STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505263	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	1050 E Mountain View Ellensburg, WA 98926

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review the facility failed to ensure residents were bathed, free from odors and provided a dignified dining experience for 5 of 5 sampled residents (Residents 13, 14, 25, 27, and 7) reviewed for dignity. These failures placed residents at risk for feelings of embarrassment, helplessness, and a diminished self-worth. Findings included . <Resident 13> Review of the medical record showed the resident was alert, oriented, and able to make their needs known. The10/18/2024 comprehensive assessment showed the resident required assistance with transfers with a mechanical lift, turning in bed, nail care and bathing. Diagnoses included cancer of the prostate (gland at the base of the urethra (tube that urine exits the body), stroke with left sided paralysis, and urinary catheter use due to urinary retention. Resident 13 was incontinent of bowels. During a concurrent observation and interview on 01/06/2025 at 10:39 AM, Resident 13's fingernails were long and could be seen over their fingers. There was a brown dark substance under their fingernails. The resident was observed still eating their breakfast which included sausage and toast with their hands. Resident 13 stated it was a while since they had a bed bath and they scratched their skin and head a lot. Resident 13's room smelled of old urine musty (unclean stale smell) near the resident and their bed. During an interview on 01/06/2025 at 10:45 AM, Staff Y, Registered Nurse (RN), who entered Resident 13 room/bedside, stated the resident's nails are horrible and need to be cleaned. Additionally, Resident 13 stated they go to a bed bath every two weeks, and it was embarrassing not to be clean especially when my family visits. Review of the East Hall Shower List for January 2025 showed Resident 13's last bed bath was 12/31/2024. The documentation for 01/03/2025 showed a refusal by the date but no documentation of refusal to the licensed nurse or a reapproach for another time for a bed bath. Review of Resident 13's 10/11/2024 care plan showed the resident was to have a shower on Tuesdays and Thursday's evenings. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2025 on 11:15 AM, Staff D, RN, stated Resident 13 refusals of baths were not documented by the staff. The last documented bath for Resident 13 was 12/28/2024. <Resident 14> Review of the medical record showed the resident was able to make their needs known. The 12/14/2024 quarterly assessment showed the resident was dependent on staff for transfers, bathing and required assistance from licensed nurses for nail care. Diagnosis includes diabetes (insufficient production of insulin causes increase in blood sugar). During an observation and concurrent interview on 01/06/2025 at 2:40 PM, Resident 14 stated they had not had a shower for over a week and their fingernails were split. Observations of Resident 14's fingernails showed all fingernails were over an inch long from the tip of the resident's fingers with a brown substance under the nails, and the left thumb nail was split down the middle. Resident 14's toenails were long one and a half inch above the tips of their toes. Additionally, Resident 14's hair was greasy and unkempt. Resident 14 stated they felt unclean and embarrassed to get out of bed into the public looking unclean. Review of the East Hall Shower List for December 2024 showed Resident 14's last shower was 12/28/2024. Review of the Medication Administration record for December 2024 and beginning of January 2025 showed no documentation for Resident 13's nail care. <Resident 25> Review of the medical record showed the resident had diagnoses of high blood pressure, chronic pain and skin wounds. The 12/14/2024 quarterly assessment showed Resident 27 was alert and able to make their needs known and was dependent on staff for all cares and transfers. Additionally, Resident 25 was on oxygen and had skin issues on their legs and buttock and was incontinent of bowel. During an interview on 01/08/2025 at 9:45 AM, Resident 25 stated they had not had a bath for some time and felt unclean and preferred not to get out of bed. Resident 13 stated they had pneumonia (infection of the lungs) in November 2024, and they were slowly recovering. The resident's hair was unkempt and stated they just felt unclean and was not motivated to get out of bed. Review of the East Hall Shower List for January 2025 showed the resident ' s last bath was 12/13/2024 with a refusal on 01/02/2025. During an interview on 01/08/2025 at 2:00 PM, Resident 25 stated they may have refused a bath that day, but at least if they had a basin of water and a washcloth that would have helped them feel better. Resident 25 stated it's just that the facility doesn't did not have enough staff and it's it was embarrassing to try and get up to go to the dining room not being presentable. <Resident 27> (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 27 was alert and oriented and able to make their needs known. The11/29/2024 assessment showed the resident was dependent on staff for transfers, toileting, transfers, bathing with setup assistant with meals. Staff used a mechanical lift for Resident 27's transfers to their electric wheelchair in which they could operate the controls for their mobility. Diagnosis included quadriplegia (paralysis that affects the body from the neck down and produces lack of control to parts of the body) due to a spinal cord injury. During an observation and interview on 01/06/2025 at 9:10 AM, Resident 27's (shared with Resident 13) room smelled musky with a pungent (smelling a very strong odor) urine smell. Resident 27 stated they knew that the room smelled, and they could not smell it until they get out of the room for a while and returned to their room. Resident 27 stated it smelled like an [NAME]. Additionally, during an observation Resident 27's hair was greasy (oily substance) and clothing was soiled. Resident 27 stated they had not had a bath in a while and would like a bath. Resident 27 stated they liked to be around people and attended activities and did not want to smell bad around them. Review of the East Hall Shower List for December 2024 and January 2025 showed Resident 27's last shower was 12/10/2024 and the resident refused a shower on 01/03/2025. During the interview on 01/06/2025 at 10:00 AM, Resident 27 stated they were not offered a bath or they would have taken it. It's embarrassing to not have a bath. During observations on 01/06/2025 at 9:10 AM, 01/07/2025 at 8:13 AM, 01/08/2025 at 1:00 PM, 01/09/2025 at 10:00 AM and 01/10/2025 at 2:00 PM. Resident 27's (shared with Resident 13) room continued to smell like urine. During an interview on 01/08/2025 at 11:20 AM, Staff D, Resident Care Manager (RCM) stated the Nursing Assistants (NA) assigned to the resident are to bath them on their scheduled days/evening, but it did not get completed. Staff D stated they try to schedule an extra NA on the floor but it's not consistent. The LNs are to trim diabetic fingernails and toenails but that is not done. It would be embarrassing to not be clean and not dressed in appropriate clothing that was not clean. That would be a dignity issue for the residents. <Resident 7> Review of Resident 7's medical record showed they were admitted with diagnoses including history of a stroke (blood flow to the brain is disrupted) with right hemiplegia (paralysis to one side of the body because of a stroke), and dementia. Review of the comprehensive assessment dated [DATE] showed Resident 7 was severely cognitively impaired and was dependent on staff for daily care activities including, dressing, grooming, hygiene and toileting. However, the resident was able to feed themselves after their meal tray was set up for them. Review of Resident 7's care plan (a detailed document that outlines a resident's specific needs) dated 12/17/2024 showed the resident used their left hand to eat and could independently feed themselves with the use of a built-up handled spoon (designed to be used by residents with limited hand mobility) and a plate with built up edges. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 01/06/2025 at 11:54 AM, showed Resident 7 feeding themselves their lunch. The resident was observed not using their spoon and putting their whole left hand in their food and licking the food off their fingers. The adaptive spoon was on the table next to them on their left dominant side. Continued observation of the resident until 12:20 PM showed Resident 7 ate their lunch without using their spoon and licking the food off their left hand. Staff did not assist the resident with handing them their spoon or provide verbal cues to assist them to use their spoon to eat. During an interview on 01/06/2025 at 12:20 PM, Staff O, NA who was assigned to oversee the meal service in the [NAME] Dining Room stated that Resident 7 usually ate by licking the food of their hand. Staff O further stated that was the normal way the resident ate therefore they did not re-direct them or assist them with their adaptive spoon. During an observation and interview on 01/06/2025 at 12:24 PM Staff Z, Licensed Practical Nurse (LPN) came into the dining room and placed Resident 7's desert bowl in front of them. Staff Z handed Resident 7 their spoon and they began eating without any noted difficulty, and no longer using their hand. Staff Z stated when Resident 7 was observed using only their hand to eat they handed them their spoon and reminded them to use it which easily re-directed them from only using their hand. <Dining Room> During an observation on 01/06/2025 at 12:28 PM, Staff O, NA began removing tablecloths from tables in the [NAME] Dining Room while Resident 7 was still eating their lunch. Resident 7 was sitting at a long table that consisted of two smaller tables pushed together. Staff O approached Resident 7 and removed the tablecloth from the adjacent table. Resident 7 stopped eating for a few seconds and looked around to see what was happening. Staff O continued to remove tablecloths from the empty tables and then got a broom and dustpan and started sweeping under Resident 7's table as they were finishing their dessert. During an interview on 01/06/2025 at 12:40 PM, Staff O stated they were cleaning up the dining room to get ready for an activity that started at 1:00 PM. During an observation on 01/06/2025 at 8:43 AM, Staff HH, l Restorative Aide was observed removing tablecloths from empty tables in the [NAME] Dining Room while Resident 7 and Resident 36 were still eating. Resident 36 stated I'm not done eating yet. During an interview on 01/09/2025 at 8:56 AM Staff C, Assistant Director of Nursing, stated they expected staff to create a homelike and dignified environment for the residents in the dining rooms. Further stating removing tablecloths and cleaning needed to wait until all the residents were done as it was not dignified to clean while residents were still eating. Reference WAC 388-97--0180(1-4) 39652

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44922 Based on interview and record review, the facility failed to ensure a prompt effort to resolve grievances (a concern that has happened or been done that you believed was unfair) was made regarding resident grievances discussed during Resident Council (RC, an independent group of nursing home residents who meet at a minimum of once a month to discuss concerns and suggestions and to plan activities that are important to them) meetings nor the residents right to file a grievance/grievance process for 4 of 5 residents (Residents 6, 12, 13, and 14) reviewed for grievances. This failed practice placed residents at risk for unmet care needs. Findings included . Review of a policy titled, Grievance, dated 03/2019, showed the Activities Director (AD) should have completed a grievance if a concern was brought up during the RC meeting. The policy showed the Social Services Director (SSD) would then review/log the concerns and forward the concerns to the department heads who would complete them with appropriate actions and follow-up. Then, the grievance would be returned to the SSD who would notify the resident/residents of the outcome to ensure the outcome was satisfactory to the resident. During an interview a RC meeting conducted by the state agency on 01/08/2025 at 10:33 AM, Residents 6, 12, 13, and 14 expressed concerns about how their call lights were not being answered timely and when the Nursing Assistants (NA) answered the call lights, they would only ask the resident that was closest to the door what they needed and left, even though they were not the resident that required assistance or turned the call light on. Resident 6 stated the residents met with the Dietary Manager at their facility RC meeting in December 2024 and voiced concerns about the food not being delivered hot. Resident 6 stated the food came out hot for about a week but then went back to being cold. Residents 12, 13, and 14 all agreed with Resident 6. Residents 6, 12, 13, and 14 stated they had no follow-up regarding their concerns brought up during their facility RC meetings and were not aware of what that process looked like. The residents stated they were not aware they were to receive follow-up with their concerns or that they could have completed a grievance anonymously. Additionally, Residents 6, 12, 13, and 14 stated they always needed to ask the staff for a grievance form and did not know they could have gotten one from a box located by the SSD ' s office or that they could tell staff verbally and they could have completed a grievance for them. Review of the 12/19/2024 RC meeting notes showed the residents voiced concerns about NAs only checking on the first resident in the room, by the door, and not ensuring that any of the other residents in the room needed assistance. The notes showed that the residents stated the NAs needed to slow down and ensure the resident ' s needs were met before leaving the room so quickly. The notes further showed that call lights were not being placed within reach of the residents. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2025 at 10:55 AM, Staff AA, AD, stated they attended the RC meetings and when the resident ' s voiced concerns, they would be written up on a grievance form and given to the SSD. Staff AA stated they did not know what happened to the grievances once they were given to the SSD. Staff AA stated they did not provide any education or reminders of the grievance process to the residents or during RC meetings. Staff AA stated they had forwarded a grievance of the 12/19/2024 RC voiced concerns to the SSD. During an interview on 01/08/2025 at 3:36 PM, Staff E, SSD, stated the AD would write up a grievance for any concerns voiced during the RC meetings and give them to Staff E. Then, Staff E would review them and forward them to the correct department manager. Staff E stated the department manager would then initiate appropriate actions and when resolved would return the grievance to the SSD. Staff E reviewed their grievance book and their log and verified they had not received or logged a grievance for concerns voiced from the RC meeting in December 2024. During a follow-up interview on 01/08/2025 at 3:55 PM, Staff AA stated they had completed grievances forms regarding resident concerns voiced in the RC meeting in December 2024 and placed them into the SSD ' s box. Staff AA stated they could not provide a copy of the grievance they completed, nor had they kept copies of the grievances for RC but needed to change their process. Reference WAC: 388-97-0460

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review the facility failed to comprehensively assess and monitor the need for a physical restraint (any physical, mechanical device or equipment that limits a resident ' s freedom of movement) when a seat belt was applied during the resident use of their electric wheelchair, for 1 of 2 residents (Resident 17) reviewed for physical restraints. This failure placed the resident at risk for a restriction of their free movement and/or activity and at an increased risk for injury when in their electric wheelchair. Findings included . Review of the facility policy titled, Physical Restraints and Enablers/Devices, revised July 2023, showed that residents had the right to be free of physical restraints (any manual method or physical or mechanical device/equipment attached to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body) .imposed for purposes of discipline or staff convenience, and not required to treat the resident ' s medical symptoms . The policy showed that if a resident was to utilize a device that had the potential to act as a physical restraint, a .Bed Rail/Bed Enabler/Device Evaluation . would be completed to evaluate if the device would be considered a restraint or an enabler (devices/equipment voluntarily used by a resident following appropriate assessments which limit the residents normal freedom of movement, with the intent of promoting independence, comfort or safety). Additionally, the policy showed that a seat belt was an example of devices that may be considered as a physical restraint. <Resident 17> Review of the resident ' s medical records showed they were admitted to the facility on [DATE] with diagnoses including a heart complication, left knee replacement, and osteoarthritis (inflammation of joints in the body) of the hips and shoulder. The 12/01/2024 comprehensive assessment showed Resident 17 had a moderately impaired cognition, was able to make their needs known, had mobility impairments to their upper body on both sides and no physical restraints (any manual method or physical or mechanical device/equipment attached to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body). During a concurrent observation and interview on 01/06/2025 at 9:47 AM, Resident 17 was settled in the dining room in their wheelchair. The resident had a black seat belt, that released via push button, around their waist. When asked if Resident 17 could show how they released the seat belt, they stated yes but then was unable to do so. During an interview on 01/07/2025 at 4:11 PM, Staff M, Nursing Assistant (NA), stated that Resident 17 was unable to unbuckle their wheelchair seat belt by themself and that staff had to buckle and unbuckle the seat belt for the resident when getting in/out of the wheelchair. Record review of Resident 17 bed rail/bed enabler/device evaluations dated 12/10/2021 and 12/20/2024, showed that bed rails were evaluated as enabler on both dates (no evaluation of a wheelchair seat belt was noted in the resident ' s medical record). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 01/08/2025 at 8:41 AM, showed Resident 17 again eating in the dining room sitting in their wheelchair. The resident was observed leaning far down on their left side on top of the wheelchair's left side arm rest, pulling tight on the residents buckled seat belt. During an interview on 01/08/2025 at 8:49 AM, Staff N, NA, stated that Resident 17 had been leaning to their left side more frequently and not able to hold themself upright in the wheelchair for long period of time. Staff N stated the seat belt was on so that the resident did not slide out of the wheelchair. Staff N stated the resident was unable to unbuckle the wheelchair seat belt by themselves. During an interview on 01/08/2025 at 12:17 PM, Staff D, Resident Case Manager, stated that Resident 17 ' s wheelchair seat belt had the potential to be considered as a physical restraint, and the resident should have had an evaluation completed to show that it was not. Staff D stated, as far as I know (Resident 17) can unbuckle themself, and the seat belt was not being used for the resident ' s safety. During an interview on 01/09/2025 at 10:20 AM, Staff C, Assistant Director of Nursing Services, stated that Resident 17 ' s wheelchair seat belt was a potential physical restraint, and the resident would need to be able to unbuckle the seat belt themselves. Staff C stated that Resident 17 was not able to unbuckle the wheelchair seat belt by themselves, and the required process was not followed regarding an assessment of the device to show that it was not a physical restraint. During an interview on 01/13/2025 at 3:10 PM, Staff A, Administrator and Staff B, Director of Nursing Services, both stated the correct process for assessing the need for a physical seat belt restraint was not followed for Resident 17. Reference: WAC 388-97-0620(1)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review the facility failed to ensure implementation of their abuse prohibition policy/procedures components of resident protection, identification, reporting and investigating for 4 of 4 residents (Resident 41, 28, 42, and 27) reviewed for abuse/neglect. This failure placed the residents at an increased risk for unidentified abuse/neglect, retaliation from the alleged perpetrator and the potential for continued exposure to abuse and/or neglect. Findings included . Review of the State Operations Manual, Appendix PP, dated 08/08/2024, the Code of Federal Regulations 483.12 (b)(1), F607, the facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of residents property, and in order to .provide protections for the health, welfare and rights of each resident residing in the facility . the facility must develop and implement components of screening, training, prevention, identification, investigation, protection and reporting/response. Review of the facility's policy titled, Abuse-Screening, Training, Identification, Investigation, Reporting, and Protection, dated 08/01/2024, showed the eight components included .Identify types of abuse .Investigate allegations of abuse .Report allegations of abuse to appropriate reporting authority .Protect our resident from abuse . Additionally, the policy showed that all resident allegation of abuse would be thoroughly investigated/reported, and that staff involved in the allegation of abuse would be immediately removed from the center until a thorough investigation can be completed. <Resident 41> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including multiple heart complications and a spinal infection. The 10/20/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Record review of a grievance (a compliant over something believed to be wrong or unfair)/concern form, dated 11/08/2024, showed, Procedure: If problem reported is potential abuse or neglect immediately notify Administrator, Director of Nursing Services (DNS), or Licensed Nurse . The form showed Resident 41 stated Staff F, Licensed Practical Nurse (LPN), had come into their room around 5:45 AM, yelled to wake them, demanded the resident's cigarettes/lighter and .Later on when the resident confronted (Staff F) to ask (Staff F) to not speak or yell at (Resident 41) so rudely the nurse started to yell at (Resident 41) again. The record showed that on 12/04/2024 Resident 41 was interviewed (26 days after the grievance was submitted). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2025 at 8:22 AM, Resident 41 stated that Staff F came in during the early morning yelling and grabbed the resident ' s hand shaking them awake and demanded it (the residents smoking supplies). The resident stated they were at first hesitant to give Staff F their smoking supplies but since (Staff F) was not backing off (Staff F kept yelling/demanding and then threatened to search the resident ' s room), Resident 41 gave up their smoking materials. Resident 41 stated they had confronted Staff F later that day and was yelled at again, (Staff F) was a b***h .not nice at all. Resident 41 stated they did not remember seeing Staff F after they had reported the grievance. Review of Resident 41's progress noted for 11/28/2024, 12/18/2024 and 12/20/2024 showed that Staff F was working with Resident 41 after the allegations were made. Review of the November 2024 incident/investigation log showed there was no documentation that an investigation had been conducted into Resident 41's allegations of abuse from Staff F. During an interview on 01/09/2025 at 11:27 AM, Staff E, Social Service Director (SSD), stated that a staff member being rude/yelling at a resident could potentially be verbal abuse and would need to be reported/investigated. Additionally, Staff E stated the staff member would need to be taken off their shift to protect the resident until a thorough investigation was completed. Review of the 11/08/2024 grievance from Resident 41showed Staff E stated that it was an allegation of verbal abuse from Resident 41 against Staff F and that it should have been reported/investigated. Staff E stated they came across Resident 41's grievance form on 12/04/2024 and informed Staff B, DNS, that same day. Staff E stated they did not take Staff F off shift in order to protect Resident 41 and informed the DNS. During an interview on 01/09/2025 at 1:52 PM, Staff B stated that Resident 41 was very alert and oriented and able to recall events. When reviewing Resident 41's grievance from 11/08/2024, Staff B stated they had not recognized it as an allegation of abuse, completed/documented the grievance interviews on 12/05/2024 with Resident 41 stating .no issues with any of the staff . in addition to Staff F's interview as .noted excitable concerns related to finding lighters on personal belongings. Educated related to professionalism, and Staff F was not taken off shift while an investigation was conducted. Staff B stated when reading the grievance again that it was an allegation of verbal abuse from Resident 41, it should have been reported/investigated, and Staff F should have been removed from working with residents until a thorough investigation was completed. During an interview on 01/09/2025 at 2:12 PM, Staff A, Administrator, stated the correct process was not followed, the allegation of abuse needed to be reported, a thorough investigation should have been completed and Resident 41 should have been protected from Staff F by the staff member being taken off the working schedule. <Resident 28> Review of the resident's medical record showed the resident admitted with diagnoses to include a wound to their right lower leg and chronic pain. The 10/09/2024 comprehensive assessment showed Resident 28's cognition was intact and was dependent on one to two staff for bed mobility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/2025 at 12:08 PM, Resident 28 stated they had an incident shortly after they admitted to the facility. Resident 28 stated they were provided care by a nursing assistant (NA) (identified as Staff BB) and a licensed nurse (LN) (identified as Staff Y, RN). The LN was extremely rough with them when they shoved on my left hip when rolling them to their side. Resident 28 stated they yelled out for the LN to stop a few times, and they finally stopped, and Resident 28 told the LN to leave them alone. At that time, the LN grabbed the NA and they both left the room. Resident 28 stated they reported this incident to Staff C, Assistant Director of Nursing Services, who removed the LN from the care of Resident 28. Resident 28 stated due to the continued pain to their left hip, they needed to have a diagnostic image completed to ensure there were no injuries. Review of the incident logs from September 2024 through 01/09/2025, showed no incidents were reported or logged for Resident 28. Review of the grievance logs from September 2024 through 01/09/2025, showed no incidents were reported or logged for Resident 28. During an interview on 01/08/2025 at 1:57 PM, Staff BB stated they recalled an incident involving Resident 28 and Staff Y a few months back. Staff BB stated Resident 28 required two people to roll them from side to side, and all other staff were busy, so Staff Y went to help Staff BB. Staff BB stated their normal process was to let Resident 28 direct them step by step how to care for them because they had pain. Staff BB stated Staff Y was busy and, in a hurry, so just started rolling the resident to their side, fast, and grabbed Resident 28's left leg the wrong way and it hurt the resident. Staff BB stated Resident 28 yelled out and yelled for Staff Y to stop a few times, which they did, and then Resident 28 asked to be left alone, so both Staff BB and Staff Y left the room. Staff BB stated they reported the incident but could not recall if they reported it to another nurse or the Administration. <Resident 42> Review of the resident's medical records showed the resident admitted with diagnoses of a left hip replacement. The 10/09/2024 comprehensive assessment showed Resident 42's cognition was intact and was dependent on two staff for bed mobility and toileting hygiene. Review of a 09/03/2024 grievance form showed Staff CC, NA, entered Resident 42's room and told them it was time to get changed. The form showed that Resident 42 told Staff CC no, but that Staff CC told Resident 42 they had to and tried to make [Resident 42] anyway. The form showed the actions taken for this grievance were that Staff CC would be removed from the facility staffing list and not allowed to work in the facility. The form additionally showed the form had not been signed as completed until 11/22/2024. During an interview on 01/09/2025 at 8:30 AM, Resident 42 stated they did not recall the specific NA's name but did not like it when there were not regulars [new NAs] that came in to provide them care, because they did not know how to provide them care specific to them. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2025 at 8:59 AM, Staff J, NA, stated they were present during the incident on 09/03/2024. Staff J stated Staff CC was a new NA to the resident and when they entered the room, Staff CC was adamant about Resident 42 receiving incontinence care. Staff J stated when Resident 42 refused to receive the care, Staff CC should have left it alone and tried to re-approach later or have someone else try, but they did not, and it made Resident 42 angry. Review of the NA's staffing schedule from September 2024 through November 2024, Staff CC worked 17 additional shifts, with the last shift ending on 11/28/2024. Review of the Incident logs from September 2024 through November 2024, showed no incident had been reported or logged. During an interview on 01/09/2025 at 10:33 AM, Staff E stated they were not aware of Resident 42's incident regarding Staff CC on 09/23/2024. Staff CC stated when they started working at the facility there were several grievances incomplete and forwarded them to Staff C and Staff A to complete and return. Staff E stated the incident on 09/23/2024 should have been elevated to an investigation and the staff member should have been removed from direct patient care pending the outcome of the investigation. During an interview on 01/09/2025 at 10:55 AM, Staff B stated they were not aware of Resident 28's incident regarding rough handling nor Resident 42's incident regarding refusal of care. Staff B stated they would have removed Staff Y and Staff CC from direct patient care and started investigations to rule out abuse or neglect, had they known. <Resident 27> Review of the medical record showed Resident 27 was alert and oriented and able to make their needs known. During an interview on 01/06/2025 at 9:00 AM, Resident 27 stated they had an issue with a staff member a few months back in 2024. They could not recall the staff name but stated it was a NA. Resident 27 stated they called them gay for having their nails painted with black nail polish. Review of the grievance log showed that a concern was made by Resident 27 to the previous SSD on 08/22/2024. The grievance was that an NA was teasing Resident 27 about their black fingernail polish and called them gay. Resident 27 was hurt by the statement by the NA. The 08/22/2024 grievance showed the SSD, and the DNS spoke to the unidentified NA in question who stated Resident 27, and they had a playful relationship and was only joking. The resident stated that they did not want the NA to work with them anymore. According to the grievance report the previous Administrator spoke with the unidentified NA on 08/28/2024 and asked them to apologize to the resident. A few days later Resident 27 was asked if they would be willing to accept an apology from the unnamed NA and Resident 27 declined. The SSD documented the resident was stable and active throughout the building. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/07/2025 at 3:09 PM, Staff C stated that the incident needed to be called in to the state, the unidentified NA would have needed to be removed from caring for residents pending a thorough investigation and abuse should have been ruled out per investigation. Staff C stated that the allegation should have been an incident report and investigation. Staff C stated the 08/22/2024 was reportable to the state agency but was not done. Staff C stated they would investigate the resident's concern since it was not investigated. During an interview on 01/09/25 at 8:49 AM, Staff C stated they were unable to identify the NA involved or an investigation to determine if the NA was still working at the facility. Reference WAC 388-97--0640(2)(a) 44922 31168

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to provide a written notice of transfer/discharge to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a person that advocates for residents in nursing homes) for 1 of 2 residents (Residents 60) reviewed for transfer/discharge notice requirements. This failure placed the residents at risk for diminished protection from inappropriate transfers/discharges, a lack of access to an advocate that could inform them of their options/rights, and to ensure the resident advocacy agency was aware of the facility practices and activities related to a transfer or discharge. Findings included . <Resident 60> Review of the resident ' s medical records showed they were admitted to the facility on [DATE] with diagnoses including heart complications and Parkinson ' s (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves, causing shaking movements) and was transferred to the hospital on 10/09/2024. The 10/09/2024 comprehensive assessment showed Resident 60 had a moderately impaired cognition. Review of progress notes for Resident 60 on 10/09/2024 showed Staff D, Resident Case Manager, documented that Resident 60 had a change in their baseline status and they were going to be emergently transferred to the local hospital. During an interview on 01/10/2025 at 10:43 AM, Staff E, Social Service Director (SSD), stated they had started working at the facility mid-November 2024 and was not aware of the requirement to provide a written notice of transfer/discharge to the LTC Ombudsman. Staff E stated they did not have a process in place to notify the Ombudsman of resident transfers/discharges and that it was not being completed. During an interview on 01/13/2025 at 3:10 PM, Staff A, Administrator and Staff B, Director of Nursing Services, stated the notification of a resident ' s transfer/discharge to the LTC Ombudsman was supposed to be completed by the SSD. Both Staff A and Staff B stated the correct process was not being followed, and a written notice should have been provided to the LTC Ombudsman regarding Resident 60 ' s transfer to the hospital. Reference: WAC 388-97 -0120(2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of the resident ' s hospital transfer for 1 of 2 residents (Residents 60) reviewed for hospital transfers. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold while in the hospital. Findings included . <Resident 60> Review of the resident ' s medical records showed they were admitted to the facility on [DATE] with diagnoses including heart complications and Parkinson ' s (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves, causing shaking movements) and was transferred to the hospital on 10/09/2024. The 10/09/2024 comprehensive assessment showed Resident 60 had a moderately impaired cognition. Review of the medical record showed a 10/09/2024 progress note documented by Staff D, Resident Case Manager, that Resident 60 had a change in their status and they were going to be emergently transferred to the local hospital (no documentation of the written notice for bed hold to Resident 60 or the resident ' s representative). During an interview on 01/10/2025 at 10:30 AM, Staff D stated the process was for staff to update the resident and/or the resident representative (RR) during a phone conversation and then document the conversation in the resident ' s medical records in a progress note or in an evaluation form. After reviewing Resident 60 ' s medical records, Staff D stated the notice of bed hold was not completed with the RR at the time of the resident transfer to the hospital. During an interview on 01/13/2025 at 3:10 PM, Staff B, Director of Nursing Services, stated the notification of bed hold should have taken place with the RR for Resident 60 during the phone call and if not in the resident medical record, then it was not completed. Reference: WAC 388-97-0120(4)

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on 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 completed or correct on/after residents admission to the facility and had the required level two referral sent if residents had a positive level one PASARR for 4 of 7 residents (Resident 9, 263, 56, 4) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR) Level 1 Screening Process, dated 07/06/2024, showed that nursing facilities will ensure residents with a positive level 1 PASARR screen have been evaluated by the designated state-authority through the level 2 PASARR process and approved for admission prior to admitting to the nursing facility. Review of the facility's undated policy, titled, PASRR (Pre-Admission Screening and Resident Review [same as PASARR]), showed every resident was to be screened through PASRR and It is the facilities responsibility to ensure the level 1 PASRR is completed and accurate prior to admission. <Resident 9> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including bipolar disorder (a mental disorder illness that causes extreme mood swings) and anxiety. The 10/19/2024 comprehensive assessment showed the resident had a severely impaired cognition, but able to make their needs known. Record review of Resident 9's level 1 PASARR forms showed two for had been completed for the resident, the first on 04/17/2024 and the second on 04/30/2024. Neither of the level 1 PASARR forms completed were accurate with the resident's diagnosis of bipolar or anxiety. During an interview on 01/09/2024 at 12:02 PM, Staff E, Social Service Director (SSD), stated they were charged with reviewing resident PASARR's. When reviewed Resident 9's level 1 PASARR screening, Staff E stated that it had not been filled out correctly with the resident mental health diagnoses and should have been referred out for a PASARR level 2 evaluation. <Resident 263> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they admitted with diagnoses to include Post Traumatic Stress Disorder (a mental health condition caused by a traumatic event that affects your ability to function normally), bi-polar disorder (a mental health condition that causes extreme mood swings), and depression (a mood disorder that causes persistent feelings of sadness and loss of interest). The 01/02/2025 comprehensive assessment showed Resident 263's cognition was moderately impaired and experienced hallucinations (false perceptions of sensory experiences that seem real but are not) and delusions (a fixed, false conviction in something that is not real or shared by other people). Additional review of Resident 263's medical record showed no level 1 PASARR. The record showed a 12/13/2024 level 2 Invalidation Assessment [the resident did not require that a level 2 psychiatric evaluation or a follow-up were needed] had been completed in relation to a positive PASARR level 1 review due to their SMIs. The assessment showed Resident 263 did not have SMI for depressive disorders, bipolar disorders, or PTSD. <Resident 56> Review of the resident's medical record showed they admitted with diagnoses to include PTSD, Attention Deficit Hyperactivity Disorder (ADHD, a persistent pattern of inattention or hyperactivity), depression, pica (a mental health condition where a person compulsively swallows non-food items), and insomnia (inability to sleep normally). Review of an 11/22/2024 PASARR level 1 assessment form showed Resident 56 had PTSD listed as the SMI identified. The assessment showed the level 1 assessment was completed by the facility staff after admission, rather than prior to admission to determine if Skilled Nursing was the appropriate placement for Resident 56. Review of an 11/21/2024 level 2 Invalidation Assessment showed Resident 56 had depression and anxiety (an unpleasant state of inner turmoil and includes feelings of dread over anticipated events) as SMI diagnoses. During an interview on 01/08/2025 at 4:00 PM, Staff DD, Admissions, stated the process was to review the PASARR assessments prior to admission. Staff DD stated that did not happen with Resident 56 because the facility/hospital they admitted from had not sent it per their request. Staff DD stated they thought that having the level 2 Invalidation Assessments was enough to show the residents had SMI and they were evaluated. During an interview on 01/14/2025 at 9:31 AM, Staff E stated they completed the PASARR level 1 for Resident 56 because they did not receive one from the receiving facility. Staff E stated they had been in the process of trying to obtain a PASARR level 1 for Resident 263 for the same reason. Staff E stated the Admissions team and themselves would no longer accept the PASARR level 2 Invalidation Assessment as adequate and correct information without the level 1 present to review for accuracy, prior to admission. <Resident 4> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's medical record showed they were admitted to the facility with diagnoses including, history of heart transplant, diabetes (higher than normal blood sugar levels) and depression. Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and required moderate assistance (helper does less than half of the activity) for grooming, dressing, hygiene and toileting. Review of Resident 4's level 1 PASARR level 1 assessment dated [DATE] showed the resident had indicators for mood disorder (depression) which required a level 2 PASRR evaluation. Continued review of the record showed no level 2 PASARR had been requested or completed to ensure Resident 4 had appropriate mental health services available to them. Reference: WAC 388-97-1915(1)(2)(a-c) 44922 39652

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review the facility failed to develop a baseline care plan (BCP) within 48 hours of admission that included resident specific initial goals and treatment plans, nor provide a summary of the required information from the BCP upon completion of the comprehensive care plan to the resident or the resident ' s representative for 5 of 10 newly admitted residents (Residents 49, 62, 60, 263, and 48) reviewed for baseline care plans. This failure placed the residents at risk for a lack of knowledge regarding the initial plan for delivery of care/services and unmet care needs. Findings included . <Resident 49> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnosis including a stroke, anxiety, dementia (a progressive disease that destroys the memory and other important mental functions) and end of life care. The comprehensive assessment dated [DATE] showed the resident preferred language was Spanish, cognition was severely impaired and sometimes could make themselves understood/understand others. Additionally, the assessment showed the resident was unable to communicate their pain verbally but had positive non-verbal, vocal, facial expressions and protective body movement signs of pain with frequency .indicators of pain or possible pain observed daily. Review of Resident 49s medical records showed no BCP had been formulated. <Resident 62> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnosis including left leg fracture, aftercare following surgery and dementia. The comprehensive assessment dated [DATE] showed the resident had a severely impaired cognition. Review of Resident 62s medical records showed a 10/22/2024 BCP with no initial nursing or therapy goals completed. The records showed the resident nor the resident's representative had received a BCP summary with their initial goals, medications, dietary instructions, services/treatment that were to be administered by the facility nor the details of their BCP. <Resident 60> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including heart complications and Parkinson's (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves, causing shaking movements). The 10/09/2024 comprehensive assessment showed Resident 60 had a moderately impaired cognition. Review of Resident 60s medical records showed no BCP had been formulated. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/10/2025 at 10:30 AM, Staff D, Resident Case Manager, stated the process was for staff to review a resident baseline care plan to convey the facility objectives/goals regarding the resident care along with feedback/input from the resident and their representatives. Staff D stated that Resident 49, Resident 62 and Resident 60 did not have a baseline care plan completed, not sure what happened but they were missed. <Resident 263> Review of the resident ' s medical record showed the resident admitted on [DATE] with diagnoses to include a right wound infection, bi-polar disorder (a mental health condition that causes extreme mood swings), depression (a mood disorder that causes persistent feelings of sadness and loss of interest), and substance use disorder (a medical condition that is defined by the inability to control the use of a particular substance or substances despite harmful consequences). The 01/02/2025 showed Resident 263 ' s cognition was moderately impaired. Review of Resident 263 ' s medical record showed a BCP that had been started on 12/29/2024 and showed no initial nursing or rehab goals had been formulated and no current medications orders were reviewed. The BCP was also started on the 3rd day of admission rather than within 48 hours of admission. The record additionally showed the resident nor the resident's representative had received a BCP summary with their initial goals, medications, dietary instructions, services/treatment that were to be administered by the facility nor the details of their BCP upon completion of the comprehensive assessment. <Resident 48> Review of the resident ' s medical record showed the resident admitted on [DATE] with diagnoses to include dementia (a progressive disease that destroys the memory and other important mental functions) and urinary retention. The 11/20/2024 comprehensive assessment showed Resident 48 ' s cognition was moderately impaired. Review of Resident 48 ' s medical record showed a 11/14/2024 BCP that had no intitial social services or rehab goals had been formulated. The BCP showed a copy of physician orders and instructions were reviewed with the provider and not the resident nor the resident ' s representative. The record additionally showed the resident nor the resident's representative had received a BCP summary with their initial goals, medications, dietary instructions, services/treatment that were to be administered by the facility nor the details of their BCP upon completion of the comprehensive assessment. During an interview on 01/14/2025 at 12:40 PM, Staff C, Assistant Director of Nursing Services, stated they were transitioning from one BCP to using something else in their new system to simplify the process, but that process was not completed yet so the BCPs were in three different areas it's a work in progress. Reference: WAC 388-07-1060(3) 44922

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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. 44922 Based on observation, interview, and record review, the facility failed to develop and/or implement comprehensive resident centered care plans for 2 of 6 residents (Residents 21 and 56) reviewed for care plan development. This failed practice put residents at risk for unmet care and/or safety needs. Findings included . <Resident 21> Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include a urinary tract infection and urine retention. The 11/22/2024 comprehensive assessment showed Resident 21's cognition was severely impaired, they required the use of a retention catheter (R/C- a device used to drain urine from the bladder) and was dependent on staff for toileting hygiene. During an observation on 01/06/2025 at 10:16 AM, Resident 21 was sitting on the edge of their bed, the r/c tubing was hanging out of their right pant leg, with the end of the tubing touching the floor. Resident 21 had a white stretchy material wrapped around their ankle, the tubing, and the bag to secure them in place. Resident 21 had a r/c leg bag (a smaller bag used to collect urine for ease of mobility) in place and urine was observed in the tubing of the r/c. During an observation on 01/07/2025 at 11:57 AM, Resident 21 was lying flat in their bed with the r/c tubing and leg bag strapped to their right leg (the leg bag was kept at the same level as the bladder rather than below). Review of the 11/18/2024 comprehensive care plan (CP) showed a CP for a urinary system with no measurable goals, interventions, or r/c specific information (areas were blank). The CP showed no focus, goals, or interventions/treatments for Resident 21 ' s urinary tract infections or for their activities of daily living (dressing, ambulation, care, personal hygiene, or how they get around the facility). During an interview on 01/14/2025, Staff C, Assistant Director of Nursing Services, stated Resident 21 did not use a leg urinary drainage bag, they only used a regular urinary drainage bag. Staff C stated staff may be using the leg bag due to Resident 21 ' s behaviors and pulling their r/c out. Staff C clarified after reviewing Resident 21 ' s record that there was no comprehensive CP developed for Resident 21 ' s r/c or their urinary tract infections. <Resident 56> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed the resident admitted to the facility with diagnoses to include opioid (a class of drugs that interact with nerve cells to reduce pain and produce euphoria) and stimulant (a substance that raises levels of physiological or nervous activity in the body), and alcohol abuse. The 11/29/2024 comprehensive assessment showed Resident 56 ' s cognition was moderately impaired and had alcohol, opioid, and stimulant abuse. An observation and concurrent interview on 01/07/2025 at 9:36 AM, Resident 56 stated they had a history of drug use and was jumped by strangers and received a brain aneurysm (a bulge in a weak area of an artery in or around your brain). Resident 56 looked as if they were confused, walking up and down the hallway from the front of the facility to their room. Resident 56 asked if they could have a cigarette because they had not smoked and used nicotine prior to admission. Review of Resident 56 ' s 11/25/2024 CP showed no SUD care plan with resident specific measurable goals and interventions had been developed for assessing risks associated with SUD, overdose, increased monitoring of resident and visitors, diversions to prevent relapse, or signs and symptoms to monitor for. During an interview on 01/08/2025 at 3:21 PM, Staff E, Social Services Director, stated they assessed Resident 56 for their trauma informed care and learned during that assessment about the drug abuse. Staff E stated they had not created a CP with resident specific goals and interventions to substance abuse disorder (SUD- a medical condition that is defined by the inability to control the use of a particular substance despite harmful consequences). Staff E stated they had not had training on SUD so was unaware that needed to be done I know what to watch and monitor for but that does not mean the rest of the staff do. Reference WAC: 388-97-1020 (1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to ensure care plans were consistently reviewed and revised to meet residents' current needs for 5 of 12 sample residents (25, 30, 13, 4, and 17) reviewed for care plans. Additionally, the facility failed to complete care conferences for 1 of 3 residents' (Resident 4) reviewed for resident/resident representative participation in care conferences. These failures to revise care plans and complete care conferences, define changes and allow resident participation in planning their care, placed residents at risk for unmet care needs. Findings included . <Resident 25> Review of the medical record showed the resident admitted to the facility on [DATE] with multiple diagnoses to include heart failure and hypoxia (low level of oxygen in body tissue), on continuous oxygen and a Bipap machine (a device that helps you breathe by pushing pressurize air into your lungs) to be worn. Review of the 12/24/2024 quarterly assessment showed Resident 25 was alert and oriented and had shortness of breath, on oxygen and a non-evasive mechanical ventilator (Bipap). During a concurrent observation and interview on 01/07/2025 at 9:30 AM, Resident 25 was on oxygen per their nasal cannula with the head of their bed elevated to 60 degrees. Review of Resident 25's revised 12/08/2024 Respiratory-Shortness of breath care plan showed interventions Bipap as ordered without parameters/settings for oxygen use or pressure delivery. There was no instruction or identification of the Bipap humidifier fill level of water, the time the Bipap would be worn by the resident, or to use distilled water in the humidifier reservoir. During an interview on 01/08/2025 at 11:05 AM, Staff D, Resident Care Manager (RCM), stated there should be parameters for the Bipap machine use. <Resident 30> Review of the medical record showed the resident admitted to the facility with after care for left foot partial amputation and Intravenous (IV) antibiotic for sepsis Methicillin-resistant Staphylococcal Aureus (MRSA, a bacterial infection) per a Peripherally Inserted Central Catheter (PICC, a flexible tube inserted into the vein for medication use or prolong periods of time). The resident was on contact isolation precautions due to wound changes of the left foot. Staff were to wear Personal Protective Equipment (PPE) mask, gloves, gown, eye protection when in contact with the resident. The 12/17/2024 comprehensive assessment showed the resident required minimal assistance with daily cares and was alert and oriented. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 30's 12/11/2024 care plan (no revision) showed the resident was still on isolation in a one bedroom in the facility the focus/problem did not identify the resident's type of IV catheter used, the size that was used, or a treatment for the maintenance (there were pre-populated items that were left blank). There was no measurement for PICC line catheter identification and care, no identification of antibiotic used or time to infuse the antibiotic, skin assessment or side effects. The care plan showed an incomplete focus for Resident 30 ' s pain and no goals or interventions were formulated. <Resident 13> Review of the medical record showed the resident was alert, oriented, and able to make needs known. The medical record showed diagnoses included a stroke with left sided paralysis and depression. Resident 13's revised care plan dated 06/29/2023 showed mood and behavior of a diagnosis of depression and Resident 13 was currently not on medication for it. The care plan showed the depression reoccurs but at this point medication is not needed. Review of the November 2024 Medication Administration Record showed an 11/21/2024 order for Duloxetine (an antidepressant) that was not identified in the revision of the care plan interventions. During an interview on 01/08/2025 at 1:00 PM, Staff D, RCM stated all care plans should be revised and completed. <Resident 4> Review of Resident 4's medical record showed the resident was admitted to the facility with diagnoses including, history of a heart transplant, diabetes (too much sugar in the blood) and melanoma (cancer of the skin). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and required moderate (the helper does less than half of the activity) assistance from staff for dressing, grooming, toileting and transfers. Review of the resident 4's physician orders for January 2025 showed they were taking a high-risk immuno-suppressant medication Tacrolimus 5 mg twice daily (a high-risk medication with specific guidelines used to prevent organ transplant rejection). During a concurrent observation and interview on 01/06/2025 at 2:38 PM showed Resident 4 sitting on their bed in their room. On the left side of their chest was a red raised 2 by 1 cm (centimeter a unit of measurement) circular lesion. The resident stated it was melanoma, and they had chosen to not have treatment for the lesion. Resident 4 pointed to their left arm and stated they had additional lesions down their arm. Review of Resident 4's care plan (a written document that outlines specific nursing care for resident needs) revised on 10/23/2024 showed no identified areas of care needs related Resident 4's high risk immuno-suppressive drug to identify interventions for monitoring and risk of adverse side effects. Additional review of the care plan showed no identification of the resident's untreated melanoma or interventions to monitor the status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 2:23 PM, Staff D, stated they had not identified the areas of concern on Resident 4's care plan for the resident's high risk immuno-suppressive medication or their skin cancer I should have put those issues on the care plan for monitoring I just missed them. <Resident 17> Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses including a heart complication, left knee replacement, and osteoarthritis (inflammation of joints in the body) of the hips and shoulder. The 12/01/2024 comprehensive assessment showed Resident 17 had a moderately impaired cognition, was able to make their needs known, had mobility impairments to their upper body on both sides and utilized an electric wheelchair for mobility. Review of Resident 17's care plan showed the resident utilized an electric wheelchair to move around their room and the facility. The care plan was revised 09/26/2024, but did not show that a seat belt physical restraint (any physical, mechanical device or equipment that limits a resident's freedom of movement) or enabling (devices/equipment voluntarily used by a resident following appropriate assessments which limit the resident's normal freedom of movement, with the intent of promoting independence, comfort or safety) device was care planned for the resident. During an interview on 01/13/2024 at 3:10 PM, Staff B, Director of Nursing Services, stated the correct process for revising the care plan for Resident 17 potential seat belt restraint was not followed. <Care Conferences> During an interview on 01/06/2024 at 2:48 PM, Resident 4 stated it was important for them to keep updated on their care while at the facility. Resident 4 stated they only remembered attending one care conference in December 2024 since my admission last July (2024 six months ago). The resident further stated they had not been informed of any other care conferences and if they had, they would have attended as they wanted to work on their discharge home. Review of Resident 4's medical record showed care conference documents dated 07/18/2024, 08/01/2024. 08/24/2024, 09/19/2024 and 12/03/2024. The documents showed the IDT members who consistently attended the meetings were, the RCM, Social Services Director (SSD) and the Director of Therapy (DOR). There was no evidence that all the required IDT members had attended or given input for the CC's. Continued review of the CC documents showed Resident 4 had attended only two meetings on 09/19/2024 and 12/02/2024. Additionally, none of the CC's reviewed showed any input from routine NA staff. During an interview on 01/08/2025 at 1:53 PM, Staff E, SSD, stated the process for CC's was to complete them initially on admission, quarterly, annually and with any change of resident condition. Staff E stated their process was to invite the resident and/or a family member/power of attorney. Staff D stated they recognized there was a problem with CC's and had been working on fixing it. Staff E stated they tried to ensure the resident was invited to all their CC's or if they were cognitively impaired, had a representative attend the meeting. Staff D further stated the IDT members did not include routine NA's input, and they had not been included or invited to any CC's. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 8:41 AM, Staff C, Assistant Director of Nursing, stated that NA staff did not attend or provide input into resident CC 's. Staff C stated they were unaware of the requirement to have NA staff as part of the CC IDT. Staff C stated, Honestly we have had problems with consistent care conferences and were working on ensuring residents or families were invited to attend. During an interview on 01/09/2025 at 2:23 PM, Staff D, RCM, stated getting care conferences done has been a struggle and was unsure of how the residents were notified of their CCs. Staff D stated they had not seen any NA staff attend or give input into resident CC's. During an interview on 01/13/2025 at 11:22 AM, Staff I, NA (a long-term employee at the facility) stated, We have never been asked to attend or participate in any of the resident's CC's. Reference: WAC 388-97-1020(c)(i)(ii)(e)(f)(5)(b) 39652 43280 44922

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review the facility failed to provide the necessary care and services to ensure residents dependent on staff received consistent showers for 2 of 5 residents (Residents 37 and 22) reviewed for activities of daily living (ADLs). The failure to receive adequate showering and grooming care according to the residents' care plan placed the resident at risk for unmet care needs, impaired skin integrity, and embarrassment. Findings included . <Resident 37> Review of the resident's medical record showed they admitted with diagnoses to include diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and asthma (a chronic respiratory condition which is caused by inflammation of the airway that causes narrowing of the airway). The 12/04/2024 comprehensive assessment showed Resident 37's cognition was intact and required the assistance of one staff for showering/bathing. During an interview on 01/06/2025 at 3:45 PM, Resident 37 stated they had not had a shower even though they were due for one and my urine smell is pretty strong. During an interview on 01/08/20245 at 8:26 AM, Resident 37 was sitting in their chair in the corner of their room, hair was disheveled, and Resident 37 stated they still had not received a shower in over a week. During an interview on 01/09/2025 at 8:55 AM, Resident 37 stated as of today they had not received a shower in nearly two weeks. Resident 37 had whiskers to their face and their skin appeared white and flaky. Resident 37 stated my rear end is so hot I am afraid I am going to leave burn marks on the wall [dirty, raw rear end]. Resident 37 smelled of sweaty body odor. Resident 37 had their walker placed at the foot of their bed with clean clothes hanging on a hanger on the arm of the walker with Old Spice (a brand of personal hygiene supplies) shampoo and body spray next to them. During an interview on 01/08/2025 at 9:10 AM, Staff GG, Nursing Assistant, stated it was their first shift, and they were assigned to the [NAME] Hall (Resident 37 resided on South Hall) with another NA to complete showers. Staff GG stated after they reviewed the shower list, themselves and the other NA decided they would split up the showers because it had been since 12/30/2024 since some of the residents had received a shower. Staff GG reviewed their shower sheet and verified that Resident 37 was one of the resident's that had not had a shower since 12/30/2024 and Staff GG was not sure if that meant the last time that they received a shower or if that was the last time they were offered a shower. Review of the shower book showed a document in it titled South Hall Showers. The document showed Resident 37's name with the days Tuesday and Friday written next to their name and a date of 12/30/2024 written beside their name. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 37's 12/01/2024 Care Plan showed the resident preferred to have showers in the evenings on Tuesdays and Fridays. Review of Resident 37's 12/08/2024 through 01/08/2025 shower tasks (a charting record where NAs document showers and refusals) showed no showers had been documented. <Resident 22> Review of the resident's medical record showed Resident 22 was admitted to the facility with diagnoses including, diabetes and a history of a cerebral vascular accident (CVA an event that occurs which blocks blood flow in the brain) and a right hemiparesis (right sided weakness as a result of a stroke). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and was dependent on staff for showering, dressing, grooming and mobility needs. During a concurrent observation and interview on 01/07/2025 Resident 22 stated they had not received a shower for over three weeks I wish someone had time to do it. Their hair was noted to be flat and oily. The resident further stated they had not received nail care which generally occurred on their shower day. I really need my nails cleaned and cut I would love to have a manicure. The residents held up their hands and it was noted their fingernails on both hands were long and dirty. Additionally, the resident had three long hairs on their chin. Review of Resident 22's shower schedule showed they had not received a shower since 12/10/2024 (over a month ago). Review of the resident ' s care plan dated 02/18/2024 shows the resident was to have a shower at least weekly to meet their bathing needs. During an interview on 01/08/2025 at 11:20 AM, Staff D, Resident Care Manager, stated the NA assigned to the resident on day/evening shifts should be completing the resident's showers and nail care on their scheduled day. Staff D further stated they tried to schedule an extra NA on the floor, but it was not consistent. Reference WAC: 388-97-1060 (2)(c) 39652

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to obtain physician assistance for a resident with a mental health and substance use disorder (SUD, a medical condition that is defined by the inability to control the use of a particular substance or substances despite harmful consequences) history, provide ongoing assessment and monitoring of identified non-pressure skin conditions, and provide care for a peripheral IV line for 3 of 4 residents (Residents 263, 28, and 13) reviewed for quality of care.These failures placed residents at risk for delay of treatment, unmet care needs, and negative health outcomes. Findings included . <Resident 263> Review of the resident's medical records showed they admitted to the facility with diagnoses to include a right foot ulcer, bi-polar disorder (a mental health condition that causes extreme mood swings), SUD, and depression (a mood disorder that causes persistent feelings of sadness and loss of interest). The 01/02/2025 comprehensive assessment showed Resident 263's cognition was moderately impaired, had mild depression, experienced hallucinations (false perceptions of sensory experiences that seem real) and delusions (a fixed, false conviction in something that is not real or shared by other people), and Post Traumatic Stress Disorder (a mental health condition caused by a traumatic event that affects your ability to function normally). The assessment also showed Resident 263 had physical and verbal behaviors towards others and the behaviors significantly interfered with the resident's care. An observation and concurrent interview on 01/07/2025 at 8:52 AM, showed Resident 263 sitting in their wheelchair (w/c) at the entrance of their room. Resident 263 had intermittent tearfulness with crying loudly at times, stating I can't breathe in this place. Please let me out of here just for a few hours, and I just want to breathe the fresh air and go on a drive to the mountains. Resident 263 stated they had an addiction to methamphetamines (a recreational drug that causes stimulation of the nervous system) and alcohol, and that they did not bother anyone else during their use, they were just happy sitting at their cabin, next to the water, in the mountains. Resident 263 stated that watering their lawn, being active, splitting wood, and being outdoors would help calm them and traffic, noise, people, and confusion made their agitation worse. Resident 263 had a wound vac (a vacuum assisted wound closure device used to heal wounds) placed to the top of their right foot, with red, blood soaked through to the top and the heel of the brown bandages. Resident 263 self-transferred from their w/c to the bed. The tubing of the wound vac was stretched upwards around the push handle on the back of the right side of the w/c, down around the break handle on the right side of the w/c, then stretched under the resident's left leg, and to the top of the right foot. Resident 263 could not straighten out their right leg and had to yell for staff to come untangle them. While in the room, Resident 263 would fall asleep but then wake up right away. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 01/07/2025 at 10:11 AM, Staff K, Registered Nurse (RN), stated Resident 263 had thrown their coffee cup earlier in the morning and had not slept again the night before (01/06/2025). Staff K stated the resident had only been getting about an hour and a half of sleep in a 24-hour period. Staff K stated the Contracted Medical Provider (CMP) had increased Resident 263's sleep medications from 100 milligrams (mg, a unit of measure) to 200 mg, but it had not helped. Resident 263's room was observed to have dried, brown streaks to the left side of the bathroom door and to the right side of the sink from the thrown coffee. Resident 263 was sitting up in their w/c at the doorway of their room. During an observation and concurrent interview on 01/08/2025 at 8:25 AM, Staff K, along with Staff E, Social Services Director, stated Resident 263 did not sleep well the previous night (01/07/2025). Resident 263 was sitting in their w/c out in the hallway, crying, wanting to go outside of the facility, and wanted to call their Resident Representative (RR). The wound vac at the time was turned off due to the resident's continued pulling on the tubing and breaking the seal. The room had Cheetos chips scattered around the floor, broken pieces of a plate scattered by the bathroom door and the sink, personal belongings (clothes, pencils, drawing pad) were scattered around the room. Resident 263 stated I feel like I am locked up like an animal .I am losing my mind in this place .I haven't slept in days, I just want to sleep .I hate my sister, she put me here and just leaves me .just give me a knife to end it all .I have mushrooms at home, I should just take them all and die. Resident 263 was observed to have a disposable razor sitting on the side of their sink and a meal tray with a fork, spoon, and butter knife on it. Staff K stated the resident was very upset that they had thrown their phone and broke it earlier so called their sister to bring them another one. Staff K then removed the tray with the utensils on it and Staff E began removing things from the room that could harm Resident 263 or others. Staff K and Staff E both confirmed this was the first time Resident 263 had made suicidal comments. Staff E further stated they called the mental health crisis hotline and assigned a one-on-one staff at the doorway to monitor Resident 263 full-time and will reassess as needed. During an interview on 01/08/2025 at 12:12 PM, Staff O, Restorative Assistant, stated Resident 263 had not made suicidal comments prior to today. Staff O stated they would get concerned that the resident could have violence towards others. Staff O stated they entered the room after breakfast to get their tray and Resident 263 asked them to reheat it in the microwave and bring it back. Staff O stated they informed the resident they could get them a new breakfast but was not allowed to reheat the food in the microwave after it had been sitting. Staff O stated Resident 263 became angry and so they stepped out of the room to give them a minute and when they did, Resident 263 tossed their plate across the room and it shattered everywhere. Staff O stated it seemed like Resident 263's behaviors were worsening every day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2025 at 2:44 PM, Staff E stated when they arrived first thing in the morning, Resident 263 had been amping up [getting excited] because they had thrown their phone and broke it. Staff E stated the resident called their RR to get their friend's phone number and started arguing with the RR, so they hung up on the resident. Staff E stated they were told by the RR that Resident 263 has had mental outbursts for years and [AGE] years of alcohol and drug use. Staff E stated the resident was not sent with any medications on discharge from the hospital for their bi-polar disorder but was sent on a low dose as needed anti-psychotic (a class of medicines used to treat psychosis and other mental and emotional conditions) medication for their agitation. Staff E stated when mental health crisis staff came to the facility, Resident 263 was not verbalizing suicidal tendencies to them, so they did not detain the resident for a psychiatric evaluation. Staff E stated they did not have any specific training on SUD and stated they would be signing themselves up for some training. Staff E stated they did not notify the medical provider. During an interview on 01/09/2025 at 9:03 AM, Staff K stated they had not had time to stop and call the physician for further interventions regarding Resident 263's lack of sleep, increased behaviors, suicidal tendencies, or that the mental health crisis hotline needed to be called. Staff K stated they did not know if any other staff had contacted the physician. Review of nursing progress notes on 01/09/2025 at 2:58 PM, showed the resident refused some of their medications and was awake all night with a few minutes here and there and maybe a one-hour stretch. The note showed Resident 263 had a few verbal outbursts. A note on 01/10/2025 at 12:05 AM, showed Resident 263 was attention seeking and had continued yelling out that was disturbing to other residents on the hall. Review of the January 2025 Medication Administration Record (MAR) showed an order dated 12/28/2024 for Sertraline (a brand of anti-depressant medicaion) that had been placed on hold since 01/01/2025. The MAR also showed a 12/26/2024 order for Risperidone (a brand of anti-psychotic medication) 0.25mg, that could be given every six hours if needed. The Risperidone was administered twice on 01/05/2025 and once on 01/06/2025 and 01/10/2025, and no administration on 01/07/2025 through 01/09/2025. An observation on 01/10/2025 at 9:03 AM, Resident 263 was sitting at the edge of their bed in between their bed and the window, their incontinence brief was ripped off and down on the floor at their feet with bowel movement on the floor and in the brief. There was bowel movement on the floor in front of the bathroom door and the floor throughout the room had dried, sticky substance. During an interview on 01/10/2025 at 9:26 AM, Staff D, Resident Care Manager (RCM), stated the facility had access to a medical provider 24 hours a day if they needed to contact them for a resident. Staff D stated they had not reached out to the provider to request additional interventions for Resident 263 and assumed other staff had already done that. Staff D stated after they searched Resident 263's medical record, it did not appear that the provider had been notified of Resident 263's changes in behavior, continued not sleeping even after a medication change eight days prior, their suicidal tendencies, or that the mental health crisis hotline had to be called in. During this interview, Resident 263 could be heard yelling and the door to the office RCM's office was closed. (continued on next page)

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Mountain View Post Acute	1050 E Mountain View Ellensburg, WA 98926

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/10/2025 at 2:50 PM, the CMP stated they had not been called or updated on Resident 263's ongoing issues until just a few minutes ago. The CMP stated Resident 263 had extensive behaviors during their hospital stay prior to admitting to the facility and there was a behavioral contract between the hospital and Resident 263 for managing those behaviors. The CMP stated Resident 263 had agreed on discharge from the hospital to follow that behavior contract. The CMP stated Resident 263 had previously received a higher dose of their sleep medication, 300 mg, and had one other psych medication, but due to their abnormal blood work that would cause decreased wound healing, the sleep medicine was decreased and the other medication was put on hold. The CMP was concerned that Resident 263 could be possibly receiving recreational drugs from outside visiting friends. Additionally, the CMP was not aware the wound vac had been discontinued due to Resident 263's increased behaviors. Review of the 12/26/2024 hospital discharge records showed there was a behavioral contract completed between Resident 263 and the hospital, but showed no details as to what that behavior contract entailed. The records showed no behavioral contract between the hospital and Resident 263 was sent on discharge. <Resident 28> Review of the resident's medical record showed they admitted to the facility with diagnoses to include cellulitis (a serious bacterial infection of the skin) of their left and right lower legs. The 10/04/2024 comprehensive assessment showed Resident 28's cognition was intact and required the assistance of one staff for personal hygiene. The assessment also showed Resident 28 received an antibiotic and Intravenous (IV, administered through a vein) medication. An observation and concurrent interview on 01/06/2025 at 10:48 AM, showed Resident 28 was lying in bed with white dressings to both lower legs. There was an IV antibiotic (a medication used to treat infections) that was hanging from an IV pole. Resident 28 had an undated peripheral IV line (a thin, flexible tube inserted into a vein that healthcare providers use to draw blood and administer IV fluids, medications, and blood transfusions) to their left upper arm and a reddened area to their right leg that was outlined with a black marker to indicate any changes in the size of the infection. Resident 28 stated they were being treated for an infection in their legs. An observation on 01/09/2025 at 3:24 PM, showed Resident 28 lying in bed, IV pole still in the room and the peripheral IV line was still observed to Resident 28's left upper arm. Resident 28 stated the IV antibiotic was completed the night before, on 01/08/2025. During an interview on 01/14/2025 at 10:47 AM, Staff Q, Licensed Practical Nurse, stated the IV dressing to Resident 28's left arm had not been changed in over a week. Staff Q stated their antibiotic had completed on 01/08/2025 and the orders were set for a specific date, so the orders dropped off the Medication Administration Record (MAR) as of 01/08/2025. Staff Q stated Resident 28's IV line had not been flushed, maintained, or the peripheral line dressing changed in over a week. Staff Q stated they called and received orders to remove the peripheral IV line and when they removed it, the tubing was yellow, the clear dressing that covered the peripheral line was disgustingly dirty and peeling away from the skin, and the line was hard and clogged. Staff Q stated their normal process was to use normal saline for flushing IV lines before and after an antibiotic was administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's January 2025 MAR showed a 01/02/2025 order for the IV antibiotic treatment with an end date of 01/06/2025, the order showed no flushing instruction before or after the IV antibiotic was administered. Then a second order on 01/06/2025 for the same IV antibiotic treatment with an end date of 01/08/2025, again, with no flushing instructions before or after the IV antibiotic was administered. The MAR showed no orders to monitor the peripheral IV site for signs or symptoms of infection or infiltration (the administered medication infiltrating into the surrounding tissues) and no changing of the peripheral IV line dressing had been scheduled. During an interview on 01/14/2025 at 12:24 PM, Staff B, Director of Nursing Services, stated on admission the orders for the IV antibiotic flushing, maintenance, monitoring, and dressing changes should have been written. Staff B stated the provider should have been called the day the antibiotic had completed so an order could be obtained to discontinue the peripheral IV line. Staff B stated orders were double checked for accuracy and those orders should not have been missed. 31168 <Resident 13> Review of the medical record showed the resident was admitted to the facility with a stroke and left sided paralysis of their body, anemia (deficiency of red blood cells that carry oxygen to body tissue) and is alert and able to make their needs known. The 10/18/2024 comprehensive assessment showed the resident required substantial assistance with turning in bed and transfers with a mechanical lift. Resident 13 wore a brief for dignity due to bowel incontinence and was at risk for skin breakdown due to immobility. During an observation and concurrent interview on 01/06/2025 at 10:32 AM, Resident 13 was in bed seated on their back with the head of the bed up, bedside table over the bed in front of the resident where the resident's breakfast tray was located. The resident had a hospital gown on with food crumbs on the front of their gown. The resident stated they needed help with changing their position in bed and rarely turned off their bottom or back in bed. Additionally, Resident 13 stated their bottom was sore and believed they had skin breakdown on their tailbone. During an observation and concurrent interview on 01/08/2025 at 9:00 AM, the resident was assisted to turn their right side by Staff T, Nursing Assistant (NA) the resident's bottom was purple in color from the tailbone to each buttock. Staff T stated Resident 13 had skin issues for some time and had been reported to the nurses. During an interview on 01/08/2025 at 11:05 AM, Staff D, RCM, was unaware that Resident 13's had skin issues. According to Staff D, the licensed nurse was to assess the residents weekly and the NAs were to report skin changes during bathing the resident. The documentation showed Resident 13 was not assessed for skin changes since 12/28/2024. Review of the East Hall Shower List Resident 13 refused a bath on 01/02/2025, and no skin issues were reported by staff. Review of the December 2024 MAR showed weekly skin checks signed by the licensed nurses but did not indicate whether there were new skin issues. The last skin check for December 2024 was 12/28/2024. There were no January 2025 skin checks for the first week of January 2025 as of 01/08/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 8:35 AM, Resident 13 was assessed by the Certified Wound Specialist (CWS) who determined Resident 13 to have a purple bottom with Moisture Associated Skin Dermatitis (MASD) inflammation related to inflammation and erosion of skin due to prolong exposure to moisture of wearing a brief and bowel incontinence). Reference WAC 388-97-1060 (1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 31168 Based on interview and record review, the facility failed to ensure treatment and services were provided to increase, maintain and/or prevent a decline in Range of Motion (ROM) mobility for of 4 of 6 residents (Residents 13, 14, 25 and 42) reviewed for limited ROM and restorative nursing services. The facility's failure to have a process in place that ensured timely processing of the program, assessment, and implementation of restorative nursing programs, placed residents at risk for not maintaining gains made while on skilled therapy, functional decline, increased dependence on staff for Activities of Daily Living. Findings included . Review of the July 2017 Restorative Nursing Services policy showed that restorative nursing may or may not accompany a formalized rehabilitative service (physical therapy, occupational, therapy or speech therapy) Restorative Assistance goals and objectives are to be individualized, resident centered and outlined in the resident's care plan. Restorative Assistance goal may include supporting and assisting residents in development and maintenance of strengthening residents physiological and psychological resources. Goals are for residents to maintain dignity and independence and participation in development and implementation of resident's care plan . <Resident 13> Review of the medical record showed the resident was alert, oriented, and able to make their needs known. Review of the medical record showed diagnoses including stroke with paralysis on the left side and loss of inability to walk. Currently, Resident 13 required a mechanical lift for all transfers. Resident 13 is alert and oriented and able to make their needs known Review of Resident 13's 08/02/2023 Restorative Assistance (RA) Nursing Program showed the resident was to have ROM to the left shoulder, elbow and wrist related to flexion contracture ' s (a bent joint that cannot be straightened) six times a week for stretches. There was no description of the type or repetition of stretches or assessment if the resident had declined or improved in the program. During an interview on 01/07/2025 at 9:00 AM, Resident 13 stated that they would like to have some real physical therapy because they felt better after getting over pneumonia they had in October 2024 and would be able to participate. Resident 13 stated they were not on a real therapy program with the RA. They come in once and a while about once or twice a week and ask me to raise my left arm. <Resident 14> Review of the medical record showed the resident was able to make their needs known. The 12/14/2024 quarterly assessment showed the resident was dependent on staff for transfers, bathing and required a mechanical lift for transfers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/07/2025 at 11:00 AM, Resident 14 stated they had declined with their arm movements and could not reach out to obtain things from their bedside table. Resident 14 stated that their fingers were stiff and the RA program they were supposed to be on at least five days a week had not been done in the last 10 days. Resident 14 stated the program was hit and miss and one RA had been absent from the program for a long time. Review of the 07/30/2024 Restorative Nursing Referral plan from physical therapy showed Resident 14's RA program included the resident was to be seated and use the TheraBand (latex resistant bands) 20 times for two repetitions for extension and 20 times for two repetitions extension and flexion (bending) of both arms. Additionally, there were instructions for elbow flexion exercises 10 times for three repetitions. There was no assessment to determine if the programs were consistent and maintained Resident 14's ROM. During an interview on 01/09/2025 at 9:13 AM, Staff C, Assistant Director of Nursing Services, stated that Resident 14 was accuarte and oriented about what went on in their care. Staff B stated if Resident 14 stated they had not had RA services for 10 days they are totally accurate. <Resident 30> Review of the medical record showed the resident admitted to the facility with after care for left foot partial amputation and Intravenous antibiotic for sepsis. The 12/17/2024 comprehensive assessment showed the resident required assistance with daily cares and was alert and oriented. Review of the 12/18/2024 Restorative Nursing Referral for Resident 30 showed instruction recommendations from the physical therapist that active ROM with grey TheraBand and weights. Resident 30 was non-weight bearing on right lower extremity (leg). During an interview on 01/07/2025 at 1:00 PM, Resident 30 stated they had been discharged from physical therapy on 12/09/2024 and were supposed to have an exercise program. Resident 30 stated it never happened. Review of the Resident 30's 12/31/2024 care plan for their RA program showed they were to use TheraBand with weights six days a week. There was no documentation that Resident 30's exercises were being done. During an interview on 01/08/2025 at 11:20 AM, Staff D, Resident Care Manager, stated they also were responsible for the Restorative Nursing program. Staff D stated they had not reviewed the 37 residents in restorative programs for maintenance of the program. Staff D stated there were no quarterly reviews of the resident ' s restorative programs. During an interview on 01/14/2025 at 9:20 AM, Staff O, RA stated that they were unaware of their supervisor for Restorative Nursing (Staff D) . Staff O stated the only orientation to the RA program that was done with them was with Staff HH, RA, not with Staff D. Staff O stated they just followed Staff HH for two days and had no other idea what else to do. Staff O had been doing the RA role for two days a week for past three weeks and works as a Nursing Assistant (NA) on the floor with residents. <Resident 42> (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they admitted with diagnoses to include a left hip replacement and a contracture (the permanent tightening of muscles, tendons, ligaments, or skin that prevents normal movement) of an unspecified joint. The 10/09/2024 comprehensive assessment showed Resident 42's cognition was intact and received no days of Restorative therapy. During an interview on 01/06/2025 at 2:04 PM, Resident 42 stated they used to walk prior to their fall that required a left hip replacement. Resident 42 stated they had no function to their left leg from the hip repair but now had no function to their right leg either. Resident 42 stated they used to be able to lift their right leg up in the air to move around but now could not lift their right leg off the bed. Resident 42 stated they used to do exercises but had not done those in a while. An observation and concurrent interview on 01/08/2025 at 12:38 PM, showed Resident 42 lying in bed and when asked, attempted to lift their right leg/foot up and could not lift it up off the bed. The left foot appeared straight at the ankle with no bend and the toes pointed downwards, not upwards towards the ceiling. Resident 42 stated they would like to have exercises but due to the pain to their left hip, they would need to have them completed while they were in bed or would need a wheelchair with leg extenders that tilted. Review of Resident 42's 08/08/2024 Restorative Program Change, showed the resident was to have active range of motion (AROM, the extent or limit to which a part of the body can be moved independently around a joint or a fixed point; the totality of movement a joint could do) exercises for bed mobility. Resident 42 was to complete these exercises to their right lower extremity seated and lying down for ten minutes daily. Review of the 08/08/2024 quarterly restorative program evaluation, showed the resident had a restorative program for AROM for bed mobility and transferring to the right lower extremity for ten minutes daily. The evaluation showed Resident 42 would be reevaluated quarterly. This was the last assessment completed for Resident 42. Review of Resident 42's 10/10/2024 Care Plan showed the resident had an AROM restorative program #1 and did not show documentation was required. The restorative program was not detailed to show what the exercises were to be completed, for how long, or how often. Review of the NA tasks charting (a place NAs chart resident specific tasks assigned to them) showed no restorative program tasks. During an interview on 01/09/2025 at 8:38 AM, Staff O stated they had worked in restorative for approximately a month, and they had not completed any restorative exercises for Resident 42. Staff O stated Resident 42 had a history of refusals of care so maybe that was why they were no longer providing them exercises. Staff O could not provide any documentation to show that Resident 42 refused their restorative programs. During an interview on 01/10/2025 at 10:46 AM, Staff B, Director of Nursing Services, stated the restorative nursing programs for their 37 residents on the program was broken and needed to be reviewed. Reference WAC 388-97-1060 (3)(d) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44922

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to ensure a resident who used chewing tobacco was assessed for 1 of 3 sampled residents (Resident 30) reviewed for smoking/chewing tobacco. This failure placed the resident at risk for interaction of medications with ingredients in chewing tobacco and/or with current health concerns. Findings included . <Resident 30> Review of the medical record showed the resident admitted to the facility on [DATE] after surgery of an infection and partial amputation of the resident's foot. The 12/17/2024 comprehensive assessment showed the resident was alert and able to make their own decisions and required minimal assistance. Additionally, Resident 30 was on a psychoactive medication and an intravenous (IV) antibiotic medication. Resident 30's diagnosis includes nicotine dependence to chewing tobacco. During an observation and concurrent interview on 01/06/2025 at 11:20 AM, Resident 30 was chewing tobacco at their bedside in their room and stated he had been chewing most of their life at home. Resident 30 stated no one had asked him about them chewing tobacco in the facility. During an interview on 01/06/2025 at 11:37 AM, Staff B, Assistant Director of Nursing Services stated they had just noticed Resident 30 chewed tobacco and was not aware of it on admission to the facility. Staff B stated they had admitted Resident 30 to the facility and did not know they had continued use of their chewing tobacco. Staff B stated it is their policy to assess all residents who smoke, or chew tobacco and Resident 30 had not been assessed and no assessment had been conducted. Reference WAC 388-97-1060 (3)(g)

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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. 31168 Based on observation, interview and record review, the facility failed to ensure a resident on continuous oxygen that required a Bipap device (an external device that helps you breathe by pushing pressurized air into your lungs and provides a fixed pressure to keep breathing airways open while you sleep) was used for 1 of 2 residents (Resident 25) reviewed for respiratory care. The failure of staff to assess and document Resident 25's refusal to use their Bipap device placed Resident 25 at risk for ineffective assisted ventilation and unmet respiratory needs. Findings included . <Resident 25> Review of the medical record showed the resident admitted to the facility with diagnosis to include hypoxia (low level of oxygen in body tissue), on continuous oxygen and a Bipap device to be worn at night. Review of the 12/24/2024 quarterly assessment showed Resident 25 was alert and oriented and had shortness of breath. During an interview on 01/08/2025 at 9:45 AM, Resident 25 stated they had not used their Bipap device for sleep for about two months now. The Bipap device was observed in their bedside cabinet drawer and Resident 25 could not reach the device at its location. Resident 25 stated that the Bipap device needed to be returned to the medical supply store. Review of the 09/07/2024 physician orders showed the Bipap device was to be used daily but did not identify the settings for the Bipap device use or the type of mask to be used with the device. During an interview on 01/08/2025 at 11:30 AM, Staff D, RCM stated Resident 25 was to wear the Bipap device every night and was unaware the resident had been refusing to wear the Bipap device. Staff D had not offered a risk and benefit option to Resident 25 of the benefit and risk of using or not using the Bipap device. Reference WAC 388-97--1060 (3)(j)(vi)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review, the facility failed to ensure there were sufficient numbers of nursing staff to provide care and services for 12 of 13 residents (Residents 13, 14, 25, 27, 6, 22, 37, 28, 263, 30, and 42) as evidenced by failures related to Resident Rights, Grievances, Activities of Daily Living (ADLs, daily actions like dressing, transferring/getting a resident up out of bed, changing briefs/toileting), Quality of Care, Resident Mobility, and Facility Assessment. Additionally, resident interviews and staff interviews provided evidence of insufficient staff. These failures place residents at risk for unmet care needs and the inability to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being. Findings included . Review of the facility's resident roster, dated 01/06/2025, showed a census of 62, of which more than half of the residents required transfer assistance via a mechanical lift or required assistance of one to two staff for ADL's. <F-550 Resident Rights> The facility failed to provide an environment that enhanced and prompted a dignified lifestyle. <Resident 13> During an interview on 01/06/2025 at 10:45 AM, Staff Y, Registered Nurse (RN), who entered Resident 13 room/bedside, stated the resident's nails are horrible and need to be cleaned. Additionally, Resident 13 stated they get a bed bath every two weeks, and it's embarrassing not to be clean especially when my family visits. <Resident 14> During an observation and concurrent interview on 01/06/2025 at 2:40 PM, Resident 14 stated they had not had a shower for over a week and their fingernails were split. Observations of Resident 14's fingernails showed all fingernails were over an inch long from the tip of the resident's fingers with a brown substance under the nails, and the left thumb nail was split down the middle. Resident 14's toenails were long one and a half inch above the tips of their toes. <Resident 25> During an interview on 01/08/2025 at 9:45 AM, Resident 25 stated they had not had a bath for some time and felt unclean and preferred not to get out of bed. Resident 13 stated they had pneumonia (infection of the lungs) in November 2024, and they are slowly recovering. Resident's hair is unkempt and stated they just felt unclean and was not motivated to get out of bed. <Resident 27> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/06/2025 at 9:10 AM, Resident 27's (shared with Resident 13) room smelled musky with a pungent urine smell. Resident 27 stated they knew that the room smelled, and they cannot smell it until they get out of the room for a while and return to their room. Resident 27 stated it smelled like an [NAME]. Additionally, during an observation Resident 27's hair was greasy and clothing were soiled. Resident 27 stated they had not had a bath in a while and would like a bath. Resident 27 stated they liked to be around people and attended activities and did not want to smell bad around them. <F-585 Grievances> The facility failed to educated/implement the grievance process for concerns voiced during resident council meetings. <Resident 6> During a Resident Council meeting on 01/08/2025 at 10:45 AM, Resident 6 stated they had voiced concerns about the food being served cold, the cold food improved for about a week and then went back to being cold again. Resident 6 stated the staff would bring in food and place it on their bedside table and not even wake them up to let them know their food was there. Resident 6 stated the NAs need to slow down when they come in to provide them care and ensure that we are getting everything we need before they leave the room, but they are so busy, it's just rush in and rush out. Resident 6 stated this caused them to have to use their call light again when they were just in their room. Resident 6 additionally stated they used a Continuous Pressure Airway Pressure (assists with pushing air into the lungs to open them for breathing) machine at night for their sleep apnea (when you briefly stop breathing while you sleep because your airways relax so much that they narrow down or completely close) and had not been cleaned. Resident 6 stated when they would use the CPAP machine it would cause them to cough so it had been over a month since they last used it. Resident 6 stated the nurses were responsible for the cleaning of the machine and mask but that had not been completed because they were too busy. <Resident 13> During a Resident Council meeting on 01/08/2025 at 11:01 AM, Resident 13 stated it used to take only 15 minutes for a call light to be answered and now it takes significantly longer. Resident 13 stated there was no particular shift this happened on. Resident 13 stated there were agency NAs and old NAs and they don't work well together so they don't know how to provide care to us so then they just don't do it. <Resident 14> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a Resident Council meeting on 01/08/2025 at 10:33 AM, Resident 14 stated they received one shower every two weeks and when asked for their shower were told by NAs that they were not on their shower list for that day. Resident 14 stated they were diabetic and were not receiving the nail care by the licensed nurses which made them feel pretty low class. Observations of Resident 14's fingernails showed black, hardened debris underneath the fingernails and some of the nails had splits in some of the long nails. Resident 14 stated they used their call light and because the call lights were not specific to a certain bed in the room, the NAs would only ask the resident closest to the door what they needed and then leave without asking any of the other residents what they needed. Resident 14 stated this caused them to have to use the call light again and wait. <F-677 ADL Care Provided for Dependent Residents> The facility failed to consistently provide the necessary care and services with bathing and grooming for dependent residents. <Resident 22> During an observation and concurrent interview on 01/07/2024 at 10:15 AM, REsident 22 stated they had not recieved a shower in over three weeks. The resident was observed to have oily flat hair, long chin hairs and long dirty finger nails on both their hands. <Resident 37> An observation and concurrent interview on 01/09/2025 at 8:55 AM, Resident 37 stated they had not received a shower in nearly two weeks. Resident 37 had an unshaven face, smelled of sweaty body odor, and their skin appeared white and flaky. Resident 37 stated their rear end was so hot they thought they would leave burn marks on the wall [dirty and raw]. During an interview on 01/08/2025 at 9:10 AM, Staff GG stated this was their first shift at this facility and they were assigned to showers for the [NAME] Hall. Staff GG stated after reviewing the shower log in the shower book, they realized some of the residents had not had a shower since 12/30/2024 or longer. Review of the South Hall Showers list, where Resident 37 resided, showed the last time Resident 37 was offered or received a shower was on 12/30/2024. <F-684 Quality of Care> The facility failed to ensure facility staff provided ongoing assessment and monitoring of skin conditions, communication with providers and care for peripheral intravenous (IV) lines. <Resident 13> During an observation and concurrent interview on 01/08/2025 at 9:00 AM, the resident was assisted to turn their right side by Staff T, Nursing Assistant (NA) the resident's bottom was purple in color from the tailbone to each buttock. Staff T stated Resident 13 had skin issues for some time and had been reported to the nurses. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2025 at 11:05 AM, Staff D, RCM, was unaware that Resident 13's had skin issues. According to Staff D, the licensed nurse was to assess the residents weekly and the NAs were to report skin changes during bathing the resident. The documentation showed Resident 13 was not assessed for skin changes since 12/28/2024. <Resident 28> During an interview on 01/14/2025 at 10:47 AM, Staff Q, Licensed Practical Nurse, stated this hallway has been the worst of the worst hallways (East Hallway) they had ever worked. Staff Q stated they had time to pass the residents their medications but if they required anything else, there would be no way to get it done. Staff Q stated they did not have time to complete all of the treatments so Resident 28 had gone without their Periphal Intravenous Line (PIV, a small tube inserted into a vein used to administer fluids or medication) flushed or dressing changed for over a week. Staff Q stated they reported their issue to Administrative staff early in the morning. Staff Q stated there was no signs or symptoms of an infection to Resident 28's PIV site to their left upper arm but there could have been. Staff Q placed a call to the provider and received orders to remove the PIV line. Review of Resident 28's January 2025 Medication Administration Records (MAR), showed an order for an IV antibiotic to be administered twice daily. The MAR showed no flushing of the PIV before or after medication administration, which is standards of practice nor were there any orders to monitor the PIV site or change the dressing to the PIV site. <Resident 263> An observation and concurrent interview on 01/07/2025 at 8:52 AM, Resident 263 was sitting in their wheelchair in the entrance way of their room. Resident 263 had intermittent tearfulness with crying loudly at times. Resident 263 stated they couldn't breathe in this place and wanted out of the facility for a few hours. Resident 263 stated they wanted to breathe the fresh air and go on a drive to the mountains. An observation and concurrent interview on 01/07/2025 at 10:11 AM, showed in Resident 263's room there was dried brown streaks of brownish black liquids that ran down the wall to the left of the bathroom door and to the right side of the wall next to the sink. Staff K, Registered Nurse (RN), stated Resident 263 had not slept again through the night and within a 24 hour period had only received an hour and a half of sleep. Staff K stated Resident 263 had thrown their coffee against the wall which caused it to splash everywhere. An observation and concurrent interview on 1/08/2025 at 8:25 AM, showed Resident 263 sitting in their wheelchair in the hallway outside of their room. Resident 263 had been intermittently crying and yelling they felt like a caged animal I haven't slept in days .I am losing my mind .just give me a knife to end it all . Staff K stated Resident 263 had not slept the previous night (01/07/2025) and began throwing items in their room. Staff K stated Resident 263 threw their cellular phone and broke it, they threw a plate against the wall after a NA was exiting the room. Resident 263's room had broken glass on the floor near the sink and the bathroom door, food and personal belongins strewn around the floor in the room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 01/09/2025 at 9:30 AM, Staff K stated they had not had time to stop and call the provider for further interventions for Resident 263 regarding their lack of sleep, increased behaviors with the crying and throwing and breaking things, and their suicidal comments. Staff K additionally stated they did not inform the provider that the mental health crisis hotline had to be called and thought someone else had already done that. During an interview on 01/10/2025 at 2:50 PM, the Contracted Medical Provider (CMP) stated they had not been made aware of Resident 263's ongoing issues until a few minutes ago. <F-688 Prevent/Decrease in Range of Motion (ROM)/Mobility> The facility failed to ensure staff provided care and services to maintain ROM/prevent decline and restorative nursing services. <Resident 13> During an interview on 01/07/2025 at 9:00 AM, Resident 13 stated that they would like to have some real physical therapy because they felt better after getting over pneumonia they had in October 2024 and would be able to participate. Resident 13 stated they were not on a real therapy program with the Restorative Aide (RA). They come in once and a while about once or twice a week and ask me to raise my left arm. There is no restorative program to help me maintain my ROM. <Resident 30> Review of the 12/18/2024 Restorative Nursing Referral for Resident 30 showed instruction recommendations from the physical therapist that active ROM with grey TheraBand and weights. Resident 30 was non-weight bearing on right lower extremity (leg). During an interview on 01/07/2025 at 1:00 PM, Resident 30 stated they had been discharged from physical therapy on 12/09/2025 and were supposed to have an exercise program. Resident 30 stated it never happened. <Resident 42> During an interview on 01/06/2025 at 2:04 PM, Resident 42 stated they used to walk prior to admitting to the facility. Resident 42 stated they had decreased function to their left leg due to a hip replacement surgery but now had no function to their right leg either. Resident 42 stated they used to get daily exercises but had not reeived them in a while. During an observation and concurrent interview on 01/08/2025 at 12:38 PM, showed Resident 42 lying in bed, when asked, Resident 42 attempted to lift their right leg up off the bed, and could not lift the leg up far enough so it did not touch the bed. The left foot appeared straightened at the ankle with no bend adn their toes were pointed downwards, not upwards towards the ceiling. Resident 42 stated they wanted exercises but would need them done while they were in bed due to the pain to their left hip. Resident 42 stated they could also do exercises if they had a wheelchair that had leg extenders and tilted. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 08/08/2024 quarterly Restorative program evaluation, showed the resident had an Active Range of Motion program (AROM, the extent or limit to which a part of the body can be moved independently around a joint or a fixed point; the totality of movement a joint could do) to both of their lower extremities that were to be completed for 10 minutes to each side, daily. During an interview on 01//09/2025 at 8:38 AM, Staff O, Restorative Assistant, stated they had worked in restorative for approximately a month. Staff O stated they had not completed any restorative exercises for Resident 42. Staff O stated that it was possible that Resident 42 had refused to do exercises but could not provide any documentation to show that Resident 42 had refused their exercise programs. <F-838 Facility Assessment> The facility failed to evaluate their resident population and/or identify the resources required to meet each resident's care/service needs. Review of the Facility Assessment, dated September 2023, showed Prestige Post-Acute Rehabilitation Center as the facility even though there was a change of ownership and license number as of 08/01/2024. The assessment had not been reviewed or udpated in 16 months (required to review and/or update annually). The assessment showed they filled vacant NA positions with the Nursing Assistant Program as needed but the facility's NA program had been suspended. The assessment additionally showed they had 16 hours of RN coverage a day, seven days a week, when they had 16 days in a 30 day look back period without 16 hours of RN coverage. <Resident Interviews> <Staff Interviews> During an interview on 01/08/2025 at 8:38 AM, Staff O, RA, stated they did not have time to complete individual exercises for each resident on a restorative program (37 Residents), during their eight hour shift, so they would need to combine three or four residents at a time and take them to the dining room and play an exercise game. Staff O stated there was only one RA scheduled a day and at times they would be pulled to the floor to work as a NA. Staff O stated they had been pulled to the floor once in the three weeks they had worked, and they only worked two days a week in restorative. During an interview on 01/08/2025 at 9:10 AM, Staff GG, NA, stated they received no orientation to the facility prior to arriving for their first shift. Staff GG stated today, 01/08/2025 was their first shift and they were hired through an agency. Staff GG stated they preferred to ask for a resident roster and receive report on resident transfers, diets, behaviors, and any special care but only recieved a report on transfers and diets I just wing it. During an interview on 01/08/2025 at 4:08 PM, Staff G, Licensed Practical Nurse (LPN), stated that 01/07/2025 was their first day working as a staff nurse in the facility and was hired through an agency. Staff G stated they were given 30 minutes by the nurse on the medication cart to orientation around the facility and then had been expected to work their shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/10/2025 at 9:27 AM, Staff Z, LPN, stated, we don't have enough staff on shift, and the NAs were not always able to get their task completed. Staff Z stated the NA's get pulled from their scheduled shower NA's and/or restorative NA's duties to work in one of the hallways, due to being short staffed. Staff Z stated that when NAs were pulled then things like residents' showers were not able to be completed. During an interview on 01/10/2025 at 2:24 PM, Staff FF, Nursing Assistant (NA), stated they were hired through an agency and normally when first working in a facility they would be oriented one to two days to become familiar with the facility/residents but got 30 minutes, since not enough staff to have a normal orientation. During an interview on 01/10/2025 at 2:29 PM, Staff K, Registered Nurse (RN), stated they had been short staff, coming in on their days off/working double shifts, been about three months. Staff K stated their daily workload as a licensed nurse had increased and the type of residents that were admitted to the facility take a lot more time to get treatments done. Staff K stated they have increased the number of staff NA's but a lot of the time the NAs are pulled from their assigned duties (Shower Aid or Restorative Aid) to work on one of the hallways due to staffing being low. Additionally, Staff K stated they utilized agency staff to help when the facility was short staff, and the agency staff did not get an orientation (beyond a 30 min handoff) but will have access to other nurses in the facility for questions or needing help to find something. During an interview on 01/13/2025 at 9:31 AM, Staff I, NA, stated the facility was short staffed all the time, and that sometimes not enough staff. Staff I stated that agency staff were being utilized to help with not having enough staff, or if the scheduled staff called off. Staff I stated, a least a couple of days a week the shower NA's or the restorative NA will get pulled to work in one of the unit hallways because short on staff, then resident showers/restorative care would need to be completed by the unit hallway NA's. During an interview on 01/13/2025 at 9:31 AM, Staff J, NA, stated that usually a shower NA was scheduled for days and evenings, but one was not on the schedule for 01/13/2025, we try to squeeze the showers in, with all the other resident care that needed to be completed. Staff J stated that night shift/early morning staff (01/12/2025 to 01/13/2025) was shorthanded so they were still trying to catch up with resident ADL cares that were not able to be completed on night shift. Staff J stated that shower NAs tended to be pulled to work one of the unit hallways due to being short staffed and some weeks it is every day, the shower NA was pulled because of having low staffing levels. No, we don't have enough staff to get everything done, we are lucky if we can get everyone up in time for breakfast. During an interview on 01/14/2025 at 10:52 AM, Staff B, Director of Nursing Services, stated they were aware of facility staff concerns regarding; NAs being unable to complete all the required resident care assignments during their shifts (showers, restorative care, ADL care) due to being shorthanded and shower/restorative NA's being pulled to work on one of the unit hallways, nursing staff working double shifts/staying late to finish charting and/or resident cares. When asked if the facility had enough nursing staff to complete the daily resident cares, Staff B stated its still not there yet, but they were attempting to hire new NA staff and utilized agency whenever possible. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/14/2025 at 11:23 AM, Staff A, Administrator, stated they were aware the NAs were frequently pulled to work on one of the unit hallways because of low staffing and nursing staff having to work overtime to complete documentation/task and the increase in the resident workload. Staff A stated that when the shower/restorative NAs were pulled it put that same workload back onto the unit hallway NAs and that it was making hard for staff to get the required resident cares completed. Staff A stated, we are missing the target (regarding a sufficient number of staff to provide the needed care and services to the residents), and agency staff were not familiar with the facility/residents and had to be taught on the go. Cross Reference: F550, F585, F677, F684, F688 Reference: WAC 388-97-1080(1)(3)(4) 31168 44922

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43280 Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing information was being posted in a place readily accessible to residents/visitors and included the required information on 3 of 7 days (01/08/2025, 01/09/2025, and 01/13/2025) of the recertification survey. This failure placed residents, family members and visitors at risk of not being fully informed of current staffing levels and resident census information. Findings included . Observations on 01/08/2025 at 10:47 AM no daily staffing roster noted anywhere in the front of the nursing home or by the nursing desk area, on 01/09/2025 at 10:02 AM, no daily staffing roster posted where the surveyor could find it, in the front where visitors could visualize it, or at the nursing desk area, and on 01/13/2025 at 9:06 AM, no daily nurse staffing posting that included the facility name, date, census, and the total number and actual hours worked per shift for Registered Nursed, Licensed Practical Nurses, and Nursing Assistants who would have been responsible for the resident's care. During a concurrent observation and interview on 01/13/2025 at 10:21 AM, Staff C, Assistant Director of Nursing Services, showed the surveyor a staffing schedule binder at the nursing station, which did not include the required nurse staffing information that was to be readily accessible to residents/visitors. Staff C stated they had not seen any other nurse staffing information that was available for residents or visitors. During an interview on 01/13/2025 at 12:13 PM, Staff B, Director of Nursing Services, stated they did not have a nurse staffing information document being posted daily, in a place readily accessible to residents/visitors. Staff B stated that night shift staff used to completed it, but it was taken out of commission and they did not know why. Staff B stated that resident and visitors should have access to the staffing data information, and they were not following the correct process. Reference: WAC 388-97-1620(2)(b)(i)

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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** 39652 Based on interview, and record review, the facility failed to identify and implement specific requirements for the timely administration of an immuno-suppressive medication Tacrolimus (used to prevent the body from rejecting a transplanted organ) for 1 of 5 residents (Resident 4) reviewed for high-risk medications. Additionally, the specific instructions for the medication were not included on the medication administration record (MAR) to ensure licensed nurses were aware of the importance with closely following the medication administration times to maintain steady levels of Tacrolimus in the blood. This failure placed Resident 4 at risk for low therapeutic blood levels of the immuno-suppressive medication and increased the risk for rejection of their transplant organ. Findings included . Record review of an undated patient pamphlet published by [NAME] Cancer Center titled Tacrolimus 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., <Resident 4> Review of the resident ' s medical record showed the resident was admitted to the facility with diagnoses that included, history of a heart transplant, diabetes (a disease in which the body has high levels of sugar in the blood stream), and heart failure (the heart does not keep up with the needs of the body) and skin cancer. Review of the comprehensive assessment dated [DATE] showed Resident 4 was cognitively intact and required moderate assistance for daily care activities in the areas of transfers, mobility and grooming. Review of Resident 4 ' s MAR's from 08/01/2024 to 01/13/2025 showed the resident was receiving Tacrolimus 5 milligrams (mg a unit of measure) every 12 hours at 9:00 AM and 9:00 PM. The indication for use of Tacrolimus was related to a heart transplant. There were no directions on the MAR to identify that the medication must be given at the same time every day to maintain appropriate blood levels of the medication and decrease the risk of organ transplant rejection. Review of the specific medication administration times for Tacrolimus from 12/31/2024 to 01/13/2025 showed Tacrolimus had been administered 27 times to Resident 4. Further review showed 12 of the medication administration times showed the medication had been given either too early or too late by at least 40 minutes outside of the specified time frame of every 12 hours. 01/02/2025 evening dose given at 8:15 PM (45 minutes early) 01/03/2025 morning dose given at 9:49 AM (49 minutes late) 01/04/2025 morning dose given at 8:12 AM (48 minutes early) 01/05/2025 morning dose given at 8:16 AM (44 minutes early) 01/05/2025 evening dose given at 8:12 PM (48 minutes early) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/07/2025 evening dose given at 8:20 PM (40 minutes early)) 01//08/2025 morning dose given at 8:07 AM (53 minutes early) 01//09/2025 evening dose given at 8:14 PM (46 minutes early) 01/11/2025 evening dose given at 8:10 PM (50 minutes early) 01/12/2025 morning dose given at 11:35 AM (2 hours and 35 minutes late) 01/13/2025 evening dose given at 1:04 AM (4 hours and 4 minutes late 01/13/2025 morning dose given at 9:47 AM (47 minutes late) During an interview on 01/10/2025 at 12:16 PM, Staff D, Resident Care Manager, stated there had been no contact with Resident 4's physician at the transplant hospital related to the resident ' s administration times of the Tacrolimus. Staff D further stated they were not aware of the requirement for strict adherence to administration times when giving Tacrolimus and the instructions had not been added to the resident ' s MAR. During an interview on 01/10/2025 at 12:31 PM, Staff Z, Licensed Practical Nurse, stated they were unaware of any specific instructions or considerations with the administration of Resident 4's Tacrolimus. During an interview on 01/14/2025 at 11:04 AM, collateral contact (Transplant Pharmacist), stated the preference was for Tacrolimus to be given specifically 12 hours apart and if not given 12 hours apart there was a risk for organ transplant rejection. During an interview on 01/14/2025 at 9:00 AM, Staff B, Director of Nursing Services, stated they expected the nurses to know what medications they were giving as well as the specifics of the medications. Additionally, if they were unfamiliar with the medication then they need to look it up, we have plenty of resources to use. Reference: WAC 388-97-1060(3)(k)(i

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44922 Based on interview and record review, the facility failed to ensure residents were free of unnecessary psychotropic medications (any medication capable of affecting the mind, emotions, and behavior) for 2 of 5 residents (Residents 21 and 263) reviewed for unnecessary medications. The facility failed to 1) consistently monitor individualized targeted behaviors, 2) attempt non-pharmacological (non-medication) interventions prior to psychotropic medication administration, 3) assess for abnormal involuntary movements (AIMS, assess the presence and severity of abnormal movements of the face, limbs, and body in patients with tardive dyskinesia (abnormal and uncontrollable movements caused by antipsychotic [drugs that treat psychosis, a collection of symptoms that affect your ability to tell what's real and what isn't] medications) prior to starting a psychotropic medication and periodically thereafter. These failures placed residents at an increased risk for experiencing medication-related adverse side effects, and unmet care needs. Findings included . Review of a policy dated 2001, titled Psychotropic Medication Use, showed if psychotropic medication was to be used the medication would need an indication for use and adequate monitoring for efficacy and adverse consequences . would be implemented. The policy showed non-pharmacological would be used to minimize the use of the medication, to use the lowest possible dose, or to discontinue the psychotropic medication. <Resident 21> Review of the resident's medical record showed they admitted with diagnoses of dementia (a group of symptoms affecting memory, thinking and social abilities) without behavioral disturbance (changes in mood or behavior). The 11/22/2024 comprehensive assessment showed Resident 21's cognition was severely impaired, had inattentiveness and disorganized thinking, and received an antipsychotic medication. An observation and concurrent interview on 01/06/2025 at 10:16 AM, Resident 21 was sitting on the edge of their bed, looking out the window of their room. There was a picture on the nightstand of their spouse and Resident 21 talked about how long they had been married. Resident was pleasant and calm. Review of Resident 21's January 2025 Medication Administration Record (MAR), showed on 12/19/2024 and order for Seroquel (a brand of anti-psychotic medication) to be given at bedtime, with no indication of use as to why the medication was given. Review of the MARs showed no orders for monitoring resident specific behaviors to show effectiveness of the medication or non-pharmacological interventions. Additional review of Resident 21's record showed no AIMS assessment had been completed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's 11/18/2024 Care Plan (CP), showed a CP for the use of psychotropic medications related to Behavior management with no resident specific goals. The CP showed to monitor for target behaviors such as wandering, disrobing, violence/aggression towards staff/others and to document per the facility protocol, but behaviors were not being documented. The CP showed no non-pharmacological interventions had been implemented. Review of a 12/05/2024 Pharmacy medication review, showed Seroquel was to be given for the diagnoses of insomnia (difficulty sleeping), which was an inappropriate medication for the treatment of insomnia. The medication review showed a recommendation to the provider to discontinue the medication. The medication review showed the provider's response was that the Seroquel was not being used for insomnia, it was being used for [diagnosis] dementia with agitation [excessive talking or purposeless motions, feeling of unease or tension, and hostile behavior at times]. <Resident 263> Review of the resident's medical record showed they admitted to the facility with diagnoses to include depression (a mood disorder that causes persistent feelings of sadness and loss of interest) and bi-polar disorder (a mental health condition that causes extreme mood swings). The 01/02/2025 comprehensive assessment showed Resident 263's cognition was moderately impaired, they experienced hallucinations and delusions and had physical and verbal behaviors towards others. The assessment also showed Resident 263 received an anti-psychotic medication. During an interview on 01/07/2025 at 8:52 AM, Resident 263 was sitting at their doorway of their room in their wheelchair, intermittently crying, stating they couldn't breathe and needed to go out of the facility for a few hours for a drive. Resident 263 stated they just wanted to go to the mountains and breathe the fresh air. Review of Resident 263's January 2025 MAR, showed an order on 12/26/2024 for Trazodone (a brand of antidepressant medication) 100 milligrams (mg, a unit of measure) at bedtime for depression. An order on 01/02/2025 to increase the Trazodone to 200 mg at bedtime for depression, and an order on 12/26/2024 for Risperidone (a brand of anti-psychotic medication) every six hours as needed for agitation. The MAR showed no monitoring for resident specific targeted behaviors or non-pharmacological interventions. Review of a 12/26/2024 informed consent form for psychoactive medication showed the Trazodone's targeted behavior was sleep hygiene and for the Risperidone the behaviors were adjustment to disease and relocation. The form also showed non-pharmacological approaches that were generic and not resident specific. Additionally, the form showed signatures for consent for the medication to be given which were all blank. Review of a 12/31/2024 informed consent form showed Risperidone was to be given for restlessness and agitation and the targeted behaviors were calm and peaceful and non-pharmacological interventions were listed and generic. Review of Resident 263's 12/27/2024 CP, showed a CP for the Trazodone related to depression with no resident specific targeted goals or behaviors (generic behaviors) or non-pharmacological interventions. The CP showed a generic CP for an anti-psychotic and a psychotropic medication CP related to behavior management for bipolar disorder with no resident specific goals or targeted behaviors (generic behaviors) developed. Additionally, the CP showed no monitoring of Resident 263's sleep pattern. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 263's medical record showed no AIMS assessment had been completed. During an interview on 01/14/2025 at 12:28 PM, Staff B, Director of Nursing Services, stated informed consent and an AIMS assessment should be completed prior to the first dose given. Staff B stated that targeted behavior monitoring, and non-pharmacological interventions were lost during their change of ownership transition and was still a discussion they were working on. Staff B stated they should have been being documented on the MAR. Reference WAC: 388-97-1060 (3)(k)(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation and interview, the facility failed to provide palatable, and warm meals at the proper temperature for 4 of 8 residents (4, 23, 41 and 48) reviewed for appetizing food and drink. This failure placed the residents at risk for less-than-adequate nutritional intake potentially leading to weight loss and dissatisfaction with their dining experience. Finding included . <Resident 4> Review of the resident's record showed they were admitted with diagnoses including diabetes (a disease that results in too much sugar in the blood) and malnutrition (when the body does not get enough nutrients). Review of the comprehensive assessment dated [DATE] showed Resident 4 was cognitively intact and was independent with eating after meal set up. During an interview on 01/06/2025 at 1:48 PM, Resident 4 stated the food is terrible here. Further stating it was often served cold which was unappetizing to them and made it difficult to eat. During a concurrent observation and interview on 01/07/2025 at 8:52 AM showed Resident 4's breakfast tray sitting on their bedside table in front of them. The portions were small and consisted of cold hard eggs and a grayish colored potato patty. Resident 4 stated See what I mean, I can't eat this food it's cold and looks terrible. < East Dining Hall> During an observation on 01/06/2025 at 12:14 PM, Resident 23 was seated at the dining table. Resident 23 received their pureed diet that consisted of pureed scalloped potatoes, poured over the white scallop potatoes was pink pureed ham with pureed green beans on a white plate. Resident 23 stated it was disgusting and not appetizing but stated they had to eat the food. Resident 23 was not offered another alternative by Nursing Assistant (NA) staff. During an observation on 01/06/2025 at 12:17 PM, Resident 41 was seated in their wheelchair at their dining table. Resident 41 was served brown chicken strips and brown French fries on a white plate. Resident 41 stated the food was cold and asked for another plate of warm food and some ranch dressing. During an observation and concurrent interview on 01/06/2025 at 12:31 PM, Staff T, NA served another plate of food which consisted of chicken strips and French fries to Resident 41 and stated the kitchen was out of ranch dressing. Resident 41 stated the food was not hot but ate it anyway. During an observation on 01/06/2025 at 12:20 PM, Resident 48 was served cubed pieces of ham, white scallop potatoes and green beans on a white plate. Resident 48 stated loudly in the east dining room that the food was garbage and not appetizing. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/2025 at 12:40 PM, Staff T, NA stated that the residents who complained of cold food were last to be served off of the hall cart that served two hallways. Staff T stated after the hall carts we finished the residents in the east dining room were served last. Staff T stated it took at least 15 minutes or more to get the food to the east dining room after the hall carts were finished. During an observation on 01/10/2025 at 12:01 PM of a test tray sent to the west dining room and placed on the meal cart showed a mechanical soft diet (soft foods that are easy to chew and swallow) which consisted of teriyaki beef, rice pilaf and broccoli. The teriyaki beef lacked flavor and did not taste like teriyaki. The rice pilaf was flavorless with a gummy consistency and the broccoli was over cooked, soft and brownish in color. The food served was not palatable or appetizing. During an interview on 01/13/2025 11:18 AM, Staff B, Director of Nursing Services, stated they expected residents dining experiences and meals to be served in a manner that supported the resident ' s nutrition and dignity. Reference WAC 388-97--1100 (1), (2)(b)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 44922 Based on interview and record review, the facility failed to A) update the assessment when a substantial change occurred when the facility experienced a change in ownership, and B) update the assessment when substantial changes occurred for sufficient staffing when the facility lost their access to a nursing assistant training program that helped fill nursing assistant vacancies. These failures placed residents at risk for unmet care needs. Findings included . Record review of the Facility Assessment Tool, dated 09/2023, for (former facility name) showed what resources were necessary to provide person-centered care for residents during both day-to-day operations and emergencies. The Facility assessment showed no change in ownership as of 08/01/2024. During an interview on 01/06/2025 at 8:50 AM, Staff B, Director of Nursing Services, stated they no longer had a nursing assistant program and that it had been suspended prior to Staff B becoming employed. During an interview on 01/09/2025 at 9:55 AM, Staff A, Administrator, stated the previous Administrator (from two weeks ago) was to update and complete the Facility Assessment once the change in ownership took place. Staff A stated that did not happen. Staff A stated they would update the Facility Assessment to reflect the status of the facility and the care and services it provided. Reference WAC: 388-97-0020

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review the facility failed to ensure residents had the cognitive capacity to understand the nature and implication of entering into a binding arbitration agreement (an alternative means of settling disputes without a jury by trial) for 2 of 3 residents (Resident 52 and 21) reviewed for arbitration. This failure placed the residents at risk for a lack of understanding of the legal contract they had signed and their right to make a choice for a jury trial in the event of a dispute with the facility. Findings included . <Resident 52> Review of the resident ' s medical records showed they were admitted to the facility on [DATE] with diagnosis including fracture of the right leg bone, stroke and dementia (a progressive disease that destroys the memory and other important mental functions). The 10/10/2024 comprehensive assessment showed the resident had a severely impaired cognition. Review of Resident 52 ' s arbitration agreement, dated 10/27/2024 showed the resident signed the legal contract themselves, on 10/27/2024, with facility Staff L, Admissions Coordinator, as the authorized agent/witness. During a concurrent observation and interview on 01/09/2025 at 3:32 PM, Resident 52 responded to verbal communication but was confused, incomprehensible (not able to be understood) and showed they did not have the mental processes in place to understand/form judgments regarding arbitration agreements. During an interview on 01/09/2025 at 3:48 PM, Staff Y, Registered Nurse, stated Resident 52 was unable to understand their care and the facility included the resident representative (RR) in care decisions. <Resident 21> Review of the resident ' s medical records showed they were readmitted to the facility on [DATE] with diagnosis including heart complications, chronic (long term) kidney complications and dementia. The 11/22/2024 comprehensive assessment showed the resident had a severely impaired cognition. Review of Resident 21 ' s arbitration agreement, dated 11/20/2024 showed the resident signed the legal contract themselves, on 11/21/2024, with facility Staff L, Admissions Coordinator, as the authorized agent/witness. During a concurrent observation interview on 01/09/2025 at 3:44 PM, Resident 21, would smile and wave at surveyor, but was confused and unable to hold a conversation about the arbitration agreement they had signed. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2025 at 3:48 PM, Staff Y, Registered Nurse, stated Resident 21 was awake/alert but was not able to understand where they were or make decisions about their treatment/care. During an interview on 01/09/2025 at 3:59 PM, Staff L stated they would read through the arbitration agreement document with residents during the admissions process. Staff L stated they would have a conversation with the resident and from that decided if a resident was able to understand the binding arbitration agreement. Staff L stated they did not reference Resident 52 or Resident 21 ' s medical record nor had Staff L talked with nursing staff about either resident ' s cognitive status before the residents signed the arbitration agreement contract. Staff L stated that Resident 52 and Resident 21 were not able to cognitively acknowledge/understand the arbitration agreements and that Staff L should have talked with the RR. During an interview on 11/20/2025 at 12:50 PM, Staff A, Administrator, Staff A stated that Resident 52 and Resident 21 were cognitively impaired, and that Staff L should not have the residents sign, acknowledging the understanding of the binding arbitration agreement. Staff A stated the correct process was not followed and the cognitive status of a resident needed to be identified before having them sign a binding legal contract. Reference: WAC 388-97-1620(2)(b)(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview and record review the facility failed to ensure cleaning, disinfecting and/or storing of oxygen care equipment was maintained in a manner to prevent infectious diseases for 3 of 3 residents (Residents 1, 36, and 35)reviewed for cleanliness of oxygen concentrator (a device that pulls air out of the environment and concentrates oxygen for use) filters and 1 of 2 residents (Resident 25) reviewed for storage of oxygen tubing when not in use. These failures placed residents at risk for infectious disease transmission and illness in their respiratory system (lungs). Findings included . <Oxygen filters> <Resident 1> Review of the Resident 1's medical record showed they were admitted to the facility with diagnoses including, obstructive sleep apnea (repeated episodes of upper airway obstruction during sleep) and dementia. Review of the comprehensive assessment dated [DATE] showed the resident was severely cognitively impaired and was dependent for grooming, dressing, transfer and mobility. Review of Resident 1's physicians orders for January 2025 showed the resident's oxygen concentrator filters were to be changed weekly. During an observation on 01/06/2025 at 10:05 AM showed Resident 1 in bed with their oxygen concentrator running with the cannula (a device that delivers oxygen through two prongs through a tube into your nose) in Resident 1's nostrils administering oxygen. Observation of the concentrators filter showed a thick layer of dust, dirt and hair on the surface of the filter which impacted the function of the filter to remove particles from the air. During an additional observation on 01/13/2025 at 11:28 AM showed Resident 1's oxygen concentrator filter still dirty with dust, dirt and hair on the surface of the filter. <Resident 36> Review of Resident 36's medical record showed they were admitted with diagnoses including, a history of bronchitis (a condition in which the upper airway becomes irritated and causes coughing and can cause respiratory infection), cerebral vascular accident (blood supply is cut off from areas in the brain) and dysphagia (difficulty swallowing often the result of a CVA). Review of the comprehensive assessment dated [DATE] showed the resident had severe cognitive impairment and was dependent on staff for grooming, dressing, transfers and mobility. Record review of the residents January 2025 physician orders showed they were required to have their oxygen concentrator filter changed weekly and as needed, however there were no signatures from licensed staff to indicate this task had been completed. During observations on 01/06/2025 at 10:17 AM and 01/13/2025 at 11:18 AM, showed Resident 36 in their room with their oxygen concentrator on delivering oxygen by the nasal cannula. Observation of the concentrator filter showed a thick layer of dust, dirt and hair on the surface of the filter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 35> Review of Resident 35's medical record showed they were admitted with diagnoses including a history of bronchitis and heart failure (the heart is not pumping blood to the body as well as it should). Review of the comprehensive assessment dated [DATE] showed the resident had severe cognitive impairment and was dependent on staff for grooming, dressing, mobility and transfers. Review of the resident's physician's orders for January 2025 showed no orders to change oxygen concentrator filters. During an observation on 01/14/2025 at 11:37 AM, showed Resident 35 in their room with their oxygen concentrator on and delivering the resident oxygen per nasal cannula. Observation of the resident's oxygen filter showed a thick layer of dust, dirt and hair on the surface of the filter which decreased the ability to appropriately filter out particles from the air as required. During an interview on 01/06/2025 at 10:20 AM, Staff Z, Licensed Practical Nurse, stated they did not change the oxygen concentrator on their shift however knew it was scheduled to be changed weekly. <Resident 25> Review of the 12/14/2024 medical record showed the resident admitted to the facility with multiple health diagnoses to include heart failure and respiratory problems which caused Resident 25 to be on continuous oxygen. During an observation concurrent interview 01/06/2025 at 11:00 AM, Resident 25's oxygen concentrator was plugged into the wall located to the left side of the resident's bed. Resident 25 had a nasal canula attached to the oxygen concentrator. The humidifier bottle (a reservoir of distilled water attached to the oxygen concentrator by a plastic tube was used to moisturize the air from the concentrator), was located on the floor with an extra-long plastic tube and not on the oxygen concentrator designated shelf for the humidifier bottle. Resident 25 responded that they had the humidifier on the floor because there was not any tubing to fit the (humidifier) bottle. An observation on 01/06/2025 at 11:10 AM, showed a large oxygen tank attached to Resident 25's wheelchair. The oxygen tank attached to the back of the resident's wheelchair had oxygen tubing attached to the oxygen tank. The long plastic tubing which is placed in Resident 25's nose for delivery of the oxygen was located on the floor. During observations on 01/07/2025 at 10:00 AM, 1:00 PM and 2:00 PM Resident 25's humidifier attached to the oxygen concentrator continued to be on the floor. During an interview on 01/08/2025 at 11:05 AM, Staff D, Resident Care Manager (RCM) stated that Resident 25's oxygen humidifier and tubing for oxygen deliver were not to be on the floor, and it was an infection control issue. Staff D stated the tubing was too long on the humidifier and could not fit into the space on the oxygen concentrator. Also, the oxygen tank attached to Resident 25's wheelchair needed to be discarded and replaced. Staff D stated the oxygen tubing would need to be in a bag off of the floor. During an observation on 01/09/2025 at 10:45 AM Resident 25's oxygen humidifier was located on the floor and not located on the oxygen concentrator off the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 11:50 AM, Staff U, Infection Preventionist (IP) stated the oxygen concentrator humidifier should not be on the floor and the tubing connected to the humidifier was too long. During an interview on 01/13/2025 at 1:40 PM Staff B, Director of Nursing Services stated they expected licensed staff to follow the physicians' orders and change the oxygen concentrator filters weekly and to maintain infection control practices related to oxygen equipment. Reference WAC 388-97-1320(2)(a) 31168

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 31168 Based on interview and record review, the facility failed to ensure residents and/or resident representatives were educated on the risks and benefits of the influenza vaccine, and consent or declination were obtained for the vaccine for 2 of 5 sampled residents (Residents 14 and 27) reviewed for influenza immunization. This failure placed residents at risk of not being fully informed before making decisions regarding immunizations and receiving the vaccine. Findings included . <Resident 14> Review of the 11/22/2024 medical record showed the resident was alert, oriented and able to make their needs known. During an interview on 01/09/2025 at 1:00 PM, Resident14 stated they received a flu vaccine every year but had not been given the vaccine in 2024/2025 and would like to have the flu vaccine. Review of the 12/03/2024 informed consent for vaccine education, consent and/or declination showed Resident 14 declined the COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing, that could result in severe impairment or death) booster. There was no documentation in the medical record to show education, consent or acceptance/ declination for choices of the Influenza Vaccine. Review of the 12/14/2024 comprehensive assessment showed Resident 14 declined the Influenza vaccine and was not in the facility at the time. During an interview on 01/14/2025 at 9:50 AM, Resident 14 stated they had not been approached to consent to receive the Influenza vaccine which they would accept. Additionally, the resident stated they had not left the building and would have accepted the vaccine. <Resident 27> Review of the medical record showed the resident was able to make their needs known and did have a representative that assisted Resident 27 in decision making. Review of the informed consent to receive the influenza vaccine was dated 11/22/2024. The resident's representative also concurred that Resident 27 received the Influenza vaccine. During an interview on 01/07/2025 at 3:00 PM, Resident 27 stated they had not received their Influenza vaccine yet and had consented to getting the vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 01/09/2025 at 11:40 AM, Staff U, Infection Preventionist (IP) stated that there were no consents, education offered to residents for vaccines for the Flu season start and they had just recently started this position (IP). Review of Staff U's line list for residents who were to be educated and consent to receive the influenza did not include Resident 14. Review of Staff U's list showed Resident 27 consented but had not received the vaccine. Additionally, Staff U was not communicating with the Medical Director as to the best time to start the Influenza vaccines for residents. During an interview on 01/09/2025 at 1:00 PM, a Collateral Contact from the local health department (Kittitas County) stated that there was a current outbreak of Influenza both types. This would be a time for the facility to have their residents and staff to have up-to date vaccines. During an interview on 01/10/2025 at 8:52 AM, Staff B the Director of Nursing Services, stated they knew the Infection control/vaccine system was broken and needed to be assessed and updated. Reference WAC 388-97-1340 (1), (2), (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505263	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	1050 E Mountain View Ellensburg, WA 98926

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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** 39652 Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable and sanitary environment was maintained for 1) 2 of 3 halls (East and West) flooring, 2) East dining room, 3) [NAME] Hall shower room, 4) rooms [ROOM NUMBERS], 5) Laundry room, 6) East clean/dirty utility room, and 7) Conference/activities room. These failures placed the residents, at risk for potential accidents and the exposure to contaminants from unclean surfaces. Findings included . <East Hall Resident Room Floors> Observations on the east hall on 01/06/2025 at 11:00 AM, 01/07/2025 at 10:30 AM, 01/08/2025 at 11:15 AM, 01/09/2025 at 12:00PM, 01/10/2025 at 9:00 AM and 01/14/2025 at 9:00 AM, showed a housekeeper swept and mopped the east hallway to include resident rooms, utility rooms, linen room and east dining room. The dark substances and dirt embedded into the floors and entry ways was not cleanable. All resident rooms on the east hallway Rooms (1-12) had uncleanable dirt embedded black dirt substances at the entry/exit thresh hold of their rooms. During an interview on 01/09/2025 at 1:00 PM, Staff V, Housekeeping Supervisor, stated they deep cleaned residents ' room on a schedule. The Nursing Assistants (NAs) were to clean the resident ' s bed on their bath day. Staff V stated room [ROOM NUMBER] had a urine smell, and it was hard to remove. <West Hall Resident Room Floors> During multiple observations on 01/07/2025 at 12:40 PM, 01/09/2025 at 3:00 PM and 01/13/2025 at 9:40 AM showed entry/exit doorway floors in rooms (18-33) with thick grime between the tiles. The black grime could not be removed by sweeping and mopping and would require a tool for scraping to remove the black substance. <East Dining Room> During observations on 01/06/2025 at 12:40 PM, the east dining room floors were split where there a patch of white caulking (a sealing material used to fill gaps between surfaces) between tiles. The split was located by the residents long dining table where areas were open and black five feet long area another four-foot area that was caulked and now had open areas on the caulking line in the dining area. The tile along the areas caulked had black substances and dirt and were not cleanable. The base heater along the right far wall of the east dining area after entering the dining room was damaged and located next to a resident ' s table. The front end to the left of the base heater was dented 10 inches into the heater and did radiate heat. A resident in a wheelchair was seated next to the base heater. <Shower Room [NAME] Hall> (continued on next page)

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	505263	A. Building B. Wing	01/14/2025

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Mountain View Post Acute	1050 E Mountain View Ellensburg, WA 98926

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During multiple observations on 01/06/2025 at 3:11 PM, 01/08/2025 at 2:42 PM and 01/13/2025 at 3:22 PM showed the shower room on the west hall had a black tar-like substance on the wall under the sink embedded in the tile grooves. Additionally, there was a black tar-like substance embedded in the grooves of the tiles on the back of the shower wall. The toilet had dark stains in the toilet bowl and dark yellow stains under the toilet seat. The wall in front of the shower had a splatter of rust-colored stains beneath the clock and two unused brackets that were in poor repair. Additionally, the sprinkler had a spider web hanging from it and the vent was dusty and dirty. <room [ROOM NUMBER]> During an observation on 01/14/2025 at 8:28 AM, room [ROOM NUMBER] showed a wall with significant deep long gouges on the right side of the wall entering the room with the longest gauge five feet long and the room smelled of stale urine. <room [ROOM NUMBER]> During a concurrent observation and interview on 01/06/2025 at 1:06 PM in room [ROOM NUMBER] Resident 4 and 22 (roommates) stated their room was too hot. Resident 22 further stated it was hard to control the temperatures as when the door was open the room got too cold and when the door was closed the room was too hot Observation of Resident 4 showed them remove their sweater and stated, it ' s just too hot in here. The residents had requested the door be closed for privacy and the room was noted to be excessively warm and uncomfortable during conversation with the residents. <Laundry Room> During observations on 01/14/2025 at 1:01 PM, the flooring tile located in front of the laundry room showed an eight-by-eight-foot area of tile with black substances coming out between the tiles. A black rubber floor mat covered some of the tiles in front of the entry to the soiled utility door and the other clean exit/entry doorway. The floor in front of the laundry entry to the clean and soiled doorways have black and brown grime substances located in the tiles and corners of the entryway. These areas were not cleanable by housekeeping staff. <East Clean/Dirty Utility Rooms> The soiled utility room sink had a damaged 12-inch area of the countertop where wood was exposed. This was in front of the sink. The lower cabinet in front of the sink had peeling and splintered wood around the edges of the cabinet doors. The clean utility room sink located to the left after entering the room, the corner of the counter of the sink cabinet was worn with wood exposed on the edge measured three by three inches. The lower left side of the sink cabinet was scarred/scratched with black marks (five feet) across the side of the wood., (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Conference / Activities Room> During an observation on 01/07/2025 at 2:38 PM, the room was a multi-purpose room and showed flooring with off white tiles that had chips and a large hole in the tile located mid-way up the left side of the room after entering in from the door. The hole measured three inches wide and one inch deep. This was not a cleanable surface but a potential fall risk for residents and staff. The door to the other side of the conference/activity room went to the outside was damaged with significant multiple chips to the door edges and multiple deep scratch marks across the length of the door. The top of the door showed patched wood border connected to the top door frame with ability to see through between the upper door frame and the wood. The conference room/activity room tile floor was in poor condition with crackling of tile among all the floor tile area. The entry way and corners of the flooring edge were stained with black and brown substances. The floors were mopped and cleaned by housekeeping staff, but the substances were not removed by the cleaning. During an interview on 01/10/2025 at 11:00 AM, Staff F, Maintenance Director, stated the facility was old and in need of many repairs. There werenot any repairs on their list at this time. During an interview on 01/14/2025 at 1:07 PM, staff V stated the facility floors were to have the wax striped and removed yearly but it had been over a year since the last removal. The facility floors were to be waxed every two months, but it had not been done. During an interview on 01/13/2025 at 2:05 PM, Staff A, Administrator, stated their expectation was to maintain a clean comfortable environment for the residents to live in. Reference WAC 388-97--3220 (1) 31168