use of right hand and left palm splints. The order read, apply in AM, remove before bed. May use rolled up washcloth in place of splint and palm guard. An observation on 06/11/2024 at 12:22 PM, showed Resident 2 was not wearing their brace or splint for hand contractures as ordered by their physician. In two separate observations on 06/12/2024 at 8:49 AM, and at 1:29 PM, Resident 2 was in bed sleeping and they were not wearing their brace, splint, or rolled washcloths in their hands. In an interview on 06/12/2024 at 11:03 AM, Staff M, Nursing Assistant (NA), stated that Resident 2 had a restorative therapy schedule for hand splints to be removed and hand hygiene and replace the hand splints every 2 hours. Staff M stated they were unsure if the resident had their therapy on their shift. An observation on 06/13/2024 at 8:36 AM, showed Resident 2 in bed resting, no washcloths, splints, or braces were in the resident's hands for their contractures. An observation on 06/13/2024 at 10:09 AM showed Staff Q, Restorative Aide (RA), enter Resident 2s' room with wash cloths and placed them in the residents' hands. Staff Q left the residents room at 10:12 AM, which was three minutes later. Review of Resident 2's therapy note dated 04/27/2024, showed education given to care staff with a return demonstration for daily passive range of motion and use of a brace/splint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 15> Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including severe dementia (the loss of thinking, remembering, and reasoning- to the extent that in interferes with ADLs), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of worry, nervousness, or unease). Review of Resident 15's most recent comprehensive assessment dated [DATE], showed the resident's cognition was severely impaired and was dependent on staff for daily care. Review of Resident 15's physician orders did not show a restorative therapy program was in place. In two separate observations on 06/11/2024 at 9:28 AM, and at 12:55 PM, Resident 15 was in their room sitting in their wheelchair with both of their hands resting on their chest. Both hands were in a fist position with no brace, splint, or washcloth in place to prevent skin to skin contact or contractures. In two separate observations on 06/12/2024 at 8:29 AM, and 1:30 PM, Resident 15 was in the dining room, clean and well groomed. The resident's hands were resting on their chest in a fist position with no brace, splint, or washcloth in place to prevent skin to skin contact or contractures. In an interview on 06/12/2024 at 8:53 AM, Staff Q, RA, stated they had a book that has a schedule of tasks for their shift. Staff Q stated they were responsible for ensuring the restorative exercises were done such as range of motion, applying braces or splints, assisting on the floor, and getting residents to the dining room for meals. In an interview on 06/12/2024 at 11:13 AM, Staff M, NA, stated Resident 15, had contractures to their hands. Staff M stated they were unsure if they had therapy services. In an interview on 06/13/2024 at 9:35 AM, Staff GG, Physical Therapist (PT), stated that a form was to be used for a restorative program with a goal for a resident once they had finished a skilled therapy program and the restorative program would begin immediately, depending on the resident's risk for decline. In an interview on 06/13/2024 at 12:00 PM, Staff E, PT, stated a residents' risk of decline is the reason for a restorative program. Staff E stated that they were unsure if Resident 15 was on a restorative program, that once they wrote a program up, they were done. Staff E stated they handed the written-up program to the resident care manager's office and was not aware of who was responsible to ensure the program was implemented. In an interview on 06/13/2024 at 1:21 PM, Staff P, Resident Care Manager (RCM), stated We don't get the forms, it is the Minimum Data Set Coordinator (MDS- a standardized assessment tool that measures health status in nursing home residents a nurse that assesses and evaluates the quality of care provided to long-term care residents) that would get that information. Staff P stated the restorative program would be downloaded in the computer and they did not see a restorative program entered for Resident 15. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/13/2024 at 1:27 PM, Staff I, MDS Coordinator, stated they had not received a form from the physical therapy department in February 2024 for Resident 15. Staff I stated there was not a restorative form given to the resident care managers or the restorative aides. Staff I stated they would input the restorative program as an order and ensure the program was on the care plan. Staff I stated that if someone was missed like that, they would go back to Staff E and have them re-evaluated and placed on a restorative program. An observation on 06/13/2024 at 1:57 PM, Staff G, Licensed Practical Nurse, entered Resident 15's room to assess the inner aspect of the resident's hands. Staff G, worked with the resident to open both hands and stated there was no odor or sores to the palms of their hands, and they were reddened. In an interview on 06/13/2024 at 2:02 PM, Staff B, Director of Nursing Services, stated their expectation was that the physical therapy department write out a restorative plan and give it to the MDS coordinator so that the plan was implemented for the resident. Reference WAC 388-97-1060 (3)(d)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview and record review, the facility failed to ensure appropriate treatment and services related to enteral (tube) feeding ([TF], the delivery of nutrients through a tube directly into the stomach) for 1 of 2 resident's (Resident 52) reviewed for TF. The use of inappropriate connections to the percutaneous endoscopic gastrostomy (PEG) tube, placed the resident at risk for contamination and loss of caloric intake due to fluid leakage between the PEG tube and the tube feeding spike set (a device that connects the PEG tube to the formula feeding bag or bottle). Findings included . <Resident 52> Review of the medical record showed Resident 52 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity level, and concentration), difficulty swallowing, and gastrostomy status (a surgical opening in the stomach for nutritional support). The 04/05/2024 comprehensive assessment showed Resident 52 was dependent on one to two staff members for activities of daily living . The assessment also showed Resident 52 had an intact cognition. During an observation on 06/10/2024 at 11:16 AM, showed Resident 52 lying in their bed, receiving their TF through their PEG tube. There was a brown paper towel wrapped around the end of the TF spike set, into the receiving end of the PEG tube. There were splatters of dried TF formula on the pole holding the tube feed and the floor around the pole. During a concurrent observation and interview on 06/12/2024 at 8:23 AM, showed Resident 52 lying in bed. The pump that delivered their TF formula was alarming. Staff J, Registered Nurse, entered the room, turned off the pump, and proceeded to disconnect the TF spike set from the PEG tube. There was a brown paper towel wrapped around the end of the TF spike set and into the PEG tube receiving end. Staff J stated the paper towel was there to keep traction on the TF spike set because it was slippery and comes apart sometimes. Staff J stated they were not trained to use a paper towel for traction, but had figured it out on my own, there is no other way to keep it together. A follow up observation at 4:05 PM, showed the same TF spike set/brown paper towel/PEG tube connection set up and splatters of TF formula on the floor surrounding the TF pole. During an interview on 06/14/2024 at 1:36 PM, Staff B, Director of Nursing Services (DNS), stated they expected the licensed nurses (LNs) to inform administrative staff if there was an issue with equipment so they could reach out to the supplier to get an adaptor or something appropriate to connect the TF spike set to the PEG tube. During an interview on 06/17/2024 at 11:02 AM, Staff A, Administrator, stated they expected the LNs to ensure they had all of the equipment and supplies necessary before starting any type of procedure. Staff A stated if there was a necessary item missing, the LNs were expected to bring that concern to the Resident Care Manager or DNS for appropriate action. (continued on next page)

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	505261	A. Building B. Wing	06/17/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1060(3)(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on observation, interview, and record review, the facility failed to ensure continuous supply of oxygen was provided for 1 of 2 residents (Resident 56), reviewed for oxygen. This failure placed the resident at risk for respiratory distress, discomfort, and negative health outcomes. Findings included . Review of the facility's 06/01/2021 revised policy, Oxygen: Transport of Patient on Continuous Oxygen, showed the facility would provide portable oxygen equipment for residents that required continuous oxygen. <Resident 56> Review of the medical record showed Resident 56 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe) and heart failure. The 05/23/2024 comprehensive assessment showed Resident 56 required moderate to substantial assistance of one staff member for activities of daily living (ADLs) and had moderately impaired cognition. Review of Resident 56's physician order dated 05/20/2024, showed oxygen was to be delivered continuously at one to two Liters (L - a unit of measure) per minute via nasal cannula (NC-a flexible tube that delivers oxygen to the nose through the nostrils). During an observation and subsequent interview on 06/10/2024 at 12:02 PM, showed Resident 56 brought into the dining room by Staff E, Therapy Director., short of breath, without oxygen and holding their oxygen tubing in their hand Staff E left the dining room and returned with an oxygen concentrator (a medical device that provides extra oxygen and needs to be plugged into an electrical outlet when used) and stated they obtained it from Resident 56's room. An observation on 06/11/2024 at 8:44 AM, showed Resident 56 brought back into their room without their oxygen on. Resident 56 was assisted from their wheelchair into their bed by Staff E, Nursing Assistant (NA). Staff E stated to Resident 56, they would go get their oxygen machine. During an interview on 06/12/2024 at 9:05 AM, Staff G, Licensed Practical Nurse, stated Resident 56 was to be on continuous oxygen of one to two L via NC. Staff G stated the facility did not have portable oxygen (provides supplemental oxygen without electricity) available for residents to use. During an interview on 06/12/2024 at 2:47 PM, Staff K, Staff Coordinator, stated the facility does have portable oxygen tanks for residents that may need to leave the facility for appointments. Staff K stated the facility does not use oxygen tanks for use in the facility, the facility used oxygen concentrators. Staff K stated when Resident 56 went to the dining room they would be without oxygen for a few minutes and then the oxygen concentrator would be brought to the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/2024 at 3:33 PM, Staff B, Director of Nursing Services, stated their expectation would be that Resident 56 would have continuous oxygen monitoring when they moved throughout the building. Staff B further stated the facility would need to obtain a physician order to transfer Resident 56 throughout the building without oxygen and if denied the order, the facility would use the portable oxygen tanks to provide continuous oxygen for Resident 56 when they moved throughout the facility. Reference WAC: 388-97-1060(1)(3)(vi)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 45117 Based on interviews and record review the facility failed to complete a performance review at least once every 12 months as required, for 5 of 5 Nursing Assistants (NAs) (Staff R, T, U, V, and W) reviewed for performance reviews. The failure to complete annual performance reviews placed residents at risk for unmet care needs from potentially unqualified staff. Findings included . <Staff R> Review of Staff R's, NA, personnel record showed they were hired on 07/10/2019. There was documentation of one performance review dated 07/09/2021, despite the requirement to complete annual performance reviews. <Staff T> Review of Staff T's, NA, personnel record showed they were hired on 04/02/2020. There was no documentation of annual performance reviews in their record. <Staff U> Review of Staff U's, NA, personnel record showed they were hired on 11/03/2022. There was no documentation of annual performance reviews in their record. <Staff V> Review of Staff V's, NA, personnel record showed they were hired on 09/25/2015. Their personnel record showed one performance review dated 01/09/2019. There was no other documentation of completed performance reviews. <Staff W> Review of Staff W's, NA, personnel record showed they were hired on 05/02/2023. There was no documentation of an annual performance review, despite the requirement for annual performance reviews for NA's. During an interview on 06/14/2024 at 12:38 PM, Staff Y, Human Resources/Payroll Manager (HR), stated the process for annual performance reviews included writing the names of each staff member on the performance review form and passing the forms out to the management staff. Staff Y stated the managers would then complete the form and return them to Staff Y. They stated if they did not get them back in a timely manner, they would make a second attempt. If they still did not get the completed performance reviews back from the management staff, they reported it to the Administrator for follow-up. Staff Y stated the process was not working. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/17/2024 at 10:36 AM, Staff B, Director of Nursing Services, stated they were responsible for the NA's performance reviews. Staff B stated it was Staff Y's responsibility to distribute the forms to Staff B when they were due. Staff B stated that was not happening. During an interview on 06/17/2024 at 11:04 AM, Staff A, Administrator, stated they were aware that the required performance reviews were not being completed timely. Staff A stated the human resources process for annual performance reviews was broken. Reference: WAC 388-97-1680

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on observation, interview, and record review the facility failed to ensure clinical records were complete and accurate for 3 of 3 residents (Residents 24, 2, and 49), reviewed for foot care. This failure placed residents at risk for medical complications and unmet care needs. Findings included . <Resident 24> Review of the medical record showed Resident 24 was initially admitted to the facility on [DATE] with diagnoses of dementia (memory loss), anxiety, and agitation. The 03/12/2024 comprehensive assessment showed Resident 24 was dependent on two staff members for activities of daily living (ADLs) and had an impaired cognition. <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis (a nerve disease that impairs movement and cognition) and dementia. The 05/17/2024 comprehensive assessment showed Resident 2 was dependent on two staff for ADLs and had a severely impaired cognition. <Resident 49> Review of the medical record showed Resident 49 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease (a progessive brain disorder that affects memory, thinking and behavior) and paraplegia (inablility to control the lower part of the body). The 05/22/2024 comprehensive assessment showed Resident 49 was dependent on two staff for ADLs and had a severely impaired cognition. Review of Residents 24, 2, and 49 Podiatry (a branch of medicine devoted to the study, diagnosis, and treatment of disorders of the foot, ankle and lower limb) notes showed; Resident seen for foot care due to increased risk status. Neuro orthopedic nails-dystrophic (deformed, thickened or discolored), calluses/skin, vascular/class findings (used to identify foot conditions for billing purposes). Onychomycosis (fungal infection), dystrophic nails. Debridement (procedure to remove debris or infected/dead tissue) of toenails with nippers (toenail clippers), Dremel (hand-held power tool). Would suggest follow-up in 2-3 months. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 06/10/2024 at 10:44 AM, showed Resident 24's left foot big toe with black crust with redness and scab at the base of the toe. Resident 24's right foot had thick, flaky toenails with black crust on the little toenail. During an interview on 06/12/2024 at 8:58 AM, Staff G, Licensed Practical Nurse, stated the Podiatrist had provided foot care to residents every few months. Staff G stated the nurses did perform skin checks however they did not perform any care for toenails. During a concurrent interview on 06/12/2024 at 1:45 PM, Staff O, Resident Care Manager (RCM) stated the Podiatrist came to the facility every couple of months for toenail care for residents. Staff P, RCM, stated the Podiatrist had been to the facility in May 2024, however the records from that visit would not be available until the following visit in July. Staff P stated there was no hand-off to nurses when the Podiatrist left the facility. Staff P stated they did not know what care was provided until after the Podiatry notes were received. Staff P stated the Podiatry notes had not been reviewed by any nurse or RCM. During a follow-up interview on 06/12/2024 at 2:11 PM, Staff P stated they reviewed other residents that were seen by the Podiatrist and stated all the Podiatrist progress notes were the same. Staff P stated this was a concern and the process was not working as there was no communication with nursing about the care that was provided. Staff P stated each resident visit by the Podiatrist should be individualized to their care and not the same copied document. During an interview on 06/13/2024 at 3:42 PM, Staff B, Director of Nursing Services, stated they had seen the photocopied document that was provided by the Podiatrist. Staff B stated the Podiatrist should notify the RCM's if they needed to be alerted of a concern with a resident's toes. Staff B stated the Podiatrist would return in 2-3 months and provide care. During an interview on 06/14/2024 at 1:15 PM, Staff A, Administrator, stated the Podiatrist records were the same for each resident in the facility and the notes were not individualized for each resident. Reference WAC: 388-97-1720(1)(a)(i)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45642 Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions (EBPs, an approach to the use of personal protective equipment (PPE) to reduce transmission of Multidrug-Resistant Organisms (MDROs) between residents in skilled nursing facilities) and hand hygiene in the dining area were implemented for 6 of 6 staff members (Staff J, N, M, Q, JJ, and KK) reviewed for infection control practices. These failures placed all residents at risk for exposure, transmission of MDRO's, and serious medical complications. Findings included . Review of the Centers of Disease Control and Prevention's (CDC) guidelines titled, Hand Hygiene for Healthcare Workers, dated 02/27/2024 showed that all healthcare personnel should protect themselves and their residents from deadly germs by completing hand hygiene, examples included. Immediately before touching a patient. Before performing tasks such as placing an indwelling device or handling invasive medical devices. When moving from a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, of contaminated surfaces. Immediately after glove removal. Review of the facility's policy titled, EBP, dated 01/08/2024, showed that EBPs were based on the CDCs guidance, Implementation of PPE usage in nursing homes was to prevent spread of Multidrug-resistant Organisms (MDROs). <Hand Hygiene> In an observation on 06/10/2024 at 11:41 AM, showed upon entering the A-Hall dining room Staff J, Registered Nurse (RN) and Staff N, Nursing Assistant (NA), did not perform hand hygiene. Staff J and Staff N, then began removing residents' trays from the dining cart without performing hand hygiene. Staff J and Staff N came in contact with resident plates when they removed the plates off the plate warmers with their bare hands and began cutting up food before placing the residents' plates onto the table . Staff J and Staff N then went back to the food cart without performing hand hygiene and grabbed another tray. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 06/10/2024 at 11:43 AM showed, Staff J, RN, served a resident their meal without performing hand hygiene, then went back to the A-Hall dining cart and grabbed another tray and began to cut up the food on the tray. Further observation showed Staff N, NA, did not perform hand hygiene, then removed bread from the plate with their bare hands, buttered a piece of bread and placed it back onto the tray and served to a resident. During an observation on 06/10/2024 at 11:48 AM showed, Staff N, NA, had removed a resident's drink from the dining table when the resident requested more coffee. Staff N, without performing hand hygiene, grabbed a new cup for another resident, filled both clean and dirty cups up and served the residents. In an observation on 06/11/2024 at 11:41 AM, showed in the A-Hall dining room Staff JJ, NA, cutting up food without hand hygiene or wearing their gloves placing butter on piece of bread and served the meal to the resident. Further observation showed Staff N, NA, did not performed their hand hygiene prior to grabbing a tray from the dining cart and serving it to a resident. Staff Q, NA, upon entering the dining room did not perform hand hygiene then grabbed a tray from the dining cart and began to feed a resident. <Enhanced Barrier Precautions> An observation on 06/12/2024 at 10:29 AM, showed Staff M, NA, and Staff KK, NA, entering a EBP room in the A-Hall. Both staff members did not put on the recommended PPE prior to entering the room and provided care to the resident. In an interview on 06/12/2024 10:47 AM, Staff M, NA, stated they used PPE in certain rooms such as the rooms with EBP signs. Staff M stated they had not realized they entered an EBP room without their PPE on. In an interview on 06/13/2024 at 12:42 PM, Staff C, IP, stated their expectation of all staff when entering an EBP room was to wear their PPE. Further, to perform hand hygiene with soap and water or sanitizing gel in and out of a resident room when performing any care with a resident. Reference WAC 388-97-1320 (1)(c)(2)(b) 46722