STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505262	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Health and Rehabilitation	2818 Northeast 145th Street Seattle, WA 98155

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47680 Based on observation, interview and record review, the facility failed to provide a homelike environment when residents were served their meals on trays for 1 of 1 dining room (Second floor Dining Room), reviewed for dining services. This failure placed the residents at risk for a less than homelike environment and a diminished quality of life. Findings included . Review of the facility's policy titled, Homelike Environment, revised in May 2017, showed, Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Observation on 12/13/2024 at 11:39 AM, in the Second Floor Dining Room, showed Resident 60, Resident 25, Resident 21, Resident 42, Resident 50, and Resident 37 were eating their food on their lunch tray. Staff J, Restorative Nurse Assistant, assisted Resident 20 eat their lunch from their tray. Observation on 12/16/2024 at 11:38 AM, in the Second Floor Dining Room, showed Staff D, Resident Care Manager, delivered Resident 50, Resident 8 and Resident 20 their lunch tray. Staff D did not remove their tray from the tables. Staff J delivered Resident 60's lunch tray, assisted in opening their straw and took the cover off the plate. Staff J did not remove their tray from the table. In another observation at 11:56 AM, Staff D assisted Resident 17 and Staff J assisted Resident 20 eat their lunch from their tray. In an interview on 12/16/2024 at 12:26 PM, Staff J was asked if it was their process to leave the meal tray on the table, Staff J stated they delivered residents their meals on the tray. Staff J verified with Staff D about the meal trays which they both stated that they use the tray in the dining room. In an interview on 12/17/2024 at 2:28 PM, Staff D was asked if they expected staff to remove the tray in the dining room, Staff D stated, Not necessarily. Staff D stated they used to remove the trays but when COVID-19 (highly contagious respiratory infection) started and since then they have always been told to leave the tray on in the dining room. In interview on 12/19/2024 at 10:27 AM, Staff B, Director of Nursing, stated that their process right now was to serve residents with the meal trays in the dining room. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-0880 (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 51090 Based on observation, interview, and record review, the facility failed to ensure bed hold (the opportunity to reserve a resident's current occupied bed while out of the facility to ensure their room was available when ready to return) notice was offered to 1 of 3 residents (Resident 65), reviewed for hospitalization . This failure placed the resident at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Review of the facility's policy titled Bed Hold, revised in December 2023, showed, It is the policy of this facility to inform the resident or resident's representative in writing of the right to exercise the bed hold provision upon admission and provide a second notice before transfer to a general acute care hospital .In the event of an emergency transfer, the second notice will be provided within 24 hours. Resident 65 admitted to the facility on [DATE]. Review of the nursing progress note dated 12/09/2024 showed Resident 65 was discharged to the hospital for medical evaluation on 12/09/2024. Further review of the nursing progress note dated 12/11/2024 showed Resident 65 returned to the facility on [DATE]. In an interview on 12/12/2024 at 9:34 AM, Resident 65 stated they had a private room before their hospital transfer on 12/09/2024 and that they returned to the facility in a shared room (room [ROOM NUMBER]). Resident 65 further stated, This really frustrates me; I need all my stuff from my old room. When asked if the facility offered them and/or their emergency contact, a bed hold notice for their hospital transfer on 12/09/2024, Resident 65 stated, No, I didn't know about a bed hold. I do not think my [emergency contact] was told about it; We [Resident 65 and their emergency contact] didn't know anything about it. Review of the electronic health record under the miscellaneous tab for December 2024 did not show documentation that Resident 65 was offered a written bed hold notice for their hospital transfer. Further review of the nursing progress notes dated 12/09/2024 through 12/15/2024 did not show documentation that a bed hold notice was offered or discussed with Resident 65. In an observation and interview on 12/16/2024 at 7:58 AM, showed that Resident 65 was no longer in room [ROOM NUMBER] with their roommate, Resident 41. Resident 41 stated that both Resident 65 and Resident 41 were put out of this room due to water leak last Thursday (12/12/2024) and that Resident 65 had been moved to another room while Resident 41 returned to room [ROOM NUMBER] when the water leak was fixed. Resident 41 further stated that they were informed that the water leak was due to something to do with upstairs and this room (room [ROOM NUMBER]); when somebody flushed the toilet, there was an overflow of clean water. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/16/2024 at 11:17 AM, showed Resident 65 was moved to room [ROOM NUMBER]. Resident 65 stated that they were moved to room [ROOM NUMBER] due to a water leak that affected their side of room [ROOM NUMBER]. When asked which room was their original room before their hospital transfer on 12/09/2024, Resident 65 stated they were in room [ROOM NUMBER]. When asked if they understood what a bed hold was, Resident 65 stated, [Staff] didn't ask me [regarding a bed hold], I went to the hospital and assumed I would keep my room; no one ever told me. When asked if they would have agreed to reserve their previously occupied bed, to include the associated costs for a bed hold, Resident 65 stated, I don't know what they would have charged me. Resident 65 stated they would have wanted to make an informed decision regarding a bed hold if it was offered to them. Resident 65 further stated that they were their own financial responsible party. In an interview and joint record review on 12/16/2024 at 11:50 AM, Staff L, Admissions, was asked if Resident 65 was offered a bed hold on their 12/09/2024 hospital transfer, Staff L stated, Yes and provided a document titled, Bed Hold Policy for Resident 65 that was completed by Staff L on 12/09/2024. Resident 65's Bed Hold Policy notice showed that their emergency contact was provided the bed hold information via in-person and that it did not show a signature from the recipient of the written notice. When asked if a copy of the written bed hold notice would be provided to the person signing it, Staff L stated Yes. When asked if a copy of the bed hold notice was provided to the recipient of the notice, Staff L stated, let me double check, I think I may have marked that wrong, I think it was by phone. When asked if they could provide a copy of the bed hold notice completed on 12/09/2024, which indicated Resident 65's emergency contact was provided the written bed hold notice in person, Staff L stated, let me get back to you on that. Staff L later provided a copy of the bed hold notice dated 12/09/2024 that showed that it was provided via phone and that the section for in-person notification was crossed out. Staff L stated they marked the document incorrectly and that the bed hold information was provided over the phone to the resident's emergency contact. Another joint record review and interview on 12/17/2024 at 7:30 AM with Staff L, showed Resident 65's face sheet listed them as their own financial responsible party and that their next of kin was listed as an emergency contact. Staff L stated that Resident 65's face sheet directed staff whom to contact for decision making and that Resident 65 was not informed about the bed hold. When asked if Resident 65 should have been informed of the bed hold, Staff L stated, I don't really know how to answer that, I just know that in my experience with [them], [they] deferred to their [emergency contact]. Staff L further stated that they did not know if Resident 65's emergency contact was able to make financial decisions on behalf of Resident 65. When asked again if Resident 65 should have been informed of the bed hold, Staff L stated, Can I get back to you on that; I need a minute if you don't mind. In a follow up interview on 12/17/2024 at 9:10 AM, Staff L stated that their process was to contact the financial responsible party when bed hold notice was discussed. Staff L further stated that for transfers to the hospital, they would try to reach the resident via phone. When asked if they attempted to contact Resident 65 about the option for a bed hold for their hospital transfer on 12/09/2024, Staff L stated, I don't remember if I tried to call at all at the hospital for Resident 65. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 12/19/2024 at 9:57 AM, Staff A, Administrator, stated that Staff L was responsible for issuing bed hold notices and that they expected staff would first discuss the bed hold notice with the resident if they were their own responsibility party. Staff A stated that if the resident was unable to be contacted, then we call family and to ask them to check with the responsible party. Staff A further stated the resident's face sheet as well as advance directives directed staff on whom to contact for bed hold notifications. Joint record review of the document titled, Bed Hold Policy, completed on 12/09/2024, showed Resident 65's emergency contact was contacted to discuss the bed hold notice. When asked if Resident 65 should have been informed of the bed hold notice due to them being their own financial responsible party, Staff A stated that they expected an effort to inform [Resident 65] would be made first. Reference: (WAC) 388-97-0120 (4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on interview and record review, the facility failed to accurately assess 1 of 20 residents (Resident 20), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding preferences to guide the development of a comprehensive activity care plan placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents when completing an MDS) Version 1.19.1, dated October 2024, showed, .The intent of items in this section (Section F- Preferences for Customary Routine and Activities) is to obtain information regarding the resident's preferences for their daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences .If a resident cannot communicate, then family or significant other who knows the resident well may be able to provide useful information about preferences .Providers are to attempt to conduct the interview with all conscious residents .If the resident is unable to complete the interview, attempt to conduct the interview with a family member or significant other . Preferences may change over time and extend beyond those included here. Therefore, the assessment of activity preferences is intended as a first step in an ongoing dialogue between the care provider and the resident .A dash (-) indicates No information. CMS [Centers for Medicare and Medicaid Services] expects dash use to be a rare occurrence. Resident 20 admitted to the facility on [DATE] with diagnosis that included dementia (memory loss). Review of Resident 20's Care Area Assessment worksheet dated 10/07/2024 showed that they discharged from hospice care services (type of care that focuses on comfort and support to people who are in the final stages of a serious illness) on 08/28/2024. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 20's Significant Change in Status (SCSA) MDS dated [DATE], showed Section F0300, Should interview for daily and activity preferences be conducted? was coded 1 indicating that the interview was attempted with the resident and that Resident 20's responses were coded as 9 for all questions, which indicated no response or non-responsive. Section F0600, Daily and activity preferences primary respondent showed it was coded 9 indicating that an Interview could not be completed by resident or family/significant other. Section F0700, Should the staff assessment of daily and activity preferences be conducted? showed it was coded 1 which indicated Yes (because 3 or more items in interview for daily and activity preferences were not completed by resident or family/significant other). Further review showed Section F0800, Staff Assessment of Daily and Activity Preferences showed it was marked None of the above which indicated the resident had no preferences applicable within the choices from items A through Z that included choosing clothes to wear, caring for personal belongings, receiving tub bath, receiving shower, receiving bed bath, receiving sponge bath, snack between meals, staying up past 8:00 PM, family or significant other involvement in care discussions, use of phone in private, place to lock personal belongings, reading books, newspapers, or magazines, listening to music, being around animals such as pets, keeping up with the news, doings things with groups of people, participating in favorite activities, spending time away from the nursing home, spending time outdoors, and participating in religious activities or practices. Review of Resident 20's Quarterly MDS dated [DATE] showed Section F0300 was dashed (-) indicating that the interview was not assessed or No information. Further review showed F0700 was dashed. A joint record review and interview on 12/18/2024 at 9:45 AM with Staff P, MDS Coordinator, showed that the facility's MDS electronic records included the RAI Manual that could be referenced by staff when MDS were being completed. Staff P stated the facility followed the RAI manual to guide coding accuracy of resident assessments. Continued joint record review with Staff P showed coded responses in Section F of Resident 20's SCSA MDS dated [DATE] and Quarterly MDS dated [DATE]. It further showed that Section F of Resident 20's SCSA MDS was signed and completed by Staff R, MDS part time. When asked if a family interview was completed or attempted for Section F of Resident 20's SCSA MDS, Staff P stated the SCSA MDS was completed by Staff R and that they would call to confirm with Staff R. Staff P further stated that they expected family to be interviewed for Resident 20 because they were not able to respond. When asked when it was appropriate to conduct staff interviews when completing an MDS, Staff P stated, We can interview staff after trying to interview the family. When asked if a resident, family, or staff interview was completed or attempted for Section F for Resident 20's Quarterly MDS, Staff P stated, No and that the coded responses by Staff O, Activities Supervisor, in Section F indicated interviews were not completed. Staff P further stated that they expected Section F of Resident 20's Quarterly MDS should have been completed and that they expected the completed MDS to have been accurate. A joint record review and interview on 12/18/2024 at 10:24 AM with Staff O, showed Resident 20's Section F of the Quarterly MDS dated [DATE] was dashed for all responses. Staff O stated they completed section F in Resident 20's Quarterly MDS and that they did not know why responses were dashed. When asked if they received training on how to complete the MDS Section F, Staff O stated, Yes. Staff O further stated that for residents who were non-verbal, they would interview family and if there were no family involved, they would interview staff. When asked if they interviewed family or significant other for Resident 20's Quarterly MDS dated [DATE], Staff O stated No, I know I did not interview the family. When asked if family interview should have been completed for Resident 20's Quarterly MDS, Staff O stated, Possibly, yes and that they always ask the [Certified Nursing Assistants]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 12/18/2024 at 3:04 PM, Staff P stated they contacted Staff R via phone on 12/18/2024 at 10:37 AM and that Staff R confirmed they completed Section F in Resident 20's SCSA MDS and that family interviews were not conducted. In an interview on 12/19/2024 at 10:37 AM, Staff B, Director of Nursing, stated that the facility followed the RAI manual to guide coding accuracy of resident assessments. When asked if family interview should have been completed for Resident 20's SCSA MDS dated [DATE] and Quarterly MDS dated [DATE], Staff B stated, Yes. Staff B further stated they expected MDS to be accurate and completed timely. Reference: (WAC) 388-97-1000 (1)(a)(b)(2)(m)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to implement activity care plan for 1 of 20 residents (Resident 20), reviewed for care planning. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy and procedure titled Comprehensive Person-Centered Care Planning, revised in August 2017, showed, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment .The comprehensive care plan will be developed by the IDT within seven days of completion of the Resident Minimum Data Set [MDS - an assessment tool] and will include resident's needs identified in the comprehensive assessment .The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment. Resident 20 admitted to the facility on [DATE] with diagnoses that included dementia (memory loss). Review of Resident 20's activity care plan revised on 10/02/2024 showed interventions included [staff to] offer in room story time and frequent 1:1 [one to one] visit. It showed, [Staff to] provide 1:1 program to support in-room activities with supplies, conversation, and comfort such as story time, room organization, and talking to [them]. It further showed that the care plan goal was that Resident 20 Will accept assistance with in-room activities to support end of life over the next 30 days as evidenced by activity documentation. Observations of Resident 20 in their room on 12/12/2024 at 11:06 AM, on 12/13/2024 at 10:39 AM, on 12/16/2024 at 8:27 AM, and on 12/16/2024 at 2:18 PM, did not show Resident 20 had one on one in-room activities. In an interview on 12/16/2024 at 2:24 PM, Staff O, Activities Supervisor, was requested to show activity documentation for Resident 20 from the last 30 days. Staff O stated they did not know how to generate the activity documentation report in Resident 20's electronic health record (EHR). Staff O further stated they would ask other staff members to assist with finding the activity documentation. When asked what other activities were provided for Resident 20, Staff O stated, We honestly just put on music for [them] and the roommate, not much .we also do friendly visits. When asked if activity documentation was available from sources other than Resident 20's EHR, Staff O stated, We document daily [on paper] and throw it away. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review of Resident 20's EHR activity documentation on 12/16/2024 at 2:40 PM with Staff O and Staff U, Assistant Director of Nursing, did not show that Resident 20 had documentation in the last 30 days that included one on one activity participation in the following: nail care, library cart/letter writing/room art, auditory (hear) stimulation, olfactory (smell) stimulation, tactile (touch) stimulation, spiritual, music, reminisce, hair styling, and family video call. It showed that resident not available and resident refused was not documented in the last 30 days. Further review did not show Resident 20's EHR had activity documentation in social activity in the last 30 days and one day (12/05/2024) in the last 30 days, was documented for independent activity to indicate Resident 20 had their TV/Radio turned on for them in their room. Staff U stated Resident 20 had also received activity support from Hospice care services. When asked if Resident 20 was discharged from hospice services in August 2024, Staff U and Staff O stated Yes. When asked if it was the facility's process for staff to document activity participation when activities were provided, Staff O stated Yes. When asked if they expected there to be documentation for Resident 20 when activities were provided, Staff O stated Yes. A joint record review and interview on 12/18/2024 at 10:34 AM with Staff O, showed Resident 20's activity care plan revised on 10/02/2024. Staff O stated, I did not make this one. When asked who was responsible for developing Resident 20's activity care plan, Staff O stated For [Resident 20] I have not made a care plan and that Staff O worked closely with Staff D, Resident Care Manager, to assist with developing care plans. Staff O further stated, I think [Staff D] made one for us .[they] help us a lot with care plans especially for Resident 20. A joint record review and interview on 12/18/2024 at 11:02 AM with Staff D, showed Resident 20's activity care plan, revised on 10/02/2024. When asked if they were involved in care planning development and revision for Resident 20, Staff D stated, Yes, I am involved. Staff D stated they signed in the EHR that they reviewed Resident 20's care plan on 10/02/2024. When asked what was reviewed for Resident 20's activity care plan, Staff D stated, I am signing off that what's in the care plan is something that can be done for the resident. Joint record review of Resident 20's activity documentation in the EHR did not show that Resident 20 had activity documentation in the last 30 days that included one on one activity participation in the following: nail care, library cart/letter writing/room art, auditory stimulation, olfactory stimulation, tactile stimulation, spiritual, music, reminisce, hair styling, and family video call. It further showed that resident not available and resident refused was not documented in the last 30 days. Staff D stated there was no activity documentation for Resident 20 in the last 30 days and that there should have been. When asked if Resident 20's activity care plan goal of Will accept assistance with in-room activities to support end of life over the next 30 days as evidenced by activity documentation was met, Staff D stated No, it needs to be revised if there is no documentation. When asked if Resident 20's activity care plan interventions were implemented, Staff D stated No, because there's no documentation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 12/19/2024 at 9:57 AM with Staff A, Administrator, did not show that Resident 20's activity documentation printed on 12/16/2024 had documentation that indicated one on one activity participation in the last 30 days. Staff A stated there was no activity documentation for Resident 20 and that all [staff] documentation was completed in the EHR. Joint record review of Resident 20's activity care plan showed the care plan goal was that Resident 20 Will accept assistance with in-room activities to support end of life over the next 30 days as evidenced by activity documentation. Staff A stated the activity department was responsible for providing an ongoing program of individualized activities for residents. Staff A further stated that the MDS and care plans should all be relatively supportive of each other. When asked if activity care plans were based on or in accordance with the comprehensive assessments. When asked if they expected activities offered and provided would be documented, Staff A stated, Yeah if it's an activity specialized for a resident in the care plan, yes. When asked if they expected staff to implement the resident individual care plan, Staff A stated, Yes, that's in our policy. Reference: (WAC) 388-97-1020 (1)(2)(a)(f)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 3 of 20 residents (Residents 17, 20 & 6), reviewed for care plan revision. The failure to revise care plans for medication administration and behaviors with oxygen use placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised in August 2017, showed, The resident's comprehensive plan of care will be reviewed and/or revised by the IDT [Interdisciplinary Team] after each assessment. RESIDENT 17 Observation on 12/16/2024 at 11:49 AM, showed Staff E, Registered Nurse, entered the Second Floor Dining Room holding two medication cups. Staff E gave one medication cup to Staff D, Resident Care Manager, who then administered the medication to Resident 17. Review of Resident 17's nutritional problem care plan intervention initiated on 12/16/2024, showed that Resident 17 was more incline to take medications during meals. Further review of Resident 17's care plan did not show to give Resident 17's medications with meals prior to 12/16/2024. RESIDENT 20 Observation on 12/16/2024 at 11:49 AM, showed Staff E entered the Second Floor Dining Room holding two medication cups. Staff E administered Resident 20's medications in the dining room. Review of Resident 20's nutritional problem care plan intervention initiated on 12/16/2024, showed, Give medications during meal times as resident is more incline to open her mouth during meals otherwise [Resident 20] will tighten [their] mouth closed due to advance dementia [severe memory loss and difficulty with daily activities]. Further review of Resident 20's care plan did not show to give Resident 20's medications with meals prior to 12/16/2024. In an interview on 12/18/2024 at 9:24 AM, Staff E was asked if their process was to give medications in the dining room, Staff E stated not unless the resident takes their medication with meals, but usually not. Staff E stated that Resident 17 and Resident 20 usually take their medications with their meals and that their medications were scheduled around their meals. Staff E further stated that it should be care planned and would have to check with Staff D. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/18/2024 at 2:19 PM, Staff D stated that if you tried to give Resident 17 and Resident 20 their medications when they were not eating, they would spit it out. Staff D stated that it should be care planned. Joint record review of Resident 17's care plan did not show to give medications with meals prior to 12/16/2024. Staff D stated that they tried to give Resident 17's medications when they were not eating and that they would spit it all out. Staff D stated that they would have expected Resident 17's care plan to be revised prior to 12/16/2024. Joint record review of Resident 20's care plan did not show to give their medications with meals prior to 12/16/2024. Staff D stated that they would have expected Resident 20's care plan to be revised prior to 12/16/2024. In an interview on 12/19/2024 at 10:29 AM, Staff B, Director of Nursing, stated that if staff were giving Resident 20 and Resident 17 their medications with meals in the dining room prior to 12/16/2024, then yes, they should have revised the care plan. RESIDENT 6 Resident 6 admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- a condition that blocks air flow and make it difficult to breathe). Review of Resident 6's December 2024 Medication Administration Record (MAR) showed an order for oxygen via mask/cannula (flexible tubing that sits inside the nose and delivers oxygen) at two liters (unit of measurement) of a minute every shift related to COPD dated 12/01/2023. Review of Resident 6's Oxygen Therapy care plan initiated on 01/02/2024, showed an intervention for oxygen settings: oxygen via nasal prongs (plastic tube placed in the nostrils to deliver oxygen)/mask at two to three liters continuously. Observation and interview on 12/13/2024 at 9:44 AM, showed Resident 6 applied their nasal cannula and was receiving five liters oxygen. Resident 6 stated that they applied the nasal cannula on and off themselves. Observation on 12/16/2024 at 8:55 AM, showed Resident 6 lying in bed receiving five liters of oxygen via nasal cannula. Joint record review of Resident 6's December 2024 MAR, interview and joint observation on 12/17/2024 at 12:13 PM with Staff F, Registered Nurse, showed an order for two liters of oxygen. When Staff F was informed that Resident 6 was observed receiving five liters of oxygen, Staff F stated that sometimes Resident 6 increases it themselves when they are frustrated. Joint observation of Resident 6's oxygen concentrator at bedside showed that the oxygen flowmeter setting was at five liters. When asked if they checked Resident 6's oxygen liter setting, Staff F stated, usually they do. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 12/17/2024 at 2:18 PM, Staff D was informed of observations of Resident 6's oxygen flowmeter setting was at five liters, Staff D stated, He does that, and that Resident 6 increases their oxygen liter setting. Staff D stated that they expected staff to go into Resident 6's room every shift to check the oxygen liter setting. Staff D stated they were not sure if Resident 6's behavior of increasing the oxygen flowmeter setting was documented but would be good to care plan. Joint record review of Resident 6's December MAR showed an order for two liters of oxygen and record review of Resident 6's Oxygen Therapy care plan showed an intervention for oxygen two to three liters continuously. Staff D stated that they would have expected the care plan and the physician orders to match. In an interview on 12/19/2024 at 1:18 PM, Staff B stated that they were not aware of Resident 6's behavior of increasing the oxygen flowmeter setting but when they were made aware of their behavior, that was when they care planned it. When asked if staff knew about the resident's behaviors, would they have expected them to revise the care plan, Staff B stated, Yes. Reference: (WAC) 388-97-1020 (5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to follow a physician's order in accordance with professional standards for 2 of 13 residents (Residents 26 & 335), reviewed for medications. These failures placed the residents at risk for medication errors, negative outcomes, and a diminished quality of life. Findings included . RESIDENT 26 Review of Resident 26's December 2024 Medication Administration Record (MAR) showed an order for oxycodone (pain medication) oral tablet 5 milligrams (a unit of measurement) to be given every eight hours as needed for pain level greater than six out of 10 started on 12/06/2024. Further review showed that Resident 26 received oxycodone when their pain was documented as less than six out of 10 for five out of 11 days. A joint record review and interview on 12/16/2024 at 9:53 AM, with Staff E, Registered Nurse (RN), showed the December 2024 MAR had a physician order to give Resident 26 oxycodone for pain level greater than six out of 10. Staff E stated that today they entered a four for Resident 26's pain level and that Resident 26 was given oxycodone. Staff E further stated that the oxycodone should not have been given if the resident's pain level was less than six. In an interview and joint record review on 12/18/2024 at 9:49 AM, Staff D, Resident Care Manager, stated that staff should follow parameters if there were parameters on a physician order. A joint record review of Resident 26's December 2024 MAR showed a physician order to give oxycodone for pain level greater than six out of 10. It further showed that oxycodone was given five out of 11 days when Resident 26 was rating their pain level at less than six. Staff D stated that the physician order was not being followed. In an interview on 12/18/2024 at 11:17 AM, Staff B, Director of Nursing, stated that they expected staff to follow [physician orders] as ordered. Staff B stated that staff should administer [pain medication] per pain level. Staff B further stated that Resident 26 should not have been given oxycodone when they rated their pain as less than six out of 10 because the order says give for pain greater than six. 51090 RESIDENT 335 Resident 335 admitted to the facility on [DATE] with diagnoses that included encounter for closed fracture (a broken bone that does not pierce through the skin) with routine healing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 335's nursing progress notes dated 12/15/2024, showed that Resident response to treatment: Resident refused [anticoagulant injection- blood thinner used to prevent and treat blood clots]. I don't think I need this medication. Further review did not show documentation that medical provider notification of Resident 335's anticoagulant medication refusal was made. A joint observation on 12/17/2024 at 7:38 AM, showed Staff N, Licensed Practical Nurse offered Resident 335 their anticoagulant injection during medication administration. Resident 335 stated Nope, not doing those anymore. Further observation showed Staff N did not provide Resident 335 education regarding anticoagulant injection refusal. In an interview and joint record review on 12/17/2024 at 7:45 AM, Staff N stated Resident 335 had refused their anticoagulant injection, more this week, [they are] getting tired of it. Joint record review of the December 2024 MAR showed Resident 335 refused their anticoagulant injection from 12/11/2024 through 12/16/2024 in addition to the refused dose on 12/17/2024 (7 days of medication refused). When asked what the facility's process was for refused medications, Staff N stated, To notify the provider and try to get [the refused medication] discontinued. Staff N further stated, It hasn't been done already, that's what I would do, as far as what the facility policy is, I don't know. In an interview and joint record review on 12/17/2024 at 9:15 AM, Staff M, RN, stated they expected nurses to educate the resident and to notify a provider whenever a resident refused medication. Joint record review of Resident 335's MAR showed Resident 335 had an active order for an anticoagulant injection and that it was refused starting on 12/11/2024 through 12/17/2024. When asked where provider notifications by nurses would be documented, Staff M stated the communication with a provider should be documented in the progress notes. Joint record review of Resident 335's progress notes dated 12/11/2024 through 12/17/2024 did not show documentation that a provider was notified regarding Resident 335's anticoagulant injection refusals. Staff M stated they expected nurses would have reported to the provider whenever Resident 335 refused their anticoagulant injection and that Specially this medication, it's an anticoagulant. In an interview on 12/19/2024 at 10:37 AM, Staff B stated, Providers should be notified after the first refusal. When asked if they expected the provider to be notified of Resident 335's anticoagulant injection refusals, Staff B stated, Yes. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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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** 51090 Based on observation, interview, and record review, the facility failed to ensure an activity program met the need of 1of 1 resident (Resident 20), reviewed for activities. The failure to implement an individualized ongoing program to support the resident in their choice of activities based on the comprehensive assessment and care plan placed the resident at risk for unmet activity pursuit, social isolation, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents when completing a Minimum Data Set [MDS - an assessment tool]) Version 1.19.1, dated October 2024, showed, .The intent of items in this section (Section F- Preferences for Customary Routine and Activities) is to obtain information regarding the resident's preferences for their daily routine and activities. This is best accomplished when the information is obtained directly from the resident or thorough family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences .If a resident cannot communicate, then family or significant other who knows the resident well may be able to provide useful information about preferences .Providers are to attempt to conduct the interview with all conscious residents .If the resident is unable to complete the interview, attempt to conduct the interview with a family member or significant other .Preferences may change over time and extend beyond those included here. Therefore, the assessment of activity preferences is intended as a first step in an ongoing dialogue between the care provider and the resident. Resident 20 admitted to the facility on [DATE] with diagnosis that included dementia (memory loss). Review of Resident 20's Care Area Assessment worksheet dated 10/07/2024 showed that they discharged from hospice care services (type of care that focuses on comfort and support to people who are in the final stages of a serious illness) on 08/28/2024. Review of Resident 20's activity assessment dated [DATE] showed that MDS-Activity Pursuit Patterns Section, was reviewed and that the information still accurately reflects Resident 20's activity pursuit patterns. It further showed that Resident 20 enjoyed being in their room and that they enjoyed one on one activities such as listening to music, sensory stimulation, nail care and story time in their room. Review of Resident 20's activity care plan revised on 10/02/2024 showed interventions included [staff to] offer in room story time and frequent 1:1[one on one] visit. It showed, [Staff to] provide 1:1 program to support in-room activities with supplies, conversation, and comfort such as story time, room organization, and talking to [them]. It further showed that the care plan goal was that Resident 20 Will accept assistance with in-room activities to support end of life over the next 30 days as evidenced by activity documentation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of Resident 20 in their room on 12/12/2024 at 11:06 AM, on 12/13/2024 at 10:39 AM, on 12/16/2024 at 8:27 AM, and on 12/16/2024 at 2:18 PM did not show Resident 20 had one on one in-room activities. In an interview on 12/16/2024 at 2:24 PM Staff O, Activities Supervisor, was requested to show activity documentation for Resident 20 from the last 30 days. Staff O stated they did not know how to generate the activity documentation report in Resident 20's electronic health record (EHR). Staff O further stated they would ask other staff members to assist with finding the activity documentation. When asked what other activities were provided for Resident 20, Staff O stated, We honestly just put on music for [them] and the roommate, not much .we also do friendly visits. When asked if activity documentation was available from other sources other than Resident 20's EHR, Staff O stated, We document daily [on paper] and throw it away. A joint record review on 12/16/2024 at 2:40 PM with Staff O and Staff U, Assistant Director of Nursing, did not show that Resident 20 had activity documentation in the last 30 days that included one on one activity participation in the following: nail care, library cart/letter writing/room art, auditory (hear) stimulation, olfactory (smell) stimulation, tactile (touch) stimulation, spiritual, music, reminisce, hair styling, and family video call. It showed that resident not available and resident refused was not documented in the last 30 days. Further review did not show Resident 20's EHR had activity documentation in social activity in the last 30 days and one day (12/05/2024) in the last 30 days, was documented for independent activity to indicate the resident had their TV/Radio turned on for them in their room. Staff U stated Resident 20 had also received activity support from hospice care services. When asked if Resident 20 was discharged from hospice services in August 2024, Staff U and Staff O stated Yes. When asked if it was the facility's process for staff to document activity participation when activities were provided to residents, Staff O stated Yes. When asked if they expected there to be documentation for Resident 20 when activities were provided, Staff O stated Yes. Review of Resident 20's Significant change in status (SCSA) MDS, dated [DATE] showed Section F0300, Should interview for daily and activity preferences be conducted? was coded 1 which indicated the interview was attempted with the resident and that Resident 20's responses were coded as 9 for all questions which indicated no response or non-responsive. Section F0600, Daily and activity preferences primary respondent showed it was coded 9 which indicated Interview could not be completed by resident or family/significant other. Section F0700, Should the staff assessment of daily and activity preferences be conducted? showed it was coded 1 which indicated Yes (because 3 or more items in interview for daily and activity preferences were not completed by resident or family/significant other). Further review showed Section F0800, Staff Assessment of Daily and Activity Preferences showed it was marked None of the above which indicated the resident had no preferences applicable within the choices from items A through Z which included choosing clothes to wear, caring for personal belongings, receiving tub bath, receiving shower, receiving bed bath, receiving sponge bath, snack between meals, staying up past 8:00 PM, family or significant other involvement in care discussions, use of phone in private, place to lock personal belongings, reading books, newspapers, or magazines, listening to music, being around animals such as pets, keeping up with the news, doings things with groups of people, participating in favorite activities, spending time away from the nursing home, spending time outdoors, and participating in religious activities or practices. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 12/18/2024 at 9:45 AM with Staff P, MDS Coordinator, showed coded responses in Section F of Resident 20's SCSA dated 09/09/2024. It further showed that Section F of Resident 20's SCSA was signed and completed by Staff R, MDS part time. When asked if a family interview was completed or attempted for Section F of Resident 20's SCSA, Staff P stated the SCSA was completed by Staff R and that they would call to confirm with Staff R. Staff P further stated that they expected family to be interviewed for Resident 20 because they were not able to respond. When asked when it was appropriate to conduct staff interviews for a MDS, Staff P stated, We can interview staff after trying to interview the family. Staff P further stated that they expected completed MDS to be accurate. In a follow up interview on 12/18/2024 at 3:04 PM, Staff P stated they contacted Staff R via phone on 12/18/2024 at 10:37 AM and that Staff R confirmed they completed Section F in Resident 20's SCSA and that family interviews were not conducted. In an interview on 12/19/2024 at 10:37 AM, Staff B, Director of Nursing, was asked if family interview should have been completed for Resident 20's SCSA dated 09/09/2024, Staff B stated Yes. A joint record review and interview on 12/19/2024 at 9:57 AM with Staff A, Administrator, did not show that Resident 20's activity documentation printed on 12/16/2024 had documentation that indicated one on one activity participation in the last 30 days. Staff A stated there was no activity documentation for Resident 20 and that all [staff] documentation was completed in the EHR. Joint record review of Resident 20's activity care plan showed the care plan goal was that Resident 20 Will accept assistance with in-room activities to support end of life over the next 30 days as evidenced by activity documentation. Staff A stated the activity department was responsible for providing an ongoing program of individualized activities for residents. Staff A also stated that the MDS and care plans should all be relatively supportive of each other when asked if activity care plans were based on or in accordance with the comprehensive assessments. When asked if they expected activities offered and provided would be documented, Staff A stated, Yeah if it's an activity specialized for a resident in the care plan, yes. When asked if they expected staff to implement the resident individual care plan, Staff A stated Yes, that's in our policy. When asked if Resident 20 was provided an ongoing program of individualized activities based on the care plan and activity documentation, Staff A stated, It's not documented. Reference WAC 388-97-0940(1)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46912 Based on interview and record review, the facility failed to implement bowel management protocol in accordance with professional standards of practice for 1 of 1 resident (Resident 48), reviewed for quality of care. This failure placed the resident at risk for discomfort, bowel impaction, and related complication. Findings included . Review of the facility's undated policy titled, Bowel Management Program, showed, Accurate and complete documentation is required to determine the resident's bowel integrity and certified staff documents bowel movements for each resident each shift. Review of Resident 48's constipation care plan, revised on 10/16/2023, showed an intervention to monitor medications for side effects of constipation. It further showed to record bowel movement (BM) pattern each day. Review of the facility's document titled, Documentation Survey Report for November 2024, showed Resident 48 did not have a BM from 11/06/2024 through 11/10/2024 (5 days) and from 11/13/2024 through 11/17/2024 (5 days). Review of the facility's document titled, Task: Bowel movement/Bowel Continence, dated 11/14/2024 through 12/13/2024, showed that Resident 48 did not have a BM from 12/04/2024 through 12/08/2024 (five days). Review of Resident 48's November 2024 Medication Administration Record (MAR) showed no documentation that any as needed (PRN) medications were given for not having a BM from 11/06/2024 through 11/10/2024 and from 11/13/2024 through 11/17/2024. Review of Resident 48's December 2024 MAR showed no documentation that any PRN bowel medications were given for not having a BM from 12/04/2024 through 12/08/2024. In an interview and joint record review on 12/17/2024 at 1:51 PM, Staff Z, Licensed Practical Nurse, stated that the Resident Care Manager (RCM) will give us a list of residents with no bowel movement. Staff Z stated that if it was one to two days without a BM, give PRN bowel medications and if four days, call the provider, and do abdominal assessment. A joint record review of the Task: Bowel movement/Bowel Continence, dated 11/14/2024 through 12/13/2024, showed Resident 48 did not have a BM from 12/04/2024 through 12/08/2024. Staff Z stated, it showed it wasn't charted, but sometimes he'll say he had one, and we would chart that it in a progress note. In a joint record review of Resident 48's progress notes, showed no documentation that Resident 48 had a BM during those dates, and no documentation of abdominal assessment or that the physician was notified. A joint record review of Resident 48's December 2024 MAR showed no documentation that Resident 48 received any PRN bowel medications for having no BM on those dates. Staff Z stated that no, he didn't [did not] get any PRN medications during those dates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 12/18/2024 at 9:49 AM, Staff D, RCM, stated that if a resident went three days without a BM, then they should start the bowel protocol. Staff D stated that they expected the licensed nurse to assess the resident to see if they were eating, had nausea, and should do an abdominal assessment. In a follow-up interview at 1:44 PM, Staff D stated that they could not find anything documented in the progress notes for the dates that Resident 48 did not have a BM. When asked if there were any interventions done for Resident 48 during the dates it was documented that they did not have a BM, Staff D stated based on progress notes and the MAR, not that I'm seeing. Staff D further stated that they did not see any documentation that the physician was notified. In an interview on 12/18/2024 at 2:05 PM, Staff B, Director of Nursing, stated that if a resident goes without a BM for three days, staff should the follow protocol and give PRN medication. Staff B stated that staff should be documenting BMs when see it and if residents were independent, staff should ask them, and document based on what the resident is saying. Staff B stated that if a resident went five days without a BM, I would expect PRN interventions to be done, and documentation of assessment done and if it was effective. Staff B further stated that there was no documentation that any PRN interventions or assessments were done when it was documented that Resident 48 did not have a BM for five days. Reference: (WAC) 388-97-1060 (1)

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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** 47680 Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted professional standards of practice for 3 of 5 residents (Residents 6, 16 & 285), reviewed for respiratory care. The failure to follow physician orders for oxygen therapy, properly store nebulizer (device used to administer medication in the form of a mist inhaled into the lungs) and oxygen equipment placed the residents at risk for respiratory infections, and related complications. Findings included . Review of the facility's policy titled, Oxygen Administration, revised in July 2019, showed, Obtain appropriate physician's order and Reassess oxygen flowmeter for correct liter flow. Review of the facility's policy titled, Respiratory Therapy-Prevention of Infection, revised November 2011, showed under Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol [constant mist of medication over a period ranging from 30 minutes to several hours] to take care not to contaminate internal nebulizer tubes. It further showed to Store the circuit in plastic bag, marked with date and resident's name, between uses. RESIDENT 6 Resident 6 admitted to the facility on [DATE] with diagnosis that included Chronic Obstructive Pulmonary Disease (COPD- a condition that blocks air flow and make it difficult to breathe). Review of Resident 6's December 2024 Medication Administration Record (MAR) showed an order for oxygen via mask/cannula (flexible tubing that sits inside the nose and delivers oxygen) at two liters (unit of measurement) a minute every shift related to COPD dated 12/01/2023. Review of Resident 6's Oxygen Therapy care plan initiated on 01/02/2024, showed an intervention for oxygen settings: oxygen via nasal prongs (plastic tube placed in the nostrils to deliver oxygen)/mask at two to three liters continuously. Observation and interview on 12/13/2024 at 9:44 AM, showed Resident 6 applied their nasal cannula and was receiving five liters of oxygen. Resident 6 stated that they applied the nasal cannula on and off themselves. Observation on 12/16/2024 at 8:55 AM, showed Resident 6 lying in bed receiving five liters of oxygen via nasal cannula. Joint record review and interview on 12/17/2024 at 12:13 PM with Staff F, Registered Nurse (RN), showed Resident 6's December 2024 MAR had a written order for two liters of oxygen. When Staff F was informed that Resident 6 was observed receiving five liters of oxygen, Staff F stated that sometimes Resident 6 increases it themselves when they were frustrated. Joint observation of Resident 6's oxygen concentrator at bedside showed that the oxygen flowmeter setting was at five liters. When asked if they checked Resident 6's oxygen flowmeter setting, Staff F stated, usually they do. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 12/17/2024 at 2:18 PM, Staff D, Resident Care Manager, was informed of observations of Resident 6's oxygen flowmeter setting was at five liters, Staff D stated, He does that, and that Resident 6 increases their oxygen flowmeter setting. Staff D stated that they expected staff to go into Resident 6's room every shift to check the oxygen flowmeter setting. Staff D stated they were not sure if Resident 6's behavior of increasing the oxygen flowmeter setting was documented but would be good to care plan. Joint record review of Resident 6's December MAR showed an order for two liters of oxygen and record review of Resident 6's Oxygen Therapy care plan showed an intervention for oxygen two to three liters continuously. Staff D stated that they would have expected the care plan and the physician orders to match. In an interview on 12/19/2024 at 10:03 PM, Staff B, Director of Nursing, stated that they expected staff to follow physician orders for oxygen settings. Staff B stated that the physician orders for two liters of oxygen were within the same range as the care plan of two to three liters of oxygen. Staff B stated that it was not inaccurate and that they followed the physician orders and not the care plan. Staff B further stated that Staff F stated that Resident 6 could have changed the oxygen flowmeter rate and not that Resident 6 was changing it. Staff B requested to interview Staff F together to clarify about Staff F's previous statement. Staff B stated that they did not know that Resident 6 changed the flowmeter setting prior to speaking to Staff F. In a follow up interview on 12/19/2024 at 11:45 AM, Staff B was asked if they wanted to interview Staff F and Staff D together to clarify as they were given different information regarding Resident 6's behavior of increasing the oxygen flowmeter setting. Staff B stated that they did not need to interview together and that they had their interviews. In another follow up interview on 12/19/2024 at 1:18 PM, Staff B stated that they were not aware of Resident 6's behavior of increasing the oxygen liter setting but when they were made aware of their behavior that was when they care planned it. When asked if staff knew about the Resident 6's behaviors would they have expected them to revise the care plan, Staff B stated, Yes. RESIDENT 16 Resident 16 readmitted to the facility on [DATE] with diagnoses that included pneumonia (lung infection). Review of Resident 16's December 2024 MAR showed an order for Ipratropium-Albuterol Inhalation Solution (a medication that relaxes the muscles in the airways and increase air flow to the lungs) three milliliters (unit of measurement) inhale orally two times a day for aspiration pneumonia (condition in which foods, stomach contents, or fluids are breathed into the lungs) dated 12/03/2024. Further review showed that it was scheduled for 9:00 AM and 9:00 PM. Observation on 12/16/2024 at 1:29 PM, did not show Resident 16's nebulizer mask was properly stored when not in use. It further showed Resident 16's nebulizer mask was on top of their bedside table laying on top of a white cloth that was folded over the mask. Observation on 12/17/2024 at 9:45 AM, did not show Resident 16's nebulizer mask was properly stored when not in use. It further showed Resident 16's nebulizer mask was on top of their bedside table laying on top of a white cloth. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint observation on 12/17/2024 at 12:08 PM, Staff F stated that they cleaned the nebulizer mask and kept it at the bedside. Joint observation with Staff F at 12:20 PM, showed Resident 16's nebulizer mask was laying on top of a white cloth on the bedside table with a book laying on top of the mask and that it was not properly stored when not in use. Staff F stated that it should have been stored in a bag. In an interview on 12/17/2024 at 2:18 PM, Staff D stated that they would expect Resident 16's nebulizer mask to be stored in a bag when not in use. In an interview on 12/19/2024 at 10:03 AM, Staff B stated they expected the nebulizer equipment to be stored in the residents' room in a bag or a bin when not in use. Staff B further stated that Resident 16's nebulizer equipment should have either been stored in a bag or in a bin when not in use. 51090 RESIDENT 285 Resident 285 admitted to the facility on [DATE] with diagnosis that included hypoxemia (a condition where there was not enough oxygen in a person's blood). A joint observation and interview on 12/17/2024 at 7:38 AM with Staff N, Licensed Practical Nurse, showed Resident 285's nasal cannula was placed on top of their wheelchair cushion and was not properly stored. Further observation showed an unsecured portable oxygen tank was placed lying on its side on a chair, with the length of the cylinder parallel to the chair's seat cushion. Staff N stated that nasal cannula, when not in use, should be stored neatly, it shouldn't be on the [wheel]chair, when asked what the facility's process was on storing oxygen therapy supplies. Staff N stated that portable oxygen tanks were normally secured to the wheelchair and that Resident 285's portable oxygen tank should be stored in the oxygen room. In an interview on 12/18/2024 at 1:39 PM, Staff M, RN, stated that the facility's process for storage of nasal cannula was that When not in use, we put it in a plastic bag and store it in the drawer. Staff M stated they would not expect nasal cannula to be placed on a wheelchair. When asked what the facility's process for storage of portable oxygen tanks was, Staff M stated, When not in use, they are supposed to come to the oxygen room to be stored on an oxygen cylinder stander, and if in use, they should be secured in a carrier [a backpack like device to secure oxygen tanks to the back of a wheelchair]. Staff M further stated that they expected portable oxygen tanks to be safely secured, in a carrier, attached to the resident's wheelchair. In an interview on 12/19/2024 at 11:06 AM, Staff B stated they expected oxygen tubing supplies to be bagged and stored when not in use. Staff B further stated they expected oxygen portable tanks to be safely secured. Reference: (WAC) 388-97-1060(3)(j)(vi)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46912 Based on observation, interview, and record review, the facility failed to appropriately store drugs and/or biologicals (diverse group of medicines made from natural sources) and medical supplies for 2 of 2 medication rooms (West 1 Medication Storage Room & Second Floor Medication Storage Room) and 1 of 3 medication carts (East 1 Medication Cart), reviewed for medication storage. This failure placed the residents at risk for receiving compromised and ineffective medications/medical supplies. Findings included . Review of the facility's policy titled, Storage of Medications, revised in March 2016, showed, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. WEST 1 MEDICATION STORAGE ROOM A joint observation and interview on 12/17/2024 at 9:13 AM with Staff Y, Licensed Practical Nurse (LPN), showed the [NAME] 1 Medication Storage Room had one Aquacel Advantage (brand name of an anti-microbial wound dressing) dressing 10 centimeter (cm-a unit of measurement) by 12 cm with an expiration date of 11/01/2024. Staff Y stated, Yes it expired on 11/01/2024. SECOND FLOOR MEDICATION ROOM A joint observation and interview on 12/17/2024 at 10:11 AM with Staff F, Registered Nurse (RN), showed the Second Floor Medication Room had the following expired medical supplies: - Two SafeDay (brand name) Intravenous (IV-refers to the administration of fluids, medications, other substances directly into the vein) administration set (flexible plastic tubing) with an expiration date of 02/24/2024. - Two SafeDay IV administration sets with an expiration date of 04/13/2024. - One SafeDay IV administration sets with an expiration date of 08/27/2024. - One SafeDay IV administration set with an expiration date of 09/08/2024. - Five SafeDay IV administration sets with an expiration date of 12/16/2024. Staff F stated that the IV administration sets were expired and that they would dispose of them. In an interview on 12/17/2024 at 1:44 PM, Staff D, Resident Care Manager, stated that they expected expired supplies and medications to get thrown out. In a follow-up interview on 12/18/2024 at 1:10 PM, Staff D stated, if they're [they are] expired, they're expired when asked about outdated medications and supplies. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/18/2024 at 2:05 PM, Staff B, Director of Nursing, stated that we shouldn't (should not) have expired medications and supplies. Staff B stated, we took out the expired IV administration sets and they should not be there. Staff B further stated that the Aquacel Advantage wound dressing was considered a medication and should be disposed of when it was expired. 51090 EAST 1 MEDICATION CART Review of the facility ' s policy and procedure titled Medication Storage Policy/Procedure, revised in March 2016, showed, The facility shall store all drugs and biologicals in a safe, secure and orderly manner .Drugs and biologicals shall be stored in the packaging, containers or other dispensing system in which they are received. A joint observation and interview on 12/17/2024 at 7:38 AM with Staff N, LPN, showed an unpackaged and unlabeled red capsule stored in the first top drawer of the East 1 medication cart during medication storage review. Staff N stated the unpackaged and unlabeled red capsule was a prescription antibiotic (used to treat and prevent bacterial infections) and That should not be there. Staff N showed a prescription blister package (a type of packaging that uses a plastic bubble to hold each individual dose of medication) from another drawer of the medication cart, of red capsules that were identical in shape, color and size to the unlabeled and unpackaged red capsule observed on the top drawer. When asked if the loose red capsule should be packaged and labeled, Staff N stated, Yes and that I will put it in the drug buster [product used to safely dispose of unwanted or expired medications] to waste it. In an interview on 12/18/2024 at 1:42 AM Staff M, RN, stated that prescription medications should be packaged and labeled. Staff M stated that they would not expect unpackaged and unlabeled prescribed medications to be stored in the medication cart. Staff M further stated that they expected prescription medications to be securely packaged and labeled when stored in the medication cart. In an interview on 12/19/2024 at 10:37 AM, Staff B stated they would not expect unpackaged and unlabeled prescription medication to be stored in the medication cart. When asked if they expected all medications are properly packaged and labeled when stored in the medication cart, Staff B stated, Yes. Reference: (WAC) 388-97-1300 (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 1 of 1 dry storage room and 2 of 2 floors (First Floor & Second Floor), reviewed for food services. The failure to label food items and cover food items during meal tray delivery placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Food Procurement, Storage and Distribution, dated 07/08/2022, showed, Food safety requires consistent temperature control from the time food leaves the kitchen, to transport and distribution to prevent contamination (e.g. covering food items). FOOD LABELING IN THE DRY STORAGE ROOM Joint observation on 12/12/2024 at 8:32 AM with Staff C, Nutritional Services Manager, showed two unopened unlabeled bags of cereal. Staff C stated it was Cornflakes and that some brands of cereal did not have labels on them. Staff C stated that when they placed it in their bins, that they would be labeled. When asked if they labeled the cornflakes when they take it out of the box, Staff C stated, I don't put a label, just follow the expiration date. In an interview on 12/17/2024 at 2:33 PM, Staff K, Dietary Aide, stated that they expected food items in the dry storage room to be labeled and that they expected the Cornflakes to be labeled. In an interview on 12/18/2024 at 3:23 PM, Staff A, Administrator, stated that generally they take the food items out of the box, label, date it and if it was past the use by date, they would discard it. When asked if they would expect the unlabeled cornflakes to be labeled, Staff A stated, generally when it's opened, it was labeled and dated. Staff A further stated, It's not what they normally do. FOOD ITEMS UNCOVERED DURING MEAL TRAY DELIVERY Observations on 12/12/2024 at 11:48 AM, showed the meal cart was parked between room [ROOM NUMBER] and room [ROOM NUMBER]. Staff H, Certified Nursing Assistant (CNA), took a tray from the meal cart and delivered it to room [ROOM NUMBER] with a cup of blueberries uncovered. Staff H took another tray from the meal cart and walked down the hallway to room [ROOM NUMBER] with a cup of blueberries uncovered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 12/13/2024 at 11:13 AM, showed that the meal cart was parked by room [ROOM NUMBER]. Staff G, Human Resources, took a tray from the meal cart and delivered it to room [ROOM NUMBER] with a cup of peaches uncovered. Staff I, CNA, took a tray from the meal cart, walked down the hallway and delivered it to room [ROOM NUMBER] with a cup of strawberries uncovered. Staff J, CNA, took a tray from the meal cart, walked down the hallway and delivered it to room [ROOM NUMBER] with a cup of peaches uncovered. Observations and interview on 12/13/2024 at 11:18 AM, showed Staff I took another tray from the meal cart, walked down the hallway to room [ROOM NUMBER] and placed the meal tray on the bedside table with a cup of peaches uncovered. Joint observation of room [ROOM NUMBER]'s meal tray showed that a cup of peaches was uncovered. When asked if the cups of dessert came covered, Staff I stated, sometimes it does. In an interview with Staff K and Staff T, Registered Dietician, on 12/17/2024 at 2:33 PM, Staff K stated that they expected food to be covered. Staff K stated that staff were supposed to deliver meal trays room to room. Staff T stated that if staff were to deliver meal trays down the hallway, walking a distance, the food on the meal tray should be covered. In an interview on 12/18/2024 at 3:23 PM, Staff A stated that generally food items on the meal tray were covered in the kitchen, delivered to the resident, and set down before anything was removed. 46912 Observation on 12/13/2024 at 11:30 AM, showed an unidentified staff carrying uncovered salad and grapes down the hallway to room [ROOM NUMBER]. Observation on 12/13/2024 at 11:32 AM, showed Staff V, CNA, carrying an uncovered fruit cup down the hallway to room [ROOM NUMBER]. In an interview and joint observation on 12/13/2024 at 11:35 AM, Staff V stated that all food should be covered while being carried down the hallway. A joint observation of the meal tray in room [ROOM NUMBER] showed the fruit cup was uncovered. Staff V stated that usually these are covered and these were not covered. On 12/18/2024 at 12:49 PM, Staff K stated they expected staff to deliver trays room to room and when walking trays down the hall, food should be covered. On 12/18/2024 at 1:48 PM, Staff A stated that generally, they [food items] are covered until set down by the resident. Staff A further stated that staff, generally take [meal trays] from room to room and wouldn't [would not] expect [food items] uncovered down the hall. Reference: (WAC) 388-97-1100 (3)

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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. 47680 Based on interview and record review, the facility failed to ensure clinical records were accurate for 1 of 3 residents (Resident 32), reviewed for resident medical records. This failure placed the resident at risk for unmet care needs and medical complications. Findings included . Review of the facility's policy titled, Charting and Documentation, revised in July 2017, showed, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of the facility's policy titled, Charting Errors and/or Omissions, revised in December 2006, showed, Accurate medical records shall be maintained by this facility. INACCURATE DISCHARGE/TRANSFER NOTICE Review of Resident 32's Nursing Home Transfer or Discharge Notice form dated 03/11/2024 and 10/22/2024, showed that it was provided to their daughter. In an interview on 12/16/2024 at 3:08 PM, Resident 32's financial power of attorney stated that Resident 32 did not have any children. In an interview on 12/16/2024 at 3:15 PM, Staff B, Director of Nursing, stated that the Nursing Home Transfer or Discharge Notice form were given to the resident, family member or power of attorney. Staff B stated that if the notices were for Resident 32, the notices would be given to [them]. Joint record review of the Resident 32's Nursing Home Transfer or Discharge Notice form dated 03/11/2024, showed that it was presented by Staff B and that it was provided to Resident 32's daughter. Staff B stated that they did not know the person notified on the form and that they must have had some other resident in mind. Staff B further stated that it was an error in documentation. INACCURATE DIAGNOSIS Review of Resident 32's admission record printed on 12/18/2024 showed diagnoses that included paranoid schizophrenia (subtype of schizophrenia [serious mental health condition that affects how people think, feel and behave] characterized by persistent paranoid delusions, where individuals hold fixed, false beliefs not grounded in reality) with an onset date of 03/18/2024. Review of the Quarterly Minimum Data Set (an assessment tool) dated 11/08/2024, showed schizophrenia was marked for Resident 32 on Section I (Active Diagnosis). Review of Resident 32's Electronic Health Record (EHR-progress notes, physician notes, hospital notes, and psychiatry notes) did not show a diagnosis of paranoid schizophrenia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Joint record review of Resident 32's diagnosis tab in the EHR and interview on 12/18/2024 at 12:02 PM with Staff S, Social Services, showed a diagnosis of paranoid schizophrenia. Staff S stated that they see a diagnosis of paranoid schizophrenia. Staff S stated that they knew Resident 32 had bipolar disorder (serious mental illness characterized by extreme mood swings) and would have to follow up. In a follow-up interview at 12:24 PM, Staff S stated that the diagnosis of paranoid schizophrenia was inaccurate, and that Resident 32 had an active diagnosis of bipolar disorder. In an interview on 12/19/2024 at 10:24 AM, Staff B, Director of Nursing, stated that they expected medical records to be completed and documented accurately. Staff B stated that they expected Resident 32's Transfer or Discharge Notice forms to be accurate. Staff B further stated that Resident 32's diagnosis of paranoid schizophrenia was inaccurate and that the diagnosis should have been bipolar disorder. 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. 46912 Based on observation, interview, and record review, the facility failed to ensure Contact Precautions (measures put in place to prevent spread of infection by direct or indirect contact with the resident or environment by staff wearing gown and gloves before entering a resident's room or environment) practices were followed for 1 of 1 resident (Resident 35), reviewed for infection control. In addition, the facility failed to appropriately use Personal Protective Equipment (PPE -use of gown and gloves) and perform hand hygiene in the laundry room for 1 of 1 staff (Staff X), reviewed for infection control. These failures placed the residents, staff, and visitors at an increased risk for infection and related complications. Findings included . Review of the facility's policy titled, Transmission Based Precautions, revised in October 2022, showed that Contact Precautions are intended to prevent transmission of infectious agents .that are spread by direct or indirect contact with the resident or the resident's environment. It showed, Donning [putting on] PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens [agents that causes disease]. It further showed that All linen should be handled as if it were highly infectious. Review of the facility's policy titled, Hand Hygiene, revised on 02/21/2022, showed, Use an alcohol-based hand rub .or, alternatively, soap .and water after removing gloves. CONTACT PRECAUTIONS Review of the facility's document titled, Order Summary Report, printed on 12/12/2024, showed that Resident 35 had an active order for Contact Isolation for a dx [diagnosis] of MRSA [Methicillin-resistant Staphylococcus aureus- an infection caused by a type of bacteria that has become resistant to some antibiotics] right hip .for 14 days, with a start date of 12/09/2024 and end date of 12/23/2024. Observation on 12/12/2024 at 11:28 AM, showed Staff W, Activities Assistant, took a meal tray to Resident 35's room. Staff W entered Resident 35's room without putting on a gown or gloves. In an interview and joint observation on 12/12/2024 at 11:35 AM, Staff W stated that if a resident was on contact precautions, we should wear proper PPE. A joint observation of the Contact Precautions signage outside Resident 35's room showed to wear a gown and gloves when entering the room. Staff W stated that I didn't [did not] wear a gown and gloves when going into Resident 35's room. On 12/16/2024 at 2:04 PM, Staff U, Infection Preventionist, stated that they expected staff to wear a gown and gloves when entering the room of a resident who was on contact precautions, including when delivering meal trays to residents. On 12/18/2024 at 11:27 AM, Staff B, Director of Nursing, stated that they expected staff to follow what the sign says, what PPE they need to use before entering the room if a resident was on contact precautions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PPE USE/HAND HYGIENE Observation and interview on 12/18/2024 at 8:35 AM, showed Staff X, Housekeeping Staff, sorting soiled laundry while wearing a mask, gloves, and a gown that was not tied in the back. It showed the gown falling off Staff X, and Staff X was touching their clothing with their soiled gloves when trying to readjust their gown. Staff X stated that yes the gown was coming off because it was not tied in the back and that the gloves they were using were dirty. Staff X left the laundry sorting room, took off their PPE, including their gloves and did not perform hand hygiene. Staff X then went to the clean area of the laundry room and started touching clean linens. Staff X stated that they did not perform hand hygiene after removing their gloves. In an interview on 12/18/2024 at 10:14 AM, Staff D, Infection Preventionist, stated that staff should perform hand hygiene after removing gloves. Staff D further stated that staff should tie their gowns, so don't [do not] come off during care. In an interview on 12/18/2024 at 11:27 AM, Staff B stated they expected staff to perform hand hygiene right after [they] remove gloves. Staff B further stated that when staff used PPE, that their gowns should be tied. Reference: (WAC) 388-97-1320 (1)(a)(c)