STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505289	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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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** 38344 Based on interview and record review, the facility failed to have psychotropic medication (medications that affect a person's mental state) consents completed prior to receiving medications for 1 of 5 sampled residents (Resident 26) reviewed for unnecessary medication use. This failure placed the resident or their legal representatives at risk for lack of knowledge to make an informed decision regarding the use of the medication, adverse side effects, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 26 readmitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set assessment (MDS), an assessment tool, dated 01/04/2025, showed Resident 26 had diagnoses of dementia (a group of thinking and social symptoms that interfere with daily functioning), anxiety disorder, and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs). Review of Resident 26's March 2025 medication administration records (MAR) from 03/01/2025 - 03/12/2025 showed the resident was prescribed and provided Clonazepam (a medication used to treat anxiety) and Divalproex Sodium (a mood stabilizer, used to treat bipolar disorder). Review of Resident 26's form titled, Informed Consent for Use of Psychotropic Medication, dated 02/21/2024, showed clonazepam documented on the form; however, there were areas on the form that were blank to include dose/frequency, duration, medication category, diagnosed condition for which the medication was prescribed, clinical indication for use, benefits expected from the medication, and possible side effects. Review of Resident 26's form titled, Consent for Use of Psychoactive Medication Therapy, dated 04/22/2021, showed psychotropic medication ordered was Depakote (another name for Divalproex Sodium). There were areas on the form that were blank to include specific condition to be treated, benefits expected from the medications, and the proposed course of the medication. During an interview on 03/12/2025 at 12:59 PM, Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM), stated a signed informed consent was to be obtained prior to residents being provided a psychotropic medication. Staff H stated Resident 26's informed consent dated 02/21/2024 for the medication clonazepam and informed consent dated 04/22/2021 for the medication Depakote were not completely filled out and were missing information, which did not meet expectations. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 3:44 PM, Staff B, Director of Nursing Services (DNS), stated Resident 26's informed consents dated 02/21/2024 and 04/22/2021 for ordered psychotropic medications were not filled out completely with required information and this did not meet expectations. Reference WAC 388-97-0260

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on interview and record review, the facility failed to honor resident shower preferences for 1 of 3 sampled residents (Resident 216) reviewed for choices. This failure placed the resident at risk for infection, medical complications, and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 216 was readmitted to the facility on [DATE] with diagnoses to include bipolar disorder (disorder associated with mood swings ranging from depressive low to manic highs), heart failure, spinal stenosis (spaces inside the bones of the spine get too small and causes pressure on the nerves) and morbid obesity (disorder that involves having too much body fat). Resident 216 was able to communicate needs. Review of the care plan, initiated 03/01/2025, did not showed instructions or preferences for showers. During an interview on 03/10/2025 at 10:30 AM, Resident 216 stated they did not get a choice about their shower. Resident 216 stated when staff ask to shower them, the only option was yes or no, and if the resident was not feeling well or was busy, they would miss the shower until the following week. Resident 216 stated they had not had a shower since admitting on 03/01/2025. During an interview on 03/12/2025 at 12:22 PM, Staff L, Licensed Practical Nurse/Unit Manager (LPN/UM), stated the showers were on a schedule and if resident were not able to have a shower, the make-up day was Sunday. During an interview on 03/13/2025 at 12:43 PM, Staff B, Director of Nursing Services, stated residents should have a choice and Resident 216 not having a shower did not meet expectation. Reference WAC 388-97-0900(1)-(4)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to obtain advanced directives (AD) and/or perform periodic reviews to determine if residents had an AD, and if not, determine whether the residents wished to formulate an AD for 3 of 4 sampled residents (Residents 22, 43, and 77) when reviewed for AD. This failure denied the residents the opportunity to direct their health care in the event they were to become unable to make decisions or communicate their health care preferences. Findings included . Resident 22 Review of the electronic health record (EHR) showed Resident 22 initially admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), depression, and was able to make needs known. Review of a progress note, dated 03/14/2024, showed social service staff provided AD paperwork to Resident 22's family member. Review of the EHR showed an attempt to schedule a care conference on 02/18/2025; however, there was no documented follow-up related to the AD. During an interview on 03/12/2025 at 10:25 AM, Staff O, Social Service Director (SSD), stated they should have followed up on the paperwork but did not. Resident 43 Review of the EHR showed Resident 43 admitted to the facility on [DATE] with diagnoses that included stroke, bipolar disorder (mental health condition characterized by significant mood swings), and weakness. Resident 43 was dependent on staff for mobility. Review of a progress note, dated 06/03/2023, showed social services attempted to reach the family member Resident 43 wanted to designate as their durable power of attorney. Review of the EHR showed no additional documentation related to follow-up or periodic review of Resident 43's AD. During an interview on 03/12/2025 at 10:25 AM, Staff O, SSD, stated Resident 43's AD should have been reviewed quarterly. Resident 77 Review of the EHR showed Resident 77 admitted to the facility on [DATE] with diagnoses to include dementia, dysphagia (difficulty swallowing) and depression. Resident 77 was assessed as sometimes understood and rarely or never understood others. Review of Resident 77's EHR on 03/11/2025 showed no AD for healthcare. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/2025 at 10:25 AM, Staff O, SSD, stated they were to follow up with Resident 77's spouse but did not. During an interview on 03/13/2025 at 1:28 PM, Staff A, Administrator, stated the expectation was AD's were discussed with the resident/resident representative at every quarterly care conference. Reference WAC 388-97-0280(1)(2)(3)(c)(i-ii); -0300 (1)(b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation and interview, the facility failed to provide a homelike environment in resident rooms for 2 of 4 hallways (200 and 100 halls) when review for environment. This failure placed residents at risk of decreased mood and a diminished quality of life. Findings included . 200 Hall Observations on 03/10/2025, 03/11/2025, and 03/14/2025 showed the wall behind Resident 65's head of their bed board with torn wallpaper and deep gouges with a small amount of flaking drywall accumulated on the floor. During an interview on 03/10/2025 at 12:53 PM, Resident 65 stated the wall had been in disrepair since they arrived in the room about three weeks ago and staff were aware. 46067 100 Hall Observations of room [ROOM NUMBER] on 03/10/2025, 03/11/2025, and 03/12/2025 showed the wall behind the head of bed A had torn wallpaper and deep gouges. Observations of room [ROOM NUMBER] on 03/10/2025, 03/11/2025, and 03/12/2025 showed the wall behind the head of bed had torn wallpaper and deep gouges. During an interview on 03/13/2025 at 1:45 PM, Staff S, Maintenance Director, stated the rooms had needed repair for months; however, the facility did not have a solution to repair them in a timely manner. During an interview on 03/13/2025 at 2:19 PM, Staff A, Administrator, stated the expectation was maintenance staff were completing weekly rounds, entering needed repairs into the system, and completing repairs within 30 days. Reference WAC 388-97-0880(1)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40817 Based on observation, interview, and record review, the facility failed to complete criminal background check prior to hire for 1 of 5 staff (Staff F) when reviewed for abuse and neglect prevention. This failure placed the residents at risk for abuse and neglect. Findings included . Review of a policy titled, Background Screening Investigations, dated 03/27/2024, showed employees cannot work in positions that involve direct contact with patients until the criminal background check was completed. During an interview and observation on 03/10/2025 at 10:34 AM, Resident 216 stated one nursing assistant was rude and pushed hard on their hip and caused them to scream. As Resident 216 was describing this, the door to the room opened and Staff F, Certified Nursing Assistant (CNA), came in and then left the room. Resident 216 stated that was the rude aide. Observation during day shift on 03/10/2025 and 03/11/2025 showed Staff F was working on the same hallway as Resident 216's room. Review of the employee file on 03/12/2025 showed Staff F, CNA, was hired on 09/05/2024. There was no background check for Staff F to show their criminal record was reviewed to allow unsupervised access to vulnerable adults. During an interview on 03/12/2025 at 2:17 PM, Staff C, Administrator in Training, stated Staff F's background check was not done and that was not an acceptable practice. Reference WAC 388-97- 0640(4)(9), -1800

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on interview and record review, the facility failed to identify and report an allegation of abuse for 1 of 2 sampled residents (Resident 216) when reviewed for abuse. This failure placed the resident at risk of further abuse, psychological distress, and diminished quality of life. Finings included . Review of the electronic health record (EHR) showed Resident 216 was readmitted to the facility on [DATE] with diagnoses to include bipolar disorder (disorder associated with mood swings ranging from depressive low to manic highs), heart failure, spinal stenosis (spaces inside the bones of the spine get too small and causes pressure on the nerves) and morbid obesity (disorder that involves having too much body fat). Resident 216 was able to communicate needs. During an interview on 03/10/2025 at 10:34 AM, Resident 216 stated the night before last there was a certified nursing assistant who was rude to them and during care pushed hard on their hip and made them scream. Resident 216 stated they reported that occurrence to the lead aide. Resident 216 stated the previous night they were not provided incontinent care, there was urine all over the floor in the morning, and a different staff member cleaned it up and told Resident 216 it looked like they were not changed all night. Review of the facility incident and grievance log on 03/12/2025 had no record of Resident 216's concerns. During an interview on 03/12/2025 at 2:08 PM, Staff L, Licensed Practical Nurse/Unit Manager, stated they were not aware of Resident 216's concerns, and staff were expected to report residents' concerns/allegations to the nurse managers, the state reporting hotline, and the administrator. During an interview on 03/12/2025 at 2:16 PM, Staff A, Administrator, stated staff were to report allegations of abuse and neglect to them immediately and Resident 216's allegations were not reported and that was not acceptable. Reference WAC 388-97- 0640(5)(6)(a)(c)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on interview and record review, the facility failed to ensure residents with mental health disorders were screened for the need of additional mental health support for 5 of 9 sampled residents (Residents 77, 95, 103, 22, and 26) when reviewed for Preadmission Screening and Resident Review (PASARR, a mental health screening tool). This failure placed residents at risk of lacking needed mental health support, avoidable adverse behaviors, and diminished quality of life. Findings included . Resident 77 Review of the electronic health record (EHR) showed Resident 77 was admitted to the facility on [DATE] with diagnoses to include dementia (impairment of brain function that causes loss of memory and thinking) with psychosis (mental disorder characterized by a disconnection from reality), anxiety, and insomnia (inability to sleep). Resident 77 was not able to communicate needs. Review of the current provider's orders, on 03/12/2025, showed Resident 77 was prescribed medications to treat their psychosis, anxiety and insomnia. Review of the PASARR form, dated 11/06/2024, showed Resident 77 did not have any of their active diagnoses included and a level 2 PASARR was not required. Resident 95 Review of the EHR showed Resident 95 was admitted to the facility on [DATE] with diagnoses to include post-traumatic stress disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event, leading to persistent symptoms like intrusive memories, avoidance behaviors, and hyperarousal), anxiety, and depression. Resident 95 was able to communicate needs. Review of the PASARR form, dated 12/18/2024, showed Resident 95 was marked only for anxiety and no level 2 PASARR was required. Resident 103 Review of the EHR showed Resident 103 was readmitted to the facility on [DATE] with diagnoses to include major depressive disorder, heart failure, and respiratory failure. Review of the EHR on 03/12/2025 showed Resident 103 was prescribed antidepressant medicine to treat their depression. Review of the PASARR form, dated 01/15/2025, showed Resident 103 did not have depression and did not require level 2 PASARR. Review of a second PASARR, dated 02/03/2025, showed Resident 103 did not have depression and did not need level 2 PASARR. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/2025 at 9:04 AM, Staff O, Social Service Director (SSD), stated the social service team reviewed the PASARR forms on admission and corrected them if needed and forwarded them to the state evaluator for level 2 PASARR. During an interview on 03/13/2025 at 12:30 PM, Staff A, Administrator, stated the PASARR forms for Residents 77, 95 and 103 were not correct and this did not meet expectation. 38344 Resident 22 Review of the EHR showed Resident 22 initially admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), depression, and was able to make needs known. Review of Resident 22's level 1 PASARR, dated 11/16/2023, showed no serious mental illness indicators marked on the form and showed no level 2 PASRR indicated. Review of Resident 22's EHR showed no other documented level 1 PASARRs or level 2 PASARRs. During an interview on 03/12/2025 at 12:32 PM, Staff O, SSD, stated Resident 22's level 1 PASARR, dated 11/16/2023, was missing a diagnosis of depression and showed not to refer for a level 2. Staff O stated Resident 22 should have been referred for a level 2 PASARR due to a diagnosis of depression and this did not meet expectations. Resident 26 Review of the EHR showed Resident 26 readmitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set (MDS), an assessment tool, dated 01/04/2025 showed Resident 26 had diagnoses of anxiety disorder and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs). During an interview on 03/13/2025 at 2:14 PM, Staff O, SSD, stated Resident 26's level 1 PASARR, dated 08/20/2021, did not show a diagnosis of anxiety disorder marked as a serious mental illness and showed no level 2 evaluation indicated. Staff O stated they were unable to locate any other level 1 PASARR in Resident 26's EHR and this did not meet expectations. Staff O stated Resident 26 needed another level 1 PASARR completed with a referral for a level 2 PASARR evaluation. Reference WAC 388-97-1915 (1)(2)(a-c)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to ensure baseline care plans were developed and implemented within 48 hours of admission and included the minimum information necessary to properly care for 3 of 21 sampled residents (Residents 30, 103 and 215) when reviewed for care plans. This failure placed residents at risk for unidentified and/or unmet care needs, negative health outcomes, and a decreased quality of life. Findings included . Resident 30 Review of the electronic health records (EHR) showed Resident 30 admitted to the facility on [DATE] with diagnoses including cancer of the colon (lower intestines), dementia (problems with memory), and diabetes (too much sugar in the blood). The resident was unable to make needs known. During an interview on 03/12/2025 at 9:01 AM, Collateral Contact Z stated Resident 30 did not eat on their own and staff took the tray out without assisting them. Review of the baseline care plan, dated 11/16/2024, did not show care areas for activities of daily living (ADLs) that included assistance with eating, oral care, hygiene, bed mobility, or dressing. Resident 103 Review of the EHR showed Resident 103 admitted to the facility on [DATE] with diagnoses of congestive heart failure (when the heart does not pump enough blood causing a buildup of fluids) kidney failure, and diabetes. The resident was dependent on staff for activities of daily living and was unable to make needs known. Review of Resident 103's care plan showed no baseline care plan was initiated for oral care or bed mobility. Review showed a care plan for rehabilitation/ADLs, initiated on 02/25/2025, which showed transfer needs only. During an interview on 03/13/2025 at 8:54 AM, Staff K ,Minimum Data Set Coordinator/Registered Nurse (MDSC/RN), stated a baseline care plan that included ADL care/assistance needs was not automatically created, and the facility had a new care plan library that did not include ADLS. Staff K stated the admission nurse should have created the baseline care plan for Residents 30 and 103. Staff K stated the current care plan for ADLs only listed the transfer/rehabilitation needs. During an interview on 03/13/2025 at 11:07 AM, Staff B, Director of Nursing Services (DNS), stated Resident 30 and 103's baseline ADL care plans were not complete and should have been. 49926 Resident 215 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 215 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (kidney failure), spinal stenosis in cervical region (spinal canal in the neck area narrows and compresses the spinal cord and nerves), diabetes (high blood sugar) and urine retention. Resident 215 was able to make needs known. Observation on 03/12/2025 at 9:25 AM showed Resident 215 sat in their wheelchair in the room with a purple sling (fabric device that aids in mechanical lift) underneath their body, and a blue color transfer sling on their bed. Resident 215 stated the purple sling was for dialysis (treatment that filters excess fluids, toxins and solutes from the blood when kidneys are not able to). Review of the baseline care plan, initiated on 03/08/2025, showed Resident 215 required a mechanical lift for all transfers and to be provided with partial moderate assist with transfer. During an interview on 03/13/2025 at 10:16 AM, Staff L, Licensed Practical Nurse/Unit Manager, stated the transfer status for Resident 215 was initiated on admission and then was updated, but whomever did the updates did not remove the previous intervention. During an interview on 03/13/2025 at 12:35 PM, Staff B, Director of Nursing Services, stated baseline care plan was initiated on admission and Resident 215's baseline care plan did not meet expectation. Reference WAC 388-97- 1020(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38344 Based on observation, interview, and record review, the facility failed to develop comprehensive care plans to reflect the resident's current medical status and/or to include all provided nursing services for 6 of 21 sampled residents (Residents 22, 26, 36, 70, 64 and 77) when reviewed for care planning. This failure placed residents at risk for not receiving needed care, a decline in condition, and a diminished quality of life. Findings included . Resident 22 Review of the electronic health record (EHR) showed Resident 22 readmitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), peripheral vascular disease (reduced blood flow to the arms and legs), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 22 had diabetic foot ulcers (a slow-healing sore/wound on the foot of someone with diabetes) and was able to make needs known. During an interview on 03/12/2025 at 1:52 PM, Resident 22 stated they received treatment to wounds on their toes on both their feet by the nursing staff. Review of Resident 22's provider's order dated 01/06/2025 showed Resident 22 was prescribed iodine (a mineral solution) to be applied to scabs of both feet, third toes, every dayshift and to discontinue when resolved. Review of the care plan, initiated on 11/17/2023, showed no focused area for Resident 22's actual skin impaired related to diabetic foot ulcers, and no intervention for nursing staff to treat the wounds on the toes. During an interview on 03/14/2025 at 1:04 PM, Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM), stated Resident 22's care plan showed potential instead of actual, skin impairment and it did not show documentation related to wounds on Resident 22's toes. Staff H stated Resident 22's care plan did not meet expectations. During an interview on 03/14/2025 at 1:40 PM, Staff B, Director of Nursing Services (DNS), stated Resident 22's care plan should have included actual skin injury, for the resident's wounds and that did not happen. Staff B stated that Resident 22's care plan related to skin integrity did not meet expectations. Resident 26 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed that Resident 26 readmitted to the facility on [DATE] and was able to make needs known. Review of the quarterly MDS dated [DATE] showed Resident 26 had diagnoses of dementia (a group of thinking and social symptoms that interfere with daily functioning), anxiety disorder, and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs). The MDS showed Resident 26 required setup or clean-up assistance with oral hygiene and was able to make needs known. During an interview on 03/10/2025 at 11:52 AM, Resident 26 stated their dentures did not fit, and staff were aware. Review of the progress note dated 10/03/2024 showed Resident 26 had complained of dentures not fitting well and their family was aware. Per resident and family request, they preferred to wait to see the facility's denturist when available in the facility. Review of Resident 26's EHR showed a care plan focus area for oral/dental care initiated on 01/06/2025 which had no documentation regarding the resident's dentures or of the need to be seen by a denturist. The care plan focus area for cognition (mental processes that occur in the brain, including learning, thinking, memory, perception, attention, and language) initiated on 01/06/2025 showed Resident 26 was at risk for complications related to cognitive impairment secondary to dementia; however, the goal (care plan goal: specific, measurable, achievable, relevant, and time-bound, focusing on the resident's needs and desired outcomes to guide care and support their well-being) was not a measurable goal. During an interview on 03/13/2025 at 12:43 PM, Staff H, LPN/UM, stated Resident 22's oral/dental care plan did not meet expectations because it did not include the resident's dentures or needing to be followed up by a denturist. During an interview on 03/13/2025 at 1:31 PM, Staff B, DNS, stated Resident 26's oral/dental care plan needed to address the resident's dentures and that did not happen. During an interview on 03/14/2025 at 12:08 PM, Staff H, LPN/UM, stated Resident 26's cognitive/dementia care plan did not have a measurable goal and should have had documented by next review date, included in the goal. During an interview on 03/14/2025 at 2:06 PM, Staff B, DNS, stated Resident 26's cognitive/dementia care plan goal was not measurable and should have been. Resident 36 Review of the EHR showed Resident 36 admitted to the facility on [DATE] with diagnoses to include diabetes, chronic obstructive pulmonary disease (COPD, blocks airflow making it difficult to breathe), and was able to make needs known. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/10/2025 at 12:10 PM showed an oxygen (O2) concentrator (a device used to deliver O2) turned on with O2 flowing at a rate of two liters per minute connected to a nasal canula (a device/flexible tube with two prongs used to provide O2 through the nose) tubing hanging from the head bed board, not being used by Resident 36. Resident 36 stated they only used oxygen if they needed it; however, they did not need oxygen at that time. Review of Resident 36's provider order dated 11/19/2024 showed an order to discontinue oxygen therapy and continue to monitor oxygen saturation (measuring the percentage amount of oxygen in the blood) every shift and as needed. Review of Resident 36's care plan focus area for Respiratory, initiated on 12/25/2024 showed Resident 36 was at risk for respiratory complications secondar to COPD and included an intervention dated 12/25/2024 to administer oxygen as ordered. During an interview on 03/14/2025 at 12:43 PM, Staff H, LPN/UM, stated Resident 36's respiratory, care plan initiated on 12/25/2024 had an intervention to administer O2 as needed; however, the resident did not have an order to provide O2 and this did not meet expectations. During an interview on 03/14/2025 at 2:24 PM, Staff B, DNS, stated Resident 36's intervention to administer O2 as needed should not have been included in the Respiratory, care plan and this did not meet expectations. Review of the quarterly MDS dated [DATE] showed Resident 36 had a feeding tube (a flexible tube used to deliver nutrition and fluids directly into the stomach or small intestine). During an interview on 03/10/2025 at 12:19 PM Resident 36 stated they were provided food through a feeding tube and orally. Review of the care plan, initiated 12/25/2024, showed a focus area for Resident 36's enteral feeding (delivering food and fluids via a tube directly into the stomach or small intestine) for at risk for complications related to the need for an enteral tube feeding; however, it did not show the location, type, and size of the feeding tube. During an interview on 03/14/2025 at 2:19 PM, Staff B, DNS, stated Resident 36's enteral feeding care plan did not meet expectations because it did not include the location, type, and size of Resident 36's feeding tube and it should have. Resident 70 Review of the EHR showed Resident 70 readmitted to the facility on [DATE] with diagnoses to include a stroke, aphasia (a communication disorder that affects both speaking and understanding language), had no speech and was rarely understood. Resident 70 had impairment of the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) of the left side of the body. Observation on 03/13/2025 at 9:56 AM showed Resident 70 laid in bed with no splint or brace in place on the left arm or left hand. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan focus area for activities of daily living (ADL) self-care performance deficit initiated on 05/05/2023, showed Resident 70 had an intervention to apply left palm guard and left elbow orthotic (brace) for two to four hours as tolerated. During an interview on 03/14/2025 at 12:54 PM, Staff H, LPN/UM, stated Resident 70's order for left palm guard and left elbow orthotic was discontinued on 05/24/2024 due to resident refusal to wear them. Staff H stated Resident 70's ADL care plan needed to be updated. Review of the care plan focus area for limited physical mobility, initiated on 01/09/2024, showed Resident 70 had interventions initiated on 11/21/2024 to have nursing rehabilitation/restorative care for passive range of motion (PROM, movement of a joint without active participation from the resident) of the lower extremities and of the left upper extremity. During an interview on 03/14/2025 at 2:45 PM, Staff A, Administrator, stated Resident 70's focus area for limited physical mobility with interventions to have nursing rehabilitation/restorative care for PROM should have never been initiated. Staff A stated they did not have a restorative program, and Resident 36's care plan should have documented functional PROM with care and Resident 36's care plan was inaccurate. 46067 Resident 64 Review of the EHR showed Resident 64 admitted to the facility on [DATE] with diagnoses that included disorder of muscle, lymphedema (tissue swelling caused by accumulation of fluid), and difficulty walking. Review of the admission MDS, dated [DATE], showed Resident 64 was assessed to have lower extremity impairment of both sides. During an interview on 03/12/2025 at 1:52 PM, Resident 64 stated Staff never do what they're supposed to do here. I'm supposed to get my legs wrapped daily and it doesn't get done. Review of Resident 64's provider's order dated 02/28/2025 showed staff were to apply ACE wraps (elastic bandage) to bilateral extremities one time a day for edema and remove at night per schedule. Observations on 03/12/2025 at 9:51 AM and 03/13/2025 at 11:03 AM showed Resident 64's legs were not wrapped Review of the March 2025 MAR showed the ACE wraps had not been applied during the month. Review of the care plan, initiated on 10/14/2024, showed no focused area for Resident 64's lymphedema and no intervention for ACE wraps. During an interview on 03/14/2025 at 7:52 AM, Staff H, LPN/UM, stated Resident 64's lymphedema should have been care planned. During an interview on 03/14/2025 at 8:33 AM, Staff B, DNS, stated the lack of lymphedema care plan did not meet expectation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49926 Resident 77 Review of the EHR showed Resident 77 was admitted to the facility on [DATE] with diagnoses to include dementia (impairment of brain function that causes loss of memory and thinking) with psychosis (mental disorder characterized by a disconnection from reality), anxiety, and insomnia (inability to sleep). Resident 77 was not able to communicate needs. Review of the significant change MDS dated [DATE] showed Resident 77 was dependent on staff to provide activities of daily leaving (ADL) care. Observations from 03/10/2025 to 03/14/2025 showed Resident 77 in bed with closed eyes. During an interview on 03/12/2025 at 9:15 AM, Resident 59, who was a roommate of Resident 77, stated Resident 77 has been in the bed for three months. Review of the care plan, dated 11/09/2024, showed Resident 77 had a focus area for rehabilitation with interventions dependent for transfers with mechanical lift. There were no instructions or directions for staff to describe what other support Resident 77 needed for activities of daily leaving. During an interview on 03/13/2025 at 12:35 PM, Staff B, DNS, stated the expectation was for the comprehensive care plan to be developed within 14 days of admission, and to include instructions about ADLs. Staff B stated Resident 77's care plan did not meet expectation. Reference WAC 388-97-1020(1),(2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to conduct timely care planning meetings with residents or responsible party for 2 of 4 sampled residents (Residents 22 and 36) when reviewed for care planning. The facility failed to revise the care plan for 3 of 21 sampled residents (Residents 30, 88, and 77) when reviewed for care plan revision. These failures placed residents at risk for unmet needs, care not provided as directed, and a diminished quality of life. Findings included . Resident 22 Review of the electronic health record (EHR) showed Resident 22 initially admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), depression, and was able to make needs known. During an interview on 03/10/2025 at 12:41 PM, Resident 22 stated they did not recall attending a care conference. Review of the EHR showed a progress note dated 02/18/2025 stating the resident wanted a care conference; however, they wanted their family member involved whom staff could not get in contact with. The EHR showed no additional documentation that a care conference was conducted. During an interview on 03/12/2025 at 10:27 AM, Staff O, Social Service Director (SSD), stated Resident 22 should have been reapproached about conducting a care conference without the family member. Staff O stated this did not meet expectation. During an interview on 03/13/2025 at 1:37 PM, Staff A, Administrator, stated the expectation was that residents were offered care conferences even if family members were unable to attend. Resident 36 Review of the EHR showed Resident 36 admitted to the facility on [DATE] with diagnoses to include diabetes, chronic obstructive pulmonary disease (COPD, blocks airflow making it difficult to breathe), and was able to make needs known. During an interview at 03/10/2025 at 12:09 PM, Resident 22 stated they did not recall attending a care conference. Review of the EHR showed no documentation a care conference was conducted. During an interview on 03/12/2025 at 10:27 AM, Staff O, SSD, stated Resident 22 did not have a care conference, but should have had one during the month of December 2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/13/2025 at 1:37 PM, Staff A, Administrator, stated the expectation was that care conferences were offered quarterly. 46148 Resident 30 Review of the EHR showed Resident 30 admitted to the facility on [DATE] with diagnoses including cancer of the colon (lower intestines), dementia, and diabetes. The resident was unable to make needs known. Review of the care plan initiated 11/16/2024 showed a care plan intervention dated 12/17/2024 for staff to empty the catheter every shift. Observations on 03/12/2025 at 9:15 AM,11:08 AM, 1:18 PM, and 3:31 PM showed Resident 30 laid in bed in a hospital gown and jacket. The resident did not have an indwelling urinary catheter. Review of the provider orders showed a completed order for catheter removal dated 12/29/2024. Resident 88 Review of the EHR showed Resident 88 admitted to the facility on [DATE] with diagnosis of cognitive communication deficit (when someone has trouble with one or more cognitive processes involved in communication) and diabetes. The resident was able to make needs known. Observation and interview on 03/11/2025 at 9:36 AM showed Resident 88 laid in bed. The resident did not have a urinary catheter. Resident 88 stated they did not currently have a urinary catheter. Review of Resident 88's care plan showed a focus area for a catheter related to urine retention dated 01/16/2025. Review of the progress notes showed an entry dated 01/28/2025, Patient is on alert related to discontinued Foley [urinary] catheter for voiding trial. Patient is incontinent of bladder and voids adequate urine. and an entry dated 01/27/2025, catheter removed per orders at 0545. During an interview on 03/12/2025 at 10:26 AM, Staff M, Certified Nursing Assistant (CNA), stated they looked at the Kardex (care delivery instructions) for care instructions and if it did not have the details, they looked at the care plan. Staff M stated Resident 88 did not currently have a urinary catheter. During an interview on 03/13/2025 at 11:07 AM, Staff B, DNS, stated it was their expectation that the care plans be updated to reflect the current needs of the residents. 49926 Resident 77 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 77 was admitted to the facility on [DATE] with diagnoses to include dementia with psychosis (mental disorder characterized by a disconnection from reality), anxiety and insomnia (inability to sleep). Resident 77 was not able to communicate needs. Review of the EHR showed Resident 77 was placed on isolation on 12/20/2024 for testing positive for COVID-19. Review of the care plan dated 12/20/2024 showed Resident 77 to continue to need isolation for COVID-19. Observations on 03/12/2025 at 9:15 AM showed Resident 77's room to have no signs for isolation. During an interview on 03/13/2025 at 10:45 AM, Staff L, LPN/UM, stated Resident 77's care plan was developed by the infection preventionist nurse and was not updated when the isolation stopped. During an interview on 03/13/2025 at 12:35 PM, Staff B, DNS, stated Resident 77's care plan did not meet expectation. Reference WAC 388-97-1020(2)(c)(d)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to follow provider's order for 1 of 5 sampled residents (Resident 215) reviewed for professional standard of care and services. This failure placed the resident at risk for avoidable pain, medical complications, and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 215 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (kidney failure), spinal stenosis in cervical region (spinal canal in the neck area narrows and compresses the spinal cord and nerves), diabetes (high blood sugar) and urine retention. Resident 215 was able to make needs known. Observation on 03/10/2025 at 10:16AM showed Resident 215 in their room with a cervical (neck) collar device on the nightstand. Observations from 03/10/2025 to 03/14/2025 showed Resident 215 without neck collar. During an interview on 03/12/2025 at 9:28 AM, Resident 215 stated they have not used the neck collar. Review of the medication administration record (MAR) for March 2025 showed an order for cervical collar for support and comfort and the order was signed for 03/09/2025 - 03/12/2025 by multiple nurses. During an interview on 03/13/2025 at 10:18 AM, Staff L, Licensed Practical Nurse/Unit Manager, stated the staff were to educate the resident and if the neck collar was not used to notify the provider. Staff L stated licensed nurses should not have documented in the MAR when the neck collar was not used. During an interview on 03/13/2025 at 12:49 PM, Staff B, Director of Nursing Services, stated the documentation of Resident 215's neck collar did not meet expectation. 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** 46067 Based on observation, interview, and record review, the facility failed to provide the necessary assistance with activities of daily living (ADLs) for 3 of 5 sampled residents (Residents 43, 30 and 88) when reviewed for dependent ADL care. This failure placed the residents at risk poor nutrition, weight loss, and a diminished quality of life. Findings included . Resident 43 Review of the electronic health record (EHR) showed Resident 43 admitted to the facility on [DATE] with diagnoses that included stroke, bipolar disorder (mental health condition characterized by significant mood swings) and weakness. Resident 43 was dependent on staff for mobility. During an interview on 03/10/2025 at 2:40 PM, Resident 43 laid in bed and stated they wanted to get out of bed more frequently but believed there were not enough staff. Observations on 03/12/2025 at 9:32 AM and 12:29 PM showed Resident 43 laid in bed. Observation on 03/13/2025 at 10:30 AM showed Resident 43 laid in bed watching television. During an interview on 03/13/2025 at 10:49 AM, Staff Y, Certified Nursing Assistant (CNA), stated staff only got Resident 43 up out of bed for appointments. Staff Y stated Resident 43 had tremors and poor positioning in their wheelchair. Staff Y stated Resident 43 had a wheelchair, but they had not seen it since it was taken for repair. Observation on 03/13/2025 at 10:51 AM showed Resident 43 pushed their call light and which was answered by Staff Y, CNA. Resident 43 requested assistance to get out of bed. Observation on 03/13/2025 at 11:53 AM showed Resident 43 laid in bed in the same position. During an interview on 03/13/2025 at 12:43 PM, Resident 43 stated Staff Y, CNA, was to get them out of bed but did not give a time and had not yet returned. Observation and interview on 03/13/2025 at 2:24 PM showed Resident 43 still in bed. Staff B, Director of Nursing Services (DNS), stated the expectation was for staff to offer to get residents up daily and make it a priority if a resident requested to get up. 46148 Resident 30 Review of the EHR showed Resident 30 admitted to the facility on [DATE] with diagnoses including cancer of the colon (lower intestines), dementia, and diabetes. The resident was unable to make needs known. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 9:01 AM, Collateral Contact Z (CCZ), stated Resident 30 did not eat on their own and staff took the tray out without assisting them. CCZ stated staff did not get Resident 30 up out of bed during the day. During an interview and observation on 03/12/2025 at 9:01 AM, CCZ stated Resident 30 needed assistance with meals and to get up out of bed. Resident 30 was observed lying in bed while CCZ assisted them with the morning meal. Observations on 03/12/2025 at 11:08 AM, 1:18 PM, and 3:31 PM showed Resident 30 laid in bed with an absorbent pad under them. Their position was unchanged. Review of Resident 30's care plan initiated 11/16/2024 showed the resident required assistance with eating meals, to get out of bed for meals, and to assist the resident to turn and reposition often. Observation on 03/12/2025 at 1:29 PM showed Resident 30 laid in bed and ate a small bite of potatoes, a small bite of the main protein, a few bites of green beans, and pushed the table away and began folding their napkin repeatedly and talking to the television. No staff was observed assisting with eating. During an interview on 03/13/2025 at 11:21 AM, Staff B, DNS, stated it was their expectation staff follow the care plan for Resident 30 and get the resident out of bed and assist as needed for meals. Resident 88 Review of the EHR showed Resident 88 admitted to the facility on [DATE] with diagnoses of cognitive communication deficit (when someone has trouble with one or more cognitive processes involved in communication) and diabetes (when the body cannot process sugar effectively). The resident was able to make needs known. Observation and interview on 03/11/2025 at 9:36 AM showed Resident 88 laid in bed and had unshaven facial hair. Resident 88 stated staff did not help them wash their face or shave and they would like to be shaven. During an interview on 03/12/2025 at 10:26 AM, Staff M, Certified Nursing Assistant (CNA), stated staff should offer shaving with morning care and showers. Staff M stated the Resident 88 had not refused shaving. Review of the care plan dated 10/18/2024 showed no intervention for personal hygiene or grooming/shaving. During an interview on 03/13/2025 at 11:17 AM, Staff B, DNS, stated it was their expectation Resident 88 should be offered shaving every day with morning care and weekly with showers. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to provide the necessary care and services for the treatment of non-pressure skin injuries and/or for edema (swelling caused by excess fluid in the body's tissues) management for 2 of 3 sampled residents (Residents 22 and 64) when reviewed for non-pressure skin conditions. These failures placed residents at risk for worsening of non-pressure injuries, medical complications, and a diminished quality of life. Findings included . Resident 22 Review of the electronic health record (EHR) showed Resident 22 readmitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), peripheral vascular disease (reduced blood flow to the arms and legs), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 22 had diabetic foot ulcers (a slow-healing sore/wound on the foot of someone with diabetes) and was able to make needs known. During an interview on 03/12/2025 at 1:52 PM, Resident 22 stated they received treatment to wounds on their toes on both their feet by the nursing staff. Review of Resident 22's provider's order dated 01/06/2025 showed Resident 22 was prescribed for iodine (a mineral solution) to be applied to scabs of both feet, third toes, every dayshift and to discontinue when resolved. Review of Resident 22's treatment administration record (TAR) dated March 2025 from 03/01/2025 - 03/13/2025 showed no order to conduct weekly skin checks. It showed an order with a start date of 01/07/2025 to apply iodine to scabs on both/feet third toes every dayshift and discontinue when resolved. The TAR showed the treatment had been documented as completed per provider order indicating wounds were not resolved. Review of Resident 22's weekly skin observation assessments from 12/29/2024 - 03/13/2025 showed Resident 22 had no weekly skin observation assessment documentation for the weeks of 12/29/2024-01/04/2025 and 01/12/2025-01/18/2025. Review of Resident 22's wound evaluation weekly assessments showed none were completed from 01/01/2025 - 03/12/2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and joint observation on 03/13/2025 at 10:15 AM, Staff T, Licensed Practical Nurse (LPN), stated Resident 22 had two scabs to the left third toe; however, they had been treating the right second toe scab, not the third toe as indicated in the order, and had not clarified the order with the provider and should have. Staff T stated a new scab was found on Resident 22's right third toe and a new blood blister was found on the right fourth toe that were not there yesterday (03/12/2025). During an interview on 03/14/2025 at 1:04 PM, Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM), stated wounds were to be measured weekly and documented in a wound evaluation assessment. Staff H stated Resident 22's wound documentation related to toes did not meet expectations because weekly measurements were not obtained and the documentation lacked clear indication of wound locations. During an interview on 03/14/2025 at 1:40 PM, Staff B, Director of Nursing Services (DNS), stated licensed nursing staff should have clarified the treatment order for Resident 22's wound to the right second toe if the order was entered in error for the right third toe. Staff B stated Resident 22's skin observation assessment dated [DATE] showed right and left third toe scabs; however, it showed no measurements and did not show a treatment was initiated. Staff B stated weekly measurements, monitoring, and required documentation did not happen for Resident 22 wounds and should have. 46067 Resident 64 Review of the EHR showed Resident 64 admitted to the facility on [DATE] with diagnoses that included disorder of muscle, lymphedema (tissue swelling caused by accumulation of fluid), and difficulty walking. Review of the admission MDS dated [DATE] showed Resident 64 was assessed to have lower extremity impairment of both sides. During an interview on 03/12/2025 at 1:52 PM, Resident 64 stated Staff never do what they're supposed to do here. I'm supposed to get my legs wrapped daily and it doesn't get done. Observations on 03/12/2025 at 9:51 AM and 03/13/2025 at 11:03 AM showed Resident 64's legs were not wrapped. Review of Resident 64's provider's order dated 02/28/2025 showed staff were to apply ACE wraps (elastic bandages) to bilateral extremities one time a day for edema and remove at night per schedule. Review of the March 2025 MAR showed the ACE wraps had not been applied on any days during the month. During an interview on 03/13/2025 at 11:23 AM, Staff T, LPN, stated Resident 64's legs were supposed to be wrapped but had not been. During an interview on 03/14/2025 at 7:52 AM, Staff H, LPN/UM, stated the order was input as no documentation required in error. Staff H stated the expectation was Resident 64's legs were wrapped daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/2025 at 8:33 AM, Staff B, DNS, stated the expectation was that orders were entered to reflect on the MAR and followed as directed by the provider. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed provide treatment or services to ensure residents increased or maintained range of motion (ROM) for 2 of 6 sampled residents (Residents 80 and 88) when reviewed for mobility. This failure placed the residents at risk for worsening mobility, developing of contractures (permanent tightening of muscle, tendons and skin, leading to deformity), and diminished quality of life. Findings included . Resident 80 Review of the electronic health record (EHR) showed Resident 80 admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (lungs cannot provide enough oxygen to the body), and chronic obstructive pulmonary disease (COPD, blocks airflow making it difficult to breathe). Review of the EHR showed Resident 80 was assessed to have impairment of upper and lower extremities (arms and legs) on both sides. During an interview on 03/11/2025 at 10:17 AM, Resident 80 stated they were no longer getting physical therapy and had discussed their concern with the provider. Resident 80 stated their partner would assist with exercises, but they only came to visit three days a week. Review of a provider note dated 01/28/2025 showed Resident 80 had not been on skilled rehabilitation services for many months and the provider would place a referral for physical therapy or believed the resident would be more appropriate for a restorative program if unable to be approved for physical therapy. Review of the Physical Therapy Discharge Summary for service dates 07/25/2024-08/08/2024 showed recommendations as follows: Restorative Program Established/Trained = Restorative Range of Motion Program Range of Motion Program Established/Trained = Partner educated on LB (lumbar spine) range of motion. During an interview on 03/12/2025 at 9:05 AM, Staff N, Director of Rehabilitation (DOR), stated Resident 80 was recommended for restorative at the discharge of physical therapy; however, they just recently started a restorative program. Staff N stated they were unaware of the provider referral and unaware if nursing was doing any restorative with residents. During an interview on 03/14/2025 at 8:02 AM, Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM), stated they were unaware of Resident 80's restorative recommendation from physical therapy. Staff H stated the expectation was restorative was care planned and completed by the Certified Nursing Assistants. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/2025 at 8:45 AM, Staff B, Director of Nursing Services (DNS), stated the facility identified a need for a formal restorative program which was in the process of starting. Staff B stated Resident 80 did not receive any restorative outside of activity of daily cares but should have based on the provider's recommendation. 46148 Resident 88 Review of the EHR showed Resident 88 admitted to the facility on [DATE] with diagnoses of cognitive communication deficit (when someone has trouble with one or more cognitive processes involved in communication) and diabetes (when the body cannot process sugar effectively). The resident was able to make needs known. Observation and interview on 03/11/2025 at 9:36 AM showed Resident 88 laid in bed. The resident had their left hand resting on their chest with the fingers curled and the skin appeared dry and flakey. Resident 88 attempted to move their fingers on the left hand but was unable and stated I can't open my hand. Review of a therapy discharge note showed Resident 88 was discharged from physical and occupational therapy on 3/10/2025 and showed Restorative Program Established / Trained = Not Indicated at This Time and Functional Maintenance Program Established/Trained = Not Indicated at This Time. During an interview on 03/12/2025 at 9:55 AM, Staff N, Director of Rehabilitation (DOR), stated Resident 88 was assessed for hand contracture last month and was ordered a hand splint. Review of an occupational therapy encounter note dated 02/07/2025 showed placed functional resting hand splint to left hand. Instructed patient on wearing schedule to wear at night to improve functional grasp. Review of the EHR showed no provider order or care plan entry for the use of a hand splint. During an interview on 03/12/2025 at 10:26 AM, Staff M, Certified Nursing Assistant (CNA), stated they were not aware of Resident 88 using a hand splint. During an interview on 03/12/2025 at 11:01 AM, Resident 88 stated they did not wear a hand splint. During an interview on 03/12/2025 at 10:13 AM, Staff B, DNS, stated the facility was starting a restorative program but had not yet. Staff B stated the therapy recommendations for the hand splint should have been added to the provider orders and care planned but was not and this did not meet their expectations. Reference WAC 388-97-1060 (3)(d)

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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** 46067 Based on observation, interview, and record review, the facility failed to ensure a safe environment was maintained related to medications at bedside and falls for 3 of 6 sampled residents (Residents 45, 5 and 22) when reviewed for accidents. Failure to ensure fall interventions were in place for Residents 22 and 5 and to assess and care plan self-medication administration for Resident 45 and placed residents at risk for avoidable injuries and a diminished quality of life. <FALLS> Review of facility document titled, Fall Protocols, undated, showed in the event of an actual fall the facility would implement a resident-centered fall prevention plan to reduce the specific risk factor of falls for each resident at risk or with a history of falls. If the falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. Resident 22 Resident 22 admitted to the facility on [DATE] with diagnoses that included diabetes (a disease that affects how the body uses blood sugar), disorder of the muscle, and peripheral vascular disease (a disorder of the blood vessels outside of the heart). The quarterly minimum data set assessment (MDS), dated [DATE], showed Resident 22 could make their needs known. Review of a fall incident report dated 11/12/2024 showed Resident 22 rolled out of bed onto the floor. Resident 22's care plan was updated on 11/17/2024 to ensure the call light was within reach and encouraged call light use and to ask for assistance. A physical therapy evaluation was ordered. The care plan showed the facility was to follow their fall protocol. Review of a fall incident report dated 12/31/2024 showed Resident 22 rolled out of bed onto the floor. Resident 22 sustained injuries and was sent to the emergency department (ED) for evaluation. Resident 22 was admitted to the hospital with a diagnosis of subarachnoid hematoma (blood in the brain) and a broken bone in the neck. Resident 22 remained in the hospital until 01/06/2025. Resident 22 was readmitted to the facility on [DATE]. Review of a fall incident report dated 01/06/2025 showed Resident 22 was found lying on the floor by staff at 9:30 PM. Resident 22 was assessed by a nurse, placed on neurological checks (an assessment of the brain), and placed on alert charting. Review showed Resident 22 was attempting to get out of the bed at 2:00 AM on 01/07/2025 and staff intervened. This fall and near fall resulted in Resident 22 returning to the ED for evaluation without admission the hospital. Review of the EHR showed Resident 22 did not have a new fall interventions put in place upon their return from the hospital on 01/06/2025. The facility failed to put a fall intervention in place after the fall on 01/06/2025 at 9:30 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a fall incident report dated 01/17/2025 showed Resident 22 had a fall by rolling out of bed. Review of the care plan showed a new fall care plan was put in place on 01/20/2025 with interventions of anticipate needs, bed in lowest position, assess for pain, overlay to mattress, and a pain medication review. During an interview on 03/14/2025 at 10:47 AM, Staff H, LPN/UM, stated all nurses were responsible for updating the care plan. Staff H stated an intervention should be put in place immediately after a resident fell . The interdisciplinary team (IDT) would then discuss the fall the next working day and put in place any additional interventions or alter current interventions. During an interview on 03/14/2025 at 11:12 AM, Staff N, Director of Rehabilitation, stated physical therapy evaluated Resident 22 post fall on 01/07/2025. Staff N stated this was an evaluation only and therapy gave no new recommendations. During an interview on 03/14/2025 at 11:30 AM, Staff B, DNS, stated it was the goal of the facility to put interventions in place to prevent residents from falling. Staff B stated the nurse on duty should make an immediate intervention, then the fall would be discussed in morning clinical meeting where the intervention would be reviewed to see if changes needed to be made to the current plan of care. Staff B stated all nursing staff was responsible to put fall interventions in place after a fall has occurred. Staff B stated it was their expectation there be an immediate intervention after each fall, and then it be documented in the notes and care plan. Resident 5 Review of the EHR showed Resident 5 readmitted to the facility on [DATE] with diagnoses that included diabetes, chronic kidney disease and congestive heart failure. Resident 5 was independent and able to make needs known. Review of incident logs for January, February and March 2025 showed Resident 5 had falls on 01/17/2025, 01/20/2025, 01/31/2025, 02/20/2025, and 03/01/2025. Review of Resident 5's care plan dated 01/21/2025 showed the resident was at risk for falls related to impaired balance and weakness. The care plan did not reflect any new interventions since 01/31/2025. Review of an incident report dated 02/20/2025 showed no interventions were implemented after Resident 5's fall. Review of an incident report dated 03/01/2025 showed an intervention for therapy to evaluate Resident 5 for an enabling grab bar for safe transfers. Observation on 03/13/2025 at 8:45 AM and on 03/14/2025 at 7:30 AM showed no grab bar present in Resident 5's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/13/2025 at 1:20 PM, Staff N, Director of Rehabilitation (DOR), stated they had completed the evaluation for Resident 5 and determined the assistive device was appropriate; however, Resident 45 needed a new bed. Staff N stated the information was sent to nursing for review. During an interview on 03/14/2025 at 8:06 AM, Staff H, LPN/UM, stated the expectation was that a new intervention was documented, care planned and implemented after each fall. Staff H stated they had not received any correspondence from therapy and should have followed up within a week on the status of the grab bar. During an interview on 03/14/2025 at 8:37 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was that fall interventions were care planned, implemented and revised if needed. Staff B stated the lack of communication between nursing and the therapy department did not meet expectations. <SELF-MEDICATION> Resident 45 Review of the electronic health record (EHR) showed Resident 45 admitted to the facility on [DATE] with diagnoses that included diabetes (too much sugar in the blood), cognitive deficit and atrial fibrillation (irregular and often very rapid heart rhythm). Resident 45 was able to make needs known. Observation and interview on 03/10/2025 at 9:40 AM showed six different colored pills on Resident 45's bedside table. Resident 45 stated nursing staff would usually leave the pills for them to take since the COVID outbreak on the 100 Hall. During an interview on 03/10/2025 at 9:42 AM, Staff W, Licensed Practical Nurse (LPN), stated leaving the medications at bedside was the resident's preference. Staff W stated Resident 45 would normally take the medications between 9:00-10:00 AM. Staff W stated there was no self-medication administration assessment and there should have been. During an interview on 03/14/2025 at 7:45 AM, Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM), stated Resident 45 should have had an assessment and order prior to the medications being left for self-administration. During an interview on 03/14/2025 at 8:27 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was residents who administered their own medications have an order, assessment and lockbox if applicable, prior to having access to their medications. Reference WAC 388-97 -1060 (3)(g) 51907

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to monitor and accurately document fluid restrictions (a diet which limits the amount of daily fluid intake) for 2 of 3 sampled residents (Residents 64 and 82) when reviewed for hydration and failed to follow provider's orders for 1 of 3 sampled residents (Resident 36) when reviewed for nutrition. This failure placed the residents at risk for medical complications and a diminished quality of life. Findings included . <FLUID RESTRICTION> Resident 64 Review of the electronic health record (EHR) showed Resident 64 admitted to the facility on [DATE] with diagnoses that included disorder of muscle, lymphedema (tissue swelling caused by an accumulation of fluid) and difficulty walking. Review of the admission minimum data set assessment (MDS) dated [DATE] showed Resident 64 was assessed to have lower extremity (legs) impairment of both sides. Observation on 03/12/2025 at 9:16 AM showed Resident 64 had a water pitcher on their bedside table, four small cups (some half full) of clear liquid, and two six-packs of Sprite on another table. Resident 64 put on their call light and requested their water pitcher be filled up, and staff came back with water pitcher full of ice and water. During an interview on 03/12/2025 at 9:28 AM, Resident 64 stated they did not believe they were on a fluid restriction because staff provided fluids all throughout the day as requested. Review of the EHR showed a provider's order for fluid restriction of 2000 milliliters (ml) per day, for nursing to provide 560 ml per day and dietary to provide 1440 ml per day. Review of the care plan dated 01/29/2025 showed a focus for fluid restriction with interventions of No fluids at bedside table, observe and document any instances of extra fluid intake consumed by the resident, and monitor and record fluid intake. Review of the nutrition task on 03/12/2025 showed no documentation of fluid intake. During an interview on 03/12/2025 at 9:51 AM, Staff H, Licensed Practical Nurse/Unit Manager (LPN/UM), stated they needed a to have a process to make certified nursing assistants (CNAs) were aware that a resident was on a fluid restriction. Staff H stated CNAs were to report fluid intake to the resident's nurse for documentation. During an interview on 03/14/2025 at 8:55 AM, Staff B, Director of Nursing Services (DNS), stated the expectation was the provider's order and care plan were followed. 46148 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 82 Review of the EHR showed Resident 82 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a chronic lung disease) and congestive heart failure (CHF, when the heart does not pump enough causing fluid buildup). The resident was able to make needs known. Observation on 03/10/2025 at 9:38 AM showed Resident 82 laid in bed. There was a full water pitcher on the overbed table. Observation and interview on 03/11/2025 at 10:22 AM showed Resident 82 laid in bed. There was a full water pitcher, a half empty bottle of soda on the overbed table, and a half drank bottle of water on the bedside table. Resident 82 stated they were aware they were on a fluid restriction and they do not drink the fluids on the meal trays. Review of the EHR showed a provider's order for fluid restriction of 2000 ml per day, for nursing to provide 560 ml per day and dietary to provide 1440 ml per day. Review of the March 2025 medication administration record (MAR) showed Resident 82 received from nursing the following liquids: 480 ml on 03/01/2025 720 ml on 03/03/2025, 03/04/2025 and 03/05/2025 620 ml on 03/06/2025 360 ml on 03/08/2025 320 ml on 03/09/2025 600 ml on 03/10/2025 Review of the nutrition task on 03/11/2025 showed no documentation of the amount of fluids consumed with meals. Review of the care plan dated 01/31/2025 showed a focus for fluid restriction with interventions to observe and document any instances of extra fluid intake consumed by the resident, and monitor and record fluid intake. During an interview on 03/12/2025 at 12:32 PM, Staff Q, Registered Dietician (RD), stated Resident 82 was not included on the list of residents currently on a fluid restriction that was provided to them by the facility. During an interview on 03/12/2025 at 10:32 AM, Resident 82's assigned nurse, Staff P, Licensed Practical Nurse (LPN), stated they would have to look at the orders to see if a resident was on a fluid restriction, and did not know of any residents who were on a fluid restriction. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/2025 at 11:27 AM, Staff B, DNS, stated Resident 82's fluids consumed should be documented in tasks, and nursing staff should be tracking the total amount consumed per day. Staff B stated Resident 82's water pitcher and bottled drinks at the bedside did not meet expectations. 38344 <NUTRITIONAL SUPPLEMENT> Resident 36 Review of the EHR showed Resident 36 admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), chronic obstructive pulmonary disease (COPD, blocks airflow making it difficult to breathe), and was able to make needs known. Review of the quarterly MDS dated [DATE] showed Resident 36 had a feeding tube (a flexible tube used to deliver nutrition and fluids directly into the stomach or small intestine). During an interview on 03/10/2025 at 12:19 PM, Resident 36 stated they were provided food through a feeding tube and orally. Review of the diet order dated 11/13/2024 showed Resident 36 was to receive a regular diet, regular texture, thin fluid consistency, for breakfast, lunch, and dinner and snacks per request and provide full fluid three times a day. Review of the March 2025 MAR from 03/01/2025 - 03/13/2025 showed an enteral feed (providing nutrition directly into the stomach or small intestine) provider order with a start date of 03/10/2025 for Resident 36 to be provided as needed, supplementing intake to optimizing nutrition, if oral intake was less than 50% at meals. It showed to bolus (a large volume of formula delivered at once through a feeding tube) one can of Glucerna 1.2 calorie (237 ml), and to flush the feeding tube with 30 ml of water before and after the bolus supplement administration. Documentation showed no supplementation was documented as provided from 03/10/2025 through 03/13/2025, and the areas to document were blank. Review of Resident 36's EHR of the task for percentage of meals eaten from 03/10/2025 - 03/13/2025 showed missing percentage of meal documentation for seven out of 12 opportunities. It showed a percentage of 0-25% was documented for dinner on 03/10/2025, lunch on 03/11/2025, and dinner on 03/12/2025. During an interview on 03/14/2025 at 12:13 PM, Staff H, LPN/UM, stated Resident 36's meal intake documentation was inconsistent with missing documentation and showed the resident had eaten less than 50% of meals three times. Staff H stated Resident 36's March 2025 MAR did not show the resident was provided a bolus supplement administration of Glucerna per provider orders and this did not meet expectations. During an interview on 03/14/2025 at 2:19 PM, Staff B, DNS, stated Resident 36's documentation for provider's order with a start date of 03/10/2025 for bolus supplement administration of Glucerna did not meet expectations. (continued on next page)

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	505289	A. Building B. Wing	03/14/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060 (3)(h)(i)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was administered in accordance with provider's orders and professional standards of practice for 1 of 2 sampled residents (Resident 36) when reviewed for enteral nutrition. The facility failed to ensure the amount of enteral formula (liquid food products) Resident 36 received was reconciled with the amount they were ordered to receive. This failure placed the residents at risk for inadequate nutrition, hydration, and other adverse outcomes. Findings included . Review of the electronic health record (EHR) showed Resident 36 admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), chronic obstructive pulmonary disease (COPD, blocks airflow making it difficult to breathe), had a feeding tube (a flexible tube used to deliver nutrition and fluids directly into the stomach or small intestine), and was able to make needs known. During an interview on 03/10/2025 at 12:19 PM, Resident 36 stated they were provided food through a feeding tube and orally. During an interview on 03/13/2025 at 2:45 PM, Staff X, Licensed Practical Nurse (LPN), stated Resident 36 received their enteral feedings starting at 7:00 PM via a feeding pump machine and it ran throughout the night until it got turned off around 8:00 AM or 9:00 AM. Review of the medication administration records (MAR) dated March 2025 from 03/01/2025 - 03/13/2025 showed a provider order with a start date of 12/17/2024 for Resident 36 to be provided one time a day of enteral feed Glucerna 1.2 calories at 65 milliliters (ml) per hour and 60 cubic centimeters (cc) water flushes per four hours via percutaneous endoscopic gastrostomy (PEG, a feeding tube inserted through the stomach wall and into the stomach to provide nutrition). It showed to start at 7:00 PM and off at 7:00 AM and was to run 12 hours until total volume of 780 ml was infused in 24 hours. Documentation showed a spot to document nurses' initials at 7:00 PM. This MAR did not show an area to document nurses initials for the time the feeding was to be turned off, or an area to document the total amount of ml fluids that were provided in a 24-hour period. During an interview on 03/14/2025 at 12:13 PM, Staff H, Licensed Practical Nurse/Unit Manager, stated Resident 36's enteral feeding documentation did not meet expectations because the March 2025 MAR did not show when the feeding was stopped and did not show the total amount of feeding provided to Resident 36 in a 24-hour period and it should have. During an interview on 03/14/2025 at 2:19 PM, Staff B, Director of Nursing Services, stated Resident 36's enteral feeding documentation should have showed an on, notation and an off, notation and the total amount provided in a 24-hour period and that did not happen for Resident 36. Staff B stated this did not meet expectations. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060 (3)(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 3 of 3 sampled residents (Residents 36, 5 and 82) reviewed for respiratory care. Failure to follow physician orders for oxygen (O2) therapy placed the resident at risk for unmet needs and potential negative outcomes. Findings included . Resident 36 Review of the electronic health record (EHR) showed Resident 36 admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), chronic obstructive pulmonary disease (COPD, blocks airflow making it difficult to breathe), and was able to make needs known. Observation on 03/10/2025 at 12:10 PM and 03/11/2025 at 11:49 AM showed an O2 concentrator (a device used to deliver O2) turned on with O2 flowing at a rate of two liters per minute connected to a nasal canula (a device/flexible tube with two prongs used to provide O2 through the nose) tubing hanging from the head bed board, not being used by Resident 36. During an interview on 03/10/2025 at 12:10 PM, Resident 36 stated they only used oxygen if they needed it; however, they did not need oxygen at that time. Observation and interview on 03/12/2025 at 1:59 PM showed the O2 concentrator turned on with O2 flowing at a rate of two liters per minute connected to a nasal canula that laid on the floor next to the left side of Resident 36's head of the bed. Resident 36 stated they did not need O2 at that time. Observation and interview on 03/13/2025 at 11:32 AM showed Resident 36 laid in bed with nasal canula in their nose with O2 running via O2 concentrator at two liters per minute. Resident 36 stated they had some difficulty breathing today so they got O2. Review of Resident 36's March 2025 treatment administration records (TAR) from 03/01/2025 - 03/13/2025 showed an order with a start date of 11/20/2024 to discontinue O2 therapy and continue to monitor O2 saturation (measuring the percentage amount of O2 in the blood) every shift and as needed. This TAR showed no parameters of what the O2 percentage should be and/or when to notify the provider. Review of Resident 36's EHR showed no active orders for O2. During an interview on 03/13/2025 at 2:50 PM, Staff X, Licensed Practical Nurse (LPN), stated Resident 36 did not have orders for O2. Staff X stated Resident 36 told them their spouse put on their O2 for them. Staff X stated the O2 concentrator should not have been in Resident 36's room. Staff X stated Resident 36's March 2025 TAR order to monitor O2 saturation should have had parameters and showed when to notify the provider and/or when to put the resident back on O2 depending on parameters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/2025 at 2:24 PM, Staff B, Director of Nursing Services (DNS), stated residents that received O2 therapy were required to have a provider's order. Staff B stated Resident 36 did not have an order for O2 and an O2 concentrator should not have been in Resident 36's room. Staff B stated Resident 36's order to monitor O2 saturations should have had parameters of O2 saturations and when to notify the provider when O2 saturations were out of parameters. Staff B stated Resident 36's respiratory care did not meet expectations. 46067 Resident 5 Review of the EHR showed Resident 5 readmitted to the facility on [DATE] with diagnoses that included diabetes, chronic kidney disease and congestive heart failure (CHF, when the heart does not pump enough causing fluid buildup). Resident 5 was independent and able to make needs known. Observations on 03/10/2025 at 1:36 PM, 03/12/2025 at 12:42 PM and 03/13/2025 at 10:33 AM showed Resident 5 received O2 set to three liters (L) per minute via a nasal canula that was connected to an O2 concentrator in place. Review of Resident 5's provider's orders showed an order dated 01/08/2025 for O2 at two L per minute via nasal cannula to keep oxygen above 90%. Review of Resident 5's care plan showed an intervention dated 01/21/2025 to administer oxygen as ordered. Review of the March 2025 MAR showed staff signed off on the provider's order to administer two L of O2 for dates 03/10/2025, 03/12/2025 and 03/13/2025. Observation and interview on 03/13/2025 at 10:54 AM, showed Staff T, LPN, observe Resident 5's O2 and stated it was set at three L and it should have been on two L. Staff T stated staff were to check the O2 setting on every shift. During an interview on 03/14/2025 at 8:35 AM, Staff B, DNS, stated the expectation was the provider's order was followed, and staff were checking the O2 level prior to signing off on the MAR. 46148 Resident 82 Review of the EHR showed Resident 82 admitted to the facility on [DATE] with diagnoses of COPD and CHF. The resident was able to make needs known. Review of the EHR showed a provider order with a start date of 01/31/2025 for oxygen to be provided at three L per minute through a nasal canula every shift for COPD. Observations on 03/10/2025 at 9:51 AM, 03/11/2025 at 1:16 PM, and 03/12/2025 at 10:50 AM showed oxygen being delivered at two L per minute through a nasal canula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/13/2025 at 9:39 AM, Staff P, LPN, stated they should check each shift if O2 was set correctly, and Resident 82 should be receiving three L per minute. During an interview on 03/13/2025 at 11:18 AM, Staff B, DNS, stated Resident 82 should have been checked once a shift for oxygen needs and they should be receiving the ordered amount. Reference WAC 388-97 -1060 (3)(j)(vi)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide non-pharmacological interventions (health interventions/approaches used instead of medication) for 2 of 11 sampled residents (Residents 26 and 88) when reviewed for unnecessary medications and/or pain management. This failure placed the residents at risk for receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included . Resident 26 Review of the electronic health record (EHR) showed Resident 26 readmitted to the facility on [DATE] with diagnoses to include anxiety disorder, high blood pressure, and chronic obstructive pulmonary disease (COPD, blocks airflow making it difficult to breathe). Resident 26 was able to make needs known. Review of the March 2025 medication administration records (MAR) from 03/01/2025 - 03/12/2025 showed an order with a start date of 05/27/2023 for Hydrocodone-Acetaminophen every six hours as needed for moderate to severe pain. Resident 26 was provided Hydrocodone-Acetaminophen 12 times either once or twice a day and there were no nonpharmacological interventions documented as provided prior to administration. During an interview on 03/14/2025, Staff B, Director of Nursing Services (DNS), stated non-pharmacological interventions should be offered/provided prior to administering an as needed pain medication. Staff B stated they were not aware that Resident 26 did not have non-pharmacological interventions documented prior to being provided as needed pain medications and this did not meet expectations. 46148 Resident 88 Review of the EHR showed Resident 88 admitted to the facility on [DATE] with diagnoses of surgical repair of severe cervical stenosis with myelopathy (when the spinal canal in the neck region narrows, leading to spinal cord compression) and diabetes (when the body cannot process sugar effectively). The resident was able to make needs known. During an interview on 03/11/2025 at 9:40 AM, Resident 88 stated they had back and knee pain all the time. Review of the EHR showed a provider's order dated 02/19/2025 for the pain medication tramadol every 12 hours as needed for pain. Review of the March 2025 MAR showed the resident received tramadol on 03/01/2025, 03/02/2025, 03/07/2025, 03/08/2025, and 03/09/2025 for pain rating of 5-6 on a scale of 1-10. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR showed an order dated 01/16/2025 to attempt non-pharmacological interventions prior to administering pain medications. On 03/01/2025, 03/02/2025, 03/07/2025, 03/08/2025, and 03/09/2025, non-pharmacological interventions were not attempted and were marked as not applicable (NA) on the MAR. During an interview on 03/13/2025 at 11:34 AM, Staff B, DNS, stated staff should have attempted non-pharmacological interventions prior to administering tramadol and marking NA did not meet their expectations. Reference WAC 388-97-1060 (3)(k)(i)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40817 Based on observation and interview, the facility failed to store and prepare food in manner which prevents food illness when reviewed for kitchen. This failure placed residents at risk for foodborne illness, avoidable discomfort, and a diminished quality of life. Findings included . Observation on 03/10/2025 at 9:09 AM showed the kitchen refrigerator contained a large undated ham. Observation showed diced turkey, diced ham, and opened hotdogs labeled 3/2025. Observation showed shredded cheese labeled 02/25/2025. Observation showed the kitchen freezer had food boxes stored on the floor. During an interview on 03/10/2025 at 9:46 AM, Staff BB, Dietary Manager, stated the boxes stored on the freezer floor were not to be stored there. Staff BB stated food being stored should have an open date when it was stored and good for seven days if removed from the original packaging. Observation on 03/11/2025 at 11:47 AM showed headphones and a cell phone charger placed in the corner of the kitchen on a counter containing peanut butter, food bags, and condiments. Observation on 03/11/2025 showed Staff CC, Dietary Aide, performed hand hygiene and turned off the water with bare hands at 12:12 PM and 12:42 PM. Observation at 12:34 PM showed Staff CC returned from the dining room and did not perform hand hygiene. Observation on 03/11/2025 at 12:25 PM showed Staff BB, Dietary Manager, removed a tray of hamburgers from the oven and placed them on the tray line without taking a temperature. Observation at 12:36 PM showed Staff BB removed a tray of fish from the oven and placed them on the tray line without taking a temperature During an interview on 03/13/2025 at 9:47 AM, Staff BB, Dietary Manager, stated food stored in the kitchen refrigerator should be labeled with open dates and kept for seven days. Staff BB stated the food labeling on 03/10/2025 did not meet expectation. Staff BB stated food placed on the tray line should have its temperature taken to ensure it was safe for consumption and the observations of hamburger and fish being placed on the tray line without temperature did not meet expectation. Staff BB stated hand hygiene should be performed when entering the kitchen and a paper towel should be used to turn off the water. Staff BB stated Staff CC's hand hygiene observations did not meet expectation. Staff BB stated personal items should be stored in the kitchen office and not in food preparation areas, and the observation of headphones and phone charger did not meet this expectation. During an interview on 03/13/2025 at 12:10 PM, Staff A, Administrator, stated stored food should be labeled according to dietary standards, food should have its temperature taken before being served, water should not be turned off with bare hand when performing hand hygiene, and personal items should not be stored in the food preparation area. Reference WAC 388-97-1100 (3), -2980

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to implement an effective antibiotic stewardship program to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use and decrease the development of adverse side effects and antibiotic resistance for 3 of 5 residents (Residents 418, 419 and 420) when reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics. Findings included . Review of the facility policy titled Antibiotic Stewardship Program, undated, showed antibiotic therapy should be based on the following guidelines: (if the infective pathogen is not known) or prophylactic therapy (given to prevent development of an infection) the therapy is prescribed using a narrow spectrum antimicrobial over the shortest duration possible to achieve therapeutic effectiveness, and if the infective agent is known - according to the microbiology results and susceptibilities. Resident 418 Review of the electronic health record (EHR) showed Resident 418 admitted to the facility on [DATE] with diagnoses including surgical repair of fracture, multiple sclerosis (a chronic autoimmune disease that affects the brain and spinal cord), and dementia. The resident received Bactrim (an antibiotic medication) for a urinary tract infection (UTI) upon return from the hospital on 12/03/2024. Review of the antibiotic line list for the month of December 2024 showed no culture had been reviewed for microbiology results and susceptibilities for Resident 418. Resident 419 Review of the EHR showed Resident 419 readmitted to the facility from a hospital visit on 01/02/2025 with diagnoses including cardiac and vascular implant infection and diabetes. The resident was prescribed Clindamycin (an antibiotic) for a UTI with a start date of 01/03/2025. Review of hospital notes showed a negative urinalysis indicating the resident did not have a UTI. Review showed no documentation Resident 419 was reviewed for microbiology results and susceptibilities or was reviewed for antibiotic stewardship. Resident 420 Review of the EHR showed Resident 420 admitted to the facility on [DATE] with diagnoses including encephalopathy (a general condition characterized by impaired brain function) and kidney stones and received ertapenem (a broad-spectrum antibiotic) with a start date of 11/24/2024. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a provider note dated 01/14/2025 showed, Concern for nephrolithiasis [kidney stone] related UTI despite being on suppressive therapy with ertapenum [sic]. Suspicion that current suppressive antibiotic was unable to treat infection. The resident continued the antibiotic through 02/25/2025. Review of the urinalysis results in the hospital documentation showed no growth. No documentation was found the resident was reviewed for microbiology results and susceptibilities or was reviewed for antibiotic stewardship. During an interview on 03/12/2025 at 2:43 PM, Staff G, Infection Preventionist/Registered Nurse, stated they currently did not request culture results for residents who were prescribed antibiotics at the hospital to review for microbiology results and susceptibilities or appropriateness of the prescribed antibiotic. During an interview on 03/14/2025 at 10:51 AM, Staff B, Director of Nursing Services, stated it was their expectation the infection preventionist review new antibiotic orders and cultures for the identified organism's susceptibility to the prescribed antibiotics. No associated WAC

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to ensure and document that each resident was informed about the benefits and risks of and had the opportunity to receive the influenza and pneumococcal vaccines unless medically contraindicated, refused or was already immunized for 4 of 5 sampled residents (Resident 87, 27, 92 and 78) when reviewed for immunizations. These failures placed the residents at an increased risk of viral infections, lack of knowledge to make an informed decision, and poor clinical outcomes. Findings included . Resident 87 Review of the electronic health record (EHR) showed Resident 87 was admitted on [DATE] with diagnoses of acute respiratory failure, asthma and diabetes. The resident was able to make needs known. Review of the EHR on 03/13/2025 showed no documentation that the resident received education on the risks and benefits of the pneumococcal vaccine and was offered, provided, refused or already received the vaccine. Resident 27 Review of the EHR showed Resident 27 was admitted on [DATE] with diagnoses of diabetes and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as viral infection or toxins in the blood). The resident was able to make needs known. Review of the EHR on 03/13/2025 showed no documentation that the resident received education on the risks and benefits of the influenza and pneumococcal vaccines and was offered, provided, refused or already received the vaccine. Resident 92 Review of the EHR showed Resident 92 was admitted on [DATE] with diagnoses of liver disease and kidney failure. The resident was able to make needs known. Review of the EHR on 03/13/2025 showed no documentation the resident received education on the risks and benefits of the influenza and pneumococcal vaccines when offered. Resident 78 Review of the EHR showed Resident 78 was admitted on [DATE] with diagnoses of gout (a form of inflammatory arthritis caused by crystals in the joints) and weakness. The resident was able to make needs known. (continued on next page)

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Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR on 03/13/2025 showed no documentation the resident received education on the risks and benefits of the influenza and pneumococcal vaccines and was offered, refused or already received the vaccines. During an interview on 03/14/2025 at 10:39 AM, Staff B, Director of Nursing Services, stated it was their expectation that all residents were provided education on the risks and benefits of the vaccines and offered/provided if appropriate on admission and annually and documented in the residents' EHRs. During an interview on 03/14/2025 at 12:46 PM, Staff A, Administrator, stated Residents 87, 27, 92 and 78 should have been educated on the risks and benefits of the vaccines, offered and administered if they needed on admission and this did not meet their expectations. Reference WAC 388-97-1340 (1), (2), (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505289	A. Building B. Wing	03/14/2025

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on interview and record review, the facility failed to ensure and document that each resident was informed about the benefits and risks of and had the opportunity to receive Covid-19 vaccine unless medically contraindicated, refused or was already immunized for 3 of 5 sampled residents (Residents 87, 27, and 92) when reviewed for immunizations. This failure placed the residents at an increased risk of Covid-19 infections, lack of knowledge to make an informed decisions and poor clinical outcomes. Findings included . Resident 87 Review of the electronic health record (EHR) showed Resident 87 was admitted on [DATE] with diagnoses of acute respiratory failure, asthma and diabetes (too much sugar in the blood). The resident was able to make needs known. Review of the EHR on 03/13/2025 showed no documentation that the resident received education on the risks and benefits of the Covid-19 vaccine and was offered, provided, refused or already received the vaccine. Resident 27 Review of the EHR showed Resident 27 was admitted on [DATE] with diagnoses of diabetes and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as viral infection or toxins in the blood). The resident was able to make needs known. Review of the EHR on 03/13/2025 showed no documentation that the resident received education on the risks and benefits of the Covid-19 vaccine and was offered, provided, refused or already received the vaccine. Resident 92 Review of the EHR showed Resident 92 was admitted on [DATE] with diagnoses of liver disease and kidney failure. The resident was able to make needs known. Review of the EHR on 03/13/2025 showed no documentation the resident received education on the risks and benefits of the Covid-19 vaccine and was offered, provided, refused or already received the vaccine. During an interview on 03/14/2025 at 10:39 AM, Staff B, Director of Nursing Services, stated it was their expectation all residents were provided education on the risks and benefits of the Covid-19 vaccine and offered/provided if appropriate on admission and annually and documented in the resident's EHR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/14/2025 at 12:46 PM, Staff A, Administrator, stated Residents 87, 27, and 92 should have been educated on the risks and benefits of the Covid-19 vaccine, offered and administered if they needed on admission and this did not meet their expectations. No associated WAC