Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505270	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Park West	1703 California Avenue Southwest Seattle, WA 98116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42203 Based on observation, interview, and record review, the facility failed to provide care and services in a manner that maintained and promoted resident rights and dignity for 4 (Residents 37, 3, 76, & 69) of 20 sample residents. The failure to obtain consent prior to psychotropic medication treatment (Resident 37) and the failure to provide adequate privacy during the provision of care (Residents 3, 76, & 69) placed residents at risk for unwanted psychotropic medications, a diminished sense of self-worth, and wellbeing. Findings included . <Consent> <Facility Policy> According to the facility's 08/25/2020 Psychotropic Medication policy when a resident received a new order for a psychotropic medication the facility would obtain informed consent (a process where a resident is informed of the risks and benefits of a treatment before they agree to receive it) prior to administration of the medication. <Resident 37> According to the 02/27/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 37 was assessed with severe memory impairment and showed verbal behaviors towards others on one-to-three days of the assessment's 7-day lookback period. The MDS showed Resident 37 had medically complex diagnoses including dementia and difficulty adjusting to new situations with mixed anxiety and depressed mood. Review of the April 2024 Medication Administration Record (MAR) showed Resident 37 had an order for an antipsychotic medication. The order showed the medication was for Vascular dementia with behavioral disturbance and psychosis. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 37's record included a 3/21/2022 consent form signed by Resident 37. The form included the names of many different psychotropic medications, organized by drug class (antipsychotics, antidepressants, sedative medications etc.) and showed the form should be used for one medication per form. The form instructed staff to circle the name of the medication the resident was asked to provide consent form. No medication on the form was circled to indicate for which medication Resident 37 was asked to provide consent. In an interview on 04/22/2024 Staff B (Director of Nursing) stated the 3/21/2022 consent form was not but should have been circled to indicate which medication Resident 37 provided consent for. Staff B stated because of this informed consent was not obtained. 43642 <Resident Care> <Resident 3> According to a 02/01/2024 Significant Change MDS Resident 3 had a functional limitation in Range of Motion (ROM) on their upper arm and lower leg on one-side and was dependent on staff for dressing, personal hygiene, and rolling from side to side in bed. Observations on 04/15/2024 at 10:32 AM showed upon entering Resident 3's room, Staff X (Certified Nursing Assistant - CNA) was providing care with no privacy curtain pulled. <Resident 76> According to a 03/20/2024 Quarterly MDS Resident 76 had a functional limitation in ROM to their upper arm on one-side and both lower legs, required substantial assistance with dressing, and was dependent on staff for personal hygiene and rolling from side to side in bed. Observations on 04/15/2024 at 10:38 AM showed upon entering Resident 76's room, Staff W (CNA) was providing care and assisting the resident with dressing with no privacy curtain pulled. Observations on 04/16/2024 at 9:12 AM showed upon entering Resident 76's room, Staff V (CNA) was providing care and assisting the resident with dressing with no privacy curtain pulled towards door or the other side of the room. At this time, Resident 76's roommate was sitting at their own bedside looking over towards Resident 76. <Resident 69> According to a 02/02/2024 Quarterly MDS, Resident 69 had a functional limitation in ROM to both upper arms and lower legs and was dependent on staff for dressing, personal hygiene, and rolling from side to side in bed. Observations on 04/19/2024 at 1:15 PM showed, while in Resident 69's room, Staff U (CNA) and Staff Y (Licensed Practical Nurse) assisted the resident to a side lying position to apply a pain patch to the resident's lower back with no privacy curtain pulled while Resident 69's backside was exposed the door opened and the resident's family member entered the room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 04/19/2024 at 1:55 PM showed upon entering Resident 69's room, Staff U was in the middle of providing incontinence care to Resident 69 with no privacy curtain pulled. Resident 69 was on their side with their backside exposed to the door and staff was securing a brief in place. In an interview on 04/19/2024 at 2:06 PM, Staff U stated they closed a resident's door to provide privacy during care and had not considered the privacy curtain being pulled to block the view from the door if opened and/or hallway during care. In an interview on 04/22/2024 at 10:22 AM, Staff F (Resident Care Manager) stated the privacy and dignity of residents was important to protect the resident's rights. Staff F stated privacy should be provided and the curtains should be pulled while staff provide care to residents. REFERENCE: WAC 388-97-0180(1-4).

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation and interview, the facility failed to ensure residents where provided with a home like environment for 2 of 3 floors (the 200 Floor and 300 Floor) and 1 of 2 elevators. The failure to ensure resident rooms were free of walls with gouges/missing paint and stained ceiling tiles and the elevator was free of broken trim left residents at risk for a less-than-homelike environment. Findings included . <Facility Policy> The facility's February 2021 Homelike Environment policy showed residents would be provided a safe, clean, comfortable, and homelike environment. The policy showed the facility environment should be clean and sanitary. <Resident Rooms> Observations on 04/15/2024 at 8:39 AM showed bed 1 in room [ROOM NUMBER] had deep gouges and exposed drywall on the wall at the head of the resident's bed and a ceiling tile falling down on one side above the resident's bed. In an interview and observation on 04/22/2024 at 3:19 PM, Staff S (Central Supply) confirmed the damage to the wall and indicated the ceiling tile was not fully secured. Observations on 04/15/2024 at 10:55 AM showed room [ROOM NUMBER] with the lower wall by the bathroom door had gouges and missing paint. In an interview at 04/22/2024 at 3:25 PM, Staff S confirmed the damage to the wall and indicated it should be fixed by staff. Observation on 04/15/2024 at 11:05 AM showed the ceiling tiles in room [ROOM NUMBER] had brown stains. Observation on 04/15/2024 at 11:27 AM showed the ceiling tiles in room [ROOM NUMBER], including the ceiling tiles inside the bathroom, had brown stains and the wall next to the resident's bed headboard had multiple deep gouges. Observations on 04/16/2024 at 8:47 AM showed bed 2 in room [ROOM NUMBER] had deep gouges and exposed drywall on the wall at the head of the resident's bed. In an interview at 04/22/2024 at 3:20 PM, Staff S confirmed the damage to the wall and stated it should be fixed by staff. Observations on 04/19/2024 at 8:52 AM showed bed 1 in room [ROOM NUMBER] with the paint scratched off the wall alongside the bed. In an interview and observation on 04/22/2024 at 3:36 PM, Staff S confirmed the damage to the wall and stated it should be fixed by staff. Observations on 04/22/2024 at 3:23 PM showed bed 1 in room [ROOM NUMBER] with the paint scratched off the wall along the side of the resident's bed and a brown stain on one of the ceiling tiles. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Hallway Ceilings> Observations of the 3rd floor ceiling on 04/15/2024 at 10:34 PM showed brown stained areas to the ceiling tiles outside of room [ROOM NUMBER], 310, and at the nurse's station. In an interview on 04/22/2024 at 3:16 PM, Staff S confirmed the brown stained ceiling tiles and stated they should be replaced. <Elevator> Observations on 04/18/2024 at 8:09 AM showed a piece of the trim on the elevator wall was broken, leaving a sharp, jagged edge at reachable/thigh level. A resident entered the elevator in a wheelchair and almost bumped into the broken area with their arm. In an interview on 04/22/2024 at 3:49 PM, Staff B (Director of Nursing) stated their expectation was for residents to have a home-like environment. Staff B stated the damaged walls should be fixed and equipment in good working condition. REFERENCE: WAC 388-97-0880.

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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. 45941 Based on interview and record review, the facility failed to ensure a system by which residents received required written notices at the time of transfer/discharge, or as soon as practicable, for 3 of 4 residents (Residents 30, 66, & 97) reviewed for hospitalization . Failure to ensure a written notification was provided to the resident and/or representative of the reasons for the discharge and in a language and manner the resident and/or representative understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> According to the facility's March 2021 Transfers and Discharges Notice policy residents should be informed in writing and in a language and format of their choice of the reason for and date or the transfer or discharge. The policy showed for emergent transfers the notification should be provided as soon as practical, and a copy provided to the State Long-Term Care Ombuds (an advocacy group). <Resident 66> According to the 12/12/2023 Discharge Return Anticipated MDS, Resident 66 discharged to the hospital on 12/12/2023 related to a change in the resident's condition. The MDS showed Resident 66 had medical conditions including kidney failure. According to a 12/12/2023 nursing progress note, Resident 66 was on their dialysis (a procedure that cleaned the blood when the kidneys could not) treatment at the Kidney Center when the resident needed to be sent out to the hospital for further evaluation. The facility was not able to provide any documentation to support Resident 66 or their representative was provided a written notification regarding the reason for their transfer and/or discharge to the hospital as required. In an interview on 04/22/2024 at 2:20 PM, Staff M (Social Services Director) stated the medical records department was responsible for providing the transfer/discharge notices. In an interview on 04/22/2024 at 2:38 PM, Staff L (Medical Records Assistant) stated they did not send a written notification to Resident 66 and/or their representative. Staff L stated they used to send transfer/discharge written notifications to residents and/or their representatives and notify the Long-Term Care Ombudsman (LTCO) only until June 2023. Staff L stated they stopped sending these notifications after June 2023 thinking it was no longer required. In an interview on 04/22/2024 at 2:54 PM, Staff M stated Staff L needed education regarding the provision of written transfer/discharge notices to residents and/or their representatives and the LTCO notification. Staff M stated the facility should have, but did not provide Resident 66 the required written transfer/discharge notice or notified the LTCO as required. 42203 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 30> According to the 03/22/2024 Quarterly MDS Resident 30 had medically complex diagnoses including heart failure, and an infection of their lower vertebrae. According to a 01/18/2024 progress note, Resident 30 was transferred to the hospital emergently at 12:30 PM on that date for a blood transfusion. A 02/28/2024 progress note showed Resident 30 required another emergent transfer to the hospital for a blood transfusion at 2:45 PM. Record review showed no documentation facility staff provided Resident 30 or their representative written notification of the reason for transfer to the hospital. <Resident 97> According to the 03/27/2024 Admission MDS had diagnoses including malnourishment, gout, and nausea. According to a 4/12/2024 progress note, Resident was sent out to hospital after the sudden onset of a headache and nausea. Record review showed no documentation facility staff provided Resident 97 or their representative written notification of the reason for transfer to the hospital. In an interview on 04/22/2024 at 2:38 PM, Staff L stated they sent no transfer notifications after June 2023 due to a misunderstanding that they were no longer required, so the process was not completed for Resident 30 or Resident 97. Refer to F625 - Notice of Bed Hold Policy Before/Upon Transfer REFERENCE: WAC 388-97-0120 (2)(a-d), -0140 (1)(a)(b)(c)(i-iii).

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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** 45941 Based on interview and record review, the facility failed to provide the resident and/or the resident's representative a written notice of the facility's bed hold (a process allowing residents who transfer from a facility temporarily to return to the same bed) policy, at the time of transfer or within 24 hours, for 2 of 4 sample residents (Resident 66 & 97) reviewed for hospitalization . This failure placed the residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized that was necessary for decision-making. Findings included . <Facility Policy> The facility's October 2022 Bed Hold and Returns policy showed all residents and/or their representatives would be provided written information regarding the facility's bed hold process both upon admission and at the time of transfer. The policy showed in the case of an emergent transfer the facility would provide this notification within 24 hours. <Resident 66> According to the 12/12/2023 Discharge Return Anticipated MDS, Resident 66 discharged to the hospital on 12/12/2023 related to a change in the resident's condition. The MDS showed Resident 66 had medical conditions including kidney failure. According to a 12/12/2023 nursing progress note, Resident 66 was on their dialysis (a procedure that cleaned the blood when the kidneys could not) treatment at the Kidney Center when the resident needed to be sent out to the hospital for further evaluation. Review of Resident 66's medical record did not show the facility discussed and/or offered a bed hold to the resident or their representative during their discharge to the hospital as required. In an interview on 04/22/2024 at 10:31 AM, Staff K (RCM) stated they were responsible for offering a bed hold to residents who discharged to the hospital. Staff K stated offering a bed hold was important because it was a resident right so the resident could make an informed decision. Staff J stated a bed hold should have, but was not provided to Resident 66 or their representative as required. 42203 <Resident 97> According to the 03/27/2024 Admission MDS had diagnoses including malnourishment, gout, and nausea. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 4/12/2024 progress note, Resident was sent out to hospital after the sudden onset of a headache and nausea. A second 04/12/2024 progress note showed the facility was not able to attain [a] bed hold for Resident 97 due to the resident's altered mental state at the time of transfer. According to a progress note Resident 97 returned to the facility on [DATE], eight days after transfer. In an interview on 04/12/2024 Staff M (Social Services Director) stated typically nursing handled the bed hold process. Staff M stated Resident 67 should have received a bed hold. Staff M stated resident's record did not show a bed hold was provided. Refer to F623 - Notice Requirements Before Transfer/Discharge REFERENCE: WAC 388-97-0120(4).

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 43642 Based on interview and record review, the facility failed to transmit the required Minimum Data Set (MDS - an assessment tool) data to the Center for Medicare and Medicaid Services (CMS) within the required time frames for 6 (Resident 33, 69, 57, 17, 73, & 51) of 20 sample residents reviewed for resident assessments. This failure placed residents at risk for delays in care planning, unmet care needs, and a diminished quality of life. Findings included . Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, revised in October 2023, showed Significant Change, Quarterly, and Annual MDS assessments must be completed no later than 14 days after the Assessment Reference Date (ARD), and it must be submitted/transmitted within 14 days of the MDS completion date to the database as required. <Resident 33> Review of Resident 33's records showed a 07/18/2023 Significant Change MDS was not completed or transmitted by staff as required to CMS until 08/07/2023, six days after the required due date. Resident 33's 02/02/2024 Quarterly MDS was not completed or transmitted by staff as required to CMS until 02/28/2024, 12 days after the required due date. <Resident 69> Review of Resident 69's records showed a 02/02/2024 Quarterly MDS was not completed or transmitted by staff as required to CMS until 02/28/2024, 12 days after the required due date. <Resident 57> Review of Resident 57's records showed a 02/01/2024 Quarterly MDS was not completed or transmitted by staff as required to CMS until 02/28/2024, 11 days after the required due date. <Resident 17> Review of Resident 17's records showed a 01/30/2024 Annual MDS was not completed or transmitted by staff as required to CMS until 02/15/2024, two days after the required due date. <Resident 73> Review of Resident 73's records showed a 01/24/2024 Quarterly MDS was not completed or transmitted by staff as required to CMS until 02/09/2024, two days after the required due date. <Resident 51> (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 51's records showed a 01/01/2024 Quarterly MDS was not completed or transmitted by staff as required to CMS until 01/16/2024, one day after the required due date. Resident 51's 02/08/2024 Quarterly MDS was not completed and transmitted by staff as required to CMS until 02/25/2024, three days after the required due date. In a joint interview on 04/22/2024 at 2:25 PM, with Staff J (MDS Coordinator) and Staff Q (MDS Coordinator), Staff Q stated they had 14 days from the ARD to complete the MDS assessment. Staff J stated an MDS should be completed and transmitted by staff timely as required and confirmed the MDS assessments for Residents 33, 69, 57, 17, 73, and 51 were not completed timely as required. REFERENCE: WAC 388-97-1000(4)(b, (5)(e)(i-iii).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 43642 Based on observation, interview, and record review the facility failed to ensure 6 (Residents 7, 57, 69, 81, 37, & 2) of 20 sample residents Minimum Data Set (MDS - an assessment tool) were completed accurately to reflect the resident's condition. This failure placed residents at risk for unidentified and/or unmet care needs. Findings included . <Resident 7> According to a 03/01/2024 Quarterly MDS, Resident 7 had no psychosis, behavioral symptoms, or rejection of care during the assessment period. Review of a 03/28/2024 restorative nursing program Care Plan (CP) showed directions to staff to provide a knee brace program seven days per week. Review of Resident 7's February 2024 restorative documentation showed staff documented the resident refused their knee brace program on two of seven days during the assessment period for the 03/01/2024 Quarterly MDS. <Resident 57> According to a 02/01/2024 Quarterly MDS, Resident 57 had no psychosis, behavioral symptoms, or rejection of care during the assessment period. Review of an 11/27/2023 restorative nursing program CP showed directions to staff to provide an active Range of Motion (ROM) program for Resident 57 three to six times per week. Review of Resident 57's January 2024 restorative documentation showed staff documented the resident refused their ROM program the four times it was offered during the assessment period. According to a revised 04/29/2023 Self-care performance CP, Resident 57 required extensive assistance from staff with bathing. Review of Resident 57's January 2024 bathing documentation showed staff documented the resident refused bathing two out of two occasions for bathing during the assessment period. In an interview on 03/22/2024 at 9:32 AM, Staff J (MDS Coordinator) stated their expectation was for rejection of care to be accurately captured on an MDS assessment. <Resident 69> According to a 02/02/2024 Quarterly MDS, Resident 69 had multiple medically complex diagnoses including an anxiety disorder. The MDS showed Resident 69 did not receive antianxiety medications during the assessment period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the April 2024 Medication Administration Record (MAR) showed Resident 69 received an antianxiety medication twice daily since 11/03/2023. In an interview on 03/22/2024 at 9:32 AM, Staff Q (MDS Coordinator) confirmed Resident 69 was received an antianxiety medication during the assessment period. Staff Q stated the antianxiety medication should be but was not identified accurately on the 02/02/2024 Quarterly MDS. 42203 <Resident 81> According to the 03/21/2024 Admission MDS Resident 81 was assessed with intact memory and was able to understand and be understood in conversation. The MDS showed Resident 81 showed no rejection of care during the assessment's seven-day lookback period. The section of this MDS addressing Resident 81's mood included instructions for staff to conduct a mood interview with the resident unless the resident was rarely or never understood in conversation. Instead, staff completed a staff assessment of Resident 81's mood. The section of this MDS addressing pain included instructions for staff to conduct a pain interview with Resident 81 unless the resident was rarely or never understood in conversation. This section was incomplete showing a - (dash) for four questions discussing with what frequency Resident 81's pain interfered with different aspects of their life, instead of including a value indicating a frequency. The MDS showed Resident 81 had obvious or likely cavity or broken natural teeth. In an interview on 04/16/2024 at 9:53 AM Resident 81 stated all their teeth were removed. Resident 81 stated they chewed using their gums and encountered no difficulty eating. In an interview on 04/22/2024 at 10:43 AM Staff Q and Staff J stated the purpose of the MDS process was periodically assess residents' health status and care needs in order to generate and update CPs. Staff Q stated they expected resident interviews to be conducted as appropriate when MDS data was collected. Staff Q stated if residents refused to participate, they expected the refusal to be documented. Staff Q stated staff completing assessments instead of resident interviews could prevent the resident's perspective from being included in the assessment. Staff Q stated this MDS was done by corporate indicating a nurse outside the facility completed the MDS. Staff Q stated remote completion of the MDS could be the cause of the pain and mood resident interviews not being completed, and the cause of the inaccurate assessment of Resident 81's dental status. <Resident 37> According to the 02/27/2024 Quarterly MDS Resident 37 had severe memory impairment and showed verbal behaviors towards others on one-to-three days of the assessment's 7-day lookback period. The MDS showed Resident 37 had medically complex diagnoses including dementia and an adjustment period disorder with mixed anxiety and depressed mood. The MDS did indicate Resident 37 had a psychotic disorder diagnosis. Review of the April 2024 Medication Administration Record showed Resident 81 received an antipsychotic medication. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 37's record showed Resident was given an Unspecified psychosis . of unkown origin diagnosis. In an interview on 04/25/2024 at 11:15 AM Staff B (Director of Nursing) stated this psychotic disorder diagnosis was active at the time of the 02/27/2024 MDS and should be included. 45941 <Resident 2> According to the 02/14/2024 Quarterly MDS, Resident 2 had medical diagnoses including anxiety and Obsessive-Compulsive Disorder (OCD - a behavior where a person would perform unwanted repetitive actions). The MDS showed Resident 2 did not receive antipsychotic medication during the assessment period. The MDS showed Resident 2's weight was marked with a dash. Review of the February 2024 MAR showed Resident 2 received an antipsychotic medication daily for their OCD behavior. In an interview on 04/22/2024 at 10:58 AM, Staff J stated Resident 2's MDS was inaccurate and should reflect the daily AP medication administration during the assessment period. Review of the weight records showed the Resident 2's weight were not obtained by staff during the assessment period. In an interview on 04/22/2024 at 11:02 AM, Staff J stated Resident 2's weight was dashed in the MDS because the nursing staff did not weigh the resident on or before the last day of the assessment observation period. Staff J stated a member of the nursing staff should have weighed Resident 2 so they could accurately complete the resident's MDS assessment, but did not. REFERENCE: WAC 388-97- -1000 (1)(b).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 42203 Based on record review and interview, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR - a mental health screening required before transfer to a nursing home) assessments were revised to reflect mental health changes for 3 of 6 residents (Residents 37, 30, & 13) reviewed for PASRRs and one supplemental resident (Resident 69). This failure left residents at risk for risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . <Facility Policy> The facility's 03/22/2024 PASRR policy showed the purpose of a PASRR assessment was to ensure residents with mental health or intellectual disabilities were appropriately placed and received the services they required. The policy showed PASRRs would be reviewed periodically for potential changes and the Social Services was responsible. <Resident 30> According to the 03/22/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 30 had medically complex diagnoses including anxiety, dementia, a psychotic disorder. Record review showed the most recent Level 1 PASRR in Resident 30's record was dated 11/28/2023. This Level 1 PASSR did not identify Resident 30's anxiety or depression diagnoses. In an interview on 04/22/2024 at 3:09 PM Staff M (Social Services Director) stated it was important for PASRRs to accurately reflect residents' current mental health status. Staff M reviewed Resident 30's 11/28/2023 Level 1 PASRR and stated it was not accurate and needed to be redone. <Resident 37> According to the 02/27/2024 Quarterly MDS Resident 37 had severe memory impairment and showed verbal behaviors towards others on one-to-three days of the assessment's 7-day lookback period. The MDS showed Resident 37 had medically complex diagnoses including dementia and difficulty adjustiung to changes with mixed anxiety and depressed mood. The April 2024 Medication Administration Record (MAR) showed Resident 37 was prescribed an antipsychotic medication for vascular dementia with behavioral disturbance and psychosis. Record review showed a 01/23/2024 pharmacist recommendation to ensure there was an appropriate diagnosis for Resident 37's antipsychotic medication. On 02/06/2024 the physician annotated the recommendation to indicate a psychosis diagnosis was the rationale. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed the most recent Level 1 PASRR in Resident 37's chart was dated 10/19/2022. This PASRR did not reflect Resident 37's difficulty adjusting to changes with mixed anxiety and depressed mood, or psychosis diagnosis. In an interview on 04/22/2024 at 3:09 PM Staff M stated when new diagnoses, treatments, or behaviors arose for residents it was important to redo a Level 1 PASRR screening. Staff M stated the 10/19/2022 PASRR did not reflect Resident 37's psychosis diagnosis. 43642 <Resident 13> According to a 02/08/2024 Quarterly MDS, Resident 13 had multiple medically complex diagnoses including depression and an anxiety disorder and required the use of antidepressant and antianxiety medications during the assessment period. Review of Resident 13's April 2024 MAR showed the resident received an antidepressant and antianxiety medications. Review of Resident 13's 02/20/2024 PASRR Level 1 form completed by staff showed one of the three questions required to be completed was left blank. In an interview on 04/26/2024 at 2:55 PM Staff M stated all three of the questions on the form should be answered but were not. <Resident 69> According to a 02/02/2024 Quarterly MDS, Resident 69 had multiple medically complex diagnoses including an anxiety disorder. Review of Resident 69's January 2024 MAR showed the resident had a medication order for an antianxiety medication to be utilized as needed for anxiety. Review of a 01/24/2024 provider progress note showed Resident 69 had an anxiety diagnosis and had medications ordered for anxiety. Review of Resident 69's 01/06/2023 and 03/25/2024 PASRR Level 1 forms showed the resident was not identified as having a Serious Mental Illness (SMI) indictor of anxiety. In an interview on 04/26/2024 at 2:55 PM Staff M stated the Level 1 PASSRs should reflect Resident 69's anxiety diagnosis but did not. REFERENCE: WAC 388-97-1975(1)(4).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the failed to ensure a person-centered comprehensive Care Plan (CP) was developed and implemented for 4 of 20 sample residents (Resident's 37, 73, 66, & 91) whose CPs were reviewed. Failure to address the individualized care needs for each resident placed residents at risk for inconsistent and/or inadequate care, and a decreased quality of life. <Facility Policy> According to the facility's [DATE] Comprehensive Person-Centered CP policy, the facility would develop a comprehensive, person-centered CP for each resident. The CP would be consistent with each resident's assessed needs, and should include objective, measurable goals. <Resident 66> According to the [DATE] Quarterly Minimum Data Set (MDS - an assessment tool) Resident 66 admitted to the facility on [DATE] and had medical diagnoses including kidney and heart failure, and high blood pressure. The assessment showed Resident 66 had no broken teeth. Observation on [DATE] at 2:33 PM and [DATE] at 8:12 AM showed Resident 66 had no upper teeth and was missing three of their lower front teeth. Resident 66 confirmed their dental condition was the case for a long time and stated they need dentures. Review of the [DATE] dental assessment showed Resident 66 was missing multiple teeth and the resident required staff assistance for their oral care. Review of Resident 66's CPs showed did not show any documentation about Resident 66's missing teeth or oral/dental health. In an interview on [DATE] at 10:25 AM, Staff K (Resident Care Manager) confirmed an oral/dental CP was not developed or implemented for Resident 66 to address the resident's missing teeth. Staff K stated the facility should have initiated the oral/dental CP for Resident 66 that directed staff to provide the resident oral care, but they did not. <Resident 73> According to the [DATE] Quarterly MDS, Resident 73 had impaired memory, was frequently incontinent of their bladder, and occasionally incontinent of their bowel. The MDS showed Resident 73 was assessed to require one-person assistance with toileting and personal hygiene. Observation on [DATE] at 8:24 AM showed Resident 73 was up in the wheelchair (w/c) in their room and smelled like urine. Review of the [DATE] bowel and bladder assessment showed Resident 73 was a candidate for a scheduled toileting program. (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 [DATE] Activities of Daily Living (ADL) CP showed Resident 73 needed one-person maximal assistance with toileting. The CP did not show a bowel and bladder CP was developed for Resident 73 to instruct staff about the toileting schedule. In an interview on [DATE] at 10:25 AM, Staff K confirmed a bowel and bladder CP was not developed or implemented for Resident 73. Staff K stated the facility should have initiated a bowel and bladder CP about Resident 73's scheduled toileting program as it related to the resident's incontinent care needs, but they did not. 42203 <Resident 37> According to the [DATE] Quarterly MDS, Resident 37 had severely impaired memory, and showed verbal behaviors towards others on one-to-three of the MDS's seven-day lookback period. The MDS showed Resident 37 had medically complex diagnoses including dementia, and an adjustment disorder with mixed anxiety and depressed mood. The MDS showed Resident 37 took an antipsychotic medication. Resident 37's comprehensive CP included a [DATE] .resident is on antipsychotics . CP. This CP included a goal for Resident 37 to be free of medication-related complications. The [DATE] antipsychotics CP did not identify which antipsychotic medication Resident 37 received, or what behaviors or other mental health conditions the antipsychotic was prescribed to treat. In an interview on [DATE] at 3:49 PM Staff B (Director of Nursing) stated it was important for residents' CPs to be comprehensive, resident-specific, and accurate. <Resident 91> Review of the [DATE] MDS dated [DATE] showed that Resident 91 has had a tracheostomy (a surgical opening made through the front of the neck into the windpipe). The [DATE] tracheostomy CP showed Resident 91 wanted Cardiopulmonary Resuscitation (CPR) if their heart or breathing stopped. This CP showed if Resident 91 required CPR staff should use an Ambu bag (a self-inflating device used for residents with specialized CPR needs) through the open stoma (a surgically made hole in the throat), use a Pediatric CPR mask with an Ambu bag attached. The pediatric mask and Ambu bag should be kept at the resident's bedside for emergent use. Observation on [DATE] at 12:17 PM showed no Ambu bag or pediatric CPR mask was available in resident 91's room. In an interview on [DATE] at 12:17 PM Staff O (Registered Nurse) searched the unit until they found an Ambu bag on the medical crash cart (a cart stocked with emergency supplies) in the private dining room. Staff O could not find a pediatric CPR mask. In an interview on [DATE] at 11:04 AM, Staff B stated a suction machine, and supplies should have been in the room per the CP directions REFERENCE WAC: [DATE](2)(a)(b).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43642 Based on observation, interview, and record review the facility failed to ensure Care Plans (CP) were updated and/or revised as needed for 2 of 20 (Residents 83 and 51) sample residents reviewed, and failed to ensure residents were provided an opportunity for a care conference for 1 of 20 sample residents (Resident 59). Failure to ensure CPs were updated to reflect current care needs and residents were given the opportunity to participate in care conferences left residents at risk for unmet care needs, lessened participation in care planning, and a diminished quality of life. Findings included . <Facility Policy> The facility's March 2022 Comprehensive, Person-Centered CP policy showed assessments of residents were ongoing and residents' CPs should be revised as information about residents and their conditions changed. The policy showed CPs should be reviewed and revised at least quarterly. 42203 <Care Plan Revision> <Resident 83> According to the 03/20/2024 Quarterly MDS Resident 83 had diagnoses including coronary artery disease and heart failure. The MDS showed Resident 83 did not receive an anticoagulant medication. The MDS showed Resident 83 had an above knee left leg amputation. Review of Resident 83's Physician's Orders (POs) showed no orders for an anticoagulant medication. The 09/16/2023 Deep Vein Thrombosis (DVT - a condition where blood clots form in veins located deep inside the body, often the legs) CP included an intervention for nursing staff to monitor laboratory values to monitor/document effect of anticoagulant therapy [.] report values outside desired range. In an interview on 04/22/2024 at 2:23 PM Staff I (Resident Care Manager - RCM) stated Resident 83 did not receive an anticoagulant medication. Staff I reviewed Resident 83's DVT CP and stated the CP was inaccurate and should be updated. 45941 <Resident 51> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 04/05/2024 Annual MDS, Resident 51's memory was impaired and had medical diagnoses including a stroke (brain injury), vision impairment, speech difficulty, and weakness on right side of their body. The MDS showed Resident 51 was assessed to require one-person partial/moderate assistance for eating. The 08/19/2022 Activities of Daily Living CP showed Resident 51 needed one-to-one eating/dining assistance from staff during meals. Observations on 04/15/2024 at 11:52 AM, on 04/17/2024 at 08:11 AM, and on 04/18/2024 at 11:46 AM showed Resident 51 was eating their meal in the dining room without any staff assistance as care planned. In an interview on 04/22/2024 at 10:10 AM, Staff K (RCM) reviewed the CP regarding Resident 51's eating status and stated the CP was not updated. Staff K stated Resident 51 did not need one-to-one staff assistance with eating and the CP needed to be revised but they were not. <Care Conferences> < Resident 59> According to the 02/28/2024 Quarterly MDS showed Resident 59 was usually understood, able to understand others, and had clear speech. The MDS showed Resident 59 had diagnoses including Parkinson's disease (brain disorder that causes uncontrollable movements in the body parts including tremors), high blood pressure, and muscle weakness. In an interview on 04/16/2024 at 10:46 AM, Resident 59 stated they did not remember having a care conference in a long time. Resident 59 stated no staff member discussed a care planning meeting for at least a year. Record review showed Resident 59's most recent documented care conference was completed on 04/07/2023. In an interview on 04/18/2024 at 1:46 PM, Staff K stated care conference meetings were offered to residents on quarterly and annually basis along with the MDS assessments. Staff K reviewed Resident 59's record and stated there was no care conference done after 04/07/2023. Staff K stated facility should schedule quarterly care conferences for Resident but did not. In an interview on 04/22/2024 at 2:24 PM, Staff M (Social Services Director) stated they usually schedule each resident's care conferences upon admission, quarterly, and annually to conform to the MDS schedule. Staff M stated they were behind in scheduling care conferences for residents due to staffing issues. Staff M reviewed Resident 59's record and stated they did not schedule Resident 59's care conference for a year. Staff M stated Resident 59 should be provided an opportunity for a care conference quarterly but was not. REFERENCE: WAC 388-97-1020(2)(c)(d).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 43642 Based on observation, interview, and record review the facility failed to ensure: Physician's Orders (POs) were clarified as needed for 6 (Residents 17, 33, 13, 57, 9, & 83) of 20 sample residents; followed for 2 (Residents 69 & 57) of 20 sample residents; nurses did not sign for incomplete tasks for 1 (Resident 69) of 20 sample residents reviewed; and orthostatic blood pressure (a process where a resident's blood pressure is taken while lying down, then sitting, then standing as practical to assess for changes in blood pressure caused by changes in elevation for safety) was monitored as required for 1 (Resident 2) of 5 residents reviewed for psychotropic medications. These failures placed residents at risk for medication errors, delayed treatment, and adverse outcomes. Findings included . <Clarification of Orders> <Resident 17> Review of Resident 17's April 2024 Medication Administration Records (MAR) showed the resident had a 07/25/2023 PO for a powdered laxative medication to be given once daily for constipation. A second 03/28/2024 PO for the same powdered laxative was also ordered to be given once daily for constipation. Both orders were scheduled to be administered at the same time. <Resident 33> The 02/02/2024 Quarterly Minimum Data Set (MDS - an assessment tool) showed Resident 33 had multiple medically complex diagnoses including high blood pressure and chronic pain. Review of Resident 33's April 2024 MAR showed a PO for a high blood pressure medication to be given once daily with directions to staff to hold the medication for a SBP less than 100. There was no documentation showing staff obtained Resident 33's blood pressure prior to the administration of the medication as directed. Review of Resident 33's April 2024 MAR showed the resident had a 12/22/2022 PO for a laxative suppository medication to be given as needed for constipation. A second 08/25/2023 PO for the same laxative suppository was also ordered to be given as needed for constipation. There was no instruction to staff which order should be administered. <Resident 13> Review of Resident 13's April 2024 MAR showed a 01/27/2023 PO for a pain medication patch to be applied, to affected areas one time daily for pain. This PO did not indicate to staff the location of Resident 13's affected areas were. <Resident 57> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 02/01/2024 Quarterly MDS, Resident 57 had multiple medically complex diagnoses including high blood pressure. Review of Resident 57's April 2024 MAR showed a PO for a high blood pressure medication to be given twice daily with directions to staff to hold the dose if the resident's SBP [Systolic Blood Pressure - a measure of the pressure in your arteries when your heart beats] or HR [Heart Rate] [were] less__. There was no parameters listed to direct staff when to hold the medication based on the blood pressure or the heart rate. There was no documentation showing Resident 57's blood pressure was monitored by staff as ordered prior to administration of the medication. In an interview on 04/22/2024 at 10:22 AM, Staff F (Resident Care Manager - RCM) stated the unclear and/or duplicate orders should be but were not clarified with the provider by staff. <Resident 9> According to the 02/29/2024 Admission MDS, Resident 9 had medically complex diagnoses including obstructive sleep apnea (a condition where breathing is disrupted during sleep, characterized by loud snoring). The MDS showed Resident 9 frequently experienced pain, but the resident's pain rarely or never interrupted their sleep. The MDS did not identify Resident 7 with depression. The April 2024 MAR included a 03/26/2024 order for 5 MG of a hormonal supplement (typically prescribed for the promotion of sleep) for major depression. In an interview on 04/22/2024 at 12:13 PM Staff I (RCM) stated they were surprised the supplement was prescribed for depression. Staff I stated the 03/26/2024 hormonal supplement order should be clarified with the physician. <Resident 83> According to the 03/20/2024 Quarterly MDS Resident 83 had diagnoses including coronary artery disease and heart failure. The MDS showed Resident 83 did not receive an anticoagulant medication. Resident 83's April 2024 MAR did not include an anticoagulant PO. The April 2024 MAR included a 02/23/2024 PO directing nursing staff to monitor for adverse side effects of Resident 83's anticoagulant medication. In an interview on 04/22/2024 at 2:23 PM Staff I stated Resident 83 no longer took an anticoagulant medication. Staff I stated the PO to monitor for adverse side effects was no longer necessary and should be discussed with the physician and discontinued. <Following Orders> <Resident 69> According to a 02/02/2024 Quarterly MDS, Resident 69 had multiple medically complex diagnoses and received scheduled pain medications during the assessment period. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the April 2024 MAR showed Resident 69 had a PO for a pain medication patch to be applied to their lower back daily for pain and to remove per schedule. The MAR identified the schedule was to apply the patch at 8:00 AM and remove at 7:59 PM.

Observations on 04/19/2024 at 1:15 PM showed Staff Y (Licensed Practical Nurse) preparing to apply a pain medication patch to Resident 69's lower back. During the observation Staff Y removed a pain medication patch already in place on Resident 69's lower back prior to applying the new patch. In an interview at this time, Staff Y stated Resident 69's pain patch should have been removed the night prior per the order.

In an interview on 04/22/2024 at 10:22 AM, Staff F stated their expectation was for staff to administer medications to residents as ordered.

<Resident 57>

According to a 02/01/2024 Quarterly MDS, Resident 57 had multiple medically complex diagnoses including diabetes and required an insulin medication during the assessment period.

Review of Resident 57's April 2024 MAR showed a PO for an insulin medication to be administered for diabetes with directions to staff to hold the dose if blood sugars were less than 110. This dose was not held as ordered on 04/04/2024 when Resident 57's blood sugar was at 99.

Review of Resident 57's March and April 2024 MARs showed an order for a pain medication to be administered as needed for a pain level of 1-4 on a 1-10 pain scale. This medication was administered by staff outside of the ordered parameters on eight of nine occasions in March 2024 and on eight of nine occasions in April 2024.

In an interview on 04/22/2024 at 3:49 PM, Staff B (Director of Nursing) stated it was their expectation nursing staff follow, clarify, obtain blood pressures prior to medication administration as ordered, and follow ordered parameters.

<Signing for Tasks Not Completed>

<Resident 69>

Resident 69's April 2024 MAR showed orders for a pain medication patch to be applied to the lower back for pain each morning and gave directions to staff to remove the patch each night at 7:59 PM. Staff documented the patch was removed in the evening on 04/17/2204, a new patch applied in the morning on 04/18/2024, and removed in the evening on 04/18/2024.

Observations on 04/19/2024 at 1:15 PM showed Staff Y removed the previously placed pain medication patch from Resident 69's lower back that was dated 04/17, indicating a new patch was not placed or removed on 04/18/2024 as signed by staff as completed.

In an interview at this time Staff F stated their expectation was for staff to follow the PO and administer and remove the pain patch as directed. Staff F stated nursing staff should not sign for tasks they did not complete.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Orthostatic Blood Pressure Monitoring> <Facility Policy> The facility's 08/25/2020 Psychoactive Medication Management Guideline policy showed when residents were prescribed a psychoactive medication staff were expected to initiate and complete monitoring for orthostatic blood monthly. <Resident 2> According to the 02/14/2024 Quarterly MDS, Resident 2 had diagnoses including anxiety, depression, and Obsessive-Compulsive Disorder (OCD - a behavior where a person would perform unwanted repetitive actions). Review of the February 2024 MAR showed Resident 2 received an antipsychotic medication daily to manage their OCD behavior. The 01/09/2024 AP medication CP showed due to Resident 2's AP medication use, staff should obtain and monitor the resident's orthostatic blood monthly. Review of Resident 2's medical record showed staff did not monitor Resident 2's orthostatic blood pressure. The facility was not able to provide any documentation demonstrating monthly orthostatic blood pressure was monitored for Resident 2. In an interview on 04/22/2024 at 10:19 AM, Staff K (RCM) stated staff should check Resident 2's orthostatic blood pressure monthly and document the results on the MAR, but did not. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i). 42203 45941

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 42203 Based on observation, interview, and record review the facility failed to ensure residents who were dependent on staff for assistance with Activities of Daily Living (ADLs - i.e. grooming, bathing, eating, etc.) received the assistance they required for 4 of 9 sample residents (Residents 61, 51, 58, & 73) and 1 supplemental resident (Resident 55). The failure to provide nailcare, bathing, and eating assistance left residents at risk for embarrassment, poor personal hygiene, and other negative health outcomes. Findings included . <Facility Policy> The facility's March 2018 ADLs Policy showed residents who could not perform ADLs independently should be provided the care, treatment, and services they required. The policy showed residents' ADL needs including bathing and hygiene would be assessed and provided accordingly. <Resident 61> According to the 04/03/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 61 had impaired vision, no rejection of care, and required substantial to maximal assistance with bathing and personal hygiene. The MDS showed Resident 61 had two pressure ulcers present on admission and diagnoses including heart failure and a history of a stroke. The 04/03/2024 Care Area Assessment (CAA) Resident 61 needed extensive assistance with all ADLs. The CAA showed a Care Plan (CP) should be developed to meet Resident 61's ADL needs to promot[e] quality of life and attaining/maintaining the highest practicable level of functioning. The 03/30/2024 Admission Assessment showed Resident 61 preferred a shower in the morning. The 03/29/2024 .ADL Self Care Performance Deficit . CP included a goal for Resident 61 to improve their current level of ADL function. The CP did not include directions showing when Resident 61 preferred to shower, how frequently, or whether the resident preferred a shower. Resident 61's Kardex (Nurse Aide instructions) not include directions showing when Resident 61 preferred to shower, how frequently, or whether the resident preferred a bath or a shower. On 04/22/2024 at 11:33 AM the 100 Unit shower scedule was observed to show Resident 61 was scheduled for showers in the afternoon on Wednesday and Saturday afternoons. Review of the bathing charting showed on no occasion since admission was Resident 61 provided a shower, with no documented refusals. In an observation on 04/15/2024 at 12:54 PM Resident 61was observed to have long dirty fingernails. Resident 61's fingernails extended past the tip of their fingers and had dirt visible under the nail tips. On 04/18/2024 at 8:16 AM Resident 61 was observed lying in bed. Resident 61's fingernails were untrimmed. Resident 61's fingernails were observed to be untrimmed on 04/22/2024 at 8:28 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2024 at 12:27 PM Staff I (Resident Care Manager - RCM) reviewed the unit's Shower Book (where Aides kept handwritten documentation of baths and showers). Staff I stated there was no evidence in the chart or the Shower Book that Resident 61 was provided a shower since admission 24 days prior. On 04/22/2024 at 12:30 PM Staff I observed Resident 61's fingernails and stated they were too long and needed to be trimmed. Staff I stated typically nails were trimmed with bathing or as needed and Resident 61's fingernail length was consistent with the resident not receiving a shower since admission 45941 <Resident 51> According to the 04/05/2024 Annual MDS, Resident 51 had impaired memory and was totally dependent on staff for their personal hygiene. The 08/19/2022 ADL self-care deficit CP showed Resident 51 required total assistance by one-to-two staff for their personal hygiene. Observations on 04/15/2024 at 9:41 AM, 04/16/2024 at 11:42 AM, and 04/18/2024 at 8:16 AM showed Resident 51's fingernails were long and dirty. Resident 51 was observed with facial hair. In an interview on 04/22/2024 at 10:10 AM, Staff K (RCM) stated Resident 51 had facial hair and with long, dirty fingernails. Staff K stated they expected the staff to provide ADL assistance to residents including personal grooming. Staff K stated staff should clip Resident 51's fingernails weekly on shower days and as needed, but did not. <Resident 58> According to the 02/10/2024 Quarterly MDS, Resident 58 had diagnoses including a respiratory infection, Parkinson's disease (a brain disorder that cause uncontrollable body movements including tremors), and difficulty walking. The MDS showed Resident 58 was assessed to require maximal assistance from staff with transfers and personal hygiene. The MDS showed Resident 58 stated it was very important for them to go outside to get fresh air. The 12/15/2023 ADL self-care deficit CP showed Resident 58 required maximal assistance from staff for transfers and included an intervention instructing staff to encourage the resident to be out of the bed daily and exercise. The ADL CP showed Resident 58 required staff assistance with personal grooming. Observations on 04/16/2024 at 12:21 PM, on 04/18/2024 at 9:16 AM and 11:46 AM, and on 04/19/2024 at 9:23 AM and 12:02 PM showed Resident 58 was lying in bed wearing a hospital gown and had long facial hair. In an interview on 04/19/2024 at 12:02 PM, Resident 58 stated they would like to get out of the bed and sit in their wheelchair to see other people in the hallway. Resident 58 stated, I think it will be better to be up in my wheelchair and eat my lunch. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/19/2024 at 12:02 PM, Staff K confirmed Resident 58 had long facial hair and was lying in bed in a hospital gown. Staff K stated the nursing staff did not shave, dress, or assist Resident 58 to transfer to their wheelchair daily as care planned. <Resident 73> According to the 01/24/2024 Quarterly MDS, Resident 73 had impaired memory. This MDS showed Resident 73 was assessed to require one-person maximal assistance from staff with personal hygiene. The 10/20/2023 ADL self-care deficit CP showed Resident 73 had a history of refusing care, and included instructions to nursing staff to stop providing ADL care when the resident refused and attempt again when Resident 73 was calmer. Observations on 04/16/2024 at 2:16 PM, 04/17/2024 at 10:04 AM, 04/18/2024 at 8:24 AM showed Resident 73 had long fingernails and facial hair. Review of Resident 73's record showed no documentation of Resident 73's preferred long nails or refused care. In an interview on 04/19/2024 at 11:24 AM, Staff K confirmed Resident 73 had long fingernails and facial hair. Staff K stated staff should provide ADL assistance including clipping Resident 73's fingernails and shaving their facial hair but did not. 50511 <Resident 55> According to the 04/16/2024 Significant Change MDS, Resident 55 was dependent on staff assistance for personal hygiene. The MDS showed Resident 55 required partial to moderate assistance with eating. The MDS showed Resident 55 had severe memory impairment. Resident 55's 04/16/2024 Kardex included instructions for CNAs to set up all needed items, assist the resident to sit in their wheelchair or on the edge of the bed at the sink, and provide cueing or assistance as needed to complete washing and drying of Resident 55's hands, face. The Kardex included instructions to provide oral care for 15 minutes three-to-six times per week. Review of the aides' nail care documentation from 3/18/2024 through 4/18/2024 showed nail care was provided once on 04/18/2024 at 8:33 PM. Observation on 04/16/2024 at 9:44 AM showed Resident 55's fingernails extended a quarter inch past the nailbed with dark debris noted under the fingernails of the right hand. Resident 55's hair was not combed, they had a beard on their face, hair was visibly growing from their ears, and their scalp had dry flaky skin. On 04/17/2024 at 9:11 AM Resident 55's hair was not combed with dry peeling skin on their scalp. Resident 55 was observed scratching their head. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/2024 at 11:32 AM, Resident 55 was observed struggling to open the containers on their lunch tray before eventually opening their ice cream container. No staff assistance was provided to set up the food on their tray. No staff were observed helping Resident 55 to eat during lunch service. On 04/18/2024 at 8:30 AM Resident 55's eyebrows were not trimmed and their beard was not shaved. On 04/19/2024 at 1:36 PM Resident 55's nails extended a quarter inch past the nail bed and were not trimmed. On 04/19/2024 at 1:59 PM Resident 55 stated they would like to be shaved and preferred to be shaved in the daytime. On 04/18/2024 at 08:30 AM Resident 55 stated that they put plastic on everything and it's hard to open. Resident states they use a red pen on his table to pop things open. Review of CNA's staff tasks for eating assistance documentation from 03/28/2024 through 04/25/2024 showed partial assistance was provided 7 times and total assistance was provided 5 times. In an interview on 04/22/2024 at 10:22 AM Staff F (RCM) stated residents who required set up assistance with meals should receive the assistance they were assessed to require. Staff F stated residents assessed to require assistance with bathing, nail care, and other ADLs should be provided the assistance they were assessed to require. REFERENCE: WAC 388-97 -1060 (2)(c).

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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. 43642 Based on observation, interview, and record review the facility failed to ensure 3 (Residents 57, 69, & 51) of 6 residents reviewed for Restorative Nursing Program (RNP) services received the care and services they were assessed to require. These failures placed residents at risk for a decline in Range of Motion (ROM), increased dependence on staff, and a decreased quality of life. Findings included . <Facility Policy> The facility's July 2017 Restorative Nursing Services Policy showed residents would receive restorative nursing care as needed to help promote optimal safety and independence. The policy showed restorative goals and objectives should be resident-centered and outlined in the resident's Care Plan (CP). <Resident 57> According to a 02/01/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 57 was cognitively intact and had multiple medically complex diagnoses including stroke with impairment of functional limitation in ROM to the upper arm on one-side and both lower legs. This MDS showed Resident 57 was dependent on staff for dressing and transfers from bed to chair, required substantial assistance from staff for rolling side to side in bed, and had no rejection of care. Review of a 06/20/2023 risk of decline in ROM CP showed directions to staff to provide an RNP for Resident 57 three-six times per week to both upper arms. Review of an 11/27/2023 RNP CP showed directions to staff to provide a splint to the right hand and perform passive ROM to right upper arm for seven hours three-six times per week. Review of an 11/27/2023 RNP CP showed directions to staff to provide Resident 57 with an active ROM program for both lower legs as tolerated three-six times per week. A 11/16/2023 Physician's Order (PO) showed Resident 57 should wear their hand splint daily for seven hours per day as tolerated. Review of February 2024 restorative documentation showed: staff only provided Resident 57 with the splint and passive ROM to their right hand on six occasions in February, rather than daily according to the POs or three-six times per week according to the CP; and staff only offered the active ROM program to Resident 57's lower legs on four occasions in February, rather than the three-six times per week according to the CP. Review of March 2024 restorative documentation showed: staff only provided Resident 57 with the splint and passive ROM to their right hand on six occasions in March, rather than daily according to the POs or three-six times per week according to the CP; and staff only offered the active ROM program to lower legs on four occasions in March, rather than three-six times per week according to the CP. (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 April 2024 restorative documentation between 04/01/2024 to 04/17/2024 showed: staff only provided Resident 57 with the splint and passive ROM to their right hand on three occasions, rather than daily according to the POs or three-six times per week according to the CP; and staff only offered the active ROM program to lower legs on three occasions, rather than three-six times per week according to the CP.

Observations on 04/16/2024 at 9:45 AM showed Resident 57's hand splint on the table next to their bed. At this time, Resident 57 stated they only wore the splint occasionally because, the provider is not always the same person and I need help to put it on. Resident 57 was unable to remember when they wore it last or last received a ROM program. On 04/17/2024 at 9:34 AM, observations showed Resident 57 was not wearing the hand splint.

In an interview on 04/18/2024 at 1:13 PM, Staff T (Restorative Aide) stated they were unable to provide residents' restorative programs as ordered/care planned done since the other restorative aide left in February. Staff T stated they were responsible for applying splints and providing the residents with their restorative programs.

<Resident 69>

According to a 02/02/2024 Quarterly MDS, Resident 69 had multiple medically complex diagnoses including loss of function to both arms and legs. This MDS showed staff identified Resident 69 had a functional limitation in ROM to both upper arms and lower legs, was dependent on staff for dressing, personal hygiene, rolling from side to side in bed, and had no rejection of care.

Observations on 04/16/2024 at 11:54 AM, 04/18/2024 at 8:17 AM and 11:52 AM, and on 04/19/2204 at 8:20 AM showed Resident 69 was not wearing a splint on their left arm.

Review of an 11/16/2023 restorative referral form, provided by the therapy department, showed recommendations for staff to provide RNP programs for Resident 69 three-six times per week to maintain soft tissue integrity and ROM to prevent contraction formation.

Review of an 11/17/2023 RNP CP showed directions to staff to provide active ROM to both lower legs three-six times per week and a revised 04/06/2023 RNP CP showed directions to staff to provide passive ROM to both lower legs.

Review of February 2024 restorative documentation showed after 02/10/2024 staff only provided the RNP programs on three occasions, rather than at least three times weekly as recommended by therapy.

Review of March 2024 restorative documentation showed staff only provided the RNP programs on five occasions, rather than at least three times weekly as recommended by therapy.

Review of April 2024 restorative documentation between 04/01/2024 - 04/16/2024 showed staff only provided Resident 69's RNPs on three occasions, rather than at least three times weekly as recommended by therapy.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/2024 at 10:22 AM, Staff F (Resident Care Manager) stated RNPs should be provided and documented by staff as directed, splints applied per therapy recommendations, and any refusals documented and followed up with social services. Staff F stated, we need to get a better [restorative] system, we need help. In a joint interview on 04/22/2024 at 3:05 PM, with Staff MM (Director of Rehabilitation) and Staff LL (Area Rehabilitation Director), Staff LL stated it was important for restorative programs to be completed per recommendations in order to maintain strength and prevent decline in ROM. Staff MM stated it was important to maintain as much function as possible for residents. In an interview on 04/22/2024 at 2:25 PM, Staff J (MDS) stated restorative programs were important to maintain a resident's functional ability, prevent decline, and to prevent contractures (permanent, irreversible limitations to ROM in a joint). Staff J stated RNPs should be completed as directed and documented in the resident's electronic records when provided and/or refused by a resident. 45941 <Resident 51> According to the 04/05/2024 Annual MDS Resident 51 had paralysis on one side of their body, a contracture to their right hand, impairment to both legs, and difficulty in speaking. The MDS showed Resident 51 participated in a ROM RNP for four days and splinting RNP for six days during the seven-day lookback period. Review of an 08/05/2022 RNP CP showed Resident 51 had two RNP programs; a splinting RNP for Resident 51 to wear a splint to their right hand for seven hours or as tolerated, Passive Range of Motion (PROM) program to be offered for right arm. The CP goal was to maintain Resident 51's right hand ROM and to manage contractures. An 04/06/2024 PO directed staff to provide PROM to Resident 5's right arm and apply a splint to their right hand for six hours or as tolerated every day shift related to right side weakness. Review of the 12/04/2023 restorative referral form showed Occupational Therapy recommended the following RNPs: PROM to Resident 51's right hand; apply a resting hand splint, six hours or as tolerated daily; Omnicycle (A therapeutic exercise bike) for 15 minutes three to six times a week. Observations on 04/15/2024 at 9:57 AM and 11:58 AM showed Resident 51 sitting in their wheelchair in the dining room with no splint on their right hand. Observations on 04/16/2024 at 9:42 AM and 11:53 AM showed Resident 51 sat in their wheelchair in the dining room with no splint on their right hand. Observation on 04/18/2024 at 9:21 AM showed Resident 51 was up in wheelchair in dining room and was not wearing their splint on their right hand. Review of the January 2024 RNP documentation showed Resident 51 received their assigned programs on only 14 times out of 30 opportunities. In February 2024, Resident 51 received their RNP on six times out of 28 opportunities. In March 2024, Resident 51 received only their RNP only six times out of 31 opportunities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/2024 at 12:21 PM, Staff T stated they were unable to provide Resident 51's RNP due to their workload with other residents' RNPs. Staff T stated they had an average of 37 resident RNP's assigned to them each day they work. Staff T stated they did not offer all the RNPs to all residents every day as assigned. In an interview on 04/18/2024 at 12:54 PM, Staff J stated they oversaw the RNP. Staff J reviewed Resident 51's RNP documentation and confirmed Resident 51 was not provided the RNPs as required. Staff J stated Resident 51 sometimes refused their programs and it was Staff J's expectation staff documented any refusals from Resident 51. Staff J stated there was a lot of challenges with the RNP because RNP staff were by themselves at this time and were pulled from their RNP duties to provide direct care to residents. REFERENCE: WAC 388-97-1060 (3)(d), (j)(ix).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42203 Based on observation, interview, and record review the facility failed to ensure the facility was free of accident hazards. The failure to: ensure appropriate supervision and storage of smoking materials for 1 of 1 (Resident 83) sample residents who smoked; ensure 1 of 1 Central Supply rooms was secured; and 2 of 3 soiled utility rooms were secured, placed residents at risk for smoking accidents, accident hazards, and diminished safety. Findings included . <Smoking> <Facility Policy> The facility's revised October 2023 Smoking Policy showed smoking was only allowed in designated smoking areas. The policy showed residents who were assessed to smoke independently may store their own cigarettes but all other residents who smoked were required to store their cigarettes with the facility. <Resident 83> According to the 03/20/2024 Quarterly Minimum Data Set (an assessment tool) Resident 83 had impaired vision and used a wheelchair. The MDS showed Resident 83 required substantial to maximal assistance with transfers, toileting, showering, and personal hygiene and had medically complex diagnoses including chronic pain, dementia, and a bone infection. The MDS showed Resident 83 had one fall with injury since the prior assessment. According to the 02/08/2024 .safe and independent smoker . Care Plan (CP) Resident 83 stored their cigarettes with the facility's receptionist. The CP included a goal for Resident 83 only to smoke in the facility's designated smoking areas (outside the building) and interventions including completion of smoking assessments per the schedule and obtaining an acknowledgement from Resident 83 of the facility's updated smoking rules. The 01/24/2024 Smoking Resident Statement of Agreement showed Resident 83 smoked two cigarettes two-to-three times a day. The agreement showed Resident 83 said they once burned their fingers while smoking. The acknowledgement included a Resident Statement of Agreement signed by Resident 83 showing the resident agreed that at no time may I have smoking materials such as lighters, matches, or cigarettes in my room and understood a violation of the Facility Smoking Policy may result in a search of my personal property, loss of my smoking privileges, and/or transfer to another facility. This Statement of Agreement was more restrictive than the facility's policy which was not updated to reflect the facility's new expectations for smoking residents. The 02/08/2024 smoking assessment showed Resident 83 was safe to smoke independently. The assessment showed Resident 83 was informed of and understood the facility's smoking policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 04/04/2024 progress note showed the facility reviewed the smoking process with Resident 83 and a paper copy of the process was added to the resident's record. In an interview on 04/16/2024 at 8:41 AM Resident 83 stated they smoked. Resident 83 stated the facility had a smoking schedule. Resident 83 stated they adhered to the facility's smoking schedule. Resident 83 stated they went outside with staff to smoke, and the facility kept their cigarettes. Resident 83 stated they had no concerns with the facility's smoking arrangements. Observation on 04/17/2024 at 11:59 AM showed a sign discussing smoking posted at the facility's front desk. The sign showed the courtyard contained the facility's designated smoking areas, and smoking times were scheduled at 9 AM, 11 AM, 1 PM, 3 PM, 5 PM, and 7 PM. A sign on a closet by the exit to the courtyard showed all [smoking] materials must be turned in to the facility staff for secure storage when returning to the facility. Failure to do so may result in room checks, body checks, and/or 30-day notice [a facility-initiated discharge process]. Observation on 04/18/2024 at 9:07 AM, and 04/18/2024 at 11:34 AM showed no residents smoking cigarettes in the smoking areas. In an interview on 04/19/2024 at 11:14 AM Staff R (Receptionist) stated none of the facility's smokers had cigarettes at that time. Staff R stated residents tended to run out of cigarettes before they could afford to buy more. In an interview on 04/19/2024 at 11:38 AM Resident 83 stated they were not out of cigarettes. Resident 83 stated they kept them in their pocket and stated they smoked a couple at my doctor's appointment that morning. In an interview on 04/19/2024 at 1:14 PM Staff B (Director of Nursing) stated the facility had a recent history of resident-to-resident altercations at the designated smoking area which prompted a revision to their smoking process. Staff B stated their experience told them the facility's smoking process required some attention to ensure there was more systematic organization and supervision of the smoking process. When asked if it was their expectation that no residents stored their own cigarettes Staff B stated Staff A (Administrator) was more knowledgeable on that matter and brought in Staff A. Staff A stated they spoke with Resident 83 to clarify the facility's expectations and reached an agreement with the resident but the conversation was not effective and the process of seeking resident cooperation with smoking expectations was a work in progress. <Central Supply Room> Observation on 04/16/2024 at 1:33 PM showed the facility's Central Supply room was unlocked, with the door open to show no staff were present inside the room. The Central Supply room was located on the first floor and there was unrestricted access to from resident areas to the hallway were the Central Supply room was located. From the doorway shelves of medical supplies including dressings and medical tubing, and bottles of over-the-counter medications and supplements were observed. In an interview on 04/16/2024 Staff S (Staffing Coordinator/Central Supply) stated they were in the bathroom at the time of the surveyors's observation the Central Supply room door was left open. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Avamere Rehabilitation at Park West		STREET ADDRESS, CITY, STATE, ZIP CODE: 1703 California Avenue Southwest Seattle, WA 98116	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/18/2024 at 9:30 AM showed the Central Supply room unsecured with the door open. Among the content of the supply room shelves were nicotine gum, bottles of magnesium supplements, medical tubing, bottles of laxatives, scissors, bottles of 70% rubbing alcohol, liquid acetaminophen, and acetaminophen suppositories. No residents were observed in the area at the time. On 04/18/2024 at 9:45 AM Staff S returned to the Central Supply room. Staff S stated who left my door open? I locked it. In an interview at that time Staff S stated it was important to ensure the Central Supply room was not left open and unsupervised. Staff S stated they would not want residents to have access to the contents of the Central Supply room because there were many potentially hazard supplies in the room. Staff S stated I wouldn't want residents to have access to any of this. 43642 <Unsecured Soiled Utility Rooms> <3rd Floor> Observations on 04/18/2024 at 12:13 PM showed the 3rd floor soiled utility room door not secured or closed all the way. The door pushed open, and no door code or key was needed to enter the room. Inside the room was an unlocked cabinet with a 2.5 Liter bottle of a disinfectant chemical with a label that read, DANGER, keep out of reach of children and a 20-ounce canister of a powder cleaning product containing bleach with a label that read, May be harmful if swallowed or inhaled. In an interview on 04/18/2024 at 12:15 PM, Staff F (Resident Care Manager) stated the door should be locked at all times to make sure nobody has access to dangerous chemicals. An observation on 04/19/2024 at 12:17 PM, showed a staff member enter the soiled utility room, exit the room, and walk away down the hallway. The door to the soiled utility room slowly closed after staff left, but the door did not secure, or latch shut. Facility staff observed the unsecured door and informed maintenance. <1st Floor> Observations on 04/19/2024 at 8:41 AM showed the 1st floor soiled utility room door not secured or closed all the way. The door pushed open, and no door code or key was needed to enter the room. Inside the room was an open container of a disinfectant chemical on the wall with a label that read, DANGER, keep out of reach of children and inside an unlocked cabinet was a can of a disinfectant spray with a label that read, hazardous to humans. Facility staff observed the unsecured door and informed maintenance. In an interview on 04/22/2024 at 3:49 AM, Staff B stated the soiled utility rooms should be secured and locked for safety reasons. REFERENCE: WAC 388-97 -1060 (3)(g).

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 43642 Based on observation, interview, and record review the facility failed to implement care for 1 (Resident 69) of 1 resident reviewed for Tube Feeding (TF - nutrition delivered into the stomach by tube) management including: failure to provide a consistent formula or rate of administration; failure to document the total intake provided over 24 hours; failure to clarify and administer the amount of water flushing required by the resident; and failure to label and date the TF formula. These failures placed Resident 69 at risk for TF complications, inadequate or excessive calorie or protein intake and/or hydration. Findings included . <Facility Policy> Review of a revised November 2018 facility, Enteral (directly to the intestine) Nutrition policy showed the nurse would confirm TF orders were complete and included: the nutritional product; delivery site; the specific access device; administration method (continuous, bolus [give large doses of formula several times a day], intermittent); volume and rate of administration .; and instructions for flushing (solution, volume, frequency, timing and 24-hour volume). <Resident 69> According to a 02/02/2024 Quarterly Minimum Data Set (an assessment tool), Resident 69 had multiple medically complex diagnoses including malnutrition and required the use of a feeding tube. This MDS showed Resident 69 received more than 51 percent of their total calories and fluid intake via TF. Review of a 01/07/2023 altered nutrition Care Plan showed Resident 69 was at risk for dehydration and identified interventions to: monitor hydration status; monitor intake and output; and provide TF per provider's order. Review of a 03/27/2024 dietician progress note showed Resident 69 required 1816 mL of fluids per day which included total free water with flush and formula. Observations on 04/15/2024 at 8:39 AM showed a Fibersource formula TF bag dated 04/15/2024, hanging on a pole with a pump in Resident 69's room. The TF machine was off. On 04/15/2024 at 9:47 AM, the same Fibersource formula TF bag was being infused to Resident 69. At 10:25 AM, the TF pump was off, and the bags were observed in Resident 69's garbage can. Observations on 04/15/2024 at 2:05 PM showed a new unlabeled, undated bag with 1000 mL of formula hung on the pole, being infused to Resident 69, and the TF pump running at 100 mL per hour. On 04/15/2024 at 2:59 PM, observations showed the formula bag was now labeled and dated for 04/15/2024, was disconnected, and not being infused to Resident 69. Observations on 04/16/2024 at 8:26 AM showed the TF machine was on and being infused to Resident 69. The bag hanging was labeled as Fibersource then crossed out and changed to Isosource. The machine was running at 300 mL per hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 04/18/2024 at 11:52 AM showed the TF machine was on and infusing formula at a rate of 150 mL per hour to Resident 69. Review of Resident 69's Physician Orders (PO) showed a 03/29/2024 PO directing staff to flush Resident 69's feeding tube with 300 milliliters (mL) of water three times a day. An 11/06/2023 PO directed staff to flush Resident 69's feeding tube with 10-15 mL of water before and after staff administrated medications to the resident. A second order on 04/10/2024 which directed staff to flush Resident 69's feeding tube with only 10 mL of water before and after staff administered medications to the resident, and a 03/29/2024 order to provide a 300 mL bolus feeding four times a day of Isosource formula, document mLs infused, for a total formula of 1200 mL in 24 hours. Record review showed there were no POs or recommendations from the registered dietician to indicate what Resident 69's total caloric and fluid intake needs were per 24 hours, or which formula the resident required. During observations of a medication pass on 04/19/2024 at 11:22 AM, showed Staff Y (Licensed Practical Nurse) prepared and administered a water flush of 30 mL prior to administering medications via feeding tube, dissolved five medications separately with 10 mL of water each, administered each dissolved medication followed by a 15 mL water flush after each medication, and finished with 30 mL water flush after all medications completed. Staff Y then administered 118 mL of water mixed with a laxative medication. The total volume administered during the morning medication pass was 238 mL. Review of Resident 69's April 2024 Medication Administration Records (MAR) showed staff did not document the total amount of fluids provided to Resident 69 each shift or a total intake for 24 hours. There was no order for the 30 mL water flush provided by Staff Y prior to medication administration. According to this MAR, Resident 69 was scheduled to receive: 1200 mL of formula; 900 mL water flush; and 546 mL water with medications; for a total of 2646 mL in 24 hours, rather than the 1816 mL recommended by the dietician. In an interview on 04/22/2024 at 10:22 AM, Staff F (Resident Care Manager) stated Resident 69's should have an order identifying the nutritional intake needs for the resident. Staff F stated their expectation was for a bolus feeding to be administered without a pump. Staff F stated if a pump was used, there should be an order with a rate of administration. Staff F stated nursing staff should document Resident 69's total amount of fluid intake every 24 hours and follow orders regarding formula and water flushes. Staff F stated the TF formula should but was not dated and labeled as required. Staff F stated the TF orders definitely needed to be clarified with the provider. In an interview on 04/22/2024 at 3:49 PM, Staff B (Director of Nursing) stated TF orders should be followed, with staff following consistent administration rates, and formula bags labeled and dated as required. REFERENCE: WAC 388-97-1060(3)(f).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview, and record review the facility failed to ensure nursing staff had the appropriate competencies and skill sets to provide nursing care and related services that assured resident safety and attained or maintained resident's highest practicable physical, mental, and psychosocial well-being as identified by resident assessments and according to individual plans of care, in consideration of the number, acuity and diagnoses of the facility's resident population, and in accordance with the facility assessment and facility policies. The facility failed to verify skills competency for 5 of 5 Certified Nursing Assistants (CNA) (Staff AA, BB, CC, DD, EE, & FF) whose training documents were reviewed, 5 of 5 CNAs (Staff GG, FF, HH, II, and W) and 1 of 1 Registered Nurses (Staff O) interviewed for special focused training for tracheostomy and stoma care. The facility's failure to validate their nursing staff's knowledge, skills, abilities, behaviors, and other characteristics necessary perform job-related functions safely and successfully placed residents at risk for incompetent care and harm and placed Resident 91 at risk for injury, harm, and death. Findings included . <Special Focus Tracheostomy & Stoma Care> <Resident 91> Review of the [DATE] Quarterly Minimum Data Set (an assessment tool) showed Resident 91 had a tracheostomy (a small surgical opening made through the front of the neck into the windpipe). The [DATE] tracheostomy Care Plan (CP) showed in an emergent situation where resident 91 required resuscitation, staff should use an Ambu bag (self-inflating resuscitator) with pediatric (child) Cardiopulmonary Resuscitation (CPR) mask. The CP showed the mask and supplies should be kept at the resident's bedside for emergent use. In an interview on [DATE] at 12:00 PM, Staff FF (Certified Nurse's Assistant - CNA) could not explain the specific CPR requirements for resident 91 and stated they would check resident's breathing in and out. In an interview on [DATE] at 12:17 PM Staff O, unit RN stated they would put the mask/bag on the resident's mouth and cover the tracheostomy. In an interview on [DATE] at 12:00 PM Staff GG, Agency CNA, could not explain resident 91's specific/specialized CPR instruction requirement. In an interview on [DATE] at 10:21 AM with Staff FF (CNA), HH (CNA), II (CNA), and W (CNA), all four staff stated they did not receive training from the facility on how to care for the tracheostomy or stoma of Resident 91 if the resident was choking or needed Cardio-Pulmonary Resuscitation (CPR). All four staff stated they had CPR cards from training outside the facility, but tracheostomy and stoma emergency care were not addressed in their CPR training. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:04 AM with Staff B (Director of Nursing) stated the last tracheostomy in-service was conducted on [DATE], about 1 year ago, and was on tracheostomy policy and procedures. Staff B stated the facility policy did not include emergency care for choking or CPR for residents with a tracheostomy but should. Staff B stated specialized CPR training should occur before staff worked with Resident 91 and current care staff on the floor were not currently trained but should be. <Competency Skills Verification> In an interview on [DATE] at 1:55 PM, Staff C (Staff Development Coordinator) stated they just started in the position two months ago in February 2024. Staff C stated there was no staff development coordinator in place prior to their hire. Staff C stated they did not have any documentation for skills verification or competency evaluations for any current staff. Staff C stated they did not have a process for staff skills evaluations on hire or annually. In an interview on [DATE] at 10:02 AM, Staff OO (Human Resources) stated the Staff Development Coordinator completed skills verification for CNAs and Licensed Nurses (LN) upon hire and annually. Staff OO stated there were no skills verification documents on file for a sample of five staff requested: Staff AA, BB, CC, DD, EE, or FF. In an interview on [DATE] at 1:51 PM, Staff C (Staff Development Coordinator) stated when care areas for special focused training were identified for specific residents, training should be provided to staff. Staff C stated they did not provide training to staff on tracheostomy or stoma care. Staff C stated there were no records to show training was provided to CNAs or Licensed Nurses for the special focus care required by Resident 91 for tracheostomy or stoma care. In an interview on [DATE] at 10:24 AM, Staff F (Resident Care Manager) stated they did not perform any special focus training for staff on how to care for a tracheostomy or stoma routinely or in an emergency for choking or CPR. Staff F stated Resident 91 had a tracheostomy and open stoma and staff were expected to know how to care for Resident 91's special needs in an emergency. In a joint interview on [DATE] at 3:26 PM with Staff B, Staff H (Regional Nurse Consultant) and Staff C, Staff C stated staff should know how to perform routine and emergency care to Resident 91 with a tracheostomy and open stoma. Staff B, H and C were asked to provide documentation of staff training to perform routine and emergency care to a resident with a tracheostomy and open stoma. No training documents were provided. REFERENCE: WAC ,d+[DATE] -1080 (1), 1090 (1).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43642 Based on interview and record review, the facility failed to ensure staff timely acted on irregularities identified by the consultant pharmacist for 1 of 5 residents (Resident 33) reviewed for medications. The failure to act on medication-related irregularities identified by the consultant pharmacist placed the residents at risk for medication-related complications. Findings included . <Resident 33> According to a 02/02/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 33 had multiple medically complex diagnoses including high blood pressure and hyperlipidemia (high levels of fat particles in the blood). Review of Resident 33's Physician Orders (PO) showed a 12/23/2022 order for a medication to be given daily for hyperlipidemia. A 10/23/2023 pharmacy consultation report revealed recommendations to facility to obtain a lipid panel blood test with the next routine lab draw for periodic monitoring. This recommendation was signed by the provider on 10/25/2023 with agree indicated. Review of the pharmacy November 2023 and December 2023 recommendations pending response list, showed the pharmacy was still unable to locate the lab order or results for the lipid panel recommended to be drawn in October for Resident 33. Review of Resident 33's records revealed the lipid blood panel was not obtained until 01/22/2024, three months after the recommendation was made and approved by the provider to obtain. Review of a 11/24/2023 pharmacy consultation report revealed recommendations to facility to decrease a steroid nasal inhaler for Resident 33 due to progress notes not indicating the resident was complaining of congestion. This report was not found in the resident's records but was obtained from a facility binder and was unsigned by the provider. Review of the pharmacy December 2023 recommendations pending response list, showed the facility had not addressed the recommendation to reduce the steroid nasal inhaler. A 02/19/2024 pharmacy consultation report revealed recommendations were again made to decrease the steroid nasal inhaler for Resident 33. This recommendation was not signed by the provider until 3/4/2024, over three months after the original recommendation was made. On 03/08/2024 the order for the steroid nasal inhaler was discontinued. In an interview on 04/22/2024 at 3:49 PM, Staff B (Director of Nursing) stated their expectation was for pharmacy recommendations to be completed timely and to be implemented by the end of the month the recommendation was made. Staff B stated any recommendations made by the pharmacy should be readily available in the resident records. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1060(3)(k)(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** 45941 Based on observation, interview, and record review, the facility failed to ensure 1 of 1 sample residents (Resident 58) was reviewed for Antibiotic (ABO) use. Failure to follow provider's recommendations and to schedule appointments to adjust medications placed residents at risk for inadequate treatment of medical conditions and the potential for adverse side effects of unnecessary medications. Findings included . <Resident 58> According to the 02/10/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 58 admitted to the facility on [DATE] and had diagnoses including kidney failure and shortness of breath. The MDS showed Resident 58 received ABO medications during the assessment period. Review of the April 2024 Medication Administration Record showed Resident 58 received a steroid medication (an anti-inflammatory medication) daily for kidney disease since 01/11/2024. Resident 58 received an ABO medication every 48 hours for long term use of systemic steroids since 11/16/2023. According to a 04/11/2024 provider note, nursing staff were directed to continue the ABO medication two times daily for Resident 58's chronic use of steroids. A 01/05/2024 nephrologist (outside kidney provider) after-visit summary instructed staff to reduce Resident 58's steroid medication dosage from 15 milligrams (mg) to 10 mg and to follow-up with the nephrologist in eight weeks. This after-visit summary did not include the ABO medication on Resident 58's current medication list. Review of a 02/19/2024 pharmacist's Medication Regimen Review showed the pharmacist consultant recommended facility staff clarify with the nephrologist, if the ABO medication should be discontinued. Review of Resident 58's record showed no documentation staff scheduled Resident 58's recommended eight-week follow up appointment with the nephrologist. There was no documentation staff clarified the ABO medication with nephrologist. In an interview on 04/22/2024 at 10:05 AM, Staff K (Resident Care Manager) stated they were responsible for following up with the nephrologist's recommendations for Resident 58. Staff K reviewed Resident 58's record and stated they should have scheduled the follow up appointment in March 2024, but missed it. Staff K stated they should have followed the pharmacy recommendations to clarify whether to discontinue the ABO medication order with the nephrologist, but they did not. 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. 42203 Based on observation, interview, and record review the facility failed to ensure residents were free of unnecessary medications for 1 of 5 (Residents 37) sample residents. The failure to ensure residents had an appropriate diagnosis in place prior to administration left residents at risk for adverse side effects, unnecessary psychotropic medications, and other negative health outcomes. Findings included . <Facility Policy> The facility's 08/25/2020 Psychoactive Medication Treatment policy showed in order to improve residents' quality of life, residents with supporting diagnoses would be provided psychoactive medications at the lowest effective dose. <Resident 37> According to the 02/27/2024 Quarterly Minimum Data Set Resident 37 was assessed with severe memory impairment and showed verbal behaviors towards others on one-to-three days of the assessment's 7-day look back period. The MDS showed Resident 37 had medically complex diagnoses including dementia and an adjustment disorder with mixed anxiety and depressed mood. Review of the physician's orders showed Resident 37 had a 10/01/2022 order for an Antipsychotic (AP) medication, give 5 Milligrams (mg) by mouth in the afternoon for vascular dementia with behavioral disturbance. The physician's orders showed Resident 37 had a previous 09/27/2022 order for the same AP medication, give 2.5 mg by mouth in the afternoon for vascular dementia with behavioral disturbance and psychosis. In a 01/23/2024 recommendation, the facility's consultant pharmacist communicated the concern that dementia was not an appropriate indication for use of an AP medication, and that Resident 37 did not have a documented psychosis diagnosis. The recommendation was signed by the physician on 02/06/2024. The physician noted indication: psychosis on the form. Review of Resident 37's active diagnoses showed a new diagnosis of Unspecified Psychosis not due to a substance or known physiological condition added on 02/07/2024. The diagnosis documentation indicated it was added by the facility's medical supply clerk. The diagnosis did not indicate who diagnosed the resident. Review of Resident 37's record showed no progress notes or other documentation demonstrating how the facility determined Resident 37 had a psychosis diagnosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/22/2024 at 9:08 AM Staff B (Director of Nursing) stated it was important to have an appropriate diagnosis when providing an AP medication. Staff B stated Resident 37's psychosis diagnosis, was added on 02/07/2024 after the concern from the pharmacist. Staff H (Regional Nurse Consultant) stated that from 09/27/2022 until 02/07/2024 Resident 37 received the AP medication without an adequate diagnosis. Staff B and Staff H stated they would provide any additional documentation found to show the diagnostic process. No further information was provided. REFERENCE: WAC 388-97-1060 (3)(k)(i).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45941 Based on observation and interview, the facility failed to ensure drugs and biologicals were secured and expired medications and biologicals were disposed of timely in accordance with professional standards in 1 of 2 medication rooms and 2 of 4 medication carts reviewed. This failure placed residents at risk for receiving expired medications and at risk for medication errors. Findings included . Facility Medication Rooms <First Floor Medication Room> Observation of the first floor medication room on 04/17/2024 at 9:53 AM, showed two ostomy pouches (external devices that collect waste from the body) expired on 11/24/2022, Intravenous (IV) tubing expired on 07/18/2023, and one bag of IV fluid 1000 expired on 01/2024. The medication room refrigerator contained one bag of IV antibiotic medication that expired on 03/01/2024 and a liquid antacid medication which expired on 02/01/2024 for a discharged resident. The medication room refrigerator contained four insulin pens, immunization injections for pneumonia, and one antianxiety liquid medication for five residents who discharged from the facility more than a month ago. In an interview on 04/17/2024 at 10:12 AM, Staff N (Licensed Practical Nurse) stated they should clean the medication room and refrigerator to remove the expired medications and other medications from the fridge for the discharged residents. Staff N stated they usually sent the medications with the discharged residents, but did not know why staff did not remove the medications from the medication room or fridge. <Pyxis Machine> Observation of the first floor Pyxis (emergency use medications) machine on 04/17/2024 at 10:17 AM, showed one bag of IV fluid that expired on 03/2024, and two bottles of an electrolyte solution which expired on 12/31/2023. In an interview on 04/17/2024 at 10:21 AM, Staff I (Resident Care Manager - RCM) stated there should not be expired medications in the Pyxis. Staff I stated the pharmacy was supposed to send the facility notifications of expired medications in the Pyxis, but they did not. <Medication Carts > Observation of the third floor medication cart on 04/17/2024 at 10:48 AM, with Staff O (Registered Nurse - RN), showed an opened nasal spray with no open date and no resident name. This medication cart had 18 loose pills in the drawers. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/17/2024 at 10:57 AM, Staff O stated there should be no loose pills in the drawers of the medication carts. Staff O stated nasal spray should be dated when opened and labeled with the resident's name for whom the spray was intended for, but they were not. Observation of the first floor medication cart on 04/17/2024 at 11:17 AM, with Staff P (RN), showed 13 loose pills in one of the drawers. Staff P stated there should be no loose pills in the drawers. In an interview on 04/17/2024 at 12:04 PM, Staff B (Director of Nursing) stated expired medications should not be kept in the medication rooms, in the Pyxis machines, or in the medication room refrigerators. Staff B stated medications for the discharged residents should be destroyed within one to two days after the residents discharged from the facility, but they did not. 43642 <Unsecured Medications> <Resident 13> Observations on 04/15/2024 at 10:28 AM, showed an unsecured steroid inhaler on Resident 13's bedside table. Next to the inhaler was a bottle of analgesic lotion and an antifungal powder. <Resident 69> Observations on 04/19/2024 at 11:57 AM showed nursing staff left an unsecured pain patch on Resident 69's bedside table upon exiting the room. In an interview on 04/19/2024 at 12:06 PM, Staff F (RCM) confirmed the pain patch was at Resident 69's bedside and stated the medication should not be left unsecured in a resident's room without staff. <Medication Cart> Observations on 04/19/2024 at 10:12 AM showed a medication cart with an unsecured, opened pain patch lying on top of the cart. The pain patch remained unsecured without staff at the cart on 04/19/2024 at 10:40 AM, 10:59 AM, and 11:21 AM. In an interview on 04/19/2024 at 11:26 AM, Staff F confirmed the pain patch was on top of the medication cart unsecured and stated, this is not supposed to be left out on the cart. In an interview on 04/22/2024 at 3:49 PM, Staff B stated staff should not leave medications unsecured at a resident's bedside or leave medications unsecured on top of the medication carts without staff present. REFERENCE: WAC 388-97-1300(2).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 43642 Based on observation, interview, and record review, the facility failed to ensure prompt dental services were provided for 1 (Resident 57) of 4 sample residents reviewed for dental services. This failure placed the residents at risk for unmet dental needs and a diminished quality of life. Findings included . <Facility Policy> Review of a revised December 2016 facility, Dental Services policy showed routine and emergency dental services were available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. This policy stated social services representatives would assist residents with appointments and transportation arrangements. <Resident 57> According to a 05/03/2023 Admission Minimum Data Set (an assessment tool), Resident 57 was cognitively intact, had no rejection of care, and was identified with obvious or likely cavities or broken natural teeth. In an interview on 04/16/2024 at 9:41 AM, Resident 57 stated they had broken teeth, oral pain, and difficulty with chewing at times. Resident 57 stated a dentist had, come by about a year ago and they discussed with the resident about obtaining dentures. Resident 57 stated they were still interested in getting dentures. Review of Resident 57's Physician Orders showed a 04/28/2023 order for dental consults as indicated. Review of a revised 04/29/2023 dental care plan showed staff identified Resident 57 had missing or carious teeth and listed interventions to staff to coordinate arrangements for dental care, transportation as needed or ordered. Review of a 06/05/2023 dental consultation showed Resident 57 was assessed with numerous decayed and broken teeth or root tips and was marked for a referral for x-rays, evaluation, and extraction of all upper and lower teeth. The dental provider marked on the form that the doctor recommended new upper and lower dentures. This form had a handwritten notation that said Resident 57 would like the extractions and dentures. In an interview on 04/22/2024 at 1:18 PM, Staff NN (Medical Records Director) stated they were responsible for the coordination and transportation of dental appointments. Staff NN stated they tried to coordinate appointments with the staffing coordinator when residents needed staff escorts, but they were short staffed, so appointments were not happening as they should. Requested from Staff NN to provide information regarding staff attempts to follow up with the dental recommendations for x-rays, evaluation, or extractions, made 10 months earlier, for Resident 57. No information was provided. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/22/2024 at 3:49 PM, Staff B (Director of Nursing) stated their expectation was for referrals to be obtained when a concern for a resident needed attention. Staff B stated referrals should be followed up timely by staff, within a week, to at least get the process started. REFERENCE: WAC 388-97-1060(1).

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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** 44296 Based on observation, interview, and record review the facility failed to implement an effective Infection Prevention and Control Program. The failure to develop and implement a water management program, ensure resident equipment and the facility environment was free of uncleanable surfaces, urinary catheter (tubing to facilitate urinary drainage) bags were secured, and Hand Hygiene (HH) was performed before, during, and after resident care left residents at risk for waterborne illness, exposure to communicable diseases, sickness, and other negative health outcomes. Findings included . <Water Management Program> In an interview on 04/17/2024 at 2:30 PM Staff E (Environmental Director) was asked to provide documentation to support the facility had a water management program that included monitoring and prevention of Legionella (bacteria that can cause severe lung infections) and other waterborne pathogens. Staff E stated the water management program should be discussed with Staff A (Administrator) because there was no current water management program. In an interview on 04/17/2024 at 2:31 PM, Staff A stated there was no current water management program that monitored for and prevented waterborne pathogens. Staff A stated there were no records from the prior environmental director. <Uncleanable Resident Equipment > Observation on 04/15/2024 at 10:22 AM showed a Certified Nursing Assistant (CNA) remove bedding from the bed nearest the window in room [ROOM NUMBER]. The outer layer of the mattress was a rubberized material. An area of the rubberized surface, over 12 inches in diameter at the foot end of the mattress was worn through exposing an uncleanable surface. In an interview at that time, the unidentified CNA stated the rubber was worn away due to exposure to urine over time. On 04/15/2024 at 10:26 AM Staff K (Resident Care Manager - RCM) stated the mattress was no longer cleanable due to the lack of integrity of the rubber coating. Staff K stated the mattress needed to be removed immediately. <Resident 69> Observations on 04/18/2024 at 11:52 AM showed a tube feeding pole in Resident 69's room with dried drips of liquid running all the way down the pole to the legs of the pole. Observations on 04/19/2024 at 11:30 AM, showed the tube feeding pole with the same dried drips of liquid. In an interview on 04/22/2024 at 3:16 PM, Staff S (Central Supply) confirmed the tube feeding pole should be clean but was not. <Resident 3> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 04/15/2024 at 9:01 AM, showed a motorized wheelchair (w/c) belonging to Resident 3 in the hallway with the arm rest's material torn exposing the underlying uncleanable surfaces. <Resident 33> Observations on 04/15/2024 at 10:55 AM showed the fabric of Resident 33's walker was ripped and torn with the foam underneath exposed and uncleanable. <Resident 24> Observation on 04/17/2024 at 09:37 AM showed the right-side leather armrest on Resident 24's w/c was torn and the foam material underneath was exposed. <Resident 93> Observation on 04/17/2024 at 11:29 AM showed the leather armrest on Resident 93's w/c was ripped/torn and the foam material underneath was exposed. <Resident 27> On 04/17/2024 at 11:37 AM, observations showed Resident 27 in the hallway sitting in their w/c. The material on the w/c armrests was torn on both sides, leaving uncleanable surfaces exposed. <Resident 31> Observation on 04/17/2024 at 1:33 PM showed Resident 31's walker was dirty with dry food stains and the walker's left side handle was wrapped with sticky ace wraps. <Dining Room> Observations on 04/19/2024 at 2:06 PM showed two dining room chairs with the material peeling on the seat cushions exposing an uncleanable foam surface underneath. In an interview on 04/22/2024 at 3:16 PM, Staff S confirmed the dining room chairs, and resident equipment had uncleanable surfaces. In an interview on 04/22/2024 at 3:49 PM, Staff B (Director of Nursing) stated facility and resident equipment should be intact and cleanable to reduce the risk of spreading infections. <Catheter Bags> <Resident 61> According to the 04/03/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 61 had medically complex diagnoses including kidney disease and a condition that restricted urinary flow. The MDS showed Resident 61 required an indwelling catheter. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Observation on 04/18/2024 showed Resident 61 lying in bed. Resident 61's catheter bag was lying on the floor. The hook used to anchor the catheter bag to Resident 61's bed frame was attached to the catheter tubing but not anchored to the bad.

Observation on 04/18/2024 at 11:23 AM showed Resident 61 being brought back to their bedroom by a facility therapist. As the therapist assisted Resident 61 to ambulate back to their room, Resident 61's catheter was observed to drag on the hall carpet, making an audible tone as Resident 61 and the therapist moved, and risking the integrity of the catheter bag.

In an interview on 04/22/2024 at 12:22 PM Staff I (RCM) stated it was important to handle catheter bags appropriately to ensure the bag maintained its integrity and prevent urine from contaminating the facility environment.

<Hand Hygiene>

<Resident 66>

In an observation on 04/17/2024 at 8:50 AM, Staff Z (CNA) was observed providing morning hygiene care to Resident 66. Staff Z collected the resident's dirty clothes from the floor to place in a bag, then took clean linens from the bedside table to make Resident 66's bed without changing their gloves or washing their hands. Staff Z accidentally bumped Resident 66's water pitcher and it landed on the floor. Staff Z picked up the water pitcher with the same dirty gloves. Staff Z removed their dirty gloves, took the water pitcher to the clean utility, rinsed the water pitcher in a sink, filled with clean water, and brought it back to Resident 66's room. Staff Z completed Resident 66's morning care, made the resident's bed, and again touched the water pitcher without changing gloves or performing HH between dirty and clean areas or changing the water pitcher.

In an interview on 04/17/2024 at 9:05 AM, Staff Z stated they should perform HH or put new clean gloves on before they touched clean areas including the water pitcher. Staff Z stated they should get a clean water pitcher from the kitchen. Staff Z stated they did not perform HH or change their gloves when providing care for Resident 66.

<Resident 51>

In an observation on 04/19/2024 at 8:31 AM, Staff V (CNA) was observed providing Resident 51 morning care including personal hygiene and incontinent care wearing disposable gloves. Staff V was observed putting on a clean brief on Resident 51, dressed them up, transferred them to their w/c, and grabbed the clean linens to make Resident 51's bed without changing their gloves or performing HH. Staff V was observed getting a brace from the nightstand and tried to put the brace on Resident 51's right hand. Staff V completed all cares including making the resident's bed without changing gloves and performing HH between dirty and clean areas.

During an interview on 04/19/2024 at 8:42 AM, Staff V stated they did not change their gloves and did not wash their hands during or after care provision or between dirty and clean areas of the facility or resident's room. Staff V stated performing HH before, in between clean and dirty processes, and after providing care to Resident 51 was necessary, but they did not perform HH correctly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/19/2024 at 8:59 AM, Staff K stated they expected staff to change their gloves and perform HH between dirty and clean care. Staff K stated HH was important to prevent the spread of infections. REFERENCE: WAC 388-97-1320 (1)(a)(c), -1320 (3). 42203 43642 45941

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 44296 Based on interview and record review, the facility failed to revise infection prevention and control policies and develop and implement an updated Antibiotic (ABO) Stewardship program to comply with the 10/24/2023 federal requirements. The facility failed to; implement protocols and a system to monitor, document, and analyze the appropriate use of ABOs; failed to include leadership support and accountability for 3 of 3 months (January, February, & March 2024) reviewed. The failure to implement an infection surveillance process that included gathering data on the resident's symptoms, type of infectious organism, assessment of infections to meet specific criteria for ABO treatment, and track the spread of infection through tracing similar organisms, placed residents at risk for potential adverse outcomes associated with the inappropriate/unnecessary use of ABOs and an increased risk for ABO resistant organisms. Findings included . Review of the facility policy Surveillance for Infections (revised 09/2017) showed the facility would conduct ongoing surveillance of infections, including data collection, and recording and interpretation. The policy directed staff to gather data including the location of the infection, presenting symptoms, laboratory records, infectious organism, treatment measures, and prevention of transmission to others. The policy directed staff to analyze the data collected to identify trends and calculate infection rates. The policy was not updated to the 10/24/2023 federal requirements. Review of the facility policy Antibiotic Stewardship (revised 12/2016) showed ABOs would be prescribed and administered to residents under the guidance of the facility's ABO stewardship program. The purpose of the ABO stewardship program was to monitor the use of ABOs in residents. The policy was not updated to the 10/24/2023 federal requirements. In an interview on 04/19/2024 at 1:23 PM, Staff C (Infection Control Preventionist - ICP) stated they were new to the position starting in February 2024 and the first month of infection control data gathering and analysis they completed was March 2024 during training with two other sister facility ICP staff. Staff C was asked to provide all documents used to complete the March 2024 infection control monitoring and analysis of the data collected for ABO use, to identify trends and calculate infection rates. Staff C provided a surveillance log, infection map, ABO list for March 2024. Staff C was not able to provide January 2024 or February 2024 infection control surveillance, analysis, data reports, or Quality Assurance Policy Improvement leadership review of infection monitoring. In an interview on 04/22/2024 at 3:26 PM with Staff B (Director of Nursing), Staff H (Resource Nurse), and Staff C reviewed the facility infection surveillance log and Staff C stated the columns for organism, symptoms and meets criteria for ABO was not documented. Staff B and Staff H stated the ABO stewardship program should track the resident's symptoms, organism causing infection with lab culture for ABO susceptibility, and analysis of criteria met for ABO treatments. Staff B and Staff H stated the ABO stewardship program was not intact and did not meet the ABO stewardship program requirements. REFERENCE: WAC 388-97-1320(1)(a)(2)(a-c).