STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505275	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colville of Cascadia, LLC	1000 East Elep Street Colville, WA 99114

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 37544 Based on observation, interview and record review, the facility failed to ensure 2 of 6 sample residents (10, 20), reviewed for Pre-Admission Screening and Resident Review (PASARR) [an assessment completed prior to admission into a skilled nursing facility to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services] was completed accurately and if indicated, a referral for additional screening had been made. This failure placed the residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet mental health care needs. Findings included . <Resident 10> Per the 03/31/2024 admission assessment, Resident 10 admitted to the facility from the hospital and had diagnoses which included depression and schizophrenia (a chronic, severe mental disorder that affected the way a person thought, acted, expressed emotions, and perceived reality). On 05/08/2024 at 10:45 AM, Resident 10 was observed sitting in their wheelchair in their room watching television. Resident 10 stated they were at the facility for wound care and were very happy with the care from the staff. A review of Resident 10's record on 05/09/2024 at 10:43 AM, found the hospital had completed a Level I PASARR on 03/27/2024, prior to the resident's admission to the facility. The PASARR documented a Level II PASARR (a more in-depth screening assessment, to identify if specialized mental health services were needed), was not required since Resident 10 met the guidelines for an exempted hospital stay (being admitted to the facility directly from the hospital after receiving acute inpatient care, and an expected length of stay at the facility being 30 days or less). A progress note on 04/11/2024 at 9:48 AM, by Staff E, Social Services, documented the resident desired to reside at the facility due to living remotely and not being able to obtain caregivers or home health assistance. Additional record review found no documentation that an updated level I PASARR had been completed as of 05/09/2024, 42 days since the resident had admitted to the facility, and 12 days past the time frame for the exempted hospital stay. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/10/2024 at 11:19 AM, Staff E confirmed that Resident 10 would need a new Level I PASARR completed since they had been at the facility longer than the expected 30 days. 47728 <Resident 20> Per the 04/07/2024 Significant Change of Condition assessment, Resident 20 returned to the facility from the hospital on 04/01/2024 following a below the knee amputation (BKA) of the left leg and had additional diagnoses which included anxiety, and a psychotic disorder. On 05/08/2024 at 11:41 AM, Resident 20 was observed lying on their bed. They stated they had no concerns and declined further interview. Review of Resident 20's record documented a level 1 PASARR had been completed on 01/06/2019 by the hospital prior to the 01/09/2019 facility admitted . No PASARR was found related to Resident 20's 04/07/2024 significant change of condition. In an interview on 05/16/2024 at 3:00 PM, Staff E confirmed that Resident 20 needed a new Level I PASARR completed since they had a significant change of condition. Reference: WAC 388-97-1915 (1)(2)(a-c)

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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. 46115 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan, to address a resident with wounds for 1 of 3 sample residents (33), whose care plans were reviewed. This failure placed the resident at risk for unmet care needs. Findings included . Per the 04/03/2024 significant change in condition assessment, Resident 33 had diagnoses which included peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), congestive heart failure (a condition that occurs when the heart can't pump enough blood to meet the body's needs), diabetes (a condition in which the body has trouble controlling blood sugar and using it for energy) and was at risk for skin breakdown. A review of Resident 33's skin evaluations documented the following: - 03/28/2024, the resident had an open area on their left buttock. - 04/09/2024, the resident had an open area to their right lower leg - 04/12/2024, the resident had a blister to their left leg. Review of Resident 33's care plan dated 12/12/2023, documented they had a care plan for alteration in skin/tissue integrity related to the need for assistance, dialysis and diabetes. The care plan also documented they had actual skin breakdown to their lower extremities. The care plan instructed nursing staff to do weekly skin assessments, but no other interventions for wound care or preventative measures were implemented for the legs and buttock wound. In an interview on 05/16/2024 at 2:02 PM, Staff B, Resident Care Manager, stated the care plan should have included the wound on Resident 33's buttock and interventions for wound healing. Reference: WAC 388-97-1020(1), (2)(a)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50027 Based on observation, interview, and record review, the facility failed to provide assistance during mealtimes for 1 of 1 sampled resident (16), reviewed for activities of daily living. This failure placed the resident at risk for decreased food and fluid intake, and possible unintended weight loss. Findings included . The 03/02/2024 significant change assessment documented Resident 16 was severely cognitively impaired, delusional and had Alzheimer's dementia (a decline in mental ability severe enough to interfere with daily life). In addition, the assessment also documented the resident required partial to moderate assistance from staff for eating. The 03/26/2024 nutritional care plan documented Resident 16 was at risk for nutritional problems related to Alzheimer's dementia. The care plan instructed staff that Resident 16 required supervision, set-up assistance, and cueing at mealtimes to facilitate food and fluid intake. On 05/08/2024 at 12:38 PM, Resident 16 was observed sitting in their wheelchair near the front entrance of the dining room facing the wall, perpendicular to and away from all other residents (whom were sitting at round tables). The resident had bowls of food and cups full of liquid sitting on their lunch tray. Resident 16 grabbed a bowl of food and dumped it on the tray table, spilling it on to their clothes, and onto the floor. Resident 16 then poured liquid from their cup into another bowl of food and continued to pour the rest of the liquid onto the tray table, which spilled over onto the floor. There were several staff members present in the room and nobody intervened to assist Resident 16. At 12:41 PM, Staff E, Social Services Director, cleaned the food and fluids off the resident, tray table and the floor. After cleaning the resident, neither Staff E nor any of the other staff present offered assistance or cueing to Resident 16 to eat their meal. At 12:51 PM, Resident 16 began to make repetitive nonsensical speech. Staff E asked the resident if they were hungry. The resident did not initially respond and started fidgeting with items left on their tray table, but after a few minutes, stated, no, to Staff E. No staff assisted or cued the resident to eat during the entire observation of the noon meal, and review of the meal monitor for 05/08/2024 documented the only food intake for Resident 16 was during dinner. On 05/13/2024 at 9:04 AM, Resident 16 was observed sitting in their wheelchair in the main dining room during breakfast. The resident's breakfast included the following items: a cup of water, a cup of a chocolate nutritional supplement, a bowl full of eggs, a mug of hot cereal. No staff was located near the resident. At 9:05 AM, Staff V, Registered Nurse, came into the dining room and administered medications to Resident 16. Staff V provided the resident hand over assistance with drinking the chocolate supplement and intermittently mixed the residual of medications in the same cup with a spoon. The resident drank 100% of the liquids from the cup and Staff V exited the dining room at 9:07 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:14 AM, the resident still had not taken any bites of food and backed their wheelchair slightly away from their tray. The only liquid the resident consumed was the liquids received during medication administration by Staff V. At 9:16 AM, staff picked up meal trays and assisted other residents out of the dining room. Resident 16 further backed away from their tray and at this time Staff E asked the resident if they wanted more eggs. The resident looked at Staff E and smiled and then Staff E walked away from the resident without providing any assistance. At 9:19 AM the resident maneuvered their wheelchair to the opposite side of the dining room and left their meal untouched. No staff were observed to have assisted or cued the resident to eat during the meal. During an interview on 05/16/2024 at 12:27 PM, Staff S, Nursing Assistant, stated Resident 16 required extensive assistance to eat and was aware of the interventions documented in the care plan. Per Staff S, the resident would get distracted during their meals and one staff member should be there to help redirect them during meals, and offer other food items, including supplements if the resident refused to eat. Staff S also stated that the resident's meals and supplements were monitored, and the amounts consumed were documented. In an interview on 05/16/2024 at 12:44 PM, Staff T, Registered Dietician, stated Resident 16 was at risk for a nutritional decline due to advancing Alzheimer's disease and that the resident required more assistance with meals now. During an interview on 05/16/2024 at 1:47 PM, the observations of Resident 16 during the breakfast and lunch meal were discussed with Staff M, Registered Care Manager. Staff M stated the expectation was that residents were supervised, assisted and cued to eat if the residents allowed it. Reference: WAC 388-97-1060(2)(c)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 47728 Based on observation, interview and record review, the facility failed to ensure one of two sample residents (15) reviewed for activities, was engaged in meaningful activities that met their interests. Failure to engage the resident in meaningful activities placed the resident at risk for boredom and diminished quality of life. Findings included Review of the 02/10/2024 comprehensive assessment showed Resident 15 had severe cognitive impairment, was unable to direct their care, and had diagnoses which included dementia and failure to thrive. The assessment showed the resident was dependent with care, including transport in their wheelchair. A staff assessment of activity preferences documented that Resident 15 enjoyed listening to music. Review of the 08/25/2022 care plan showed Resident 15 was dependent on staff for meeting all emotional, intellectual, physical, and social needs. Activity interventions included people watching, sensory stimulation, and music. The following continuous observations were made: On 05/09/2024, from 9:44 AM to 12:12 PM, Resident 15 was awake, sitting up in wheelchair in darkened room facing curtain covered window. No television or radio was on in room. No one entered the room or interacted with the resident during this time. On 05/10/2024 at 10:10 AM, Resident 15 was awake and sitting up in wheelchair in a darkened room. At 11:00 AM, Resident 15 was pushed in their wheelchair to a music program; the resident was seated behind and away from other residents during the activity. The music activity ended at 11:30 AM and Resident 15 remained in the same position and location until 12:15 PM when a staff member pushed the resident in their wheelchair into the dining room for the lunch meal but did not interact with the resident. No one interacted with Resident 15 until 12:45 PM when a staff member sat down beside the resident and talked to them and assisted them with eating lunch. On 05/13/2024 at 9:32 AM, Resident 15 was awake sitting up in their wheelchair in a darkened room facing the window. No television or radio was on in the room. At 10:09 AM, Staff BB, activity aide, entered the resident's room and invited Resident 15's roommate to a music activity but did not interact with or invite Resident 15 to the music program. No one interacted with Resident 15 until 10:49 AM when Staff K, Nursing Assistant, entered Resident 15's room and stated they were going to lay the resident down. Review of facility May 2024 activity calendar showed a sensory activity at 9:30 AM on 05/09/2024, 05/10/2024, and 05/13/2024. In an interview on 05/10/2024 at 10:08 AM, Staff Z, Activity Director, stated the sensory activity was resident specific and the residents who wanted to attend either came on their own or let the staff know and they brought them down. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 2:35 PM Staff AA, Nursing Assistant, stated Resident 15 was a full assist and the staff had to get them up and take them in their wheelchair to activities. When asked if something should have been provided when resident was sitting alone in their room, Staff AA replied yes, and stated they should have opened the curtains, offered television or music, and/or provided personal care such as applying lotion to the resident. In an interview on 05/16/2024 at 2:45 PM, Staff Z, Activity Director, stated Resident 15's program of activities consisted of sensory activities. They stated Resident 15 was nonverbal, and the staff brought them to anything they could watch or listen to, and they applied lotion to the resident. When asked how regularly Resident 15 participated, Staff Z stated during weekly sensory visits and weekly rounds by the activity staff. Staff Z stated Resident 15 should have attended sensory group if they were up in their wheelchair. When asked why resident 15 wasn't invited/included in the music activity on 5/13/2024 Staff Z stated they should have been included. In an interview on 05/16/2024 at 3:27 PM, with Staff C, Resident Care Manager (RCM), they stated two-hour rounding was done for residents that sit alone in their room and it was totally inappropriate for Resident 15 to have been sitting in a dark room with curtains pulled for two hours. Reference: WAC 483.24(c)(1) -0940 (1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42802 Based on observation, interview and record review, the facility failed to provide effective bowel management for 2 of 3 residents (26, 37), reviewed for constipation. These failures placed residents at risk of unmet care needs and resulted in an emergency room visit for Resident 26, for further medical treatment. Findings included . According to an undated Bowel Protocol policy, staff was to initiate the following if a resident did not have a bowel movement (BM) in 72 hours: 1) Give Milk of Magnesia (MOM) or Miralax (types of laxatives, given by mouth) on evening shift. 2) Administer a suppository (laxative medication inserted into the rectum) on night shift 3) Administer an enema (liquid laxative medication, instilled into the rectum) on day shift. <Resident 26> According to an admission assessment, dated 05/01/2024, Resident 26 had diagnoses which included diabetes and septicemia (a life-threatening infection.) The resident was able to make decisions regarding their care. In addition, Resident 26 was incontinent of bowel and required maximum staff assistance with positioning and toileting. Resident 26's admission orders, dated 04/25/2024, included MOM, Miralax, Dulcolax suppository and Fleets enema, with parameters for administration, to be given as needed. A review of Resident 26's Bowel Function Reports for April and May, 2024, showed no BM was documented until 05/02/2024 (seven days after admission to the facility.) A further review of the medical record showed that no bowel medications were offered, given or refused during that time. Resident 26's Bowel Function Report for May, 2024, showed that there was not another BM documented until 05/12/2024, 10 days later. A review of Resident 26's Medication Administration Record (MAR) for May, 2024 documented that MOM was given on 05/09/2024 at 12:26 PM and 05/10/2024 at 10:09 AM. The MAR further documented that Miralax was given on 05/11/2024 at 4:51 AM. No suppositories or enema's were given. A review of the progress notes documented No BM in 48 hours, see BM's on 05/08/2024, 05/09/2024, and 05/10/2024. No entries on the MAR or progress notes documented that any bowel interventions or other medications were offered or refused. A nursing progress note, dated 05/12/2024 at 3:30 AM, documented that the resident had not had a BM and complained of discomfort. The resident was sent to the hospital, returned at breakfast and had an extra large BM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/2024 at 3:30 PM, Resident 26 stated that they got really plugged up and went to the hospital where they were given something up my butt to get things moving. They further stated that they had a BM every day since and felt a lot better. During an interview on 05/15/2024 at 8:41 AM, Staff Q, Registered Nurse (RN) stated that they got a printed report sheet at the beginning of their shift, that showed if a resident had no BM for a certain amount of time and the steps for each shift to take. During an interview on 05/15/2024 at 9:38 AM, Staff O, NA, stated that the NA's charted when residents had a BM. They further stated that if there was nothing charted in the bowel function record, they assumed that they didn't have a BM because if it wasn't charted, it wasn't done. During an interview on 05/15/2024 at 10:40 AM, Staff R, RN stated they got a printout of residents that have gone two or three days without a BM, to follow up on. During an interview on 05/15/2024 at 3:40 PM, Staff B, Director of Nursing (DON), clarified that their expectation was for the NA's to chart the residents BM's, and for the nurses to follow up with interventions. They stated they were unsure why the facility bowel protocol had not been followed, and this did not meet the their standard of care for bowel management. Reference: WAC 388-97-1060(1) 46115 <Resident 33> Per the 04/03/2024 significant change in condition assessment, Resident 33 had moderate cognitive impairments and required partial to moderate assistance with toileting. Review of the care plan dated 12/12/2023 documented the resident had chronic pain and instructed nursing staff to implement appropriate bowel management when opiates were ordered per the physician's orders. Review of the May 2024 Medication Administration Record (MAR) documented on 03/28/2024, the physician had ordered a laxative (Milk of Magnesia) to be given if the resident had not had a BM in 48 hours, and if there still was no BM by the next shift, an additional laxative (Dulcolax suppository) was to be given, and if no BM by the next shift, an additional laxative (Fleets enema) was to be given. Review of the bowel records from 02/16/2024 through 05/13/2024, showed Resident 33 had no BM's from 02/16/2024 through 02/18/2024 (three days), 02/23/2024 through 02/25/2024 (three days), and from 04/18/2024 through 04/22/2024 (five days). Additional review of the MARS for February 2024 through May 2024, documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 33's record that stated the reason for the omissions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 2:02 PM, Staff M, Resident Care Manager, confirmed Resident 33 did not have a BM on the above dates and the bowel protocol should have been followed. 50027 <Resident 37> Per the 02/18/2024 quarterly assessment, Resident 37 was able to make their needs know and required moderate to substantial assistance with toileting. Review of the May 2024 Medication Administration Record (MAR) documented on 05/16/2023, the physician had ordered a laxative (Milk of Magnesia) to be given if the resident had not had a BM in 48 hours, and if there still was no BM by the next shift, an additional laxative (Dulcolax suppository) was to be given, and if no BM by the next shift, an additional laxative (Fleets enema) was to be given. On 07/05/2023 a laxative (MiraLax) was ordered to be given every 24 hours as needed for constipation. Review of the bowel records from 03/14/2024 through 05/14/2024, showed Resident 37 had no BM's from 03/14/2024 through 03/16/2024 (three days), 04/16/2024 through 04/21/2024 (six days), and from 04/25/2024 through 04/27/2024 (three days). Additional review of the MARS for March 2024 through May 2024, documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 37's record that stated the reason for the omissions. In an interview on 05/16/2024 at 1:31 PM, Staff M, Resident Care Manager, confirmed Resident 37 did not have a BM on the above dates and the bowel protocol should have been followed. Reference: WAC 388-97-1060 (1)

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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. 50027 Based on observation, interview, and record review, the facility failed to provide adequate supervision and assess a resident for smoking safety for 1 of 2 sampled resident (37), reviewed for accidents. Findings included: The 02/20/2024 quarterly assessment documented Resident 37 was able to make decisions regarding their care, had diagnoses which included stroke, which resulted in weakness and paralysis on their right side. In addition, the assessment documented the resident required set-up to substantial/maximal assistance from staff to complete activities of daily living. On 05/09/2024 at 1:02 PM, Resident 37 was observed smoking, using the left hand. While smoking, Resident 37 dropped a lit cigarette, and it rolled down by their foot. Resident 6 picked up the cigarette and handed it back to them. Resident 37 took a puff of the cigarette and dropped it again. The cigarette rolled down the front of their sweatshirt and onto their right sleeve and then bounced onto the left thigh area of their sweatpants. Resident 37 then picked up the cigarette and continued smoking. The resident was not wearing a smoking apron at the time of the incident. On 05/09/2024 at 2:01 PM, Resident 37 was observed to have a burn hole in the upper left thigh area of their sweatpants with no visible burn to the skin in that area. Residual cigarette ashes were present on the front of their sweatshirt and the right lower sleeve. During an interview on 05/09/2024 at 2:20 PM, Resident 6 confirmed that they picked up Resident 37's cigarette and handed it back to them. Resident 6 stated that Resident 37 had difficulties using their left hand and had dropped their cigarette in the past. During an observation on 05/09/2024 at 3:10 PM, Resident 37 attempted to light their cigarette and it fell out of their mouth and onto the front of their sweatshirt. They picked the cigarette up, placed it in their mouth again and lit it. The resident was not wearing a smoking apron. Review of the 09/01/2022 smoking care plan documented Resident 37 was independent with smoking but required assistance from staff to get to the smoking area. In addition, nursing staff were instructed to complete a smoking assessment quarterly, annually and with any change of condition that affected the ability to smoke. A review of the smoking assessments documented the last smoking assessment had been completed on 08/18/2023. No other documentation was found to show a smoking assessment had been completed quarterly or annually as directed in the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/2024 at 4:21 PM, Staff A, Administrator and Staff B, Director of Nursing were informed of the observations of Resident 37 smoking and concern expressed for their safety while smoking independently. When informed of the date of the last smoking assessment for Resident 37, Staff B stated they wanted the residents to be safe and all residents who smoke would be assessed immediately and interventions implemented for Resident 37. During an interview on 05/16/2024 at 1:31 PM, Staff M, Resident Care Manager, confirmed that Resident 37 should have had a more recent smoking assessment. Reference: WAC 388-97-1060 (3)(g) 1060

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	505275	A. Building B. Wing	05/16/2024

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Colville of Cascadia, LLC	1000 East Elep Street Colville, WA 99114

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46115 Based on interview and record review, the facility failed to provide needed pain management for 1 of 3 sampled residents (6), reviewed for pain. This failure placed residents at risk of uncontrolled pain and a diminished quality of life. Findings included . According to the 03/29/2024 quarterly assessment, Resident 6 was admitted with diagnoses which included osteoarthritis, migraines and chronic pain syndrome and was able to make their needs known. Additionally, the assessment documented the resident had pain frequently that would impact their sleep and day to day activities. In an interview on 05/08/2024 at 3:37 PM, Resident 6 stated they had been out of their Hydrocodone 5 milligram (mg) tablets (a narcotic used to treat pain) for about three days and was not offered anything else for pain relief. The resident stated they were told by nursing staff that there was nothing else they could do. A review of the Medication Administration Records for May 2024, documented physician orders for acetaminophen (Tylenol) every four hours as needed (PRN) for pain, Hydrocodone 10/325 mg routinely three times per day and Hydrocodone 5/325 mg daily PRN for migraine pain. The records documented Resident 6 had received their scheduled Hydrocodone 10 mg/325 mg, but had not received the PRN Hydrocodone 5/325 mg from 05/06/2024 through 05/08/2024. The records documented on the evening of 05/08/2024 the resident had pain rated as a four (on a scale of 1-10, with 10 being the worst) and had not received any Tylenol and no non-medication interventions were offered during that time. The progress notes for May 2024, documented no communication with the physician, related to Resident 6 not having their PRN pain medication. In an interview on 05/16/2024 at 2:18 PM, Staff M, Resident Care Manager, verified Resident 6 had been out of their Hydrocodone 5/325mg PRN pain medication from 05/06/2024 through 05/10/2024 and the physician should have been notified. Reference: WAC 388-97-1060(1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46115 Based on interview and record review the facility failed to consistently collaborate care with the dialysis center, and accurately monitor the fluid restriction for 1 of 1 sampled resident (33) reviewed for dialysis care. These failures placed residents at risk of unrecognized complications, unmet care needs and a diminished quality of life. Findings included . Review of the Long Term Care Facility Outpatient Dialysis Services Coordination Agreement, between the facility and the dialysis center dated 10/15/2022, documented there should be documentation of collaboration of care and communication between the long-term care facility and the dialysis center. According to the 04/03/2024 significant change in condition assessment, Resident 33 had a diagnosis of end stage renal disease (kidneys stop working and are not able to remove waste or extra water from the blood) and was dependent on dialysis. Resident 33 was able to make their needs known. The 12/21/2023 dialysis care plan instructed nursing staff to send the Dialysis Communication form to the dialysis clinic for each visit attended by the resident and to ensure the form was returned with them. Per Resident 33's record, the following dates did not have the Dialysis Communication form filled out by the dialysis clinic: 01/22/2024, 01/31/2024, 02/02/2024, 02/05/2024, 02/19/2024, 03/04/2024, 03/06/2024, 03/08/2024, 03/11/2024, 03/13/2024, and 03/15/2024. No documentation was found in the resident's record regarding the incomplete documentation. A review of the provider orders documented on 02/08/2024, the resident was on a 1000 milliliter (ml) fluid restriction. The fluid restriction instructed nursing to provide 200 ml's on day shift, 100 ml's on evening shift, 100 ml's on night shift and night shift was to calculate the amount of fluids the resident had received in a 24 hour period. Per the May 2024 Medication Administration Record (MAR), Resident 33 had an order dated 03/28/2024 that instructed nursing staff to provide the above amount of fluid. The MAR also documented on 04/08/2024, the nursing staff needed to provide 100 ml's of fluid on day shift, 100 ml's on evening shift and 80 ml's on night shift. The nursing staff signed for each fluid restriction, although the amount of fluids were different on each order. Per the May 2024 MAR, the day shift recorded five days in which the amount of fluids given was 100 ml's, all other days ranged from 60 ml's to 360 ml's. The evening shift recorded five days in which the amount of fluids given was 100 ml's, all other days ranged from 60 ml's to 300 ml's. The night shift recorded ten days in which the amount of fluids given was 80 ml's, all other days ranged from 50 ml's to 100 ml's. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 2:02 PM, Staff M, Resident Care Manager stated they were unsure of which fluid restriction was followed by the nursing staff and night shift was responsible for calculating the amount of fluids consumed for the day. Staff M stated the dialysis communication forms were faxed and sent with the resident to dialysis. Staff M added the expectation was the forms would have been returned timely or follow up with the dialysis clinic should have occurred and this was important for the collaboration of care. Reference WAC 388-97-1900 (1), (6)(a-c)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46115 Based on interview and record review, the facility failed to ensure recommendations from the pharmacist were addressed in a timely manner, for 1 of 5 sample residents (30), reviewed for unnecessary medications. These failures placed residents at risk for receiving an inaccurate dosing of medication, adverse side effects, and the risk of receiving a medication longer than medically necessary. Findings included . The Consultant Pharmacy Report, dated 01/2024, documented Resident 30 received Peridex mouth wash and it was recommended the resident should not brush their teeth, rinse mouth, eat or drink following the rinse to be added to the Medication Administration Record (MAR). The same recommendation was made for 02/2024 and again for 03/2024. A review of Resident 30's record showed no response from the provider or nursing regarding the recommendation until 03/04/2024 (two months after the recommendation was made). In an interview on 05/16/2024 at 10:38 AM, Staff C, Resident Care Manager, stated the pharmacy recommendations were received and if it pertained to nursing, the nurse managers would add the orders to the MAR. Staff C verified the order for the Peridex should have been completed in a timely manner, and thought they had a week to do so. Reference: WAC 1300 (4)(c)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42802 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent for 2 of 4 sampled residents (2, 9), observed during medication pass. Specifically, 2 errors were made during 27 medication administration opportunities, resulting in an error rate of 7.41 percent. Errors in medication administration placed residents at potential risk for not receiving the full therapeutic effect of the medication. Findings included . According to Medscape.com, the warnings section for both Brimonidine Eye Drops and Refresh Eye Drops shows to wait five minutes between instilling eye drops, if more than one product is administered. <Resident 2> During an observation on 05/15/2024 at 7:22 AM, Staff R, Registered Nurse (RN) prepared medications for Resident 2. The resident had two different eye drop medications ordered, Brimonidine (medication to treat elevated pressure in the eye) one drop in the left eye, and Refresh eye drops (lubricant, for dry eyes), two drops to each eye. Staff R administered the Brimonidine eye drops, then immediately administered the Refresh eye drops. Staff R did not wait the minimum of five minutes between administration of different eye medications. During an interview on 05/15/2024 at 7:50 AM, following the observation, Staff R acknowledged that they should have waited five minutes in between eye drops. <Resident 9> During an observation on 05/15/2024 at 7:41 AM, Staff Q, RN, administered a Multivitamin with Minerals, one tablet, with the rest of the Resident 9's morning pills. During an observation and interview on 05/15/2024 at 8:41 AM, this surveyor looked at the order in the electronic medical record (EMR) with Staff Q, which showed Multivitamin with Folic Acid 400 micrograms (mcg) once a day. Staff Q then compared it to the bottle of Multivitamin with Minerals, that was given. Staff Q acknowledged that Folic Acid was not listed as an ingredient on the bottle, and they should have looked for another bottle with the Folic Acid. Staff Q stated they understood why it was a medication error. Reference: WAC 388-97-1060(3)(k)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46115 Based on observation and interview, the facility failed to ensure appropriate hand hygiene was performed during the meal service for 1 of 2 dining rooms. These failures placed the residents at risk for infections and unmet care needs. Findings included . During a lunch observation on 05/08/2024 at 12:22 PM in the assisted dining room, Staff W, Admissions Coordinator, prepared coffee for the residents, touched their straws with bare hands, touched the tablecloth and clothing protectors, adjusted a resident's glasses, and served another cup of coffee without performing hand hygiene in between. In an observation at 12:25 PM, Staff W gave a cleansing wipe to a resident to wash their hands, passed a tray, touched a resident's clothing protector, and without hand hygiene being performed, opened food items for a resident and passed another tray. During an observation on 05/08/2024 at 12:34 PM, Staff W was assisting four residents to eat at the same table. Staff W rubbed the arm of a resident to wake them up and gave them bites of food. Staff W touched the resident's wheel on their wheelchair, and without hand hygiene being performed, gave another resident bites of their food. In an observation on 05/08/2024 at 12:38 PM, Staff X, Nursing Assistant, moved a chair, fixed a resident's clothing protector, and without hand hygiene being performed, gave another resident drinks of their fluid and bites of their food. During an observation on 05/08/2024 at 12:55 PM, Staff U, Nursing Assistant, picked up unclean dishes and without hand hygiene being performed, grabbed clean wash cloths and assisted residents to wash their hands and faces. In an interview on 05/08/2024 at 1:09 PM, Staff X stated hand hygiene was performed prior to passing trays and feeding residents. Staff X added they should have performed hand hygiene prior to feeding the resident and after they had touched things to prevent the spread of germs. In an interview on 05/08/2024 at 1:13 PM, Staff U stated hand hygiene was performed before and after each meal tray was passed and when touching things. Staff U added they should have sanitized their hands prior to washing the resident's hands and faces. In an interview on 05/08/2024 at 1:16 PM, Staff W stated hand hygiene was performed upon entering the dining room, between meal trays being passed, before and after resident's hands were washed and after touching things. Staff W added they should have sanitized their hands after touching the items mentioned above to prevent cross contamination. In an interview on 05/16/2024 at 5:24 PM, with Staff A, Administrator and Staff B, Director of Nursing, observations of the lack of hand hygiene during meal service was discussed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1320 (1)(c) 50027