STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505272	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Mount Vernon	2120 East Division Street Mount Vernon, WA 98273

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 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** 43954 Based on observation, interview, and record review the facility failed to ensure the environment was clean, comfortable, and homelike for 3 of 3 halls with stained carpet and failed to provide maintenance for resident rooms with broken blinds. These failures placed residents at risk for diminished dignity, and diminished quality of life. Findings included . <BROKEN BLINDS> In an observation on 04/22/2024, room [ROOM NUMBER] was observed to have broken blinds in the window. In an observation on 04/23/2024 at 9:08 AM, room [ROOM NUMBER] was observed to have broken blinds in the window. In an observation on 04/30/2024 at 2:18 PM, room [ROOM NUMBER] was observed to have broken blinds in the window 37890 <CARPETS> Observation of the facility carpeting on 05/01/2024 at 1:35 PM, showed: - A dark stained area extending approximately two feet in a semicircle at the residents' doorways in Rooms 101, 102, 103, 104, 205, 404. - A grapefruit sized dark stained area near room [ROOM NUMBER]. - Two cantaloupe sized areas of staining near the Main Nurses Station. - A cantaloupe sized darked stained areas near Rooms 304, 311, 204 and near the Mt [NAME] room. - A one by three-foot stained area near room [ROOM NUMBER]. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A one-by-one-foot-stained area near room [ROOM NUMBER]. - A one by two-foot-stained area near the social services office. - One large irregular shaped area of mixed bleach spots and staining in the 200 hall. - In the 400 Hall, a one by four-foot irregular area of mixed bleach, discolored and dark stained. - Numerous areas (too numerous to count) ranging from the size of a dime to size of a golf ball-stained areas scattered throughout all carpeted areas of the facility. In an interview on 04/30/2024 at 2:26 PM, Staff DD, Maintenance Director, stated there was a leak that had just been repaired related to the carpeting stains. Staff DD stated housekeeping was responsible for cleaning carpets, and Staff A, Administrator, was getting quotes to replace the flooring. Staff DD stated it was their responsibility to fix or replace broken blinds and stated the blinds break regularly. Staff DD stated they usually attempted to wait until the resident room was empty to replace broken blinds. In an interview on 05/01/2024 at 12:09 PM, Staff A stated they had talked about the carpet stains and the need for new flooring for a long time and were in the process of having the carpet replaced. Refer to WAC 388-97-0880 (1),(2)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview, and record review the facility failed to ensure 1 of 3 sampled residents (Resident 55) was free from physical abuse by a cognitively impaired resident (Resident 57) who had a known history of unwanted touching and sexual aggression towards other residents (Resident 13 and 52). Failure to consistently provide supervision, and prevent unwanted touching by Resident 57, placed residents at risk for abuse, feeling safe, injury, and a potential decrease quality of life. Findings included . Review of the facility's policy titled, Abuse Prevention updated 07/18/2023, stated it is the policy to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. The facility staff were to identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as verbally aggressive behavior, sexually aggressive behavior, wandering into other's rooms/space and residents with communication disorders. Facility staff were to identify, correct and intervene in situations in which abuse, neglect .is more likely to occur to include trained and qualified staff . According to the Washington State Reporting Guidelines for Nursing Homes (Purple Book), dated October 2015, defined mental abuse as verbal or nonverbal action that humiliates, harasses, coerces, intimidates, or isolates a vulnerable adult. Physical abuse included striking, slapping, pinching, choking, kicking, shoving, or prodding. <RESIDENT 55> Resident 55 readmitted to the facility on [DATE], for rehabilitation after a joint replacement. Review of the Admission Minimum Data Set (MDS - and assessment tool) assessment, dated 04/12/2024, showed the resident had no cognitive impairment and required one person assistance for bed mobility, and transfers. Review of a progress note dated 03/07/2024 at 1:16 PM, showed while in the dining room, Resident 55 was approached by another Resident 57 who yelled at them and hit them on the left shoulder several times with an open hand. The note showed the residents were separated immediately and Resident 55 was assured of their safety. Review of Resident 55's care plan, dated 04/08/2024, showed a focus problem of potential psychosocial well-being related to receiving physical aggression during a resident-to-resident altercation. The care plan interventions included allowing the resident to answer questions and to verbalize feelings, perceptions, and fears, observe for latent bruising and pain to the left shoulder, observe resident feelings relative to the incident and place on alert for psychosocial distress although the incident occurred on 03/07/2024. <RESIDENT 13> (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 13 admitted on [DATE] with high blood pressure. According to the annual MDS assessment, dated 01/31/2024, Resident 13 had moderate cognitive impairment. Review of the facility investigation, dated 03/21/2024 at 7:15 PM, showed Resident 13 reported that a woman (Resident 57) came into their room and kissed them on the lips. The facility informed Resident 13 they would ensure this did not happen with them or anyone else again. <RESIDENT 52> Resident 52 admitted on [DATE] with diagnoses to include stroke and depression. According to their quarterly MDS assessment, dated 03/12/2024, they had severe cognitive impairment. Review of the facility investigation dated, 03/21/2024 at 7:50 PM, Resident 52 reported to a Nursing assistant Certified (NAC) that a female resident entered their room, started rubbing their belly and tried to slide their (Resident 57) hand down their pants. Resident 52 grabbed Resident 57's hand and removed it then told Resident 57 to leave. <RESIDENT 57> Resident 57 was admitted to the facility on [DATE], with diagnoses to include vascular dementia with psychotic disturbance, cognitive communication deficit, and delusional disorders. Review of the End of Medicare Stay MDS assessment, dated 03/30/2024, showed the resident had severe cognitive impairment, signs of delirium and continuous behaviors of inattention (reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli), disorganized thinking, and altered level of consciousness that did not fluctuate. Resident 57 required staff physical assistance with ambulation. Review of Resident 57's incident history showed the following triggers and resident-to-resident encounters: - On 02/29/2024 at 7:14 PM, a progress note showed the resident was wandering into other residents' rooms that evening. - On 03/07/2024 at 1:16 PM, Resident 57 approached another Resident (Resident 55, began to yell, and hit them on the shoulder several times with an open hand. - On 03/19/2024 at 5:44 PM, a progress note showed Resident 57 was going uninvited into other resident's rooms and was not easily redirected. - On 03/21/2024 at 7:15 PM, Resident 57 wandered into a room uninvited and kissed Resident 13. - On 03/21/2024 at 7:45 PM, 30 minutes later, Resident 57 wandered into another resident's [Resident 52's] room and touched their belly and pubic area without consent. - On 04/20/2024 at 4:24 PM, Resident 57 approached Resident 55 again, rubbed and patted the residents back. Resident 55 asked them to stop. Resident 57 became agitated and struck the resident's left shoulder multiple times with an open hand. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 04/22/2024 Resident 55 reported Resident 57 hit them in the hallway the day prior. Review of the facility's investigation for the 04/22/2024 allegation where Resident 55 reported they were hit by Resident 57 showed they determined the allegation of abuse was not substantiated through interviews of staff. Review of Resident 57's care plan showed a focus problem of physically aggressive behavior and history of resident-to-resident altercations beginning 03/07/2024. The intervention included for staff to intervene before the resident's agitation escalated and guide them away from their source of distress. If the response was aggressive, staff were directed to walk calmly away and approach Resident 57 later. The care plan was revised on 03/11/2024 with Resident 57 being moved to a different hall away from the Resident 55 they physically attacked. The care plan was revised on 03/22/2024 to include sexual behaviors with two male residents that occurred on 03/21/2024. The care plan goal was that Resident 57 would not harm themselves or others through the review date. The one-to one supervision intervention was revised for the one-on-one caregiver to remain within a close distance (not defined). There was no care plan intervention to direct staff to ensure Resident 57 did not come into contact with prior residents they had abused, Resident's 13, 52 or 55, or to provide supervision of Resident 57 around other vulnerable residents. Review of the witness statement, dated 04/20/2024 at 5:00 PM Staff O, Nursing Assistant Certified (NAC), was assigned to provide one on one supervision for Resident 57 on 04/20/2024. Staff O documented they took the resident to the dining room at 4:00 PM. When dinner was served the resident ate everything in two minutes. Resident 57 then stood up and started walking towards Resident 55. The staff member documented they were walking right behind Resident 55 and when Resident 57 began walking toward Resident 55, they immediately intervened and were with the resident the whole-time, step by step. Staff O's witness statement showed Resident 57 walked across the dining room prior to the altercation, rubbed Resident 55's shoulders, Resident 55 told Resident 57 to stop then the resident began slapping Resident 55's back. Review of a witness statement dated 04/20/2024 at 5:40 PM, Staff N, NAC, showed Resident 57 was sitting on the other side of the dining room. Resident 57 got up and went across the dining room where Resident 55 was sitting and began rubbing their shoulder. Resident 55 said That's enough out loud and Resident 57 slapped them on their back. Staff N wrote in their witness statement they got up and told them (Staff O) they should have stopped (Resident 57) from touching (Resident 55). Staff N documented the one-to-one staff member (Staff O) who was assigned to supervise Resident 57 was standing on the other side of Resident 55 at the time of the altercation. Review of the progress note, dated 04/20/2024 at 9:00 PM, showed the Staff HH, LPN was called to the dining room by a NAC (not identified) who alerted them that Resident 57 had been touching and patting Resident 55 who requested them to stop touching them at which time, Resident 57 began striking Resident 55 with an open hand on their left shoulder. The documentation showed one on one supervision from a distance was in place as ordered and the assigned one-to one NAC was within sight as directed Resident 55 reported they had no pain, and they were just pissed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility incident investigation included Resident 55's description of the incident as She walked up to the side of me, petting, touching. I said get away from me and she just started whacking me. Resident 55 denied pain and said they were just pissed. The incident conclusion, dated 04/20/2024, did not indicate if the allegation was unsubstantiated or substantiated and was dated on 04/25/2024, a day after the investigation should have been completed. Review of the facility incident investigation, dated 04/22/2024 at 4:30 PM, showed Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS), and Staff C, RN/Assistant Director of Nursing Services (ADNS), interviewed Resident 55 who told them Resident 57 was walking down the hall and started pawing them, then whacked them, and then went off on him. Resident 55 said Resident 57 hit them on their left shoulder before dinner. Included with the investigation, was a statement by Staff P, Physical Therapist Assistant (PTA), that documented on 04/22/2024 they overheard Resident 55 stating to another staff member that another patient had hit them in the head but that it did not hurt at all. The facility obtained several statements that showed Resident 57 had received one on one supervision throughout the shift on 04/22/2024 and unsubstantiated the allegation of physical and verbal abuse. In an interview on 04/23/2024 at 12:59 PM, Resident 55 stated, There were prior instances with a female resident who they called crazy lady [Resident 57] who hit them. Resident 55 said, So they (facility) get the bright idea to move her down the hall. Well, that was not a great idea since I have to go down there (by their room) everyday, twice a day for therapy. Then there was an instance [Resident 57] walked on over to me in the dining room and the girl watching her had no clue about the prior instances with [Resident 57] and me. The other aides in the dining room got after that girl for not knowing. Resident 55 said that yesterday while in the hallway around 3:00 PM, a female staff member and (Resident 57) were close by. Resident 55 said the crazy lady started screaming at me F**k You, F**k Off. Resident 55 commented, that poor girl (staff member) had no idea either that there were prior incidents between them. Resident 55 said they told these girls it was not their fault; they did not know. The resident said, They should know who to have [Resident 57] avoid, if they are going to watch [Resident 57]. I feel harassed. I will be calling the state if I go home, and [Resident 57] starts calling me there. That crazy lady has some nerve coming in here and sitting on the bed next to my wife. I had to hear about that for days. In an interview on 04/23/2024 at 1:16 PM, Staff B and Staff C were alerted that Resident 57 reported that Resident 55 had been with their one on one in the hallway yesterday around 3:00 PM when Resident 57 started screaming profanity at them. Resident 55 said the one-on-one staff did not know of the prior incidents with them and they should know to avoid them. Staff B and C were notified Resident 55 stated they were upset that incidence with Resident 57 kept occurring and they said they felt harassed. In an interview on 04/23/2024 at 1:26 PM, Staff B showed a green binder labeled one to one that had Resident 57's care plan in it. There were pages set up for the staff to write down any triggers. There were no staff entries documented yet. A copy of the binder contents was requested from Staff B. Staff B said there was documentation in Resident 57's care plan about the dining room incident, and they were unaware of any recent incident between Resident 55 and Resident 57 other than the altercation that occurred on 04/20/2024. Staff B commented they would go interview Resident 55 in about 40 minutes. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/25/2024 at 9:14 AM, Resident 55 said, I have put enough energy to it. I don't see things changing here. The facility blames it on the State of [NAME] laws. [Resident 57] has the ability to make me uncomfortable, [Resident 57] tracks me. It is a shame we have to dedicate a guard for [Resident 57] and take them away from their duties and they are not providing patient care to [Resident 57]. The other night [Resident 57] tried to break out of [their] room. Resident 55 commented, Is this too caustic, yes. Resident 55 stated they had five or six physical confrontations with Resident 57 and two of them had occurred in the dining room. I don't want to spend anytime more thinking about this. It really bothers me. It is just unfortunate that [Resident 57] takes away from staff resources to guard [them]. There were two situations [Resident 57] got away from [their] guard and I told the staff this, I told the Director of Nurses this. I told them it was not the staff's fault; they did not know why they were watching [Resident 57]. In an interview on 04/29/2024 at 2:37 PM, Staff D, RN, said Resident 57 was placed on one-to-one supervision after something happened. Staff D said the resident used to be in room [ROOM NUMBER] by the door, which was a highly visible area, across from the nurse's station so they could keep an eye on them. Staff D said one day, Resident 57's family and their boyfriend stopped visiting and things went downhill after that as their behaviors and wandering escalated, and the staff had to call for more supervision for Resident 57. In an interview on 05/01/2024 at 9:01 AM, Staff P, Physical Therapy Assistant, was asked about the statement they provided on 04/23/2024 regarding the allegation on 04/22/2024. Staff P said they had overheard Resident 55 telling a staff member (whom they could not recall who that was) that a resident hit them over the head. Staff P said they thought the allegation had already been reported. In an interview on 05/01/2024 at 9:16 AM, Staff F, License Practical Nurse/Resident Care Manager, stated they were at work the first time Resident 57 hit Resident 55 in the dining room. Staff F said that was Resident 57's first behavior in the regard to hitting other residents. Staff F said for the second altercation in the dining room, there was a one on one in place for Resident 57 although they had been downgraded to distant supervision as the resident seemed frustrated being followed by staff. At the time of the second altercation, Resident 57 was to be supervised in line of sight (able to see the resident from a distance) of the staff, and now staff were to be in arm's reach of Resident 57. Staff F said they report allegations to Staff A, Administrator, who was the facility's abuse and neglect coordinator and staff above them, tell them what to do. Staff F said the incident where Resident 57 hit Resident 55 would be called battery. Staff F was unaware of the two incidences that occurred on 03/21/2024. During Quality Assurance Performance Improvement (QAPI) interview on 05/01/2024 at 12:52 PM, Staff A, Staff B, Staff C, Staff T, RN/Regional Director of Clinical Services, and Staff U, RN/Divisional Director of Clinical Services, were present. Staff B and Staff C said they had placed Resident 57 on one-on-one monitoring as an intervention to prevent altercations. Staff B said they placed blank papers in a binder for the one-on-one staff to write on, but they did not track and document to behaviors or events that triggered Resident 57. Staff B said they thought Resident 55 looked like Resident 57's boyfriend, they may have gone up to Resident 55, gave them affection, and when they were told to stop, they hit them as you would a spouse. A second request was made to Staff B for a copy of the contents in Resident 57's binder. Staff A, Administrator stated they were going to discuss Resident 55 in the next QAPI meeting. No other information was provided to show the facility provided adequate supervision or evaluated the effectiveness of the interventions. There was no assessment of Resident 57's allegation of physical abuse on 04/22/2024 as documented by Staff P. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to WAC388-97-0640(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview, and record review, the facility failed to implement policies and procedures for ensuring the reporting of allegations of potential abuse or neglect for 3 of 3 sampled residents (Resident 69, 5 and 55) reviewed for allegations of abuse and/or neglect and injuries of unknown source. The failure of staff to identify, report, and initiate an investigation for allegations placed residents at risk of being victims of unidentified and uninvestigated abuse and/or neglect and limited the thoroughness of investigations. Findings included . Review of the facility policy titled, Abuse - Reporting and Response, dated 10/13/2023, showed the facility would report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source .and report within the required timeframes. <RESIDENT 69> Resident 69 admitted on [DATE] with diagnosis which included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality) with delusions (fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary). Review of the resident's admission care directives showed the resident was cares in pairs (two staff present when care was received). Resident 69 was no longer a current facility resident. Review of a facility incident investigation, dated 03/28/2024, showed Staff W, Nursing Assistant Certified (NAC), reported that last week they were told by Resident 69 a nurse had inappropriately touched them during their medication pass. In an interview on 04/22/2024 at 2:26 PM, Staff W stated they knew Resident 69 well and it was typical for them to make accusations, which was why they were care in pairs. Staff W stated they were with another NAC (Staff X) when the resident made the allegation. Staff W stated they were applying cream on the resident's bottom when the resident stated to make sure they don't go too deep like the nurse did and stated the nurse stuck their finger in their rectum. Staff W stated they had reported it to the nurse (Staff Y, Licensed Practical Nurse (LPN)). Staff W stated they reported it to Staff V, Registered Nurse (RN)/Resident Care Manager (RCM), after they reported to Staff Y, but did not make a report to the hotline. In an interview on 04/22/2024 at 2:38 PM, Staff X stated they were with Staff W and were providing incontinence care to Resident 69 when the resident stated the nurse in the morning went too deep when applying the cream to their bottom. Staff X stated they thought the resident was making an allegation, were aware they were a mandated reporter, and required to report allegations immediately, but stated when they told (Staff Y), they kind of brushed it off, so then they didn't think it was a big deal. Staff X stated they believed they told Staff Y the same day the allegation occurred but did not make a report to the hotline. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/24/2024 at 6:00 AM, Staff Y stated they had overheard the two nursing assistants (Staff W and Staff X) discussing the allegation from Resident 69, but denied it being reported to them. Staff Y stated they were all finished with their rounds and were at the nursing station at the same time charting. Staff Y stated they overheard the conversation and the two aids discussing that the allegation was made a week ago, and that this was the reason Resident 69 was supposed to have cares in pairs, so Staff Y stated they assumed it was already reported and dealt with. Staff Y stated they were approached by Staff A, Administration, later that same day to provide a statement. On 04/24/2024 at 7:28 AM, with Staff B, RN/Director of Nursing Services (DNS), and Staff A were interviewed. Staff B stated the allegation was reported to the facility on [DATE] by Staff W. Staff A added the facility believed it had just happened and believed they were reporting and investigating timely until they began collecting statements and discovered the allegation had been made approximately a week prior. The resident was alert, but their memory was murky due to delusions, so the resident denied making the statement. <RESIDENT 5> Review of a provider note, dated 03/06/2024, showed Resident 5's family member was concerned about an open area on the resident's back. The provider note showed there was a one-centimeter open area which looked like an abrasion, was superficial, directed staff keep a foam dressing on the area, and observe it. The resident was not cognitively able to report what may have happened but was able to communicate they did not have pain. Review of Resident 5's physician order, dated 03/06/2024, showed an order was entered the same day for a foam dressing placed to the back of the neck over the spine. Review of Resident 5's record showed the skin assessment, dated 03/05/2024, the day prior, showed the resident's skin was intact. Review of Resident 5's skin assessments, dated 03/12/2024, 03/19/2024, 03/27/2024, 04/03/2024, and 04/10/2024, showed there were no new skin issues identified but the dressing to the neck was identified on the assessment to protect the resident's skin. Review of the March 2024 state incident reporting log showed no entry for Resident 5 regarding an injury of unknown source. In an joint interview on 04/30/2024 at 1:57 PM, Staff G, RN/RCM, stated they were not aware of any skin issue for Resident 5. Staff B added they did not see an incident report completed or anything on the reporting log. < RESIDENT 55> Resident 55 readmitted to the facility on [DATE], for rehabilitation after a joint replacement. Review of the Admission MDS assessment, dated 04/12/2024, showed the resident had no cognitive impairment and required one person assistance for bed mobility, and transfers. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility incident investigation involving Resident 55, dated 04/22/2024, included a statement by Staff P, Physical Therapist Assistant (PTA), that documented on 04/22/2024 they overheard Resident 55 stating to another staff member that another patient had hit them in the head but that it did not hurt at all. In an interview on 05/01/2024 at 9:01 AM, Staff P, Physical Therapy Assistant, was asked about the statement they provided on 04/23/2024 regarding the allegation on 04/22/2024. Staff P said they had overheard Resident 55 telling a staff member (whom they could not recall who that was) that a resident hit them over the head. Staff P said they thought the allegation had already been reported. Review of the April 2024 state incident reporting log showed no entry for Resident 55 regarding an resident to resident altercation. There was no follow up about Staff P's statement of the allegation reported to an unknown staff member. In an interview on 05/01/2024 at In12:52 PM, Staff B, DNS said they had not looked into it as Resident 55 had inconsistent stories. Staff B said the facility completed root cause analysis for resident to resident incidents. No additional information was provided. This is a repeat citation from surveys dated 02/28/2023 and 10/17/2023. Refer to WAC 388-97-0640 (2)(b),(5),(7)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review, the facility failed to ensure the Resident Assessment Instrument (RAI - an assessment of a resident's needs, strengths, goals, and preferences, included thorough summaries of the Care Area Assessments, - a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned), to holistically analyze the plan of care for 3 of 6 sampled residents (Residents 5, 29 and 121) reviewed for comprehensive assessments. This failure placed the residents at risk of not having appropriate services provided based on the resident's individualized needs. Findings included . Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, showed the RAI consists of three basic components: the Minimum Data Set (MDS - and assessment tool) assessment, the CAA process, and the RAI Utilization Guidelines (instructions for when and how to use the RAI that include instruction for completion of the RAI as well as structured frameworks for synthesizing the MDS and other clinical information). Once a CAA has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses that included intracranial injury with loss of consciousness (brain injury), unspecified convulsions (involuntary contraction of muscles), unspecified voice and resonance disorder (inability to communicate with voice), contracture left ankle and contracture of left upper arm. Review of Resident 5's Annual CAA assessment, dated 02/24/2024, showed Resident 5 triggered for communication and functional abilities. The CAA worksheet for communication and functional abilities showed no evidence a comprehensive analysis of findings was thoroughly completed and did not contain Resident 5's goals, preferences, strengths, needs or alternative means of communication available nor input from the resident or their representative. <RESIDENT 29> Resident 29 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain that causes changes in reasoning, planning, memory, and judgement), muscle weakness, atrial fibrillation (irregular heartbeat), and high blood pressure. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 29's Annual CAA assessment, dated 08/17/2023, showed Resident 29 triggered for cognition/dementia and psychotropic medication use. The CAA worksheet for cognition/dementia and psychotropic medication use showed no evidence of a comprehensive analysis of findings was thoroughly completed and did not contain Resident 29's or their representative's goals, preferences, strengths, or needs. The written problem/need for both triggered were identical to each other. <RESIDENT 121> Resident 121 admitted to the facility on [DATE] with diagnoses to include a stroke, vascular dementia, unspecified protein calorie malnutrition (the body lacks enough protein and energy to function properly). Review of Resident 121's Admission CAA assessment, dated 04/26/2024, showed Resident 121 triggered for nutrition and urinary incontinence. The CAA worksheet for nutritional status and urinary incontinence showed no evidence a comprehensive analysis of findings was thoroughly completed and did not contain Resident 121's or their representative's goals, preferences, strengths, or needs. The written problem/need for both triggered were identical to each other. Review of Residents 121's initial assessment for urinary incontinence, dated 04/16/2024, showed Resident 121 needed a referral to a urologist related to their urinary urgency/frequency. During Quality Assurance Performance Improvement (QAPI) interview, on 05/01/2024 at 1:06 PM, Staff A, Administrator, Staff B, Registered Nurse (RN)/Director of Nursing Services, Staff C, RN/Assistant Director of Nursing Services, Staff T, RN/Regional Director of Clinical Services and Staff U, RN/Divisional Director of Clinical Services were present. Staff B said there was a [NAME] effect when the MDS was wrong then the CAA and the care plan would not be correct. Staff B said the expectation for the CAA's were they were accurate, personalized, and show how we reach the goals of care. Cross Reference to: CFR 483.21(a), (a)(1)(i)(ii), F655 - Baseline Care Plan CFR 483.21(b), (b)(1),(c)(3)(i - iv), F656 - Develop/implement Comprehensive Care Plan CFR 483.21(b),(b)(2)(i-iii), F657 - Care Plan Timing And Revision Refer to WAC 388-97-1000 (1)(a)(2)(q)(5)(a)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview, and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR - a federally required screening of all individuals who has both an Intellectual Disability or Related Condition and a Serious Mental Illness prior to admission to a Medicaid-certified nursing facility or a significant change of condition) assessments were completed timely for all residents following significant change in status for 3 of 5 sampled residents (Resident 10, 51 and 57) reviewed for possible serious mental disorders and related conditions. This failure resulted in a potential inability to receive and benefit from Level II PASSR services for Resident's 10, 51 and 57, and other residents at risk for a decreased quality of life. Findings included . Review of the facility policy titled, Pre-admission Screening and Resident Review (PASRR), revised 09/05/2023, showed the facility will ensure that potential admissions are screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASARR Level I and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. A positive Level I (a screening to determine if a resident may have a Serious Mental Illness, Intellectual Disability, or a Related Condition and if positive a Level II PASRR is required) screen necessitates an in-depth evaluation of the individual by the state designated authority, known as PASARR Level II (an in-depth evaluation to determine whether the resident requires specialized rehabilitation services), which must be conducted prior to admission to a nursing facility. <RESIDENT 10> Resident 10 admitted to the facility on [DATE] with diagnoses to include vascular dementia (a general term for problems with reasoning, planning, memory, and other thought processes cause by brain damage from impaired blood flow to the brain) with other behavioral disturbance, metabolic encephalopathy (a condition in which the brain function is disturbed due to different diseases or toxins in the body), and psychotic disturbance characterized by a loss of touch with reality characterized by altered thinking, perceptions, and behavior) with hallucinations due to a physiological condition. Review Resident 10's Level I PASRR, dated 01/22/2024, showed the resident had a serious mental illness (MI) indicator however mood disorder and psychotic disorder were not marked. The PASRR was marked as the resident was likely to require fewer than 30 days of nursing facility services. The PASRR indicated a Level II PASRR was not indicated. The PASRR was not revised upon admit for the assessment inaccuracy when psychotic disorder was not marked nor when the hydroxyzine (antianxiety medication) was ordered for anxiety, the Zyprexa (antipsychotic medication) was ordered, and the length of the resident's stay was over 30 days. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's Psychotropic Care Area Assessment (CAA - a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned), dated 01/23/2024, showed the resident had dementia, a history of hallucinations and was started on Seroquel (antipsychotic medication) to treat this. The CAA showed the resident had episodes at calling out at night and increased confusion. The CAA did not show the resident had anxiety. In an interview on 4/29/2024 at 3:03 PM, Staff I, Social Service Director (SSD), said Collateral Contact (CC) 4, a PASRR contractor, received a copy of their Level I PASRR, but they did not have any documentation that showed CC4 was notified of Resident 10's PASRR. Staff I said CC 4 told them not to revise the PASRR's, so they just sent the PASRR's to them. At 3:15 PM, Staff I confirmed they did not have anything that showed they contacted CC4. In a phone interview on 05/02/2024 at 11:34 AM. CC5, Advanced Registered Nurse Practitioner (ARNP), stated Resident 10 admitted with a diagnosis of psychotic disorder and was on Seroquel. CC5 said they added a low dose of Zyprexa to help the resident who would scream when their spouse left the facility. CC5 said they spent eight hours in the facility at a time and noted the resident was in distress, scared, and listening to them was sad. CC5 said since the resident had been on the Zyprexa they had calmed and no longer screamed. 43954 <RESIDENT 51> Resident 51 was admitted to the facility on [DATE] with diagnoses to include dementia without behavioral disturbance, anxiety, depression, psychotic disorder, and cognitive communication deficit. Review of Resident 51's progress note, dated 09/05/2023 at 5:24 PM, showed the resident had attempted to go outside of the building since 9:00 AM that morning, became verbally aggressive, and became physically violent with staff. Resident 51 was sent to the emergency room . Review of Resident 51's progress note, dated 09/11/2023, showed the resident was admitted back to the facility after a psychological consult. Resident 51 was started on Depakote (anticonvulsant used for mood stabilization) and risperidone (antipsychotic medication). Review of Resident 51's PASRR, dated 04/28/2023, showed the resident had a diagnoses of depression and dementia. Anxiety and psychotic disorders were not checked as a current diagnosis. There were no further PASRR evaluations in the medical record. In an interview on 04/29/2024 at 3:19PM, Staff I stated a new PASRR should have been completed for Resident 51 after September 2023 when the resident showed new verbal and physical aggression and eloped. Staff I stated they should have completed a new PASRR and had not. In an interview on 05/01/2024 at 11:39 AM, Staff B, Registered Nurse (RN)/Director of Nursing Services, stated a new PASRR should have been completed for Resident 51 when they exhibited new verbal and physical behaviors and had been sent to the emergency room for a psychological evaluation. <RESIDENT 57> (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 57 was admitted to the facility on [DATE] with diagnoses to include delusional disorder (a type of psychotic disorder where a resident can't tell what's real from what's imagined), cognitive communication deficit, depression, and vascular dementia. Review of Resident 57's PASRR, dated 02/03/2024 (required to be done prior to the resident admitted), showed they had a mood disorder (depression), and no delusional disorder was identified and no PASRR Level II was indicated. Review of Resident 57's five-day admission Minimum Data Set (MDS - an assessment tool) assessment, dated 02/15/2024, showed they had severe cognitive impairment, with inattention (reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli), disorganized thinking, and no altered level of consciousness. The assessment showed Resident 57 did not show physical, verbal, or other behavioral symptoms. Review of Resident 57's progress note, dated 02/15/2024 at 12:31 PM, showed the resident had a care conference and there was no documentation related to behaviors. Review of Resident 57's end of Perspective Payment System Part A (a required assessment) stay MDS assessment, dated 03/30/2024, showed they had severe cognitive impairment, inattention, disorganized thinking, and an altered level on consciousness. There was no documentation related to behaviors. Review of Resident 57's progress note, dated 02/15/2024 at 12:31 PM, showed the resident had a care conference and there was no documentation related to behaviors. In an interview on 04/29/2024 at 3:19PM, Staff I stated they had completed another PASRR for Resident 57 on 03/22/2024 related to the resident exhibited new behaviors and sent it to the PASRR level II evaluator. Staff I provided a copy of the PASRR, dated 03/22/2024. Staff I stated they had not followed up with the PASRR level II evaluator. In an interview on 05/01/2024 at 11:39AM, Staff B stated Resident 57's PASRR Level II should have been followed up on if they did not hear from or receive documentation from the PASRR Level II evaluator. Review of documentation submitted by CC4, received on 05/01/2024 at 10:58 PM, showed they did not receive any referrals on Resident 10 or 51 but received a referral on Resident 57 on 03/22/2024. During Quality Assurance Performance Improvement (QAPI) interview on 05/01/2024 at 1:14 PM, Staff A, Administrator, Staff B, Staff C, RN/Assistant Director of Nursing, Staff T, RN/Regional Director of Clinical Services were present. Staff B stated they had not been aware of an PASRR issues. Refer to WAC 388-97-1975

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview, and record review, the facility failed to implement a baseline care plan for 1 of 2 sampled residents (Resident 121) reviewed for baseline care plans. The failure to develop an effective and person-centered baseline care plan for falls placed the resident at risk for health complications, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Baseline Care Plan, revised in 08/17/2022, showed, A baseline care plan will be developed for every resident within 48 hours of admission to provide an initial set of instructions needed to provide effective and person-centered care of the resident that meet professional standards of care. Resident 121 admitted to the facility on [DATE] with diagnosis to include a stroke, vascular dementia, and unspecified protein calorie malnutrition (not consuming enough protein and calories). Review of Resident 121's care plan, dated 04/16/2024, showed the resident was at risk for falls related to their history of stroke with left sided weakness and dementia with poor safety awareness. The goal of the care plan included Resident 121 would not sustain serious injuries requiring hospitalization . Interventions included assisting with activities of daily living as needed, call light within reach, complete a fall assessment, to have nonskid socks always on, to orientate Resident 121 to their room. There was no documented intervention addressing Resident 121's urinary urgency. Review of Residents 121's initial assessment for urinary incontinence, dated 04/16/2024, showed Resident 121 needed a referral to a urologist related to their urinary urgency/frequency. In an interview on 04/23/2024 at 12:32 PM, Collateral Contact 2 (CC2), Resident 121's family member, stated they had not received or reviewed a care plan for Resident 121. CC2 stated they had a care conference scheduled for 04/24/2024. In an interview on 05/01/2024 at 9:08 AM, Staff F, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated the process for developing an initial care plan included learning as much as possible about the resident from their discharge documentation from the hospital, fill in the care plan electronically in the resident's electronic health record, and schedule a care conference within 48 hours of a resident admitted to the facility to review it. In an interview on 05/01/2024 at 12:15PM Staff B, Registered Nurse/Director of Nursing Services (DNS), stated they recently became aware of issues with the completion and implementation of baseline care plans and were in the process of developing a performance improvement plan. Reference: (WAC) 388-97-1020 (3)

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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** 36787 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 3 of 7 sampled residents (Resident 47, 59 and 121) reviewed for comprehensive care planning. The failure to ensure the comprehensive care plan was person-centered to maintain or attain the resident's highest practicable well-being placed the residents at risk of not receiving services that would meet their desires or wants and a decreased quality of life. Findings included . <RESIDENT 47> Resident 47 admitted on [DATE] with cancer, hip fracture, anxiety, and protein calorie malnutrition. Review of the Significant Change Minimum Data Set (MDS - an assessment tool) assessment, dated 04/06/2024, showed Resident 47 had a condition that may result in a life expectancy of less than six months. In an interview on 04/22/2024 at 2:27 PM, Resident 47 said they were unsure about the plans for them. The resident stated they had a lot going on and they never stop worrying. The resident said I am dying and that is a lot to deal with. I do not want chemo anymore. My quality of life is terrible. The resident said they had not seen any hospice staff yet but would like them to help with their grief and coping. The resident stated that all they did was worried resulting in stomach issues. The resident said they did have a counselor that visited but they sometimes did not feel up to talking because they felt sick. Review of the physician's orders showed Resident 47 was taking the medication Clonazepam for anxiety. The resident was not on an anti-depressant medication. Review of the comprehensive care plan showed there was no care plan addressing the resident's diagnosis of cancer, anticipatory grieving, or goals to continue chemotherapy or transition to end of life care. There was an antidepressant care plan in place although the resident was not on an anti-depressant. The antidepressant care plan lacked the resident's history that included therapy or their goals. <RESIDENT 59> Resident 59 was readmitted to the facility on [DATE] with diagnoses to include collapsed and displaced vertebrae, and multiple myeloma (cancer of plasma cells that weakens bones). A review of the resident's Admission MDS assessment, dated 03/05/2024, identified the resident to have moderately impaired cognition and memory and they did not reject care. The MDS assessment showed the resident was always continent of bowel, was not on a bowel toileting program and did not have constipation present. (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 bowel records from admission 03/01/2024 through 03/06/2024, the resident had no bowel movement. Review of the admission physician orders showed Resident 59 had orders to administer Milk of Magnesium (MOM) daily after no BM for three days, then administer Dulcolax suppository as needed if no results from Milk of Magnesia (MOM) daily, and then administer a Fleet enema as needed if no results from the suppository. Review of the care plan showed there had been no constipation care plan developed until 04/22/2024 after Resident 59 was diagnoses with a bowel impaction. The care plan showed Resident 59 was at risk for constipation related to Oxycodone (a narcotic) and lacked the resident's other risk factors for constipation that included other narcotics and decreased mobility. The care plan goal was not resident specific. 47047 <RESIDENT 121> Resident 121 admitted to the facility on [DATE] with diagnosis to include a stroke, vascular dementia (a general term for problems with reasoning, planning, memory, and other thought processes cause by brain damage from impaired blood flow to the brain), and unspecified protein calorie malnutrition (not consuming enough protein and calories). Review of Residents 121's initial assessment for urinary incontinence, dated 04/16/2024, showed Resident 121 needed a referral to a urologist related to their urinary urgency/frequency. Review of Resident 121's Care Area Assessment (CAA a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned) for urinary incontinence, dated 04/26/2024, showed Resident 121 had urinary incontinence and placed them at risk for skin breakdown. The CAA did not address Resident 121's urinary frequency or a referral to a urologist. In an interview on 04/23/2024 at 12:32 PM, Collateral Contact 2 (CC2), Resident 121's family member, stated they had not received or reviewed a care plan for Resident 121. CC2 stated they had a care conference scheduled for 04/24/2024. CC2 stated they were concerned about Resident 121's frequent urination. In a review of Resident 121's care plan, dated 04/16/2024, showed Resident 121 had urine incontinence with a goal for the resident not to have skin breakdown. Interventions included assist with toileting and perineal care (washing the genitals and anal area) as needed. The care plan did not address Resident 121's frequency/urgency of urination nor a referral to a urologist. In an interview on 05/01/2024 at 1:19 PM, Staff B said they were not aware of any care plan issues other than the baseline care plans. This is a repeat citation from surveys dated 05/19/2023. Refer to WAC 388-97-1020 (3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 6 of 8 sample residents (Residents 47, 55, 32, 5, 29, and 121) whose CPs were reviewed. These failures placed residents at risk for unmet care needs and diminished quality of life. Findings included . Review of the facility policy titled, Comprehensive Care Plans and Revisions, revised 08/22/2023, showed the facility would ensure the timeliness of each resident's person-centered, comprehensive CP, and that the comprehensive CP was reviewed and revised by an interdisciplinary. The policy showed the facility would monitor residents over time to identify changes in condition and update the CP as warranted to reflect goals and interventions. <RESIDENT 47> Resident 47 admitted on [DATE] with cancer, hip fracture, anxiety, and protein calorie malnutrition. In an interview and observation on 04/22/2024 at 2:22 PM, Resident 47 said they just hurt and could not get comfortable. The resident was observed making frequent position changes and said they were just trying to get comfortable. Review of Resident 47 physician's orders, 04/24/2024, directed staff to administer Morphine Sulfate ER (Extended Release) twice daily, Morphine Sulfate and Acetaminophen every four hours as needed for pain. Review of the Significant Change Minimum Data Set (MDS- an assessment tool) assessment, dated 04/06/2024, showed Resident 47 was on scheduled pain medication for frequent severe pain. The pain Care Area Assessment (CAA a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned) revealed the area triggered secondary to resident complaints of pain during their pain interview. The assessment showed each resident was carefully monitored throughout the day and night by a licensed nurse and evaluated for pain. The physician was to be immediately notified if there is no pain relief from the current regimen. Contributing factors include recent acute medical condition requiring hospitalization , surgery, pressure ulcer(s), and/or chronic pain, Osteoarthritis, Rheumatoid Arthritis, and Fracture. The CAA showed the CP would be developed, reviewed to improve, and maintain management of the resident's pain status as it relates to recent surgery, pressure ulcers, therapy sessions, Activities of Daily Living (ADL), retraining and functionality, mobility, and history of pain. Review of Resident 47's CP, 01/08/2024, showed the resident expressed pain related to a hip fracture. The goal was for the resident to express pain relief through the review date. The interventions were to administer pain meds as ordered and evaluate the effectiveness of pain interventions. The CAA assessment was not transferred to the CP for nursing staff to utilize. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 55> Resident 55 readmitted to the facility on [DATE], for rehabilitation after joint replacement. Review of the Admission MDS assessment, dated 04/12/2024, showed the resident had no cognitive impairment and required one person assistance with one staff member for bed mobility, and transfers. Review of a nursing progress notes on 03/07/2024 at 1:16 PM, showed while in the dining room, Resident 55 was approached by another resident who yelled at them and hit them on their left shoulder several times. The note showed the residents were separated immediately and Resident 55 was assured of their safety. Review of Resident 55's nursing progress note on 04/20/2024 at 9:00 PM, showed the nurse was called to the dining room by a nurse's aide who alerted them that fell ow resident had been touching and patting Resident 55 who requested that they stop touching them at which time the other resident began striking Resident 55 with an open hand on their left shoulder. Resident 55 reported they had no pain, and they were just pissed. Review of Resident 55's CP, dated 04/08/2024, showed a focus problem of potential psychosocial well-being related to receiving physical aggression during a resident-to-resident altercation. The CP interventions included allowing the resident to answer questions and to verbalize feelings. perceptions and fears, observe for latent bruising and pain to the left shoulder, observe resident feelings relative to the incident and place on alert for psychosocial distress although the incident occurred on 03/07/2024. There were no revisions when another resident-to-resident altercation occurred on 04/20/2024 at the same location. On 04/23/2024, Resident 55 alleged another incident said to have occurred with the same resident the day prior, 04/22/2024. There CP was not updated to reflect the resident's goals or interventions to prevent further incident with the other resident. In an interview on 05/01/2024 at 1:25 PM, Resident 47 and Resident 55's care plans were discussed with Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS). Staff B said they were unaware of issues with care plan revisions. 43954 <RESIDENT 32> Resident 32 was last admitted to the facility on [DATE] with diagnoses to include lung disease, asthma, diabetes mellitus, depression, anxiety, and chronic pain syndrome. Review of Resident 32's CP showed the resident was to be administered anti-anxiety medications as ordered by the Physician and to be educated on the risks and benefits of anti-anxiety medications, dated 01/21/2022 and revised on 10/10/2022. An intervention on the CP directed staff to observe for and report any adverse reactions to their anti-anxiety medication, dated 01/21/2022. Review of Resident 32's February 2024 through April 2024 Medication Administration Record (MAR), showed the resident had no anti-anxiety medications. Review of Resident 32's current provider orders showed no anti-anxiety medication was ordered. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Resident 32's behavior progress note, dated 03/07/2024 at 12:24 PM, showed the anti-anxiety medication was discontinued on 12/09/2022. In an interview on 04/29/2024 at 3:19 PM, Staff I, Social Service Director, stated they were unsure if Resident 32 was taking an anti-anxiety medication. Staff I stated there should be no interventions for an anti-anxiety medication if they were not taking one. In an interview on 05/01/2024 at 11:39 AM, Staff B stated CPs should be revised on an on-going basis and should change when the resident changes. Staff B stated CPs should be resident specific and current. 47047 <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses that included intracranial injury with loss of consciousness (brain injury), unspecified convulsions (involuntary contraction of muscles), unspecified voice and resonance disorder (inability to communicate with voice), contracture left ankle and contracture of left upper arm. <Position/Mobility> In an interview on 04/26/2024 at 09:01 AM Staff A, Administrator, stated the facility does not have a restorative nursing program, however Resident 5 was receiving restorative nursing. In an interview on 04/29/2024 at 3:14 PM Staff F, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated the facility did not have a restorative nursing program. Review of Resident 5's March 2024 and April 2024 Treatment Administration Record (TAR), showed on order for passive range of motion (PROM- when someone physically moves or stretches a part of your body) with gentle stretching to left upper and lower extremity with left hand splint placement and active assist range of motion (AAROM - a type of exercise that involves moving a joint with some help from an external force) to right upper and lower extremity and head with neck splint placement three to six times a week for at least 15 minutes. The order directed the unit nurse to monitor compliance and completion of the program everyday shift for functional mobility maintenance starting 06/11/2021. This treatment was marked as not completed for the months of March and April 2024. Review of Resident 5's CP, dated 03/04/2019, showed resident 5 had three active restorative programs, one initiated on 03/14/2019 for PROM/gentle stretching to left upper and lower extremities, one initiated on 11/23/2020 for application of a brace to the left hand and neck, and one on 07/26/2021 for application of braces to the left hand and neck accompanied by PROM. The CP was not updated to reflect Resident 5's care needs. <Communication> In an interview with Collateral Contact 1 (CC1), resident 5's family member, stated the resident's speech generating device was broken and remained in the corner of Resident 5's room for at least a year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 5's CP, dated 10/21/2020, showed Resident 5 used the speech generating device to communicate with their family. There was no documentation found in the CP that showed the speech generating device was broken and not available for the resident to use. In an interview on 04/29/2024 at 2:56 PM, Staff O, Nursing Aide Certified (CNA), stated they did not know for what the speech generating device in Resident 5's room was used for. In an interview on 04/29/2024 at 2:58 PM, Staff F stated they did not have knowledge of Resident 5's use of the speech generating device. In an interview on 05/01/2024 at 9:08 AM, Staff F stated resident's CP's were revised as a team, they were still learning about the CP process, and that daily clinical rounds were part of the process in revising CP's. <RESIDENT 29> Resident 29 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain that causes changes in reasoning, planning, memory, and judgement). Observation on 04/23/2024 at 1:54 PM, Resident 29 was observed to have several missing teeth and a metal piece of dental hardware on their upper jaw visible from the front of their mouth when they smiled. In an interview on 04/30/2024 at 2:01 PM, Staff K, NAC, stated Resident 29 did have a partial but does not wear it any longer because it is broken. Staff K stated Resident 29's partial had been broken from at least October 2023. Review of Resident 29's progress note, showed the resident was seen by the dental hygienist 01/24/2024 and Resident 29's tissue and gums in their mouth was raw under their dentures. In a review of Resident 29's CP, dated 10/25/2022, showed a CP focus for dental care. The CP showed that Resident 29 had dental problems with upper partials and numerous missing lower teeth. CP interventions included to coordinate arrangements for dental care, transportation as needed and as ordered, observe and report as needed any oral/dental problems needing attention. The CP with a focus on dental had not been updated since 10/25/2022 and did not include recommendations and observations of the dental hygienist and information about the status of Resident 29's partial. <RESIDENT 121> Resident 121 admitted to the facility on [DATE] with diagnosis to include unspecified protein calorie malnutrition (the body lacks enough protein and energy to function properly). Review of Resident 121's weight showed on 04/16/2024, the resident weighed 136.5 lbs. On 04/21/2024, the resident weighed 127 pounds which was a 6.96 % loss of weight in six days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of Resident 121's CP, dated 04/16/2024, showed a focus area/goals and interventions related to being at risk for weight fluctuations. The goal for Resident 121 was that they would maintain adequate nutritional status by maintaining weight within 5 percent of 136.5 pounds and consume at least 75 precent of two of their meals. Interventions included inviting Resident 121 to activities that promote additional intake, monitoring and recording their intake at meals, and an evaluation by the Registered Dietician. In the special instructions section of Resident 121's CP showed that Resident was on a mechanical soft diet and required one to one feeding assistance. There was no information in the CP regarding Resident 121's weight loss. This is a repeat citation from surveys dated 02/28/2023, 05/19/2023, and 10/17/2023. Refer to WAC 388-97-1020(c)(i)(ii)(e)(f)(5)(b)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review, the facility failed to provide care and services to maintain oral health for 1 and 3 sampled residents (Resident 29) and communication devices in functional order for 1 of 1 sampled resident (Resident 5) reviewed for activities of daily living. This failure placed residents at risk for a decrease ability to communicate, maintain oral health, have unmet care needs, and a diminished quality of life. Findings included . <COMMUNICATION> RESIDENT 5 Resident 5 admitted to the facility on [DATE] with diagnoses that included intracranial injury with loss of consciousness (brain injury), unspecified convulsions (involuntary contraction of muscles), unspecified voice and resonance disorder (inability to communicate with voice), contracture left ankle and left upper arm. In an interview, on 04/22/2024 at 2:06 PM, Collateral Contact 1 (CC1), Resident 5's family member, stated the Tobii DynaVox (a speech generating device) was broken and remained in the corner of Resident 5's room for at least a year. Review of Resident 5's Annual Minimum Data Set (MDS - an assessment tool) assessment triggered Care Area Assessment (CAA a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned), dated 02/24/2024, showed Resident 5 triggered for communication and functional abilities. The CAA worksheet for communication and functional abilities showed no evidence a comprehensive analysis of findings was thoroughly completed and did not contain Resident 5's goals, preferences, strengths, needs or alternative means of communication available nor input from resident's representative. There was no reference to the use of speech generating device. Review of Resident 5's care plan, dated 10/21/2020, showed Resident 5 used the speech generating device to communicate with their family. There was no documentation found in the care plan that showed the speech generating device was broken. Review of Resident 5's March 2024 and April 2024 Medication Administration Record (MAR), showed Resident 5 required assistance to call their family member on their computer via Skype once nightly between 7:30 PM-8:00 PM when they were in bed starting 12/27/2021. The MAR contained dash marks (-) for each day of the month. On 04/25/2024 at 1:53 PM, Resident 5's speech generating device was observed sitting in the corner of the resident's room, unplugged. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/2024 at 1:57 PM, Resident 5's speech generating device was observed sitting in the corner of the resident's room, unplugged. In an interview on 04/29/2024 at 2:56 PM Staff O, Nursing Aide Certified (CNA), stated they did not know for what the speech generating device in Resident 5's room was used for. In an interview on 04/29/2024 at 2:58 PM Staff F, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated part of their job duties included ensuring the MAR was being completed. Staff F stated they did not know what Resident 5's speech generating device was or what it was used for. Staff F stated the order on the MAR for Resident 5 to call their family member nightly did not occur and the dashes indicated no it was not done. <ORAL CARE> RESIDENT 29 Resident 29 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain that causes changes in reasoning, planning, memory, and judgement), muscle weakness, atrial fibrillation (irregular heartbeat), and high blood pressure. On 04/23/2024 at 1:54 PM, Resident 29 was observed to have several missing teeth and a metal piece of dental hardware on their upper jaw visible from the front of their mouth when they smiled. Resident 29's face, around their mouth, had a brown hue of dried food/liquid. In a review of Resident 29's Kardex (resident specific reference guide, containing parts of the care plan, utilized by NAC's, which provides specific information on how to care them), dated 04/30/2024, showed Resident 29 had their own teeth with some partial and they were dependent with oral care. The Kardex directed staff to report changes to the nurse and remind Resident 29 to remove their partial nightly to soak. In an interview on 04/30/2024 at 1:45 PM, Staff AA, Registered Nurse (RN), stated Resident 29 had their own teeth and required assistance to brush them. In an interview on 04/30/2024 at 1:52 PM, Staff EE, NAC, stated Resident 29's teeth were like rotting and Resident 29 does not let the staff take care of their teeth. Staff EE stated they did not know if Resident 29 had partials. In an observation and interview won 04/30/2024 at 2:01 PM Staff K, NAC, stated Resident 29 did have a partial but does not wear it any longer because it was broken. Staff K stated Resident 29's partial had been broken since at least October 2023. Staff K located a baggie of toothbrushes (all which were dry and no indicators of wetness) and full tubes of toothpaste in their bedside table. Staff K stated Resident 29 had not had their teeth brushed. Refer to WAC 388-97-1060(2)(a)(v)(3)(vii)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 monitor, assess, and take timely action in accordance with professional standards of practice for 17 of 32 resident's (Residents 59, 47, 5, 55, 1, 14, 23, 27, 31, 34, 40, 50, 58, 62, 63, 69 and 70) reviewed for bowel care and management, 1 of 1 resident (Resident 49) for a hospice referral and 1 of 1 resident (Resident 121) for neurological checks. These failures resulted in harm to Resident 59 when they experienced discomfort, pain, and hospitalization for a bowel impaction (the result of constant constipation when poop was stuck inside of the rectum). These failures placed the residents at risk for constipation, discomfort, a worsening of their condition, and a delay in receiving hospice care and services. Findings included . Review of the facility policy titled, Bowel Protocol, revised 09/12/2023, showed to provide interventions for signs and symptoms of constipation that are consistent with current standards of practice. The policy directed staff to record in the electronic health records (EHR), each time a resident had a bowel movement. The facility in coordination with the residents attending practitioner will implement standing orders to address a lack of bowel movement. The protocol noted the orders may vary within the facility for each attending practitioner and depend on the individual needs of the resident. <BOWEL MANAGEMENT> RESIDENT 59 Resident 59 was readmitted to the facility on [DATE] with diagnoses to include collapsed and displaced vertebrae (back bones) multiple myeloma (cancer of plasma cells that weakens bones), torticollis (condition where neck muscles contract), and emphysema (lung disease with shortness of breath). A review of the resident's Admission Minimum Data Set (MDS- an assessment tool) assessment, dated 03/05/2024, identified the resident to have moderately impaired cognition and memory, and they did not reject care. The MDS assessment showed the resident was always continent of bowel, was not on a bowel toileting program and did not have constipation present. During an interview on 04/22/2024 at 10:53 AM, Resident 59 was in bed with a pained expression (grimacing, furrowed brow, and look of displeasure) on their face. They stated they had constipation and now they thought they were headed the other way (loose stools). Resident 59 said they needed to try to have a bowel movement (BM). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan, dated 04/22/2024, showed there had been no constipation care plan developed until 04/22/2024. The care plan showed Resident 59 was at risk for constipation related to oxycodone (narcotic) use. The care plan did not document other narcotics with a potential to increase constipation or specify the resident's usual bowel patter or goals. The care plan goal said the resident would pass soft, formed stool but did not include the resident goals and preferred frequency of BM's through the review date. The care plan was incomplete with SPECIFY FREQ (a place marker in the software that directs the staff to specify the frequency) was still in place The interventions included: follow facility bowel protocol for bowel management, observe for medication side effects of constipation, and to keep the physician informed of any problems. Additional interventions included to observe for reported as needed (PRN) signs and symptoms of complications related to constipation. Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, Bradycardia (slow, low pulse), Abdominal distension, vomiting, small loose or stools, fecal smearing, Bowel sounds, Diaphoresis, Abdomen: tenderness, guarding, rigidity, fecal compaction. The care plan included an incomplete intervention directing staff to teach the resident/family/caregivers the relationship between constipation and food, fiber intake, medicine, treatment regimen, disease process (SPECIFY) and psychosocial factors. Teach the resident/family/caregivers to identify and avoid causative factors (SPECIFY: lack of exercise, not enough fiber). Review of physician's orders, dated 04/22/2024, showed Resident 59 received three narcotics with a known side effect of constipation (Dilaudid every four hours PRN, Oxycodone 15 milligrams (mg) every three hours routinely and Oxycontin 20 mg two times a day routinely). Review of the bowel medications directed the licensed nurse to implement the following: - Order, dated 03/01/2024, if the resident had no BM in three days give Milk of Magnesia (MOM - a laxative) at bedtime. Administer a Dulcolax (a laxative) suppository PRN if no results from the MOM. Administer a Fleet (a laxative) enema PRN if not results from the suppository. - Dilaudid 2 mg to 4 mg every four hours PRN, dated 03/19/2024. - Oxycontin two times a day, dated 04/10/2024. - Oxycodone 10 mg to 15 mg every three hours PRN, dated 04/10/2024. - The facility received orders on 04/10/2024 to add Senna once daily. - MiraLAX (a laxative) 17 grams was ordered PRN daily for constipation on 04/23/2024 at 10:23 AM. -MiraLAX 17 grams was ordered every Wednesday, Friday, and Sunday for constipation on the day after the resident was sent out to the hospital (04-24-2024). Review of Resident 59 bowel monitor and Medication Administration Record (MAR) for March 2024, showed the following: -The resident had a BM's on ten days of the month. - There was no BM documented from admit, 03/01/2024 until 03/07/2024, a total of at least six days (review of the clinical record showed there was no information on when the residents last BM was prior to admit) documented with no BM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- On 03/16/2024, a PRN constipation medication was given three days of no BM before an intervention was taken which was effective. - On 03/20/2024, MOM was administered after four days with no BM since 03/16/2024, and the MOM was effective. - On 03/26/2024, the resident received senna after no bm for four days which was documented in the MAR to be effective, although the bowel monitor (a separate record used to document BM's) did not show the resident had a BM. - On 03/27/2024, and the resident received senna. The nurse documented the medication was ineffective. No additional medications were administered when the medication was documented as ineffective. - The resident had three days with no BM, from 03/29/2024 until 04/01/2024, and no bowel medications were given. Review of the bowel monitor and MAR for April 2024, showed no BM documented from 04/04/2024 to 04/10/2024, a PRN constipation medication was given on 04/02/2024 which was ineffective. No additional medications were administered when the medication was ineffective. On 04/07/2024, a PRN medication was given and was ineffective. On 04/08/2024 MOM was given with no results, and then on 04/10/2024 MOM was given a second time and ineffective. No additional medications were administered when the medication was ineffective. The resident then received a Dulcolax suppository on 04/10/2024 which was documented as effective in the MAR although no BM was documented as occurred. In an interview on 04/23/2024 at 9:00 AM, Resident 59 was observed in bed with a pained expression on their face (grimacing, furrowed brow, and look of displeasure), and their knees were drawn up towards their chest. The breakfast tray was observed on their over bed table untouched. There was a bath basin near their side, and they said they were too sick to eat. The resident said they were having terrible abdominal pain and nausea and were miserable. Review of a progress note, dated 04/23/2024 at 7:16 AM, showed Resident 59 was nauseated and the nurse administered Ondansetron (anti-nausea medication) for nausea. Review of a nursing progress note, dated 04/23/2024 at 2:57 PM, showed Resident 59 was complaining of constipation and abdominal pain. Their abdomen was assessed to be rigid (hard) and tender to the touch. Staff F, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), documented they were still awaiting the STAT (urgently) x-ray to be taken before proceeding with a suppository or enema. Staff F noted the provider was notified that morning and had started the resident on routine MiraLAX and senna daily. Review of nursing progress note, dated 04/23/2024 at 3:03 PM, showed Resident 59 was nauseated and the nurse administered Ondansetron. The medication was ineffective as the resident had an emesis (vomiting). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the progress note, dated 04/23/2024 at 7:06 PM, showed Resident 59 had an emesis (vomited) around 4:30 PM. Staff D, Registered Nurse (RN), asked the resident to roll over, the resident reported abdominal pain with turning, and the nurse observed so hard stool coming out of the resident rectum. The nurse asked the resident if it was okay to be sent out to the hospital as the x-ray was going to take a while and an enema or suppository would not be effective due to the symptoms as the LN (licensed nurse) documented a suspected impaction at this point. Review of the facility's Nursing Home to Hospital Transfer Form, dated 04/23/2024 at 6:25 PM, showed Resident 59 was transferred to the hospital for constipation and had a pain level of six (on a zero, no pain, to 10 severe pain scale) in their abdomen. The resident's last BM was on 04/22/2024. In an interview on 04/24/2023 at 7:32 AM, Staff F said Resident 59 went out to the hospital last night. Staff F said they heard the resident had a bowel impaction, but they hadn't verified that on the hospitals electronic health record (EHR) yet. Review of the nursing progress notes from 04/01/2024 to 04/21/2024, showed no documentation the physician was notified or consulted regarding Resident 59's constipation until 04/23/2024. In an interview on 04/25/2024 at 9:01 AM, Staff D said they were the nurse who sent Resident 59 out to the hospital last night. Staff D said the resident had been having small BM's every day and did not trigger on the bowel alert (an alert system within the facility's EMR to notify staff of no bowel movement in 72 hours). Staff D said the resident complained of abdominal pain, they gave them prune juice, and MiraLAX. Staff D said the resident had vomited brown emesis. Staff D said they positioned the resident on their side to see a very hard stool.: Staff D said they had orders for an enema or suppository but there was a hard BM present, so they couldn't administer these medications. Staff D said they had already received an order for the abdominal x-ray, but it had not been taken yet. Staff D said at that time, they encouraged the resident to go out to the hospital for treatment and to get the x-ray sooner and they refused. Staff D called the residents family member who talked with them, and they agreed to go. Review of the history and physical from the emergency department physician, dated 04/23/2024, showed there was mild tenderness to palpation and the fecal load (BM filled intestines) was evident on abdominal palpation. Review of Resident 59's hospital emergency department dictation, dated 04/23/2024, showed the resident was seen for abdominal pain. The present illness showed the resident was on multiple pain medications. The resident reported they were given prune juice as they had not had a bowel movement for the past week. The resident threw up the prune juice and felt the urge to vomit since. The resident complained of abdominal pain and a history of a hernia (bulging of an organ or tissue through an abnormal opening) repair. The physician noted diffuse (spread over a wide area) abdominal tenderness. Review of the hospital's abdominal Computed Tomography (CT -exam of internal images of the body) scan results, dated 04/23/2024 at 10:24 PM, showed Resident 59 had a marked amount of fecal material in the rectum with wall thickening possibly related to stercoral colitis (occurs when a resident has chronic constipation leading to stagnant fecal matter). The CT showed distension (abnormally swollen) in the small bowel. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the emergency department admission report, dated 04/23/2024, showed Resident 59 presented with a concern for worsening abdominal pain, lack of a bowel movement, and vomiting. The resident had been receiving significant amounts of opioids (narcotics) for discomfort. Review of Resident 59's emergency department note, dated 04/23/2024, showed the CT scan was reviewed with the surgeon who said this did not require surgical intervention and would be appropriate for medical admission with enema and bowel preparation. They attempted manual disimpaction (a procedure to remove trapped stool by breaking it up and removing it) and were able to remove a small amount of stool however the procedure was discontinued per resident request due to the degree of discomfort. The plan was for several enemas to loosen and remove stool which may require recurrent attempts at manual disimpaction, depending on success and fullness of enema. The resident diagnoses were fecal impaction and stercoral colitis. Review of a hospital note, dated 04/24/2024, showed Resident 59 had a repeat x-ray that continued to show a large fecal load (large presence of stool in the intestines). Review of a hospital noted, dated 04/25/2023 at 5:44 PM, showed Resident 59 continued passing soft stool throughout the night, requiring multiple (incontinent) brief changes. In an interview on 04/26/2024 at 9:15 AM, Staff B, Registered Nurse (RN)/Director of Nursing Services, provided Resident 59's bowel monitors beginning 03/01/2024 and said they (the bowel records) were concerning. Staff B said they reviewed the current bowel protocol and were now working on changing the order to reflect the Medical Director's standing orders for constipation. Staff B said they have reviewed every resident's chart for bowel pattern and constipation and in serviced nursing staff to review the BM monitors twice a day. <RESIDENT 47> Resident 47 was admitted on [DATE] with diagnoses to include colon cancer, protein calorie malnutrition (the body lacks enough protein and energy to function properly) and gastroesophageal reflux disease. Review of the Admission MDS assessment, dated 01/12/2024, showed the resident was cognitively intact, occasionally incontinent of bowel, was not on a toileting program, and had no constipation. Review of a nursing progress note, dated 03/28/2024 at 2:40 AM, showed communication with a physician as the nurse noticed Resident 47 had been requesting Zofran (anti-nausea medication) lately, their bowel movements were not regular, and occasionally there was no BM for three days. The note showed the resident vomited a small amount of brown emesis and complained of right abdominal pain. The nurse noted the resident was on routine Oxycontin, Oxycodone, and Tylenol which were prone to cause constipation. Resident 47 was not on any routine laxatives, and the nurse inquired about routine laxative medication and a test to rule out bowel obstruction. Review of a nursing progress note, dated 03/28/2024 at 4:12 AM, showed Resident 47 received a Dulcolax suppository which was effective. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing progress note, dated 03/31/2024 at 10:44 PM, showed at 5:10 PM Resident 47 was experiencing an altered mental status, complained of abdominal pain, and nausea and vomiting. At 9:30 PM, the resident was experiencing involuntary movement in all extremities and weakness. The resident reported they had abdominal pain of a 10 out of 10 and felt like someone was pushing on it. The 8:00 pm and 9:00 pm medications were held for the new symptoms. The resident continued to vomit thick saliva. The on-call provider was called, and the resident went to the hospital at 10:10 PM. Review of the readmission physician orders, dated 04/03/2024, showed Resident 47 was receiving Morphine Sulfate twice a day, a narcotic with known side effect of constipation. There were orders for MOM to be given if there was no BM in three days to be administered at bedtime, then a Dulcolax suppository PRN if no results from MOM daily, and then Fleet enema a PRN if no results from the suppository. There was also an order for Senna twice a day PRN for constipation. Review of the April 2024 bowel monitors showed Resident 47 had no BM from 04/03/2024 to 04/07/2024 and no BM from 04/13/2024 to 04/17/2024. Review of the April 2024 MAR showed Resident 47 received PRN MOM on 04/06/2024 at 9:19 PM after no bowel movement for five days. The results of this intervention was documented as unknown. The MAR showed no additional bowel medications were administered when the MOM did not elicit a bowel movement. Review of Resident 47's nursing progress note, dated 04/07/2024 at 8:05 AM, showed the administration of the PRN MOM was unknown. There was no additional assessment or information documented. Review of the current care plan showed there was no constipation care plan developed for Resident 47 until 04/24/2024. In an interview on 04/30/2024 at 12:06 PM, Resident 47 said they had struggled with constipation since they admitted . The resident said their usual bowel pattern was daily and they would like to go daily. In an interview on 05/01/2024 at 11:01 AM, Resident 47 was in bed on their right side and stated they did not feel well, their stomach was upset, and they were constipated. Review of the bowel monitor on 05/01/2024, showed Resident 47's last BM was on 04/28/2024. <RESIDENT 5> Resident 5 admitted on [DATE] with diagnoses to include left sided paralysis. The annual MDS assessment, dated 02/11/2024, showed the resident was frequently incontinent of bowel and did not have constipation. The resident was nonverbal and communicated by hand gestures. Resident 5's care plan showed they were at risk for constipation related to decreased mobility and a diminished appetite. The goal was for the resident to pass soft, formed stool at the preferred frequency of every two to three days. The care plan directed staff to follow the facility bowel protocol and observe for medication side effects of constipation and inform the physician of any problems. The staff were to record the bowel pattern each day. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the physician's orders, dated 12/14/2023, showed Resident 5 received a Bisacodyl suppository every other day routinely for constipation and could receive an additional suppository daily PRN. The resident had an order for a Fleet enema every 72 hours PRN for constipation, MOM PRN daily if no BM in three days, and MiraLAX daily PRN. Review of the 04/01/2024 through 04/25/2024 bowel monitors, showed Resident 5 had no BM's from 04/08/2024 until 04/13/2024, five days. Review of the bowel records from 04/01/2024 to 04/25/2024 showed the resident had bowel movements on eight days. Review of the 04/01/2024 through 04/25/2024 MAR's, showed Resident 47 did not receive any PRN medications as ordered for constipation. <RESIDENT 55> Resident 55 readmitted on [DATE]. A review of the resident's Admission MDS assessment, dated 03/05/2024, identified the resident to have moderately impaired cognition and memory and they did not reject care. The MDS assessment showed the resident was occasionally incontinent of bowel, was not on a bowel toileting program and did not have constipation present. Review of the bowel monitor and MAR, dated 04/08/2024 through 04/24/2024, showed Resident 55 had no BM documented from 04/13/2024 until 04/17/2024, a total of four days with no BM. There was no BM documented from 04/18/2024 until 04/24/2024. Review of a nursing progress note dated 04/17/2024 at 5:56 PM, showed Resident 55 was offered MOM PRN they refused the offer, and reported they had a BM yesterday. Review of the bowel monitor did not include the BM on 04/16/2024 as reported by Resident 55. In an interview on 04/29/2024 at 11:55 AM, Staff B said they had not been following the current signed bowel policy. Staff B said there were batch orders (orders to automatically be put in) on admission for bowels management that included MOM, then a suppository then Fleets enema but that order was not automatically checked and needed an (physician) order. Staff B said residents on narcotics should have the bowel protocol marked and an order for Docusate in case they need it. Staff B said they did not know why the batch orders would not have been addressed for residents on narcotics or if no BM was recognized. In an interview on 04/29/2024 at 2:29 PM, Staff D said they thought Resident 55 had regular BM's and the aides were not documenting their BM's accurately. Staff D said the bowel protocol was to give MOM if there was no BM in three days. Staff D said if the resident triggered on the no BM report (report that indicated when a resident has not had a BM in 72 hours), they would go interview the resident to validate accuracy. Staff D said that they did see BM's for Resident 59, but the facility had temporary and agency staff who did not chart BM's, so the charting may be wrong. Staff D said for resident's who took narcotics, were not very active, they would obtain an order for a routine medication to treat the constipation. Staff D said they did reach out to the Resident 59's doctor and received routine bowel medication orders the morning of 04/23/2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During Quality Assurance Performance Improvement (QAPI) interview on 05/01/2024 at 1:30 PM, Staff A, Administrator, Staff B, Staff C, RN/Assistant Director of Nursing, Staff T, Regional Director of Clinical Services and Staff U, Divisional Director of Clinical Services were present. Staff B said they had not been aware there was an issue with bowel monitoring. Staff B said they were now running the bowel report every day and would be implementing a new bowel protocol that should be reviewed and signed by the Medical Director today (05/01/2024). Staff B said the nursing staff were to review the report twice a day and this was an audit that will not go away. In an interview on 05/02/2024 at 11:34 AM, Collateral Contact 5 (CC5), Advanced Registered Nurse Practitioner (ARNP), stated their expectation for constipation notification is that the facility notifies them on day 4. CC5 said that if a resident had not had a bowel movement for three days and all interventions had been tried such as a suppository or enema they could help. CC5 stated that they had been getting notified of no BM's on day five through written communication, which did not work. In an interview on 05/02/2024 at 11:45 AM, Staff M, Registered Dietician (RD), stated they looked for nausea, vomiting, appetite and if there was any constipation or loose stools on their visits. Staff M said they would work with the provider for medications that could assist with these constipation issues. <RESIDENT 1> Review Resident 1's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 1 had no BM's from 04/18/2024 until 04/23/2024, for five days. Review of the April 2024 MAR, showed Resident 1 did not receive medications to relieve their constipation. <RESIDENT 14> Review Resident 14's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 14 had no BM's from 04/05/2024 until 04/08/2024, for four days. Review of the April 2024 MAR, showed Resident 14 did not receive medications to relieve their constipation. <RESIDENT 23> Review of Resident 23's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 23 had no BM's from 04/02/2024 until 04/06/2024, for five days. Review of the April 2024 MAR, showed Resident 23 received MOM on 04/05/2024 at 9:12 AM that was effective although there was no BM documented on the bowel monitor. <RESIDENT 27> Review of Resident 27's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 27 had no BM's from 04/20/2024 until 04/25/2024, for five days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the April 2024 MAR, showed Resident 27 received constipation medications, Miralax on 04/24/2024 at 4:33 AM and Senna at12:54 AM, that were documented to be ineffective. No additional bowel medications were administered when the resident did not have results. <RESIDENT 31> Review of Resident 31's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 31 had no BM's from 04/18/2024 until 04/22/2024, for five days. Review of the April 2024 MAR, showed Resident 31 did not receive medications to relieve their constipation. <RESIDENT 34> Review of Resident 34's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 34 had no BM's from 04/06/2024 until 04/10/2024, for four days. Review of the April 2024 MAR, showed Resident 34 did not receive medications to relieve their constipation. <RESIDENT 40> Review of Resident 40's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 40 had no BM's from 04/19/2024 until 04/22/2024, for four days. Review of the April 2024 MAR, showed Resident 40 did not receive medications to relieve their constipation. <RESIDENT 50> Review of Resident 50's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 50 had no BM's from 04/13/2024 until 04/16/2024, for four days. Review of the April 2024 MAR, showed Resident 50 did not receive medications to relieve their constipation. <RESIDENT 58> Review of Resident 58's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 58 had no BM's from 04/19/2024 until 04/23/2024, for five days. Review of the April 2024 MAR, showed Resident 58 did not receive medications to relieve their constipation. <RESIDENT 62> Review of Resident 60's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 62 had no BM's from 04/12/2024 until 04/15/2024, for four days. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the April 2024 MAR, showed Resident 62 did not receive medications to relieve their constipation. <RESIDENT 63> Review of Resident 63's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 63 had no BM's from 04/06/2024 until 04/09/2024, four days. Resident 63 did not have a BM from 04/12/2024 to 04/16/2024, for five days. Review of the April 2024 MAR, showed Resident 63 did not receive medications to relieve their constipation on 04/08/2024. Resident 63 did receive MOM on 04/15/2024 with no BM results from the medication. No additional medications were administered when the resident did not have a BM. <RESIDENT 69> Review of Resident 69's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 69 had no BM's from 04/01/2024 until 04/04/2024, for four days. Review of the April 2024 MAR, showed Resident 69 did not receive medications to relieve their constipation. <RESIDENT 70> Review of Resident 70's bowel monitors, dated 04/01/2024 through 04/26/2024, showed Resident 70 had no BM's from 04/10/2024 until 04/14/2024, for four days. Review of the April 2024 MAR, showed Resident 70 did not receive medications to relieve their constipation. <HOSPICE> Resident 47 admitted on [DATE] with cancer, hip fracture and protein calorie malnutrition. Review of a nursing progress note for Resident 47 dated 04/11/2024 at 12:03 PM showed that an order to consult hospice was entered. There were no other progress notes about hospice. In an interview on 04/22/2024 at 2:27 PM, Resident 47 said they were unsure about the plans for their stay or discharge. The resident stated they had a lot going on and they never stop worrying. The resident said I am dying and that is a lot to deal with. I do not want chemo anymore. My quality of life is terrible. The resident said they had not seen any hospice staff yet but would like them to help with their grief and coping. In an interview on 04/24/2024 at 10:45 AM, Staff I, Social Services Director (SSD), stated the local hospice agency was not able to provide services until Resident 47 was on a certain type of medical insurance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/25/2024 at 10:53 AM, Collateral Contact (CC) 3, Referral Center Manager for the hospice agency, said they had not heard about Resident 47 since they were at the hospital in late December 2023 or January 2024. CC3 said they had not heard from this facility, but they could accept the resident under their current pending financial/payor source as their payor source was not a barrier to utilize hospice services. In an interview on 04/26/2024 at 9:15 AM, Staff B said there was a reason Resident 47 could not go on hospice and to talk with Staff I. In an interview on 04/26/2024 at 9:28 AM, Staff A said the facility wanted Resident 47 on hospice services and they felt they would benefit from it, but they had always been told the hospice agency would not accept residents that were pending their financial/payor source. Staff A said they would look into the lack of documentation regarding the referral and follow up. Review of a progress note on 04/26/2024 at 10:32 AM, showed Staff I sent the hospice referral to the local hospice agency via fax. In an interview on 04/29/2024 at 11:30 AM, Resident 47 said they were going to go on hospice services now since it looked like they were going to be going that way. 47047 <NEUROLOGICAL CHECKS> Resident 121 admitted to the facility on [DATE] with diagnosis to include a stroke, vascular dementia, unspecified protein calorie malnutrition. Review of Resident 121 incident report dated 04/22/2024 showed that Resident 121 had an unwitnessed fall in their room. The incident report contained a form for neurological flow sheet which was dated 04/22/2024 and contained 15-minute neurological checks every 15 minutes from 2:45 AM until 3:30 AM and 30-minute neurological checks every 30 minutes from 4:00 AM until 4:30 AM. The neurological flow sheet was empty for the one hour, four hour and 3 days following the fall. In an interview on 04/24/2024 at 3:55 PM Staff C stated they did not have additional information to provide for the investigation. When asked about the neurological checks, Staff C, stated the only checks completed were on the neurological flow sheet however, there were some progress notes addressing Resident 121's overall status as they were on alert charting. This is a repeat citation from survey 12/04/2023. Refer to WAC 388-97-1060 (1)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview and record review, the facility failed to comprehensively assess and ensure timely and appropriate services/interventions were provided to maintain, increase and/or prevent a decrease in range of motion (ROM - was the extent that a joint can move within the expected [normal] range of values) for 2 of 5 sampled residents (Resident 29 and 5) reviewed for ROM and restorative nursing services. Resident 29 experienced harm when they developed a significant, potentially avoidable, left-hand contracture (a permanent tightening of the muscles tendons, skin that causes joint to shorten and become stiff which prevents normal movement a body part affected) and placed other residents at risk for developing new contractures and/or worsening of existing contractures. Findings Included . <RESIDENT 29> Resident 29 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain that causes changes in reasoning, planning, memory, and judgement), muscle weakness, atrial fibrillation (irregular heartbeat), and high blood pressure. Review of Resident 29's Quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 02/03/2024, showed the resident had no impairment in their functional ROM of their upper and lower extremities during the prior seven days. Review of Resident 29's care plan, dated 10/25/2022, showed the resident required Activities of Daily Living (ADL - dressing, bed mobility, transfers, toileting, personal hygiene, etc.) assistance and therapy service to maintain or attain their highest level of function with the goal of attaining their prior level of function. The care plan interventions included cueing and supervision with Resident 29's mobility and ADL's as needed, and therapy services as ordered. In an observation on 04/23/2024 at 1:58 PM and 04/25/2024 at 2:32 PM, Resident 29 was lying in bed on their left side, and their left hand was observed in a rigid (unable to bend or be forced out of shape; not flexible) fist position. In an interview and observation on 4/25/2024 at 2:32 PM, Staff Q, Physical Therapist/Director of Rehabilitation, asked Resident 29 to open their left hand fully. Staff Q extended Resident 29's thumb, pointer finger and when attempted to extend the other three fingers (middle, ring, and pinky), Resident 29 stated that it hurt. Resident 29's middle finger, ring finger and pinky finger were fixed in a seized/clutch like position. Staff Q stated Resident 29 had a contracture of their left hand. On 04/26/2024 at 10:08 AM, Resident 29 was observed walking back to their room with the use of a walker. Resident 29 held the walker with both hands, their left hand holding the handle differently than the right. Resident 29 held the walker handle with their thumb and pointer finger. Resident 29's middle finger, ring finger, and pinky finger were observed fixed in a seized clutch like position. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/25/2024 at 2:32 PM, Staff Q stated Resident 29 did not have any documentation of past therapy at the facility and did not have a documented contracture. Review of the Facility Assessment, dated 03/17/2024, showed the facility's workforce profile had 0.08 hours allotted per patient day (PPD) of restorative certified nursing assistant care with and emergency PPD of 0.05 hours. If the hours were not able to be staffed by an employee of the facility, agency staff was identified as the backup. In an interview on 04/26/24 9:01 AM Staff A, Administrator, stated the facility did not have a restorative program (person centered nursing care designed to improve or maintain the functional ability of residents) related to staffing challenges during the COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise [a general feeling of discomfort/uneasiness], headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) pandemic. In an interview on 04/25/2024 at 2:41PM, Staff S, Nursing Assistant Certified (NAC), stated they assisted Resident 29 during the evening shift. Staff S stated Resident 29 had some arthritis (swelling and tenderness of one or more joints) and used their right hand more than their left. Staff S stated they had not provided Resident 29 with any passive range of motion (PROM when someone physically moves or stretches a part of your body) services. In an interview on 04/25/2024 at 2:50 PM, Staff R, NAC, stated they were not aware of any differences in Resident 29's right and left hand. In an interview on 04/29/2024 at 11:02 AM Staff E, Registered Nurse (RN)/MDS Coordinator, stated they collect information for the MDS assessment through nurse and nursing aide interviews, utilization review meetings, and chart reviews. When asked how a resident's ROM was determined, Staff E stated they rely on the nursing staff and therapy. Staff E stated they do not complete an in-person assessment with the resident regarding their ROM. Staff E stated they were unaware of Resident 29's left hand contracture and did not know for how long they had it. Staff E stated the facility did not have a restorative program. Review of an Occupational Therapy (OT) evaluation, dated 04/26/2024, showed Resident 29's left hand middle, ring and pinky fingers had impaired extension and a contracture which resulted in Resident 29 having a decreased ability to grasp objects with their left hand. <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses that included intracranial injury with loss of consciousness (brain injury), unspecified convulsions (involuntary contraction of muscles), unspecified voice and resonance disorder (inability to communicate with voice), contracture of the left ankle and left upper arm. Review of the OT evaluation, dated 04/04/2022, showed Resident 5's left upper extremity (LUE) had spastic hemiplegia (muscle tightness and involuntary contractions) resulting in the shortening and tightening of their shoulder, elbow, wrist, and hand. A PROM of their LUE with daily application of a hand/wrist splint by nursing aides were recommended to prevent further contractures. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Review of the OT discharge summary dated 05/27/2022, recommended Resident 5 continue with upper extremity PROM and splint applications. Review of Resident 5's medical record from 04/28/2023 through 4/22/2024, showed they had not received any additional OT services. Review of Resident 5's care plan, dated 06/30/2021, showed the resident had a focus on ADL Self-Care Deficit as they used a left-hand splint, were at risk for contractures, had limited ROM and impaired voluntary movements of all extremities left worse than right side and neck due to history of their brain injury. The goals were Resident 5 would not have worsening of their upper extremity contracture and they would actively participate in splinting program. Interventions included: -Restorative program left hand orthoses (splints). Nursing to put on at the beginning of the night shift and it is to remain on for 6 hours initiated 5/26/2022. -Application of a brace on their right hand in the morning and off at night and use of a right leg splint and neck brace when up in their wheelchair initiated 02/13/2019. -Application of a brace to left hand and neck brace in the morning (0700) and off at night (2000) when up in the wheelchair daily. Perform PROM three to six times a week for at least 15 minutes initiated 06/30/2021. -Passive ROM/gentle stretching to left upper and lower extremity with left hand splint placement, Active Assistive ROM (AAROM - a type of exercise that involves moving a joint with some help from an external force) to right upper and lower extremity three to six times a week for at least 15 minutes initiated 03/04/2019. Review of Resident 5's Treatment Administration Record (TAR) for March 2024 and April 2024, showed on order for PROM with gentle stretching to their left upper and lower extremity, apply a left-hand splint, provide AAROM to right upper and lower extremity and head with neck splint placement three to six times a week for at least 15 minutes. The order directed the unit nurse to monitor compliance and completion of the program every day shift for Functional Mobility Maintenance starting 06/11/2021. This treatment was marked as not completed for the months of March and April 2024. Review of Resident 5's medical record from 06/05/2023 through 04/22/2024, showed no documentation to indicate the resident received PROM during routine nursing care. In an interview on 04/22/2024 at 2:39 PM, Collateral Contact 1 (CC1), Resident 5's family member, stated Resident 5 had not received therapy anymore and they used to get therapy at least yearly. CC1 stated they felt Resident 5 had declined in their ROM and they used to be able to do more. In an observation on 04/22/2024 at 2:39 PM Resident 5's left, and right hands were observed without a hand splint, their left hand rested on an arm trough (a provided support needed for resident's whose arm has little or no function). In an observation on 04/30/2024 at 2:35 PM, Resident 5's left, and right hands were observed without a hand splint and their left hand rested on an arm trough. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	In an interview and record review on 04/29/2024 at 3:14 PM, Staff F stated the facility did not have a restorative program. Reviewed Resident 5's March and April 2024's TAR with Staff F, and they stated the licensed nurse documented a n on the TAR for the resident's PROM indicated the treatment was not done. Staff F stated they did not know how ROM was being assessed, the risk to the resident if the PROM was not provided, or the process for obtaining a referral for therapy services. Refer to 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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interview and record review, the facility failed to ensure adequate supervision to prevent accidents for 1 of 2 residents (Resident 121) reviewed. The facility failed to adequately supervise a resident who were assessed to be fall risk and placed residents at risk for injury and negative outcomes. Findings included 47047 Review of the facility's policy, Fall Management, reviewed on 12/04/2023, showed the facility would assess residents upon admission/readmission, quarterly, with change in condition, and with any fall event for any fall risks and identify appropriate interventions to minimize the risk of injury related to falls. Resident 121 admitted to the facility on [DATE] with diagnosis to include a stroke, vascular dementia (a general term for problems with reasoning, planning, memory, and other thought processes cause by brain damage from impaired blood flow to the brain), unspecified protein calorie malnutrition (the body lacks enough protein and energy to function properly). Review of Resident 121's nursing progress, note dated 04/16/2024, showed they were at risk for falls related to urinary urgency, lack of strength, and poor safety awareness. Resident 121 was admitted to room [ROOM NUMBER], close in proximity to the nurse's station, and was on isolation precautions. Resident 121 was noted to be off isolation precautions on 04/19/2024 and moved to a different room. Review of Resident 121's nursing progress note, dated 4/22/2024, showed the resident had a non-injury fall in their room (room [ROOM NUMBER] farther from the nurse's station) at 2:45 AM when trying to ambulate to the bathroom without assistance. Review of Resident 121's care plan, dated 04/16/2024, showed the resident was at risk for falls related to their history of stroke with left sided weakness and dementia with poor safety awareness. The goal of the care plan included Resident 121 would not sustain serious injuries requiring hospitalization . Interventions included assisting with activities of daily living as needed, call light within reach, complete a fall assessment, to have nonskid socks always on, and to orientate Resident 121 to their room. There was no documented intervention addressing Resident 121's urinary urgency. Review of Resident 121's Care Area Assessment (CAA - a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned) for urinary incontinence, dated 04/26/2024, showed Resident 121 had urinary incontinence and placed them at risk for skin breakdown. The CAA did not address Resident 121's urinary frequency. The CAA for risk for falls showed Resident 121 had cognitive impairment and was at risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility incident report dated 04/26/2024 contained contradictory information about Resident 121's use of their call light, cognitive status, and incontinence status from information found in their medical record. The incident report described Resident 121 not wanting to use their call light and did not want to be incontinent. The incident report did not contain a complete root cause analysis or full assessment of Resident 121 and their risk factors for falls. In an interview on 04/23/2024 at 12:32 PM Collateral Contact 2 (CC2), Resident 121's family member, stated they had not received or reviewed a care plan for Resident 121. CC2 stated they had a care conference scheduled for 04/24/2024. In an interview on 04/24/2024 at 3:55 PM Staff C, Registered Nurse/Assistant Director of Nurses, stated they did not have additional information to provide for the investigation. Staff C stated there were some progress notes addressing Resident 121's overall status as they were on alert charting. WAC Reference: WAC 388-97-1060(1)(3)(g)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to accurately monitor meal intake and resident weights, and failed to implement and evaluate the effectiveness of weight loss interventions to determine if additional interventions were needed for 2 of 2 sampled residents (Resident 59 and 121) reviewed for nutrition. These failures placed residents at risk for weight loss, inadequate nutrition, and diminished quality of life. Findings included . Review of the facility's policy, weights and heights, reviewed 08/23/2023, showed all residents are weighed within 24 hours of admission and weekly for four weeks and as needed thereafter or more as determined by the Resident at Risk (RAR) committee and/or physician order. Review of the facility policy titled, Resident at Risk (RAR) Policy, revised 04/25/2023, showed the facility conducted weekly resident at risk meetings to review residents who were identified or had the potential for developing nutritional issues. A list of actions or reviews were listed for different members of the team to complete prior to the meeting. For the nurse designee, one task included ensuring weights had been obtained and documented in the medical record/ reviewing current snack/supplement intake and considering the cause to review pain management, psychosocial needs, and/or mood/depression. During the meeting, the care plan was to be updated with interventions that were resident specific and individualized. Documentation to be recorded in the medical record to include significant change/progression /digression of intervention/changes to interventions/other pertinent information related to risk status/updating the care plan. <RESIDENT 59> Resident 59 was admitted on [DATE] with diagnoses to include multiple myeloma (a cancer that forms in plasma cells then accumulates in the bone marrow), protein calorie malnutrition (the body lacks enough protein and energy to function properly), vertebral fractures, and muscle weakness and anxiety. The Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 03/05/2024, showed Resident 59 was able to make needs known, had a swallowing disorder, and difficulty or pain with swallowing. Review of the admission mini nutritional assessment, dated 03/01/2024, showed Resident 59 had a severe decrease in food intake and a weight loss greater than 6.6 pounds in the last three months. The body mass index (BMI - a measure of body fat) was noted to be less than 19 with a nutrition status as malnourished. Review of the admission Registered Dietician (RD) assessment, dated 03/04/2024, showed Resident 59 had their own teeth, difficulty swallowing and complaints of pain with swallowing. The RD assessed the resident's current intake to meet their estimated nutritional needs. Review of the physician order, dated 03/01/2024, showed Resident 59 received a nutritional supplement twice daily for pressure ulcers and malnutrition upon admit. On 03/08/2024, the resident was started on a secondary nutritional supplement to be administered four times a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 59's weighed 108 pounds on their admission to the facility (03/01/2024). On 03/17/2024 the resident weighed 108.3 pounds. The resident was weighed one month later on 04/16/2024, and weighed 100.1 pounds, a 7.9 weight loss in 47 days. The nutritional care plan, dated 03/08/2024, showed Resident 59 had a nutritional problem, malnutrition related to multiple myeloma, cervical spine fractures and need to always wear a neck brace. The goal was for the resident to have a gradual weight gain and maintain nutritional status by maintaining their weight within five percent 108 pounds and consuming at least 75% of at least two meals. Review of Resident 59's provider visits progress notes, dated 03/28/2024 and 04/02/2024, showed no mention of intake, or weight loss and did not address the protein calorie malnutrition diagnoses. Review of a Nutrition/Dietary Note, dated 04/17/2024, showed Resident 59 needed one on one supervision for meals, and a 7.9 pounds or 7.3% weight loss in one month. The RD recommended adding a multivitamin, consider Mirtazapine (anti-depressant that stimulates appetite) to promote intake and to continue to monitor weights, intake, medications, skin, gastrointestinal system, and labs as ordered by the physician. Review of Resident 59's April 2024 Medication Administration Record, showed the nutritional meeting recommendations were not implemented or updated. Review of Resident 59's meal monitor, dated 03/01/2024 to 04/23/2024, showed the resident refused six meals, consumed 0-25% for 17 meals, ate less than 50 % for 32 meals, and ate 51-75% for 47 meals. In an interview and observation on 04/22/2024 at 10:40 AM, Resident 59 said they were sent to the facility to gain weight so they could have neck surgery and start chemotherapy. The resident said This is not the best place to gain weight. I didn't even get breakfast this morning .lost in the shuffle, I guess. The food is inedible here. I got to 108 pounds, but it has gone down. In an interview on 04/23/2024 at 9:00 AM, Resident 59 was in bed with a pained expression (grimacing, furrowed brow, and look of displeasure) and complained of terrible abdominal pain and nausea. Their breakfast meal was not observed to be touched. In an interview on 04/24/2024 at 7:32 AM, Staff F, Licensed Practical Nurse (LPN)/Resident Care Manager, said Resident 59 had gone out to the hospital the night before. Review of the hospital nutrition assessment, dated 04/25/2024, showed Resident 59 had malnutrition, present on admit with a BMI of 17.44. The resident reported they lost weight while at the nursing home and their usual body weight was 160-170 pounds. The resident reported they had a poor appetite, and their goal was to gain weight to be able to undergo surgery to their neck fracture. The hospital RD documented severe muscle wasting and fat loss in orbital, temporal and clavicle areas. The RD noted increased nutrient needs related to nutrient demand by cancer and underweight status. In an interview on 04/29/2024 at 2:52 PM, Staff D, Registered Nurse (RN), said residents were to be weighed weekly unless there were specific orders. Staff D said they get a red alert at the top of their PCC (electronic medical record) screen. They said the warning clues them in when there are issues with vitals or weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/2024 at 9:45 AM, Staff F said they could not give an answer for when weights were to be obtained. They stated some were daily and some were monthly. Staff F said there was a systemic issue that was being worked on. They said they had attended one nutrition meeting in February or March and did not know when the dietician visits the facility. In an interview on 05/01/2024 at 1:44 PM, Staff B, RN/Director of Nursing Services, said they were not aware of nutrition being an issue. They stated their expectation was for weights on admission and for three days. Staff B said if the resident was assessed nutrition at risk, they should be weighted weekly. Staff B said they completed an audit and Resident 59 was not seen in RAR. Staff B said the RD was supposed to come weekly but was not at the facility last week. In a phone interview on 05/02/2024 at 11:34 AM, Collateral Contact (CC) 5, Advanced Registered Nurse Practitioner (ARNP), said the facility should communicate through fax or call for weight changes. CC5 said they believed the facility used the MDS guidelines in terms of calculating significant weight loss. CC5 was asked if they were aware Resident 59 had weight loss and they responded they were usually the one to pick up on weight loss and they had not been notified of any weight loss for Resident 59. In a phone interview on 05/02/2024 at 11:45 AM, Staff M, RD, stated Resident 59 was assessed by another RD, and they had not seen Resident 59 yet. Staff M said new residents were seen on admission initially then if they were high risk, they would follow up on them weekly. Staff M said residents should be weighed daily on admit then weekly thereafter. Staff M said Resident 59 was an example of falling through the cracks. They said had they been aware of weight loss before by weekly weights they could have implemented additional interventions before the weight loss was significant. Staff M said when weight loss was identified, they would meet with the resident to discuss their food preferences, nutrition supplements and fortified foods. They would look at nausea, vomiting and appetite, see if there was any constipation, loose stools, or any GI symptoms. Staff M said then they would work with the provider for medications that could assist with nausea, constipation or loose stools and maybe initiate an appetite stimulant medication. 47047 <RESIDENT 121> Resident 121 admitted to the facility on [DATE] with diagnosis of unspecified protein calorie malnutrition. In a review of Resident 121's MDS assessment, dated 04/19/2024, showed the resident required the assistance of another person to eat their meal. The assessment also showed the resident had malnutrition. Review of Resident 121's weight, dated 04/16/2024, the resident weighed 136.5 lbs. On 04/21/2024, the resident weighed 127 pounds which was a 6.96 percent weight loss in six days. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a review of Resident 121's care plan, dated 04/16/2024, showed a focus area/goals and interventions related to being at risk for weight fluctuations. The goal for Resident 121 was that they would maintain adequate nutritional status by maintaining weight within five percent of 136.5 pounds and consume at least 75 precent of two of their meals. Interventions included inviting Resident 121 to activities that promote additional intake, monitoring and recording their intake at meals, and an evaluation by the RD. In the special instructions section of Resident 121's care plan showed that Resident was on a mechanical soft diet and required one to one feeding assistance. There was no information in the care plan regarding Resident 121's weight loss. In a review of Resident 121's Nutrition Assessment Summary, dated 04/24/2024, completed by Staff M showed Resident 121 had unintentional weight loss and consumed less than 50 percent of their meals. In a review of Resident 121's Care Area Assessment (CAA a systematic process to interpret the triggered information from the MDS assessment to assess the potential problem and determine if the area should be care planned) worksheet, dated 04/26/2023, showed the resident would have a care plan to address their nutritional decline and malnutrition. The CAA showed the resident was on a regular diet with thin liquids altered diet, they ate 50-100 percent of their meals, had a weight loss of nine pounds since admission, and a referral would to the dietician was warranted. Review of Resident 121's provider progress note, dated 04/23/2024, did not address Resident 121's weight loss. Review of Resident 121's hospital discharge summary, dated 04/16/2024, showed Resident 121 weighed 148 pounds on 04/03/2024. Review of Resident 121's meal monitor from 04/16/2024 through 04/27/2024, showed no documentation for percentage of their meal eaten for three out of 32 documentation opportunities. Review of the completed documentation, the resident consumed between 0-25 percent eight out of 32 documentation opportunities, seven of those were breakfast and lunch. Review of Resident 121's Kardex (Resident specific reference guide, containing parts of the care plan, utilized by NAC's, which provides specific information on how to care them), dated 04/24/2024, showed that they required a one person assist for feeding, encouragement to eat, was on a mechanically altered diet and was only to eat with supervision. On 04/22/2024 at 12:13 PM, Resident 121 was observed in the dining room in a wheelchair. Resident 121 was served their meal at 12:17 PM. Resident 121 received no assistance with their meal, which was mechanically altered, and eaten less than 10 percent of their meal. At 12:40 PM, Staff FF assisted Resident 121 back to their room. Resident 121 was not offered assistance with their meal or alternative meal/food options. In an interview on 04/22/2024 at 12:45PM, Staff FF stated they did not know the identity of Resident 121, whom they had just returned to their room. In an interview on 05/01/2024 at 12:15 PM, Staff B stated the dietician was not in the building last week and was scheduled to be in the building on 05/02/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/02/2024 at 10:19 AM, Staff M stated the process for reviewing residents for nutrition occurred at admission and an initial assessment completed. Staff M stated that lab work, hospital records, diet history, and speech and language therapy notes were all reviewed. Staff M stated they reviewed Resident 121 initially on 04/25/2024. Staff M stated there was RD coverage in the facility once a week. Staff M stated they did not know Resident 121's weight at the hospital and were not notified of Resident 121's weight loss by the facility staff. This is a repeat citation from survey 05/19/2023. Refer to WAC 388-97-1060 (3)(h)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 37890 Based on interview, and record review, the facility failed to complete required annual performance reviews for 3 of 3 sampled Nursing Assistant Certified (Staff W, X, and Z) reviewed for annual performance review after one year of employment. Failure to complete annual performance evaluations, and ensure these staff members were adequately trained, placed all residents at risk for unmet care needs. Findings included . Staff W, Nursing Assistant Certified (NAC), was hired 01/31/2023. Review of Staff W's requested employee file information showed no Annual performance review was provided for the prior year. Staff X, NAC, was hired 08/10/2022. Review of Staff X's requested employee file information showed no Annual performance review was provided for the prior year. Staff Z, NAC, was hired 10/14/2021. Review of Staff Z's requested employee file information showed no Annual performance review was provided for the prior year. In an interview on 04/23/2024 at 3:40 PM, Staff B, Registered Nurse/Director of Nursing Services stated the annual performance evaluations were not done. Refer to WAC 388-97-1680 (2)(a-c)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, and administering of all drugs, to meet the needs of each resident for 1 of 1 resident (Resident 59). Failure to ensure timely receipt and administration of ordered medications placed Resident 59 and other residents at risk for anxiety, discomfort, and withdrawal symptoms of headache, fatigue, dizziness, and constipation. Findings included . Resident 59 was admitted on [DATE] with diagnoses to include multiple myeloma (a cancer that forms in plasma cells then accumulates in the bone marrow), protein calorie malnutrition (the body lacks enough protein and energy to function properly), vertebral fractures, emphysema (a lung condition that causes shortness of breath and reduces the amount of oxygen in the blood), and anxiety. Review of Resident 59's physician order, dated 03/01/2024, directed nursing staff to administer Chantix 0.5 milligrams (mg), a medication for smoking cessation once a day for three days, then two times a day for three days, then increase the dose to 1 mg two times a day for eleven weeks. Review of Resident 59's March 2024 Medication Administration Record (MAR), showed 10 documented on doses beginning 03/02/2024 through 03/09/2024 for the AM doses. There were two PM doses that were documented as administered on 03/05/2024 and 03/06/2024. The MAR documentation codes indicated a 10 indicated Other/See Progress Notes. The MAR's showed Resident 59 missed ten doses over eight days. The omission of the medication involved six nurses. The MAR documentation showed a medication error as the resident did not taper up to the 1 milligrams (mg) dose from 0.5 mg as ordered. The resident began receiving 1 mg twice daily beginning on 03/10/2024. Review of Resident 59's progress note dated 03/02/2024 at 2:16 PM, showed the order for Chantix (medication to help stop smoking) 0.5 mg for eleven doses then 1 mg for 42 doses then 0.5 mg by mouth one time a day for smoking cessation for three days. The progress note indicated the pharmacy said they had not received order. The order was faxed to the pharmacy, and they were, awaiting the medication. There was no mention the provider was notified. Review of a progress note dated 03/03/2024 at 10:14 AM showed Chantix medication had not arrived from pharmacy. There was no mention the pharmacist or provider was notified. Review of Resident 59's progress note, dated 03/04/2024 at 11:37 AM, 03/05/2024 at 12:11 PM, and 03/06/2024 at 8:37 AM, 03/07/2024 at 9:28 AM, showed the order for Chantix but did not show why the medication was not administered or follow up if the medication was not available. There was no mention the provider was notified. Review of Resident 59's progress note, dated 03/07/2024 at 8:32 PM, showed the order for Chantix but did not show why the medication was not administered or follow up if the medication was not available. There was no mention the provider was notified. The progress note showed Resident Care Manager (RCM) aware. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 59's progress note, dated 03/08/2024 at 2:25 PM and 6:53 PM, showed the order with no follow up or provider notification. Review of Resident 59's progress note, dated 03/09/2024 at 9:46 AM, nine days after the order, showed pharmacy was contacted and the medication was on back order and would be delivered upon restock. The physician was updated, and no alternative orders were given. Review of Resident 59's April 2024 MAR's, showed 10 was documented on Chantix AM and PM doses on 04/20/2024, 04/21/2024, 04/22/2024, and 04/23/24 AM dose. Review of Resident 59's progress notes, dated 04/20/2024 at 2:55 PM and 5:39 PM, 04/21/2024 at 6:57 AM and 5:53 PM, 04/22/2024 at 10:05 AM, and 8:25 PM and 04/23/2024 at 9:36 AM sailed to show why the medication was not administered, if there was follow up or provider notification. In an interview an 04/29/2024 at 2:23 PM, Staff D, Registered Nurse (RN), said they recalled Resident 59 being out of Chantix and they called the pharmacy who said they would send it. Staff D said later the pharmacy said the insurance would not cover it. Staff D said they failed to document the pharmacy conversations in the medical record. Staff D said they did not notify the Director of Nursing or provider. In an interview on 05/01/2024 at 9:40 AM, Staff F, Licensed Practical Nurse/RCM, said they were trained by an agency nurse, Staff D who was big on reordering medications. Staff F said they would first check the Pyxis (secure system with emergency dose medications) to see if the medication was there. Staff F said they did not have good information on the process. Staff F said Staff B, Director of Nursing was focusing on medication availability. In an interview on 05/01/2024 at 1:58 PM, Staff B, RN/Director of Nursing Services stated they were not aware of medication availability issues. Staff B said the expectation would be the nurses call the pharmacy, check the Pyxis, call the provider and notify them if medications were unavailable then document what they did. This is a repeat deficiency from 05/11/2023. Refer to WAC 388-97-1300 (1)(b)(ii)(3)(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to ensure 3 of 5 sampled residents (Resident's 51, 29, and 10) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure consents were obtained, person-centered behavioral interventions were in place, appropriate indications were present for psychotropic medications and that residents received gradual dose reductions. These failures placed the residents at risk for medication-related complications and for receiving unnecessary psychotropic medication. Finding included . As referenced in the Food and Drug Administration (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. Review of facility policy, Psychotropic Medication Management, dated 11/29/2023, directed staff to only give psychotropic medication when necessary to treat a specific diagnosed and documented condition, implement a GDR (gradual dose reduction) and other non-pharmacological interventions, limit PRN (as needed) psychotropic medications which are antipsychotic medications to 14 days and not enter a new order without first evaluating the resident. A consent was required for each medication. 43954 <RESIDENT 51> Resident 51 was admitted to the facility on [DATE] with diagnoses to include dementia without behavioral disturbance, anxiety, depression, and psychotic disorder (mental disorder characterized by a disconnection with reality). Review of Resident 51's current provider orders, showed an order for hydroxyzine (medication used to treat anxiety) 25 milligrams (mg) every four hours as needed for anxiety and aggression related to dementia, initiated 12/11/2023. Resident 51 had an order for divalproex (mood stabilization medication) sodium 125 mg at bedtime for dementia with behaviors, initiated 12/11/2023. An additional order for divalproex sodium 250 mg once a day for dementia with aggressive behaviors. Resident 51 had an order for risperidone (antipsychotic medication) 2 mg at bedtime related to dementia without behavioral disturbance, initiated 09/11/2023. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 51's psychotropic medication consents, showed there was no consent for the use of hydroxyzine. Review of Resident 51's psychotropic medication consents, showed divalproex sodium was signed by the resident on 09/11/2023 with a proposed course of three months. Review of Resident 51's psychotropic medication consents, showed risperidone consent was signed by the resident on 09/11/2023 with a proposed course of three months. Review of Resident 51's April 2024 Medication Administration Record (MAR), showed there was no 14 day stop date for the use of as needed hydroxyzine. In an interview on 04/29/2024 at 3:19 PM, Staff I, Social Service Director (SSD), stated that any psychotropic medication needed to have a signed consent completed. Staff I stated the nurses were to obtain consents. Staff I stated they had not heard of a psychotropic medication of having a three-month course and they would have documented prolonged use of medication on the consent. Staff I stated a new consent should have been filled out after the proposed medication course of three months ended. In an interview on 05/01/2024 at 10:36 AM with Staff GG, Licensed Practical Nurse (LPN), stated when an as needed psychotropic medication was used, the effectiveness and reason it was given need to be documented. Staff GG was asked about Resident 51's hydroxyzine as-needed order and they confirmed there was no stop date and was unaware there should be one. In an interview on 05/01/2024 at 11:39 AM, Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS), stated consents need to be obtained for all psychotropic medication use and there should only be one medication per consent. Staff B stated the nurses and resident care managers were responsible for obtaining consents. When asked about consents signed for three-month courses should be reviewed at the three months and a new consent would be needed. Staff B stated Resident 51's consents for divalproex and risperidone should have been completed three months after signed and hydroxyzine order should have had a consent if used for anti-anxiety. Staff B was unaware as-needed psychotropic medications required a 14 day stop date or documentation should support prolonged use. Staff B stated the diagnoses given for hydroxyzine, risperidone, and divalproex were not acceptable and needs to be specific to the resident symptoms, behaviors. 47047 <RESIDENT 29> Resident 29 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain that causes changes in reasoning, planning, memory, and judgement), muscle weakness, atrial fibrillation (irregular heartbeat), and high blood pressure. Review of Resident 29's care plan, dated 10/25/2022, showed they used psychotropic medications (Risperdal-an antipsychotic medication) related to a diagnosis of vascular dementia with behavioral disturbance. The non-pharmacological interventions for Resident 29 related to their use of Risperdal (antipsychotic medication) found on the care plan included: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Invite to social activities. - Play their preferred language of music and/or shows. - Invite family and friends for comfort and companionship. The care plan showed that Resident 29 had a gradual dose reduction (GDR - a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) on 09/17/2022 which failed. Review of Resident 29's Care Area Assessment (CAA - a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned), dated 08/17/2023, showed they received Risperdal and sertraline (an antidepressant medication) daily with failed attempts to decrease in the past with noted increased behaviors, that were distressing to them. Resident 29 was noted to have advancing dementia with difficulty making their needs know. Review of Resident 29's April MAR, showed Resident 29 had orders for Risperdal administered at dinner for paranoia related to delusional disorders starting 12/13/2023. The April MAR showed the same interventions found in the care plan and showed dashes indicating the interventions were not used. The April MAR showed a behavior monitor for crying, statements of being afraid, paranoid comments, hitting staff, and screaming. Resident 29 exhibited behaviors three days out of the month of April. There was no documentation to show which behaviors Resident 29 exhibited. Review of Medication Regime Review (MMR), dated 01/16/2024, showed Resident 29 was prescribed Risperdal 1 mg nightly at bedtime. On 12/14/2023 the time in which the Risperdal was given changed from in the evening to nightly and on 06/17/2023 the dose of Risperdal was 0.5 mg twice daily. There was a GDR noted on 09/16/2020 in which Resident 121 was taking Risperdal 0.25 mg nightly at bedtime. There was no other GDRs noted in the MRR. Review of Resident 29's progress note, dated 11/04/2022, showed the interdisciplinary behavior meeting recommended an increase in Resident 29's use of Risperdal from 0.5 mg back to 1 mg, described as a failed GDR. The progress note showed that Resident 29 had a decrease in their Risperdal on 06/17/2022, five months prior. In a review of consents for use of Sertraline and Risperdal showed: -No consents were found for Sertraline. -Consent for Risperdal, dated 10/26/2019, with a signature of Resident 29's representative present. The proposed course of treatment was checked for prolonged for delusions associated with dementia. -Consent for Risperdal, dated 05/23/2022, Resident 29's representative name printed and not signed by facility representative. The proposed course of treatment of one month was checked for paranoia and tearfulness. (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 05/01/2024 at 10:23 AM, Staff I stated Resident 29 was due to be reviewed for a GDR. Staff I stated Resident 29 was reviewed 02/27/2023 for a decrease in the use of Risperdal but it was determined not to be appropriate as Resident 29 exhibited behaviors to include aggression, paranoia (believing that people were out to get them) and required frequent reassurance that the facility was their home. In an interview on 05/02/2024 at 11:34 AM, Contact 5 (CC 5), Advanced Registered Nurse Practitioner (ARNP), stated they did not recall Resident 29 by name and looked their records up. After CC 5 reviewed the records, they stated that Resident 29 was one that walked, cried a lot, and rammed staff with their walker. When asked about the use of Risperdal and process for GDR, CC 5 stated Resident 29 was reviewed in November 2023 for a reduction and was found that a reduction would be distressful to them. CC 5 stated they had only attended one interdisciplinary behavior meeting, which was last month. CC 5 stated during the meeting they reviewed behavior logs and discussed if GDRs were indicated. <RESIDENT 10> Resident 10 admitted on [DATE] with diagnoses to include metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), vascular dementia with behavioral disturbance and psychotic disorder (severe mental disorder that cause abnormal thinking and perceptions) with hallucinations (seeing something that is not there). Review of the current physician's orders, showed Resident 10 admitted with an order for Quetiapine (Seroquel - antipsychotic medication) 25 mg two times daily for dementia with behavioral disturbance, an inappropriate indication. The following day, on 01/23/2024 an order was received to add Quetiapine 12.5 mg in the afternoon for dementia, which was an inappropriate indication. Review of a nursing progress note, dated 03/20/2024 at 9:56 AM, showed Resident 10 had a diagnosis of dementia and psychotic disturbance with hallucinations and had been on Seroquel since admission with a midday dose added on 02/02/2024 for agitation and possible hallucinations. The note showed Resident 10 had been stable with no behavioral issues or evidence of hallucinations. Review of Resident 10's nursing progress notes, dated 01/22/2024 to 05/01/2024, showed the resident did not have any hallucinations. In an interview on 04/29/2024 at 3:03 PM, Staff I said Resident 10 did not exhibit any behaviors. Staff I said Resident 10's spouse wanted them on the medication. In an interview on 05/02/2024 at 11:34 AM, CC 5 said the resident admitted with a diagnosis of psychotic disorder and was on Seroquel. CC 5 said they ordered a low dose of Seroquel to help them with their screaming especially when their spouse left the facility. CC 5 said they spent eight hours at the facility at a time and Resident 10 was in distress, scared, and listening to them was sad. CC 5 said they tried snacks and other attempts to calm them but that was not successful. CC 5 said since the resident had been on the Seroquel they had calmed, no longer screamed, and could communicate with the use of his writing board. Refer to WAC 388-97-0300((3)(a-b), -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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on observation, interview and record review, the facility failed to ensure there was safe and secure storage of drugs and biologicals when 1 of 4 medication carts (400 hall) was left unlocked and unattended, and medication found on the facility floor in 2 of 2 residents (Resident 17 and 32) rooms. These failures placed residents at risk of taking medications that were not prescribed to them, side effects, possible harm, and decreased quality of life. Findings included . <RESIDENT 17> Resident 17 was admitted to the facility on [DATE] with diagnoses to include anxiety, depression, and a hip fracture. In an observation on 04/23/2024 at 11:23 AM, Resident 17 had Systane (dry eye lubricant) eye drops and Imodium (anti-diarrheal medication) caplets at bedside and stated they brought the medications from home. Medication boxes for Systane eye drops and Imodium both had labels with guidance to keep out of the reach of children. In an observation on 04/24/2024 at 9:37 AM, Systane eye drops, and Imodium were present in boxes on Resident 17's over the bed table. In multiple observation on 04/25/2024 at 9:05 AM, 12:25 PM, there was a box of Resident 17's Systane eye drops on their over bed table, no box of Imodium was seen. In an observation on 04/26/2024 at 9:05 AM, Resident 17's Systane eye drops in the box were on the over the bed table. In an observation on 04/26/2024 at 1:02 PM, Resident 17 was ambulating with their walker and the Imodium box was visible in the basket of their walker. In an interview on 04/26/2024 at 1:02 PM, Staff CC, Registered Nurse (RN), stated they were caring for Resident 17 and stated they were unsure what a self- medication program was. Staff CC stated none of their residents, including Resident 17 were on a self-medication program. In an interview on 04/29/2024 at 2:24 PM, Staff D, RN Agency, stated there were no residents on a self-medication program, including Resident 17. Staff D stated there would be a lock box and an assessment by a nurse manager for a self-medication program. (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 05/01/2024 at 3:14 PM, Resident 17 walked up and said I have some questions for you. You came in and found my eye drops and cream, so they took them away from me. I need those eye drops, or I will go blind. Now I haven't had any eye drops since. I even thought about calling my eye doctor to call over here. I need those. I know you were just doing your job, but I need them. Staff T, RN/Regional Director of Clinical Services, was alerted about Resident 17's concern. <RESIDENT 32> Resident 32 was admitted to the facility on [DATE] with diagnoses to include lung disease, asthma, depression, anxiety, and chronic pain. In an observation on 04/22/2024 at 10:45 AM, Spiriva (lung medication) inhaler was observed on Resident 32's over the bed table. Resident 32 stated they had asked the nurse to get something during medication pass and they had left the medication on the over the bed table. <UNSECURE MEDICATIONS> In an observation and interview on 04/25/2024 at 11:24 AM, a medication cart was observed to be unlocked in the 400 hall with the keys hanging from the lock. There was no nurse around the medication cart. Staff G, RN/Resident Care Manager (RCM), walked down the hallway and saw the keys hanging out of the lock and locked the cart and took keys out of the cart. Staff G stated the keys were to be with the nurse and the medication cart should be locked. Staff L, RN, came out of a resident room and went to the medication cart. Staff G gave the keys back to Staff L. Staff L stated the normal process was to lock the cart every time they were away from it. In an observation on 04/25/2024 at 2:15 PM, a sealed plastic container of eye drops was located on the facility floor in front of the maintenance office. Staff DD, Maintenance Director, stated they were unsure of what they were. Staff F, LPN/RCM was informed of the eye drops found on the floor. In an interview on 05/01/2024 at 11:39 PM, Staff B RN/Director of Nursing Services, stated Resident's 17 and 32 were not on self-medication programs and medication should never be left at the bedside. Staff B acknowledged medication carts should be always locked when a nurse was not at the cart. Refer to WAC 388-97-1300(2) 36787

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review, the facility failed to ensure prompt dental services were provided for 1 of 1 (29) residents reviewed for dental care. This failure placed Resident 29 and all other residents at risk for pain, unmet dental needs, and a diminished quality of life. Findings included . Resident 29 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain that causes changes in reasoning, planning, memory, and judgement), muscle weakness, atrial fibrillation (irregular heartbeat), and high blood pressure. In a review of Resident 29's care plan, dated 10/25/2022, showed a care plan focus for dental care. The care plan showed that Resident 29 had dental problems with upper partials and numerous missing lower teeth. Care plan interventions included to coordinate arrangements for dental care, transportation as needed and as ordered, observe and report as needed of any oral/dental problems needing attention. The care plan showed a canceled appointment for Resident 29 to have fillings and work done due to COVID -19 pandemic dated 01/30/2020. On 04/23/2024 at 1:54 PM, Resident 29 was observed to have several missing teeth from their upper and lower jaw and a metal piece of dental hardware was visible on the front of their upper jaw when they smiled. In an interview on 04/23/2024 at 2:12 PM Collateral Contact 2 (CC2), Resident 29's family member, stated they did not know much about the status of Resident 29's dental needs. Review of a dental hygienist note, dated 07/25/2023, showed Resident 29 required reminders to have their denture out at night to allow their tissue to rest. Review of Resident 29's progress notes, dated 04/28/2023 through 04/29/2024, showed Resident 29 was seen by the dental hygienist on 01/24/2024 and Resident 29's gums and tissues was very raw underneath dentures. The dental hygienist asked that Resident 29's provider look at their gums. There was no other documentation found in Resident 29's Electronic Medical Records regarding their dental status, referrals, appointments, if their provider assessed their gums, or contact with Resident 29's representative. In an interview on 04/30/2024 at 1:45 PM Staff AA, Registered Nurse (RN), stated Resident 29 had their own teeth and required assistance to brush them. In an interview on 04/30/2024 at 2:01 PM Staff K, Nursing Assistant Certified (NAC), stated Resident 29 did have a partial but did not wear it any longer because it was broken. Staff K stated Resident 29's partial had been broken since at least October 2023. (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 05/02/2024 at 11:34 AM with Collateral Contact 5 (CC5), Advanced Registered Nurse Practitioner, stated they had attempted to look at Resident 29's oral cavity after they saw the dental hygienist visit and Resident 29 refused. CC5 stated that they do not recall if they documented the encounter with Resident 29. In a follow up interview on 05/02/2024 at 12:43 PM with CC5, they stated they reviewed the dental hygienist note from 01/24/2024 and had written on the note that Resident 29 refused to allow an exam of their oral cavity. No other information was provided. Refer to WAC 388-97-1060 (3)(j)(vii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47047 Based on interview, observation, and record review, the facility failed to provide appetizing and palatable food to 9 of 12 residents (6, 8, 12, 14, 23, 25, 44, 59, and 60). This failure placed residents at risk for weight loss, inadequate nutrition, and a diminished quality of life. Findings included . <RESIDENT INTERVIEWS> In an interview and observation on 04/22/2024 at 10:40 AM, Resident 59 said they were sent to the facility to gain weight so they could have neck surgery and start chemotherapy. The resident said This is not the best place to gain weight. I didn't even get breakfast this morning .lost in the shuffle, I guess. The food is inedible here. I got to 108 pounds, but it has gone down. In an interview on 04/22/2024 at 11:14 AM, Resident 14 (Resident Council President) stated the food was mediocre and was the biggest issue discussed repeatedly at resident council. Resident 14 described the eggs to be cold on delivery whether eating in the dining room and cited the meal does not come on a heated tray. Resident 14 stated they asked for cottage cheese and fruit the day prior and was given yogurt and canned mandarin oranges because the kitchen did not have cottage cheese. In an interview on 04/22/2024 at 2:00 PM, Resident 60 stated the facility had a tendency to serve a lot of boiled spinach. In an interview on 04/23/2024 at 9:42 AM, Resident 25 said the food was not good, it's terrible and the seasoning is terrible. <RESIDENT COUNCIL MEETING> In an interview on 4/25/2024 at 2:04 PM, Resident 6 stated they were told at the last resident council they could not discuss the kitchen. Resident 6 stated they had discussed wanting more fresh fruit and vegetables and there has been no change and told that they were unable accommodate due to the corporate budget. In an interview on 04/25/2024 at 2:05 PM, Resident 12 stated the facility did not honor their choices from the menu that they have chosen. In an interview on 04/25/2024 at 2:07 PM, Resident 44 stated there was a lack of condiments for their meals, the meals come to them on Styrofoam plats at dinner, the meals are cold, and there were only two choices at meals. <RESIDENT COUNCIL MINUTES> Review of March 2024 minutes documented, there was a shortage of coffee. <REVIEW OF MENUS> (continued on next page)

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	505272	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Mount Vernon	2120 East Division Street Mount Vernon, WA 98273

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's menus, showed there was a total of four menus. There were two menu cycles through a seasons (Fall/Winter and Spring/Summer) every four weeks. There were 13 weeks in Spring/Summer and 10 to12 weeks in Fall/Winter. <GRIEVANCES> Reviewed of a grievance, dated 10/23/2023, showed Resident 8's family member reported that the resident was served the same consistent meal and would like to see Resident 8 be served with nutritional snacks such as thickened shakes and cottage. cheese/fruit. Reviewed grievance, dated 10/23/2023, showed Resident 14, Resident 6, Resident 23 and Resident 12 reported the evening snacks and cart was not being offered. <TEST TRAY> Observation of a test tray for a regular diet on 04/26/2024 at 12:56 PM, showed fish sandwich. There was one leaf of lettuce and a slice of tomato on top of a fish patty contained between a hamburger bun. The lettuce was wilted and the tomato warm to touch. There were three plastic cups, one with juice, one with water and one with milk. There was a dessert cup with vanilla pudding and a berry sauce on top. The fish sandwich lacked flavor, had no appetizing value, and there were no condiments. In an interview on 05/01/2024 at 12:15 PM Staff A, Administrator, stated they were not aware of the ongoing food complaints, felt the concerns around meals were addressed last year and had seen a decrease in grievances related to food/meals. Refer to WAC 388-97-1100 (1), (2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43954 Based on interview, and record review, the facility failed to ensure resident medical records were accurate and consistent for 3 of 17 sample residents (Residents 11, 29 and 51) whose resident records were reviewed. The facility failed to ensure other resident information was not a part of Resident 11 and Resident 51's medical records and records (PASRR-preadmission screening and Resident Review and dental hygienist note) were accessible for Resident 29 in their medical records. These failures placed residents at risk for unidentified and/or unmet care needs, missed opportunities for care planning, and inaccessible health care instructions if/when needed. Findings included . <RESIDENT 11> Resident 11 admitted to the facility o 03/31/2022 with diagnoses to include Parkinson's disease (disorder of the central nervous system that affects movement), depression, and dementia (progressive or persistent loss of intellectual functioning). Review of Resident 11's current care plan, showed there was another resident's information included related to catheter. In an interview on 04/29/2024 at 3:19 PM, Staff I, Social Service Director, stated Resident 11 had never gone by a different name and the information in the care plan was an error. In an interview on 05/01/2024 at 10:36 AM, Staff GG, Licensed Practical Nurse (LPN), stated they have not updated a care plan. Staff GG stated if a care plan needs to be updated, they leave a note for the Resident Care Manger (RCM). In an interview on 05/01/2024 at 11:39 AM, Staff B, Registered Nurse (RN)/Director of Nursing Services, stated their expectation was resident care plans where they should be resident specific and should not reflect other resident's information. <RESIDENT 51> Resident 51 was admitted to the facility on [DATE] with diagnoses to include dementia without behavioral disturbance, anxiety, depression, and psychotic disorder (mental disorder characterized by a disconnection with reality). Review of Resident 51's current care plan, showed there was another resident's information included related to resident guardian. In an interview on 05/01/2024 at 3:19 PM, Staff I stated Resident 51 should not have another resident name in their care plan. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/01/2024 at 11:39 AM, Staff B stated their expectation was resident care plans should not reflect other resident's information. 47047 <RESIDENT 29> Resident 29 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage from impaired blood flow to the brain that causes changes in reasoning, planning, memory, and judgement), muscle weakness, atrial fibrillation (irregular heartbeat), and high blood pressure. PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) In a review of Resident 29's progress note, dated 12/06/2023, showed the facility received an invalidation assessment of the residents PASRR (a federally required screening of all individuals who has both an Intellectual Disability [ID] or Related Condition [RC] and a serious mental illness [SMI] prior to admission to a Medicaid-certified nursing facility or a significant change of condition) from the PASRR assessor. There was no invalidation assessment found after a complete review of Resident 29's medical record both in paper form and electronic form. In an interview on 05/01/2024 at 10:23 AM, Staff I stated they were unable to locate the invalidation assessment noted in the progress notes. DENTAL In a review of Resident 29's progress notes dated 01/24/2024 showed the dental hygienist had seen them. There was no dental hygienist note found after a complete review of Resident 29's medical record both in paper form and electronic form. In an interview on 05/02/2024 at 11:34 AM, Collateral Contact 5 (CC 5), Advanced Registered Nurse Practitioner, stated they signed the dental hygienist note, dated 01/24/2024, and the note might not have been in the medical record due to the facility medical records staff being out for an extended period of time. This is a repeat citation from surveys dated 05/11/2023 and 10/17/2023. Refer to WAC 388-97-1720 (1)(a)(i-iv).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 37890 Based on record review, and interview, the facility failed to ensure 2 of 5 Certified Nursing Assistants (NACs) (Staff X and Z) reviewed for training, had the required 12 hours per year of in-services and required annual dementia training. This failure placed residents at risk of less than competent care and services from staff. Findings included . Staff X's was hired on 08/10/2022. Review of their employee file showed they did not have the required 12 hours of in-service education or the required dementia training for the prior year. Staff Z was hired on 10/14/2021. Review of their employee filed showed they did not have the required 12 hours of in-service education for the prior year. In an interview on 04/23/2024 at 2:02 PM, Staff BB, Registered Nurse/Staff Development Coordinator, stated there were assigned annual general requirements for each staff which included abuse and dementia education. Staff BB stated the computer program tracked the education for staff, including how many total hours of education they had done. In an interview on 04/23/2024 at 3:40 PM, Staff B, RN/Director of Nursing, stated the staff annual employee evaluations were not up to date and review of education requirements was part of the annual evaluations. Refer to WAC 388-97-1680 (2)(a-c)