STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505276	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frontier Rehab & Extended Care	1500 3rd Avenue Longview, WA 98632

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on interviews and record review, the facility failed to ensure residents were able to use personal possessions in their room, including a personal refrigerator, that did not infringe on the rights of other residents for 1 of 1 sampled residents (17) reviewed for resident rights. This failure placed the resident at a risk of a diminished quality of life. Findings included . Facility policy entitled Resident personal refrigerators and food brought in by family and visitors, updated August 2020, documented, under procedure 6 Residents or responsible party may provide their own UL [Underwriters Laboratories, an organization that tests and certifies products to ensure public safety] approved personal refrigerator for use in their room, provided the room can accommodate the refrigerator's electrical load and physical space. Designated refrigerators are available in the Center for storage of resident foods. Resident 17 was admitted to the facility on [DATE] with diagnoses including paraplegia. The quarterly Minimum Data Set assessment, dated 01/23/2025, indicated Resident 17 was alert and oriented. The facility grievance log showed three entries for Resident 17; dated 08/13/2024, 10/07/2024, and 11/26/2024; for missing sodas (carbonated beverages). A grievance, dated 01/14/2025, was for leftover pizza being thrown out. On 02/04/2025 at 2:20 PM, Resident 17 said he had asked the facility for permission to bring in a personal refrigerator. Resident 17 said he was told by both social services and administration that this request was not allowed. Resident 17 said he filled out grievance forms several times due to his personal soda and food items disappearing from the shared resident refrigerator. At 3:29 PM, Staff G, Resident Care Manager and Registered Nurse, stated, Yes, I know that Resident 17 asked for a refrigerator, but the regulations don't allow it. On 02/06/2025 at 2:51 PM, Staff A, Administrator, said he was not sure if the facility had a policy about personal refrigerators. Staff A was aware Resident 17 had requested a personal refrigerator, but the request was denied. Staff A said he told Resident 17 he could bring in an ice chest. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:10 PM, Staff C, Social Services, said Resident 17 had requested to bring in a personal refrigerator. Staff C said Resident 17's soda kept coming up missing and the resident wanted to keep it in his room. Staff C said this request was denied because personal refrigerators were not allowed. Staff C said a personal refrigerator would have to be temped and logged. When asked about the facility's policy showing a resident could bring in their own UL approved personal refrigerator, Staff C said she was unaware of the policy and if that were the case, there would be no reason to deny Resident 17's request. Reference WAC 388-97-0860 (2)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 37934 Based on observation, interview and record review, the facility failed to ensure residents' medical information were maintained in a manner to ensure privacy and confidentiality when staff failed to properly secure the electronic health record (EHR) for 1 of 1 sampled resident (36) reviewed for privacy and confidentiality. This failure placed residents at risk for loss of confidential medical information and a diminished quality of life. Finding included . On 02/06/2025 at 9:11 AM, while walking past the Oceanside medication cart, Resident 36's EHR, the resident's personal health information, was observed being displayed on the medication cart computer. There were no facility staff around. At 9:12 AM, Staff O, Licensed Practical Nurse, was observed walking out of the nurse's station office and towards the resident hallway. At 9:13 AM, Staff A, Administrator, was observed walking past the medication cart. As Staff A walked by, Staff A was asked what the process was for protecting the EHRs of residents. Staff A walked back to the medication cart and attempted to lock the computer but was not able to do so. Staff A went to the Oceanside hallway and retrieved Staff O. At 9:14 AM, Staff O said she usually locked the screen but was distracted. Staff O said the medication cart computer with residents' EHR was supposed to be locked or closed. Reference WAC 388-97-0360 (1)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 51254 Based on observations and interviews, the facility failed to ensure the facility had comfortable noise levels for 2 of 3 sampled residents (86 & 244) reviewed for safe and comfortable homelike environment. This failure placed residents at risk for excessive noise levels and a diminished quality of life. Findings included . 1) On 02/03/2025 at 9:46 AM, Resident 86 said it was hard to relax or sleep because of the constant slamming door just outside of her room. Resident 86 said this caused her the inability to relax and sleep because it jolted her awake. On 02/04/2025 at 10:45 AM, the double doors that closed off the countryside corridor were observed to slam shut loudly. For the following 15 minutes, the doors opened and closed 22 times. At 12:55 PM, Staff J, Maintenance Director stated, Yes, the doors do slam, and they are loud. It's because they are solid and heavy. Staff J said the doors must be closed due to the flu outbreak. Staff J said the doors had to slam in order to latch closed. 2) On 02/06/2025 at 12:09 PM, Resident 244 said there was a lot of noise in the hall that sounded like a door slamming. Resident 244 said she had only been at the facility one day and hoped it did not continue. On 02/07/2025 at 9:51 AM, Staff A, Administrator, said to ask Staff J about the doors. Staff A said Staff J oversaw any maintenance concerns. Reference WAC 388-97-0880 (4)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	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** 51254 Based on interview and record review, the facility failed to ensure residents were free from verbal abuse when reported concerns about verbal abuse were not followed up on and preventative interventions were not initiated for 1 of 2 sampled residents (17) reviewed for abuse and/or neglect. Resident 17 experienced harm when a staff member verbally abused him with profanity and condescending comments; and when the resident's request, to not have the staff member provide care, was disregarded which continued to upset the resident. This failure placed residents at risk for psychological harm, verbal abuse and a diminished quality of life. Findings included . The facility policy entitled Prevention of All Types of Abuse, Neglect, Mistreatment, Involuntary Seclusion, Exploitation, and Misappropriation of Resident Property, revised October 2022, noted, Center supervisors and staff [as appropriate] correct and intervene in reported or identified situations in which abuse, neglect, or misappropriation of property is more likely to occur by analyzing the following [items that would make residents more vulnerable to abuse] . d. the supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care, etc. Resident 17 was admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis of the legs and lower body), pressure wounds and chronic pain. The Quarterly Minimum Data Set assessment, dated 01/23/2025, indicated Resident 17 was cognitively intact. The August 2024 Accident/Incident Log did not show an entry for Resident 17 regarding care concerns or verbal abuse. The August 2024 Grievance Log did not show an entry for Resident 17 regarding care concerns or verbal abuse. (continued on next page)

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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 - Actual harm Residents Affected - Few	On 02/03/2025 at 2:10 PM, Resident 17 said he was cussed out by a staff member in August 2024. Resident 17 said he had recorded the date in his cell phone note pad which he used to record events for tracking purposes. Resident 17 said he was told by Staff E, Licensed Practical Nurse (LPN), on 08/20/2024, that his pain medication had been delivered by the pharmacy. The resident said later on 08/20/2024 when the evening nurse came in to give him his medications, the evening nurse told him the pain medication had not been delivered. Resident 17 said he subsequently missed a dose of a long acting pain medication that evening. The resident said on the morning of 08/21/2024, Staff E came into his room to give him his morning medication, and the resident said to Staff E, Hey, you lied to me. Resident 17 said Staff E smirked at him, and said what do you mean. Resident 17 said he told Staff E, you told me the pain medication had been delivered when it had not. Resident 17 said Staff E appeared to become upset, face turned red, and in a raised tone of voice stated, I don't give a f**k what you think. Resident 17 said he asked Staff E to calm down as Staff E's outburst had startled him. Staff E continued to make condescending comments toward the resident. Resident 17 said Staff E said no one would want to take care of Resident 17 since all he does is complain. The resident said he asked Staff E to leave his room. Resident 17 said he immediately called both Staff C, Social Worker, and Staff G, Resident Care Manager and Registered Nurse, to report the outburst and had asked them both to come to his room. Resident 17 said he told both Staff C and Staff G about the verbal attack he had received from Staff E. Resident 17 said he told Staff C and Staff G that he had lost trust in Staff E, and that he must be able to trust his nurses as he is dependent on them for care. The resident said he also asked for Staff E not to be his nurse after this incident. Resident 17 said Staff E came back into his room about an hour later and said I hear you told [Staff C and Staff G] on me. Well, I got your pain medication here. That is, if you trust me enough to take them. Resident 17 said he felt like Staff E's behavior was cocky, intimidating and vindictive; and it caused the resident mental anguish. Resident 17 said there were additional times Staff E was assigned to the resident. The resident would call Staff G each time to have Staff E reassigned. Resident 17 indicated how many times do I have to report that I do not want this nurse providing care for me. When the resident was asked how it made him feel, Resident 17 said it made him feel like crap, and said how many times did he have to feel disregarded. The September 2024, October 2024, November 2024, and February 2025 Medication Administration Record documented Staff E was assigned to work with Resident 17 on the following dates: 09/01/2024 09/02/2024 09/11/2024 09/12/2024 10/11/2024 10/12/2024 10/17/2024 10/18/2024 10/31/2024 11/04/2024 11/05/2024 02/04/2025 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 02/04/2024 at 12:31 PM, Staff G said if a resident voiced concerns with care, he would have them fill out a grievance form. When asked how the staff would know if a resident had a grievance or abuse allegation, Staff G said he would interview the resident. Staff G said back in August he got a voice message from Resident 17 wanting to talk to him about Staff E. Staff G said he went and asked Staff E what happened, and Staff E told me Resident 17 was upset about information he did not like, and the resident asked Staff E to leave the room. When asked about the process for handling an allegation of abuse, Staff G said he would notify the Director of Nursing Services (DNS) and the Administrator (ADM). Staff G said he did not interview Resident 17 because he trusted what Staff E had told him. At 12:50 PM, Staff B, DNS and RN, said she was not sure of the details of the event as reported by Resident 17. Staff B said Staff G had mentioned something about running out of medications and the resident not liking what the nurse had told him regarding the situation. When asked what types of concerns were considered a grievance, Staff B said food concerns, missing items, things not considered abuse. Staff B said they would follow The Purple Book (The state's guidelines for the protection of nursing home residents along with guidelines for preventing, investigating, determining, and reporting incidents of resident abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation or misappropriation of resident property.) for an allegation of abuse. Staff B said she did not interview Resident 17, and assumed Staff G would have. On 02/07/2025 at 12:30 PM, Staff E said if an allegation of abuse was reported to him, he would talk to the staff member and have someone else resume care of the potential victim. When asked what other measures he would take, Staff E said, none that he could think of. When asked if Staff E had been providing care for Resident 17, Staff E said not since August 2024. When asked about giving medication to Resident 17, Staff E said not since August 2024. When asked about providing treatment to Resident 17, Staff E said not since August 2024. Staff E said he had never been back in that room (Resident 17's room) until 02/04/2025. On 02/11/2025 at 9:10 AM, Staff A, Administrator, said he was in communication with Resident 17 on the date of the alleged verbal abuse had occurred. Staff A said he received a text message from Resident 17 on 08/21/2024, which asked the Administrator to come see Resident 17 as soon as possible when he got into work that day. Staff A said it had something to do with running out of medications. Staff A was unable to recall if he went down to see Resident 17 about his concern. Reference WAC 388-97-0640 (1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on interview and record review, the facility failed to ensure allegations of verbal abuse were investigated to prevent further abuse for 1 of 2 sampled residents (17) reviewed for investigations of abuse. This failure placed residents at risk for abuse and a diminished quality of life. Findings included . The facility policy entitled Prevention of All Types of Abuse, Neglect, Mistreatment, Involuntary Seclusion, Exploitation, and Misappropriation of Resident Property, revised October 2022, noted, Center supervisors and staff [as appropriate] correct and intervene in reported or identified situations in which abuse, neglect, or misappropriation of property is more likely to occur by analyzing the following [items that would make residents more vulnerable to abuse] . d. the supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care, etc. Resident 17 was admitted to the facility on [DATE] with diagnoses including paraplegia, multiple pressure wounds and chronic pain. The Quarterly Minimum Data Set assessment, dated 01/23/2025, indicated Resident 17 was cognitively intact. The August 2024 Accident/Incident Log did not have an entry for Resident 17 regarding care concerns or verbal abuse. A subsequent facility investigation was not completed. The August 2024 Grievance Log did not have an entry for Resident 17 regarding care concerns or verbal abuse. On 02/03/2025 at 2:10 PM, Resident 17 said he was cussed out by Staff E, Licensed Practical Nurse, on 08/21/2024. The resident said Staff E told him his pain medication had been delivered by the pharmacy on 08/20/2024. Later on 08/20/2024, the evening nurse gave Resident 17 his evening meds and told him the pain medication had not been delivered causing him to miss a dose of a long acting pain medication that evening. Resident 17 said when Staff E came into his room, on 08/21/2024, to give him his morning medication, the resident said to Staff E, Hey, you lied to me. Resident 17 said Staff E smirked at him and said what do you mean. Resident 17 said you told me the pain medication had been delivered when it had not been. Staff E appeared upset, face turning red, and in a raised tone of voice stated, I don't give a f**k what you think. The resident said he was startled by the outburst. Staff E continued to make condescending comments toward the resident. Staff E said no one would want to take care of Resident 17 since all he does is complain. The resident said he asked Staff E to leave his room. Resident 17 said he immediately called both Staff C, Social Services, and Staff G, Resident Care Manager, to report the outburst and had asked them both to come to his room. The resident said he told both Staff C and Staff G about the verbal attack he had received from Staff E. Resident 17 said he told Staff C and Staff G that he had lost trust in Staff E, and that he must be able to trust his nurses as he is dependent on them for care. The resident said he asked for Staff E not to be his nurse after this incident. Resident 17 said Staff E came back in his room about an hour later, and said I hear you told [Staff C and Staff G] on me. Well, I got your pain medication here. That is, if you trust me enough to take them. Resident 17 said he felt like Staff's behavior was cocky, intimidating, vindictive and it caused the resident mental anguish. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The September 2024, October 2024, November 2024, and February 2025 Medication Administration Record documented Staff E was assigned to work with Resident 17 on the following dates: 09/01/2024 09/02/2024 09/11/2024 09/12/2024 10/11/2024 10/12/2024 10/17/2024 10/18/2024 10/31/2024 11/04/2024 11/05/2024 02/04/2025 On 02/04/2024 at 12:31 PM, Staff G, Resident Care Manager and Registered Nurse (RN), said if a resident voiced concerns with care, he would have them fill out a grievance form. When asked how the staff would know if a resident had a grievance or abuse allegation, Staff G said he would interview the resident. Staff G said back in August he got a voice message from Resident 17 wanting to talk to him about Staff E, Licensed Practical Nurse (LPN). Staff G said he went and asked Staff E what happened, and Staff E told me Resident 17 was upset about information he did not like, and the resident asked Staff E to leave the room. When asked about the process for handling an allegation of abuse, Staff G said he would notify the Director of Nursing Services (DNS) and the Administrator (ADM). Staff G said he did not interview Resident 17 because he trusted what Staff E had told him. At 12:50 PM, Staff B, DNS and RN, said she was not sure of the details of the event as reported by Resident 17. Staff B said Staff G had mentioned something about running out of medications and the resident not liking what the nurse had told him regarding the situation. When asked what types of concerns were considered a grievance, Staff B said food concerns, missing items, things not considered abuse. Staff B said they would follow The Purple Book (The state's guidelines for the protection of nursing home residents along with guidelines for preventing, investigating, determining, and reporting incidents of resident abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation or misappropriation of resident property.) for an allegation of abuse and abuse investigations. Staff B said she did not interview Resident 17, and assumed Staff G would have. Staff B indicated she did not understand that this had to do with an allegation of abuse. On 02/07/2025 at 8:58 AM, Staff P, Nursing Assistant, said she would tell a nurse if a resident reported to her being abused. Staff P said she would document it, tell a nurse, notify management and notify the mandatory reporter. Staff P indicated she was a mandatory reporter. At 9:32 AM, Staff Q, Staff Development Coordinator and RN, said staff were trained about abuse on hire and annually. The training included the different types of abuse and how to report any allegation to the abuse officer, which was the ADM or the DNS, so they can call it in. At 12:30 PM, Staff E said if an allegation of abuse was reported to him, he would talk to the staff member and have someone else resume care of the potential victim. When asked what other measures he would take, Staff E said, none that he could think of. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/2025 at 9:10 AM, Staff A, ADM, said he was in communication with Resident 17 on the date of the alleged verbal abuse had occurred. Staff A said he received a text message from Resident 17 on 08/21/2024, which asked the ADM to come see Resident 17 as soon as possible when he got into work that day. Staff A said it had something to do with running out of medications. Staff A was unable to recall if he went down to see Resident 17 about his concern. Reference WAC 388-97-0640 (6)(a)(b)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51254 Based on observation, interview, and record review, the facility failed to ensure the recommendations on the Preadmission Screen and Resident Review (PASARR) level II were followed for 1 of 7 sampled residents (35) reviewed for PASARR. This failure placed residents at risk of not receiving necessary mental health services and a diminished quality of life. Findings included . Resident 35 was admitted to the facility on [DATE]. The annual Minimum Data Set assessment, dated 01/09/2025, showed Resident 35 was severely cognitively impaired. Resident 35 triggered a significant change PASARR to be completed on 12/12/2024 for new/changed behaviors. This PASARR indicated Resident 35 now required a Level II PASARR assessment by a licensed mental health professional or mental health agency for individual services. The Level II PASARR recommendations were received on 01/02/2025 by the facility for implementation. Resident 35's medical record showed the recommendations were not fully implemented by the facility to assist staff with interventions and strategies to alleviate symptoms of agitation and aggression after received on 01/02/2025. On 02/06/2025 at 8:58 AM, Resident 35 was observed sitting on the side of the bed with hands folded in lap. When asked what he was doing, Resident 35 stated, Nothing . There is nothing to do. When asked what he would like to do, Resident 35 stated, I would listen to classic rock if I could. Resident 35 pointed to two pairs of headphones and said they did not work. Resident 35 said he was not sure why they stopped working. At 3:02 PM, Staff H, Social Services Assistant, said if there was a change to the Level I PASARR she would redo the form to indicate a Level II assessment was needed. Staff H said she would forward the revised form to the mental health assessor for interventions. Staff H said when the facility received the recommendations from the level II, they would put them into the care plan. Staff H was unable to find the completed recommendations for the behavior interventions located in Resident 35's electronic health record. Reference WAC 388-97-1060 (1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to ensure a comprehensive care plan was developed and implemented for 2 of 5 sampled residents (43 & 70) reviewed for care plans. This failure placed residents at risk for not receiving personalized care and a diminished quality of life. Findings included . 1) Resident 43 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD). The Annual Minimum Data Set (MDS) assessment, dated 11/20/2024, showed Resident 43 was alert and oriented. Review of Resident 43's electronic health record (EHR) did not show PTSD was not addressed in the comprehensive care plan. On 02/06/2025 at 1:33 PM, when asked if Resident 43 had a care plan for PTSD with measurable goals and interventions, Staff I, Resident Care Manager and Licensed Practical Nurse, after reviewing the care plan, stated, It doesn't look like he has a care plan for that. 2) Resident 70 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia. The Annual MDS, dated [DATE], documented Resident 70 was alert and oriented. Review of Resident 70's EHR did not address dementia in the comprehensive care plan. On 02/06/2025 at 1:40 PM, when asked if Resident 70 had a care plan for Dementia with measurable goals and interventions, Staff I said she did not see it in the EHR. On 02/07/2025 at 9:51 AM, Staff B, Director of Nursing Services and Registered Nurse, said it was the expectation that residents with Dementia or PTSD diagnoses had care plans that addressed the residents individual needs. Reference WAC 388-97-1020 (1)(2)(a)(b)

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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** 37934 Based on observation, interview and record review, the facility failed to ensure bowel management interventions were initiated and/or implemented for 2 of 5 sampled residents (61 & 295), failed to ensure physician orders were initiated and/or implemented for 1 of 4 sampled residents (57), and failed to ensure care plan interventions to elevate feet were implemented for 1 of 7 sampled residents (86) reviewed for quality of care. These failures placed residents at risk for unnecessary discomfort, health complications, and a diminished quality of care and quality of life. Finding included . <Bowel Management> The facility's policy entitled, Bowel Protocol, updated 03/2018, documented, If a resident does not have a bowel movement for three days, the nurse administers the physician ordered bowel program . in the event the center has no specific bowel program the nurse administers medication as ordered as followed: --Administer milk of magnesia per physician order on day four. --If milk of magnesia offers no results, administer a stimulant laxative suppository (Bisacodyl, etc.) per physician order on the next shift, during waking hours only. --If resident continues to have no results from suppository, administer an enema on the next shift, during waking hours only. --If no results from enema, notify physician. 1) Resident 61 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 01/02/2025, showed the resident was alert and oriented. The Bowel Movement (BM) task sheet documented Resident 61 had a BM on 01/10/2025 at 9:25 PM. Resident 61's next BM was on 01/15/2025 at 12:23 PM, almost 111 hours since the last BM (more than 4 1/2 days). The January 2025 Electronic Medication Administration Record (EMAR) did not show documentation Resident 61 had any interventions between 01/10/2025 and 01/15/2025. The BM task sheet documented Resident 61 had a BM on 02/02/2025 at 1:29 PM. Resident 61's next BM was on 02/07/2025 at 5:59 AM, about 112 hours since the last BM (more than 4 1/2 days). A progress note, dated 02/06/2025 at 10:37 AM, documented the administration of milk of magnesia (constipation medication). The bowel protocol was initiated about 105 hours after his last BM (about 4 days and 9 hours). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/2025 at 9:40 AM, Staff I, Resident Care Manager (RCM) and Licensed Practical Nurse (LPN), said the bowel protocol should be initiated if a resident did not have a BM after 72 hours. While reviewing the BM task sheet, Staff I said Resident 61 had a BM on 01/10/2025 and another BM on 01/15/2025. Staff I said the Bowel Protocol should have been initiated on 01/13/2025. Staff I said the Bowel Protocol should have also been initiated on 02/05/2025. 50416 2) Resident 295 was admitted to the facility on [DATE]. The Admission MDS assessment, dated 01/21/2025, documented the resident was alert and oriented. The January 2025 BM task sheet documented Resident 295 did not have a BM in 7 days from 01/16/2025 to 01/22/2025. Review of Resident 295's January 2025 EMAR documented Milk of Magnesia was administered on 01/20/2025 after 4 days with no BM but was ineffective. The EMAR showed Milk of Magnesia was administered again on 01/23/2025, 3 days later. A physician's order, dated 01/15/2025, documented Bisacodyl Suppository 10 MG (milligram). Insert 1 suppository rectally as needed for Constipation. If no results from Milk of Magnesia, administer per MD order on next shift, during waking hours only. On 02/05/2025 at 2:40 PM, Resident 295 said he had an episode of constipation where he had not had a BM in 8 days. On 02/07/2025 at 9:40 AM, Staff G, RCM and LPN, said per the bowel protocol and physician orders, Resident 295 should have received Milk of Magnesia on the fourth day of not having had a BM, but if Milk of Magnesia was ineffective, Resident 295 should have received a Bisacodyl Suppository. After reviewing Resident 295's EMAR to see if the resident received a Bisacodyl Suppository, Staff G stated, Doesn't look like he got anything. Staff G was unable to find documentation of Resident 295 refusing additional bowel interventions. At 9:51 AM, Staff B, Director Of Nursing Services and Registered Nurse (RN) said it was the expectation licensed nurses followed the bowel protocol and should have medicated Resident 295 with the PRN (as needed) Bisacodyl as ordered after Milk of Magnesia was ineffective. 47518 <Physician Orders> Resident 57 was admitted to the facility on [DATE]. The Annual MDS assessment, dated 11/25/2024, indicated Resident 57 was alert and oriented. A Nursing Progress Note, dated 01/03/2025 at 12:00 PM, documented Resident 57 had fallen. The Note documented, at 3:54 PM, a physician order for an x-ray of Resident 57's left foot, ankle, and knee. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nursing Progress Note, dated 01/04/2025 at 6:34 PM, documented, Spoke with on-call . physician via phone call. She stated according to res. [Resident 57's] XR [x-ray]) results, she appears to have a fx [fracture] to her L [left] great toe. She stated res. needs to begin wearing a hard sole open-toe post-op [post operative] shoe. Res. notified. Messaged RCM about shoe request. The Secure Conversations Progress Note, dated 01/06/2025 at 8:05 AM, documented, .physician stated according to res. XR results, she has a L great toe fx. She stated res. needs to wear a hard sole open toe post op shoe . Review of the Fall with Fracture investigation note, dated 01/08/2025, documented, .X rays came back with left great toe fracture. New order for resident to wear hard sole platform shoe. Shoe ordered, waiting for arrival. Review of Resident 57's electronic health record (EHR) did not show a physician's order for a hard sole open toe post operative or platform shoe. On 02/03/2025 at 3:41 PM, Resident 57 said she had fallen last month and broke her big toe. Resident 57 said she was supposed to get a stationary shoe but never did. Resident 57 said the doctor ordered it, and stated, .he was surprised it wasn't here. Resident 57 was observed not wearing a hard sole open toe post operative shoe. On 02/05/2025 at 9:59 AM, Resident 57 said she asked facility staff about the shoe a couple of times when she did not get it. Resident 57 said the doctor was going to re-order it. Resident 57 said she wondered what she was supposed to be doing with her foot, and stated, I am just very careful and used my left footrest and kept this leg up. A Nursing Progress Note, dated 02/05/2025 at 11:06 AM, 33 days after Resident 57's fall, documented, resident never received a platform shoe for great toe fx r/t [related to] unavailable. Ordered through therapy. Resident aware . At 12:19 PM, Staff I said the doctor ordered a sturdy, platform shoe for Resident 57 after the resident fractured her toe. Staff I said the doctor was notified that Resident 57 did not get the shoe. Staff I said she did not find documentation the provider was notified and stated, .there was not an official progress note showing that he was notified . Staff I said it was their practice when conversations happened with the doctor, it should be documented to include any refusals, changes, or orders that cannot be followed through. At 2:39 PM, after reviewing Resident 57's record to see if the physician order was inputted into the resident's EHR for the hard sole shoe, Staff I said she could not find the order for the special shoe, and stated, .we failed to input it into the physician orders, the verbal order for the post op shoe. At 3:31 PM Staff B said it was her expectation nurses documented conversations with a physician, especially if they were given directions from the physician. Staff B said if they received a verbal order from the physician, she expected it would get into the physician orders, and stated, I mean that's the way we could follow up. 51254 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Care Plan Interventions> Resident 86 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease and a fractured right femur. The 5-day MDS assessment, dated 01/03/2025, showed Resident 86 was alert and oriented. The renal insufficiency care plan, dated 12/30/2024, noted the intervention to elevate feet when sitting up in chair to help prevent dependent edema [swelling caused by an accumulation of excess fluid in the body's tissue]. On 02/03/2025 at 9:46 AM, Resident 86 said she had swelling in both legs and her legs became painful when she sat up too long. Resident 86 said this swelling to her legs was new since her surgery. On 02/04/2025 at 10:00 AM, Resident 86 was observed sitting in the wheelchair with feet resting on the floor. Resident 86 said her legs were painful. Resident 86 said she tried to use compression stockings to help the swelling, but they were uncomfortable. At 12:13 PM, Resident 86 was observed sitting in the wheelchair with feet resting on the floor. On 02/05/2025 at 9:28 AM, Resident 86 was observed sitting in the wheelchair with feet on foot pedals of wheelchair. At 12:28 PM, Resident 86 was observed sitting in the wheelchair with feet on the floor. On 02/06/2025 at 8:32 AM, Resident 86 was observed sitting in the wheelchair with her feet on the floor. Resident 86 lifted her blanket to show her swollen legs and feet and said they start to ache when her legs were down. At 8:34 AM, Staff M, LPN, said the nurse would tell the Nursing Assistants (NA) to elevate legs for residents. Staff M said the residents also had care directives hung in the closet for the NAs to follow for direct patient care interventions. After reviewing the care directives for Resident 86, Staff M indicated the interventions for elevating the resident's legs were not identified in the care directive. Staff M said she would notify the RCM so they could update the form. At 10:00 AM, Staff G, RCM and RN, said the interventions should be on the care directive for the NA to follow. Staff G said whoever did the care plan must have missed it. Reference WAC 388-97-1060 (1)(3)(c)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on observation, interview, and record review, the facility failed to ensure altered consistency liquids were provided and consistent with the resident's care plan (CP) for 1 of 1 sampled residents (74) reviewed for hydration. This failure placed residents at risk for aspiration (accidental inhalation of food or liquid into the airways), dehydration, and a decreased quality of life. Findings included . Resident 74 was admitted to the facility on [DATE]. The 5-day Minimum Data Set assessment, dated 01/15/2025, documented the resident was alert and oriented and had a stroke history. Resident 74's diet order, dated 01/30/2025, documented, nectar thick liquid consistency. On 02/04/2025 at 9:12 AM, Resident 74's room was observed to have a water pitcher containing thin liquid water. Resident 74 said some of the staff who pass water did not know she was on thickened liquids. The resident's care plan, printed and posted in Resident 74's room closet, documented, FLUID CONSISTENCY: mildly thick. At 9:40 AM, Staff E, Licensed Practical Nurse (LPN), said there was some thin water in the resident's room. Staff E stated, That was a mistake on our part. Staff E said Certified Nursing Assistants (CNAs) would get information on resident diet orders during morning report, and also from the care plan on the resident's closet door. At 9:45 AM, Staff F, CNA, said a water pass was usually done with meal pass, and residents with thickened liquid orders get their liquids from the kitchen, who gives them to the nurses. Staff F said she was aware of Resident 74's thickened liquid orders from report given when she came on shift. On 02/06/2025 at 1:30 PM, Staff G, Residential Care Manager and LPN, said thickened liquid orders were on a resident's baseline care plan, as well as on the resident's tray cards/meal ticket slips as well. Staff G said Resident 74's thickened liquid orders had changed recently. Staff G said on 02/04/2025 Resident 74's diet order documented mildly thickened liquids. Staff G said residents on a thickened liquid order should not have thin liquids in their rooms. At 3:06 PM, Staff B, Director of Nursing Services and Registered Nurse, said residents should not have liquid at the bedside inconsistent with the MD (medical doctor) order. Reference WAC 388-97-1060 (3)(i)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51254 Based on observations, interviews, and record review, the facility failed to ensure medically related social services (SS) were provided to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 5 sampled residents (17) reviewed for medically related social services. This failure placed residents at risk for unmet psychosocial care needs and a diminished quality of life. Findings included . Resident 17 was admitted to the facility on [DATE] with a diagnoses including paraplegia. The Quarterly Minimum Data Set assessment, dated 01/23/2025, indicated Resident 17 was alert and oriented. Review of the care plan, entitled Risk for psychosocial well-being r/t (related/to) [being in the facility for] long-term care, revised 01/10/2025, documented [Resident 17] is a younger resident . [Resident 17] should speak with SS to assist him in setting realistic goals. On 02/03/2025 at 2:10 PM, Resident 17 said he was cussed out by a staff member in August 2024. Resident 17 said he had talked with Staff C, SS, about numerous concerns with staff and care concerns within the facility. Resident 17 said he has talked to SS regarding incidents related to staff treatment (including the incident in August 2024), training concerns, personal items request, and personal challenges. At 3:24 PM, Staff C said she was aware Resident 17 did not wish to have certain staff take care of him. Staff C said Resident 17 was particular to how he wanted things done. Staff C said she was aware he had asked not to have certain staff take care of him for things like positioning, wound care, and did not like argumentative staff. When asked about SS role in advocating for Resident 17's complex medical condition and concerns, Staff C said she should have followed Resident 17 more closely. Staff C said she had not formally addressed concerns between nursing staff and Resident 17. Staff C said she should have done more charting and care plan interventions to assist staff with providing care to Resident 17. Staff C said she had not consulted with the Social Services Director to help mitigate the concerns for Resident 17. On 02/07/2025 at 9:50 AM, Staff D, Social Services Director, said she would expect a social worker to advocate, troubleshoot concerns, get family support, help resident reach out, and care plan items. Staff D said she would expect there to be an interdisciplinary approach to make sure Resident 17's concerns were being addressed. Staff D said she would expect SS to provide emotional support, help identify coping strategies and to be supportive of the resident. Staff D said each of these concerns should have been addressed in the care plan. Refer to F600 & F610 Reference WAC 388-97-0960 (1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to ensure medical records were maintained to be complete and accurate for 2 of 5 sampled residents (43 & 70) reviewed for resident records. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . 1) Resident 43 was admitted to the facility on [DATE] with diagnoses including Depression and Post Traumatic Stress Disorder (PTSD). The Annual Minimum Data Set (MDS) assessment, dated 11/20/2024, showed Resident 43 was alert and oriented. Review of Resident 43's PASARR Level I, dated 11/13/2020, documented Resident 43 showed indicators for mood disorders, but section IV of the Level I PASARR did not indicate service needs. Review of Resident 43's electronic health records (EHR) did not show a corrected PASARR Level I, dated 11/13/2020, and did not show a Level II PASARR determination or evaluation. On 02/05/2025 at 2:28 PM, when asked if Resident 43's Level I PASARR was accurate, Staff H, Social Services Assistant, stated, We need to do a new PASARR. When asked if there was an updated or corrected Level I PASARR in the EHR, Staff H was unable to locate a corrected Level I PASARR in Resident 43's EHR. 2) Resident 70 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder and Psychotic Disorder with Delusions due to known physiological condition. The Annual MDS, dated [DATE], documented Resident 70 was alert and oriented. Review of Resident 70's Level I PASARR, dated 10/19/2023, documented, Level II evaluation required for SMI [serious mental illness]. A Level II PASARR evaluation was not located in Resident 70's EHR. On 02/05/2025 at 2:33 PM, when asked if there was a Level II PASARR evaluation in Resident 70's EHR, Staff H was not able to locate a Level II PASARR in Resident 70's EHR. Reference WAC 388-97-1720 (1)(a)(i-iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37934 Based on observation and interview, the facility failed to ensure staff properly donned (putting on) and doffed (removing) personal protective equipment (PPE) for 1 of 1 sampled licensed nurse (Staff O, Licensed Practical Nurse) reviewed for infection prevention and control. This failure placed residents at risk for the spread of infection transmission in the facility and a diminished quality of life. Findings included . The Center for Disease Control and Prevention's (CDC) Contact Precautions sign, undated, indicated, Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: .Put on gown before room entry. Discard gown before room exit. On 02/07/2025 at 12:45 PM, Staff O was observed in Resident 46's room. Staff O had Resident 46's right arm in her gloved hands. Outside of Resident 46's room, next to the right side of the door, was a sign that read Contact Precaution. After Staff O exited the room, Staff O said she was attempting to find Resident 46's vein. Staff O said she was supposed to wear PPE anytime they provided care to Resident 46. At 1:10 PM, Staff A, Administrator, said he expected staff to abide by the posted precaution signs. Reference WAC 388-97-1320 (1)(a)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51254 Based on observations and interviews, the facility failed to ensure essential equipment was in safe operating condition when batteries died while transferring residents on 2 of 4 mechanical lifts reviewed for physical environment. This failure placed residents at risk of being injured and a diminished quality of life. Findings included . On [DATE] at 2:07 PM, Resident 17 said the battery on the mechanical lift had died numerous times during transfers. Resident 17 said he was left suspended in the mechanical lift between the bed and chair while staff left the room or called others to swap out the battery. Resident 17 said the nursing staff also struggled with maneuvering the mechanical lifts due to hair tangled in the wheels of the mechanical lifts. Resident 17 said he felt there was a concern for safety due to both issues. On [DATE] at 10:13 AM, the mechanical lift in the Country Side short hall was observed sitting in the hallway with hair tangled in the rear wheels. On [DATE] at 11:50 AM, Resident 17 was observed when Staff L, Nursing Assistant (NA), and Staff F, NA, were using a mechanical lift to transfer Resident 17 from the bedside commode to the bed. During the transfer the mechanical lift stopped midway with the resident suspended in the sling when the battery died . Resident was left hanging in the air for two minutes while staff went to the door of the room and asked another staff to bring a different charged battery. Staff F said some of the Hoyer (type of lift) batteries held charges longer than other, and sometimes they died while in use. During the transfer of Resident 17, the wheels appeared difficult to turn causing a jerking motion of Resident 17. The wheels on the mechanical lift were tangled with a large amount of what appeared to be hair and lint making the wheel motion less smooth. On [DATE] at 10:15 AM, Staff K, Housekeeping Supervisor, said there was no schedule for cleaning the wheels on the mechanical lifts. After inspecting the Hoyer lift machine, Staff K stated, Oh, yes. That does need to be cleaned. At 12:54 PM, Staff J, Maintenance Supervisor, said the Hoyer lift batteries dying had been an ongoing issue. Staff J said the staff did not put them into the charger correctly. Staff J said this was user error and he had told the staff multiple times how to insert the batteries correctly. When asked about routine maintenance on the batteries, Staff J said he did random tests on the batteries to see if they were still good. Staff J said he did not have a maintenance log for these checks but did them when he thought of it. Reference WAC [DATE] (1)(2) .