STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505280	A. Building B. Wing	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renton Health & Rehabilitation	80 Southwest Second Street Renton, WA 98057

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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 - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure informed consent (a process explaining the risks and benefits of a treatment prior to use) was obtained prior to administration of psychotropic (affecting mental state) medications for 2 of 5 (Residents 20 & 34) reviewed for unnecessary medications and for bed rails for 1 of 2 residents (Resident 60) reviewed for accident hazards. This placed residents at risk for unwanted treatment. <Findings included> <Facility Policy> According to the facility policy titled, Use of Psychotropic Medication, revised 08/2024, residents needing psychotropic medications would be educated on the risks and benefits. <Facility Policy> According to a facility policy titled, Proper Use of Bed Rails, revised 03/2024, showed the facility would obtain informed consent from the resident or resident representative prior to installation and use of the bed rails. The policy showed risks and benefits of bed rail use for the resident would be provided to the resident or resident representative as part of the informed consent. <Resident 34> According to the 07/24/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 34 had diagnoses including anxiety and depression. The MDS showed Resident 34 took antianxiety and antidepressant medications. Review of the physician's orders showed Resident 34 had two antidepressant orders, both with start dates of 05/31/2024. Resident 34 had one order for an antianxiety medication with start date of 05/30/2024. Record review showed three informed consent documents explaining the risks and benefits of the two antidepressants and the antianxiety medication. Each form was dated 08/15/2024. Each form was signed by Resident 34 on 09/06/2024. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/16/2024 at 1:02 PM Staff P (Registered Nurse - RN, RN Manager) stated informed consent should be obtained from a resident prior to administration of a psychotropic medication. Staff P stated the facility should have but did not provide Resident 34 informed consent prior to administering the three psychotropic medications. <Resident 20> According to the 06/10/2024 Quarterly MDS Resident 20 had no memory impairment, and diagnoses including depression. The MDS showed Resident 20 took antidepressant medications. Record review showed a 05/16/2024 order for an antidepressant medication. Record review showed an informed consent form for the antidepressant with an effective date of 05/16/2024. The form was not signed by Resident 20 but showed verbal consent was given on 05/16/2024 The form was signed electronically by Staff C (RN Manager) on 09/06/2024, over three months later. A copy of this form with undated handwritten signatures by Staff P and Staff C, and a digital signature date for Staff C of 09/06/2024. The form was scanned in to Resident 20's record by Staff R (Medical Records Supervisor) on 09/13/2024. In an interview on 09/13/2024 at 12:29 PM Staff C stated their signature date of 09/06/2024 was the date the form was finalized in the electronic record. When asked if they could demonstrate consent was obtained prior to 09/06/2024 Staff C showed the hand signed form including only the 09/06/2024 electronic signature date. In an interview on 09/13/2024 at 12:37 PM Staff R stated they were given the form to scan into the record that day by Staff P. 47836 <Resident 60> According to the 07/15/2024 Admission MDS Resident 60 was admitted on [DATE] with a diagnosis that resulted in paralysis to the left side of their body. The assessment showed Resident 60 had no memory impairment. Record review showed a 07/24/2024 physician order for bilateral quarter bed rails to Resident 60's bed. Review of Resident 60's records showed no consent documentation for the use of the bed rails. On 09/10/2024 at 10:02 AM, Resident 60 was observed to have bed rails attached to both sides of their bed. Resident 60 stated staff did not discuss the risks and benefits of the bed rails with them or obtain their consent for the side rails. In an interview on 09/15/2024 at 10:26 AM Staff C stated prior to placing bed rails on a resident's bed, they were expected to complete a safety device assessment on the resident, explain risks and benefits of the bed rails, obtain the residents consent, and care plan the bed rails to ensure all staff were aware of the reason for the bed rails. Staff C stated they had not obtained consent for Resident 60's bilateral bed rails but should have. Staff C stated it was important to obtain resident consent to ensure the resident was included in their plan of care and aware of all treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to F656 - Develop/Implement Comprehensive Care Plan REFERENCE: WAC 388-97-0260.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 45941 Based on interview and record review, the facility failed to notify 5 (Resident 1, 6, 25, 219, & 119) of 23 residents reviewed, who were Medicaid recipients, when their personal fund account balances reached $1800 (i.e. within $200 of the $2,000 resource limit beneficiaries could possess, without their Medicaid coverage being impacted). This failure placed residents at risk for personal financial liability for their care. The facility failed to ensure funds were reimbursed to the state Office of Financial Recovery (OFR), within 30 days of resident discharge or death, for 1 (Resident 219) of 3 discharged residents reviewed. This failure caused a delay in reconciling resident accounts within 30 days as required. Findings included . Review of a revised 08/2024 Resident Personal Funds policy, showed the facility must notify each resident who received Medicaid benefits: when the amount in the resident's account reached $200 less than the Supplemental Security Income (SSI) resource limit for one person; and if the amount in the account reached the SSI resource limit, the resident may lose eligibility for Medicaid or SSI. This policy showed, upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility would convey within 30 days the resident's funds to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State Law. <Notice of Medicaid Balances> Review of the facility's Trial Balance report showed the following resident balances over the resource limit, as of 09/10/2024: Resident 6 - $7213.83; Resident 25 - $5533.75; Resident 1- $6543.31; Resident 219 - $3286.02; Resident 119 - $3744.05. In an interview on 09/13/2024 at 9:27 AM, Staff N (Business Office Manager - BOM) stated the facility did not have a BOM for a few months and they were helping in the business office. Staff N stated they were aware of the broken system in the business office. Staff N confirmed Residents 1, 6, 25, and 219 were all over the $2000 limit and stated, the system was broken. No further documentation was provided from the facility. <OFR Fund Disbursement> <Resident 219> Record review showed Resident 219 was discharged from the facility on 05/30/2024. Review of trust records showed the resident had a balance of $3286.02, which was not transferred to the resident or to OFR until 09/13/2024, more than three months after discharge. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/13/2024 at 9:30 AM, Staff N stated, upon a resident's discharge, accounts should be closed, and any remaining funds sent to OFR before 30 days at the very most. Staff N confirmed Resident 219's account was not closed. Staff N stated Resident 219 was transferred to another facility and their personal fund was not sent with the resident. REFERENCE: WAC 388-97-0340(4)(5).

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Notice of Medicare Non-coverage (SNF-NOMNC - a required form notifying the resident that their skilled services coverage was ending and would no longer be covered by their Medicare A benefits) as required for 2 of 4 residents (Resident 219 and 119) reviewed for beneficiary notification. This failure placed Residents 219, 119, and other residents at risk for not being fully informed and losing their right to an appeals process. Findings included . <Facility Policy> According to the facility policy titled, SNF Beneficiary Notices Under Medicare Part A, revised 06/2023, the facility would inform Medicare A beneficiaries when they no longer met the skilled coverage criteria. The policy showed a NOMNC was given by the facility to all Medicare beneficiaries at least two days before the end of their Medicare covered Part A stay because the notice contained information regarding the beneficiary's right to an expedited appeals process review by a Quality Improvement Organization. The policy showed the facility would maintain a log of notices that had been provided to residents/representatives. <Resident 219> According to the 05/15/2024 Discharge Return not anticipated Minimum Data Set (MDS - an assessment tool), Resident 219 was admitted to the facility on [DATE] and was discharged to the community on 05/15/2024. Review of Resident 219's record showed a 05/14/2024 Physician Order for the resident to discharge home. Review of Resident 219's record did not show a NOMNC was provided to the resident to explain their Medicare A benefits. <Resident 119> According to the 05/22/2024 Discharge Return not anticipated MDS, Resident 119 was admitted to the facility on [DATE] and was discharged to the community on 05/22/2024. Review of the 05/22/2024 Nursing progress note showed Resident 119 was discharged home. Review of Resident 119's record did not show a NOMNC was provided to the resident to explain their Medicare A benefits. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/12/2024 at 9:45 AM, Staff D (Social Services Director) stated it was important to provide beneficiary notices to residents whose skilled services were ending so residents could prepare themselves for a safe discharge or they could exercise their right to an appeals process if/when residents felt they needed more services. Staff D stated they should have but did not provide Resident 219 or 119 a NOMNC as required. REFERENCE: WAC 388-97-0300(1)(e), (5), (6).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation and interview, the facility failed to ensure walls in resident rooms were maintained in a homelike condition for 9 of 18 rooms sampled (Rooms 22, 26, 32, 34, 50, 42, 47, 48, & 49). The failure to ensure rooms were free from gouges (Rooms 22, 32, 50, 48), resident televisions were mounted (room [ROOM NUMBER]), fans in resident rooms were clean (room [ROOM NUMBER]), and sinks, toilets, and bathroom fixtures in resident rooms were free from rust and maintained in clean, sanitary conditions (Rooms 22, 32, 34, 42, 47, & 49). These failures left residents at risk for a diminished quality of life and a less than homelike environment. Findings included . <room [ROOM NUMBER]> Observation of room [ROOM NUMBER] on 09/10/2024 at 10:46 AM showed wall behind the bed nearest the door was gouged where the bed rubbed against the wall, exposing drywall. The bathroom in room [ROOM NUMBER] had considerable dark yellow stains on the tile underneath and around the toilet. In an interview on 09/16/2024 at 9:18 AM Staff O (Maintenance Supervisor) stated the wall should be repaired. Staff O stated the bathroom tile was gross and should be cleaned. <room [ROOM NUMBER]> Observation in room [ROOM NUMBER] on 09/11/2024 at 10:58 AM showed the television was not mounted on the wall. Instead the television rested on top of a dresser at an angle that made viewing from the resident bed less manageable than necessary. In an interview on 09/16/2024 at 9:18 AM Staff O stated all televisions should be mounted on walls. 43642 <room [ROOM NUMBER]> Observations on 09/10/2024 at 9:47 AM showed room [ROOM NUMBER] bed 1 with deep gouges and exposed drywall on the wall next to the resident's bed. The toilet seat had brown dried smears across the toilet seat rim and down the front of the toilet. The white paint was also worn off the toilet seat rim in the front and the back. The roll of toilet paper was sitting on the floor near the toilet and the holder for the toilet paper was missing. On 09/11/2024 at 10:17 AM, over 24 hours later, observations showed the same dried brown smears on the toilet,worn off paint on the toilet rim, missing toilet paper holder, and the toilet paper sitting on the ground next to the toilet. In an interview on 09/16/2024 at 8:49 AM, Staff O stated the wall gouges needed to be patched and fixed, toilets and bathrooms should be cleaned every day and as needed, and the missing toilet paper holder and toilet seat rim needed to be replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<room [ROOM NUMBER]> Observations on 09/10/2024 at 9:59 AM showed room [ROOM NUMBER] bed 1 had a standing fan full of dust debris on the front grill. The debris was blowing and moving with the flow of air in the room during observations. In the bathroom, there was a roll of toilet paper on the floor and the holder for the toilet paper was missing. In an interview on 09/16/2024 at 8:49 AM, Staff O stated the fans in the facility needed to be cleaned and would be taken care of. Staff O stated a clean and homelike environment was important for residents to be able to feel comfortable, as the facility was their home. 46479 <room [ROOM NUMBER]> Observation on 09/10/2024 at 9:58 AM showed room [ROOM NUMBER] Bed 2 with multiple gouges and scrapes along the wall, behind the resident's headboard. In an interview on 09/16/2024 at 9:10 AM, Staff O confirmed the gouges on the wall behind the resident's headboard and stated the wall needs repaired. 50511 <room [ROOM NUMBER]> Observation on 09/10/2024 at 10:36 AM toilet seat cover in bathroom was lifted to expose the underside of the lid. Observed several cracked and chipped paint on toilet seat rim. Observed bathroom floor tiles next to toilet had brown dirt on the tiles. <room [ROOM NUMBER]> Observation on 09/10/2024 at 10:51 AM bathroom sink had brown rust stains around the drain hole,sink was cracked, chipped and dented on the lower left corner of the sink. Observed the cracks and dents were covered with white chalking material and white pain brushed over the dents. Floor around the bathroom was brown with dirt and debris. <room [ROOM NUMBER]> Observation on 09/10/2024 at 12:52 PM wall behind room [ROOM NUMBER] Bed 2 had several gouges with cracked paint, window blinds were dented and twisted. <room [ROOM NUMBER]> Observation on 09/10/2024 at 12:50 PM room sink had jagged, torn, pink foam partially falling off the sink covering the corners of the sink. Floor in bathroom had brown debris in corners of the bathroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/13/24 at 09:38 AM Staff P (Registered Nurse Manager) observed the pink foam falling off the sink, Staff P stated it should not be there as there was no purpose for the pink foam, that it should be removed. In an interview on 09/16/2024 at 8:49 AM, Staff O stated the wall gouges needed to be patched and fixed, toilets and bathrooms should be cleaned every day and as needed, and the missing toilet paper holder, toilet seat rim and sink needed to be replaced. REFERENCE: WAC 388-97-0880.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 43642 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS -an assessment tool) accurately reflected the status for 3 (Resident 37, 51, & 61) of 19 residents reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 37> Review of a 07/24/2024 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 37 had clear speech, understands, and was understood by others. This MDS showed staff assessed Resident 37 with broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, (obvious or likely cavity or broken natural teeth, and mouth or facial pain, discomfort or difficulty with chewing. Observations on 09/10/2024 at 10:38 AM showed Resident 37 with multiple lower teeth and no upper denture in their mouth. In an interview at this time, Resident 37 stated they were waiting to have their dentures fixed. In an interview on 09/16/2024 at 1:35 PM, Staff BB (MDS Coordinator, Registered Nurse) reviewed Resident 37's 07/24/2024 Annual MDS, stated staff incorrectly marked the section indicating the resident had no natural teeth, and needed to be corrected. <Resident 51> Review of a 06/26/2024 Quarterly MDS showed Resident 51 had multiple medically complex diagnoses including stroke and had a functional limitation in range of motion to one side of their lower extremity. This MDS showed in the last seven days of the assessment period, Resident 51's normal mobility device was a walker. Observations on 09/12/2024 at 11:05 AM and 09/13/2024 at 2:12 PM, showed Resident 51 reclined in a wheelchair in the hallway positioned next to staff. In an interview on 09/16/2024 at 1:35 PM, Staff BB reviewed Resident 51's 06/26/2024 Quarterly MDS and stated, that was an error, [they] do not use a walker. Staff BB stated the MDS needed to be corrected. 42203 <Resident 61> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 08/13/2024 Quarterly MDS, Resident 61 had intact memory and had a preferred language that was not English. This MDS showed Resident 61 had clear speech and was understood and able to understand others in conversation. Section F (Preferences for Customary Routine and Activities) of this MDS had two sections, a resident interview section, and a staff assessment section. The MDS directed the staff completing the assessment to skip the resident interview only if the resident was rarely or never understood and a family member or significant other was not available. The resident assessment section was marked with zero, indicating Resident 61 was rarely/never understood, contradicting earlier in the assessment where Resident 61 was assessed to always be understood. Instead of a resident interview a staff assessment of Resident 61's daily and activity preferences was completed. This assessment provided less specific information and lacked Resident 61's perspective on their choices and preferences. In an interview on 09/13/2024 at 12:29 PM Staff BB stated facility activities staff were responsible for completing Section F for residents. Staff BB reviewed Resident 61's records and stated staff should have, but did not, interview Resident 61, using translation services, if necessary, to ensure the resident's preferences were included in the assessment. REFERENCE: WAC 388-97-1000 (1)(b).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 43642 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the residents' mental health conditions for 1 of 5 (Resident 51) residents reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Facility Policy> According to the facility policy titled, Admissions Criteria, revised July 2024, all new admission and readmissions must go through a PASRR screening prior to admission. The policy showed the facility's social worker was responsible for making referrals for Level II PASRR services. <Resident 51> According to a 06/26/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 51 had multiple medically complex diagnoses including dementia, anxiety, and schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors). Review of Resident 51's physician orders showed the resident had been receiving an antipsychotic medication from 09/06/2023 until 04/17/2024 for acute psychosis. On 07/23/2024 the same antipsychotic medication was restarted for Resident 51 with an indicated diagnosis of psychosis and schizophrenia. Review of a 01/18/2023 Level 1 PASRR showed staff identified Resident 51's only serious mental illness indicator was anxiety and the resident's primary language was English. Staff did not identify Resident 51's primary language was Vietnamese, as identified by staff on the resident's 01/13/2024 admission assessment. No updated PASRR Level 1 was found addressing Resident 51's psychosis. In an interview on 09/16/2024 at 12:33 PM, Staff D (Social Service Director) stated PASRR's were important to identify if residents required Level 2 evaluations and to assist residents with being successful in the facility. Staff D stated their expectation was for Level 1 PASRR's to be accurate and should be updated with changes. Staff D reviewed Resident 51's records and stated the primary language was identified inaccurately and stated the Level 1 should have been updated to include the diagnoses identified for the antipsychotic medications for Resident 51. REFERENCE: WAC 388-97-1975(1)(9).

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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** 47836 Based on observation, interview, and record review, the facility failed to develop and/or implement a comprehensive Care Plan (CP) for 4 of 17 sampled residents (Residents 60, 39, 58, & 1) whose comprehensive CPs were reviewed. The failure to develop comprehensive, individualized CPs with resident-specific goals and/or interventions placed residents at risk for unmet care needs and a decreased quality of life. Findings included . <Facility Policy> According to a facility policy titled, Proper Use of Bed Rails, revised 03/2024, showed the facility would implement ongoing monitoring and supervision of the bed rails by way of the resident's care plan. The policy showed direct care staff would be responsible for care and treatment in accordance with the care plan for the bed rails. According to a facility policy titled, Comprehensive Care Plan, revised 08/2024, showed resident specific services that were furnished to maintain the resident's highest practicable physical well-being would be documented in the CP. The policy showed resident specific interventions would be documented in the residents CP. The policy showed the comprehensive CP would be reviewed and revised with each quarterly Minimum Data Set (MDS - an assessment tool). <Resident 60> According to the 07/15/2024 Admission MDS Resident 60 was admitted on [DATE] with a diagnosis that resulted in paralysis to the left side of their body. The assessment showed Resident 60 had no memory impairment. Record review showed a 07/24/2024 physician order for bilateral quarter enabler bars to Resident 60's bed. Review of Resident 60's CP showed no documentation of bilateral bed rails. On 09/10/2024 at 10:02 AM Resident 60 was observed to have bed rails attached to both sides of their bed. Resident 60 stated staff did not discuss the risks and benefits of the bed rails with them or obtain their consent for the side rails. In an interview on 09/15/2024 at 10:26 AM Staff C (Registered Nurse Manager) stated they were expected to care plan the bed rails to ensure all staff were aware of the bed rails and the reason for their use. Staff C stated they had not care planned the bilateral bed rails for Resident 60 but should have. <Resident 39> (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 07/16/2024 Quarterly MDS Resident 39 was admitted on [DATE] with diagnoses that included brain damage, weakness, stiffness of joints, pressure ulcers, and lower urinary tract symptoms. The assessment showed Resident 39 had an indwelling urinary catheter and was dependent on staff for all care/needs. Record review showed a 05/21/2024 physician order for an indwelling urinary catheter. Review of Resident 39's CP showed no documentation of a urinary catheter. Observation and interview on 09/10/2024 at 1:49 PM showed Resident 39 with an indwelling catheter in place. Resident 39's representative stated they wanted it removed but was told by staff that they needed it in place until the resident's wounds to their buttocks had healed. In an interview on 09/15/2024 at 10:26 AM Staff C stated it was important to CP urinary catheters so staff would know how to care for the resident. Staff C stated Resident 39's catheter was not on their CP but should be. 42203 <Resident 58> According to the 07/30/2024 Quarterly MDS Resident 58 had diagnoses including a history of stroke and difficulty swallowing. The MDS showed Resident 58 received over half their daily calorie intake via a feeding tube (tubing that allows liquid nutrition to pass directly into the stomach for people with swallowing difficulties). According to the revised 05/13/2024 resident requires tube feeding . CP Resident 58 still received nutrition by feeding tube. Review of the physician's orders showed a 05/23/2024 order for a bolus (using gravity rather than a pump) feeding four times a day for Resident 34. This order was discontinued on 07/04/2024. In an interview on 09/16/2024 at 11:02 AM Staff AA (Dietician) stated Resident 20 successfully graduated from the tube feeding and was now able to meet their nutritional needs with oral intake. Staff AA stated the CP was no longer necessary. 50511 <Resident 1> According to the 09/09/2024 Quarterly MDS, Resident 1's medical conditions included stroke, aphasia (a comprehension and communication disorder), hemiplegia (paralysis on one side of the body), depression and a mood disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's revised 06/30/2024 nursing CP showed the resident gets easily annoyed with care and may refuse care from staff they were not familiar with. The goal listed on the CP was resident would allow care from nursing staff. Interventions listed on the CP were to build rapport with resident, educate resident on importance of care, knock on the resident door, re-approach resident after they calmed down. The CP did not identify what to do for Resident 1's rejection of care or provided instructions for the nursing staff on documenting refusals or notifying hospice services of resident's refusal of care. Review of the Kardex (care staff summary of care needs) on 09/13/2024 showed resident was to have bed baths twice a week in the morning, the Kardex did not provide instructions on what to do for refusals of bed baths. Review of the August 2024 Medication Administration Record and Treatment Administration Record did not show instructions for staff regarding refusals of care. Observation on 09/11/2024 at 9:12 AM, Resident 1's hair was greasy, and room smelled of body odor. Observation on 09/12/2024 at 12:27 PM, body odor observed, resident still in hospital gown, hair appeared greasy. Observation on 09/13/2024 at 7:52 AM, fingernails were long, 1/4 inches extended past nail bed. Resident shook head yes to a question if they would like their fingernails cut. Resident shook their head no to wanting toenails to be cut. Hair appeared greasy and room smelled of body odor. In an interview on 09/13/2024 at 8:49 AM, Staff V (Certified Nursing Aid) stated resident refused bathing all the time and was the reason why their hair was greasy. Staff V stated that if the resident refused something the staff were to just stop what they were doing to not upset the resident more. In an interview on 09/13/2024 at 9:35 AM Staff P (Registered Nurse Manager) stated the care staff should notify nursing staff when the resident refused care. Staff P stated the nursing staff needed to know about refusals, or it could become a hazard for the resident, staff must report to the floor nurse and document refusals of care. In an interview on 09/16/2024 at 10:42 AM, Staff B (Director of Nursing) stated their expectation for nursing and care staff was to ensure resident does not have odor and for staff to update and document refusals in the resident's care plan. Refer to F552 - Right to be informed/Make Treatment Decisions. REFERENCE: WAC 388-97-1020(1), (2)(a)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42203 Based on interview and record review the facility failed to provide nursing care within professional standards. The failure to follow physician's orders for 2 of 19 sample residents reviewed (Residents 34 & 20), clarify physician's orders when required, and sign for physician orders not completed for 2 of 19 sample residents (Residents 25 & 52) placed residents at risk for unmet care needs, medication errors, and ineffective treatment. Findings included . According to the facility's Medication Administration policy revised 08/2024, staff would correct any medication discrepancies and report to the nurse manager. <Following Orders> <Resident 34> According to the 07/24/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 34 had occasional pain that almost constantly affected their sleep and day-to-day activities. The MDS showed Resident 34 took opioid medications as needed. Review of the June 2024 Medication Administration Record (MAR) showed a 06/07/2024 physician's order for an as needed opioid pain medication 5-325 Milligram (MG), give one pill every 12 hours as needed for a pain level of 5-10/10. The MAR showed Resident 34 was given the as needed opioid pain medication for a pain level of 3 on 06/29/2024. Review of the July 2024 MAR showed Resident 34 was given the as needed opioid pain medication for a pain level of 4 on 07/19/2024 and 07/27/2024. Review of the August 2024 MAR showed an 08/05/2024 physician's order for an as needed opioid pain medication 5-325 MG, give one pill every 12 hours as needed for a pain level of 5-10/10. This MAR showed on 08/06/2024 Resident 34 was given the medication for a pain level of 3. <Resident 20> According to the 06/10/2024 Quarterly MDS, Resident 20 had diagnoses including chronic pain. The MDS showed Resident 20 used opioid pain medications. Review of the June 2024 MAR showed Resident 20 had two orders for as needed opioid pain medications: a 05/30/2024 order for a an opioid pain medication 5 MG, give one tablet for a pain level of 4-6/10 every four hours as needed; a 05/30/2024 order for a an opioid pain medication 5 MG, give two tablets for a pain level of 7-10/10 every four hours as needed. This MAR showed Resident 20 was given two tablets for a pain level of less than 7/10 on 06/05/2024, 06/07/2024, 06/09/2024, 06/11/2024, 06/14/2024, 06/18/2024, 06/19/2024, 06/25/2024, and 06/27/2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the July 2024 MAR showed Resident 20 was given one pill of the opioid pain medication for a pain level of 3 on 07/09/2024, less than the 4-6/10 range indicated on the order. This MAR showed Resident 20 was given two tablets of the opioid pain medication for a pain level of less than 7-10/10 on 07/01/2024, 07/06/2024, twice on 07/10/2024, 07/11/2024, and on 07/23/2024. Review of the August 2024 MAR showed Resident 20 was given two tablets of the opioid pain medication for a pain level of less than 7-10/10 on 08/01/2024, 08/02/2024, twice on 08/09/2024, and on 08/15/2024. Review of the September 2024 MAR showed Resident 20 was given two tablets of the opioid pain medication for a pain level of less than 7-10/10 on 09/01/2024 and 09/02/2024. In an interview on 09/16/2024 at 1:02 PM Staff P (Registered Nurse Manager) stated it was important to the follow the physician provided parameters for as needed pain medications. Staff P stated nurses should, but did not, provide the correct dose of a pain medication for the resident's stated pain level. 46479 <Clarifying Physician Orders/Signing for Tasks Not Completed> <Resident 25> According to the 08/01/2024 Annual MDS, Resident 25 had a diagnosis of arthritis and experienced occasional pain during the assessment look-back period. Observation on 09/11/2024 at 8:47 AM showed Resident 25 lying in bed. A topical pain patch was located on the resident's right shoulder and was dated 9/9, two days earlier. Review of Resident 25's order summary showed a 06/06/2024 order directing staff to apply a topical pain-relieving patch to the resident one time daily. This order directed staff to remove the patch at bedtime. Review of Resident 25's September 2024 MAR on 09/11/2024 showed staff documented when the pain patch was put on the resident. There was no where on the MAR for staff to document the pain patch was removed at bedtime as ordered. This MAR showed staff signed they placed a new patch on Resident 25 on 09/10/2024 and 09/11/2024. In an observation and interview on 09/11/2024 at 8:59 AM, Staff S (Licensed Practical Nurse - LPN) was preparing to apply the pain patch to Resident 25. Staff S observed the patch dated 9/9, removed it, and applied a new patch to the resident's shoulder. In an interview on 09/11/2024 at 2:04 PM, Staff M (LPN Supervisor) confirmed they were the assigned staff for Resident 25 on 09/10/2024. Staff M stated they did not apply a new pain patch to the resident on 09/10/2024 as ordered and they should not have signed the MAR indicating the pain patch was provided to the resident. <Resident 52> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 07/17/2024 Quarterly MDS, Resident 52 had pain during the assessment look-back period. Review of Resident 52's order summary showed an 08/19/2024 order directing staff to apply a topical pain patch to the resident's back in the morning for 12 hours and remove the patch in the afternoon. Review of Resident 52's September 2024 MAR directed staff to remove the patch at 7:59 AM and place a new patch on the resident at 8:00 AM. The MAR did not direct the staff to remove the patch after 12 hours as ordered by the physician. In an interview on 09/16/2024 at 9:50 AM, Staff B (Director of Nursing) stated it was their expectation pain patches were removed after 12 hours. Staff B stated the pain patch orders needed to be clarified for Resident 25 and Resident 52. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure Activities of Daily Living (ADL) assistance was provided for dependent residents for 3 (Residents 52, 60, & 1) of 6 residents reviewed for ADLs and one supplementary resident (Resident 58). Facility failure to provide ADL assistance as needed placed residents at risk for poor hygiene and feelings of diminished self-worth. Findings included . <Facility Policy> The facility's reviewed 08/2024 Activities of Daily Living (ADLs) policy showed, ADLs included bathing, dressing, grooming, oral care, transfers, toileting, and assistance with eating. The policy showed residents assessed to be unable to complete ADLs independently should receive the assistance they required. <Resident 58> According to the 07/30/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 58 had diagnoses including a history of stroke, heart failure, one-side partial paralysis, lack of coordination, and an abnormal posture. The MDS showed Resident 58 needed substantial to maximal assistance to transfer from their bed to a chair. Review of the physician's orders showed a 05/31/24 order to ensure Resident 58 was up and dress[ed] in [their] wheelchair for activities one time a day for activities and socializing . and a 07/15/2024 order to please have [Resident 58] up in [their] wheelchair every morning for daily activities in the morning . Review of the revised 08/20/2024 resident has an ADL self-care performance deficit . Care Plan (CP) showed Resident 58 was totally dependent on staff for dressing. This CP showed Resident 58 was dependent on the assistance of two staff to transfer using a mechanical lift. Observation on 09/10/2024 at 10:39 AM showed Resident 34 in bed with their television on. On 09/12/2024 at 1:39 PM Resident 58 was observed in bed watching television. On 09/13/2024 at 8:06 AM Resident 58 was observed in bed. Observations on 09/16/2024 at 8:35 AM, 9:11 AM, 10:44 AM, and 11:02 AM showed Resident 58 in bed. In an interview on 09/16/2024 at 9:11 AM, Resident 58 stated they would prefer to get up over staying bed. In an interview on 09/16/2024 at 12:55 PM Staff P (Registered Nurse - RN, RN Manager) stated they expected aides to follow the orders and CP, and get up Resident 58 out of bed daily. Staff P stated they did not think Resident 58 would refuse to get out of bed, and added there was no reason for the resident to remain in bed. 46479 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 07/17/2024 Quarterly MDS, Resident 52 had intact thinking abilities, was understood, and could understand others in conversation. This MDS showed Resident 52 was dependent on staff for assistance with personal hygiene including shaving. Review of Resident 52's physician orders showed a 04/30/2024 order directing licensed nursing staff to check the resident's fingernails and toenails every Friday and to trim as needed. Review of Resident 52's September 2024 treatment administration record showed the licensed nurse signed the order that the resident's nails were checked and trimmed on 09/06/2024 and 09/13/2024. In an observation and interview on 09/10/2024 at 9:57 AM, Resident 52 was lying in bed. Long black hair was observed on Resident 53's upper lip and chin. Their fingernails on both hands were long, extending well beyond the tip of their fingers. Some nails were chipped with jagged edges. Resident 52 stated they preferred their fingernails shorter. In an observation and interview on 09/16/2024 at 9:02 AM, Resident 52 was lying in bed. The resident still had long black hair to their upper lip and chin. Resident 52's fingernails on both hands were long. Some of the resident's nails were chipped with jagged edges. Resident 52 stated they preferred their facial hair be trimmed. They had an electric razor on their nightstand. Resident 52 stated they could shave themselves, but staff always put the razor where the resident was unable to reach it. Resident 52 stated staff did not offer to cut their fingernails on the Friday three days prior as ordered. In an interview on 09/16/2024 at 10:01 AM, Staff B (Director of Nursing) stated the licensed nursing staff should offer nail care as ordered to Resident 52. Staff B stated it was their expectation staff offer shaving assistance to residents on bath days and as needed. Staff B stated if a resident refuses care or the staff did not get to an assigned task, staff were expected to document accordingly. 47836 <Resident 60> According to the 07/15/2024 Admission MDS, Resident 60 was admitted on [DATE] with a diagnosis that resulted in paralysis to the left side of their body. The assessment showed Resident 60 had no memory impairment. This MDS showed Resident 60 was dependent on staff for personal hygiene needs. Observation and interview on 09/10/2024 at 9:40 AM showed Resident 60 with long, dirty fingernails. Resident 60 stated staff have not offered assistance with nail care since admitted to the facility. In an interview on 09/11/2024 at 1:50 PM, Staff F (CNA - Certified Nursing Assistant/Bath Aide) stated they were responsible for all resident's nail care and facial hair shaving on each resident's shower day. Staff F stated there was not anywhere in the electronic health records to document refusals of nail care or shaving, only refusals of bathing. Staff F stated they would notify the Resident Care Manager (RCM) of all refusals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/13/2024 at 10:07 AM Staff C (RN Manager) stated Resident 60 should have an order for Licensed Nurses (LN) to do nail care because the resident had diabetes (unstable blood sugar levels), but they did not. In an interview on 09/16/2024 at 10:01 AM Staff B stated nail care should be offered on scheduled bath days. Staff B stated Diabetic residents should have an order for LNs to provide nail care. Staff B stated if residents refused nail care, staff were expected to document the refusal in the residents' records. 50511 <Resident 1> According to the 09/09/2024 Quarterly MDS, Resident 1's medical conditions included stroke, aphasia (a comprehension and communication disorder), hemiplegia (paralysis on one side of the body), depression, mood disorder and weakness. The MDS functional assessment showed the resident required maximum assistance for oral hygiene, toileting, showers, lower body dressing, putting on footwear, and resident was incontinent of bowel and bladder. Review of functional care plan revised 06/30/2024 showed resident needed one-person extensive assistance with bed baths in the morning on Wednesday and Saturdays; to avoid resident scratching staff were to keep fingernails short and to cut nails on day of resident's bath. Review of Kardex (care staff summary of care needs) on 09/13/2024 showed staff would check nail length and trim and clean on bath day, resident required extensive assistance for personal hygiene. Review of caregiver task sheets for September 2024, showed staff completed a bed bath for resident on 09/04/2024, 09/07/2024, 09/11/2024, and 09/14/2024. Observation on 09/11/2024 at 9:12 AM, resident 1's hair was greasy, and room smelled of body odor. Observation on 09/12/2024 at 12:27 PM, body odor observed, resident still in hospital gown, hair appeared greasy. Observation on 09/13/2024 at 7:52 AM, fingernails were long,1/4 inches past nail bed. Resident shook head yes to the question that they would like their fingernails cut, shook head no to toenails being cut. Hair appeared greasy and room smelled of body odor. In an interview on 09/13/2024 at 8:49 AM, Staff V (CNA) stated resident refused bathing all the time and was the reason why their hair was greasy. In an interview on 09/13/2024 at 9:35 AM Staff P stated staff must take care of the resident even if the resident refused care the staff must offer alternatives to help the resident. In an interview on 09/16/2024 at 10:42 AM Staff B stated staff were to ensure that resident did not smell of body odor and document care was provided. REFERENCE: WAC 388-97-1060(2)(c).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50511 Based on observation, interview, and record review the facility failed to provide the necessary care and services to maintain residents' highest practicable level of well-being for 2 of 2 sampled residents (Resident 1 & 7) reviewed for hospice care. This failure placed residents at risk for not receiving necessary end- of- life care and services, and a diminished quality of life. Findings included . <Facility Policy> Review of the facility's Providing End of Life Care policy revised 08/2024, the facility would utilize a systematic approach for recognition, assessment, treatment, and monitoring of end-of-life care. The policy stated the facility and resident/family would coordinate the resident's Care Plan (CP) and implement interventions in accordance with the comprehensive assessment for the resident's needs, goals, and preferences. If the resident chose hospice services, the CP would specify the care and services to be provided by the facility and by hospice services. The facility would maintain communication with the resident, resident representative, and hospice services as it related to the provision of care and services and provided. <Resident 1> According to the 09/09/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 1's medical conditions included stroke, the inability to comprehend and communicate, paralysis on one side of their body, depression, mood disorder, and weakness. The MDS showed Resident 1 was receiving hospice care. Review of the revised 06/11/2024 Functional CP showed Resident 1 had hospice services in place. The interventions listed directed nursing staff to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Review of September 2024 caregiver tasks showed resident would have bed baths in the morning on Wednesdays and Saturdays and as needed. No refusals of bathing were documented from 09/01/2024 through 09/16/2024. <Activities of Daily Living> Observation on 09/11/2024 at 9:12 AM showed Resident 1 had greasy hair and the resident's room smelled of body odor. Observation on 09/12/2024 at 12:27 PM showed Resident 1 wearing a hospital gown and their hair was still greasy. The resident's room smelled of body odor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/13/2024 at 7:52 AM showed Resident 1 with long fingernails that extended 1/4 inch past their nail bed. Resident 1 shook their head yes when asked if they would like their fingernails cut and shook head no to toenails being cut. Resident 1's hair was still greasy and their room smelled of body odor. In an interview on 09/13/2024 at 8:49 AM, Staff V (Certified Nursing Assistant) stated Resident 1 refused bathing all the time which was why the resident's hair was greasy. In an interview on 09/13/2024 at 9:35 AM, Staff P (Registered Nurse Manager) stated the facility needed to know if Resident 1 was not receiving the care listed on the CP. If the resident refused care, there should be a compromise or alternatives provided, the facility needed to know about refusals and discrepancies of care so that hospice would know as well. Staff P stated hospice services provided showers only, but the facility needed to talk to hospice about Resident 1's refusals of care. In an interview on 09/16/2024 at 8:30 AM, Staff T stated hospice sends care staff to shower Resident 1, but the resident refuses care by hospice staff. In an interview on 09/16/2024 at 10:39 AM Staff B (Director of Nursing) if there was a need for change of orders or care needs, hospice should provide care notes to the facility and hospice staff should meet with the facility nurses regarding whatever is needed by the resident and in accordance with the CP. Staff B stated their expectation was for hospice and the facility to coordinate services. <Medication Orders> Review of the June 2024 Medication Administration Record (MAR) showed a 05/31/2024 order for a high blood pressure medication to be administered one time daily on odd days. The June 2024 MAR showed the blood pressure medication was discontinued on 06/18/2024. Review of hospice medication orders dated 09/06/2024 showed the same high blood pressure medication was to be given one time a day on odd days. The hospice orders did not show the medication was discontinued. In an interview on 09/16/2024 at 10:39 AM, Staff B verified the high blood pressure medication was discontinued by the facility's provider on 06/18/2024. Staff B stated the medication order to discontinue the high blood pressure medication should be coordinated with hospice services so medication reconciliation between the facility and hospice services could occur. 43642 <Resident 7> According to a 07/22/2024 Quarterly MDS, Resident 7 had multiple medically complex diagnoses including cancer and required hospice services while a resident at the facility. According to a revised 07/15/2024 Terminal Prognosis CP, Resident 7 was admitted to hospice services on 07/06/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's physician orders on 09/10/2024 showed no current order for hospice services. Review of Resident 7's records revealed no documentation from hospice services in the resident's records from 07/24/2024 until 09/10/2024, almost two months later. In an interview on 09/16/2024 at 11:15 AM, Staff R (Medical Records Supervisor) stated as soon as they received any hospice notes, they upload them into the resident records. Staff R stated they had no current backlog of hospice notes to upload. In an interview on 09/16/2024 at 12:57 PM, Staff C (Resident Care Manager) reviewed Resident 7's records and stated there was not, but should be, a physician's order for hospice services. Staff C stated their expectation was all hospice communication and visits be available in the resident records. Staff C reviewed Resident 7's records and was unable to locate any hospice records from 07/24/2024 until 09/10/2024. Staff C checked the hospice binder at the nurse's station but there were no logged visits for Resident 7. REFERENCE: WAC 388-97-1060(1).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43642 Based on observation, interview, and record review the facility failed to ensure a restorative program was provided for 1 of 2 (Resident 37) sample residents identified by staff with mobility limitations and reviewed for Range of Motion (ROM). These failures placed residents at risk for declines in ROM, reduction in mobility, increased dependence on staff, and a decreased quality of life. Findings included . <Facility Policy> According to a revised July 2024 facility, Restorative Nursing Services policy, residents would receive restorative nursing care as needed to help promote optimal safety and independence. The policy showed restorative nursing services included splinting and bracing. The policy showed recommendations for restorative nursing services would be made at the time of discharge from therapy as needed and communicated to the aide responsible either by the discharging therapist or nurse overseeing the restorative program. <Resident 37> According to a 07/24/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 37 had multiple medically complex diagnoses including stroke with muscle weakness or the loss of ability to move on one side of their body, had no Restorative Nursing Programs (RNP) and no rejection of care during the assessment period. This MDS showed staff assessed Resident 37 with an impairment in functional limitation in ROM to one side of their upper arm and both sides of their lower legs. Observations on 09/10/2024 at 1:39 PM showed a knee brace on Resident 37's wheelchair while they were in bed. In an interview at this time, Resident 37 stated they did not wear the knee brace for a long time and were no longer on a restorative program. Review of Resident 37's physician orders showed a 01/19/2024 order for a Physical Therapy (PT) evaluation for position, contraction, and splint management. PT services started on 01/29/2024. According to a 05/14/2024 PT discharge summary Resident 37 was discharged from PT with an RNP for ROM to their right knee and positioning with a pillow between their legs for hip comfort. A 05/14/2024 restorative nursing referral form showed a recommendation for an RNP for right knee extensions and repositioning for right hip alignment. Review of Resident 37's records showed no RNP was initiated by staff after the referral by PT was made on 05/14/2024. In an interview on 09/16/2024 at 12:57 PM, Staff C (Registered Nurse Manager) reviewed Resident 37's records and confirmed there was no RNP implemented after the 05/14/2024 therapy referral. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/16/2024 at 1:10 PM, Staff II (Director of Rehabilitation) stated restorative programs were important to prevent further decline and/or maintain the level of where a resident was when they were discharged from therapy. Staff II stated it was their expectation an RNP be established within 24-48 hours after a referral was provided to nursing staff. In an interview on 09/16/2024 at 1:16 PM, Staff B (Director of Nursing) stated an RNP should be implemented timely after a referral was obtained from therapy to prevent a decline in function. Staff B stated it was their expectation an RNP referral from May 2024 would be implemented by staff. REFERENCE: WAC 388-97-1060(3)(d), (j)(ix).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure the environment was free of accident hazards for 1 of 1 laundry room and failed to ensure resident rooms were free of fall hazards for 1 of 3 (Resident 11) residents reviewed for falls. These failures placed residents at risk for elopement, ingestion of chemicals, and falls. Findings included . <Laundry Room Door> Observation on 09/10/2024 at 1:43 PM showed the door to the facility's laundry room was unlocked. The key code to unlock the door did not function. The door opened freely and allowed access to the laundry room. Observation on 09/11/2024 at 8:30 AM showed the laundry room door remained unlocked, entered the laundry room and a middle door was open. Inside the laundry room was a cart containing laundry detergent and other chemicals. The exterior door opening to the rear of the building was propped open and a large fan was placed in the doorway. There was nothing preventing a wandering resident from passing through the laundry room to the outside. In an interview at that time, Staff CC (Laundry Aide) stated the laundry room lock was broken for two weeks. Staff CC stated they reported the broken lock to the facility's Head of Maintenance. Staff CC said laundry staff typically kept the exterior door open when they worked to allow ventilation. In an interview on 09/11/2024 at 11:10 AM, Staff A (Administrator) confirmed the door lock was broken and needed repair. Staff A stated the laundry door should be locked, and residents should not be allowed free access to the laundry room. 50511 <Resident Falls> <Facility Policy> According to the facility's Fall Prevention Program policy, revised 08/2024, the facility would reduce the risk of falls by assessing fall risk, residents would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Interventions would include a clear pathway to the bathroom and bedroom, implement routine rounding schedules, and encourage residents to wear shoes or slippers with non-slip soles when walking. <Resident 11> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 07/10/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 11 was admitted to the facility on [DATE]. The MDS showed Resident 11's medical conditions included arthritis, abnormal posture, lack of coordination, history of pain, altered mental status, and a history of falls with injury. The MDS showed Resident 11 required maximal assistance from staff with transfers from lying to sitting, chair to bed assistance, and required moderate assistance with upper and lower body dressing including putting on and taking off footwear. Review of the revised 07/15/2024 Functional Care Plan (CP) showed the resident was at risk for falls due to weakness, medications used, history of falls, poor safety awareness, unsteady balance, and clutter in the room and on the floor. The goal identified showed the resident would be free of minor injury through the review date. Interventions directed staff to encourage and assist the resident with keeping a clear pathway in their room to allow for safe mobility, encourage and assist with putting on non-skid socks, encourage resident to use call light, ensure the resident had appropriate footwear when transferring, help with transfers to the commode, follow current interventions for falls. The CP showed the resident required supervision to dress instead of maximum assistance as stated on the MDS. The CP did not provide instructions on how often clutter should be cleared, did not show how often staff were to assist with transfers to commode, and did not show how often staff were to check if resident had appropriate footwear on. Review of the safety Kardex (directions to care staff) on 09/12/2024 showed the staff were to ensure the resident was wearing appropriate footwear when transferring, ensure Resident 11's pathway was clear of clutter, and to notify the physician if interventions were unsuccessful. In an interview on 09/10/2024 at 12:43 PM, Resident 11 stated they sat around too much. Resident stated they had pain and used a toilet commode because they could not walk due to their physical balance being off. In an interview on 09/11/2024 at 8:56 AM, Resident 11 stated they have had several falls, and the staff tried to keep tabs on them. Observation on 09/13/2024 at 7:51 AM showed Resident 11 sitting on the edge of the bed. The bed was cluttered with blankets and many various items. Resident 11 had a gripper sock on their right foot and no sock on their left foot. There was a stack of four to five pieces of paper in the middle of the resident's bedroom floor. The room was cluttered with various items in bins on the floor and items were scattered on dresser and the bed including papers, blankets, clothing, and books. Observation on 09/16/2024 at 8:16 AM showed various items including books, papers, buckets with toiletries lying directly on the floor. The toilet commode was placed in between the bed and next to the wheelchair, only small area was clear for Resident 11 to walk around. Review of the 08/30/2024 fall investigation report showed the resident was found on the floor, the resident had a nonskid sock on their left foot and their right foot was bare. The resident did not call for staff assistance when transferring. In an interview on 09/16/2024 at 11:14 AM, Staff D (Social Services Director) stated Resident 11 had a lot of clutter in their room, the facility stored some of the resident's stuff. Staff D stated staff discussed action plans to reduce clutter in Resident 11's room but would need to check interventions to ensure the CP was more personable. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/16/2024 at 11:16 AM, Staff GG (Director of Rehabilitation) stated they were working on falls with Resident 11 and that the resident's cognition was not good. Staff GG stated Resident 11 did not follow staff instructions to pull the call light when needing assistance. In an interview on 09/16/2024 at 10:51 AM Staff B (Director of Nursing) confirmed Resident 11 had clutter on the floor and the facility provided storage for the resident's additional items. Staff B stated the facility's plan was to continue to offer to remove things from Resident 11's room. Staff B stated nursing staff were expected to offer and assist resident with their care needs. REFERENCE: WAC 388-97-1060(3)(g).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42203 Based on observation, interview, and record review the facility failed to ensure weights were adequately monitored for 1 of 1 (Resident 58) residents reviewed for hydration/weights. The failure to monitor weights as ordered placed residents at risk for weight loss, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's August 2024 Weight Monitoring policy, a weight monitoring schedule should be developed for all residents at the time of admission. The policy showed resident weights would be collected monthly or more frequently, as needed. <Resident 58> According to the 07/30/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 58 needed supervision with eating and had diagnoses including a history of stroke, one-sided partial paralysis, and swallowing difficulties. The MDS showed Resident 58 received over half their calories via feeding tube (tubing allowing liquid nutrition to flow directly to the stomach avoiding the esophagus). Observation on 09/10/2024 at 12:38 PM showed two nursing aides assist Resident 58 to sit up in bed. The aides set up Resident 58's lunch tray and the resident fed themselves. Review of the physician's orders showed a 05/23/2024 order for Resident 58 to receive 390 Milliliters of liquid nutrition four times a day via a gravity feeding. This order was discontinued on 07/04/2024. Record review showed a 05/01/2024 physician's order directing nursing staff to weigh Resident 58 monthly. Record review showed Resident 58 weighed 210 pounds (Lbs.) on 06/01/2024. Resident 58 was next weighed on 07/14/2024 (10 days after they graduated from tube feeding to receiving their dietary intake by mouth) when they weighed 211.4 Lbs. Resident 58 was next weighed on 08/01/2024 when they weighed 202. 6 Lbs., on 08/14/2024 they weighed 203.2 Lbs. This was the last weight obtained and documented for Resident 58. According to a 07/04/2024 progress note written by Staff AA (Dietician) Resident 58 began a trial discontinuation of tube feeding on that date. This note showed the July 2024 weight measurement for Resident 58 was pending. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff AA on 09/16/2024 at 11:02 AM Staff AA stated when a resident graduated from tube feeding to oral intake it was important to monitor their weight to ensure they continued to receive adequate nutritional intake. Staff AA stated it would be valuable to know Resident 58's weight at the time the tube feeding was discontinued. Staff AA reviewed Resident 58's weights and confirmed a weight was not collected for over a month prior to the discontinuation of tube feeding, and not for two weeks after the tube feeding was discontinued. Staff AA stated that Resident 58's weight was not measured since 08/14/2024. Staff AA reviewed the September 2024 Medication Administration Record (MAR) where staff noted Resident 58 refused to be weighed. Staff AA stated nursing staff should have collected Resident 58's weight at a later date, but the MAR did not have space where nursing staff could add a weight after their refusal on 09/01/2024, and this may be the reason Resident 58 was not weighed yet in September 2024. REFERENCE: WAC 388-97-1060 (3)(h).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47836 Based on observation, interview, and record review the facility failed to ensure medications were stored, labeled, dated when opened, and discarded when expired for 1 of 2 medication carts (Garden Wing Cart), 1 of 1 medication rooms (West Hall Medication Room Refrigerator), and for 1 of 19 residents (Resident 60) observed. The facility failed to ensure 2 of 4 medication carts were locked when left unsupervised by staff. The failure to ensure medication refrigerators were double locked, medications were discarded when expired, eye drop medications were dated upon opening, medication carts were locked, and medications were not left at bedside, placed residents at risk for ineffective treatment, expired medications, and contaminated medications. Findings included . <Facility Policy> According to a facility policy titled, Medication Storage, revised 08/2024, the facility would secure narcotics and controlled substances under double lock and key. The policy showed medication rooms and carts would be inspected routinely for discontinued and outdated medications. The policy showed the facility would destroy the discontinued and outdated medications upon finding. This policy showed all drugs would be stored in locked compartments such as medication carts and only authorized personnel would have access to the keys to locked compartments. <West Hall Medication Room Refrigerator> Observation and interview on 09/10/2024 at 9:15 AM showed a narcotic medication in the west hall medication room refrigerator. The west hall medication room door was locked but the refrigerator inside of the medication room was unlocked with the narcotic medication stored inside of the refrigerator. At this time, Staff M (Licensed Practical Nurse -LPN Supervisor) stated the narcotic medication should be under double locks. Staff M stated the refrigerator should be kept locked. <Garden Wing Cart> Observation and interview on 09/10/2024 at 9:22 AM showed a bottle of medication expired on 08/2024, a liquid solution expired on 03/2024, and two bottles of eye drop medications without an open date written on them. At this time, Staff Q (Registered Nurse - RN) stated the expired medications should be removed from the medication cart and destroyed. Staff Q stated the eye drops should be dated upon opening so staff knew when to discard them, but they were not. <Resident 60> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 09/13/2024 at 9:41 AM showed a tube of medicated cream on Resident 60's over the bed table. Resident 60 stated staff left it there sometimes, which they didn't mind because it reminded them to ask the staff to apply it for them. At this time, Staff E (LPN) stated medications at bedside were required to be locked up in resident rooms. Staff E stated staff were expected to complete a self-medication assessment on the resident for safety and obtain a physician order before leaving medications with the resident. Staff E stated Resident 60 was not assessed and did not have a physician order to keep medications at their bedside. In an interview on 09/16/2024 at 12:32 PM Staff B (Director of Nursing) stated they expected staff to remove all expired medications from the carts and medication rooms, not administer expired medications to the residents, and to destroy the medications. Staff B stated they expected the staff to date eye drops upon opening and dispose of the drops after 28 days. Staff B stated residents with medications in their rooms should have an assessment for a self-medication program, ensure the resident knew how to store the medication properly, lock the medication in their room, and know the reason they were taking the medication. Staff B stated it was not facility policy to have medications unsecured at bedside without a resident assessment done for safety of self-administering. 43642 <Unlocked Medication Carts> <Unit Catsablanca> Observations on 09/11/2024 at 12:56 PM showed the medication cart on the Catsablanca unit was unlocked with no staff in the area. Staff Y (RN) was sitting at the nurse's station without the ability to view their unlocked medication cart. It was not until 1:19 PM, 23 minutes later, when Staff Y passed the medication cart, went back, and locked the cart. In an interview on 09/11/2024 at 1:19 PM, Staff Y stated the medication cart should be locked since there were medications inside. Staff Y stated having unsecured medications was a safety risk. In an interview on 09/16/2024 at 1:16 PM, Staff B stated their expectation was for nursing staff to lock the medication carts when they were away from the cart. Staff B indicated the carts had medications in them and anyone, including confused residents could access them. Staff B stated that would be dangerous. 50511 <Unit Wild West> Observation on 09/11/2024 at 12:58 PM showed the medication cart on the Wild [NAME] unit was unlocked. Staff S (LPN) was assigned to the unit was not in the hallway at the time of observation. This surveyor was able to open top and bottom drawers of medication cart and observed medications in the cart. In an interview on 09/11/2024 at 1:28 PM Staff S stated the medication cart should be locked for patient safety. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFERENCE: WAC 388-97-1300(1)(b)(ii). 45941

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46479 Based on observation, interview, and record review the facility failed to ensure prompt dental services were provided for 2 (Residents 52 & 37) of 5 residents reviewed for dental services. This failure placed residents at risk for oral discomfort and a diminished quality of life. Findings included . <Facility Policy> According to the facility's Dental Services policy, revised 08/2024, oral and denture care would be provided in accordance with identified needs and as specified in the resident's Care Plan (CP). The facility would assist residents with making dental appointments and arranging transportation when necessary. <Resident 52> According to the 07/17/2024 Minimum Data Set (MDS - an assessment tool), Resident 52 was understood and could understand others in conversation. The MDS showed Resident 52 had intact mental processing abilities. The MDS showed Resident 52 had mouth/facial pain and discomfort when chewing. Resident 52 was dependent on staff for cleaning and putting in their dentures. Review of Resident 52's revised 11/13/2023 Oral/dental CP showed the resident had problems with their oral cavity and the facility would coordinate arrangements for dental care, including transportation, as needed. The care plan showed staff did not identify Resident 52 was without teeth and used upper dentures. Review of a 02/12/2024 in house denture consult showed Resident 52 had upper dentures and had no lower teeth or lower dentures. This consult showed Resident 52's dentures were [AGE] years old, they were loose/ill fitting, and the teeth were worn down. The consult showed the doctor recommended new dentures. A handwritten note on the side of the consult read [patient] wants new dentures. Review of Resident's 52's progress notes from 02/2024 to 09/2024 showed no documentation staff followed up with the dentist's recommendations for new dentures. Review of Resident 52's dental consults show the resident was not seen by the dentist since 02/12/2024. In an observation and interview on 09/10/2024 at 10:02 AM, Resident 52 stated they needed bottom dentures. Resident 52 was wearing their top dentures but did not have bottom dentures. Resident 52 stated they had an appointment with the in-house dentist a few months ago. Resident 52 stated they sat in their wheelchair for three hours waiting for the dentist and was informed the dentist was overbooked for the day, so the resident was unable to be evaluated. In an interview on 09/13/2024 at 12:43 PM, Staff R (Medical Records Supervisor) stated the medical records department was responsible for scheduling follow up appointments. Staff R reviewed Resident 52's appointment binder and verified staff did not schedule a denture appointment for Resident 52 as recommended. Staff R stated Resident 52 should have a denture appointment by now, but did not. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/13/2024 at 12:56 PM, Staff B (Director of Nursing) stated it was their expectation staff followed up and made and appointment for Resident 52, but staff did not. 43642 <Resident 37> According to a 07/24/2024 Annual MDS, Resident 37 had clear speech, was understood, and able to understand others, and required substantial assistance from staff for oral hygiene. This MDS showed staff identified Resident 37 had broken or loose-fitting dentures, obvious or likely cavities, mouth or facial pain, and discomfort or difficulty with chewing. Review of a 05/12/2021 physician order showed Resident 37 may have dental consults as needed. Review of a 11/30/2021 dental CP showed staff identified a goal that Resident 37 would be free of infection, pain or bleeding in the oral cavity and gave directions to staff to coordinate arrangements for dental care, transportation as needed/as ordered. Review of Resident 37's dental visits showed: On 07/09/2024 the dental clinic documented Resident 37's front upper denture was loose, and the resident needed to see a denturist for a consult; On 06/05/2024 the dental clinic documented Resident 37 had a loose denture and recommended to have the upper denture realigned. Review of a 07/24/2024 progress note showed staff documented Resident 37 reported having difficulty with chewing due to a loose upper denture and the resident was not wearing the denture due to it being loose. Staff documented Resident 37 was seen by dental services on 07/09/2024, 06/05/2024, and 02/06/2024. A progress note from 05/29/2024 showed documentation Resident 37 reported they do not wear their upper dentures because they are loose and needed a re-fitting. Review of a 07/29/2024 dental care area assessment showed staff documented Resident 37 reported a loose upper denture, was not wearing it, and was seen by dental services 07/09/2024 for denture follow up. Goals of care are no new acute oral issues through review date. In an interview on 09/10/2024 at 10:38 AM, Resident 37 stated they wanted their upper dentures fixed and stated, I saw a dentist awhile ago, they said they were working on them. In an interview on 09/16/2024 at 11:00 AM, Resident 37 stated their upper dentures have been loose for a long time. When asked if Resident 37 would wear their upper dentures if they fit, the resident stated, Oh yes! I would wear them all the time. In a joint interview with Staff R and Staff HH (Certified Nursing Assistant) on 09/16/2024 at 11:15 AM, Staff HH stated if a resident needs a denture readjustment, they would call the dental clinic to get the appointment scheduled. Staff HH stated as soon as they receive a referral from dental, they call and usually get the appointment scheduled within two weeks, including for denture realignment. Staff HH denied having any pending dental appointments scheduled or that needed to be scheduled for Resident 37 since June 2024. Staff HH reviewed Resident 37's records and stated they would have expected a follow-up appointment to be scheduled already for the loose dentures. Staff R stated the referral, must have been overlooked, and it was missed. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/16/2024 at 1:16 PM, Staff B stated their expectation was for staff to schedule referrals and/or follow up appointments for denture re-alignment or if a resident was having any pain or discomfort. Staff B stated the appointment, whether in-house or in the community, should be scheduled promptly. REFERENCE: WAC 388-97-1060(1).

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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. 50511 Based on observation and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in 1 of 1 facility kitchens and for one unit refrigerator reviewed for food services. The failure to clean the facility's kitchen ice machine, cover food during transport, perform hand hygiene between glove use, and maintain sanitary unit refrigerators placed the residents at risk for food borne illness (illness caused by ingesting contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . <Facility Policy> According to the facility's revised August 2024 Food Safety Requirements policy, the facility would store, prepare, distribute and serve resident meals in accordance with professional standards of food service safety. The policy showed to prevent foodborne illness, dietary staff should clean and sanitize the internal components of the ice machines according to manufacturer's guidelines. The facility's revised July 2024 Ice Machines and Ice Storage Chest policy, ice machines and ice storage/distribution containers would be used and maintained to ensure a safe and sanitary supply of ice. The policy showed the facility would establish procedures for cleaning and disinfecting ice machines and ice storage chests that adhered to the manufacturer's instructions. The infection preventionist (or designee) would maintain a copy of these procedures. <Dirty Equipment> <Ice Machine> In an observation and interview on 09/10/2024 at 9:06 AM, the top portion of the facility's ice machine was observed to have brownish-black mold-like debris on the cover and on the plastic dispenser that led into the bottom portion of the ice machine. The bottom portion where the ice was held, had a streak of pink mold-like debris on the interior frame of the ice maker. When Staff Z (Dietary Supervisor) wiped the pink material with their gloved hand, some pink was noted on their glove. When Staff Z wiped the brownish-black material with a napkin, the area sampled wiped clean, and the remnants were on the napkin. Review of the daily cleaning log showed cleaning was last completed on September 8th, two days previous. In an interview at this time, Staff Z stated the kitchen staff provided a daily wipe of the ice machine and the maintenance staff provided deep cleaning to the ice machine. Staff Z stated maintenance was responsible for cleaning the top part of the ice machine and indicated it was cleaned, last month. Staff Z stated they were unaware of the date when the maintenance staff provided a deep cleaning of the ice machine but would check. When asked if they expected the ice machine to be clean, Staff Z stated yes. (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 09/16/2024 at 2:02 PM, Staff O (Maintenance Supervisor) stated they were unable to locate any maintenance logs for the cleaning of the ice machine since they were last here in October 2023. Staff O stated the ice machine should be cleaned monthly and receive a deep clean quarterly. When asked if they were able to determine when the ice machine was last cleaned, Staff O stated, no. <Wall Fans> Observations during initial kitchen rounds on 09/10/2024 at 9:18 AM showed two mounted upper wall fans facing over a food preparation area and the dishwashing area. Both fans were dirty with hanging debris from the front grill that moved with the flow of air into the kitchen during observations. Observations on 09/12/2024 at 9:49 AM showed the dirty fan was running while staff were brushing melted butter on breadsticks in the adjacent food preparation area. In an interview on 09/10/2024 at 9:06 AM, Staff Z confirmed the fans were dirty and needed to be cleaned. <Hand Hygiene/Cross Contamination> Observations during initial kitchen rounds on 09/10/2024 at 9:18 AM showed Staff DD (Dietary Aide) handling dirty food containers and dishes. Then, while wearing the same soiled gloves, Staff DD removed clean dishes out of the dishwasher. Observations during meal preparation rounds on 09/12/2024 at 9:49 AM showed Staff EE (Dietary Cook) take out a thermometer, touch the probe with their bare fingers, and put the now-soiled thermometer probe into a pan of ground sausage. Staff EE checked the temperature and then disinfected the probe. Observation on 09/12/2024 at 9:54 AM showed Staff EE cutting up partially thawed chicken on a cutting board while wearing gloves. Staff EE then reached under the counter to obtain a clean pan, while still wearing the soiled gloves, and touched the edges of several clean pans while trying to get a pan to use. Staff EE removed their gloves and without performing hand hygiene, removed a pan of ground chicken from the oven, sanitized a thermometer probe, checked the temperature of the ground chicken, and placed it back in the oven prior to performing hand hygiene. Staff EE put on new gloves and finished cutting up the chicken, removed gloves, did not perform hand hygiene, and took a clean pan from under the counter, then went to wash their hands. Observations on 09/12/2024 at 10:43 AM showed Staff DD pick up a stack of clean plates, press them against their body, and carried them over to the plate warmer holder. The top plate made contact with Staff DD's apron and name badge. Observations on 09/13/2024 at 11:50 AM, showed Staff FF (Dietary Cook) wearing gloves while assisting with tray line. Staff FF turned around to get some condiments from a nearby shelf, touched the counter, shelf surface, and condiment container. Staff FF then returned to tray line, and using the same soiled gloves, placed parsley garnish on the residents' plates. In an interview on 09/13/2024 at 1:45 PM, Staff Z (Dietary Supervisor) stated it was their expectation staff perform hand hygiene with each glove change, when moving from dirty to clean in the dishwashing area, and after touching contaminated items or surfaces. Staff Z stated items should be sanitized prior to touching food products. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42203 <Uncovered Desserts> Observation of the Garden Way unit on 09/10/2024 at 12:32 PM showed two nurse's aide distributing lunch trays from a cart placed mid-way down the hall. Each tray included a cookie in a placed in a plastic cup. The cookies were not covered. The nurse's aides delivered trays to each resident without moving the cart down the hall. The further the resident room was from the cart, the longer their cookie was exposed to the hall environment. In an interview on 09/13/2024 at 1:45 PM, Staff Z stated it was their expectation food be covered in the hallways if the tray is passing other rooms. Staff Z stated staff were supposed to be moving the tray cart to each room during delivery, so the uncovered food was brought directly to the resident. <Unit Refrigerator> Observation on 09/16/2024 at 7:52 AM showed the unit refrigerator located between the Collectable Court and Garden Way units was unclean. The lower shelf and vegetable crisper below were covered with considerable amount of a purple-red dried up fluid. In an interview at that time, Staff Z stated the refrigerator was dirty and needed to be cleaned. REFERENCE: WAC-388-97 -1100 (3). 43642

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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. 42203 Based on observation, interview, and record review the facility failed to establish and maintain infection control practices that provided a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to 1) ensure staff used personal protective equipment for residents reviewed for Transmission Based Precautions (TBP); 2) perform hand hygiene during resident care and during dining service; and 3) provide catheter care with professional standards. These failures placed residents at risk for the development and transmission of communicable diseases and related complications. Findings included . <Facility Policy> According to the facility's Infection Control Policy and Practices policy dated March 2023, the facility would prevent, detect, investigate and control infections by maintaining a safe and sanitary environment, and to help prevent and manage transmission of diseases and infections. The policy stated the facility would manage transmission of diseases and infections by implementation of isolation precautions for standard and transmission-based precautions (germs and infections transmitted through direct contact, air, droplets) and establish guidelines for the safe cleaning of reusable resident-care equipment. The policy stated all staff would be trained on infection control policies and practices including how to find and use pertinent procedures and equipment related to infection control. <Transmission Based Precautions> <Resident 58> According to the 07/30/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 58 had an infectious immune disease. The MDS showed Resident 58 received artificial nutrition through a feeding tube that entered directly to their digestive tract. According to the 05/02/2024 Resident is being treated for [an infectious immune disease] . Care Plan (CP) staff should use universal precautions when providing care to Resident 58. According to the 05/09/2024 Resident requires Enhanced Barrier Precautions (EBP) . CP Resident 58 required EBP related to their feeding tube. Observation on 09/10/2024 at 12:38 PM showed an EBP sign outside Resident 58's room directing care staff to perform hand hygiene and wear a gown and gloves when providing resident care. At that time two nurse's aides were observed repositioning Resident 58 up in their bed for lunch. Both aides put on gloves but did not gown up before repositioning Resident 58 and setting up their lunch tray. In an interview on 09/16/2024 at 12:48 PM Staff K (Licensed Practical Nurse - Infection Control) stated it was important for all staff to follow precaution signs to help minimize the chance spreading communicable diseases and exposure of infectious materials. Staff K stated the aides should put on gowns as directed by the sign but did not. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43642 <Hand Hygiene> <Resident 51> Observations on 09/12/2024 at 8:14 AM showed Staff X (Certified Nursing Assistant - CNA) performing incontinence care for Resident 51. Staff X wore gloves and used wipes during the incontinence care. After completing the incontinence care, Staff X, with the same soiled gloves, touched the skin on Resident 51's arms and legs while assisting to put on a new brief. Staff X then removed their soiled gloves and put on a new pair, without performing hand hygiene and continued to assist Resident 51 with dressing. Staff X then removed their gloves, opened the door with their soiled hands, exited the room, and went across the hallway to another room to wash their hands. In an interview on 09/16/2024 at 8:49 AM, Staff K stated their expectation was for staff to remove gloves and perform hand hygiene after providing incontinence care, prior to touching anything else. 46479 <Resident 22> Observation on 09/11/2024 at 12:41 PM showed Staff U (CNA) providing incontinence care to Resident 22. Staff U was observed to remove Resident 22's soiled brief, clean the resident with wipes, and place a new, clean brief on the resident. Staff U did not change their gloves after touching the soiled brief and before placing the clean brief on Resident 22. After placing the clean brief, Staff U continued wearing the soiled gloves and adjusted Resident 22's gown. Staff U touched Resident 22's shoulder and hip while helping the resident turn in bed. Staff U grabbed Resident 22's blankets and covered the resident up. Staff U took the package of wipes, opened the dresser drawer, and placed the wipes in the drawer while continuing to wear the soiled gloves. Staff U removed their soiled gloves and washed their hands. In an interview on 09/11/2024 at 12:48 PM, Staff U acknowledged they did not remove their soiled gloves before touching Resident 22, their gown, linens, and dresser drawer. Staff U stated they should change their soiled gloves before placing the clean brief on Resident 22. 50511 <Urinary Catheter> <Resident 11> Review of the 07/10/2024 Quarterly MDS showed Resident 11 had diagnoses including a blockage in their urinary tract, urinary bladder malfunction, and a history of urinary tract infections. The MDS showed Resident 11 had a surgically placed catheter tube below their belly button that drained urine directly from the bladder. The MDS showed Resident 11 had a diagnosis of infection due to a Multidrug-Resistant Organism (MDRO). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/10/2024 at 12:43 PM showed Resident 11 had a catheter in place with the drainage tube extending from their right leg. The catheter drainage bag was observed lying directly on the floor and contained urine in the bag. In an observation and interview on 09/11/2024 at 8:53 AM Resident 11's catheter drainage bag was lying on the floor. Resident 11 stated they had a history of frequent urinary tract infections. Observation on 09/16/2024 at 8:16 AM showed Resident 11's catheter bag containing urine and lying on the floor under the bed. In an observation and interview on 09/16/2024 at 9:58 AM, Staff T (Licensed Practical Nurse) removed the catheter bag from the floor and hung it on the side of the bed. Staff T stated the catheter bag should not be on the floor. Staff T stated the resident's bed was low which caused the catheter bag to be too close to the floor or on the floor. Staff T stated the catheter should not be on the floor due to infection control. In an interview on 09/16/2024 at 10:51 AM, Staff B (Director of Nursing) stated staff should be checking residents with catheters to make sure the catheter bag was hanging below the bladder on the side of the bed with a privacy bag. Staff B stated the catheter bag should not be on the floor for infection control. <Enhanced Barrier Precautions> <Resident 11> Review of the revised 04/02/2024 nursing focus CP, showed EBP were required due to Resident 11 having a catheter. Goals listed on the CP included reducing the risk of transmission spread of MDROs. Precaution instructions included the use of gowns and gloves during high contact resident care including, but not limited to, dressing, bathing, transfers, linen changes, incontinent care, wound and/or indwelling device care. Observation on 09/14/2024 at 12:43 PM showed an EBP sign posted on the door to instruct staff about the precautions for Resident 11. In an observation an interview on 09/13/2024 at 9:50 AM, Staff P (Registered Nurse Manager) read the EBP signage posted on door to Resident 11's room and stated staff should follow the precautions listed, such as wearing gloves and gowns for resident care. Observation on 09/16/2024 at 9:58 AM showed Staff T assisting Resident 11 transfer to the bedside commode. Staff T removed the catheter drainage bag from floor and hung it on the bed. Staff T had gloves on but did not have a gown on as directed by the EBP sign. In an interview on 09/16/2024 at 10:09 AM Staff K stated EBP precautions required staff to use gloves and gowns for any close contact to reduce cross contamination for MDROs. Staff K stated it was their expectation when staff provided care to a resident with a catheter, staff wore gloves and gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/16/2024 at 10:41 AM, Staff B (Director of Nursing) stated they expected the staff to follow the signage posted on the door for EBP. The staff should determine what services they help a resident with and determine what is needed in providing care for a resident with EBP. <Uncleanable Surfaces> <Resident 32> Observations on 09/10/2024 at 9:47 AM showed Resident 32's toilet seat rim with the white smooth protective layer worn away exposing a brown uncleanable material on the front and back of the toilet seat. <Resident 6> Observations on 09/10/2024 at 9:59 AM showed Resident 6 sitting up in their wheelchair. The armrests on the wheelchair were torn with the foam exposed. <Resident 51> Observations on 09/11/2024 at 10:12 AM showed Resident 51's wheelchair armrests wrapped in small strips of clear plastic tape that was peeling up on each edge of the tape. In an interview on 09/16/2024 at 8:49 AM, Staff K stated it was important for surfaces to remain cleanable to decrease the risk of bacteria spreading and to prevent cross contamination. REFERENCE: WAC 388-97-1320(c),(2)(a)(b).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 45941 Based on interview and record review, the facility failed to implement an effective Antibiotic (ABO) Stewardship Program, to promote appropriate use of ABO's, reduce the risk of unnecessary ABO use, and decrease the development of an ABO resistance for 3 of 5 sampled residents (Resident 223, 224, & 38) reviewed. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of ABO's. Findings included . <Facility Policy> According to a facility policy titled, ABO Stewardship Program, dated 06/17/2024, ABOs would be prescribed and administered to the residents under the guidance of the facility's ABO Stewardship Program as part of the facility's overall infection prevention and control program. The policy showed appropriate indications for use of ABO's included meeting the Loeb minimum Criteria for clinical definition of active infection. This policy stated when a Culture and Sensitivity (C&S - a test to identify a specific type of bacteria and determine which ABO's will treat the infection best) was ordered, the results will be communicated to the prescriber as soon as available to determine if ABO therapy should be continued, modified, or discontinued. In an interview on 09/11/2024 at 12:18 PM Staff K (Licensed Practical Nurse - Infection Control) stated the facility used the McGeers criteria (a tool used for infection surveillance activities and management of ABO usage). Staff K stated when a resident admitted to the facility with an infection, the staff were expected to obtain, from the hospital, the appropriate diagnosis for the prescribed ABO, start and stop date of ABOs, lab results, and data to ensure the resident meets McGeers criteria. Staff K stated when a resident acquired an infection in house, the staff were expected to ensure the resident's symptoms met the McGeers criteria, the prescribed ABO was appropriate and needed, lab results were communicated to the prescriber to ensure the least invasive ABO was prescribed, the order was complete with name, dose, and length of course, and had an appropriate diagnosis. <Resident 223> According to the June 2024 ABO line listing, Resident 223 received ABOs for a Urinary Tract Infection (UTI) that occurred in the facility and did not meet the criteria. Resident 223's June 2024 Medication Administration Record (MAR) showed that Resident 223 received 2 1/2 days of the 7-day course of ABO's prescribed for the UTI. Review of the May 2024 physician orders showed a 05/29/2024 order to collect a Urinalysis (UA) to rule out UTI. Review of Resident 223's medical records showed no documentation or results of a UA to assess for UTI, a C&S report to ensure appropriate ABO prescription, or if McGeers criteria was met. Review of the lab results in Resident 223's record showed no specimen was collected as ordered. (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/11/2024 at 1:35 PM, Staff K stated the facility should have followed the policy. Staff K reviewed Resident 223's record and stated staff did not follow the physician orders to collect the urine to rule out UTI. In an interview on 09/11/2024 at 1:44 PM, Staff W (Nurse Practitioner) stated Resident 223 had painful urination. Staff W stated they ordered a UA to rule out UTI, but staff did not follow the order. <Resident 224> According to the June 2024 ABO line listing, Resident 224 was treated with ABO for Pneumonia from 07/01/2024 thru 07/15/2024. Review of Resident 224's record showed the facility received a Chest X-Ray (CXR) report from radiology on 06/28/2024 showing Resident 224 had pneumonia. Review of Resident 224's record showed no documentation that staff communicated the report with Resident 224's provider. Review of July 2024 physician orders showed Resident 224 had an order to start on ABO on 07/01/2024. In an interview on 09/11/2024 at 1:45 PM, Staff C (Registered Nurse Manager) stated they expected staff to notify the provider immediately after they received the reports from the lab. Staff C stated after hours and over the weekend, they had on call provider to communicate any concerns related to the residents. Staff C reviewed Resident 224's record and stated staff did not communicate with the provider about Resident 224's CXR report on 06/28/2024. In an interview on 09/11/2024 at 1:51 PM, Staff W stated the facility did not report the abnormal CXR to them on 06/28/2024. Staff W stated they reviewed the CXR report on 07/01/2024 in the facility and ordered the ABO at that time. In an interview on 09/12/2024 at 11:00 AM, Staff B (Director of Nursing) stated they expected staff to communicate the results of abnormal resident reports with the provider immediately to prevent a delay in treatment. <Resident38> According to the July 2024 ABO line listing, Resident 38 was treated with three different ABOs from 07/25/2024 thru 07/31/2024 for Pneumonia. Review of Resident 38's record showed they had altered mental status and shortness of breath on 07/25/24 and the provider ordered to obtain a CXR immediately to rule out pneumonia. Resident 38's record showed the CXR was completed on 07/27/2024 with no diagnosis of pneumonia. In an interview on 09/11/2024 at 1:55 PM, Staff W reviewed Resident 38's record and stated the CXR did not show pneumonia. Staff W stated they should have reviewed ABO medications, but they did not. REFERENCE: WAC 388-97-1060(3)(k)(i).