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	05/09/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to thoroughly investigate a fall, for one of five sampled residents (Resident 218), reviewed for falls. The failure to complete a thorough investigation placed the residents at risk for potential negative health outcomes. Findings Including . <Resident 218> Review of the medical record showed Resident 218 was admitted to the facility on [DATE] with diagnoses to include dementia, muscle weakness, lack of coordination and repeated falls. The comprehensive assessment dated [DATE] showed Resident 218's cognition was severely impaired and was dependent on staff for activities of daily living (ADLs). Review of the facilities incident reporting log dated 04/13/2025 showed that the resident had a fall in the dining room and that resulted in Resident 218 being sent to the emergency room for evaluation and treatment of a laceration (a cut) to the left forehead. Review of the facilities investigation of Resident 218's fall dated 04/13/2025 did not show witness statements to reflect a thorough investigation. During an interview and observation on 05/08/2025 at 4:20 PM, Staff C, Resident Case Manager (RCM), stated they recognized that there were no witness statements, and would have to speak to the Director of Nurses (DNS). Staff C stated that the DNS would obtain witness statements for all investigations. During an interview on 05/09/25 at 9:57 AM, Staff C, RCM, stated they could not find the witness statements for Resident 218's investigation. Additionally, that the facility had a form for witness statements that should be filled out after an incident. During an interview on 05/09/25 10:40 AM, Staff M, Nursing Assistant (NA), stated when a resident had a fall staff were to report it immediately to the nurse and fill out a form of what, when, where, what was seen during the incident. Staff M stated that sometimes they get busy and forget to fill out the form, the form goes back to the nurse before the end of the shift. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/2025 at 11:29 AM, Staff L, Registered Nurse, (RN) stated Yes, I remember I was at the med cart when one of the residents came and said that I needed to come quickly that someone had fallen. Staff L stated they found Resident 218 lying on her left side and was bleeding from the forehead, spoke to the resident to see if they would respond, assessed the resident to see if we could move them. In the same interview Staff L stated that it took four staff members to place Resident 218 back into their wheelchair and put the resident in bed. Staff L stated they had performed first aid and called the hospice. Shortly after the hospice nurse arrived, they spoke to the physician and had to send Resident 218 to the emergency room for evaluation and treatment. Staff L stated they document a change in condition and monitor the resident. During an interview on 05/09/2025 at 11:59 AM Staff N, NA, stated they were aware of Resident 218's fall. Staff N stated post fall they gathered supplies for the team, and they noticed there was blood. Staff N stated they went to the laundry room for towels to clean up and gave the supplies to the team. Staff N stated the post-fall procedure is that they report the incident to the nurse, then we take care of the situation. Staff N stated staff must fill out a report by the end of shift, we are given a form to fill out. Everyone on the floor is to fill out a form, so the facility knows where and what everyone was doing during the incident. During an interview on 05/12/2025 at 2:05 PM Staff O, NA, stated they were aware of the incident with Resident 218, that they had sat the resident in the dining room and had forgotten to place the drop-down seat (a reclining seat that prevents the resident from going forward) and they had sustained a fall. Staff O stated they would normally fill out a form when an incident happened, that they had filled out the witness statement for the fall on 05/11/2025. During an interview on 05/09/2025 at 12:32 PM, Staff A, Administrator, acknowledged the incident report did not have witness statements. Reference: WAC 388-97-0640 (6)(a)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 44922 Based on observation, interview, and record review the facility failed to review and validate the Preadmission Screening and Resident Reviews (PASARR, an assessment to ensure individuals with Serious Mental Illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were accurate on admission for 3 of 5 residents (Residents 57, 24, and 45) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . <Resident 57> Review of the resident's medical records showed they were admitted with diagnoses to include dementia, depression, and anxiety. The 03/26/2025 comprehensive assessment showed Resident 57's cognition was severely impaired and they received psychotropic medications. Review of Resident 57's 12/20/2024 PASARR showed the resident had no SMIs and did not require a Level II evaluation (to confirm that an individual has a mental illness or intellectual disability and assessed their need for specialized services), even though depression and anxiety were present upon admission. <Resident 24> Review of the resident's medical records showed they were admitted with diagnoses to include dementia, depression, and anxiety. The 04/10/2025 comprehensive assessment showed Resident 24's cognition was intact and they received psychotropic medications. Review of Resident 24's 02/26/2025 PASARR showed the resident had SMIs and did not require a Level II evaluation (to confirm that an individual has a mental illness or intellectual disability and assessed their need for specialized services), despite the resident's documented diagnoses of depression, anxiety, and dementia upon admission. <Resident 45> Review of the resident's medical records showed they were admitted with diagnoses to include dementia, depression, and obsessive-compulsive disorder (OCD-a pattern of thoughts and fears known as obsessions that lead to repetitive behaviors known as compulsions). The 03/04/2025 comprehensive assessment showed Resident 45 had moderately impaired cognition and received psychotropic medications. Review of Resident 45's 02/26/2025 PASARR showed the resident had no SMI's and did not require a Level II evaluation. The PASARR showed no diagnoses of depression or OCD, even though both diagnoses were present upon admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/2025 at 9:05 AM, Staff J, Social Services Director, stated the admissions staff reviewed PASARRs during the referral process, prior to the resident coming from the hospital. Staff J stated they reviewed PASARRs after residents admitted to the facility and did not have access to them until they were uploaded into the resident's electronic health record. Staff J stated they reviewed PASAARs quarterly and if there were changes to diagnoses that they were aware of. Staff J stated if a resident was admitted with an incorrect PASARR they would call the hospital and try to get a corrected one, but that's hard to do and rarely did they receive a corrected one. Staff J stated if they reviewed a PASARR and it was incorrect; they would complete a new one. Staff J was not aware that Resident 57's PASARR was incorrect on admission. During an interview on 05/08/2025 at 9:46 AM, Staff K, Admissions, stated when they reviewed PASARRs prior to admission, they verified whether they had a completed PASARR, and if they required a Level II evaluation prior to being admitted to the facility. Staff K stated they did not verify the PASARRs against the residents' diagnoses to ensure they were correct and thought the Director of Nursing Services or the Administrator would do that during their review. Staff K stated they were following the process of the current PASARR form and did not know the form had not been updated with the new process. Staff K stated they had received training on the new process and knew it had become effective as of 07/01/2024. During an interview on 05/08/2025 at 3:53 PM, Staff A, Administrator, stated Admissions staff had been trained on the new process for PASARRs and the PASARRs should have been correct or corrected prior to admission to the facility. WAC Reference: 388-97-1915 (1)(2) 45642 48368

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F 0684 Level of Harm - 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** 31168 Based on observation, interview, and record review the facility failed to 1) thoroughly evaluate and monitor the significant changes in a resident's respiratory condition and increased sedation from medications given for 1 of 3 residents (Resident 1) reviewed for change of condition; 2) accurately assess and notify the provider timely of wound changes for prompt medical evaluation for 1 of 3 residents (Resident 11) reviewed for skin conditions; 3) follow through with specialized services for 2 of 2 residents (Resident 34 and 57) reviewed for quality of care. This failed practice placed residents at risk of not receiving the care and services they needed to prevent a decline in their health and/or mobility. Additionally, Resident 1 experienced actual harm due to a delay in obtaining prompt medical treatment that resulted in hospital intervention and treatment for over sedation and aspiration pneumonia (a lung infection that occurs when stomach contents or mouth secretions are inhaled into the lungs). Resident 11 experienced harm when there was a delay in notification to the provider that a wound had worsened and caused severe pain. Findings included . <Resident 1> The medical record showed the resident was admitted on [DATE] with diagnoses including a left thigh bone fracture with surgical repair, Rheumatoid arthritis (a chronic autoimmune disease that attacks healthy cells and tissues located in the joints of both sides of the body), heart disease, chronic oxygen use and chronic pain. The 03/13/2025 admission assessment showed Resident 1 was alert and oriented and made their needs known. During an interview and concurrent observation on 05/05/2025 at 2:45 PM, Resident 1 stated they were in pain and hurt all over and felt they could not breathe and felt that they were not receiving their oxygen. The resident was lying in bed with oxygen cannula (a medical device that delivers through two prongs that fit into the nostrils) connected to the oxygen concentrator. Resident 1's face showed their skin was gray, ashen (white) in color, pale and flakey. The residents' lips were dry with gummy/sticky substances at the corners of their mouth. Resident 1 was slow to respond to questions and closed their eyes and opened them between answering questions and spoke in a low soft voice. During an interview on 05/05/2025 at 2:50 PM, Staff I, Licensed Practical Nurse (LPN), stated that they informed staff of Resident 1's concerns with pain and shortness of breath. During an observation on 05/05/2025 at 3:00 PM, Staff C was in the resident's room and stated the resident's blood pressure and oxygen level were good at 93% (normal levels are 92% and above). During an interview on 05/05/2025 at 3:05 PM, Staff U, Advanced Registered Nurse Practitioner (ARNP), stated they thought the resident was experiencing some symptoms. Staff U stated Resident 1 might be having a stroke, had been responding slowly to their questions, and drowsy. Resident 1's oxygen level was at 94%. Review of the 05/05/2025 progress notes, documented at 3:20 PM, showed Staff U wrote an order for an additional Oxycodone (narcotic pain medication) dose for Resident 1's increased pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a progress note on 05/05/2025 at 3:38 PM showed new orders from Staff U for laboratory orders, a chest x-ray and an electrocardiogram (EKG-process of recording of heart beating). Review of a 05/05/2025 at 9:52 PM progress note showed no respiratory lung assessment documented and oxygen levels were at 94%. During an observation and concurrent interview on 05/06/2025 at 8:17 AM, Resident 1 was in their bed with the head of the bed at a 35-degree angle in which the resident had to partially lean forward to reach their over bed table to pick up items such as food on their tray then they had to lay their head back on the bed to swallow their food. Resident 1 was confused as to where they were and the day and season of the year. The resident had their oxygen nasal cannula connected to the oxygen concentrator. Resident 1's skin was pale white to their face with dry lips and oral mucus membranes. The resident complained of pain, shortness of breath and being weak. When the Surveyor immediately notified Staff EE, LPN, they stated it was their second day on that particular assignment at the facility and they were unfamiliar with resident conditions and would get information from the computer. Review of the 05/06/2025 at 8:41 AM progress note showed Resident 1 was in no distress and their oxygen level was 92%. Review of the 05/06/2025 at 1:00 PM progress note showed Resident 1 was observed to be lethargic (drowsy). Resident 1's blood pressure was 88/46 (normal blood pressure 120/80), oxygen level 61% (normal is 92% and above) oxygen. Resident 1 was sent to the hospital. The progress notes also stated the chest x-ray, EKG and laboratory request were not completed on 05/05/2025 from Staff U. Review of the 05/06/2025 Hospital emergency room (ER) physician's report showed the resident was confused and had been weaker than usual. According to the Emergency Medical Services (EMS) ER report the resident was unresponsive when they arrived at the facility. The ER physician's review of Resident 1's medications showed high risk medications to include Seroquel (an anti-psychotic medication), Gabapentin (an anti-convulsant medication used for pain) and Oxycodone (opioid [class of drugs used to reduce pain] narcotic pain reliever). The 05/06/2025 report showed Resident 1 experienced an opioid overdose due to the medication given together in a close amount of time and the accumulation of side effects produced by the resident's medications. Resident 1 was given Narcan (medication that blocks opioid receptors in the brain to reverse the overdose). Additionally, the 05/06/2025 hospital ER report showed Resident 1 had developed a respiratory sepsis (infection) which was diagnosed as Aspiration Pneumonia. During an interview on 05/08/2025 at 9:58 AM, Staff T, Registered Nurse (RN), stated they realized the nursing staff did not immediately act upon changes in Resident 1's condition. Additionally, the facility failed to monitor side effects of the multiple medications given to Resident 1 and would recommend changes. <Resident 11> (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 11's medical record showed they admitted on [DATE] with diagnoses to include end stage renal disease (your kidneys have failed and can no longer effectively filter waste and excess fluid from your blood) and osteomyelitis (a bone infection). The 02/12/2025 comprehensive assessment showed the residents 'cognition was moderately impaired and required substantial to maximum staff assistance with bed mobility and transfers. The assessment also showed Resident 11 was at risk for developing pressure injuries (PIs- areas of skin and tissue damage caused by prolonged pressure, friciton, or sliding). Record review of a progress note titled Situation, Background, Assessment, and Recommendation (SBAR- a form used to communicate changes to the provider) dated 03/29/2025 showed Resident 11 acquired a PI to their coccyx (tailbone) measuring 1.0 centimeter (cm, a unit of measure) by 1.0 cm. The SBAR further showed the provider responded with new intervention orders. The March 2025 provider orders showed no new orders since 02/10/2025 had been initiated. Record review of the outside wound care consultant 04/14/2025 wound assessment showed the left coccyx wound was closed but remained high risk with new orders to use house emollient (softens and smooths dry, rough, or flaky skin) cream during perineal (the area between the genitals and the rectum) care and as needed. Record review of the April 2025 orders showed no new or updated orders were initiated for the coccyx wound on 04/14/2025. Record review of a communication form (a form used by nursing staff to communicate changes to the interdisciplinary team) dated 05/04/2025 showed Staff L, Licensed Practical Nurse, (LPN), stated Resident 11's coccyx wound was worsening and presented with eschar (a thick, dead tissue that forms over a wound, espicially after an injury). Staff L requested Resident 11 be seen by the outside wound consultant when they were in the facility for wound rounds on 05/05/2025. Further review of the record showed no evaluation or assessment of the worsening of the coccyx wound and no notification to the provider. During an interview on 05/07/2025 at 1:57 PM, Staff L stated the wound on Resident 11's coccyx was an unstageable PI related to the eschar covering the wound bed and they were unable to see what the wound looked like underneath the eschar. Staff L stated they were not sure why the communication form did not get addressed. During an interview on 05/07/2025 at 3:06 PM, Staff D, Resident Case Manager (RCM), stated they were unaware the area to Resident 11 's coccyx was opened, I thought it was all healed. An observation and concurrent interview on 05/07/2025 at 3:38 PM, with Staff C, RCM and Staff D, showed Staff D removed the foam dressing from Resident 11 's coccyx. The coccyx had a wound with eschar, full thickness skin loss, and surrounding the wound bed was red and moist tissue. Staff D and Staff C both stated they were not sure what stage the wound was but if they had to say they would stage it as an unstageable PI related to not being able to see the wound bed. Measurements of the wound were measured as: area 7.73 cm, length 3.28.cm, width 2.65 cm. An observation and concurrent interview on 05/07/2025 at 3:45 PM, showed Resident 11 lying in bed on their back. Resident 11 stated it is so painful to sit and lay on my bottom. The resident stated the medication helped but the wound still hurt them during the changing of their wound dressing. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of the May 2025 treatment medication record (TAR) showed Staff C had documented they completed the wound treatment for Resident 11's coccyx wound on 05/05/2025. During an interview on 05/07/2025 at 4:28PM, Staff C stated they signed that they completed the wound care on Resident 11 on 05/05/2025. Staff C stated they did not actually see the wound or do the wound care. Staff C stated they assumed the wound care consultant would be doing the wound care as Mondays were the days they came into the facility. Staff C looked at the outside wound consultant's notes from 05/05/2025 and stated, it does not look like she addressed the coccyx wound. Record review of the outside wound consultant 05/05/2025 wound assessment notes for Resident 11 showed no assessment of the coccyx wound. During an interview on 05/08/2025 at 8:09 AM, Staff L stated they could not remember exactly when the wound started changing. Staff L stated the process for an existing wound that worsened would be to notify the wound consultant and place a note in the binder for the doctor to review. Staff L stated they had asked the RCMs what to do and they stated to put it on the communications form and that they had done that on maybe Friday, Saturday or Sunday they would have to look they could not remember. Staff C stated they only did a visual on the wound and did not do an assessment or obtain measurements. Staff C stated they should have done a better assessment, measured the wound and called the provider for further orders on 05/04/2025. During an interview on 05/08/2025 at 8:24 AM, Staff A, Administrator, stated the process for communication forms from the nursing staff was they addressed all communication forms each morning in the morning meeting. Staff C stated Staff L's communication of Resident 11's coccyx wound worsening should have been addressed in the morning meeting on 05/05/2025. Staff A stated the expectation for Staff L was to do a complete assessment of Resident 11's coccyx wound including measurements and to notify the provider. Staff A stated the RCMs were responsible for doing an immediate follow-up on 05/05/2025 and the process was not followed. An observation and concurrent interview on 05/08/2025 at 8:39 AM showed Resident 11 lying in their bed on their back moaning oh it hurts, oh it hurts. Resident 11 stated their pain to their bottom was so painful and they just could not stand it. During an interview on 05/08/2025 at 8:58 AM, Staff V, Nursing Assistant (NA), stated they had seen the wound on Resident 11's coccyx on 05/05/2025 and it had looked the same as last week, it had looked the same for about three weeks. Staff V stated their process was to notify the nurse for any skin issues or changes and with Resident 11 they must notify the nurse every time the dressing comes off which is often, so the nurses were aware of the changes to the wound. During an interview on 05/08/2025 at 3:13 PM, Staff W, NA, stated they had seen the wound on Resident 11's coccyx the evening before (05/07/2025) and it had black areas and was open. Staff W stated they had also seen it the Friday before and the wound had been like that for about three weeks. Staff W stated the nurses were aware of the change in the wound because they had to go and get the nurse to place a new dressing when it came off. Staff W stated their process for any wound that was new or had changes was to immediately tell the nurse on the floor and all the nurses were aware of how Resident 11's wound looked. Staff W stated Resident 11 has had an increase in pain and they have had to reposition Resident 11 a lot more recently because it helped with the pain they had on their bottom. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/08/2025 at 3:18 PM, Staff Y, LPN, stated they had seen the wound to Resident 11's coccyx on Tuesday (05/06/2025) and they were unable to see the wound bed because there was a white, soft scab covering it. Staff Y stated they did not know how to stage a PI and they did not notify the provider because it was just a scab. During an interview on 05/08/2025 at 3:22 PM, Staff D stated they were responsible for entering new orders from the 04/14/2025 outside wound consultant visit. Staff D stated the order was missed. Staff D stated they became aware of Resident 11's coccyx wound on 05/07/2025 (3 days after the communication form was written). Staff D stated they and Staff C were responsible for reviewing communication forms from nursing staff during morning meetings. Staff C stated they missed the communication about Resident 11's coccyx wound on 05/05/2025 because they had worked the night before and arrived late. Staff C stated Staff D was on the floor that morning, and since the RCMs were not at the meeting, the communication for Resident 11's wound just got missed. Record review on 05/08/2025 of a Skin and wound evaluation opened by Staff C on 05/07/2025 showed the assessment was blank (four days after communication from Staff L on the worsening of Resident 11's coccyx wound.) During an interview on 05/08/2025 at 3:51 PM with Staff D and Staff C, Staff C stated they did not know how to assess the wound on Resident 11's coccyx. Staff C stated they waited for the outside wound consultant to call and complete their tele health (using technology like phone or video calls to deliver healthcare services remotely) assessment of the wound before they finished their assessment or changed any orders. Both Staff C and Staff D stated they were unaware identifying the stage of a wound was within their scope of practice as a nurse and should get some training. During an interview on 05/09/2025 at 9:23 AM, Staff U, Advanced Registered Nurse Practitioner, stated the process for a significant change in wound was to call them or the on-call provider for further orders immediately. Staff U stated the four-day delay in notifying a provider or completing an assessment was a delay in treatment because a wound could change quickly. Staff U stated a complete assessment of the wound should have been done immediately, and the correct process was not followed for Resident 11. During an interview on 05/09/2025 at 11:18 AM, Staff A stated Staff L should have completed a change in condition and notified the provider for further orders. Staff A stated the inter disciplinary team was responsible for reviewing all communications from the prior day/eve in the morning meetings and they did not do that. Staff A stated they expect immediate action on any significant change with wounds. Staff A stated there was a delay in treatment for Resident 11 from 05/04/2025 to 05/09/2025 and the overall process was not followed correctly for Resident 11. <Resident 34> Review of the resident's medical records showed they admitted with diagnoses to include Alzheimer's disease (a brain disorder that slowly destroys a person's memory and thinking skills) and malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). The 03/10/2025 comprehensive assessment showed Resident 34's cognition was severely impaired and had not experienced behaviors during the assessment period. The assessment showed Resident 34 was independent upon staff for their activities of daily living (ADLs, basic skills needed daily to maintain your health and wellbeing). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An observation on 05/05/2025 at 12:19 PM, showed Resident 34 in the dining room, sitting in their wheelchair (w/c), leaning down towards their left side. Resident 34 was being assisted with their meal and the NA attempted to reposition the resident to an upright position but then went right back to leaning to their left side. Review of a 10/25/2024 physical therapy (PT) note showed Resident 34 was seen for a left sided lean. The note showed Resident 34 would have a wedge placed to the left side of the back rest of their w/c to assist with positioning. An observation and concurrent interview on 05/06/2025 at 10:08 AM, showed Resident 34 was observed sitting in their wheelchair (w/c), during an activity, leaning over to their left side with their head lying on a white bed pillow. The white pillow was resting on the arm rest of the w/c, and Resident 34's shoulder and left arm were resting in the seat, alongside them. The white pillow had a wet area the size of a softball from where Resident 34 had been lying and had drooled. Staff I, LPN, stated Resident 34 at times would sit straight up and then just gradually start tilting favoring their left side. Staff I stated staff had to assist and reposition the resident to sit up straight when they would lean over to their left side. Staff I stated they used the white pillow for positioning the resident. Staff I did not attempt to reposition Resident 34 to an upright position. There was no wedge observed in the w/c. Staff I stated they had not seen a wedge for Resident 34. An observation on 05/07/2025 at 10:11 AM, showed Resident 34 sitting outside on the patio, in their w/c, with their head resting on a white bed pillow, to their left side. Resident 34 had headphones on listening to music. Staff were not observed attempting to reposition Resident 34 to an upright position. There was no wedge observed in the w/c. During an interview on 05/08/2025 at 11:57 AM, Staff P, Physical Therapy Assistant/Rehab Director, stated Resident 34 was no longer using the wedge in the w/c due to the resident was throwing out the wedge and refusing to use it all the time. Staff P stated they could not find a care plan for the wedge or for the repositioning of the resident, when they were observed leaning to their left side. Staff P stated they did not know where the staff would have documented that the resident was throwing out or refusing the wedge. During an interview on 05/08/2025 at 2:50 PM, Staff D, Resident Care Manager (RCM), stated Staff P would communicate specialized equipment changes to them and then they would update the residents' care plan so staff would know what care to provide. Staff D stated conversations with the PT are falling through the cracks and the wedge was missed. I did not know anything about the wedge. Staff D stated they were not aware of Resident 34's wedge for their w/c so that did not get care planned, therefore staff were unaware Resident 34 was to use it and were unable to document on it. Staff D stated Resident 34 was now leaning more so needed a new PT evaluation. <Resident 57> Review of the resident's medical records showed they admitted with diagnoses to include dementia, liver transplantation (to remove a diseased or injured liver and replace it with a healthy liver from another person), and chronic hepatitis (inflammation of the liver). The 03/26/2025 comprehensive assessment showed Resident 57's cognition was severely impaired and was dependent upon staff for ADLs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 57's 12/23/2024 hospital discharge orders showed Instructions for Follow-up Providers . Patient should be referred to a nearby gastroenterologist (a medical doctor who specializes in conditions affecting the digestive system)/hepatologist (a medical doctor who specializes in conditions affecting the liver and the bile ducts) to manage the liver transplant and immunosuppression (drugs that prevent your immune system from attacking healthy cells and tissues by mistake) therapy. Review of Resident 57's 05/2025 physician orders showed orders on 12/31/2024 for a referral to Gastroenterology for Resident 57's diagnoses of long-term use of immunosuppressants, liver transplantation, hepatitis, and liver cancer (a disease resulting from uncontrolled growth and division of abnormal cells). This order was discontinued and reordered on the evening of 05/05/2025. Review of the provider's note dated 01/19/2025, showed for staff to continue with the current therapies for Resident 57's liver transplantation and routine follow-up with hepatologist. During an interview on 05/08/2025 at 2:43 PM, Staff D stated they did not have a reason for why the referrals were not followed through with other than I have been busy, and it was not in my vision .I just need to find time to work on them. During an interview on 05/08/2025 at 3:55 PM, Staff A, Administrator, stated they expected referrals to be followed through on within a week, but my expectations were more like three to four days. During an interview on 05/09/2025 at 8:42 AM, Staff B, Director of Nursing Services, stated they would have expected referrals to be processed and followed up on immediately and should not have taken this long. Reference WAC 388-97-1060(1) 44922 48368

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to ensure the supervised fall risk residents received adequate supervision of one staff assistance in the dining room, and proper use of fall prevention devices for 1 of 5 residents (Resident 218) reviewed for falls. Resident 218 experienced harm when they fell forward out of their wheelchair when staff forgot to place the drop-down seat into the reclining position after transferring the resident to their wheelchair and sustained an injury to their left forehead that required hospital intervention for control of bleeding and stitches. Findings included . <Resident 218> Review of the medical record showed Resident 218 was admitted to the facility on [DATE] with diagnoses to include dementia (the loss of thinking, remembering, and reasoning to the extent that interferes with daily living), epilepsy (a brain condition that causes recurring seizures), lack of coordination, and repeated falls. The comprehensive assessment dated [DATE] showed Resident 218's cognition was severely impaired, dependent on staff for activities of daily living (ADL, fundamental tasks individuals perform daily for personal care) and was on hospice (a program that gives special care to people who are near the end of life). Review of the care plan dated 01/19/2025 showed Resident 218 was at risk for falls related to their cognitive loss, lack of safety awareness, and history of seizures with fall. Further review showed interventions which included ensuring appropriate footwear was in place, engage the drop seat (a reclining seat that prevents a resident from going forward) wheelchair for positioning, and monitoring Resident 218's whereabouts frequently, and assist them away from cluttered areas. Review of the facilities incident reporting log dated 04/13/2025 showed Resident 218 had a fall in the dining room that resulted in an injury. During an interview on 05/09/2025 at 11:29 AM, Staff L, Registered Nurse (RN), stated they were alerted to a resident who fell and needed assistance immediately. Upon entering the dining room, Staff L stated they found Resident 218 lying on their left side and was bleeding from their forehead. Staff L, RN stated that it took four staff members to transfer Resident 218 back into their wheelchair, wheel them to their room, and put the resident in bed. Staff L stated they had performed first aid to a laceration on Resident 218's forehead and called the hospice nurse. Staff L stated shortly after the hospice nurse arrived, they spoke to the physician about the resident's laceration and the continued bleeding. The hospice physician ordered Resident 218 to be sent to the emergency room for a higher level of evaluation and treatment. Review of the local hospital records dated 04/13/2025 at 9:32 AM showed that Resident 218's encounter visit was due to an unwitnessed fall when the resident sustained a three-centimeter (a unit of measure) laceration to the left forehead. Further review showed the resident responded to voice, had no pain and back to baseline for discharge to the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/09/2025 at 11:59 AM Staff N, Nursing Assistant (NA), stated the post-fall procedure was that staff were to report the incident to a nurse and filled out a statement form by the end of shift. Staff N stated everyone on the floor was to fill out a witness form, so the facility knew where and what everyone was doing during the incident. During an interview on 05/12/2025 at 2:05 PM Staff O, NA, stated they were present during the incident with Resident 218. Staff O stated they had provided care to the resident, transferred the resident to their drop seat wheelchair, and then sat the resident in the dining room for breakfast. Staff O stated that they had forgotten to place the drop-down seat into the reclining position after transferring Resident 218 to their wheelchair and they had fallen forward a fall. Staff O stated the resident was sent to the emergency room for laceration to the forehead and came back to the facility with dissolvable stitches. During an interview on 05/09/2025 at 12:32 PM, Staff A, Administrator, acknowledged the investigation had not been completed. Reference: WAC 388-97-1060 (3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on interview and record review, the facility failed to ensure a resident who was admitted with a urinary catheter (a tube which drains urine from the bladder into a collection bag), received a referral to a urologist to determine function and continued use of a urinary catheter for 1 of 3 residents (Resident 1) reviewed for extended urinary catheter use. This placed the resident at risk for continued decline in urinary function. Findings included . <Resident 1> A review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses of urinary retention (inability to empty the bladder) with a urinary catheter, and heart disease. The 03/13/2025 comprehensive assessment showed the resident was alert and oriented, had a urinary catheter and history of UTIs. During an observation and concurrent interview on 05/05/2025 at 9:25 AM, the resident had a urinary retention catheter with the urinary collection bag. During the interview the resident stated they had the catheter on and off but during their hospital stays. Resident 1stated they had many Urinary Tract Infections (UTIs) at the facility and was placed on many antibiotics. The resident stated they were not on a urinary catheter prior to being admitted to the facility. Review of the hospital physician's discharge notes dated 03/10/2025 showed the resident had the urinary catheter placed in the hospital on 03/04/2025. The resident developed a UTI while in the hospital on 03/06/2025 and was placed on antibiotics and discharged with a retention urinary catheter to the facility. Review of the 03/24/2025 urinalysis culture (a sensitivity test used to diagnose UTIs and by identifying the bacteria in the urine and determining which antibiotic to use) report showed the resident had a UTI and started on an antibiotic. Review of the 04/29/2025 progress notes showed the resident complained of a burning sensation and pain in their bladder a urinalysis Review of the 05/01/2025 urinalysis culture report showed the resident had a UTI and started on an antibiotic for five days. During an interview on 05/06/2025 at 11:00 AM, Staff C, Resident Care Manager (RCM) stated they did not refer Resident 1 to a urologist to obtain orders for an assessment whether to trial the resident off from the retention catheter or to determine why the resident had continued UTIs. Reference WAC 388-97-1060-(3)(c)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview and record review, the facility failed to ensure residents at risk for weight loss were reviewed for of 1 of 5 sampled residents (Resident 1) reviewed for nutrition. Resident 1 experienced harm as they had a 18.67% significant, unplanned, weight loss from 03/13/2025 to 04/22/2025 (40 days) and was found to have low protein levels and skin issues. This placed residents at risk for unplanned weight changes, health complications and nutritional decline. Findings included . <Nutritional Assessments> Review of the facility's 05/01/2023 Food and Nutrition Services Policies and Procedures showed that residents were assessed on admission and routinely thereafter. The residents' goals, diet order, reason for their diet order and components of the diet were discussed with the residents as well as their likes and dislikes. The dietician completed comprehensive or on-going assessments of any residents with nutritional concerns. Residents with dietary concerns were assessed at least monthly. <Weights> Review of the facility's 06/15/2022 Weight policy, showed residents were weighed on admission, then weekly for four weeks, and then monthly thereafter. Significant weight change management would be reviewed by the licensed nurse for assessment. All significant weight changes must be communicated to the physician and the dietitian. All recommendations would be assessed by the Interdisciplinary team and noted in the progress notes and the care plan. <Resident 1> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to include skin breakdown (Moisture Associated Skin Dermatitis (MASD) skin irritation or erosion caused by prolong exposure to moisture such as urine or stool), protein caloric malnutrition (when a person does not consume enough proteins and calories to meet their nutritional needs), post-surgery of a fractured left thigh bone after a fall and Rheumatoid arthritis(a chronic autoimmune disease that attacks healthy cells and tissues located in the joints of both sides of the body) and a Urinary Tract infection(UTI). Review of the 03/13/2025 comprehensive assessment showed the resident was alert and oriented and weighed 175. 8 pounds. The diet showed Resident 1 was ordered a Lacto-ovo-vegetarian diet (this diet consisted of acceptable amounts of milk products and eggs but no animal meat products). During an observation on 05/05/2025 at 7:48 AM, Resident 1's skin to their tail bone was bright red with purple areas of skin color and redness to the sacrum (triangular bone at the base of the spine) and peeled brown skin to each side of the sacrum. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview and concurrent observation on 05/05/2025 at 12:20 PM, Resident 1 was in bed with the over the bed table placed in front of them and their lunch meal on the table. The resident stated they had not had much of an appetite and had lost some weight but were unsure of the amount of weight loss. The resident had eaten a quarter of their lunch meal and stated they had enough. Resident 1 stated they were not on a weight loss plan. Resident 1 stated that since they had been admitted to the facility, they had experienced two episodes of UTIs and had not felt the same since they felt weak and unable to participate with therapies. During an interview on 05/05/2025 at 12:45 PM, Staff W, Nursing Assistant, (NA), stated they do not offer other food if a resident does not want to eat. Staff W stated if the resident wanted something else they would ask the kitchen. Review of Resident 1's facility weights showed: Resident 1's height was five foot seven inches. 03/13/2025 at 12:10 PM 175.8 pounds 04/22/2025 at 1:46 PM 143.0 pounds 05/01/2025 at 2:13 PM 151.6 pounds 04/29/2025 at 11:05 AM 151.6 pounds Review of the total weight loss percentage from 03/13/2025 to 04/22/2025 (40 days) was 18.67% (34.8 pound weight loss), a significant weight loss. Review of the percentage of weight gain from 04/22/2025 and 05/01/2025 was 8.6 pounds. Review of the total weight loss percentage from 03/13/2025 to 05/01/2025 (49 days) was 13.77% (a 32.4 pound eight loss), significant weight loss. Review of Resident 1's 03/10/2025 care plan showed the resident was at nutritional risk related to poor intake at times. The care plan goal was that the resident would consume 75% to 100% of two meals a day. Care plan interventions included encouragement of 100% consumption of all fluids, honor the resident's food preferences within meal plan and evaluate for proper consistency of diet. A review of the 03/14/2025 Nutrition progress note showed a Nutrition Assessment was completed. There were no other nutritional assessments or progress notes after the 03/14/2025 assessment as of 05/05/2025. The Nursing Assistant Task charting from 04/09/2025 through 05/05/2025 showed the documented meals consumed by Resident 1 ranged from 25% to 75%. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's 05/06/2025 hospital emergency room (ER) visit showed laboratory blood work that the resident had a low protein level of 2.3 (normal reference range is 3.4-5.0), Sodium (an electrolyte) was 132 (normal reference range 135-145). Resident 1 tested positive for pneumonia (respiratory infection) due to aspiration of food and fluids according to the 05/06/2025 physician's emergency room report. Resident 1 was sent to theER on [DATE] at 1:00 PM due to breathing difficulties and non-responsiveness. During an interview on 05/07/2025 at 10:03 AM, Staff U, Advanced Registered Nurse Practitioner (ARNP), stated they were unaware Resident 1 had weight loss and had not been eating well. Staff U stated Resident 1's skin issue would affect their nutrition. Staff U stated Resident 1 probably had fluid buildup in their lungs due to not being out of bed and not moving around much that affected the resident's respiratory issues. During an interview on 05/07/2025 at 10:45 AM, Staff C, Resident Case Manager (RCM), stated they were to inform the Interdisciplinary Team (IDT) about resident's skin issues and weight loss. The dietician, RCMs, and the ARNP were to be involved. Resident 1 was not included for the nutrition at risk discussion for weight loss. Staff C stated there was no report to the IDT concerning Resident 1's significant weight loss. During an interview on 05/09/2025 at 11:17 AM, Staff Q, Registered Dietician, stated they were not aware of Resident 1's weight loss. Staff Q stated they did their assessment and the resident's weight was 175.6 pounds. Staff Q stated Resident 1's documented intake was normal and had no swallowing or chewing issues. Staff Q stated the facility may have not accurately weighed the resident potentially showing a discrepancy in the process. Staff Q stated they completed the comprehensive nutrition assessment within seven days from admission. Staff Q stated they were onsite at the facility one day a month but did have weekly nutrition at risk meetings over the phone with the staff. Staff Q stated that the information on weights and food consumption was not always accurate and if a resident refused meals there was no further documentation of why they refused or what was offered to the residents in place of a meal. Staff Q stated there was a lack of accuracy in the information given and they would try to get clarity. Staff Q stated they did recently notice on 05/03/2025 that Resident 1 was not eating their 75% food consumption. Staff Q stated Resident 1 also had skin issues and there were gaps in information about skin issues and how quickly they were caught and acted upon. Staff Q stated there was not a robust type of meeting, there were missing parts of information about the residents' condition and the care for the residents needed to be better. During an interview on 05/09/2025 at 11:50 AM, Staff A, Administrator, stated they realized the lack of through nutritional at risk and resident weight reviews. Staff A stated they recognized the situation and had to work on the discrepancy. Reference WAC 388-97-1060-(3)(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to ensure continuous oxygen delivery was provided according to physician orders, monitored respiratory status, and the maintaining of respiratory equipment for 2 of 2 residents (Residents 1 and 53), reviewed for respiratory status. This failed practice placed residents at risk of unmet needs, discomfort, and secondary medical complications. Findings included . Review of the facility's 08/07/2023 Oxygen policy showed to label, date and attach pre-filled humidifier bottle. The policy included replacing the disposable set-up (oxygen tubing and nasal canula) every seven days. <Resident 1> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include anemia, heart disease and required continuous oxygen. The 03/13/2025 comprehensive assessment showed the resident was alert and oriented and able to make their needs known. Review of Resident 1's oxygen orders dated 03/10/2025, showed to monitor the resident's oxygen level every shift. Additionally, to clean the oxygen concentrator filter every seven days. During an observation and concurrent interview on 05/05/2025 at 3:01 PM, Resident 1 was lying in bed complaining about the oxygen tubing being irritating to their nose and behind their ears. Observation of Resident 1's oxygen tubing showed the tubing was cloudy and opaque (not transparent) skin around the nasal cannula (tubing carrying oxygen through the nose) was flakey, dry with slight redness at the edges of the nostrils. Resident 1 stated that their nose was irritated, and they had to remove the oxygen cannula because of the irritation. The resident stated their ears where sore where the oxygen tubing was placed behind their ears. Observation of Resident 1's skin behind their ears showed a slight redness. Resident 1 stated the staff did not change the oxygen tubing. During an observation and concurrent interview on 05/05/2025 at 3:10 PM, there were no labels on Resident 1 ' s oxygen tubing, or a label from the last time the tubing had been changed. Additionally, the resident did not have sterile water connected to the oxygen concentrator to humidify the oxygen as ordered by the physician. When asked about the labeling and the sterile water to humidify the oxygen, Staff I, Licensed Practical Nurse (LPN), stated they would inform the resident's nurse about it. During an interview on 05/06/2025 at 9:00 AM, Staff EE, Agency Licensed Practical Nurse (LPN), stated they were unaware of the oxygen tubing not being labeled or having sterile water for humidified air on the concentrator. (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 observation on 05/06/2025 at 9:50 AM, Resident 1's oxygen concentrator continued not to have sterile water on oxygen concentrator for humidification of oxygen. Resident 1's oxygen tubing had not been changed. Additionally, the oxygen concentrator filters were not clean and had build-up of white fuzzy dust. <Resident 53> Review of the medical records showed Resident 53 was admitted to the facility on [DATE], with diagnoses to include interstitial pulmonary disease (a group of lung disorders that cause inflammation and scaring to the tissue around the air sacs of the lungs), dementia (the loss of thinking, remembering, and reasoning, to the extent that effects activities of daily living), and the need for assistance with personal care. The comprehensive assessment dated [DATE] showed the residents' cognition was severely impaired and required assistance from one to two staff members for personal care. Review of Resident 53's Physician orders showed the resident was to wear oxygen at 2 L/min (a liter of oxygen flow per minute) via Nasal Cannula (a tubing that enters the nose to deliver oxygen) continuously. Additionally, an order dated 05/02/2025, showed that due to continuous oxygen, verify oxygen saturation (the amount of oxygen circulating in the blood) stayed above 92% when resident was transferred from one location to the other or during showers, every shift. During an observation on 05/07/2025 at 10:27 AM, Resident 53 sitting in their wheelchair in the outside activities with a blanket on their legs and a portable tank of oxygen on the back of their wheelchair. The resident's oxygen tank showed the pressure gauge at zero psi (pounds per square inch) indicating no oxygen. Resident 53 ' s tank was empty. During an observation on 05/07/2025 at 11:18 AM, Resident 53 was sitting in their wheelchair in the dining room with their oxygen tank empty. The resident had an oximeter (a small device that measures blood oxygen levels) on their right finger, the device showed their oxygen saturation was at 86%. Resident 53 was repeating I'm not sure why I feel this way I'm not sure why I feel this way. During an observation on 05/07/2025 at 11:42 AM, Resident 53 was in their wheelchair with a portable oxygen tank on the back of it, sitting in the dining room, and their oxygen tank continued was still empty, (one hour and 15 minutes after the first observation). During an interview on 05/07/2025 at 12:28 PM, Staff L, Registered Nurse stated nurses handled monitoring and the administration of oxygen for a resident. Staff L stated the nursing assistants were to notify a nurse for any issues, such as needing to have oxygen turned on. Staff L stated that they did not realize Resident 53's oxygen was empty. Reference: WAC 388-97-1060 (3)(j)(vi) 45642

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 44922 Based on observation, interview, and record review the facility failed to ensure an Omnibus Budget Reconciliation Act (OBRA) registry (a registry that identified, prior to employment, if a Nursing Assistant (NA) was eligible to work in a skilled nursing facility) verification to show that an individual met competency evaluation requirements and had no disqualifying findings for 5 of 5 NAs (Staff AA, BB, CC, O, and S) reviewed for staff qualification and background review. This failed practice placed residents at risk of unmet care needs, abuse, neglect, and misappropriation. Findings Included . Review of the policy titled Abuse Prohibition dated 10/24/2022, showed the facility would screen potential employees for a history of abuse, neglect, and mistreatment of residents by obtaining information from past employees and checking with the appropriate licensing boards and registries. Review of Staff AA's, NA, personnel file showed Staff AA was hired on 08/13/2024 but did not start working until 10/03/2024 as a NA. The file showed the OBRA registry was verified on 03/18/2025 (over five months after providing direct, unsupervised, care to residents). Review of Staff BB's, NA, personnel file showed Staff BB was hired on 12/13/2024 but did not start working until 01/24/2025 as a NA. The file showed no documentation of OBRA registry verification. Review of Staff CC's, NA, personnel file showed Staff CC was hired on 10/04/2024 but did not start working until 12/04/2024 as a NA. The file showed that no OBRA registry had been verified. Review of Staff O's, NA, personnel file showed Staff O was hired on 12/13/2024 but did not start working as a NA until 01/07/2025 as a NA. The file showed that no OBRA registry had been verified. Review of Staff S's, NA, personnel filed showed Staff S was hired on 03/23/2022 but did not start working as a NA until 06/25/2024. The file showed that no OBRA registry had been verified. During an interview on 05/07/2024 at 3:24 PM, Staff DD, Human Resources, stated they had not requested OBRA registry verifications until that morning (05/07/2025) for Staff BB,CC, O, and S. Staff DD stated they were aware of the requirement to complete OBRA registry verifications prior to a NA being employed but had not done that. During an interview on 05/08/2025 at 3:44 PM, Staff A, Administrator, stated they were aware they had an issue with OBRA registry verifications not being completed timely and had realized during an audit they had fixed one part of their problem but not the OBRA registry verifications. WAC Reference: 388-97-1660 (3)(c)

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	505261	A. Building B. Wing	05/09/2025

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview and record review, the facility failed to ensure 2 of 6 residents (Residents 51 and 57) were free of unnecessary drugs due to lack of monitoring, timely administration, and care planning of high-risk medications. This failed practice placed residents at risk of receiving medications incorrectly, subtherapeutic (relating to drug dosages administered at too low a level to produce a therapeutic effect) treatment, and adverse side effects. Findings included . Record review of an undated patient pamphlet published by [NAME] Cancer Center titled Tacrolimus (a medication to prevent the body from rejecting a transplanted organ) Reference Guide showed, Tacrolimus must be taken at the same time every day to keep steady levels of Tacrolimus in your blood. If there is a missed or late dose, contact your physician. The guide showed to monitor for common side effects that include high blood pressure, headache, tremors or shaking, nausea or vomiting, and diarrhea or constipation and to follow-up with your provider if the side effects are hard to control or won't go away. Review of the Pharmacyclics LLC patient pamphlet revised date 02/2024 titled Imbruvica (Ibrutinib) showed, that Ibrutinib is a cytotoxic medication (which means it is designed to kill cancer cells but can also harm normal cells if absorbed through the skin) and caregivers should wear disposable gloves when handling Ibrutinib capsules or tablets. Additionally, to monitor for side effects that include hemorrhage (large, uncontrolled bleeding from a blood vessel), infections, high blood pressure, liver problems, most common side effects diarrhea, muscle pain, bone pain and joint pain. <Resident 51> Review of the medical record showed Resident 51 admitted to the facility on [DATE] with diagnoses that included chronic lymphocytic leukemia (a type of cancer in the blood and bone marrow), dementia (the loss of thinking, remembering, and reasoning to the extent that interferes with Activities of Daily Living [ADLs]), and muscle weakness. The comprehensive assessment dated [DATE] showed the resident ' s cognition was severely impaired and was independent with ADLs. Review of the care plan dated 02/27/2025, showed there was no focused care plan for cancer, use of cytotoxic medication, no interventions to monitor for adverse side effects nor guidance for specialized handling. During an observation and concurrent interview on 05/08/2025 at 7:34 AM, during a medication pass, Staff R, Medication Assistant Certified (MAC), stated that the medication administration record for Imbruvica (a cytotoxic medication) showed no directives to wear gloves. In the same interview Staff C, Resident Care Manager (RCM), stated that it would be safer to wear gloves when administrating the Imbruvica medication. During an interview on 05/08/2025 at 11:08 AM, Staff D, RCM, stated they were not aware of the precautions for a cytotoxic medication, or the adverse effects such as the increased risk of hemorrhage. Staff D stated they should have used their nursing judgement. (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 05/09/2025 at 1:24 PM, the Contracted Pharmacist stated the monitoring of Imbruvica would be to make sure routine cardiac function tests and labs were done. The monitoring of blood pressures, and to monitor for bleeding or bruising. The facility would also have to ensure administration of the Imbruvica medication was at the same time every day and to give with a full glass of water. <Resident 57> Review of the resident's medical records showed they admitted to the facility with diagnoses to include a liver transplantation (to remove a diseased or injured liver and replace it with a healthy liver from another person), liver cancer, chronic hepatitis (ongoing inflammation of the liver), and immunosuppressive therapy (use of drugs that prevent your immune system from attacking healthy cells and tissues by mistake) . The 03/26/2025 comprehensive assessment showed Resident 57's cognition was severely impaired and was dependent upon staff for their ADLs. Review of Resident 57's physician orders showed an order on 12/23/2024 for Tacrolimus (a brand of an immunosuppressant drug) capsules to be taken twice daily at 7:00 AM and 7:00 PM. On 04/30/2025 the 12/23/2024 Tacrolimus order was discontinued and a new order for Tacrolimus granules in a packet that had to be mixed with water was ordered due to Resident 57 experiencing swallowing issues. Review of the orders showed there were no directions on either of the Tacrolimus orders to show the medication needed to be administered at the same time every day to maintain adequate levels in the blood. The indication for use of the Tacrolimus was for liver transplantation. Review of Resident 57's labs to test for therapeutic levels showed Tacrolimus labs had not been obtained since admission on 12/23/2024. Review of Resident 57's 03/24/2025 care plan showed there was no care plan for the liver transplantation or for the use and monitoring of immunosuppressant therapy for therapeutic range, adverse side effects, or special directions for administration. Review of Resident 57's Medication Administration Records (MARs) from 03/01/2025 through 03/30/2025 showed the Tacrolimus had not been administered on the evening of 03/06/2025, the evening of 03/10/2025, and the morning of 03/21/2025 because the resident refused or was sleeping. Review of the MARs from 04/20/2025 through 05/08/2025 showed Tacrolimus was administered 32 times. The records showed 11 times the medication was administered at least 50 minutes early or late, with the longest time being four hours and 57 minutes late and once where the medication was not given. 04/20/2025 the morning dose was not given due to the resident refusing 04/24/2025 the morning dose was given at 7:50 AM (50 minutes late) 04/26/2025 the morning dose was given at 7:58 AM (58 minutes late) 04/26/2025 the evening dose was given at 6:03 PM (57 minutes early) 4/30/2025 the evening dose was given at 12:37 AM (five hours and 37 minutes late) 05/01/2025 the morning dose was given at 11:57 AM (four hours and 57 minutes late) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/02/2025 the morning dose was given at 9:37 AM (two hours and 37 minutes late) 05/02/2025 evening dose was given at 8:51 PM (one hour and 51 minutes late) 05/03/2025 the morning dose was given at 8:35 AM (one hour and 35 minutes late) 05/04/2025 the evening dose was given at 8:02 PM (one hour and two minutes late) 05/07/2025 the evening dose was given at 6:03 PM (57 minutes early) 05/08/2025 the morning dose was given at 8:38 AM (one hour and 38 minutes late). During an observation on 05/08/2025 at 11:08 AM, Resident 57 was being assisted to their wheelchair. Resident 57 had tremors (a rhythmic movement of a body part that's involuntary) to their right hand while at rest sitting in their wheelchair (which could be a side effect of the Tacrolimus). Resident 57's hand was tremoring to the point that it would fall off the arm rest of the wheelchair either to their side or to the right side of the wheelchair. During an interview on 05/08/2025 at 2:43 PM, Staff D, Resident Care Manager, stated they were not aware that Tacrolimus had special instructions for administration and handling. Staff D stated they thought therapeutic levels should have been checked at some point but were not sure when that should have been, I probably need to get working on that. Staff D stated they were not familiar with immunosuppressant drugs and needed to learn more about them. During an interview on 05/09/2025 at 1:15 PM, the Contracted Pharmacist stated Tacrolimus was to be administered at the same time every day and Tacrolimus was on the list of hazardous drugs (medications that pose a risk to healthcare workers, patients, and the environment due to their potential to cause serious health effects like cancer, birth defects, or fertility problems) so adverse side effects should have been monitored, and the medication should have been administered with gloves. The Contracted Pharmacist stated they had not ordered Tacrolimus lab tests for Resident 57 and felt the transplant doctor should have been responsible for ordering and monitoring labs, as well as the ones the pharmacist had ordered. During an interview on 05/09/2025 at 8:42 PM, Staff B, Director of Nursing Services, stated they did not have additional monitoring or education for residents on immunosuppressant therapy. Staff B stated they knew the medication should not be handled without the use of gloves but would have expected the pharmacist to alert them to any special instructions if there were any. WAC Reference: 388-97-1060 (3)(k)(i), (4) 45642

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31168 Based on interview, observation, and record review, the facility failed to provide appetizing and palatable meals for 3 of 3 residents (Resident 24, 1 and 36) reviewed for the dining experience. These failures resulted in residents expressing dissatisfaction with the food and placed residents at risk for inadequate nutritional intake and weight loss. Findings included . Review of the 05/01/2023 Mealtimes and Delivery policy showed when meal food delivery was ready to begin the nutrition services employee (dietary department) alerted the nursing department that food was ready to be delivered. During an observation on 05/07/2025 at 11:20 AM, showed the lunch meal was checked for holding temperatures for serving the lunch meal. The following temperatures were taken and were within the temperature guidelines to include 135 degrees Fahrenheit (F) and 41 degrees F as follows: Chicken Fried Steak--185 degrees F Puree/Mech Soft------165 degrees F Salisbury Steak -------158 degrees F Potato Wedges--------180 Degrees F Puree Potatoes--------155 Degrees F Green Beans----------170 degrees F Carrots----------170 Degrees F Milk----------38 Degrees F During an observation on 05/07/2025 at 11:35 AM, showed the dietary staff prepared the residents meal trays in serve out. The residents meal trays were placed in the cart for distribution at 11:42 AM. Dietary staff then call for nursing staff on C-Hall to get the cart. The C-Hall staff retrieved the lunch meal cart at 11:43 AM and the C-Hall meal cart and did not start serving residents until 12:00 PM, (more that 17 minutes after preparation of meals). During an interview and observation on 05/07/2025 at 11:50 AM, A test tray for resident tray for Resident 24 was taken from the meal A-Hall cart by Staff N, Nursing Assistant (NA) took the meal tray for Resident 24. Staff N took the meal tray out of the A-Hall cart and uncovered the top of the lunch meal, cut the chicken fried steak, put butter on the dinner roll and re-covered the lunch meal and brought it to the resident's room at 12:08 PM. The test tray (same as Resident 24's meal tray) was also brought at the same time to the resident's room and retrieved the tray by the Staff HH, Dietary Manager and the surveyor for temperature testing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/2025 at 12:09 PM lunch was test tray was read at temperature of: Normal Temperatures for food are as follows: Chicken fried steak--118 degrees F Chicken fried Steak------135 degrees F Green Beans--------- 115 degrees F [NAME] Beans----------145 degrees F Potato wedges-------100 degrees F Potato Wedges----------145 degrees F Milk----------50 degrees F Milk----------41 degrees F Pineapple----------50 degrees F Pineapple----------41 degrees F During an interview and observation on 05/07/2025 at12:15 PM, Resident 24 stated the meal was okay but cold and it was not too appetizing. The chicken fried steak was cold, and the green beans were cold. During an interview and observation on 05/07/2025 at 12:20 PM, Resident 36 who eats in the C-Hall dining room stated the food was not tasty and cold. During an interview and observation 05/07/2025 at 12:30 PM, Resident 1 who ate in their room on C- Hall stated the food was lukewarm. During an interview on 05/07/2025 at 12:40 PM, Staff HH stated the lunch meal was cold and not at the appropriate temperature and stated it's not good for resident's to not have hot foods hot. Additionally, the milk temperature was 50 degrees F as well as pineapple dessert that was to be cold. During an interview with Staff A, Administrator, stated they were aware that there were concerns about meals served cold and there were delays in serving meal trays. Reference WAC 388-97-1100 (1), (2) 45642

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable and sanitary environment was maintained for 5 of 8 resident rooms (Rooms 6, 43, 41, 35 and 11) and 2 of 3 shower rooms (A hallway and C hallway), reviewed for environment. This failure placed the residents at risk for potential accidents and not feeling safe/secure with their environment. Findings included . Review of a document titled, Facility Assessment, dated 01/31/2024, showed the facility would provide maintenance and housekeeping services to ensure a safe and comfortable environment for the residents. <Resident Rooms> During the Resident Council meeting on 05/06/2025 at 3:24 PM Resident 217 stated in room [ROOM NUMBER] their bathroom always had water on the floor, and they were unsure where it came from. An observation on 05/06/2025 at 4:09 PM, showed, the bathroom flooring in room [ROOM NUMBER] had a stained area that measured 41 inches, with a strong odor of mildew (damp musty odor). The floor had a three-inch (a unit of measure) area circumference (the distance around something) cracked into the flooring with exposed cement. The bathroom wall to the left of the toilet had paint chips and dry wall damage. An observation of resident room [ROOM NUMBER], on 05/07/2025 at 9:16 AM, showed the back of the door had multiple deep gauges to the wood with chipped and missing paint. An observation of resident room [ROOM NUMBER]-A, on 05/07/2025 at 9:42 AM, showed the wall behind the bed had six feet (a Unit if measure) missing piece of trim mid wall with exposed rough jagged edges. An observation of Resident room [ROOM NUMBER] ' s bathroom, on 05/07/2025 at 9:44 AM, showed the floor had a 3 by 4-inch missing piece of tile with the cement floor exposed. An observation of resident room [ROOM NUMBER]-B, on 05/07/2025 at 9:53 AM, showed the wall behind the head of the bed had multiple vertical deep gouges in the sheet rock with missing paint. Further observation showed the trim that extended the length of the room mid wall behind the beds had multiple deep gouges with exposed wood showing. An observation of resident room [ROOM NUMBER]-A and B, on 05/07/2025 at 9:54 AM, showed the wall behind the head of bed A and B had multiple vertical deep gauges in the sheet rock and was missing paint. Further observations showed the trim behind bed A and Bed B mid wall had multiple deep gouges with exposed wood showing. <Shower rooms> (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 05/07/2025 at 9:48 AM, Hall C shower room had tiles missing along the bottom of the wall measuring 10.5 feet (a unit of measure) by 11 feet. The back of the shower door had multiple areas with chips of paint missing. The tile had areas of a black substance. Additionally, the floor tiles in each corner had a slimy brown substance one inch out from the wall and one inch up the wall. An Observation on 05/07/2025 at 10:47 AM, The A-hall shower room had cracked flooring with exposed concrete and broken tiles. The resident handrail/grab bar had a thick white layer of soap scum underneath the bar. In the corners of the flooring had dark exposed concrete. During an interview on 05/09/2025 at 10:02 AM, Staff H, Maintenance Director, stated the staff communicated any issues or repairs needed through an electronic maintenance log (a system on the computer that creates work orders). Staff H stated they had not been made aware of the issues in the rooms or the shower rooms, and they were not notified through their electronic system, so they did not get a work order. Staff H stated they did not walk rounds of the facility on a consistent schedule and only did room checks for any repairs needed when a resident was moved or discharged . Staff H stated they depended on the staff to inform them of any issues. Staff H stated they were working on all the issues, and it was a big project. During an interview on 05/09/2025 at 11:12 AM, Staff A, Administrator, stated they would expect walking rounds of the facility to be done daily, and the interdisciplinary team should be checking rooms at least three times weekly and reporting through the electronic system to Staff H. Staff A stated the process was not followed and these rooms were missed. Reference: WAC 388-97-3220(1) 45642