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	05/23/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to inform residents and/or their representatives about their right to have their bed held while hospitalized for 2 of 4 sampled residents (Residents 51 and 19), reviewed for hospitalization s. This failure precluded the residents and/or their representatives to participate in decisions regarding their right to return to the same facility upon hospital return, and the right to know how much the facility would charge for holding their bed. Findings included . Review of a revised April 2025 facility policy titled Bed-Hold Readmission showed, the facility issued two notices related to bed-hold policies. The first notice was given well in advance of any transfers such as information in the admission packet, and the second notice provided to the resident and/or the resident representative at the time of transfer to the hospital, or in cases of emergency transfer, within 24 hours of transfer. <Resident 51> Review of a 05/04/2025 admission assessment showed Resident 51 admitted to the facility on [DATE] with medically complex conditions. The assessment showed the resident had moderate cognitive impairment. Additional review of the medical record showed Resident 51 was their own responsible party. Review of a April 2025 nursing progress note showed on 04/30/2025 Resident 51 readmitted from the hospital. The note prior to 04/30/2025 was 04/24/2025 but showed no documentation of a change in condition or reason for hospital transfer. Review of a Census List showed Resident 51 went to the hospital on 04/25/2025. Additional review of the medical record showed there was no information that showed why Resident 51 was transferred to the hospital and no documentation was found to show staff informed the resident and/or their representative of their right to hold their bed at the time of or shortly after the 04/25/2025 hospital transfer. Further review of a May 2025 nursing progress notes showed on 05/11/2025 Resident 51 experienced a change in condition after a fall and required a transfer to the hospital. Additional review of the medical record showed no documentation staff informed the resident and/or their representative of their right to hold their bed at the time of or shortly after the 05/11/2025 hospital transfer. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above findings were shared with Staff N, Resident Care Manager (RCM), on 05/15/2025 at 8:56 AM. Staff N confirmed there was no documentation staff informed Resident 51 and/or their representative of their right to hold their bed or provided Resident 51 a notice of bed hold policy at the time of transfers to the hospital and it should have been offered and documented, as required. 47328 <Resident 19> According to the 04/10/2025 quarterly assessment, Resident 19 had severe cognitive impairment with inattention and disorganized thinking. The assessment further showed Resident 19 exhibited worsening verbal and physical behaviors directed towards others that significantly interfered with Resident 19's care, participation in activities or social events, placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. Review of after visit hospital summaries showed Resident 19 was transferred to the hospital on 09/12/2024, 01/13/2025, 02/26/2025, 02/28/2025, 03/03/2025, and 03/08/2025 for various reasons. Review of September 2024 through April 2025 nursing progress notes showed the following: -01/14/2025 Resident 19 was transferred to the hospital after they sustained a fall. No documentation was found to show staff informed Resident 19 and/or their representative of their right to hold their bed or reviewed the bed hold policy at time of hospital transfer. -02/28/2025 Resident 19 was transferred to the hospital related to increased agitation. No documentation was found to show staff informed Resident 19 and/or their representative of their right to hold their bed or reviewed the bed hold policy at time of hospital transfer. -03/03/2025 Resident 19 was hospitalized . No documentation was found to show staff informed Resident 19 and/or their representative of their right to hold their bed or reviewed the bed hold policy at time of hospital transfer. -04/11/2025 Resident 19 was transferred to the hospital related to combative behaviors towards staff. No documentation was found to show staff informed Resident 19 and/or their representative of their right to hold their bed or reviewed the bed hold policy at time of hospital transfer. Review of December 2024 through March 2025 provider progress notes showed Resident 19 was transferred to the hospital on 12/27/2025 after they sustained a fall with a femur fracture, on 03/03/2025 after they sustained a fall out of their wheelchair, and on 03/25/2025 after they were involved in a resident-to-resident altercation. Additional review showed no documentation to show staff informed Resident 19 and/or their representative of their right to hold their bed or reviewed the bed hold policy at time of hospital transfer. Review of the 04/11/2025 emergent transfer assessment showed Resident 19 was transferred to the hospital for agitation and violent behaviors. Additional review showed no documentation staff informed Resident 19 and/or their representative of the notice of their right to hold their bed or reviewed the bed hold policy at time of hospital transfer. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/22/2025 at 10:56 AM, Staff D, RCM, reviewed Resident 19's medical record. Staff D acknowledged staff should document they informed residents and/or their representative of their right to hold their bed or provided a notice of bed hold policy at time of hospital transfer. In an interview on 05/22/2025 at 10:56 AM, Staff B, Director of Nursing, stated if a resident was transferred to the hospital, they expected staff to document they informed the resident and/or their representative of their right to hold their bed or provided a notice of bed hold policy at time of hospital transfer. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated if and/or when a resident was transferred to the hospital, they expected staff to document they informed the resident and/or their representative of their right to hold their bed or provided the a notice of bed hold policy. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b).

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47328 Based on interview and record review the facility failed to maintain financial information in a secure manner to prevent unauthorized access for 1 of 2 sampled residents (Resident 49), reviewed for personal property. This failure placed residents at risk of misappropriation, financial exploitation and diminished quality of life. Findings included . According to the 04/22/2025 quarterly assessment, Resident 49 had moderate cognitive impairment and was able to clearly verbalize their needs. Review of the 04/19/2024 care plan showed Resident 49 was impulsive and utilized the services of a payee (an appointed person to manage finances when an individual was unable to do so). The care plan showed Resident 49 was inclined to send money to their family, but it was not in Resident 49's best interest. Additional record review found a front and back color copy of a bank card with four numbers handwritten below the card, scanned into Resident 49's electronic clinical health record accessible to any nursing staff with access to the health record. In an interview on 05/22/2025 at 8:37 AM, Staff E, Social Services Coordinator, stated residents could keep bank cards on their person, if they chose to. Staff E explained a bank card was considered a valuable that was at high risk to be lost or stolen by others and should be stored securely to prevent unintended access. Staff E reviewed the color copy of the bank card and acknowledged the handwritten numbers was Resident 49's pin number and should not have been scanned into the health record like it was. In an interview on 05/22/2025 at 9:35 AM, Staff B, Director of Nursing, stated bank cards should be stored securely to prevent unintended access related to the high risk for potential misappropriation. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to maintain and store bank card information in a manner to prevent access by unauthorized individuals. Reference WAC 388-97-0360, 0500 (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40297 Based on observation and interview, the facility failed to ensure a homelike and safe environment and equipment that was in good repair for 2 of 2 halls and 2 residents (Resident 36 and 50). Failure to ensure floor tiles were replaced, the ends of metal wheelchair brake extenders were covered, and room walls and base board heater paint were intact, placed the residents at risk of injury and a diminished quality of life. Findings included . <Resident 36> An observation of Resident 36's room (room [ROOM NUMBER]) on 05/13/2025 at 12:28 PM showed the wall behind the resident's bed was gouged and dented from the headboard. The baseboard between the resident's bed in the room was scuffed with the paint peeling off. <Resident 50> An observation of Resident 50's wheelchair on 05/12/2025 at 10:52 AM showed bilateral metal wheelchair brake extenders with no rubber protectors on the tip. Rubber protectors served to cover the metal end and prevent injury. <B Unit> An observation on 05/13/2025 at 12:28 PM of the floor near room [ROOM NUMBER] in front of the exit door, showed broken tiles with some patches missing, and others cracked. A rug was observed in front of the tiles. <Special Care Unit> An observation on 05/13/2025 at 1:28 PM between rooms [ROOM NUMBERS] showed a broken or gouged tile area of approximately 3 inches by 1 1/2 inches with a depth of about 1/10 of an inch. The above findings were shared with Staff W, Maintenance Director, in an observation and interview on 05/22/2025 at 8:22 AM. Staff W stated they completed monthly checks on all the wheelchairs in the facility and if unable to address a wheelchair repair issue they collaborated with the therapy department to coordinate with a wheelchair vendor. Staff W stated they did not know of the missing protectors for Resident 50's wheelchair brake extenders and said they needed to be covered to prevent an injury like a skin tear. In the continued interview on 05/22/2025 at 8:22 AM, Staff W made the following comment about the broken and missing tiles on B Unit, We are aware of stuff like this. That's why we have the carpets here. It will be repaired. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the continued interview on 05/22/2025 at 8:22 AM, Staff W made the following comment about the broken tiles in the Special Care Unit, That one I will have to fix right away. In the continued interview on 05/22/2025 at 8:22 AM, Staff W stated they did not have a schedule to check on room conditions but that room [ROOM NUMBER], is on the list to be remodeled. The scheduled remodeling was contingent on the room being vacant of residents. Staff W stated, Management is aware. Reference WAC 388-97-0880.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 47328 Based on observation, interview and record review, the facility failed to identify, report, protect, assess and prevent a pattern of resident-to-resident verbal and physical abuse. This included identifying a known pattern of aggressive behaviors by Residents 19. Abusive behaviors identified by staff included hitting, punching, kicking, ramming into other residents with a wheelchair (w/c), verbal abuse, threats and intimidation of other residents. The facility failed to recognize these instances as abuse, analyze the circumstances of these abusive behaviors, or implement plans for prevention or recurrence of abuse for 11 of 12 sampled residents (Resident 19, 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41), reviewed for abuse. Failure to recognize, analyze, and act upon multiple incidents of resident-to-resident altercations as abuse and provide adequate supervision and care planning with effective interventions placed all 61 residents at risk of serious injury or harm and represented an immediate jeopardy (IJ). 13 residents experienced fear when they were subjected to repeated unpredictable outbursts of verbal abuse and actual physical injuries such as coffee thrown on them, grabbing, scratching, punching, kicking, and skin tears. On 05/20/2025 at 5:40 PM, the facility was notified of the identified IJ related to F600 CFR S483.12 (a)(1) Freedom from Abuse and Neglect. Onsite verification by surveyors on 05/23/2025 at 10:25 AM showed, the facility removed the immediacy by reviewing Resident 19's medications and placing Resident 19 on one to one (1:1) supervision until lower level of care was determined to be appropriate. The survey team verified the facility educated all staff to the abuse prevention policies and procedures. All residents were interviewed to determine feeling safe and secure in the facility. Findings included . Review of the facility policy titled, Preventing Abuse revised August 2023 showed, the facility would identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property was more likely to occur. Staff were to observe residents, visitors and staff to identify inappropriate behaviors and deploy sufficient staff on each shift to meet the needs of the residents. The policy instructed staff to assess, care plan and monitor residents who exhibited behaviors which might lead to conflict such as verbally aggressive behaviors such as screaming, cursing, intimidating, or demanding behaviors and physically aggressive behaviors such as hitting, kicking, grabbing, scratching, biting, pushing, wandering, rummaging, threatening gestures, or throwing objects. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility policy titled, Identification and Investigation of Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin revised August 2023 showed, the facility reviewed reports of grievances, complaints, and allegations of abuse, neglect, injuries of unknown injury to identify a pattern or isolated incidents. The policy instructed staff to determine a root cause of any incident and evaluate the resident for signs of negative psychosocial impact of the incident to include fear of a person or place or extreme changes in behavior. The facility was to protect all residents from physical and psychosocial harm during and after the investigation by responding immediately to protect the alleged victim and provided increased supervision of the alleged victim and other residents as indicated. Staff were to immediately report all incidents and allegations of abuse to the CEO or designee, the State Survey Agency, and Law Enforcement if a crime was suspected. Once an incident was reported it was to be thoroughly investigated within five working days by conducting resident and staff interviews, determine root cause of the incident and implement corrective action to immediately address safety issues, updated care planned interventions based on the investigation findings, and complete staff training as indicated. According to the 04/10/2025 quarterly assessment, Resident 19 had severe cognitive impairment with inattention and disorganized thinking. The assessment further showed Resident 19 exhibited worsening verbal and physical behaviors directed towards others that significantly interfered with Resident 19's care, participation in activities or social events, placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. Review of the facility October 2024 through May 2025 incident report tracking log showed Resident 19 was involved in 11 resident-to-resident altercations with 10 different peers (Resident 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41) on the following dates: 10/16/2024, 11/07/2024, 01/11/2025, 01/13/2025, 02/10/2025, 02/27/2025, 03/08/2025, 04/04/2025, 04/11/2025, 04/25/2025, and 05/10/2025. Review of the facility resident-to-resident incident reports showed the following: - 10/16/2024- Resident 19 allegedly struck Resident 27 on the hand with a spoon while in the dining room - 11/07/2024- Resident 33 threw coffee on Resident 19 in the dining room - 01/11/2025- Resident 19 randomly grabbed, kicked, and shook Resident 3's walker as they walked down the hall - 01/13/2025- Resident 19 yelled, grabbed at, and stopped Resident 41 from entering the dining room. The incident included a 01/13/2025 staff statement that showed Resident 19 continued to escalate with anger trying to grab and hit anyone close to [them]. - 02/10/2025- Resident 19 grabbed at Resident 31. Resident 19 called Resident 31 a fucking asshole! and grabbed Resident 31's shirt neck collar. Resident 31 open handedly slapped Resident 19 in the face. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- 02/27/2025- Resident 19 was self-propelling their WC and spontaneously grabbed, hit, scratched, and kicked at Resident 49. Resident 49 sustained a scratch that bled and required first aide. Resident 49 did not know why Resident 19 attacked them. Root cause of incident was identified as Resident 19 was agitated and within close proximity of another resident. - 03/08/2025- Resident 19 was yelling and hitting at Resident 43 and Resident 21. The incident included a 03/08/2025 statement where Resident 21 was asked if they felt safe in the facility. Resident 21 replied Yes, but if [Resident 19] comes back I will be scared to death. - 04/04/2025- Resident 19 yelled at Resident 37 to remove their hat when sitting at the dining room table. After the meal, at the nurses' station, Resident 19 continued to yell at Resident 37 and allegedly ran over Resident 37's toes with their WC. - 04/11/2025- Resident 19 unprovoked began to punch Resident 45 with a closed fist, in the hallways, as Resident 45 rolled past Resident 19. - 04/25/2025- Resident 19 had a second physical altercation with Resident 31, in the dining room, with staff present but who did not observe the altercation. Resident 19 and Resident 31 grabbed and hit at each other. Resident 31 sustained a skin tear to their arm. - 05/10/2025- Resident 19 had a third verbal and physical altercation with Resident 31. Resident 31 yelled I am going to kill you! Residents 19 and 31 were observed grabbing and hitting each other. Resident 31 sustained a scratch to the back of their hand and Resident 19 sustained a scratch to the tip of their nose. Review of the 09/10/2024 self-care deficit care plan showed Resident 19 was able to self-propel their wheelchair (WC) independently. The 10/17/2024 care plan showed Resident 19 had potential to yell and strike out at other residents related to dementia and poor impulse control. Interventions included to assess and anticipate Resident 19's needs, give positive feedback, frequent safety checks when out of bed, reapproached with different staff when agitated, and maintain a consistent routine. On 11/01/2024 Resident 19 was placed on 15-minute safety checks around the clock, on 03/27/2025 a basket of favorite things was placed at the nurses' station for Resident 19 to rummage through, and on 04/28/2025 Resident 19 was to be in staff's direct line of sight when in the dining room for meals. Review of the 03/25/2025 Staff Z, Medical Doctor, progress note showed Resident 19 was started on Zyprexa (antipsychotic, medication that affect the mind, emotions and behaviors) for dementia with agitation. Resident 19's became less aggressive without sedation, more interactive, and pleasant while on Zyprexa and was a danger to others without it. Review of 04/15/2025 Staff Z, provider progress note showed Resident 19's wheeled themselves around the facility, would be calm for extended periods then violently attack other residents who irritated [them]. Resident 19 was off of Zyprexa as state insists on GDRs [Gradual Dose Reductions, when antipsychotic medication was gradually, slowly and carefully reduced to find the lowest effective therapeutic dose to prevent unnecessary medication use]. Additional record review showed Resident 19's Zyprexa was decreased and discontinued on 04/01/2025. Review of October 2024 through May 2025 nursing progress notes the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- 10/16/2024 Resident 19 was witnessed hitting another resident during dinner. Resident 19 was involved in two different resident-to-resident altercations with two different peers. - 10/24/2024 Resident 19 yelled at peer as they walked down the hall. - 10/27/2024 Resident 19 was started on 15-minute safety checks while awake related to yelling, arguing, and hitting other residents without combativeness. - 10/28/2024 Resident 19 wandered the into others' rooms rummaging through their belongings. - 11/08/2024 Resident 19 yelled out and banged on the wall for two and a half hours, from 2 PM until 4:30 PM. - 11/28/2024 Resident 19 loudly and persistently yelled at their roommate. Resident 19's roommate did not answer, to avoid aggravating Resident 19 further. - 12/06/2024 Resident 19 yelled and argued with the resident in room [ROOM NUMBER] B related to use of the shared bathroom. - 12/16/2024 Resident 19 exhibited yelling and aggressive behaviors towards staff and other residents. Resident 19 was independent with WC mobility, impulsive, and destructive to property. - 12/18/2024 Resident 19 yelled out through the night shift. Resident 19's roommate along with other facility residents complained about the disruptive behavior and interrupted sleep. - 01/01/2025 Resident 19 was extremely agitated and upset while they self-propelled their WC down the hall yelling at other residents and staff, confronting the resident in room [ROOM NUMBER] A. - 01/11/2025 Resident 19 attacked Resident 3 as they walked down the hall. - 01/13/2025 Resident 19 aggressively grabbed at a male peer, causing them to cry. - 01/14/2025 Resident 19 tore their room apart by throwing water, knocking furniture over, throwing clothing and blankets around, while a roommate remained in the room. - 01/26/2025 Resident 19 was approached and confronted by Resident B. Resident B yelled at Resident 19 I am tired of you yelling all the time. Resident 19 hit Resident B in the face. - 02/10/2025 Resident 19 and 31 were involved in a physical altercation. Resident 31 open handedly slapped Resident 19 face. - 02/11/2025 Resident 19 was in a foul mood as they repeatedly propelled up and down the hall. The resident in room [ROOM NUMBER] A reported experiencing a run in with Resident 19. The resident in 35 A reported Resident 19 yelled at them and called them stupid. - 02/15/2025 Resident 19 was angry much of the time and got into fights with other residents. - 02/19/2025 Resident 19 was visibly upset and grabbed Resident 4's arm and would not let go. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- 02/25/2025 Resident 19 was agitated, aggressive, yelled, and screamed out as they self-propelled down the hall, calling peers names such as whores. Numerous residents on the unit were upset by Resident 19's behaviors and began cursing at Resident 19. - 02/27/2025 Resident 19 was involved in a resident-to-resident altercation with Resident 49. - 02/28/2025 Resident 19 threw water on a peer and attempted to go after them. - 04/04/2025 Resident 19 displayed violent behaviors towards another resident after the evening meal. - 04/11/2025 Resident 19 quickly became upset, yelled, and hit Resident 45 with a closed fist. - 04/15/2025 Resident 19 will be calm for extended periods then will violently attack other residents who have irritated [them]. - 04/22/2025 Resident 19 screamed and yelled for about 4 hours. - 04/25/2025 Resident 19 was involved in a second resident-to-resident altercation with Resident 31. - 04/29/2025 Resident 19 was self-propelling their WC up and down hallways throughout the facility and continues with random acts of boisterous yelling/calling out which mimics the call of Tarzan, often times startling other resident's and staff. - 05/10/2025 Resident 19 was involved in a third resident-to-resident altercation with Resident 31. Eight additional facility incident report investigations for resident-to-resident altercations involving Resident 19, not identified on the facility accident and incident log, on the following dates 10/28/2024, 11/28/2024, 12/06/2024, 01/01/2025, 01/26/2025, 02/11/2025, 02/19/2025, and 02/25/2025 were requested on 05/19/2025 at 5:22 AM, from Staff A, Administrator. Only one of the eight requested incident investigation was provided, 01/26/20205. Review of the facility census as of 05/12/2025 showed Resident 19, 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41 continued to resided at the facility. During observation on 05/12/2025 at 11:12 AM, Resident 19 was sitting in their WC, with a scab to the tip of their nose approximately the size of a pencil eraser, yelling out . Resident 19 self-propelled their WC down the hall. Similar observations were made at 11:16 AM, 11:27 AM, 2:05 PM, and 3:40 PM. In an interview on 05/13/2025 at 10:44 AM, Resident 49 stated Resident 19 used to grab and hit me. Resident 49 explained Resident 19 wandered the halls all day and night looking for trouble, their behavior flipped easily, and Resident 19 goes around beating up people here. During observation on 05/13/2025 at 11:41 AM, Resident 19 self-propelled down the hall and yelled out. Another resident yelled back for Resident 19 to be quiet! (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview with the resident council on 05/14/2025 at 10:25 AM, stated Resident 19 wandered, was disruptive, and aggressive towards others. The council explained Resident 19 was spontaneous, unpredictable, with quickly fluctuating behaviors and could be smiling and friendly one minute then flying off the handle at residents and staff then next minute. The council voiced feeling unsafe due to Resident 19's continued behaviors. During observation on 05/15/2025 at 2:18 PM, Resident 19 was heard yelling out, resembling Tarzan, from the conference room. Resident 19 was observed at the opposite end of the hall, approximately 10 resident rooms, two offices, a dining room, and nurses station down the hall. In an interview on 05/16/2025 at 11:18 AM, Resident 4's representative stated Resident 19 targeted and threatened Resident 4. The representative explained they observed Resident 19 wander up and down the halls yelling. Review of Resident 4's medical record showed Resident 19 followed and chased Resident 4. Resident 4 alleged Resident 19 bruised their arm on 02/28/2025. In an interview on 05/19/2025 at 4:06 AM, Staff I, Registered Nurse, stated it was difficult to manage resident behaviors on night shift. Staff I explained Resident 19 yelled out at times and the behavior bothered other residents. Staff I acknowledged Resident 19's behaviors placed them at risk for harm or abuse. Staff I further stated Resident 19 had been involved in numerous resident-to-resident altercations even while on 15-minute safety check monitoring. In an interview on 05/19/2025 at 8:00 AM, Staff E, Social Service Coordinator, stated resident behaviors were tracked by nursing staff via nursing progress notes, social services and the provider would be notified of odd or abnormal behaviors so additional follow up could be done. Staff E further stated allegations of potential abuse were investigated by conducting resident and staff interviews to get a broader picture of the incident. Staff E was asked if instances of resident-to-resident altercations were considered abuse. Staff E explained if there was physical contact then yes that was definitely an allegation of abuse but instances of yelling back and forth were not considered potential abuse unless the yelling involved threats. Staff E stated Resident 19's mood and behaviors could quickly randomly fluctuate and escalate to the point of being too ramped up to calm down. Staff E explained Resident 19 enjoyed to self-propel their WC up and down the hall but that could create resident-to-resident altercations because Resident 19 would get upset when peers were in the way and lashed out physically. Staff E was asked if any residents voiced concerns over Resident 19's behaviors. Staff E stated Resident 4 would often be irritated with Resident 19. Resident 4 would look out into the hall, if they saw Resident 19, they would ask staff to escort them to the therapy gym to avoid interacting with Resident 19. Staff E acknowledged Resident 19's behaviors placed them and others at risk for abuse and Resident 19 was involved in the most resident-to-resident altercations. Staff E explained Resident 19 had been involved in resident-to-resident altercations even while on 15-minute safety check monitoring because Resident 19 was mobile, and it was difficult to anticipate what would trigger them. Staff E acknowledged staff should protect residents from abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 05/19/2025 at 8:55 AM, with Staff B, Director of Nursing, and Staff C, Clinical Resource Nurse. Staff B reviewed Resident 19's medical record. Staff B acknowledged Resident 19 enjoyed self-propelling their WC throughout the facility, had quickly fluctuating verbally and physically aggressive behaviors towards others that placed them at risk for abuse. Resident 19 was involved in numerous verbal and physical resident-to-resident altercations even while on 15-minute safety checks. Staff B explained if a resident exhibited physical behaviors towards others it was reported, investigated, and addressed as potential abuse but verbally aggressive behaviors were documented and monitored per the facility behavior monitoring policy as behaviors experienced. Staff B acknowledged the facility had not been addressing verbally aggressive altercations as potential verbal abuse and should have. Staff B further stated the facility had not protected residents from abuse. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to identify, monitor, investigate, report, and protect residents from abuse, as required. Reference WAC 388-97-0640 (1) Refer to F725 for additional information.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 47328 Based on interview and record review the facility failed to ensure a resident was not administered as needed injectable antipsychotics (medication that affected the brain, emotions, or behaviors) unless the medication was necessary to treat a specific condition documented in the clinical record for 1 of 6 sampled residents (Resident 19), reviewed for unnecessary medications. This failure placed residents at risk of side-effects from the medications, unnecessary chemical restraints, and a diminished quality of life. Findings included . According to the 04/10/2025 quarterly assessment, Resident 19 had severe cognitive impairment with inattention and disorganized thinking. The assessment further showed Resident 19 exhibited worsening verbal and physical behaviors directed towards others that significantly interfered with Resident 19's care, participation in activities or social events, placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. Review of October 2024 through March 2025 nursing progress notes showed Resident 19 exhibited verbally and physically aggressive behaviors towards others, loudly and persistently yelled, banged on walls, rummaged, was argumentative, impulsive, wandered, and was involved in recurrent resident-to-resident altercations. On 02/28/2025 Resident 19 threw water on a peer and attempted to go after them. Resident 19 had increased agitation, attempted to hit or kick staff as they walked by and required three staff to redirect Resident 19 to prevent resident to resident altercations. Resident 19 was transported to the emergency room for evaluation of their combative behaviors. A 03/01/2025 note at 5:21 AM showed Resident 19 slept without yelling or outbursts observed. At 7:08 AM, Resident 19 was administered a medication for nausea. A 4:25 PM note showed Resident yelling out through out day. 1:1 activities provided by writer as well as po [oral] fluids offered through out shift. Resident complaining of generalized discomfort, unable to identify cause. Review of the 02/28/2025 hospital after visit summary showed Resident 19 was seen for confusion and delirium (temporary confusion and disorientation). Resident 19 was given an oral antipsychotic while at the hospital and prescribed injectable Haldol (antipsychotic medication) as needed every four hours for agitation and delirium upon discharge. Review of provider orders showed a 02/28/2025 order for Resident 19 to be administered injectable Haldol every four hours as needed for agitation and delirium. Review of the March 2025 Medication Administration Record showed Resident 19 was administered injectable Haldol on 03/01/2025 at 3:21 PM with behavior observed marked as NO and effective results. Additional record review showed insufficient documentation to justify the administration of the injectable antipsychotic to treat a medical symptom. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 03/25/2025 progress note by Staff Z, Medical Doctor, showed Resident 19 struck a resident and was sent to the hospital emergency department. The hospital ordered an injectable antipsychotic but we don't do that here. In an interview on 05/22/2025 at 10:48 AM, Staff N, Resident Care Manager, explained as needed antipsychotic medications were limited to a 14-day period and required an adequate diagnoses for use because they should not be administered for something inappropriate with appropriate documentation in the medical record. Staff N further stated the facility did not utilize as needed injectable antipsychotics like Haldol. Staff N reviewed Resident 19's medical record. Staff N acknowledged Resident 19 was administered injectable Haldol on 03/01/2025 but there was poor documentation to justify the use. In an interview on 05/22/2025 at 11:02 AM, Staff B, Director of Nursing, stated they facility tried to limit orders for as needed antipsychotics. Staff B explained if as needed antipsychotics were used, there should be detailed behavior notes and justification for use in the medical record. Staff B reviewed Resident 19's medical record. Staff B acknowledged the 03/01/2025 documentation in Resident 19's medical record was not sufficient to justify or warrant administration of as needed injectable Haldol. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to adequately document if and/or when an as needed antipsychotic was administered. Reference WAC 388-97-0620 (1)(a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47328 Based on interview and record review the facility failed to repeatedly implement the facility abuse prevention policy to include identification of potential instances of abuse, reporting allegations to the State Survey Agency as required, thoroughly investigate allegations, review interventions for effectiveness, revise interventions as needed, and communicate, coordinate, review, and track allegations of abuse through the Quality Assurance and Performance Improvement (QAPI) program for 1 of 11 sampled resident (Resident 19), reviewed for abuse. This failure placed residents at risk of abuse, psychosocial harm, and diminished quality of life. Findings included . Review of the facility policy titled, Preventing Abuse revised August 2023 showed, the facility would identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property was more likely to occur. Staff were to observe residents, visitors and staff to identify inappropriate behaviors and deploy sufficient staff on each shift to meet the needs of the residents. The policy instructed staff to assess, care plan and monitor residents who exhibited behaviors which might lead to conflict such as verbally aggressive behaviors such as screaming, cursing, intimidating, or demanding behaviors and physically aggressive behaviors such as hitting, kicking, grabbing, scratching, biting, pushing, wandering, rummaging, threatening gestures, or throwing objects. Review of the facility policy titled, Identification and Investigation of Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin revised August 2023 showed, the facility reviewed reports of grievances, complaints, and allegations of abuse, neglect, injuries of unknown injury to identify a pattern or isolated incidents. The policy instructed staff to determine a root cause of any incident and evaluate the resident for signs of negative psychosocial impact of the incident to include fear of a person or place or extreme changes in behavior. The facility was to protect all residents from physical and psychosocial harm during and after the investigation by responding immediately to protect the alleged victim and provide increased supervision of the alleged victim and other residents as indicated. Staff were to immediately report all incidents and allegations of abuse to the CEO or designee, the State Survey Agency, and Law Enforcement if a crime was suspected. Once an incident was reported it was to be thoroughly investigated within five working days by conducting resident and staff interviews, determine root cause of the incident and implement corrective action to immediately address safety issues, updated care planned interventions based on the investigation findings, and complete staff training as indicated. According to the 04/10/2025 quarterly assessment, Resident 19 had severe cognitive impairment with inattention and disorganized thinking. The assessment further showed Resident 19 exhibited worsening verbal and physical behaviors directed towards others that significantly interfered with Resident 19's care, participation in activities or social events, placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility October 2024 through May 2025 incident report tracking log showed Resident 19 was involved in 11 resident-to-resident altercations with 10 different peers (Resident 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41) on the following dates: 10/16/2024, 11/07/2024, 01/11/2025, 01/13/2025, 02/10/2025, 02/27/2025, 03/08/2025, 04/04/2025, 04/11/2025, 04/25/2025, and 05/10/2025. Review of the facility resident-to-resident incident report investigations showed the following: -10/16/2024 contained only one statement, no other staff or resident interviews were included, and no documentation was found to show abuse or neglect was ruled out. -02/10/2025 (first altercation with Resident 31) contained only one statement, no other staff or resident interviews were included. -02/27/2025 contained only one statement, no other staff or resident interviews were included. Root cause was determined to be Resident 19 was agitated and within close proximity of another resident. The care plans were updated as indicated. Abuse and neglect was ruled out related to care plans being followed. Additional record review of Resident 19's care plan showed no documentation interventions were revised or new interventions implemented as indicated. -03/08/2025 Resident 19 initiated physical aggression towards Resident 21 and 43. The investigation did not contain staff or other resident interviews. Abuse and neglect was ruled out related to care plans being followed and incident occurred within line of site of staff. Resident 21 was educated to avoid Resident 19 and request staff remove Resident 19 from the vicinity. Resident 19's care plan was again updated as indicated. Additional record review of Resident 19's care plan showed no documentation interventions were revised or new interventions implemented as indicated. -04/04/2025 contained only one statement, no other staff or resident interviews were included, and no documentation was found to show abuse or neglect was ruled out. Root cause was determined to be Resident 19 had severe cognitive impairment with unknown situational comprehension. Resident 19 continued on 15-minute safety checks and the facility was refraining from adding 1 on 1 staff with [Resident 19] as it is believed this will cause further agitation. Care plan updated as indicated. Additional record review of Resident 19's care plan showed no documentation interventions were revised or new interventions implemented as indicated. -04/11/2025 Resident 19 initiated physical aggression toward Resident 45. The investigation contained no resident or staff interviews. Resident 45 was educated to avoid Resident 19 and not wear their headphones in the hallway. Abuse and neglect was ruled out because the care plan was being followed. Resident 19's care plan updated as indicated. -04/25/2025 (second altercation with Resident 31) while in the dining room with staff present but who did not observe the incident. The investigation contained no resident or staff interviews. Abuse and neglect was ruled out because the care plan was being followed. Resident 19's care plan updated to be within line of site of staff while in the dining room. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-05/10/2025 (third altercation with Resident 31) while near the nurses' station. The investigation contained two staff statements but no other resident interviews. Resident 31 was provided television headphones. Root cause was not established, and abuse and neglect was not ruled out. The provider reviewed Resident 19's medical record on 05/16/2025, six days after the incident occurred, and made recommendations for blood work and recommended adding a vitamin. Additional record review of Resident 19's care plan showed no documentation interventions were revised or new interventions implemented. Review of the 09/10/2024 self-care deficit care plan showed Resident 19 was able to self-propel their wheelchair (WC) independently. The 10/17/2024 care plan showed Resident 19 had potential to yell and strike out at other residents related to dementia and poor impulse control. Interventions included to assess and anticipate Resident 19's needs, give positive feedback, frequent safety checks when out of bed, reapproached with different staff when agitated, and maintain a consistent routine. On 11/01/2024 Resident 19 was placed on 15-minute safety checks around the clock, on 03/27/2025 a basket of favorite things was placed at the nurses' station for Resident 19 to rummage through, and on 04/28/2025 Resident 19 was to be in staff's direct line of sight when in the dining room for meals. Additional record review showed the facility did not re-evaluate interventions for effectiveness, modify interventions or implement new interventions to prevent recurrence of resident-to-resident altercations each time a resident-to-resident altercation occurred. Review of October 2024 through February 2025 nursing progress notes showed Resident 19 was involved in eight additional resident-to-resident altercations on the following dates 10/28/2024, 11/28/2024, 12/06/2024, 01/01/2025, 01/26/2025, 02/11/2025, 02/19/2025, and 02/25/2025 not identified on the facility accident and incident log, not reported to the State Survey Agency, or investigated, as required. The incident investigations were requested on 05/19/2025 at 5:22 AM, from Staff A, Administrator. Only one of the eight requested incident investigation was provided, 01/26/2025. Review of the October 2024 through April 2025 QAPI committee minutes showed the following: -10/29/2024 No documentation found to show allegations of abuse, investigations, and corrective action was tracked by QAPI to ensure a thorough investigation was conducted, ensure residents were protected, an analysis was conducted as to why the situation occurred, review of risk factors contributing to abuse, and if there was a need for systemic action to be taken. -01/21/2025 The facility self-reported three allegations that were unsubstantiated. -04/30/2025 No documentation found to show allegations of abuse, investigations, and corrective action was tracked by QAPI to ensure a thorough investigation was conducted, ensure residents were protected, an analysis was conducted as to why the situation occurred, review of risk factors contributing to abuse, and if there was a need for systemic action to be taken. In an interview on 05/14/2025 at 10:25 AM, the resident council stated Resident 19 wandered, was disruptive, and aggressive towards others. The council explained Resident 19 was spontaneous, unpredictable, with quickly fluctuating behaviors and could be smiling and friendly one minute then flying off the handle at residents and staff the next minute. The council voiced feeling unsafe due to Resident 19's continued behaviors. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/19/2025 at 8:00 AM, Staff E, Social Service Coordinator, stated resident behaviors were tracked by nursing staff via nursing progress notes, social services and the provider would be notified of odd or abnormal behaviors so additional follow up could be done. Staff E further stated allegations of potential abuse were investigated by conducting resident and staff interviews to get a broader picture of the incident. Staff E was asked if instances of resident-to-resident altercations were considered abuse. Staff E explained if there was physical contact then yes that was definitely an allegation of abuse but instances of yelling back and forth were not considered potential abuse unless the yelling involved threats. Staff E stated Resident 19's mood and behaviors could quickly randomly fluctuate and escalate to the point of being too ramped up to calm down. Staff E explained Resident 19 enjoyed to self-propel their WC up and down the hall but that could create resident-to-resident altercations because Resident 19 would get upset when peers were in the way and lashed out physically. Staff E acknowledged Resident 19's behaviors placed them and others at risk for abuse and unfortunately Resident 19 was involved in the most resident-to-resident altercations. Staff E explained Resident 19 had been involved in resident-to-resident altercations even while on 15-minute safety check monitoring because Resident 19 was mobile, and it was difficult to anticipate what would trigger them. Staff E acknowledged staff should protect residents from abuse. In an interview on 05/19/2025 at 8:55 AM, with Staff B, Director of Nursing, and Staff C, Clinical Resource Nurse. Staff B reviewed Resident 19's medical record. Staff B acknowledged Resident 19 enjoyed self-propelling their WC throughout the facility, had quickly fluctuating verbally and physically aggressive behaviors towards others that placed them at risk for abuse. Resident 19 was involved in numerous verbal and physical resident-to-resident altercations even while on 15-minute safety checks. Staff B explained if a resident exhibited physical behaviors towards others it was reported, investigated, and addressed as potential abuse but verbally aggressive behaviors were documented and monitored per the facility behavior monitoring policy as behaviors experienced. Staff B acknowledged the facility had not been addressing verbally aggressive altercations as potential verbal abuse and should have. Staff B further acknowledged the facility had not protected residents from abuse. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to implement the facility's abuse prevention policy and identify, monitor, investigate, report, and protect residents from abuse, as required. Reference WAC 388-97-0640 (2) Refer to F600, F725, F867, and F865 for additional information.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to coordinate with the State designated authority to ensure residents with a mental disorder received integrated care based on their needs for 3 of 7 sampled residents (Residents 34, 37, and 40) reviewed for Pre-Admission Screening and Resident Review (PASRR, a two part screening; Level I determined presence of a Severe Mental Illness, SMI, or Developmental Disability and if present required a Level II evaluation by a specialized evaluator to determine if nursing home placement was the appropriate level of care, and what behavioral health or other community services were recommended. A Level II was required to be completed prior to nursing home admission.) Specifically, the facility failed to ensure Resident 34's PASSR level II recommendations were implemented, Resident 40's Level II evaluation was completed timely, and Resident 37's Level I screening was not completed correctly prior to admission. These failures placed the residents at risk of decline in their psycho-social needs or inability to benefit from all services they were entitled to. Findings included . <Resident 34> The 04/08/2025 admission assessment documented Resident 34 had diagnoses that included anxiety, alcohol dependence, and history of other behavioral disorders. The resident was cognitively intact and made decision regarding their healthcare. A review of the record documented Resident 34 transferred to the facility from a nursing facility located in a neighboring county to be closer to family. A PASRR Level II Behavioral Health Notice of Determination completed on 02/14/2025 documented Resident 34 had a mental health diagnosis and may benefit from specialized behavioral health services. Upon further review of the record, there were no orders for a behavioral health referral and no behavioral health provider evaluations or progress notes. During an interview on 05/16/2025 at 9:09 AM, Resident 34 stated they wanted to get well and regain the ability to walk. Resident 34 stated they knew they would have to work hard because they were an alcoholic and addict and without support, it was easy for them to go back to their old ways, and Resident 34 stated they did not want to do that. <Resident 40> The 03/26/2025 quarterly assessment documented Resident 40 had diagnoses that included delusions (persistent belief in false thoughts in spite of contrary evidence) and major depression with psychotic symptoms (a disconnection from reality). Resident 40 was moderately cognitively impaired and took antipsychotic and antidepressant medications daily. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the record documented Resident 40 admitted to the facility 12/15 2022 from a neighboring state. The 12/16/2022 PASRR Level I screening indicated no Level II evaluation was necessary at that time. A 04/21/2024 Physician Assistant (PA) progress note documented Resident 40 was still delusional despite an increase in their antipsychotic medication. There were no recommendations for a behavioral health referral or changes to the resident plan of care. A new PASRR Level I was completed on 05/08/2024, indicated the resident had SMI, and a Level II evaluation was indicated related to behaviors of self-isolation, delusions and hallucinations. The Level I was submitted to the State evaluator agency. A review of Staff E, Social Services Coordinator progress notes documented the PASRR Level II request was resent on 05/08/2024. Resident 40 continued to have delusions, distressing hallucinations and dreams. In early December 2024, Staff E called the PASRR evaluator and was told they were back logged and concentrated on hospital patient evaluations first. There were no other progress notes that indicated the status of the Level II evaluation request was followed up on. During an interview on 05/19/2025 at 6:48 AM, Staff E stated they resubmitted a PASRR screening for Resident 40 in May of 2024. They stated if they had not heard back from the evaluators, they sent an email, and the evaluators had been good about answering. Staff E stated they had not reached out to the evaluators regarding Resident 40 since December of 2024, and acknowledged this was not timely. Staff E stated Resident 37 had Level II behavioral health recommendations but had not followed up and acknowledged Resident 37 had not been referred to any behavioral health services. <Resident 37> A record review documented Resident 37 was admitted on [DATE]. A 04/23/2025 quarterly assessment documented Resident 37 had diagnoses that included lung cancer and depression. Resident 37 was cognitively impaired, had a depression evaluation (PHQ9) score of 14 related to feeling bad about themselves, having little energy, having little pleasure or interest in doing things and feeling down. Resident 37 took an antidepressant medication daily. A Level I PASRR dated 01/14/2025 incorrectly documented Resident 37 had no SMI and a Level II evaluation was not indicated. During an interview on 05/12/2025 at 3:28 PM, Resident 37's spouse stated Resident 37 took antidepressant medicine and had been taking it for years because of depression. During an interview on 05/20/2025 at 2:07 PM, Staff E, Social Services Coordinator, stated PASRRs were reviewed by them and the admission nurse upon admission to ensure they were completed correctly. Staff E was unaware that Resident 37's PASRR Level I screening showed no SMI. Staff E stated Resident 37 began having behaviors in February 2025 so a request for a Level II evaluation was completed and submitted. Staff E agreed the Level II should have been completed prior to Resident 37's admission related to their history of depression. Reference: WAC 388-97-1915(4) (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F740 for additional information.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review the facility failed to ensure services provided consistently and routinely met professional standards of practice for 2 of 4 sampled residents (Resident 51 and 19), reviewed for hospitalization s. Specifically, the facility failed to repeatedly ensure resident hospital transfer documentation was completed as required to include the basis for hospital transfer, specific resident needs unable to be met by the facility, facility attempts to meet the needs, services available at the receiving facility to meet needs, and what information was conveyed to the receiving provider. This failure placed residents at risk of potential delays in emergent hospital treatment, unmet care needs, and potential complications. Findings included . Review of the facility policy titled, Documentation of Resident Health Status Needs and Services revised October 2022 showed, staff were to document in a resident's medical record as soon as the encounter concluded to ensure accurate recall of the data. The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress including their response to treatments and/or services, and changes in their condition, plan of care goals, objectives and/or interventions. The policy instructed staff to record pertinent resident data that may include change of condition, infection, illness, actions taken, provider and family notifications, consultations, any unusual or abnormal outcomes, decline in activities of daily living, events and accidents and communications with others regarding the resident. The American Nurses Association (ANA) is a national professional organization that represents the interests of registered nurses in the United States and sets and promotes high standards of nursing practice to ensure quality and ethical care for patients. The ANA developed the document, Nursing: Scope and Standards of Practice, with its fourth edition released in 2021. The resource informs and guides nurses in providing safe, quality, and competent patient care. The resource outlined and described 18 standards of practice for nursing professionals to follow. Review of the Nursing: Scope and Standards of Practice resource showed the first six standards included: 1. Assessment: effectively collect data and resident information that is relative to their condition or situation. 2. Diagnosis: analyze the data gathered during the assessment phrase, to determine potential or actual diagnoses. 3. Outcomes Identification: effectively predict outcomes for the resident. 4. Planning: After identifying a diagnosis and outcomes, develop a plan or strategy to attain the best possible outcome for the resident in need. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Implementation: Implement the identified plan. This may be done by coordinating care for the residents, such as administering treatment, or implementing/following provider orders. 6. Evaluation: After implementation, a nurse must monitor and evaluate the patient's progress towards the expected outcome or health goals. <Resident 51> Review of a 05/04/2025 admission assessment showed Resident 51 admitted to the facility on [DATE] with medically complex conditions to include cancer, high blood pressure, and the presence of a pacemaker (a small, battery-powered device that is surgically implanted to help control the heart's rhythm). The assessment showed the resident had moderate cognitive impairment. Additional review of the record showed Resident 51 had two designated Emergency Contacts. Review of a 04/30/2025 progress note showed Resident 51 readmitted from the hospital. The note prior to 04/30/2025 was documented on 04/24/2025 and showed no change in condition. Review of a Census List showed Resident 51 went to the hospital on 04/25/2025. Additional review of the record showed no information that showed how the nurses assessed Resident 51 and the result of their assessment, what care needs were identified prior to the transfer, discussed the transfer with the resident and addressed their concerns, the reason for the resident's subsequent transfer to the hospital, that the provider or emergency contacts were notified, or what information was conveyed to the receiving hospital. The above findings were shared with Staff N, Resident Care Manager (RCM), on 05/15/2025 at 8:56 AM. Staff N said they expected the nurse to document information relevant to hospital transfers on the Emergent Transfer form. The Emergent Transfer form showed documents sent to the receiving hospital at the time of transfer including an assessment of the resident in a Resident Transfer Form (Evaluation or InterAct) and who was notified of the transfer event. Staff N stated there should be a progress note that detailed the account of the circumstances that led to Resident 51's transfer to the hospital, to include how the nursing process was applied to show an assessment of the resident, looking at the information gathered during the assessment phase, determining what could be causing the change in condition, and notifying the provider based on the likely outcome of the assessment. <Resident 19> According to the 04/10/2025 quarterly assessment, Resident 19 had severe cognitive impairment with inattention and disorganized thinking. The assessment further showed Resident 19 exhibited worsening verbal and physical behaviors directed towards others that significantly interfered with Resident 19's care, participation in activities or social events, placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. Review of after visit hospital summaries showed Resident 19 was transferred to the hospital on 09/12/2024, 01/13/2025, 02/26/2025, 02/28/2025, 03/03/2025, and 03/08/2025 for various reasons. Review of September 2024 through April 2025 nursing progress notes showed the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-01/14/2025 Resident 19 was transferred to the hospital after they sustained a fall. No documentation was found to show the specific resident needs the facility was unable to meet, facility attempts to meet the needs, services available at the receiving facility to meet needs, and what information was conveyed to the receiving provider. -03/03/2025 Resident 19 was hospitalized . No documentation was found to show the specific resident needs the facility was unable to meet, facility attempts to meet the needs, services available at the receiving facility to meet needs, and what information was conveyed to the receiving provider. -04/11/2025 Resident 19 was transferred to the hospital related to combative behaviors towards staff. No documentation was found to show services available at the receiving facility to meet needs, and what information was conveyed to the receiving provider. Review of December 2024 through March 2025 provider progress notes showed Resident 19 was transferred to the hospital on 12/27/2025 after they sustained a fall with a femur fracture, on 03/03/2025 after they sustained a fall out of their wheelchair, and on 03/25/2025 after they were involved in a resident-to-resident altercation. Additional review showed no documentation the required information was conveyed to the hospital. Review of the 04/11/2025 emergent transfer assessment showed Resident 19 was transferred to the hospital for agitation and violent behaviors, documentation showed all the required information was not conveyed to the receiving facility. In an interview on 05/22/2025 at 10:56 AM, Staff D, RCM, reviewed Resident 19's medical record. Staff D acknowledged omissions in documentation related to hospital transfers. Staff D acknowledged staff should document the reason for hospital transfer and the information conveyed to the hospital which shows the nursing process and professional standards of practice. In an interview on 05/22/2025 at 11:07 AM, Staff B, Director of Nursing, stated if a resident was transferred to the hospital, they expected staff to document information conveyed to the hospital, as required. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to document information conveyed to the hospital when transfers to hospital occur, as required. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i). Refer to F552 and F745 for additional information.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure the staff notified the provider for 3 of 3 sampled residents (Resident 34, 40 and 61) reviewed for change in condition. Specifically, the staff failed to notify the provider when Resident 34 experienced extremely low blood sugars, Resident 40 experienced significantly low blood pressures (BP), and Resident 61 experienced elevated blood sugars. This failure precluded the provider's involvement in coordinating care and placed the residents at risk of further adverse or deteriorating clinical outcome. Findings included . The 11/28/2017 facility policy Resident Change of Condition documented that upon recognition of a potentially life-threatening condition or significant change in status, the nurse was to communicate with other health care providers. The physician was to be informed at the time of the event as soon as possible. Notification should occur immediately if any symptom, sign or apparent distress is sudden in onset, or a marked change in relation to usual symptoms and signs or unrelieved by measures already prescribed. In addition to others, staff were to document the resident assessment, care provided, physician response, orders, and resident status and response. <Resident 34> The 04/08/2025 admission assessment documented Resident 34 had diagnoses that included end-stage kidney disease dependent on dialysis (a mechanical way of ridding the body of toxins when the kidneys no longer functioned) and diabetes. Resident 34 was cognitively intact and received daily insulin injections. The 04/02/2025 Diabetes Care Plan instructed staff to consult with the Registered Dietician regarding dietary restrictions and compliance with nutritional regimen as indicated, administer diabetic medications as ordered and monitor for side effects. If hyperglycemic (a blood sugar level greater than 300 milligrams per deciliter, mg/dl) follow insulin medication orders or contact the provider and follow orders. If hypoglycemic (a blood sugar level less than 70mg/dl) treat according to the hypoglycemic protocol. Document the treatment, interventions, symptoms and assessment in progress notes. Resident 34 had the following provider orders: -04/02/2025 check fingerstick blood sugar levels before meals and at bedtime. If result is below 70mg/dl, initiate hypoglycemic protocol and notify the provider. If greater than 400mg/dl, notify the provider and follow directives. -04/02/2025 hypoglycemic protocol-if able to take oral, give 15mg fast-acting carbohydrate (a type of nutrition that contains sugar), recheck blood sugar in 15 minutes. If still less than 70, give another 15gm fast acting carbohydrate. Recheck in 15 minutes. If still less than 70mg/dl, notify the provider. Once above 70mg/dl, give a protein snack or assist to next meal. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-04/02/2025 glucagon (a type of sugar) pen-type auto injector, inject 1mg as needed for blood sugar less than 70mg/dl and the resident is unable to swallow. Recheck in 15 minutes. If no improvement, notify the MD immediately. May repeat the process. On 05/06/2025 at 8:37 AM, Staff M, Licensed Practical Nurse (LPN), documented Resident 34 had a fingerstick blood sugar level of 46 and required two doses of fast-acting oral glucose gel (per the hypoglycemic protocol). At 8:49 AM, the resident moaned, groaned, was very lethargic, drifted off to sleep, then briefly woke to call out for water or help. Resident 34 stated at that time, I do not want to die. The progress note also documented Resident 34 had a low oxygen saturation level of 86% (normal level ranges from 95 to 100% on room air) while receiving supplemental oxygen at 2 liters (L). This required the supplemental oxygen to be increased to 3L. The Resident Care Manager was notified, and Staff M documented they would recheck the resident's blood sugar in 10 minutes. There was no documentation that the blood sugar level was rechecked, that the resident's oxygenation status was rechecked, or that the provider was notified of the resident's condition. The May 2025 Medication Administration record (MAR) had no documentation of the administration of the fast-acting glucose gel. Furthermore, Staff M's progress notes documented that at 11:27 AM, Resident 34 refused all oral medications. At 12:17 PM, the resident was ill with Norovirus and ate and drank poorly. At 12:36 PM, the resident's blood sugar was 118 mg/dl. The resident had large loose foul-smelling diarrhea. The resident continued to require extra supplemental oxygen for levels that hovered around 88-90%, and their oxygen levels dropped if the resident talked. The resident slept for long intervals, then moaned and groaned when awake and stated they did not want to die. The progress note did not document that the provider was notified. <Resident 40> The 03/26/2025 quarterly assessment documented Resident 40 had diagnoses that included stroke and high blood pressure. Resident 40 was moderately cognitively impaired and was dependent on staff for most of their activities of daily living. The 01/04/2023 stroke care plan instructed staff to give medications as ordered, monitor and document side effects and effectiveness, and obtain vital signs (heart rate, blood pressure, respirations or temperature, for example) per protocol, and document and advise the provider of abnormal findings. A review of the May 2025 Medication Administration Record documented Resident 40 required alert charting for gastroenteritis beginning 05/05/2025 and discontinued on 05/10/2025. Staff were to document signs and symptoms, if symptoms improved or worsened, vital signs, adverse side effects if antibiotics had been ordered every shift for monitoring. Further review of the MAR documented a blood pressure of 88/60 (extremely low) on 05/06/2025, 05/07/2025, and 05/08/2025. On 05/09/2025, blood pressures of 92/64 and 90/60 were recorded. Medication Resident 40 took for managing their high blood pressure met parameters and was held on 05/07/2025 and 05/08/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 05/05/2025 at 1:05 AM nursing progress note documented the resident slept when checked, and their blood pressure was recorded as 142/64. At 2:42 PM, the resident had nausea and was given anti-nausea medication. There were no other progress notes until 05/09/2025 that documented the nausea/vomiting/diarrhea alert charting was discontinued. There were no progress notes that documented assessments of the resident when their blood pressure results were low, and no note that documented the provider was notified. During an interview on 05/22/2025 at 11:50 AM, Staff M, LPN, reviewed the blood pressures of 88/60 that Staff M had entered on the MAR. They stated they did not remember talking to any providers about the low blood pressures and stated Resident 40 did not normally run low and this would have indicated a change for the resident. Staff M stated if Resident 40 had been ill, the low blood pressures could indicate the resident was dehydrated and they would want the provider to know. Staff M stated they took care of Resident 34 on 05/06/2025. The resident was not eating, and medications were held. Staff M stated they thought they spoke to the Nurse Practitioner but was unable to see where that had been documented. Staff M stated any vital signs that were out of the normal range was to be reported to the provider and this was not done and should have been. Staff M acknowledged they also did not document the administration of the fast-acting glucose gel and should have. During an interview on 05/22/2025 at 2:24 PM, Staff O, Nurse Practitioner, stated when a resident was sick and had abnormal vital signs, it could signal that they were dehydrated or might require a visit to the emergency room and they would want to be notified of low blood sugars and low blood pressures. 40297 <Resident 61> Review of a 04/27/2025 admission assessment showed Resident 61 admitted to the facility on [DATE], was assessed as cognitively intact, and had the diagnosis of diabetes. Review of Resident 61's April and May 2025 Medication Administration Record (MAR) showed the staff administered insulin to the resident. The MAR instructed the nurses to check the resident's blood sugar before meals and at bedtime and to notify the provider if the blood sugar was greater than 300 and follow their instruction. Review of the April 2025 MAR showed the staff obtained blood sugars above 300 on 04/21/2025 at 4:30 PM at 401, 04/21/2025 at 8:00 PM at 401, 04/28/2025 at 8:00 PM at 315, and 04/30/2025 at 4:30 PM at 322. Additionally, no blood sugar measurements were recorded as obtained on 04/25/2025 at 8:00 PM. Review of the progress notes showed no documentation why the staff did not obtain the blood sugar on 04/25/2025 or that they notified the provider as ordered to obtain further instructions for the management of the elevated blood sugars. Review of the May 2025 MAR showed the staff obtained blood sugars above 300 on 05/10/2025 at 8:00 PM at 338. Additionally, no blood sugar measurements were recorded as obtained on 05/02/2025 at 8:00 PM. Review of the progress notes showed no documentation why the staff did not obtain the blood sugar on 05/02/2025 or that they notified the provider as ordered to obtain further instructions for the management of the elevated blood sugar. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above findings were reviewed with Staff C, Clinical Resource Nurse, on 05/16/25 at 9:57 AM. Staff C acknowledged the elevated blood sugars, the missing blood sugar measurements, and confirmed there was no documentation in the medical record that showed the nurses notified the provider of the elevated blood sugars above 300 as ordered. Reference WAC 388-97-1060 (1) Refer to F760 for additional information.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 47328 Based on observation, interview, and record review, the facility failed to consistently provide effective monitoring and supervision, implement interventions, develop adequate and effective interventions to prevent repeated falls with adverse and injurious sequelae related to those falls for 3 of 7 sampled residents (Residents 19, 50, and 60), reviewed for falls. Resident 19 experienced harm when they had repeated falls as evidenced by a dislocated hip on 09/12/2024, a right femur (leg bone) fracture on 01/14/2025, and a back fracture on 03/03/2025. Resident 50 experienced harm when they fell a total of 36 times between 04/04/2024 to 05/17/2025 and sustained a range of injuries, to include hospital transfers for their treatment. Resident 60 experienced harm when they fell and sustained a fracture to their eye socket and left lower leg and had a delay in discharge to the community. These failures placed the residents at risk for further repeat serious injuries such as fractures, disability, or death and represented an immediate jeopardy (IJ). In addition, the facility failed to assess, evaluate, and implement interventions for potential risks associated with substance use disorders (SUD) for 1 of 3 sampled residents (Resident 49), reviewed for SUD. On 05/20/2025 at 5:40 PM, the facility was notified of the identified IJ related to F689 CFR S483.25 Accidents and Supervision. Onsite verification by surveyors on 05/23/2025 at 10:25 AM showed, the facility removed the immediacy by placing both Resident 19 and 50 on one to one (1:1) supervision. The survey team verified the facility educated all staff to the policies and procedures for accident prevention and fall interventions, including notification to management of ineffective fall interventions. The facility reviewed accidents that occurred the past 30 days to ensure care planned interventions were resident specific. The facility reviewed Resident 19 and 50's care plans and ensured interventions were pertinent to the root-cause of the falls. Resident 60 discharged from the facility on 05/19/2025. Findings included . Review of the facility policy titled, Fall Response and Management revised May 2021 showed, nursing staff would assess a resident who had fallen for injuries, obtain vital signs, document the fall in the resident's medical record, notify the family and provider, and immediately implement interventions to prevent a repeat fall. For a fall with injury staff was to evaluate the resident's injury, assess for pain, provide first aide as needed for minor injuries, determine whether head trauma was experienced, monitor neurologic assessments (neuro and/or neuro checks, a series of tests that assess mental status, reflexes, movement, and pupil reaction to evaluate brain and nervous system function), notify the family and provider. The policy further showed staff were to determine causal factors of a fall, revise the residents care plan with interventions, and communicate the fall and intervention changes to staff. Review of the Neurological Evaluation Flow Sheet used by the facility to assess for any neurological changes instructed staff to complete a neuro evaluation with vital signs every 15 minutes for one hour then every hour for four hours then every four hours for 20 hours. The form included a graph to document the required information on. <Resident 19> (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the 04/10/2025 quarterly assessment, Resident 19 admitted to the facility on [DATE] with diagnoses including weakness, dementia, and hip fracture. The assessment further showed Resident 19 had severe cognitive impairment and required substantial staff assistance for transfers. Resident 19 sustained two or more non-injury falls since their admission. Review of the 09/10/2024 hospital discharge summary showed Resident 19 sustained a fall that resulted in a right hip fracture. Resident 19's right hip was surgically repaired, and they discharged to the facility. Review of the facility September 2024 through May 2025 incident report tracking log showed Resident 19 sustained 15 falls on the following dates: 09/12/2024, 10/10/2024, 10/16/2024, 10/25/2024, 10/30/2024, 11/20/2024, 12/10/2024, 12/19/2024, 12/23/2024, 01/14/2025, two falls 03/07/2025, 03/22/2025, 05/02/2025, and on 05/12/2025. Review of October 2024 through May 2025 nursing progress notes showed Resident 19 additionally sustained falls on 12/06/2024 and on 03/03/2025 in the dining room that resulted in a hospital transfer, not identified on the facility accident and incident log. The 12/06/2024 and 03/03/2025 facility fall incident reports were requested from Staff A, Administrator, on 05/19/2025 at 5:22 AM. No documentation was provided. Review of the facility fall incident reports showed the following: - 09/12/2024 Resident 19 fell near their bed when self-transferring to the bathroom and was transported to the hospital for evaluation related to right hip pain. Resident 19's recently surgically repaired hip was displaced and required sedation to reinsert the hip. - 10/10/2024 Resident 19 fell while self-toileting and reached down to pull up their pants. Omission in neuro check documentation. - 10/16/2024 Resident fell at the nurses' station reaching for an item out of reach. Resident 19 sustained a skin tear to their right hand. - 10/25/2024 Resident 19 fell when attempting to make their bed and their wheelchair (WC) rolled away. Anti-roll back WC brakes were to be implemented. - 10/30/2024 Resident 19 fell when they stood up in the dining room and their WC rolled away. Again, anti-roll back WC brakes were to be implemented. - 11/20/2024 Resident 19 fell when they attempted to self-transfer into bed. Staff was educated on putting Resident 19 to bed upon request. No documentation of staff education was provided. Omission in neuro check documentation. - 12/10/2024 Resident 19 slid off the toilet and hit their head on the wall. Resident 19 was educated on use of the call light. Staff was educated on toileting Resident 19 before and after meals. No documentation of staff education was provided. Omission in neuro check documentation. (continued on next page)

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	505275	A. Building B. Wing	05/23/2025

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- 12/19/2024 Resident 19 fell next to their closet and sustained a left-hand skin tear. Therapy was to possibly increase ambulation in a restorative nursing program. Omission in neuro check documentation. - 12/23/2024 Resident 19 ambulated out of the bathroom using their roommate's walker. Staff educated to keep the roommate's walker out of Resident 19's sight. No documentation of staff education was provided. - 01/14/2025 Resident 19 again fell reaching for an item out of reach while at the nurses' station. Root cause identified as Resident 19 did not request or accept assistance from staff. Resident 19 sustained a right femur peri-prosthetic (around the artificially replaced hip) fracture that required surgical repair. - 03/07/2025 at 4 AM Resident 19 fell out of bed on the opposite side of the fall mat. All interventions in place continue current care plan, and frequent rounding. - 03/07/2025 at 5:45 PM Resident 19 again fell out of bed. A fall mat was added to both sides of the bed. Omission in neuro check documentation. - 03/22/2025 Resident 19 was found on the floor in their room again on the opposite side of fall mat. Fall mats were again added to both sides of the bed. Omission in neuro check documentation. - 05/02/2025 Resident 19 was on the floor. Root cause was determined to be recent illness involving nausea, vomiting, and diarrhea. Staff were to monitor and treat symptoms as able and provide frequent toileting. - 05/12/2025 Resident 19 was on the floor next to their bed. A perimeter mattress was added. Omission in neuro check documentation. Review of the 01/23/2025 falls care plan showed Resident 19 was at risk for falls related to confusion, history of falls, and poor safety awareness. Interventions instructed staff to keep the door to the room open, reinforce safety awareness, maintain the floor free of clutter, and monitor for injuries when falls were sustained. A 11/21/2024 intervention showed Resident 19 was to have a fall mat on the exit side of the bed, 12/23/2024 a call for assistance sign was placed in the room, 12/31/2024 encourage Resident 19 to use the bathroom before and after meals, 03/03/2025 Resident has the right to fall, and 05/13/2025 perimeter mattress was added to define the edges of the bed. Additional record review showed care plan interventions were not reviewed and/or revised each time Resident 19 sustained a fall. Review of the 09/12/2024 hospital after visit summary showed Resident 19 right hip was dislocated and was given sedation to reinsert the hip back into the socket. Review of the 01/21/2025 hospital discharge summary showed Resident 19 sustained a per-prosthetic right femur fracture which required surgical intervention for repair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the 03/03/2025 Computed Tomography (CT, medical imaging that create detailed images of the inside of the body) imaging showed Resident 19 fell out of their WC which resulted in back and hip pain. The imaging results showed a significant back fracture likely acute [new onset] given the history of fall and tenderness. In an interview on 05/20/2025 at 9:50 AM, Staff K, Nursing Assistant, stated when a fall occurred, they notified the nurse so they could assess the resident for potential injuries and implement neuro checks when falls occurred, documenting them on the paper form. Staff K further stated new fall interventions needed to be implemented immediately to prevent recurrent falls and potential injuries. Staff K acknowledged Resident 19 sustained a few falls even while on 15-minute safety checks. In an interview on 05/20/2025 at 10:04 AM, Staff L, Registered Nurse, stated residents were assessed for fall risk upon admission, after falls, with changes of condition, and quarterly. A fall was a change in plane. Staff L explained when a fall occurred residents would be assessed for injuries, completed a fall report, notify the family, nurse management and provider. Neuro checks were to be initiated when a head injury was witnessed or if a fall was unwitnessed, documenting them on the paper form in the fall packet. Staff L acknowledged a new fall intervention needed to be implemented immediately because residents could fall again in the window of time it took to implement the intervention. Staff L acknowledged Resident 19 sustained repeat falls some with some requiring hospital transfer and fractures sustained even while they were on 15-minute safety check monitoring. In an interview on 05/20/2025 at 1:00 PM, Staff B, Director of Nursing, explained the facility fall process. Staff B stated a fall was a change in plane, a new fall intervention needed to be implemented immediately after a fall occurred to prevent recurrence, and neuro checks completed for unwitnessed fall or falls with head injury, documenting them on the paper form. Staff B reviewed Resident 19's medical record. Staff B acknowledged Resident 19 sustained a fall on 09/12/2024 that resulted in dislocation of the recently surgically repaired hip, a fall on 01/14/2025 that resulted in a right femur fracture, and on 03/03/2025 that resulted in a broken back. Staff B stated they expected staff to follow all the appropriate steps when a fall occurred. 40297 <Resident 50> Review of a 04/07/2025 quarterly assessment showed Resident 50 admitted to the facility on [DATE] with medically complex conditions, to include dementia, repeated falls, and impaired vision. This assessment showed the resident had moderately impaired cognition, required supervision or touching assistance from the staff for ADLs (Activities of Daily Living) and experienced falls since their admission to the facility or their prior assessment. The assessment showed Resident 50 was always continent of bowel and bladder and was not on a toileting program. In an observation on 05/15/25 at 8:36 AM, Resident 50 was seated in their wheelchair, eating their breakfast in front of a small table against the wall. The call light was approximately five feet away from the resident, clipped to its own cord attached to the wall above the bed. Signage on the opposite wall showed instructions that said, Play it safe. Use your call light for help. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview and observation on 05/12/2025 at 10:55 AM showed Resident 50 in bed and stated, I fall quite frequently. I have progressive palsy (loss or reduction of movement in a part of the body, often accompanied by shaking or trembling) and they've gone over things that I do that cause the falls like how I turn and so forth. The resident said they had fallen five times since admission to the facility. Review of Resident 50's 11/04/2024 care plan showed the staff identified the resident fell because of dementia, an unsteady walk, leaning forward in their wheelchair to pick items up from the floor and transferring from bed or wheelchair unassisted. The care plan showed the 04/05/2024 goal of the resident will be free of fall related injuries. The care plan informed the staff Resident 50 required assistance for transfers. The care plan showed that on the day of admission, 04/05/2024, the staff added the following interventions, Provide direct supervision while resident is toileting, Reinforce safety awareness: use call light, lock brakes on chair before transferring. When rising from a lying position, sit/rest at edge of the bed at least 10 seconds before transferring, Respond to resident requests timely. Anticipate needs. Keep call light and bedside table items within reach. On 12/01/2024, the staff added, Pharmacist to review medications quarterly and prn when falls occur to address fall risk side effects. Develop plan with risks and benefits as indicated. On 01/06/2025, the staff added, will get ice cream if [the resident] does not have a fall in 30 days. On 02/05/2025, the staff added, Resident agreed to wear pull ups at night for urine urgency. On 04/21/2025, the staff added, make sure to help remind [resident] to position the wheelchair at a 45-degree angle facing the bed, so that [the resident] can still reach the arm rests and make small steps, and travel a shorter distance, to decrease risk of falls. On 05/08/2025, the staff added, Educate resident to call out for help and to wait for assistance as it is [their] preference not to use the call light. Review of a toileting care plan initiated on 04/05/2024 showed Resident 50 was continent of urine and required assistance to the bathroom. The care plan informed the staff on 04/05/2024 the resident, manages toileting and incontinent episodes and assist with maintaining supplies as needed and to toilet the resident with morning and afternoon cares, before meals, at bedtime and as needed. On 01/14/2024, the care plan instructed the staff to place a stack of washcloths on bedside table for resident use. On 01/28/2025, the care plan instructed the staff to help the resident use the urinal by lowering their pants to their knees, tuck folded washcloth under penis (Keep stack on bedside table), and Wait a minute before removing cloth until dribbling stops. A 04/05/2024 ADLs care plan showed on 05/13/2024, it instructed the staff to complete Frequent rounding with the 4P's to help anticipate resident needs. Help keep room free from clutter. The 4P's stand for: Pain, Position, Placement, and Personal Needs. This approach may be used by anyone who entered a resident room for any reason to help prevent falls and developed a culture that checked in with the resident and addressed their needs at different times of the day. Review of progress notes from 04/05/2024 to 05/17/2025 showed staff identified Resident 50 fell frequently, was impulsive, forgetful to use their call light, and self-transferred in and out of bed or wheelchair. Documentation showed the staff continued to ask the resident to use the call light or call for help even though it was identified Resident 50 was impulsive and does not call for help/assistance with transfers or mobility and transfers without use of call light. Sometimes will yell help when is about to fall or needs help. Requires frequent reminders. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the progress notes showed Resident 50 fell 36 times (4/30/2024, 05/03/2024, 05/06/2024, 05/09/2024, 05/11/2024, 05/17/2024, 05/22/2024, 06/04/2024, 06/14/2024, 07/18/2024, 08/01/2024, 08/26/2024, 09/20/2024, 10/27/2024, 11/04/2024, 11/11/2024, 12/16/2024, 01/12/2025, 01/19/2025, 01/25/2025, 02/02/2025, 02/14/2025, 02/16/2025, 03/04/2025, 03/07/2025, 03/25/2025, 03/26/2025, 03/26/2025, 04/03/2025, 04/19/2025, 04/24/2025, twice on 05/03/2025, 05/05/2025, 05/14/2025, and 05/17/2025) from 04/05/2024 to 05/17/2025. Review of the electronic medical record from 04/05/2024 to 05/17/2025 showed Resident 50 experienced injuries of varying severity related to 36 falls that included abrasions (05/09/2025, 05/11/2024, 06/14/2024, 07/18/2024, 08/01/2024, 11/11/2024), contusions (an injury to soft tissue that causes bleeding beneath the skin, usually without breaking the skin itself, 08/01/2024, 08/26/2024, 11/11/2024, 03/27/2025), lacerations (08/01/2024, 08/26/2024, 02/02/2025) closed head injuries (08/01/2024, 03/27/2025), swelling to right side of forehead (10/27/2024), skin tears (03/04/2027, 03/07/2025, 04/20/2025), and multiple transfers to the Emergency Department (08/01/2024, 02/02/2025, 05/07/2025). Review of progress notes and investigative review documents associated with the falls showed no documentation the facility evaluated why previous interventions were ineffective and revised or developed interventions accordingly or developed effective interventions to compensate for Resident 50's forgetfulness and impulsiveness, like increased supervision or monitoring of the resident to intercept self-transfers to complete their ADLs. Facility reviews of the falls showed the staff continued to ask of Resident 50 to request assistance by using the call light and ultimately to call out for help, both repeatedly failed interventions. The facility investigations of the falls failed to show the facility considered what actually prompted the resident to self-transfer and effectively address the root-cause of the falls which precluded the staff from anticipating the resident's needs differently. The investigative reviews repeated interventions already established on Resident 50's day of admission and shortly thereafter to address the continued falls and did not determine how the interventions failed to prevent falls and their associated injuries. The investigations and their conclusions did not define for the staff what frequent checks or rounding of the resident entailed or show how staff supervision of the resident changed. Record review showed 10 of the 36 falls were related to Resident 50's toileting needs. The care plan showed no revision of the toileting program to effectively anticipate this ADL which required staff assistance. No documentation was located to show the facility requested a review by the pharmacist as instructed in the care plan. Investigative reviews associated with the 09/20/2024, 10/27/2024, 11/04/2024, 11/11/2024 falls showed the facility concluded the resident desires to fall and maintain their independence even if that means [they are] going to fall. Resident 50 fell another 20 times after 11/11/2024. In an interview on 05/20/2025 at 9:58 AM, Staff R, Nursing Assistant - Registered, stated they were formally re-assigned to Resident 50 for the first time on 05/20/2025 after their shift had already started but had assisted another aide with the resident on a previous occasion during training. Staff R stated they obtained information on resident care by getting report from the nurse and shift to shift report from another aide. When asked if Resident 50 had any falls, Staff R stated, Not that I'm aware of. Staff R stated they thought Resident 50 transferred in or out of bed or wheelchair because they needed to, use the rest room and they transferred, Either before or after lunch. Staff R stated that a resident who was cognitively impaired, impulsive, and showed they were not receptive to reminders or signage would require supervision of, every 15 minutes checks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 05/20/2025 at 8:10 AM, Staff M, Licensed Practical Nurse (LPN), stated Resident 50 experienced several falls, doesn't call for help, will self-transfer, eyesight is very poor. Staff M stated the resident, can't seem to get his feet situated, sometimes [they] will step on one foot with the other and loses balance and flops back, does not sit down, rarely calls for help. Staff M indicated the resident's poor balance, impaired vision, poor body mechanics, and no safety awareness placed them at risk for falls. Staff M stated Resident 50 had no pattern when they self-transferred out of bed or wheelchair but that the staff, try to get in there before breakfast, before meals, because [the resident] likes to sit up for [their] meals. Staff M said that even though they parked their medication cart by Resident 50's room so they could hear the resident when they moved around, and staff made frequent checks and placed the wheelchair by the bed to prevent the resident from falling, it did not help decrease or prevent Resident 50's falls. Staff M stated they felt there was not enough staff to monitor the resident to make sure they did not fall when trying to transfer out of bed or the wheelchair. Staff M stated they did not think an increase in supervision was attempted by the facility to prevent Resident 50 from falling and that even with frequent checks Resident 50 fell . Staff M stated, It's hard to be there when you don't have enough staff. In an interview on 05/20/2025 at 8:40 AM, Staff S, Occupational Therapist, stated they wanted to be notified immediately if fall interventions were not effective, If that's what we are working on. Staff S stated they were unaware Resident 50 fell 36 times but knew the resident fell , a lot of times because they did not listen, was forgetful and impulsive. Staff S stated that impulsivity and decreased safety awareness were the main reasons for Resident 50's fall occurrences. When asked if increased supervision was attempted to help decrease falls or prevent Resident 50 from falling, Staff S stated, I know the aides were checking on [the resident] regularly. We haven't done that before. Staff S stated that staff could try 10-minute interval checks on the resident and concluded the signage on the wall was ineffective in preventing Resident 50 from falling. In an interview on 05/20/2025 at 8:20 AM, Staff T, Therapy Director, stated that they wanted to be notified when a resident fell at the time of occurrence or anytime there is a problem. Staff T stated they identified when interventions were suitable for a resident at risk for falls, Through the assessment process. Sometimes it's trial and error. Staff T explained that because of Resident 50's progressing palsy, they were going to lose the ability to sequence events, experience vision loss, and become increasingly dizzy. Staff T said Resident 50 did not want to wait for help to go to the bathroom because they were afraid of experiencing incontinence. When asked at what point was a recommendation made to increase and define the type of supervision required to help prevent falls and associated injuries, Staff T stated, We have discussed that and talked about if a different room would help but right now [the resident] is close to the door and we all pass by. Staff T stated to prevent falls for a resident who was cognitively impaired, impulsive, and not receptive to reminders or signage, the resident required, more frequent checks, asking every two hours if they need to go to the bathroom. Staff T stated, With somebody like [Resident 50], I would almost like to go back to the sensor pad pressure alarm because it will sound off when the resident is moving, and staff can be there to help [the resident]. To have a 1:1 on [Resident 50] would be super costly. Staff T stated, I don't think there's a trend to Resident 50's falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The above findings were shared in a joint interview on 05/20/2025 at 10:21 AM with Staff B Director of Nursing, and Staff C, Clinical Resource Nurse. Both staff acknowledged the ineffective fall prevention interventions in Resident 50's care plan. Staff C acknowledged the consistently inadequate reviews of the falls that failed to determine what truly prompted Resident 50 to self-transfer, along with staff misperception of the resident's ability to recall or process information. When asked if the facility effectively supervised Resident 50 to prevent falls and their associated injuries, Staff B answered, No. When asked if the facility attempted to increase supervision of the resident Staff C answered, No and that doing so could have possibly prevented Resident 50 from falling. On 05/22/25 at 12:23 PM, Staff M (the nurse assigned to Resident 50) was observed walking past the resident's room with another staff. Resident 50 was observed by the surveyor standing up from the wheelchair next to their bed and transfer to the bed holding on to the grab bar to the left side, placing themselves on the bed, with the call light underneath them. Resident 50 admitted they self-transferred and said, No, I don't want to fall, then pulled the bed linens over themselves. Observation directly outside of Resident 50's room showed a clipboard on the handrail with a form titled Resident Monitoring Tool. The form showed Resident 50 was on 15-minute checks but no documentation the staff checked on the resident on or around 11:30 AM, 11:45 AM, 12:00 PM, or 12:15 PM. Review of progress notes between 05/21/2025 and 05/22/2025 showed that despite the 15 minute checks, the staff continued to identify Resident 50 self-transferred to the bathroom both with assist and unattended, does not call for help nor has called out loud for help, found several times already up in [their] wheel chair, Nurse is alerted outside of room doorway, when the bathroom door bangs into the room door that this resident is on the move . able to sit up and get out of bed & into wheel chair very quietly without being heard . TV volume up relatively high that also hinders the sounds of [their] movement. Another 05/21/2025 note showed, Continues to self-transfer quietly without staff noticing despite being moved closer to nurses station. Attempt to redirect and instruct on use of call light without effect. Cart nurse unable to stand at doorway or next to doorway for long periods of time to monitor resident as other residents need meds [medications]/cares as well. Another 05/21/2025 note showed, Resident was up again at this time, while this nurse was documenting previous note, noises/crashes were heard from [their] room and resident again was found seated in [their] wheelchair not 7 minutes from prior use of bathroom and was assisted to bed at that time . Another 05/21/2025 note showed, Resident is impulsive and transfers without use of call light. Sometimes will yell help when [they are] about to fall or needs help. Requires frequent reminders and observation. Resident has limited safety awareness and poor vision. Stiff/rigid body mechanics makes transfers difficult as well as bending at the hips/low back to sit . often times flops backwards into wheelchair. In an interview on 05/22/2025 at 12:35 PM, Staff M stated Resident 50 self-transferred, Last night, even with the 15-minute checks. Staff M stated they felt the 15-minute checks were ineffective as the resident did not call for help, I could be standing right here and will not always hear [them]. Staff M stated they did not tell anybody about the failed 15-minute checks, that they should have reported the failed intervention, Right away. I'll do it right now. The above findings were shared with Staff A (Administrator), Staff B, Staff C, and Staff Q (Director of Clinical Services) on 05/22/2025 at 1:12 PM. Staff C said they ensured interventions were effective by making observations of the staff and resident and reviewing the progress notes. Staff B stated they expected the staff to alert them of failed fall prevention interventions, As soon as they know it's not working. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<Resident 60> Review of a 05/01/2025 admission assessment showed Resident 60 admitted to the facility on [DATE] with a diagnosis of a stroke, orthostatic hypotension (when the blood pressure drops when you sit or stand up), and diabetes. This assessment showed the resident had intact cognition, was dependent on the staff for toileting hygiene, required partial to substantial assistance for transfers, and used a wheelchair for mobility. The staff assessed Resident 60 was frequently incontinent of urine and always continent of bowel and had no toileting program. The assessment showed Resident 60 had no falls prior to admission but fell since admission to the facility. Review of a 04/25/2025 progress note showed the staff identified Resident 60 required extensive assistance with transfers and ADLs, Left sided weakness secondary to CVA [cerebrovascular accident, a stroke]. A 04/26/2025 note showed the resident, Has left sided weakness. Requires 2 person assist for transfers, bed mobility and toileting. Review of Resident 60's care plan showed 04/25/2025 instructions to the staff to provide assistance of 1 or more person for toilet transfers going to the right side with the use of the grab bar, that Resident 60 required constant verbal cues for sequencing and left sided neglect. The interventions also asked the staff to, Stay with patient when on toilet to decrease risk of falls, and Respond to resident requests timely. Anticipate needs. Keep call light and bedside table items within reach. Review of a 04/27/2025 progress note showed when the nurses walked down the hallway to administer medication to another resident, they heard Resident 60 yelling for help. The resident was found lying on their left side with their upper body under the edge of the bed. No injuries were sustained from this fall. The progress notes showed, Interventions placed were to encourage resident to use call light for assistance, frequent bathroom checks and bed to remain in lowest position. Review of 04/28/2025 care plan intervention showed the resident was totally dependent on staff when transferred by two or more staff in a mechanical lift and used the bed pan for toileting. Review of 04/29/2025 care plan intervention showed the staff placed a Call don't fall sign in Resident 60's room and the staff was asked to Monitor resident position in bed or wheelchair for safety upon entry and exit from room and with rounding. Anticipate resident needs. Review of a 05/03/2025 progress note showed a staff member assisted Resident 60 to the toilet per resident request and that the resident asked the aide to step out for privacy. The aide stepped out and was standing outside the door when the resident reached for wipes on their wheelchair and because of left sided weakness fell on [their] left side hitting [their] left orbital [eye socket] area. The note showed the nurse applied an ice pack to Resident 60's face, educated staff not to leave the resident unattended, and called the provider who gave orders to transfer Resident 60 to the hospital. Review of a 05/03/2025 Incident Note showed the fall resulted in a left orbital fracture (a break in one or more of the bones surrounding the eye socket). Nursing interventions included, Educated staff not to leave [resident] unattended, an intervention which was in place on 04/25/2025 (Stay with patient when on toilet to decrease risk of falls), two days prior to the fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of investigative documents associated with the fall of 05/03/2025 showed Resident 60 was sent to the hospital secondary to being on an anticoagulant (a blood thinner) and acknowledged the fall resulted in a fracture of the left orbital area. The investigation concluded Resident 60 did not use the call light to request assistance and attempted to use their affected side to reach for an item within the reach of their unaffected side, which caused the resid[TRUNCATED]

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 47328 Based on interview and record review the facility failed to identify, assess, and address potential signs and/or symptoms of Post Traumatic Stress Disorder (PTSD) for 1 of 8 sampled residents (Resident 19), reviewed for mood and behavior. This failure placed residents at risk of re-traumatization, unmet behavioral health needs, and diminished quality of life. Findings included . According to the website www.mayoclinic.org Post Traumatic Stress Disorder (PTSD) was a mental health condition that could develop after witnessing or being part of an extremely stressful or terrifying event. Symptoms could include flashbacks (feelings that the traumatic event was occurring again), nightmares (repeated disturbing dreams), intrusive thoughts, severe anxiety, avoidance (not wanting to think or talk about a traumatic event), changes in mood or thinking and physical and emotional reactions. These symptoms last more than one month, cause major problems in social or work situations and affect how well a person gets along with others. Review of the facility policy titled, Behavioral Health Services revised April 2025 showed the facility provided appropriate behavioral health services to residents identified through their individualized comprehensive assessment as needing support with their emotional well-being to attain or maintain the highest practicable physical, mental and psychosocial well-being. The policy further showed behavioral health encompassed a resident's whole emotional and mental well-being, which included the prevention and treatment of mental health, substance use disorders, and trauma or PTSDs. Trauma informed care was defined as approached to care that treated the whole person, taking into account past trauma and the resulting coping mechanisms when attempting to understand behaviors and treat the resident. The policy showed residents would be monitored and assessed for signs and/or symptoms of withdrawal from substance use, depression, adjustment difficulties, history of trauma, and PTSD symptoms which may include flashbacks or disturbing dreams, extreme discontentment, or emotional and behavioral expressions of distress such as outbursts of anger, irritability, or hostility. The interdisciplinary team was to identify reversible and treatable causes and address them promptly. The policy instructed staff to complete training related to communication, interpersonal skills, trauma informed care, and mental health and social service needs to gain the knowledge and skill sets to effectively interact with residents. According to the 04/10/2025 quarterly assessment, Resident 19 had diagnoses including dementia, depression, and violent behavior. The assessment further showed Resident 19 had severe cognitive impairment with inattention and disorganized thinking. Resident 19 exhibited worsening verbal and physical behaviors directed towards others that significantly interfered with Resident 19's care, participation in activities or social events, placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 10/17/2024 behavioral care plan showed Resident 19 had the potential to demonstrate yelling and striking out at others related to dementia and poor impulse control. The care plan instructed staff to get Resident 19 up in their wheelchair (WC) if they yelled out in their sleep, utilize a sound machine while in bed, perform 15-minute safety checks, and assist Resident 19 through congested areas because they triggered aggression. Review of the 09/10/2025 clinical admission evaluation showed Resident 19 had a history of behaviors, was confused, and did not want to talk about trauma. Review of the 09/12/2025 psychosocial evaluation showed Resident 19 had not experienced significant traumatic events with a comment written as Resident 19 said life is what it is. A summary at the end of the assessment showed Resident 19 was a Navy Veteran without any family support. Review of September 2024 through April 2025 nursing progress notes showed the following: - 09/12/2024 Resident 19 was restless in bed at times, calling and yelling out. - 09/18/2024 at 4:15 AM, Resident 19 yelled out and banged on wall, would close eyes and pretend to sleep - 09/20/2024 at 1:15 AM, Resident 19 yelled out through the night - 11/08/2024 Resident 19 was observed yelling out between 2:00 PM and 4:30 PM - 11/09/2024 Resident 19 continued to have distressing outbursts when in bed and pounds on the wall. - 11/16/2025 at 5:25 AM, Resident 19 was observed yelling and banging on the walls throughout NOC [night 10 PM through 6 AM] shift. - 12/15/2024 at 4:23 AM, Resident 19 yelled and screamed throughout entire shift. - 12/18/2024 at 4:24 AM, Resident 19 was awake and yelling out most all shift. - 12/27/2024 at 4:30 AM, Resident 19 was yelling out all night. Will not stop. - 12/28/2024 Resident 19 slept most of the night but started screaming when they were still sleeping and Resident 19 did not realize they were screaming. - 12/31/2024 at 5:55 AM, Resident 19 was awake all-night yelling and screaming, would not calm themselves, would not awaken and continued screaming while sleeping. - 01/07/2025 at 5:14 AM, Resident 19 was yelling and screaming 4-5 hours during the night. Unable to calm [themselves]. - 01/12/2025 at 6:42 AM, Resident 19 slept entire shift but woke up yelling at approximately 4:30 AM. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 01/13/2025 at 4:31 AM, Resident 19 yelled out all night, no interventions could calm them down. - 02/03/2025 Resident 19 woke up yelling continuously. - 02/06/2025 Resident 19 went to bed and did not experience any night terrors. - 03/13/2025 at 4:43 AM, Resident 19 yelled out for about 1 hour. - 03/15/2025 Resident 19 yelled and screamed out from 4:50 AM until 5:05 AM. - 03/16/2025 Resident 19 yelled and screamed out from 03/15/2025 11:30 PM until 03/16/2025 2:45 AM, over 3 hours. - 04/09/2025 Resident 19 began yelling out at approximately 6:30 AM. Resident 19 was in laying in bed with their eyes closed. When asked what was wrong, Resident 19 replied I was having a bad dream. - 04/13/2025 Resident 19 yelled out from 2:22 AM until 2:55 AM, remained in bed the entire time, and eventually went back to sleep. - 04/22/2025 at 5:37 AM, Resident 19 screamed and yelled for about 4 hours. In an interview on 05/19/2025 at 4:16 AM, Staff J, Nursing Assistant, stated Resident 19 experienced uncontrollable yelling, had woken up from being asleep yelling but it was my understanding [Resident 19] has PTSD. In an interview on 05/19/2025 at 8:00 AM, Staff E, Social Services Coordinator, reviewed Resident 19's medical record. Staff E stated Resident 19 experienced unpredictable and uncontrollable behaviors at times, and it was difficult to anticipate what would trigger their behaviors. Staff E further stated if Resident 19 did not sleep well, their behaviors would be worse the following day. Staff E acknowledged they had not received much training on trauma informed care. Staff E further acknowledged Resident 19 was a veteran, but they had not been assessed for potential signs and/or symptoms of PTSD and no interventions had been attempted to address recurrent nightmares experienced. In an interview on 05/19/2025 at 8:55 AM, Staff B, Director of Nursing, reviewed Resident 19's medical record. Staff B acknowledged Resident 19 was a veteran but the facility had not attempted to assess or address potential signs and/or symptoms of PTSD such as yelling at night during sleep or nightmares experienced. In an interview on 05/23/2025 at 9:36 AM, Staff A, stated they expected staff to receive adequate training in order to have adequate skills and competencies to meet the needs of the facility resident population. No associated WAC Refer to F600, F725, and F726 for additional information.

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation, interview and record review, the facility failed to consistently ensure the facility had enough staff to provide adequate supervision and safe care according to the facility acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and/or care plans for 3 of 7 sampled residents (Resident 19, 50, and 60), reviewed for falls. Resident 19 experienced harm from repeated falls as evidenced by a dislocated hip on 09/12/2024, a right femur (leg bone) fracture on 01/14/2025, and a back fracture on 03/03/2025. Resident 60 experienced harm when they fell three times and sustained a fracture to their eye socket and left lower leg. Resident 50 experienced harm when they fell a total of 36 times from 04/04/2024 to 05/17/2025 and experienced a range of injuries, to include hospital transfers for their treatment. Additionally, the facility failed to identify, report, protect, assess and d provide staff supervision to prevent a pattern of resident-to-resident verbal and physical abuse by Residents 19 towards 10 different peers (Resident 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41). These failures placed residents at risk for further repeat serious injuries such as fractures, repeat abuse, potentially avoidable accidents and diminished quality of life. Findings included . Review of the facility assessment reviewed May 2025 showed, the facility provided care to residents who required assistance with activities of daily living such as toileting, transfers, ambulation and fall prevention. The assessment further showed facility staffing included nurse managers, licensed nurses, nursing assistants, and ancillary department staffing. Staffing levels were determined by acuity and regulatory requirements that met the minimum staffing requirements. Staffing was reviewed daily to ensure appropriate staffing ratios to meet requirements and acuity level of current resident population which consisted of residents that may require additional staff to help mitigate falls and manage behaviors. The facility utilized staffing agencies to meet the facility staffing goals and additional staffing efforts were coordinated under the facility Quality Assurance and Performance Program (QAPI) via a Performance Improvement Plan (PIP). <Resident 19> According to the 04/10/2025 quarterly assessment, Resident 19 had severe cognitive impairment with inattention and disorganized thinking. The assessment further showed Resident 19 exhibited worsening verbal and physical behaviors directed towards others that significantly interfered with Resident 19's care, participation in activities or social events, placed others at significant risk for physical injury, significantly intruded on the privacy or activity of others and significantly disrupted care or the living environment. Resident 19 sustained two or more non-injury falls since their admission. RESIDENT-TO-RESIDENT ALTERCATIONS (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of the facility October 2024 through May 2025 incident report tracking log showed Resident 19 was involved in 11 resident-to-resident altercations with 10 different peers (Resident 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41) on the following dates: 10/16/2024, 11/07/2024, 01/11/2025, 01/13/2025, 02/10/2025, 02/27/2025, 03/08/2025, 04/04/2025, 04/11/2025, 04/25/2025, and 05/10/2025. Review of the 09/10/2024 self-care deficit care plan showed Resident 19 was able to self-propel their wheelchair (WC) independently. The 10/17/2024 care plan showed Resident 19 had potential to yell and strike out at other residents related to dementia and poor impulse control. Interventions included to assess and anticipate Resident 19's needs, give positive feedback, frequent safety checks when out of bed, reapproached with different staff when agitated, and maintain a consistent routine. On 11/01/2024 Resident 19 was placed on 15-minute safety checks around the clock. Additional review showed Resident 19 was involved in repeat resident-to-resident altercations while on 15-minute safety check monitoring. Review of the facility resident-to-resident incident reports showed the following: - 10/16/2024- Resident 19 allegedly struck Resident 27 on the hand with a spoon while in the dining room - 11/07/2024- Resident 33 threw coffee on Resident 19 in the dining room - 01/11/2025- Resident 19 randomly grabbed, kicked, and shook Resident 3's walker as they walked down the hall - 01/13/2025- Resident 19 yelled, grabbed at, and stopped Resident 41 from entering the dining room. - 02/10/2025- Resident 19 grabbed at Resident 31. Resident 19 called Resident 31 a fucking asshole! and grabbed Resident 31's neck collar. Resident 31 open handedly slapped Resident 19 in the face. - 02/27/2025- Resident 19 was self-propelling their WC and spontaneously grabbed, hit, scratched, and kicked at Resident 49. Resident 49 sustained a scratch that bled and required first aide. Resident 49 did not know why Resident 19 attacked them. Root cause of incident was identified as Resident 19 was agitated and within close proximity of another resident. - 03/08/2025- Resident 19 was yelling and hitting at Resident 43 and Resident 21. - 04/04/2025- Resident 19 yelled at Resident 37 to remove their hat when sitting at the dining room table. After the meal, at the nurses' station, Resident 19 continued to yell at Resident 37 and allegedly ran over Resident 37's toes with their WC. - 04/11/2025- Resident 19 unprovoked began to punch Resident 45 with a closed fist, in the hallway, as Resident 45 rolled past Resident 19. - 04/25/2025- Resident 19 had a second physical altercation with Resident 31, in the dining room, with staff present but who did not observe the altercation. Resident 19 and Resident 31 grabbed and hit at each other. Resident 31 sustained a skin tear to their arm. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	- 05/10/2025- Resident 19 had a third verbal and physical altercation with Resident 31. Resident 31 yelled I am going to kill you! Residents 19 and 31 were observed grabbing and hitting each other. Resident 31 sustained a scratch to the back of their hand and Resident 19 sustained a scratch to the tip of their nose. FALLS Review of the 09/10/2025 hospital discharge summary showed Resident 19 sustained a fall that resulted in a right hip fracture. Resident 19's right hip was surgically repaired, and they discharged to the facility. Review of the facility September 2024 through May 2025 incident report tracking log showed Resident 19 sustained 15 falls on the following dates: 09/12/2024, 10/10/2024, 10/16/2024, 10/25/2024, 10/30/2024, 11/20/2024, 12/10/2024, 12/19/2024, 12/23/2024, 01/14/2025, two falls 03/07/2025, 03/22/2025, 05/02/2025, and on 05/12/2025. Review of the facility fall incident reports showed the following: - 09/12/2024 Resident 19 fell near their bed when self-transferring to the bathroom and was transported to the hospital for evaluation related to right hip pain. Resident 19's recently surgically repaired hip was displaced and required sedation to reinsert the hip. - 10/10/2024 Resident 19 fell while self-toileting and reached down to pull up their pants. - 10/16/2024 Resident 19 fell at the nurses' station reaching for an item out of reach. Resident 19 sustained a skin tear to their right hand. - 10/25/2024 Resident 19 fell when attempting to make their bed and their wheelchair (WC) rolled away. - 10/30/2024 Resident 19 fell when they stood up in the dining room and their WC rolled away. - 11/20/2024 Resident 19 fell when they attempted to self-transfer into bed. - 12/10/2024 Resident 19 slid off the toilet and hit their head on the wall. - 12/19/2024 Resident 19 fell next to their closet and sustained a left-hand skin tear. - 12/23/2024 Resident 19 ambulated out of the bathroom using their roommate's walker - 01/14/2025 Resident 19 again fell reaching for an item out of reach while at the nurses' station. Resident 19 sustained a right femur peri-prosthetic (around the artificially replaced hip) fracture that required surgical repair. - 03/07/2025 at 4 AM Resident 19 fell out of bed on the opposite side of the fall mat. All interventions in place continue current care plan, and frequent rounding. - 03/07/2025 at 5:45 PM Resident 19 again fell out of bed. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	- 03/22/2025 Resident 19 was found on the floor in their room again on the opposite side of fall mat. - 05/02/2025 Resident 19 was on the floor in their room. - 05/12/2025 Resident 19 was on the floor next to their bed. Review of the 01/23/2025 falls care plan showed Resident 19 was at risk for falls related to confusion, history of falls, and poor safety awareness. Interventions instructed staff to keep the door to the room open, reinforce safety awareness, maintain the floor free of clutter, and monitor for injuries when falls were sustained. A 11/21/2024 intervention showed Resident 19 was to have a fall mat on the exit side of the bed, 12/23/2024 a call for assistance sign was placed in the room, 12/31/2024 encourage Resident 19 to use the bathroom before and after meals, 03/03/2025 Resident has the right to fall, and 05/13/2025 perimeter mattress was added to define the edges of the bed. Additional record review showed care plan interventions were not reviewed and/or revised each time Resident 19 sustained a fall. Review of the 09/12/2024 hospital after visit summary showed Resident 19 right hip was dislocated and was given sedation to reinsert the hip back into the socket. Review of the 01/21/2025 hospital discharge summary showed Resident 19 sustained a per-prosthetic right femur fracture which required surgical intervention for repair. Review of the 03/03/2025 Computed Tomography (CT, medical imaging that create detailed images of the inside of the body) imaging showed Resident 19 fell out of their WC which resulted in back and hip pain. The imaging results showed a significant back fracture likely acute [new onset] given the history of fall and tenderness. <Resident 60> According to the 05/01/2025 admission assessment, Resident 60 admitted to the facility on [DATE] with a diagnosis of a stroke, orthostatic hypotension (when the blood pressure drops when you sit or stand up), and diabetes. This assessment further showed Resident 60 had intact cognition, was dependent on the staff for toileting hygiene, required partial to substantial assistance for transfers, and used a wheelchair for mobility. The assessment showed Resident 60 had no falls prior to admission but fell since admission to the facility. Review of Resident 60's 04/25/2025 care plan showed staff were to respond to requests timely, keep frequently used items within reach, provide assistance of one or more staff for toilet transfers related to Resident 60 required constant verbal cues for sequencing, and for staff to stay with Resident 60 when on toilet to decrease risk of falls. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of May 2025 nursing progress note showed a staff member assisted Resident 60 to the toilet on 05/03/2025 per resident request and that the resident asked the nursing assistant (NA) to step out for privacy. The aide stepped out and was standing outside the door when the resident reached for wipes on their wheelchair and because of left sided weakness fell on [their] left side hitting [their] left orbital [eye socket] area. The note showed the nurse applied an ice pack to Resident 60's face, educated staff not to leave the resident unattended, and called the provider who gave orders to transfer Resident 60 to the hospital. On 05/14/2025 staff reported they had run over Resident 60's leg when transporting resident down the hallway. The incident was described as the resident's left foot came off the wheelchair footrest (for the user's foot to rest on), the aide did not notice and rolled the wheelchair over Resident 60's left foot. The nurse then completed an assessment and found Resident 60's left leg with visible swelling, complaints of pain to the knee, calf and thigh, and a bruised area to a swollen ankle. On 05/15/2025 Resident 60 was assessed to be in uncontrollable pain, swelling to left ankle, and a bruise with a superficial scratch to the back of resident's left calf. Resident 60 stated repeatedly, I want to go to the hospital. The staff transferred Resident 60 to the local emergency department. Review of the facility fall incident reports showed the following: -05/03/2025 Resident 60 fell while on the toilet which resulted in a left orbital fracture (a break in one or more of the bones surrounding the eye socket). Nursing interventions included, Educated staff not to leave [resident] unattended, an intervention which was in place on 04/25/2025 (Stay with patient when on toilet to decrease risk of falls), two days prior to the fall. -05/21/2025 Resident 60's left foot fell off the foot pedal during transport unbeknownst to the aide. The aide and resident were going through the resident room's doorway, the residents foot became lodged between the door and the wheelchair, the aide did not know the foot was caught, pushed three times due to the resistance, and ran over the left foot. The investigation concluded it was an accident that resulted in a new distal end of left fibula [calf bone] fracture. <Resident 50> According to the 04/07/2025 quarterly assessment, Resident 50 admitted to the facility on [DATE] with medically complex conditions, to include dementia, repeated falls, and impaired vision. This assessment showed the resident had moderately impaired cognition, required supervision or touching assistance from the staff for ADLs and experienced falls since their admission to the facility or their prior assessment. During observation and interview on 05/12/2025 at 10:55 AM Resident 50 was in bed and stated, I fall quite frequently. I have progressive palsy (loss or reduction of movement in a part of the body, often accompanied by shaking or trembling) and they've gone over things that I do that cause the falls like how I turn and so forth. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Review of nursing progress notes from 04/05/2024 to 05/17/2025 showed the staff identified Resident 50 fell frequently, was impulsive and forgetful to use their call light, and self-transferred in and out of bed or wheelchair. documentation showed that staff continued to ask the resident to use the call light or call for help evenh it was identified that Resident 50 was impulsive and does not call for help/assistance with transfers or mobility and transfers without use of call light. Sometimes will yell help when is about to fall or needs help. Requires frequent reminders. The notes further showed Resident 50 fell 36 times (4/30/2024, 05/03/2024, 05/06/2024, 05/09/2024, 05/11/2024, 05/17/2024, 05/22/2024, 06/04/2024, 06/14/2024, 07/18/2024, 08/01/2024, 08/26/2024, 09/20/2024, 10/27/2024, 11/04/2024, 11/11/2024, 12/16/2024, 01/12/2025, 01/19/2025, 01/25/2025, 02/02/2025, 02/14/2025, 02/16/2025, 03/04/2025, 03/07/2025, 03/25/2025, 03/26/2025, 03/26/2025, 04/03/2025, 04/19/2025, 04/24/2025, twice on 05/3/2025, 05/05/2025, 05/14/2025, and 05/17/2025) from 04/05/2024 to 05/17/2025. Review of Resident 50's 11/04/2024 care plan showed the staff identified they had impaired mobility with actual falls due to dementia, unsteady walking, leaning forward in their wheelchair to pick items up from the floor and transferring self from bed or wheelchair. The care plan instructed staff on Resident 50 required assistance for transfers. The care plan showed that on the day of admission, 04/05/2024, the staff added the following interventions: provide direct supervision while resident is toileting, reinforce safety awareness: use call light, lock brakes on chair before transferring, utilize device. When rising from a lying position, sit/rest at edge of the bed at least 10 seconds before transferring, respond to resident requests timely, anticipate their needs, keep call light and bedside table items within reach. On 12/01/2024 pharmacist to review medications quarterly and prn when falls occur to address fall risk side effects. Develop plan with risks and benefits as indicated. On 01/06/2025 Resident 50 would get ice cream if they did fall in 30 days. On 02/05/2025 Resident 50 agreed to wear pull ups at night for urine urgency. On 04/21/2025 make sure to help remind [resident] to position the wheelchair at a 45-degree angle facing the bed, so that [the resident] can still reach the arm rests and make small steps, and travel a shorter distance, to decrease risk of falls. On 05/08/2025 Educate resident to call out for help and to wait for assistance as it is [their] preference not to use the call light. Additional record review showed care plan interventions were not reviewed and/or revised each time Resident 50 sustained a fall. Review of the medical record from 04/05/2024 to 05/17/2025 showed Resident 50 experienced injuries of varying severity related to the 36 falls that included abrasions (05/09/2025, 05/11/2024, 06/14/2024, 07/18/2024, 08/01/2024, 11/11/2024), contusions (an injury to soft tissue that causes bleeding beneath the skin, usually without breaking the skin itself; 08/01/2024, 08/26/2024, 11/11/2024, 03/27/2025), lacerations (08/01/2024, 08/26/2024, 02/02/2025) closed head injuries (08/01/2024, 03/27/2025), swelling to right side of forehead (10/27/2024), skin tears (03/04/2027, 03/07/2025, 04/20/2025), and transfers to the Emergency Department (08/01/2024, 02/02/2025, 05/07/2025). Review of November 2024 through April 2025 grievance log showed grievances related to excessively long call light wait times on 11/06/2024, 03/02/2025, 03/20/2025, and 04/01/2025. In an interview on 05/14/2025 at 10:26 AM, the Resident Council stated the facility did not have sufficient staff. The Council explained they experienced excessively long call light wait times, staff did not answer call lights during mealtimes, so residents had to wait until the meal was over or have an incontinent episode if they needed to toilet during mealtimes, waiting up to an hour to have their call light answered. A resident's spouse in attendance of the meeting, acknowledged they often toileted their spouse to help direct care staff because staff were too busy with other residents and there is not enough staff. The Council again stated, the facility is severely undermanned. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	In an interview on 05/19/2025 at 4:06 AM, Staff I, Registered Nurse, stated the facility did not have enough staff. Staff I explained they worked night shift and was lucky if they worked with two-three nursing assistants. Staff I further stated it was difficult to manager behaviors on night shift, if a resident needed one:one (1:1) monitoring, they would have to pull a nursing assistant off the floor to provide the needed increased monitoring which left the floor short so I take a section. In an interview on 05/20/2025 at 11:37 AM, Staff P, Licensed Practical Nurse (LPN), stated they were a full-time LPN. Staff P explained the facility was short staffed and routinely worked as a NA three out of five workdays. In an interview on 05/22/2025 at 3:01 PM, Staff D, Resident Care Manager, stated staffing levels were based on census. Staff D explained the facility cared for residents that required two staff assist, were dependent on staff assistance, used mechanical lifts to transfer which required two staff for use, were high fall risks, and exhibited behaviors. Staff D further stated the facility attempted to staff four NAs for both day and evening shifts and two NAs for night shift, but that was not enough staff. The facility utilized agency staffing daily but Staff D continued to hear residents and family's voice concerns over lack of staffing. Staff D acknowledged some falls and resident-to-resident altercations could have been prevented if the facility had more staff. During an interview and record review on 05/22/2025 at 3:12 PM, Staff X, Staffing Coordinator, stated the facility utilized a staffing level guide based on census and the minimum staffing requirements to staff the facility, as instructed. Staff X explained the form was reassessed quarterly by management, we count heads [residents] not acuity. Staff X provided a copy of the staffing guide. Review of the staffing guide provided showed a graph with columns for 1) census, 2) day shift nurses, NA, and restorative NA numbers, 3) evening shift nurse and NA staffing numbers, and 4) night shift nurse and NA staffing numbers. Staff X further stated they were also an NA, often worked the floor to help out due to short staffing, and had not had a full weekend off in a month. Staff X acknowledged staff had voiced staffing concerns, we are struggling, we are having a rough time with staffing. In an interview on 05/22/2025 at 3:43 PM, Staff B, Director of Nursing, stated the facility utilized a staffing guide based on the minimum staffing standards that was reassessed daily with census and acuity. Staff B stated they expected the facility to be staffed with sufficient staff to provide adequate care to the facility residents based on their plans of care. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected the facility to have adequate staffing coverage to meet the needs of the facility resident population. Reference WAC 388-97-1080 (1), 1090 (1) Refer to F600, F689, F726, and F727 for additional information.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47328 Based on interview and record review, the facility failed to develop and implement a system to evaluate staff competencies in skills and techniques related to diabetes management, medication administration, Post Traumatic Stress Disorder (PTSD), Substance Use Disorders (SUD), Gradual Dose Reductions (GDR), trauma informed care, fall management, or incident root cause analysis to ensure staff provided necessary care and responded to each resident's individualized needs for 8 of 10 sampled staff (Staff P, L, AA, BB, CC, DD, EE, and FF), reviewed for nursing services. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment reviewed May 2025 showed, the facility provided care to residents who were diabetic, received blood thinners, had histories of SUD, trauma/PTSD, anxiety, cognitive impairment, and other medical conditions related to mental health. The facility provided person-centered/directed care by building relationships, providing emotional and mental well-being support, support helpful coping mechanisms, determining resident preferences and routines and incorporating the information into the care planning process. The assessment further showed staff competencies were completed during new employee orientation for new hires. Staff received the mandatory 12 hours of required topic training and as needed training conducted when the need was identified. <Staff P> Review of Staff P's, Licensed Practical Nurse (LPN), personnel file showed they were hired on 04/17/2025. Review of Staff P's training records showed no training or competency documentation related to diabetes management, medication administration, PTSD (a mental health condition that could develop after witnessing or being part of an extremely stressful or terrifying event), SUD, GDR [when psychotropics (medications that affect the brain, feelings, and emotions) were slowly and carefully decreased to find the lowest effective therapeutic dose to prevent unnecessary medication use], trauma informed care, fall management, or incident root cause analysis. In an interview on 05/20/2025 at 11:37 AM, Staff P, LPN, acknowledged they did not receive adequate training and did not have their skills and/or competencies assessed. <Staff L> Review of Staff L's, Registered Nurse, personnel file showed they were hired on 03/31/2025. Review of Staff L's training records showed no training or competency documentation related to diabetes management, medication administration, PTSD, SUD, GDRs, trauma informed care, fall management, or incident root cause analysis. <Staff AA> (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Staff AA's, LPN, personnel file showed they were hired on 11/14/2024. Review of Staff AA's training records showed no training or competency documentation related to diabetes management, medication administration, PTSD, SUD, GDRs, trauma informed care, fall management, or incident root cause analysis. <Staff BB> Review of Staff BB's, LPN, personnel file showed they were hired on 08/01/2022. Review of Staff BB's training records showed no training or competency documentation related to diabetes management, medication administration, PTSD, SUD, GDRs, trauma informed care, fall management, or incident root cause analysis. <Staff CC> Review of Staff CC's, Nursing Assistant (NA), personnel file showed they were hired on 03/12/2024. Review of Staff CC's training records showed no training or competency documentation related to PTSD, SUD, GDRs, trauma informed care or fall management. <Staff DD> Review of Staff DD's, NA, personnel file showed they were hired on 04/16/2024. Review of Staff DD's training records showed no training or competency documentation related to PTSD, SUD, GDRs, trauma informed care or fall management. <Staff EE> Review of Staff EE's, NA, personnel file showed they were hired on 03/18/2025. Review of Staff EE's training records showed no training or competency documentation related to PTSD, SUD, GDRs, trauma informed care or fall management. <Staff FF> Review of Staff FF's, NA, personnel file showed they were hired on 08/01/2022. Staff FF's training records showed no training or competency documentation related to PTSD, SUD, GDRs, trauma informed care or fall management. In an interview on 05/22/2025 at 3:01 PM, Staff D, Resident Care Manager, stated if they received any training related to PTSD, SUD, trauma informed care, or GDRs, documentation would be located in the computerized training record files. In an interview on 05/22/2025 at 3:43 PM, with Staff B, Director of Nursing, and Staff C, Clinical Resource Nurse. Staff B explained the facility reviewed staff competencies by holding a skills fair and utilized a computerized training system to complete annual trainings, as required. Staff B and C were asked if staff received training on PTSD, SUD, GDR, or trauma informed care. Staff C was unsure and would follow-up. In a follow-up interview on 05/22/2025 at 4:12 PM, Staff C, acknowledged the facility had no documentation staff received training on PTSD, SUD, GDR, or trauma informed care. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to receive adequate training in order to have adequate skills and competencies to meet the needs of the facility resident population. Reference WAC 388-97-1080 (1), 1090 (1) Refer to F600, F605, F684, F689, F699, F740, F760, F941, F944, and F946 for additional information.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47328 Based on interview and record review the facility failed to ensure a Registered Nurse (RN) was on duty a minimum of eight consecutive hours a day, seven days a week, as required. This failure placed all residents at risk of lack of RN oversight for care provided, unmet care needs, and a diminished quality of life. Findings included . A review of the 30-day Staffing Pattern from 04/12/2025 through 05/12/2025 showed there was no RN on duty a minimum of eight hours a day, as required, for the following dates: 04/12/2025, 04/19/2025, 04/26/2025, 05/08/2025, and 05/10/2025. In an interview on 05/22/2025 at 11:35 AM, Staff M, Licensed Practical Nurse (LPN), acknowledged they had worked without an RN on duty. Staff M explained most LPNs can handle most of the same things as an RN but the facility contacted the Director of Nursing as needed, when there was no RN on duty. In an interview on 05/22/2025 at 3:00 PM, Staff D, Resident Care Manager, acknowledged there had been days without an RN on duty but they were on-call in case of emergencies. In an interview on 05/22/2025 at 3:12 PM, Staff X, Staffing Coordinator, reviewed the 30-Day staffing pattern. Staff X acknowledged some days had no RN on duty. Staff X stated, getting RN coverage is hard. Staff X explained they notified the Staff B, Director of Nursing, when unable to staff RN coverage, as required. In an interview on 05/22/2025 at 3:43 PM, Staff B reviewed the 30-Day staffing pattern. Staff B acknowledged some days did not have RN coverage, as required. Staff B further stated they expected staff to schedule an RN on duty, as required. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to schedule an RN on duty, as required. Reference WAC 388-97-1080 (3)(a) Refer to F725, F600, F689, F867 for additional information.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure behavioral health services were provided for 2 of 3 sampled residents (Residents 34 and 40), reviewed for mood and behavior. This failure created risk for residents to experience a decline in their psychosocial well-being. Findings included . <Resident 34> The [DATE] admission assessment documented Resident 34 had diagnoses that included end-stage kidney disease dependent on dialysis (a mechanical way of ridding a body of toxins when the kidneys no longer function), diabetes, and alcohol dependence. Resident 34 was cognitively intact, made their own decisions regarding their care, had no behaviors and did not reject their care. A Level II Behavioral Health Preadmission Screen and Resident Review (PASRR, a screening completed prior to skilled nursing facility admissions that determined a need for behavioral health services for residents) Notice of Determination dated [DATE] documented Resident 34 had a mental health diagnosis, met requirements for nursing facility level of care, and may benefit from specialized behavioral health services. At the time of the record review on [DATE] at 12:12 PM, the Level II PASRR Psychiatric Evaluation Summary, a document that detailed a resident's specific behavioral health needs and recommendations, was not included in Resident 34's electronic medical record (EMR). The [DATE] provider History and Physical documented Resident 34 had transferred to the facility from a nursing facility in an adjacent county, had been non-compliant with their dialysis and medications and continued their non-compliance at the facility. The resident had a social history of alcohol and illicit drug use and provided vague answers when interviewed by the provider. The [DATE] care plan documented Resident 34 had a history of substance abuse. Staff were instructed to set clear expectations with the resident, discuss with the resident and their family any issues that may lead to substance abuse/misuse, and if the resident appeared intoxicated or under the influence remove them from involvement with other residents. On [DATE], the care plan was updated to include Resident 34 exhibited potential mood disturbance, anger, and irritability and verbal abuse toward staff. Staff were instructed to analyze the circumstances and triggers and what de-escalated the behavior and document, assess the resident's coping skills and support system. The care plan did not include goals and interventions developed related to Resident 34's behavioral health needs. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of nursing progress notes from [DATE] to [DATE] documented Resident 34 became overloaded with fluid easily and was argumentative and belligerent with staff when staff did not provide the resident with extra drinks that were not part of the resident's diet and fluid care plan. Resident 34 refused to go to their scheduled dialysis sessions, refused to follow dietary restrictions, and refused medications to control their blood sugar levels and yelled and swore at staff when they attempted to encourage compliance. The progress notes did not include documentation that the resident was offered any behavioral health referrals or support related to their anger, irritability and non-compliance. Further review of progress notes documented that on [DATE], Resident 34 received a large dose of long-acting insulin (medication used to control blood sugar levels in diabetes management) that was ordered for a different resident. Between [DATE] and [DATE], Resident 34 developed symptoms of extremely low blood sugar, became pale, lethargic, sweaty, and had altered levels of consciousness. Resident 34 required emergent administrations of rescue medications five different times during that time period. On [DATE] at 8:39 AM, Resident 34 was observed lying in bed. The resident had eaten breakfast and appeared tired and pale. Resident 34 stated they did not know how low their blood sugar had become during the night but remembered they had been talking and not making sense. They stated when their blood sugar went down so low they felt like they were going to die. On [DATE] at 9:09 AM, Resident 34 was observed seated on the edge of their bed. Resident 34 stated they felt much better that morning, but had been afraid to go to sleep the night before because they thought they would not wake up if they did. The resident stated they would catch themself dozing off, then startle awake and felt like they could not breathe and became anxious. Resident 34 stated they wanted to get better, be able to walk again and get rid of using oxygen so they could get on a kidney organ donor list. Resident 34 stated they knew they would have to work hard and needed support because they were an alcoholic and addict. They stated that without support it was easy for them to go back to their old ways, and they did not want to do that. Resident 34 stated they knew a couple of missionaries in the area and was going to see if they would visit the resident. During an interview on [DATE] at 6:48 AM, Staff E, Social Services Coordinator, stated they were aware Resident 34 had a Level II PASRR determination but had not received a copy of the Psychiatric Evaluation Summary. Staff E thought the summary was needed before behavioral health services were implemented so Resident 34 had not been referred for services. Staff E stated they had not discussed alcohol dependence with Resident 34 and was not aware Resident 34 made statements regarding returning to old ways and needing support. Staff E stated the facility was in the process of changing behavioral health providers. Their current provider did not come to the building in person, only did visits remotely through an online internet forum. Staff E stated the resident's history and refusals of care and medications could have been a flag that they needed behavioral health services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:20 PM, Resident 34 was not in their room. The resident's bed was made and two bags of personal belongings were packed and on the bed. Upon inquiry, Staff A, Administrator, stated Resident 34 had left the faciity on [DATE] at approximately 8:00 PM, had not signed out, and left with a man that staff were not familiar with in an older Suburban-type vehicle. The resident had not returned yet, and their family and the police had been notified. Staff A stated on [DATE] at 4:30 PM, Resident 34 had left with the same gentleman without signing out but had returned on their own at 11:00 PM. Staff A stated they had called the dialysis center and were notified the resident had not shown up for their dialysis session and Staff A was waiting for an update from the police. At 2:25 PM, Staff A stated the police notified the facility the resident was with a friend and knew the resident's location. A review of additional progress notes documented Resident 34 left the faciity on [DATE] at approximately 8:00 PM and had not signed out. Staff B, Director of Nursing, was notified on [DATE] at 1:00 AM that Resident 34 had not returned to the facility. A decision was made to wait until morning to see if the resident returned. It was further documented that Resident 34 returned to the facility on [DATE] at 4:45 PM and smelled of marijuana. The resident was placed on alert charting for withdrawal symptoms after a family member's statement that Resident 34 became agitated when they came down from drinking. The resident denied drinking or drug use, but agreed to a toxicology screen and blood work at dialysis and a make-up dialysis session was scheduled for [DATE]. During an interview on [DATE] at 10:51 AM with Staff A, Administrator, Staff B, Director of Nursing, Staff C, Clinical Resource Nurse, and Staff Q, Director of Clinical Services, Staff C stated the facility's behavioral health team was changing beginning [DATE] and Resident 34 was on the list to be seen by the providers. When asked, Staff B stated they had not followed up yet to see if there were any results from Resident 34's toxicology blood work. <Resident 40> Review of the record documented Resident 40 admitted to the facility on [DATE]. The [DATE] quarterly assessment documented Resident 40 had diagnoses that included stroke, major depressive disorder with psychotic (loss of contact with reality) symptoms and delusional (a false belief despite evidence to the contrary) disorder. The resident had moderate cognitive impairment, socially isolated often, felt bad about themselves, depressed and hopeless, had little energy, sleep disturbances and little interest or pleasure doing things half or most days. Resident 40 was dependent on staff for most activities of daily living and took an antipsychotic, antianxiety and antidepressant medication daily. The [DATE] care plan documented Resident 40 had potential to exhibit behaviors related to a history of stroke and delusions. Staff were instructed to assist the resident to develop more appropriate methods of coping and interacting, encourage to express feelings, explain all procedures, the resident did not like to be reminded of realty and believed they had snakes and pet dogs in their room, allow them to be happy with their hallucinations, PASRR level II request faxed to the state assessor. On [DATE], the care plan was updated to include help redirect the resident when they are having hallucinations, had seen a telehealth counselor at their previous facility. Social Services to assist the resident in communicating with a counselor. On [DATE], the care plan was updated to include monitor behavior episodes and attempt to determine the underlying cause and document the behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Level I PASRR completed on [DATE] documented a Level II psychiatric evaluation to determine behavioral health needs was indicated. There was no Level II assessment in the resident's EMR. A [DATE] Physician Assistant progress note documented Resident 40 was still delusional despite an increase in their antipsychotic medication. A repeat Level I PASRR completed on [DATE] documented Resident 40 had serious mental illness, and a Level II psychiatric evaluation was indicated. The form documented the resident self-isolated, refused care, and had hallucinations and delusions. Resident 40's care plan did not have additional goals or interventions developed related to their ongoing psych-social needs or behavioral health concerns related to ongoing distressing delusions, self-isolation and hallucinations. A review of Staff E, Social Services Coordinator, progress notes documented that in May of 2024, a request for a Level II PASRR behavioral health evaluation was resubmitted as Resident 40 continued to have delusions and distressing hallucinations and dreams. Facility provider progress notes dated [DATE] and [DATE] did not mention Resident 40's mental health needs or any changes to their behavioral health careplan. From ,d+[DATE] to ,d+[DATE], there were no behavioral health referrals or behavioral health provider progress notes in Resident 40's EMR. A further review of Staff E progress notes documented in early December of 2024, the State PASRR evaluator was called in follow up, and notified Staff E that the evaluators were backlogged and were concentrating on hospital residents first. On [DATE], Staff E asked Resident 40 if they wanted a session with the facility psychiatric provider via a telehealth conference and Resident 40 declined. On [DATE], Resident 40 stated they felt better, were adopting 14 children and would then have 19 children total with their famous multi-billionaire fiance. On [DATE], Resident 40 cried uncontrollably, stated their son died in a car accident. The following day, Resident 40 stated the car accident was a dream. A [DATE] quarterly long term care (LTC) Case Management Summary documented Resident 40 took antipsychotic medications and no gradual dose reduction (GDR) was recommended so their symptoms did not worsen. The care plan was not updated to include behavioral health interventions to provide the resident relief from distressing symptoms of their delusions. On [DATE], further Staff E progress notes documented a gradual dose reduction of Resident 40's antipsychotic medications was contraindicated because of risk of worsening long-term psychiatric symptoms. A [DATE] Nurse Practitioner annual wellness progress note documented no specialist referrals were necessary or appropriate at this time. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:03 AM, Resident 40 was observed lying in their bed. The privacy curtain was pulled so that the resident was unable to be viewed from the door. There was a bar over their head to assist them to move in bed, and a wheelchair was across the room, not in use. The resident had a very flat (void of expression) affect. When asked how they were doing, Resident 40 asked How much time do you have, then declined to elaborate. They stated they did not use their wheelchair, and did not like to leave their room. The resident was observed in bed with the privacy curtain pulled on [DATE] at 9:02 AM and 4:15 PM, and [DATE] at 8:20 AM. During an interview on [DATE] at 6:48 AM, Staff E stated Resident 40 came to their facility from the neighboring state and they resubmitted Resident 40's PASRR evaluation in May of 2024. Staff E stated they were aware regulations regarding PASRR referrals had changed in ,d+[DATE] and was told by the evaluators they did not need to resubmit new evaluation requests for all the residents. The recommendation was for resident PASRRs be reviewed when there were care conferences and resubmitted at that time if needed. Staff E stated they followed up with the evaluators regarding Resident 40 in December of 2024, but had not reached out since. Staff E stated Resident 40 had been attending teleconference behavioral health sessions at their previous facility but had not done any after their admission. Staff E stated their current provider only did teleconference sessions, which Resident 40 declined. Resident 40 did not want to leave their room and the facility had no providers that came in person to the facility so Resident 40 did not get counseling services. Staff E stated Resident 40 continued to have delusions so staff tried to re-enforce the happier ones because the resident did not like their perception of reality challenged. Staff E stated some of Resident 40's delusions were distressing to the resident and were potentially harmful psychologically. They stated they believed a counselor was the best one to help Resident 40 navigate their mental illness. During an interview on [DATE] at 03:17 PM, Staff D, Resident Care Manager, stated Resident 40 still had many active delusions but had declined teleconference sessions with the facility's current provider. Staff D confirmed the facility currently had no providers that came to the facility in person and the facility was working to obtain more behavioral health providers. Staff D stated Staff E usually developed the care plans regarding residents social-behavioral needs, but nursing was able to add to a care plan if they identified an area of concern. Staff D stated they expected to see elements of behavioral health incorporated in to Resident 37's care plan, and acknowledged they should be looking for those elements when the initial comprehensive admission assessment was completed. During a follow-up interview on [DATE] at 3:52 PM, Staff E stated care plans were to be reviewed and if interventions were not effective others should be implemented. Staff E stated when the LTC case management care conferences were held, that was a time that care plans could be updated and the updates could be completed by them or nursing. Staff E stated the facility had intended to have meetings every Tuesday to ensure care plans were reviewed timely but those had not happened. Reference: WAC ,d+[DATE]-(1060)(3)(e) Also see F644 related to PASRR evaluations

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure appropriate medically related social services were provided to meet residents' needs at the time of transfer to the hospital or discharge to the community. Specifically, Social Services failed to ensure the basis for discharge was supported by documentation in the medical record for 1 of 4 sample residents (Resident 4), reviewed for discharge. This failure placed the resident at risk of placement in an unsuitable environment, increased risk of harm, and psychological distress. Additionally, Social Services failed to notify the Office of the State Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes who protect and promote the resident rights under federal and state law and regulations) of 37 transfers to the hospital for 5 of 5 months (January, February, March, April and May 2025) reviewed. Failure to notify the Ombudsman of hospital transfers, precluded the Ombudsman from effectively advocating for the residents' rights and ensuring the residents were not being unfairly or improperly discharged or transferred. Findings included . Review of the facility policy titled, Discharge Planning Process revised April 2025 showed, the interdisciplinary team (IDT), including the resident and resident advocate, identify the discharge needs of each resident to develop interventions to meet the needs the resident's discharge goals and needs to ensure a smooth and safe transition form the facility to the post-discharge setting. Discharge planning began at admission ad was based on the resident's assessment, goals for care, desire to be discharged , and the resident's capacity for discharge. Discharge planning included procedures for determining the resident was discharged to a location that safely met their needs and preferences. For residents who desired to discharge to a location that was determined to not be feasible, the medical record must contain information about who made the decision and the rationale for the decision. The policy further showed discharge planning included identifying changes in the resident's condition, which may have an impact on the discharge plan, warranting revision to interventions. The IDT was to consider caregiver's availability and the resident's or caregiver's capacity and capability to perform required care, as part of the identification of discharge needs process. The IDT was to timely document basis on the resident needs, and document in the clinical record the evaluation of the resident's discharge needs, the discharge plan, and discussions with the resident and/or the resident's advocate. BASIS FOR DISCHARGE (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 02/04/2025 quarterly assessment showed Resident 4 admitted to the facility on [DATE] with medically complex conditions, to include Parkinson's disease (a progressive neurological disorder) seizures (sudden brief disruptive brain activity), anxiety, depression and chronic pain. The assessment further showed Resident 4 was cognitively intact, was dependent on staff assistance for bathing, required substantial/maximal assistance for bed mobility and transfers, and set-up or clean up assistance for other Activities of Daily Living (ADLs). Resident 4 had no indicators of depression or behaviors that interfered with their care or affected the well-being of other residents and no behavior changes from the previous assessment. The assessment showed no active discharge planning was occurring for the resident to return to the community and the resident did not want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community. Review of the diagnosis list showed Resident 4 had the absence of the right leg above the knee, or amputation. Review of a 10/30/2024 care plan showed Resident 4 previously lived in an apartment locally but planned to remain in the facility until they were fitted for a prosthetic (a device designed to replace a missing part of the body), their wound healed and could get an apartment in the area with care givers. The care plan showed Resident 4 was unable to reside at home due to [their] inability to attend to [their] ADL's and [their] multiple medical conditions. The care plan also showed the facility would establish a pre-discharge plan with resident/resident advocate, evaluate progress, and revise the plan as details were determined. Review of a 12/18/2024 Social Service progress note showed, Rural resources helped Resident 4 fill out apartment applications for apartments in nearby towns and re-iterated that the resident desired to have caregivers in the community after they were fitted with a prosthesis. Review of a 02/28/2025 behavior progress note showed staff interviewed Resident 4 about the accusation they made that another facility resident (Resident 19) bruised their right forearm and adamantly insisted the bruise was not from a recent fall but from Resident 19, that they had voiced concerns about. The note documented Resident 4 was not a good historian and had fixated on this other resident 'assaulting' [them]. Resident 4 made the staff aware Resident 19 targeted them by following and chasing them. Review of Resident 19's nursing progress notes showed that on 02/19/2025 Resident 19, visibly upset, met Resident 4 in the hallway while propelling their wheelchairs near Staff E's, Social Services Coordinator, office. Resident 19 grabbed Resident 4's long sleeve shirt and did not want to let go and told Resident 4, I do not like you. Resident 4 answered, [Resident 19] always does this. Staff E then came out of [their] office and pried [Resident 19's] hands off [Resident 4's] clothing. When Staff E asked Resident 19 why they grabbed Resident 4, Resident 19 told Staff E because Resident 4, is alive. The progress note showed, No staff saw who started the res-to-res [resident to resident] altercation but that Resident 4 was known to dislike and confront dementia residents. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 4's progress notes showed on 04/09/2025 a care conference was held; the facility issued a 30-day notice to Resident 4 as they were independent in their ADLs and the last day at the facility would be 05/08/2025. The note further showed Resident 4, has been struggling to live peacefully with residents that have dementia. Other residents' behaviors caused Resident 4 to have verbal and physical outbursts towards them. Resident 4 was educated on ignoring the dementia residents as they pass by, but Resident 4 challenged them directly. Resident 4 struggled with anger issues and Resident 4's representative would find the resident housing in a month or Resident 4 would move in with the representative locally. Additional record review showed no documentation Resident 4 was involved in any resident-to-resident altercations or displayed behavior that endangered their safety or of other individuals in the facility. Review of the 04/09/2025 Nursing Home Transfer or Discharge Notice showed the reason for Resident 4's discharge was because, the safety of other individuals in this facility is endangered due to the status of the resident. The form showed Resident 4 and a former Administrator of the facility signed the notice. Review of the September 2024 through May 2025 facility incident reporting log showed no entries Resident 4 was involved in any resident-to-resident altercations or displayed behavior that endangered their safety or the safety of other individuals in the facility, contrary to the basis for discharge in the 04/09/2025 Nursing Home Transfer or Discharge Notice given to the resident. Review of the March 2025 through May 2025 Treatment Administration Record (TAR) showed an order that instructed the staff to, Monitor and document all behaviors! such as accusations, anxiety, verbal behaviors and physical behaviors towards staff or other residents. The TAR showed the nurses documented their initials and either a + or a - symbol. In an interview on 05/23/2025 at 8:41 AM, Staff LL, LPN, stated the - symbol in the TAR meant no behavior was identified and the + meant a behavior occurred. Additionally, Staff LL stated when the nurse chose the + symbol, it prompted a narrative box wherein an explanation of the behavior observed was to be documented. Additional review of the TAR showed Resident 4 did not exhibit behaviors from 03/09/2025 through 05/07/2025. Review of a 04/17/2025 Mental Health Provider progress note showed Resident 4, discussed interpersonal challenges [they] experienced with other residents at the facility, particularly [Resident 19]. The note showed Resident 4 told the provider they were asked to leave the facility due to [their] behavior and use of language towards other residents. The client described [their] emotional reactions to the behaviors of other resident [and] expressed feelings of frustration, anger, and helplessness. The client also shared feelings of regret and remorse for [their] own actions that resulted in [the] discharge from the facility. Review of a 05/07/2025 Discharge Note showed the facility discharged Resident 4 to live in a tiny home outside of [the representative's] house. Resident 4 discharged at wheelchair level due to their leg amputation and with no mention or status of obtaining the prosthetic. Review of an associated 05/07/2025 Planned Discharge Summary showed the Reason(s) for Discharge was Condition Improved, contrary to the basis for discharge in the 04/09/2025 Nursing Home Transfer or Discharge Notice given to the resident. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/15/2025 at 2:15 PM with Resident 4's former roommate, Resident 36 stated they lived with Resident 4 for a Couple of months. Resident 36 stated they never felt afraid of Resident 4. Resident 36 said Resident 4 tried to stay away from Resident 19 and did not witness Resident 4 exhibit verbal or physical aggression towards Resident 19. In an interview on 05/16/2025 at 11:18 AM, Resident 4's representative stated Resident 4 was discharged from the facility, because they don't want [the resident] there. The Resident Representative (RR) further stated they were told by Staff E that Resident 4, was cussing out everybody and was pretty much independent and they're gonna' release [the resident]. It was a total surprise [Resident 4] was being released, came out of left field there. The RR stated Resident 4 informed them Resident 19, was coming after [Resident 4] and there were other issues too [of] other clients going through [their] room and taking stuff. The RR further added Resident 4 also informed them Resident 19 made threats to Resident 4 and they were not used to dealing with that type of confrontation from another resident. The RR said, It all came to a head in the discharge notice. They never shared this stuff with us. We were very disappointed. [The facility] didn't keep us in the loop. Then we get a special meeting that they are discharging [Resident 4] so now we are building a tiny house in our backyard. We had 30 days to build this. The RR said Resident 4 was not independent and required a caregiver. In an interview on 05/19/2025 at 4:24 AM, Staff OO, Agency NA, said they were familiar with Resident 4. Staff OO explained if a resident showed concerning behaviors, they would document the behavior in the electronic medical record and, we also write a witness statement and give it to the nurse. Staff OO described Resident 4's behaviors as, making allegations of abuse towards staff and asking for requests repeatedly. Staff OO stated Resident 4 displayed no mood outbursts, did not know of any behaviors that placed the resident or other residents at risk for harm or endangerment, resident-to-resident altercations, or of other resident concerns against Resident 4. In an interview on 05/21/2025 at 9:15 AM, Staff K, Nursing Assistant (NA), stated Resident 4's behaviors consisted of, snooty or rude remarks, and did not yell at or was physically aggressive towards other residents nor did their mood deteriorate or escalate throughout their stay at the facility. Staff K said Resident 4's mood or behaviors did not place themselves or other residents at risk of verbal or physical abuse and was unaware if other residents voiced concerns about Resident 4's mood or behavior or incidents of resident-to-resident altercations. In an interview on 05/21/2025 at 9:38 AM, Staff M, Licensed Practical Nurse, stated Resident 4 was wheelchair bound, had an amputated leg, and did not place others at risk for harm. Staff M stated Resident 4 became irritated when they had to maneuver their wheelchair through the room to get to their bed by the window. Staff M did not recall Resident 4 was involved in any verbal or physical resident-to-resident altercations. The above findings were shared with Staff E on 05/23/2025 at 8:29 AM. Staff E stated Resident 4 was discharged from the facility as, It was a combination of effects. We gave [Resident 4] a 30-day notice because of [their] behaviors. Staff E said Resident 4 was, egging them [other residents] on. When asked to reconcile the medical record with the reason for discharge in the 04/09/2025 Transfer or Discharge Notice given to Resident 4, Staff E stated, Nursing and CNAs [Nursing Assistants] potentially didn't document [Resident 4's] behaviors very well. Staff E acknowledged the medical record did not show how Resident 4's presence in the facility endangered the safety or health of others, nor support a discharge from the facility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	OMBUDSMAN NOTIFICATION On 05/15/2025 at 3:28 PM, the Survey team requested documentation that showed residents who experienced a transfer to the hospital between January 2025 through May 2025. Review of the discharge report provided by the facility showed a total of 37 transfers to the hospital occurred between 01/01/2025 and 05/16/2025. Review of a facility Ombudsman Notification History Report from 11/20/2024 through 04/30/2025 showed no inclusion of the 37 transfers to the hospital. The facility only notified the Ombudsman of planned discharges to the community or another level of care. The above findings were shared with Staff E on 05/16/2025 at 1:21 PM. Staff E stated they were responsible for notifying the Ombudsman monthly of normal discharge from the facility and for 30 day notices we fax it right away on that date. Staff E stated, As far as I know we don't need to notify the Ombudsman [for hospital transfers]. We haven't been trained on that. I did not know that. Staff E acknowledged they did not notify the Ombudsman of hospital transfers as, It was not the practice. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected the Ombudsman to be notified of hospital transfers. Reference WAC 388-97-0960 (1). Refer to F600, and F699 for additional information. 47328

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure medications were administered as prescribed for 2 of 6 sampled residents (Residents 34 and 61) reviewed for medication administration. Resident 34 received an injection of Lantus insulin (a type of insulin used to treat high blood sugar that provided a consistent level of insulin over a 24-hour period and mimicked the body's natural insulin production) that was 7.2 times their prescribed dose that was ordered for a different resident (Resident 42). Resident 34 experienced harm when they had an extended period of symptomatic hypoglycemia (extremely low blood sugar) that required administration of rescue medications on five different occasions to normalize their blood sugar level and symptoms. Additionally, Resident 61 did not receive their ordered doses of a blood thinner and an injectable medication that managed weight and blood sugar which placed the resident at risk for unintended health consequences. Findings included . The ISMP, or the Institute for Safe Medication Practices, is a recognized leading authority in medication safety information. It is dedicated to preventing medication errors and promoting safe medication practices. According to the ISMP, insulin and anticoagulants (blood thinners) are considered high alert medications. High alert medications are drugs that bear a heightened risk of causing significant harm to the resident when they are used in error. The consequences of an error can be devastating to residents. <Insulin> <Resident 34> The 04/08/2025 Admission assessment documented Resident 34 had diagnoses that included diabetes, and end-stage kidney disease dependent on dialysis (use of a machine to filter toxins from the body when the kidneys no longer functioned). Resident 34 was cognitively intact and received insulin injections (medications that lowered blood sugar levels) daily. During an initial interview on 05/13/2025 at 10:18 AM, Resident 34 was observed seated on the edge of their bed. Their half-eaten breakfast tray remained on their overbed table. The resident was alert, pointed to a container of orange juice and stated normally they were supposed to limit their fluids but were given orange juice because they were given too much insulin that morning. A review of the record documented the following: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The 04/02/2025 care plan showed Resident 34 had diabetes. Staff were instructed to administer diabetes medications as ordered by the provider, monitor for effectiveness and side effects, monitor/record/report to the provider signs or symptoms of hypoglycemia (low blood sugar) to include sweating, tremors, fast heart rate, pale skin color, confusion, or slurred speech. If hypoglycemic, defined as a blood sugar level below 70 milligrams per deciliter (mg/dl), staff were to treat according to the hypoglycemic protocol, document the treatment, interventions, symptoms, and assessment in the progress notes. Resident 34 had the following provider orders: -04/02/2025 check finger stick blood sugar level before meals and at bedtime. If blood sugar is below 70 mg/dl, initiate hypoglycemic protocol and notify the provider. -04/02/2025 hypoglycemic protocol-if able to take oral, give 15 grams (gm) of fast acting carbohydrates, recheck blood sugar in 15 minutes. If still less than 70mg/dl, give another 15 gm fast acting carbohydrate. Recheck blood sugar in 15 minutes. If still less than 70 notify the provider. Once above 70mg/dl, give a protein snack or assist to next meal. Document intervention on the Medication Administration Record (MAR) as follows: J=4 ounces of fruit juice, S=4 ounces of soda, C=6 saltine crackers, G=tube of glucose gel. May repeat in 15 minutes. -04/02/2025 Glucagon (fast acting sugar solution) HypoPen injector, inject 1mg as needed for blood sugar less than 70mg/dl and unable to swallow. Recheck in 15 minutes. If no improvement, notify the MD immediately. -04/15/2025 Lantus (long acting, effect lasted 24 hours) insulin, inject 10 units at bedtime. -04/15/2025 Humalog (fast acting, short duration of effect) insulin, inject 3 units before meals. -05/13/2025 at 11:00 AM check fingerstick blood sugar every hour for 12 hours for diabetic monitoring. -05/14/2025 at 6:00 AM alert charting; Lantus 72 units given, monitor for signs/symptoms of hypoglycemia, document a health status note if side effects occur. 72 units was given instead of 10 units = 7.2 times the prescribed dose of lantus. Significant medication error. A review of nursing progress notes documented the following events: A late nursing entry progress note effective 05/13/2025 at 10:42 AM documented the Medical Director was notified of the occurrence at 10:32 AM. At 11:06 PM, Resident 34's blood sugar result was 80. The resident ate shrimp with cocktail sauce. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 05/14/2025 at 12:03 AM, Resident 34's blood sugar result was 109. There were no signs of hypoglycemia. At 1:02 AM, the blood sugar result was 103, with no signs of hypoglycemia. At 2:04 AM, the blood sugar result was 85. The resident was given half of a peanut butter and jelly sandwich and had no signs of hypoglycemia. At 2:41 AM, the resident had not eaten the sandwich and stated they felt stuffed. At 3:27 AM, the blood sugar result was 83 and there were no signs of hypoglycemia. At 4:24 AM, the on-call provider was notified that the blood sugar level was 70 and Resident 34 was having difficulty taking anything orally other than juice. Instructions were given to give the glucagon injection if the blood sugar dropped below 70. At 6:11 AM, Resident 34's blood sugar was 64, and the resident was given the rescue glucagon injection. On 05/14/2025 at 12:59 PM, a progress note documented alert charting regarding Lantus 72 units given. No adverse drug reaction from the Lantus administration, the resident awakened easily, ate breakfast, and went to dialysis at 9:30 AM. The note documented the blood sugar levels had been within normal limits even though rescue glucagon had been administered. On 05/14/2025 at 3:23 PM, a progress note documented the registered nurse (RN) from dialysis called and notified the facility that Resident 34's blood sugar was 50 earlier, the resident was given a dose of rescue glucagon gel, and the blood sugar came up to 91. The blood sugar then dropped to 38 (a critical level). More glucagon gel was administered, and the blood sugar came up to 89. On arrival back to the facility, Resident 34's blood sugar was 48 and the charge nurse attended to the resident. Resident 34 was pale and sweating and was given another injection of glucagon and two packets of sugar. At 3:39 PM, Resident 34 was given another packet of sugar for a blood sugar of 62. The resident reported they ate only yogurt from their sack lunch at dialysis. On 05/14/2025 at 9:34 PM, the progress note documented the resident had no adverse drug reaction from the 72 units of Lantus given the day prior. The blood sugars ranged from 48 to 299 and the resident ate well. Resident 34 was given their own scheduled bed time dose of Lantus 10 units for the blood sugar result of 299. Monitoring continued. The progress notes did not document any further review with the provider of blood sugars results or notification the resident had received rescue medications four times thus far. On 05/15/2025 at 4:40 AM, the progress notes documented the nursing assistant notified the nurse that Resident 34 had abnormal behavior and mumbled their words. The resident was sweating and lethargic and unable to swallow and had little response. Resident 34's blood sugar was 36, and glucagon was injected at this time. At 5:05 AM, the repeat blood sugar was 72. The resident reported they had not eaten dinner before bed, only Cheetos. The provider, Director of Nursing, and Resident Care Manager were notified. On 05/19/2025, Staff O, Nurse Practitioner (NP), documented Resident 34 was seen for a Federally Mandated Visit. When evaluated, the resident was in bed, sleepy but agreeable to the visit. The resident reported adequate appetite, denied pain, and had been started on an antibiotic for a urinary tract infection. There was no mention in the progress note that the resident had been symptomatic with low blood sugar levels the days prior. A review of the May 2025 MAR did not show documentation of the administration of glucose gel per the hypoglycemic protocol, or the rescue injections of glucagon. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A 05/13/2025 at 8:00 AM incident report documented Resident 34 was given 72 units of Lantus intended for another resident. The provider had been notified, and staff were instructed to check blood sugar levels every hour for 12 hours and hold Resident 34's scheduled insulin. The incident report documented that on 05/14/2025, the post-incident review was completed. Findings noted that during the morning medication pass, Resident 34 was to receive 10 units of Lantus while a different resident was to receive 72 units of insulin. Staff P, Licensed Practical Nurse, recently licensed, was orienting and worked in tandem with Staff L, RN. They simultaneously checked blood sugars and prepared medications for multiple residents. Staff P was handed a pre-drawn insulin syringe, became confused and administered 72 units of Lantus to the wrong resident. It was recommended that both Staff P and Staff L be provided with education regarding the rights of medication administration. The investigation packet included a Cascadia Healthcare Medication Administration-Oral competency checklist. The form instructed one on the correct procedure for administering medications to include comparing the medication label with the MAR to ensure the right medication was given, preparing medications for one resident at a time, ensuring the right resident by checking the resident's name, photo, and asking the resident to identify themselves, and checking to ensure the right dose by checking the medication label and the order. Staff B, Director of Nursing initialed that Staff P had been satisfactorily reviewed regarding ensuring the right resident, right medication, right dose, right route, right time, in the appropriate form, with the right documentation, right rationale and right response. The form was signed and dated by Staff P on 05/19/2025. On 05/15/2025 at 8:39 AM, Resident 34 was observed in bed covered in blankets. The resident looked pale and appeared tired. Resident 34 stated they did not know how low their blood sugar had been during the night, but was aware they had been talking and did not make sense. Resident 34 stated that when their blood sugar dropped down so low, they felt like they were going to die. Resident 34 stated they currently had a headache, and they did not understand why their blood sugar levels were all over the place. On 05/16/2025 at 9:09 AM, Resident 34 was observed seated on the edge of their bed. They were dressed, groomed, had color in their cheeks, and were more animated than the prior observation. Resident 34 stated they felt much better and ate well. They stated they had been afraid to go to sleep the night prior because they thought if they did, they were going to die. They stated they caught themselves dozing off and snapped awake then felt anxious. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/19/2025 at 6:14 AM, Staff L, RN, stated in the beginning of their shift on 05/13/2025, they instructed Staff P that they would prepare medications for Resident 42 and Staff P was to stay right by their side. Staff L was to hand the medication to Staff P, then go with Staff P and observe Staff P give medications to Resident 42 because the facility residents did not wear identification bracelets. Staff L stated they prepared the medications for Resident 42, handed them to Staff P, and stated they would meet Staff P in the resident's room. Staff L stated they closed their laptop and looked at the narcotic sign out book, then went in Resident 42's room. Staff L did not see Staff P in the room and saw that Staff P had gone in the room next door. Staff L stated when they went in Resident 34's room, Staff P had already finished injecting Resident 42's insulin into Resident 34. Staff L stopped Staff P before any other pills were administered. Staff L stated they discussed resident identification, but Staff P was flustered so they focused on the management of Resident 34 for hypoglycemia and Staff P did not give any other medications after that. Staff L stated they should have gone in the room with Staff P to give the medications. They stated they had not been given a checklist to verify Staff P's competencies while they were oriented. Staff P was unsure what on-boarding Staff P had received when they began their employment. Staff P was not aware Resident 34 required the use of rescue medications five times and agreed the resident had been harmed. During an interview on 05/20/2025 at 11:34 AM, Staff P stated they had worked for the facility for about one month and they had just received their LPN license recently. Staff P stated their orientation to the facility included filling out paperwork, instructions on how to don and doff personal protective equipment and hand hygiene. Staff P stated there had been a recent skills fair, and staff read information from a poster board then signed that they had read it. Staff P stated they had not been given a medication competency checklist until after they had given Resident 34 the wrong insulin. Staff P stated they had been told that the best way to learn who the residents were was to work as a nursing assistant and so they mainly worked obtaining blood sugars and vital signs instead of learning the role as an LPN. Staff P stated on the morning of the medication error, they had checked the blood sugars for both Resident 42 and Resident 34. Staff P stated Staff L prepared the medications for Resident 42 and handed them to Staff P. They had taken Resident 34's blood sugar last, so took the medications to Resident 34 and gave Resident 34 the insulin intended for Resident 42. They became distraught after the medication error and intended to submit their letter of resignation after the surveyor interview was concluded. During an interview on 05/21/2025 at 2:38 PM with Staff D, Resident Care Manager (RCM), and Staff N, RCM, Staff D stated the RCMs each took a hall and watched staff nurses pass medications from start to finish. They stated each nurse completed the competency yearly and signed a form. Staff N and Staff D stated they had been made aware of the insulin error right away, right after Staff P and Staff L had notified the provider. When asked if they had considered sending Resident 34 to the emergency room or having a provider see the resident, Staff N stated they notified the provider, gave the glucagon and did closer monitoring and they were able to manage the resident. Staff N stated if they had given the glucagon and the resident did not improve or if the resident had become unconscious, they would have sent the resident to the hospital. Staff N stated they had just recently gone over a document, 10 Rights for Safe Medication Administration with the nursing staff and provided the staff a copy, which included ensuring the resident and the right dose. Staff D stated they expected staff to document all medications including rescue medications to be documented in the MAR. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/22/2025 at 2:24 PM, Staff O, NP, stated they had been notified through their on-call service that Resident 34 had been given someone else's insulin. Staff O stated they examined the resident on 05/19/2025 for staff reports of symptoms of a urinary tract infection but had not been notified that Resident 34 had required rescue medications 5 different times. They agreed the resident might need to be hospitalized to stabilize their blood sugar. Staff O stated they expected to be notified when a resident had blood sugars in the 30's and required rescue medications. They said waiting until a resident was unconscious before sending them to the emergency room was too late. 40297 <Anticoagulant> <Resident 61> Review of a 04/27/2025 admission assessment showed Resident 61 admitted to the facility on [DATE], was assessed as cognitively intact, and had the diagnosis of diabetes with long term use of insulin and atrial fibrillation (an irregular heart rhythm). This assessment showed Resident 61 received an anticoagulant (a blood thinner) and insulin. Review of an April 2025 MAR showed an order to administer Xarelto (an anticoagulant) every evening. The MAR showed NA or Medication Not Available on 04/24/2025. Review of a 04/24/2025 eMAR Note showed the reason the medication was not available was because the Medication [was] back ordered [,] spoke with [pharmacy]. Review of a pharmacy inventory list for the emergency medication stock in the facility showed the Xarelto was available. Review of the progress notes showed no documentation of what the staff did to procure the anticoagulant or notified the provider of the missed dose. The above findings were shared with Staff B on 05/16/2025 at 9:05 AM. Staff B stated that Xarelto was available in the emergency medication stock and that the nurse should have called the provider and let them know the medication was not given or missed. Staff B stated the facility monitored for missed medication doses by pulling a daily report from the electronic medical record and reviewed medication errors in the daily clinical meeting. When asked if the facility identified and addressed why the staff failed to administer the Xarelto to Resident 61, Staff B stated, they completed a risk management review if the drug could cause harm, to include a drug like Xarelto. When asked if the facility completed a review on the missed high alert drug dose, Staff B stated, For that one, nope. <Other> Review of a pharmaceutical package insert showed Ozempic was an injectable medication that when used along with diet and exercise helped improve glycemic (blood sugar) control and reduced the risk of major adverse cardiovascular (heart) events in individuals with diabetes. Following the dosing schedule was essential for the medication to work correctly. If a dose was missed, it should be administered as soon as possible within five days after the missed dose. If more than five days had passed, the missed dose should be skipped and the next dose administered on the regularly scheduled day. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 61's April and May 2025 Medication Administration Record (MAR) showed an order for the staff to administer an injection of Ozempic every Friday. The scheduled doses for 04/25/2025, 05/02/2025, and 05/09/2025 were marked as NN or Other/See Nurse Notes. Review of the progress notes for 04/25/2025 showed no documentation why the staff did not administer the Ozempic. Review of a 04/29/2025 provider note showed, Ozempic daily and Continue Ozempic. Review of a 05/02/2025 electronic MAR (eMAR) Note showed the staff did not administer the Ozempic because the medication was still, On order, that Staff N, Resident Care Manager, was aware, and pharmacy needed permission from the facility to bill the facility for the medication before dispensing it. The note showed Staff B had the required paperwork to authorize billing to the facility. Review of a 05/06/2025 provider note showed, Ozempic daily. Review of a 05/09/2025 eMAR Note showed that on the scheduled third weekly dose, the staff administered the Ozempic for the first time since admission to the facility. In an interview on 05/16/2025 at 8:58 AM, Staff B, Director of Nursing, said, I know there was like a discussion about [the resident] bringing in [their] medication from [previous community living setting]. I think [the resident] told us not to order it or [they were] gonna' bring it and [they] didn't bring it in, and we didn't pay for it. Staff B acknowledged the staff did not administer Resident 61 the Ozempic as ordered on 04/29/2025 and 05/02/2025 and constituted medication errors. Reference WAC 388-97-1060 (3)(k)(iii). Refer to F684 for additional information.

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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. 42802 Based on observation, interview and record review, the facility failed to ensure medications were labeled in accordance with accepted professional standards and expired medications were removed from inventory. Specifically, insulin pens were not labeled with the date opened in one of two medication carts, and expired Bisacodyl suppositories (a medication to treat constipation) were found in one of two medication carts and the only medication room. This failed practice placed residents at risk of receiving expired medications, that may not have been fully effective. Findings included . According to Medscape.com, insulin pens must be discarded 28 days after opened. The facility policy titled Medication Management, revised 10/15/2022, documented medications were to be discarded by the expiration date or earlier. <Rehab Medication Cart> During an inspection of the Rehab medication cart on 05/21/2025 at 12:31 PM, the following was noted: 1) An opened Lantus (a long-acting insulin) pen for Resident 47, without a date of when the pen was opened. 2) An opened Novolog (a fast-acting insulin) pen for Resident 54, without a date of when the pen was opened. 3) Three Bisacodyl suppositories, with an expiration date of 01/2025 (4 months ago.) During a concurrent interview, Staff G, Registered Nurse, RN stated that if they came across any expired medications when passing meds, they would discard them. Staff G then discarded the insulin pens and the suppositories. Staff G stated they thought a nurse went through the carts periodically to check for expired meds. During an interview on 05/21/2025 at 3:26 PM, Staff H, RN stated the usual practice was to mark the date when the insulin pen was opened, so staff knew to discard them after 30 days. Additionally, Staff H stated they would not give medications that had expired. A review of Resident 47's medical record documented they received Lantus daily since 04/07/2025. A review of Resident 54's medical record documented they received Novolog as needed starting on 04/15/2025. The Medication Administration Record (MAR) showed it was given 12 times in May of 2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Medication Room> During an inspection of the facility medication room with Staff F, Resident Care Manager, RCM, observed an opened box of Bisacodyl suppositories that expired on 04/2025 (last month). Staff F stated their expectation was that expired medications should be discarded so they were not inadvertently given, and that insulin pens should be dated when first opened, so they could be discarded after 28 days. Reference: WAC 388-97-1300(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40297 Based on observation, interview and record review, the facility failed to ensure staff performed the required hand hygiene (HH) during meal service for 1 of 2 dining rooms (DR) observed. This failure placed the residents at risk for foodborne illnesses. Findings included . An observation on 05/12/2025 at 12:23 PM showed Staff KK, Agency Nursing Assistant (NA), placed clothing protectors on nine residents. During the application of the clothing protectors, Staff KK touched the residents' hair, neck, or clothing. No HH was observed between residents. Staff KK proceeded to the take a bag of clothing protectors and placed it on a counter behind the DR's entry door closest to the kitchen. Staff KK then walked out then right back in from the other entry door (farthest from the kitchen), touched a male resident in a wheelchair (wc) and walked out of the DR without completing HH. Staff KK then returned to the DR, went over to a female resident, touched their wc and left arm, went over to attend to another resident's request for Kleenex, went to get the Kleenex on the counter and did not complete HH. Staff KK left the DR, then returned with a male resident at 12:29 PM and situated the resident at a DR table and did not complete HH. Staff KK then moved the male resident to another table, locked their wc brakes, completed no HH, went to a female resident at another table, applied the clothing protector around their neck, touched their wc, completed HH then stepped out of the DR. On 05/12/2025 at 12:33 PM, Staff E, Social Services Director, brought in a female resident in their wc to the DR. Staff E then went to another table where another female resident was seated, and with no HH completed in between touching a wc and a resident, touched the other female resident's wc. Staff E then completed HH. On 05/12/2025 at 12:45 PM, Staff Y, Nursing Assistant, walked inside the DR, got a meal tray from the tray cart, took the tray to a male resident, then pushed upwards their beanie-like hat, took a glass of milk off the tray and poured it into an adaptive cup, screwed the cup's lid on tightly, then removed the lunch plate and placed it on the table. Staff Y then touched their hat again, then their chin, and then completed HH. On 05/12/2025 at 12:48 PM, Staff KK returned to the dining room with a surgical mask below their nose. Staff KK went to get a clothing protector and placed it around a female resident, served them milk, locked their wc brakes, and poured water in an adaptive cup. While attempting to encourage the female resident to eat their lunch, Staff KK picked up a spoon, then touched the resident's right shoulder, then stepped away, and exited the DR. Staff KK returned to the DR and assisted with a fluid spill at a table nearby, wiped down the table, then went to another table. Staff KK did not complete HH and picked up a cup of milk and gave it to the female resident they were encouraging to eat prior to leaving the DR. Staff KK picked up a spoon and fed the female resident, put their hands in their pockets and walked to another table, then back to the female resident's table, and continued to feed them. Staff KK touched their thighs and kept offering food and fluids to the female resident with no HH completed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/15/2025 at 9:42 AM, Staff R, NAR - Registered, stated HH was completed, before and after and if we make contact with anything. Staff R acknowledged that placing clothing protectors placed staff at risk of touching the resident's hair, neck, or clothing and required HH between residents. Staff R stated HH was required after touching a resident, wc, or staff/resident clothing. In an interview on 05/15/2025 at 9:45 AM, Staff K, NA, stated HH was required after touching a resident, wc, or staff/resident clothing. In an interview on 05/15/2025 at 10:00 AM, Staff Y stated, We all have to wash hands and sanitize hands before touching food. We make sure we don't touch the food or plates. Staff Y stated they completed HH, Before and after feeding the resident, acknowledged that placing a clothing protector on a resident put them at risk for touching the resident's hair, neck, or clothing and required HH. Staff Y stated HH was required after touching a resident, wc, or staff/resident clothing. Reference WAC 388-97-1100 (3), -2980.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37544 Based on observation, interview, and record review, the facility administration failed to effectively use its resources to maintain facility compliance with Federal regulatory requirements to ensure potential situations of abuse were identified and proper measures were taken for 11 of 12 sampled residents (Residents 19, 31, 49, 21, 43, 27 37, 33, 45, and 3) reviewed for abuse, provide adequate nursing staff to supervise residents and complete care timely for 3 of 7 sampled residents (Residents 19, 50, and 60) reviewed for falls, provide behavioral and/or mental health services for 2 of 8 sampled residents (Resident 34 and 40) reviewed for mood and behavior, administer medications as prescribed for 2 of 6 sampled residents (Residents 34 and 61) reviewed for medication administration, and implement appropriate infection control measures for 3 of 3 nursing units reviewed for infection control. In addition, the Administration failed to effectively utilize their Quality Assurance and Improvement Program (QAPI) to address and follow up timely on identified concerns. These failures created multiple situations that caused harm to residents, and two separate situations of an immediate jeopardy (IJ: a situation that had occurred that could result in harm, serious injury and/or death). related to abuse and accident hazards. Findings included . Refer to F600 CFR 483.12, Freedom from Abuse and Neglect Administration failed to identify, report and assess a pattern of abuse related to resident-to-resident altercations by Resident 19. In addition, Administration failed to identify, assess or implement interventions for potential incidents of abuse for Residents 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41. These failures created an IJ situation. Refer to F689 CFR 483.25, Accident Hazards and Supervision/Devices Administration failed to ensure there was adequate supervision to prevent accidents related to falls, which led to substantial injuries to Residents 19, 50, and 60. These failures resulted in harm to the residents and created an IJ situation. Refer to F 725, CFR 483.35, Sufficient Nursing Staff Administration failed to provide adequate nursing staff to ensure care and services were provided to residents timely and to keep residents free from falls and injuries. This failure caused harm to Residents 19, 50, and 60. Refer to F760, CFR 483.45, Residents are free of any significant medication errors Administration failed to ensure medications were administered as prescribed to avoid significant medication errors for Residents 34 and 61. This failure resulted in harm to Resident 34. Refer to F880, 483.80, Infection Control (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administration failed to ensure the facility's infection control program was implemented according to acceptable standards of infection control practices to prevent and stop the spread of a contagious disease which caused illness to 27 of 61 residents and 33 staff members. REPEAT CITATIONS: Administration failed to ensure that previous citation's corrective measures were maintained and sustainable as evidenced by the following citations being repeated: - Refer to F689 CFR 483.25, Accident Hazards and Supervision/Devices, cited on 05/16/2024 and 05/25/2024. - Refer to F880, 483.80, Infection Control, cited on 05/16/2024 In an interview on 05/22/2025 from 10:53 AM to 11:17 AM, the following above concerns were discussed with Staff Q, Director of Clinical Services and Staff PP, Regional Director. During the interview, Staff PP stated they were aware of communication issues prior to the survey team's arrival at the facility and stated that the previous Administrator had not addressed some concerns, as a result, a new Administrator was hired around the beginning of this month (May 2025). Both Staff Q and Staff PP stated they were aware of issues concerning Resident 19 with regards to resident-to-resident altercations, but were not aware of the other concerns that the survey team had identified. Staff Q stated they were not aware of the depth of the identified issues until being informed by the survey team. Reference WAC: 388-97-1620(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 37544 Based on interview and record review, the governing body acted with disregard to the well-being of the residents of the facility; by not providing adequate oversight and monitoring of the appointed Corporate Officers/Administrator and/or the Director of Nursing. Failure to identify potential incidents of abuse, provide adequate nursing staff to supervise residents and complete care timely, provide mental health services, administer medications as prescribed, address and follow up timely on identified concerns, and implement appropriate infection control measures created multiple situations that caused harm to residents, and two separate situations of an immediate jeopardy (IJ: a situation that had occurred that could result in harm, serious injury and/or death). related to abuse and accident hazards. Findings included . Refer to F600 CFR 483.12, Freedom from Abuse and Neglect The governing body failed to identify, report and assess a pattern of abuse related to resident-to-resident altercations by Resident 19. In addition, the governing body failed to identify, assess or implement interventions for potential incidents of abuse for Residents 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41. These failures created an IJ situation. Refer to F689 CFR 483.25, Accident Hazards and Supervision/Devices The governing body failed to ensure there was adequate supervision to prevent accidents related to falls, which led to substantial injuries to Residents 19, 50, and 60. These failures resulted in harm to the residents and created an IJ situation. Refer to F 725, CFR 483.35, (a) Sufficient Nursing Staff The governing body failed to ensure the Administrator effectively and efficiently provided adequate nursing staff to ensure care and services were provided to residents timely and to keep residents free from falls and injuries. This failure caused harm to Residents 19, 50, and 60. Refer to F760, CFR 483.45, Residents are free of any significant medication errors The governing body failed to ensure medications were administered as prescribed to avoid significant medication errors for Residents 34 and 61. This failure resulted in harm to Resident 34. Refer to F880, 483.80, Infection Control The governing body failed to ensure the facility's infection control program was implemented appropriately and the proper measures were taken to prevent the spread of a contagious disease which caused illness to 27 of 61 residents and 33 staff members. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REPEAT CITATIONS: In addition, Administration failed to ensure that previous citation's corrective measures were maintained and sustainable as evidenced by the following citations being repeated: - Refer to F689 CFR 483.25, Accident Hazards and Supervision/Devices, cited on 05/16/2024 and 05/25/2024. - Refer to F880, 483.80, Infection Control, cited on 05/16/2024 In an interview on 05/22/2025 from 10:53 AM to 11:17 AM, the following above concerns were discussed with Staff Q, Director of Clinical Services and Staff PP, Regional Director. During the interview, both Staff Q and Staff PP stated they were aware of issues concerning Resident 19 with regards to resident-to-resident altercations, but were not aware of the other concerns that the survey team had identified. Staff PP stated they had been aware of communication issues prior to the survey teams arrival at the facility and recent changes to the Administration and Clinical Resource Nurse positions had been made. Staff Q stated they were not aware of the depth of the identified issues until being informed by the survey team. Reference: WAC 388-97-1620 (2)(c)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 47328 Based on interview and record review, the facility failed to develop, implement and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that identified deficiencies, implemented good faith efforts for corrective actions, and evaluated implemented corrective actions or performance improvement activities for effectiveness. The facility's QAPI program failed to timely recognize already compromised care and services that resulted in a potential for a pattern of resident harm. Findings included . Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) revised April 2024 showed, the facility monitored quality deficiencies related to facility operations and practices causing negative outcomes through the QAPI process. The QAPI committee served as a preventative function by reviewing and improving facility systems and took actions toward enhancing quality of care and quality of life for facility residents. The QAPI framework was established through five elements: 1) design and scope, 2) governance and leadership, 3) feedback, data systems and monitoring, 4) Performance Improvement Projects (PIPs), and 5) systematic analysis and systemic action. The committee was to meet monthly to identify performance improvement opportunities through tracking and trending of data that necessitated quality assessment and assurance activities against state and national benchmarks. The QAPI committee was to prioritize action plans and evaluate effectiveness of the process improvement activities. The policy included a list of potentially preventable events the facility may monitor including various high-risk medication use to include blood thinners and diabetes medications, care events such as falls, elopements, instances of abuse, neglect or misappropriation and infection such as respiratory infections and infectious diarrhea. The facility QAPI committee reported routinely to the governing body. Review of the facility QAPI Plan dated May 2025 showed the governing body appointed the facility executive director/administrator responsible for management of the facility and reported to and was accountable to the governing body. The governing body was responsible for the development and implementation of the QAPI program by identifying and prioritizing problems based on performance indicator data, ensure corrective actions address gaps in systems, evaluate effectiveness of corrective actions, and set clear expectations for safety, quality, rights, choices, and respect. The facility utilized a web-based application that allowed the governing body and Quality Assessment and Assurance (QAA) committee to access and view virtually all of an organization's QAPI activity including quality assessments, facility QAPI self-assessment, care area investigations, PIPs, and detailed reporting. Review of the July 2024 through April 2025 QAPI Committee minutes showed the following: - 07/21/2024 the facility experienced 25 falls, six falls were repeat falls, no falls with major injury identified. The facility identified one medication error. Staffing challenges with the need for more nursing staff. No PIPS in place. - 10/29/2024 the facility again experienced 25 falls, six falls were repeat falls, no falls with major injury identified. The facility identified one medication error. Staffing challenges with the need for more nursing staff. No PIPS in place. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 01/21/2025 the facility experienced 39 falls, 18 were repeat falls, no falls with major injury identified. Summary of fall trends showed frequent fallers were identified and corrective action was documented as implement fall meetings. The facility identified six medication errors, no trend or corrective action documented. Staffing challenges with the need for more therapy staff to perform timely evaluations. No PIPS in place. - 04/30/2025 the facility experienced 24 falls in April, with two residents sustaining repeat falls, and 1 fall with fracture. Summary of fall trends showed no tracking or trending. No documentation of tracking or trending for medication errors or staffing was found. No PIPs in place. Review of the September 2025 through May 2025 facility accident and incident tracking log showed the documentation did not meet the minimum required information to include date and time of the incident, nature of occurrence, incident location, incident findings, actions taken, if the State abuse reporting hotline was notified of the incident and by whom to easily track and trend facility incidents. Additional review showed some residents were involved in recurrent verbal and physical resident-to-resident altercations and sustained repeat falls that resulted in hospitalization and numerous fractures. In an interview on 05/23/2025 at 11:34 AM, with Staff A, Administrator, Staff B, Director of Nursing, and Staff C, Clinical Resource Nurse. Staff C stated QAPI collected data through the facility clinical stand-up meeting where falls, infections, and grievances were reviewed. Staff A explained QAPI prioritized identified concerns based on trends and negative trends, implementing PIPs when needed. Staff B stated the facility had two current PIPs in place, one for care planning and the second related to falls which was implemented approximately November 2024 and consisted of implementation of a fall meeting. When Staff B was asked about the effectiveness of the falls PIP, Staff B replied, the PIP is going to be drastically revised. Reference WAC 388-97-1760 (1)(2) Refer to F600, F689, F725, F760, F867, F868, F835, and F837 for additional information.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47328 Based on interview and record review, the facility failed to maintain a Quality Assessment and Assurance Program (QAA) that identified deficiencies and implemented appropriate preventative or corrective actions. The facility's QAA program failed to timely recognize already compromised care and services that resulted in a potential for a pattern of resident harm. Findings included . Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) revised April 2024 showed, the facility monitored quality deficiencies related to facility operations and practices causing negative outcomes through the QAPI process. The QAPI committee served as a preventative function by reviewing and improving facility systems and took actions toward enhancing quality of care and quality of life for facility residents. The QAPI framework was established through five elements: 1) design and scope, 2) governance and leadership, 3) feedback, data systems and monitoring, 4) Performance Improvement Projects (PIPs), and 5) systematic analysis and systemic action. The committee was to meet monthly to identify performance improvement opportunities through tracking and trending of data that necessitated quality assessment and assurance activities against state and national benchmarks. The QAPI committee was to prioritize action plans and evaluate effectiveness of the process improvement activities. The policy included a list of potentially preventable events the facility may monitor including various high-risk medication use to include blood thinners and diabetes medications, care events such as falls, elopements, instances of abuse, neglect or misappropriation and infection such as respiratory infections and infectious diarrhea. The facility QAPI committee reported routinely to the governing body. During the unannounced Recertification Survey conducted from 05/12/2025 to 05/23/2025, the following areas of deficiency were identified by the survey team: Free from Abuse and Neglect (Please refer to F600 for additional information): The facility failed to identify, report, protect, assess and prevent a pattern of resident-to-resident verbal and physical abuse. This included identifying a known pattern of aggressive behaviors by Residents 19. Abusive behaviors identified by staff included hitting, punching, kicking, ramming into other residents with a wheelchair (w/c), verbal abuse, threats and intimidation of other residents. The facility failed to recognize these instances as abuse, analyze the circumstances of these abusive behaviors, or implement plans for prevention or recurrence of abuse. Failure to recognize, analyze, and act upon multiple incidents of resident-to-resident altercations as abuse and provide adequate supervision and care planning with effective interventions placed all residents at risk of serious injury or harm and represented an immediate jeopardy (IJ) that was called on 05/20/2025. Specifically, residents expressed fear when they were subjected to repeat unpredictable outbursts of verbal abuse and actual physical injuries such as coffee thrown on them, grabbing, scratching, slapping, punching, kicking, and skin tears. Quality of Care (Please refer to F684 for additional information): (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to ensure the staff notified the provider for 3 of 3 sampled residents (Resident 34, 40 and 61) reviewed for change in condition. Specifically, the staff failed to notify the provider when Resident 34 experienced extremely low blood sugars, Resident 40 experienced significantly low blood pressures (BP), and Resident 61 experienced elevated blood sugars. This failure precluded the provider's involvement in coordinating care and placed the residents at risk of further adverse or deteriorating clinical outcome. Free Of Accident Hazards/Supervision/Devices (Please refer to F689 for additional information): The facility failed to provide effective monitoring and supervision and implement adequate interventions to prevent Resident 19, Resident 50, and Resident 60 from falling and experiencing adverse and injurious sequalae related to falls, to include transfers to the hospital. Specifically, Resident 19 sustained repeated harm because of falls as evidenced by a dislocated hip on 09/12/2024, a right femur (leg bone) fracture on 01/14/2025, and a back fracture on 03/03/2025. Resident 50 fell a total of 36 times from 04/04/2024 to 05/17/2025 and experienced a range of injuries, to include hospital transfers for their treatment. Additionally, Resident 60 fell three times and experienced a fracture to their eye socket and left lower leg. These failures placed the residents at risk for further repeat serious injuries such as fractures, disability, or death and represented an immediate jeopardy (IJ) that was called on 05/20/2025. In addition, the facility failed to assess, evaluate, and implement interventions for potential risks associated with substance use disorders (SUD) for 1 of 3 sampled residents (Resident 49), reviewed for SUD. Behavioral Health Services (Please refer to F740 for additional information): The facility failed to ensure behavioral health services were provided for 2 of 8 sampled residents (Residents 34 and 40), reviewed for mood and behavior. This failure created risk for residents to experience a decline in their psychosocial well-being. Residents are Free of Significant Medication Errors (Please refer to F760 for additional information): The facility failed to ensure medications were administered as prescribed for 2 of 6 sampled residents (Residents 34 and 61), reviewed for medication administration. Resident 34 received an injection of Lantus insulin (a type of insulin used to treat high blood sugar that provided a consistent level of insulin over a 24-hour period and mimicked the body's natural insulin production) ordered for a different resident. Additionally, Resident 34 received the wrong dose of medication used to decrease diarrhea, and Resident 61 did not receive doses of a blood thinner and an injectable medication that managed weight and blood sugar. This failure caused harm to Resident 34 when they experienced an extended period of symptomatic hypoglycemia (extremely low blood sugar) and required administration of rescue medications on five different occasions and created the potential for unintended health consequences for the residents. Infection Prevention and Control (Please Refer to F880 for additional information): (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to maintain an effective infection control program that identified, reported, and controlled the spread of communicable diseases for residents and staff during a Norovirus [a highly contagious gastro-intestinal (GI, affected the stomach and intestines) virus that caused nausea, vomiting and diarrhea] outbreak and to implement . Basic infection prevention interventions that included enhanced barrier precautions, transmission-based precautions, prompt reporting of a laboratory confirmed Norovirus outbreak to the State Survey Agency and local health departments, and exclusion of staff members from work according to the recommended standards. These failures facilitated a Norovirus the outbreak which spread to all 3 of 3 nursing units and 27 of 61 residents and 33 staff members and placed residents at risk for potential unintended health consequences, and the potential spread of other infectious diseases or organisms resistant to antibiotics. Sufficent Staffing (Please refer to F725 for additional information): The facility failed to repeatedly ensure the facility had enough staff to provide care according to the facility acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and/or care plans for 3 of 7 sampled residents (Resident 19, 50, and 60), reviewed for falls. Specifically, Resident 19 sustained repeated harm because of falls as evidenced by a dislocated hip on 09/12/2024, a right femur (leg bone) fracture on 01/14/2025, and a back fracture on 03/03/2025. Resident 50 fell a total of 36 times from 04/04/2024 to 05/17/2025 and experienced a range of injuries, to include hospital transfers for their treatment. Resident 60 fell three times and experienced a fracture to their eye socket and left lower leg. Additionally, the facility failed to identify, report, protect, assess and prevent a pattern of resident-to-resident verbal and physical abuse by Residents 19 towards 10 different peers (Resident 31, 49, 21, 43, 27, 37, 33, 45, 3, and 41). Abusive behaviors identified by staff included hitting, punching, kicking, ramming into other residents with a wheelchair (w/c), verbal abuse, threats and intimidation of other residents. These failures placed all residents at risk for further repeat serious injuries such as fractures, repeat abuse, potentially avoidable accidents and diminished quality of life. QAPI Program/Plan, Disclosure/Good Faith Attempt (Please Refer to F865 for additional information): The facility failed to develop, implement and maintain an effective, comprehensive, data-driven Quality Assurance and Performance Improvement (QAPI) program that identified deficiencies, implemented good faith efforts for corrective actions, and evaluated implemented corrective actions or performance improvement activities for effectiveness. The facility's QAPI program failed to timely recognize already compromised care and services that resulted in a potential for a pattern of resident harm. QAA Committee (Please Refer to F868 for additional information): The facility failed to maintain a Quality Assessment and Assurance (QAA) committee that met at least quarterly and included the Infection Preventionist who was a required member of the QAA committee. This failure minimized the effectiveness of the interdisciplinary QAA team ' s ability to identify processes and outcomes related to infection control practices and disease management. Additionally, this failure resulted in 27 of 61 residents and 33 staff members contracted Norovirus (highly contagious, gastrointestinal (GI), infectious illness that caused nausea, vomiting, and diarrhea). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 05/23/2025 at 11:34 AM, with Staff A, Administrator, Staff B, Director of Nursing, Staff C, Clinical Resource Nurse, and Staff Q, Director of Clinical Services, the above areas of concern were reviewed. Staff B acknowledged the facility was aware of the concerns identified by the survey team, but no corrective action had been attempted except for falls. Staff B explained a PIP for falls was initiated which included conducting weekly fall meetings, but it was not effective and needed to be drastically revised. Staff Q stated there was a change in the facility Administrator and Resource Nurse May 1, 2025. Summary The current facility QAA/QAPI process failed to identify critical areas of care that were ultimately elevated to the level of harm and immediate Jeopardy (IJ). The DNS and the Administrator stated the QAPI process needed to be revised, however, this showed the facility QAA/QAPI process evidently failed to provide early detection of these concerns. Reference WAC 388-97-1760 (1)(2)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47328 Based on interview and record review the facility failed to maintain a Quality Assessment and Assurance (QAA) committee that met at least quarterly and included the Infection Preventionist who was a required member of the QAA committee. This failure minimized the effectiveness of the interdisciplinary QAA team ' s ability to identify processes and outcomes related to infection control practices and disease management. Additionally, this failure resulted in 27 of 61 residents and 33 staff members contracted Norovirus (highly contagious, gastrointestinal (GI), infectious illness that caused nausea, vomiting, and diarrhea). Findings included . Review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI) revised April 2024 showed, the facility monitored quality deficiencies related to facility operations and practices causing negative outcomes through the QAPI process. The QAPI committee served as a preventative function by reviewing and improving facility systems and took actions toward enhancing quality of care and quality of life for facility residents. The committee was to consist of the Administrator, Director of Nursing, a physician, the infection preventionist, and three additional facility staff responsible for direct resident care and services. Review of the July 2024 through April 2025 QAPI Committee Minutes showed the following: - 07/21/2024 No input from the Infection Preventionist related to infection prevention and control data. The signature section for committee participants showed no documentation the Infection Preventionist attended the meeting, as required. - 10/29/2024 a soft tissue infection trend was identified, no other infection prevention and control data was found. The signature section for committee participants showed no documentation the Infection Preventionist attended the meeting, as required. - 01/21/2025 No input from the Infection Preventionist related to infection prevention and control data. The signature section for committee participants showed no documentation the Infection Preventionist attended the meeting, as required. - 04/30/2025 No input from the Infection Preventionist related to infection prevention and control data. The signature section for committee participants showed no documentation the Infection Preventionist attended the meeting, as required. Review of the facility GI outbreak line listing showed the facility identified a Norovirus outbreak on 05/03/2025. The outbreak included 24 residents and 25 staff who experienced GI symptoms. In an interview on 05/22/2025 at 4:09 PM, Staff F, Infection Preventionist, stated the QAPI committee met quarterly. Staff F acknowledged they were not monitoring any infection control practices for trends, did not have any infection control Performance Improvement Projects and had not participated in any QAPI meetings as of that date. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Reference: WAC 97-388-1760(1)(2) Refer to F867, F865, and F880 for additional information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46033 Based on observation, interview and record review, the facility failed to maintain an effective infection control program that identified, reported, and controlled the spread of communicable diseases for residents and staff during a Norovirus [a highly contagious gastro-intestinal (GI, affected the stomach and intestines) virus that caused nausea, vomiting and diarrhea] outbreak and to implement basic infection prevention interventions that included enhanced barrier precautions, transmission-based precautions, prompt reporting of a laboratory confirmed Norovirus outbreak to the State Survey Agency and local health departments, and exclusion of staff members from work according to the recommended standards. These failures facilitated a Norovirus the outbreak which spread to all 3 of 3 nursing units and 27 of 61 residents (Residents 50, 11, 40, 38, 43, 51, 19, 59, 46, 63, 28, 21, 41, 37, 23, 47, 67, 48, 34, 6, 32, 33, 3, 22, 20, 35, and 5) and 33 of 86 staff members (CC, JJ, Y, SS, J, AA, TT, UU, VV, A, F, WW, LL, GG, K, EE, G, D, N, FF, XX, U, YY, ZZ, AAA, II, RR, BBB, E, CCC, DDD, EEE, and FFF) and placed residents at risk for potential for unintended health consequences, and the potential spread of other infectious diseases or organisms resistant to antibiotics. Findings included . The Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated September 2024 and retrieved from https://www.cdc.gov/infection-control/hcp/isolation-precautions/index.html documented facilities were to implement contact + standard precautions for a minimum of 48 hours after the resolution of symptoms or to control institutional outbreaks. Standard precautions were based on the principle that all blood, body fluids and secretions may contain infectious agents, and included the use of hand hygiene, and donning (to put on) personal protective equipment (PPE) to include gowns, gloves, masks and eye protection if exposure could be anticipated, such as by splashes for example. Contact precautions prevented transmission of organisms spread by direct or indirect contact with the patient or their environment. Healthcare personnel were to don a gown and gloves when entering a room to care for a resident on contact precautions and discard the PPE before exiting the room. The CDC 2011 Norovirus Prevention and Control Guidelines for Healthcare Settings retrieved from https://www.cdc.gov/infection-control/hcp/norovirus-guidelines/index.html recommended ill staff be excluded from work for a minimum of 48 hours after the resolution of symptoms. The CDC 07/12/2002 Implementation of Personal Protective Equipment (PPE, gloves, disposable gowns, eye protection or masks, for example) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html recommended the use of Enhanced Barrier Precautions (EBP) as an infection control intervention. EBP recommended the use of gown and gloves during high contact resident care activities when Contact Precautions did not apply for residents with wounds or indwelling medical devices, such as feeding tubes or catheters. High contact care activities included dressing, bathing/showering, transferring, changing linens, providing hygiene, wound care and assisting with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Transmission-Based Precautions Conventional Plan dated April 2024, documented the Infection Preventionist was to be notified of the suspected infectious or contagious disease and surveillance was to be initiated. Transmission-based precautions were to be initiated, to include placing and maintaining an adequate supply of appropriate PPE at the resident room door and posting the appropriate precaution notice in a visible location outside the room. EBP was recommended for use high contact care activities in resident rooms where residents had wounds, indwelling medical devices, central lines, urinary catheters, feeding tubes or colonization with multi-drug resistant organisms and was intended for the resident entire length of stay unless the device was removed or the wound healed. Contact precautions were required upon identification of a positive culture or report of a diagnosis that required isolation. Staff were to immediately post corresponding precaution notices visibly outside the room. Gown and gloves were required upon entry to the resident's room. Residents were to be removed from transmission based precautions 24 hours after they no longer had symptoms or per disease specific directives, whichever was longer. <Norovirus Outbreak/EBP Precautions> On 05/12/2025 at 9:32 AM, a recertification survey commenced at the facility. Upon entry, Staff A, Administrator, stated there were no residents on isolation at that time but there had been residents isolated the week prior for suspicion of Norovirus. On 05/12/25 at 10:23 AM, the door to Resident 41's room had a red stop sign on the door and a yellow bag that hung on the doorframe that contained PPE. An unidentified male Nursing Assistant (NA) was observed entering the room and donned a pair of disposable gloves only. The signage on the door did not document what type of isolation was in place, only to ask the nurse before the room was entered. On 05/12/2025 at 11:23 AM, Resident 63 was observed in bed. An indwelling urinary catheter (a tube inserted into the bladder that allowed urine to drain) hung from the right side of their bed and the resident said it would eventually be removed when they became strong enough to go to the bathroom. The entry to the resident's room entry had no signage to instruct the staff that EBP was indicated or what PPE was to be worn during resident care. On 05/12/2025 at 11:28 AM, a SPECIAL DROPLET/CONTACT PRECAUTION signage was posted on the outside of Resident 58's room door, at eye level. The signage instructed persons to perform hand hygiene and wear a N95 respirator (a mask that filtered out organisms coughed into the air), eye protection, gloves, and a gown prior to room entry. Staff Y, NA, was observed entering Resident 58's room and did not perform hand hygiene or don PPE, as instructed on the posted sign. Staff Y approached Resident 58 in bed, pulled down their covers, adjusted Resident 58's feet then recovered them with their blankets. At 11:31 AM, Staff Y exited Resident 58's room. When asked about the isolation sign posted on Resident 58's room door, Staff Y stated they were not sure why the signage was there but acknowledged they should have donned PPE as instructed on the posted signage. (continued on next page)

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	505275	A. Building B. Wing	05/23/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/12/2025 at 3:28 PM, Resident 54's entry had EBP signage on top of a PPE cart, but also a sign for Contact Precautions on the wall above the PPE cart. As the Surveyor donned PPE as required for Contact Precautions, Staff AA, Licensed Practical Nurse, approached and told the Surveyor that PPE for Contact Precautions was not required unless wound care was going to be completed. When asked what precautions Resident 54 was on, whether Contact or EBP, Staff AA said, EBP but if wound care then Contact. Upon entering Resident 54's room, the resident was observed in bed, with a dressing over an intravenous (IV, into the vein) line to their upper left arm dated 05/09/2025. The resident confirmed the IV line was for antibiotic administration twice a day. On 05/13/2025 at 8:48 AM, Resident 34 was observed eating breakfast in their room. They reported they had dialysis (medical procedure that removed waste and excess fluid from the blood when the kidneys were unable to do so) three times a week and had a dressing visible over a dialysis port (surgically created blood access to be used during dialysis treatments) on their chest. There was no signage at the entrance to the resident's room that notified staff that EBP precautions were indicated, and there was no PPE cart at the entrance for staff use. On 05/13/2025 at 8:56 AM, Resident 20 was observed sleeping in their bed. The resident had tube feeding formula (nutrition provided through a tube inserted into one's abdomen when one is unable to eat or swallow) that hung on an infusion pump. A large syringe used to insert liquid medications manually into the abdominal tube was on the resident's overbed table. There was no signage at the entrance to the resident's room notifying staff that EBP precautions were indicated and there was no PPE cart at the entrance for staff use. On 05/14/2025 at 8:32 AM, Resident 54's entry continued to have signage for both EBP and Contact Precautions remaining on the PPE cart and on the wall above the PPE cart respectively. On 05/14/2025 at 8:47 AM, the SPECIAL DROPLET/CONTACT PRECAUTION signage remained posted on Resident 58's room door. Staff HH, NA, was observed entering Resident 58's room and did not don PPE or perform hand hygiene as instructed and asked Resident 58 if they wanted to get up for breakfast. At 9:00 AM, an unidentified female staff entered Resident 58's room, without performing hand hygiene or donning PPE, and placed a breakfast tray on the bedside table. At 9:03 AM, Staff HH put on a pair of gloves without performing hand hygiene but did not put on a gown, N95, or eye protection and began to assist Resident 58 eat their breakfast. On 05/14/25 09:06 AM, Resident 5 was observed from the door of their room. The resident was in bed, unkempt and had a pink basin on the bed beside next to them. Resident 5 stated, You don't want to come close. I am sick. The resident stated the day prior, they had come down with that bug that was going around. Resident 5 then began retching into the basin after, they stated they were unable to keep even water down. There was no Contact Isolation signage at the entry to the resident's room, and no PPE cart near the room for staff use. On 05/14/2025 at 9:32 AM, review of the State Agency incident reporting application had no intakes from the facility for a GI or suspected Norovirus outbreak. A copy of the line list of residents ill with GI symptoms was requested at 9:47 AM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/14/25 at 10:16 AM, Staff F, Infection Prevention, Licensed Practical Nurse (LPN), provided the list of residents affected by the GI outbreak. Staff F stated the first case was identified on 05/03/2025, and the last case was on 05/06/2025 so the outbreak resolved at that time. They stated stool samples were sent out on 05/03/2025 and resulted positive by culture for Norovirus four days later. Staff F stated most residents were ill for only 24 hours and the outbreak affected 24 residents, plus staff. Staff F stated they had become ill as well and had instructed staff they were able to return to work if they were free of fever or symptoms for 24 hours. Staff F stated they called the local health department three times, and was told Norovirus was not reportable to the county or the state and offered no guidance on managing the outbreak. A list of staff who were part of the outbreak was requested at this time. A review of the Resident outbreak line list documented Resident 37 had an onset of symptoms on 05/02/2025 and was the first case of 24 on the list. No other residents were added to the list after 05/06/2025. Resident 20 was not included on the line list but had documented illness, and Residents 5 and 35 became ill during the course of the survey. A review of the staff outbreak line list documented 14 staff (CC, JJ, Y, SS, J, AA, TT, LL, D, N, CCC, DDD, EEE, and FFF) became ill on 05/04/2025, three staff (WW, EE, BBB) became ill on 05/09/2025, and 33 staff in total became ill. On 05/14/2025 at 11:11 AM, Resident 20 was awake and resting in bed. The tube feeding pump remained in the room. Resident 20 stated they had been ill the week prior with diarrhea for four days but felt better. There was still no signage for EBP at the room's entrance. Across the hall, there was no EBP signage or PPE cart observed at the entrance to Resident 34's room. When reviewed, Resident 20 was not included on the outbreak line list. On 05/14/2025 at 4:15 PM, Resident 5 was observed from the entry to their room. Resident 5 stated they felt worse than they had earlier in the day and had vomited a large amount. The resident sipped water. There was no Contact precautions signage or PPE cart at the entrance to the resident's room. On 05/15/2025 at 9:17 AM, Resident 5 was observed and stated they were no longer vomiting or having diarrhea. They stated they were able to sip water now. There was no Contact precautions signage or PPE cart at the resident's entrance. On 05/15/2025 at 9:20 AM, the entries to Resident 20 and Resident 34's rooms had no EBP signage or PPE cart present. On 05/15/2025 at 9:25 AM, abbreviated record reviews were completed for the residents included in the Norovirus outbreak and it was confirmed that none of the residents required hospitalization related to GI symptoms. A review of Resident 40's record documented the resident had diagnoses that included stroke and depression with psychotic symptoms. From 05/05/2025 to 05/10/2025, the resident was placed on alert charting related to GI illness. A review of the May 2025 medication administration record documented the resident's vital signs were monitored related to the GI illness. On 05/06/2025, 05/07/2025, and 05/08/2025, blood pressures of 88/60 (extremely low, normal average BP 120/80) were recorded. On 05/09/2025, a blood pressure of 92/60 was recorded. There were no progress notes that documented if the resident had symptoms as a result of the low blood pressures, or that the provider had been notified of the low blood pressures. Resident 40 shared a room with Resident 5. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/15/2025 at 10:10 AM, the Community Health Specialist at the local county health department stated they had not been notified of the Norovirus outbreak at the facility and outbreak reporting was required. They stated their department assisted facilities during outbreaks by providing guidance on how long residents were to remain on isolation and recommended that staff be excluded from work for 48 hours after their symptoms resolved. They stated they followed the CDC guidance regarding Norovirus. During an interview on 05/15/2025 at 10:31 AM, Staff M, LPN, acknowledged they had been on the medication cart and passed medications on 05/14/2025 to Resident 5. They stated they had received recent education regarding hand hygiene, and how to manage residents that were actively ill. Staff M stated they did not know how many residents had been ill during the outbreak, but stated they were aware two residents had become ill since the week prior. They stated Resident 35 had vomited and had a high fever that started on 05/14/2025. Staff M stated they knew how to tell if a resident was ill because there was a PPE cart in the hall and there was usually signage on the resident's door. Staff M stated Resident 5 should have had Contact precaution signage on their door but there was none. Staff M stated staff told the Resident Care Managers (RCM) when a resident was ill, and the RCMs obtained the PPE carts and hung up the signage, but that any staff could do those things. Staff M had not told Staff F that Resident 5 had been vomiting, but thought Staff F was probably aware. Staff M was unsure if Staff F was aware that Resident 35 was now ill as well. During an interview on 05/15/2025 at 10:41 AM, Staff G, Registered Nurse (RN), stated they became ill with Norovirus and, was home for two days. Staff G stated the facility instructed them they could return to work when free from nausea, vomiting, diarrhea, or fever for 24 hours. During an interview on 05/15/2025 at 10:53 AM, Resident 5 stated while they had been sick, none of the staff had worn gowns when they helped take care of them. Resident 5 stated some staff sometimes wore gloves. During observation and interview on 05/15/2025 at 10:55 AM, Staff LL, LPN, stated they had gotten sick during the Norovirus outbreak. They stated they did not have to call in because they happened to be sick on their two days off. Staff LL stated they were able to tell what residents were sick because there would be a sign on their door and a PPE cart. Staff LL had not been told that Resident 5 was ill but had been told about Resident 35. At this time, the entry to Resident 35's room is observed with the surveyor, and there was no PPE cart or Contact precautions sign present. When asked how staff were made aware of resident illness, Staff LL stated they were told in report, or there might be an alert on the dashboard in the electronic medical record. Staff LL looked at the dashboard and saw there was an alert for Resident 35 on the dashboard, but none for Resident 5. Staff LL stated if the correct PPE was not worn, staff could spread illness to other residents and residents were vulnerable. On 05/15/2025 at 11:09 AM, a cart of PPE was now observed at the entry to Resident 35's room, however, there was still no Contact precautions sign. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/15/2025 at 11:10 AM, Staff F, Infection Prevention LPN, stated they had just been made aware that two residents were sick. They were aware that Resident 35 had vomited but had not been told that Resident 5 had been vomiting all day on 05/14/2025 and they were going to investigate why they were not informed. Staff F stated there was a difference between Contact precautions and EBP. Residents with wounds, tubes or drains were to require EBP. Staff F was not aware that Residents 20 and 34 had no signage indicating staff should use EBP. Staff F stated they usually made rounds to ensure the appropriate signage was in use when indicated but had not been able to complete their rounds that week. Staff F stated staff were instructed that they had to be free of Norovirus symptoms for 24 hours before they were to return to work. They had been keeping track of those employees that were ill but stopped after they got to about 25 staff because no one was reporting staff illnesses to them. Staff F stated they had notified the local health department both by phone and by email of their outbreak but was unaware the State Survey Agency was also supposed to be notified. Staff F stated they expected staff to wear the appropriate PPE, wash their hands, and notify them if residents were ill. They stated residents who have Norovirus could become dehydrated (body loses more fluids than were taken in), have electrolyte (body minerals) imbalances, or worse, could even die. On 05/15/2025 at 1:44 PM, an email correspondence was provided that documented Staff F contacted the State Department of Health on 05/12/2025 at 9:51AM, ten days after the first case of Norovirus was identified. The Department of Health recommended the facility contact their local health department. On 05/16/25 at 8:49 AM, observations of the nursing units were made. Resident 35's room had a white facility made EBP sign at the entry to their door. This was covered with a red stop sign that instructed persons to ask the nurse before entering. This was instead of a Contact precautions sign indicated because of the resident's GI illness. Resident 34 had a white facility made EBP sign at the entry to their room. Resident 20 continued to have no EBP signage. Resident 5 had no Contact precautions signage or PPE cart at their room and was still within the 48-hour window of their symptoms having resolved. There was one PPE cart in the entire hall, and this was positioned at the entry of Resident 35's room. During observation and interview on 05/16/2025 at 10:06 AM, Staff Y was observed entering Resident 58's room with an unidentified NA. A Special Droplet/Contact precaution sign was at the entrance of the room. Neither staff donned PPE. Staff Y exited the room and picked up an incontinence pad and re-entered the room. Upon exiting the room, Staff Y was asked if PPE was required at entrance to Resident 58's room, and Staff Y went to ask for clarification. Staff Y returned then stated they were to don PPE only if they provided care to the resident, but since they only took a tray in the room, it was not required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/16/2025 at 10:34 AM with Staff A, Administrator, Staff C, Clinical Resource Nurse, and Staff MM, Regional Director. Staff C stated they had currently taken over infection control duties related to the continued Norovirus outbreak. Staff C stated care plans had been updated, orders for precautions had been entered, and signage was being hung at that time. Staff A stated they had been made aware of the outbreak when the first case was identified, and stated they assumed Staff F had also been notified and each morning in report, the outbreak and those residents that became ill were discussed. Staff C confirmed that staff who became ill should have been excluded from work for 48 hours after their symptoms resolved and confirmed that staff were to don PPE at any time a room on Contact precautions was entered. Staff C stated they had talked with the local health department on 05/15/2025 and the outbreak had now been reported and if Staff F or any of the RCMs were unaware of a Resident becoming ill, it indicated a problem with the facility communication regarding the outbreak. Staff MM stated the use of non-standardized precaution signage contributed to staff confusion regarding Contact precautions and EBP and stated if staff had to hunt for PPE supplies, they would not use them. Staff MM agreed that breaches in infection control practices could contribute to the spread of Norovirus. During an observation of medication administration and interview on 05/19/2025 at 7:31 AM, Staff BB, LPN, dispensed medications for Resident 5. A Contact precaution sign was now posted at the entrance to their room. Staff BB donned a pair of gloves without performing hand hygiene and entered the room and pulled the privacy curtain partially open. The posted signage with verbiage that instructed staff to don gloves and a gown prior to room entry was pointed out to Staff BB. Staff BB stated the contact precautions were for Resident 5's roommate, by the window, not for Resident 5., but they would seek clarification from Staff F. When asked what PPE Staff BB was to don when they passed medication to Resident 5, they slowly read the Contact precaution signage then donned the PPE as instructed on the sign. On 05/19/2025 at 9:55 AM, Staff DD, NA, was observed aiding Resident 5. The Contact precautions sign remained on the entrance to the room. Staff DD had no PPE on. During an interview on 05/20/25 at 12:23 PM, Staff NN, agency LPN, stated during the Norovirus outbreak they were instructed to work on 05/15/2025 when they were sick and had a fever. Staff NN showed a text message thread on their personal cell phone and had documented their fever of 101.3 degrees Fahrenheit with a picture of a thermometer. Staff NN stated they took acetaminophen (over-the-counter medication) to reduce their fever, arrived at the facility at 3:30 PM on 05/15/2025, and worked a double shift. Staff NN stated they had 05/16/2025 off. They worked a partial shift on 05/17/2025, but was still sick, so went to the hospital and had an evaluation. Staff NN provided a copy of their hospital after-visit summary which documented Staff NN was diagnosed with gastroenteritis (GI illness). During an interview on 05/22/2025 at 2:24 PM, Staff O, Nurse Practitioner, after review of CDC Norovirus guidelines, stated they would not expect a staff member with a fever to work. Staff O stated they were new to the facility and had seen Resident 40 once. They stated they had not been notified of any low blood pressures and in their professional opinion, any resident that had been ill with nausea, vomiting, diarrhea and a low blood pressures of 88/60 would require notification to the provider for concerns of dehydration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/23/2025 at 10:51 AM with Staff A, Staff B, Director of Nursing, Staff C, and Staff Q, Regional Director of Clinical Services. Staff B acknowledged staff were to be excluded from work for 48 hours after Norovirus symptoms resolved. <Infection Prevention Annual Policy Review> A review of the facility Infection Prevention program policies revealed the following: -The policy titled, Transmission-based Precautions Conventional Plan had a revision date of 04/02/2024. -The policy titled, Surveillance of Healthcare Associated Infection was revised 09/10/2020. -The policy titled, Antibiotic Stewardship was revised 10/15/2022. -The policy titled, Employee Influenza Immunizations had a release date of 10/01/2027. -The policy titled, Influenza Program was revised on 08/01/2023. -The policy titled, Pneumococcal Program was revised on 05/31/2023. -The policy titled, COVID Vaccination for Residents and Staff was revised on 08/01/2023. During an interview on 05/23/2025 at 10:10 AM, Staff F stated they were unsure who was responsible for reviewing the infection prevention policies. They stated they thought the corporate office reviewed them. Staff F stated the policies they had been given were dated from late 2024 so they believed the policies were reviewed yearly. Reference WAC 388-97-1320 (1)(a)(2)(b-c) Refer to F684 for additional information. 40297 47328

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 46033 Based on interview and record review, the facility failed to maintain minimum documentation that staff were educated regarding risks and benefits of the COVID-19 (a viral illness that caused fever, difficulty breathing or possibly death) vaccine, were offered the vaccine, and the COVID-19 vaccine status of the staff as required for 1 of 1 staff reviewed. This failure placed staff and residents at risk of and exposure to illness from COVID-19. Findings included . The revised 08/01/2023 facility policy COVID-19 Vaccination for Residents and Staff documented staff were educated of the risks and benefits associated with the COVID-19 vaccine so they could make an informed decision regarding immunization. Education and re-education was documented in the employee file. Staff have the opportunity to accept or refuse a vaccine or booster and may change their decision at any time. During an interview on 05/22/25 at 4:09 PM, Staff F, Infection Preventionist, Licensed Practical Nurse, was asked if they were the one that kept track of staff COVID vaccinations. Staff F stated the facility did offer the COVID vaccines the year prior but referred the surveyor to Staff QQ, Human Resources, and thought Staff QQ kept track of staff vaccines. During an interview on 05/23/2025 at 09:48 AM, with Staff QQ and Staff RR, Business Office Manager, Staff QQ stated they offered a COVID-19 to new employees only and was unsure who offered the staff vaccines when boosters came out or yearly. They would only have a form in a new employee's file and was unsure if nursing had records of all employees COVID vaccination statuses. A request was made to observe Staff RR's employee file. Staff RR stated when the COVID vaccines first came out they were offered the vaccine but had not been offered one in several years. A review of the employee file had forms dated from the year 2020 that documented Staff RR had declined the COVID vaccine. Staff RR stated they did not get vaccines and did not sign a declination each year that documented they had been educated regarding the risks/benefits of COVID vaccines. During a follow-up interview on 05/23/2025 at 10:10 AM, Staff F stated they began working in Infection Prevention for the facility in February of 2025 and the position had been vacant prior to that but was unsure for how long. Staff F was able to locate on the facility computer an Excel spreadsheet that documented staff COVID vaccinations, but the documentation had not been updated since 2023. Reference: WAC 388-97-1320(1)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on observation and interview the facility failed to maintain a resident call light system that was functionable and audible, as required. This failure placed all facility residents at risk of potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included . During observation on 05/12/2025 at 12:16 PM, a call light was visibly lit up above a resident room but not audible in the hallway. Similar observations were made at 12:36 PM, on 05/13/2025 at 8:23 AM, 8:38 AM, 10:13 AM, and 12:47 PM, and on 05/19/2025 at 4:09 AM. During an observation on 05/12/2025 at 12:46 PM, the call light indicator board at the nurses' station showed one or more resident room call lights were lit up as activated but not audible in the hallway. Similar observations were made at 3:30 PM, on 05/13/2025 at 8:40 AM, 10:14 AM, 10:41 AM, 11:41 AM, 1:27 PM, on 05/14/2025 at 8:37 AM, on 05/15/2025 at 8:42 AM and 2:22 PM, on 05/16/2025 at 8:35 AM, on 05/19/2025 at 4:30 AM and 4:49 AM. In an interview on 05/14/2025 at 10:26 AM, the Resident Council stated they experienced excessively long call light wait times, sometimes waiting up to an hour. The Council acknowledged the call lights do not make a sound at all. During an observation and interview on 05/20/2025 at 9:57 AM, Staff K, Nursing Assistant, stated the facility had been having issues with call light audibility. Staff K walked to room [ROOM NUMBER] and activated the call light, the light lit up outside the room, but no sound was audible from the hallway. When the surveyor and Staff K looked down the hall attempting to visualize activated call lights outside of the resident rooms, brown speaker appearing boxes were observed intermittently placed throughout the hallway, adjacent to the call light placement, obscuring visibility of some call lights. Staff K acknowledged some call lights were blocked from view when in the hall or at the nurses' station related to speaker box placement. Staff K further acknowledged the call lights were not audible when activated. During an observation and interview on 05/20/2025 at 10:14 AM, the call lights were observed down the hall with Staff L, Registered Nurse, who explained the brown boxes that obscured visibility of some call lights was an overhead paging system. Staff L acknowledged the call lights had not been audible in over a year. During an observation and interview on 05/20/2025 at 10:19 AM, Staff W, Maintenance Director, stated our call light system is horrible. Staff W explained the annunciator, portion of the system that made call lights audible, constantly shorts out and goes out. The surveyor and Staff W walked down to the call light indicator board at the nurses' station, the call lights for room [ROOM NUMBER] and 32 were lit up on the board as activated but no sound was heard. Staff W pointed out a low click emitted from the indicator board. Staff W explained the click was the annunciator, when a call light was activated, the annunciator would typically click and trigger the call light audible beeping but it froze again and was not allowing the call lights to be audible when activated. (continued on next page)

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	05/23/2025

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

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 05/20/2025 at 10:44 AM, Staff W explained they did monthly facility rounds to check for needed repairs, but staff would typically enter a maintenance work order if items or equipment were in disrepair. Staff W acknowledged they had not received a work order for the non-audible call light system and had not implemented more frequent rounding to ensure the call light system was functioning appropriately, as required. During a follow-up observation and interview on 05/20/2025 at 10:51 AM, Staff W stated they fixed the annunciator and the call lights were audible again. Staff W pointed out a single intermittent beep heard in the hallway; no call light was observed visibly on above a room door. The Surveyor and Staff W again walked down to the call light indicator board at the nurses' station, no resident room lights were lit up as activated but the single intermittent beep was still audible. Staff W was asked to turn on a resident room call light. Staff W activated the call light in room [ROOM NUMBER], the light lit up above the room door but there was no audible change in the frequency of the single intermittent beep, the beep was the same if a call light had been activated or not. In an interview on 05/23/2025 at 9:36 AM, Staff A, Administrator, stated they expected staff to ensure the resident call light system was visible, audible, and in working order, as required. Reference WAC 388-97-2280 (1)(a) Refer to F 689 for additional information.

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	505275	A. Building B. Wing	05/23/2025

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 37544 Based on interview and record review, the facility failed to ensure direct care staff were provided the mandatory effective communication training for 10 of 10 sampled staff (Staff P, L, AA, R, BB, K, CC, DD, EE, and FF) reviewed for communication training. This failure placed all residents at risk of unmet care needs and diminished quality of life. Findings included . Review of the following employee files found no documentation that showed effective communication training had been provided as required: - Staff P, Licensed Practical Nurse - Staff L, Registered Nurse - Staff AA, Licensed Practical Nurse - Staff R, Nursing Assistant, registered - Staff BB, Licensed Practical Nurse - Staff K, Nursing Assistant - Staff CC, Nursing Assistant - Staff DD, Nursing Assistant - Staff EE, Nursing Assistant - Staff FF, Nursing Assistant In an interview on 05/22/2025 at 4:12 PM, Staff C, Clinical Resource Nurse, stated the previous Administrator did a lunch and learn meeting with the staff for effective communication training, but there was no signature sheet, and they were unable to find any documentation that showed the trainings had been completed. In an interview on 05/23/2025 at 9:36 AM, Staff A, stated they expected staff to receive adequate training in order to have adequate skills and competencies to meet the needs of the facility resident population. Reference WAC: 388-97-1680

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	505275	A. Building B. Wing	05/23/2025

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 37544 Based on interview and record review, the facility failed to ensure the mandatory Quality Assurance and Performance Improvement (QAPI) training was provided as required for 10 of 10 sampled staff (Staff P, L, AA, R, BB, K, CC, DD, EE, and FF) reviewed for training requirements. This failure placed all residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's 05/08/2025 QAPI plan showed the facility had a process in place to recognize, assess, and implement steps to improve the quality of life, care and services at the facility, however, the plan did not specify or include the type of training the staff would receive or how often training would occur. Review of the following employee files found no documentation that showed the facility provided the mandatory QAPI training: - Staff P, Licensed Practical Nurse - Staff L, Registered Nurse - Staff AA, Licensed Practical Nurse - Staff R, Nursing Assistant, Registered - Staff BB, Licensed Practical Nurse - Staff K, Nursing Assistant - Staff CC, Nursing Assistant - Staff DD, Nursing Assistant - Staff EE, Nursing Assistant - Staff FF, Nursing Assistant In an interview on 05/21/2025 at 1:49 PM, documentation was requested from Staff A, Administrator, that showed the facility provided the mandatory QAPI training. In an interview on 05/23/2025 at 9:36 AM, Staff A stated they expected staff to receive adequate training in order to have adequate skills and competencies to meet the needs of the facility resident population. (continued on next page)

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	505275	A. Building B. Wing	05/23/2025

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/23/2025 at 10:39 AM, Staff A was again asked for the mandatory QAPI training, and by the conclusion of the survey at 1:15 PM, no documentation had been received. No Associated WAC.

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	505275	A. Building B. Wing	05/23/2025

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 37544 Based on interview and record review, the facility failed to ensure the mandatory Compliance and Ethics training was provided as required for 9 of 10 sampled staff (Staff P, L, AA, R, BB, K, CC, DD, EE, and FF) reviewed for training requirements. This failure placed all residents at risk for unmet care needs and a diminished quality of life. Review of the following employee files found no documentation that showed the mandatory Compliance and Ethics training had been provided: - Staff P, Licensed Practical Nurse - Staff L, Registered Nurse - Staff AA, Licensed Practical Nurse - Staff R, Nursing Assistant, registered - Staff K, Nursing Assistant - Staff CC, Nursing Assistant - Staff DD, Nursing Assistant - Staff EE, Nursing Assistant - Staff FF, Nursing Assistant In an interview on 05/21/2025 at 1:49 PM, documentation was requested from Staff A, Administrator, that showed the facility had provided the mandatory Compliance and Ethics training. In an interview on 05/23/2025 at 9:36 AM, Staff A, stated they expected staff to receive adequate training in order to have adequate skills and competencies to meet the needs of the facility resident population On 05/23/2025 at 10:39 AM, Staff A was again asked for the trainings, and by the conclusion of the survey at 1:15 PM, no documentation had been received. Reference WAC: 388-97-1680(2)(c)