STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505290	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard Bremerton, WA 98310

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation and interview, the facility failed to respect and value the residents' private space by not knocking and/or announcing themselves for 3 of 4 sampled residents (Resident 19, 48 & 63) reviewed under resident rights for dignity. This failure placed residents at risk for being treated with lack of dignity and a diminished quality of life. Findings included . Facility policy titled Residents Rights, revised 11/23/2016, documented, The resident has a right to dignified existence, self-determination and communication with, and access to individuals and services inside and outside the Facility. On 11/04/2024 at 10:34 AM, Staff F, Certified Nursing Assistant (CNA), walked into room [ROOM NUMBER]B without knocking or announcing themself. At 10:46 AM, when asked about how staff show dignity to residents before entering a resident room, Staff F said knocking on the door and introducing myself. When asked if it was acceptable to walk in without knocking or announcing themselves, Staff F said no, I should have knocked. At 11:05 AM, Staff G, Housekeeping, walked into room [ROOM NUMBER]A without knocking or announcing themself. When asked about knocking and announcing, Staff G said I forgot. At 11:30 AM, while in an interview with Resident 19, Staff H, CNA/Shower Aid, walked into the room without knocking or announcing themself. Staff H observed Resident 19 in an interview, turned around and walked out of the room. At 3:12 PM, Staff G, Housekeeping, walked into to room [ROOM NUMBER] without knocking or announcing themself. On 11/12/2024 at 10:05 AM, Staff E, Resident Care Manager, said it is expected staff are knocking and/or announcing themselves before entering a resident's room. When multiple incidents reported of failure to knock and/or announcing before walking into a residents room, Staff E said that was not acceptable and we need to retrain. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:45 PM, Staff B, Director of Nursing Services, said staff were expected to knock and announce themselves before entering a resident's room. Staff B said this was not acceptable. WAC 388-97-0180 (2)

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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** 50945 Based on record review and interview, the facility failed to ensure that residents had signed consent prior to psychotropic (group of drugs to treat mental health conditions) medication administration and that residents had the correct risks and benefits provided, for 1 of 5 residents (Resident 21) reviewed for unnecessary medications. This failure placed residents at risk of receiving medication without knowledge of the medication or correct side effects, and a decreased quality of life. Findings included . Review of the Electronic Health Record (EHR) showed Resident 21 was admitted to the facility on [DATE]. Resident 21 had diagnoses of depression (overwhelming feeling of sadness and hopelessness) and dementia (condition affecting memory and thinking) with psychosis (detachment from reality). Review of the Annual Minimum Data Set, an assessment tool, dated 08/26/2024, showed Resident 21 was dependent on staff for care. <Consent Form> Resident 21 was prescribed risperidone, which is an antipsychotic medication (decreases thoughts and feelings that are not based on reality). Review of the EHR showed that consent was signed on 08/31/2023 for risperidone using an anticonvulsant (decreases seizure activity) form, 12/12/2023 for risperidone on an antianxiety (decreases stress) form, and then 05/3/2024 for risperidone on an antipsychotic form. Review of the three consent forms used for risperidone showed different common side effects were listed based on drug classification. The anticonvulsant consent form for Resident 21 listed most common side effects being: nausea/vomiting, appetite changes, sedation/drowsiness, dizziness, blurred vision. The antianxiety consent form listed frequent side effects being: drowsiness, dizziness, drunken walk, and disorientation. The antipsychotic consent form listed frequent side effects being: drowsiness, jaundice (yellowing of the skin), shakiness, blurred vision, restlessness, skin rash, dizziness, and urinary retention. During an interview on 11/13/2024 at 1:44 PM, Staff C, Resident Care Manager (RCM), said that Resident 21's consent forms with different classifications did not review the correct risks and benefits for risperidone. During an interview on 11/13/2024 at 9:04 AM, Staff B, Director of Nursing Services (DNS), said their expectation was that risperidone would be classified as an antipsychotic and that consent would have been signed for Resident 21 based on this classification. < Medication before Consent> Review of the EHR showed that Resident 21 signed consent for venlafaxine (an antidepressant) on 05/17/2024. Review of the administration record showed that Resident 21 had doses of venlafaxine before consent was signed, with administration starting on 05/03/2024. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/2024 at 1:44 PM, Staff C, RCM, reviewed the EHR, said Resident 21 received venlafaxine on 05/03/2024 and their expectation was that consent would have been obtained before the first dose of venlafaxine. During an interview on 11/13/2024 at 9:04 AM, Staff B, DNS, said their expectation was that prior to giving venlafaxine, the facility would have obtained consent for Resident 21. Reference WAC 388-97 -0300(3)(a), -0260, -1020(4)(a-b)

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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** 37044 Based on interview and record review, the facility failed to ensure resident choices regarding bathing frequency were honored for 2 of 4 residents (Residents 376 and 176) reviewed for choices. The facility's failure to accommodate resident preferences related to frequency and type of bathing placed residents at risk for feelings of un-cleanliness, powerlessness, diminished self-worth, and a decreased quality of life. Findings included . 1) Resident 376 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 11/05/2024, showed the resident was cognitively intact, required physical assistance with bathing, and choices related to bathing were identified as Very Important. On 11/04/2024 at 2:59 PM, Resident 376 reported that they were not asked how many or what type of bathing they preferred. Rather, upon admission they were informed they would get one shower a week on Sundays. Since I have been here, I have had one shower (resident made air quotes with her fingers.) All she did was put some stuff in my hair, didn't wash my back or legs or use soap. They just ran the water over me and that is it. That is not a shower. Resident 376 said they showered daily at home but indicated it would be acceptable if they were showered three times a week while at the facility. An activities of daily living (ADL) care plan, initiated 10/30/2024, directed staff to provide one person assistance with bathing weekly and as necessary. Resident 376's bathing record showed they were scheduled to be bathed/showered once a week on Sundays. Review of the electronic health record (EHR) showed there was no documentation present to show the facility promote or attempted to facilitate resident self-determination through support of resident choice. 2) Resident 176 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact, required physical assistance with bathing, and choices related to bathing were identified as Very Important. On 11/04/2024 at 3:38 PM, Resident 176 said they were not asked about the type or frequency of bathing they preferred. The resident reported staff just informed them that they would be showered one day per week. Resident 176 said they preferred daily showers but while at the facility, they wanted one at least every three days. An ADL care plan, revised 10/30/2024, showed the resident required substantial assistance with bathing. The care plan did not identify the frequency of bathing. Resident 176's bathing record showed they were scheduled to be bathed/showered once a week. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR showed there was no documentation present to show the facility promoted or attempted to facilitate resident self-determination through support of resident choice. On 11/12/2024 at 1:18 PM, Staff C, Resident Care Manager, said initially all residents were assigned one shower a week upon admission, but the frequency could be changed at resident request or during the initial care conference to their desired frequency. On 11/13/2024 at 12:41 PM, Staff B, Director of Nursing Services, said residents should be asked their desired method and frequency of bathing. When asked why Staff C, who was performing admissions, said residents were initially assigned one shower a week upon admission, but could be changed later if requested Staff B explained the facility had identified problems with the shower schedules so they went through and revised the schedules and used a default of one shower per week as a start off point. Then they would personalize the schedules over time based on residents' feedback. Reference WAC 388-97-0900 (1)(3)

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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** 46793 Based on interview and record review the facility failed to provide an Advanced Directive (AD, a written instruction of health care directions) for 4 of 5 sampled residents (Residents 59, 28, 43 & 60) reviewed for ADs. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . 1) Resident 59 was admitted to the facility on [DATE]. The Quarterly Minimal Data Set (MDS, an assessment tool), dated 10/10/2024, documented Resident 59 was cognitively intact. Resident 59's Electronic Health Record (EHR), documented an AD receipt was signed by Resident 59 on 10/15/2024, indicating Resident 59 had chosen not to formulate an AD at this time. Review of Resident 59's EHR documented, prior to 10/15/2024, no other attempts to offer or assist Resident 59 with formulating an AD. On 11/06/2024 at 2:43 PM, Staff I, Patient Advocacy Resource, said he was unable to locate any other AD's for Resident 59. At 2:54 PM, Staff B, Director of Nursing Services (DNS), said AD's had not been completed, this had been identified as an issue and a Performance Improvement Plan (PIP) had been completed to correct the issue. 37044 2) Resident 28 admitted to the facility on [DATE]. Review of their EHR showed no AD or AD receipt was present. On 11/06/2024 at 2:43 PM, Staff I, Patient Advocacy Resource, said they were unable to locate documentation to show the facility had asked Resident 28 if they had an AD and/or informed them of their right to formulate one. Staff I acknowledged that this should have occured as part of the admission process. 50392 3) Resident 43 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE] documented Resident 43 was moderately cognitively impaired. No AD or AD receipt was found in the EHR. On 11/08/2024 at 12:18 PM, Staff I, Patient Advocacy Resource, said that an AD or AD receipt should have been done upon admission. When asked if it was done for Resident 43, Staff I said he would follow up on it. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/2024 at 9:00 AM, Staff I said he was unable to locate an AD or AD receipt for Resident 43, and that it should have been done by this time. 4) Resident 60 was admitted to the facility on [DATE]. The Admission MDS dated [DATE] documented Resident 60 was cognitively intact. No AD or AD receipt was found in the EHR. On 11/08/2024 at 12:18 PM, Staff I, Patient Advocacy Resource, said that an AD or AD receipt should have been done upon admission. On 11/12/2024 at 9:01 AM, when asked if he was able to locate an AD or AD receipt for Resident 60, he said he was unable to locate them. When asked if it should have been done by now, Staff I said yes. Reference WAC 388-97-0280 (3)(c)(i-ii)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation and interview the facility failed to maintain a safe, clean and comfortable environment through maintenance of the hallway and dining room carpets for 3 of 3 halls (Olympic, Mountainview and Medicare) observed. This failure has the potential to place residents at risk for not having a homelike environment and a diminished quality of life. Findings included . On 11/05/2024 at 11:41 AM, in the hallway with room [ROOM NUMBER], near the double doors there were worn areas and stains observed on the carpet and blue tape on the carpet appeared to prevent the carpet from peeling up. On 11/12/2024 at 4:19 PM Staff A, Administrator, said the carpets needed to be replaced and she has a contractor that should be starting the work within the next 30 days. 37044 <Olympic Hallway> On 11/13/2024 at 11:02 AM, observation of the carpet in the activity room in the Olympic Hallway showed the carpet was worn and heavily soiled. There was a three by four-foot circular stain just inside and to the right of the entrance. Five additional one by one-foot dark brown circular stains with distinct edges were noted on the carpet throughout the room. The stains appeared to be the result of spilled liquids that had dried prior to being cleaned up. On 11/05/2024 at 1:12 PM, Staff C, Resident Care Manager, said the activity room had been previously used as the assist dining room. <Mountainview Hallway> On 11/13/2024 at 11:04 AM, observation of the carpet in front of the first kiosk in the Mountainview hallway showed the carpet had been cut in multiple places and replaced with non-matching carpet (different color and pattern). An approximately eight-foot by four-foot section of carpet had been replaced with darker brown carpet with a different pattern and an approximately 18 foot by three-foot section had been replaced with light brown carpet of a different pattern. The seams (between the carpet patches and the original carpet) had been secured with black duct tape. 50488 <Medicare Hallways> Medicare A and Medicare B Nurses station and hallways (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/04/2024 at 1:00PM, two dinner plate sized dark brown stains were seen on the carpet by the Medicare hall nurse's station. A large, approximately three-feet by three-feet, dark brown stain was seen outside of room [ROOM NUMBER] and another slighly smaller stain was seen outside of room [ROOM NUMBER]. Several squares of carpet up and down the hallways were coming up at the seams. The squares under the fire doors outside of the nurse's station had blue, black, and tan peices of tape holding the seams together. The transition was missing between the hallway carpet and the hard surface flooring for room [ROOM NUMBER]. On 11/05/2024 at 1:23 PM, Staff M, Maintenance Supervisor, was asked about the condition of the carpets. He said that he knew they were in bad shape, and that he was trying to replace them. He stated, There has just been too much red tape. Reference WAC 388-97 -0880

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to ensure grievances were initiated, logged, investigated, and/or promptly resolved/responded to for 1 of 1 residents (Resident 40) and the Resident Council reviewed for grievances. This failure placed residents at risk for feelings of frustration, powerlessness, and a decreased quality of life. Findings included . Review of the facility's policy titled Grievances, revised 02/01/2017, showed that general concerns could be voiced at Resident Council (a group of residents that meet regularly to discuss living at the facility) meetings, and that the concern would be evaluated and investigated. A response would occur within three working days to the individual with the concern, to acknowledge the steps taken for resolution. <Resident Greivance> Resident 40 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessement tool), dated 10/17/2024, documented Resident 40 was cognitively intact. On 10/22/2024, Resident 40 filed 2 grievances: 1) Resident 40 documented residents were not receiving restorative services due to restorative aides being pulled from assigned job, due to staff shortages. 2) Resident 40 documented residents were not getting showers due to shower aides being pulled from assigned job, due to staff shortages. Neither grievance was documented on the Grievance log. Grievances were not addressed until 11/05/2024 (14 days later). On 11/12/2024 at 12:45 PM, Staff B, Director of Nursing Services, said the process for grievances included completing the grievance form, and turning it into Social Services (SS) who would review it and speak with the resident. Once all questions were answered, SS would review it with the DNS and Administrator, who would sign off on the grievances. Then the form would be uploaded into the EHR. Staff B said all grievances concerns were discussed in stand-up meeting. When shown the missing grievances not filed on the Grievance log, Staff B said the grievances should have been documented on the Grievance log. 50945 <Resident Council> During an interview with members from the Resident Council on 11/06/2024 at 1:00 PM, concerns were brought forward about the grievance process. When asked if the facility considers their views and acts promptly to resolve grievances and implement recommendations, the Resident Council members said not normally. One member said they had filed five grievances and only heard back from the facility twice. Another member said they felt like they did not have anyone to go to with a grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of recent Resident Council meeting minutes, multiple dates had concerns brought up without grievances filed. During the 05/21/2024 meeting, a concern was brought up about sufficient staffing and no grievance was filed. During the 08/20/2024 meeting, a concern was brought up about appointment notifications and no grievance was filed. During the 09/17/2024 meeting, concerns were brought up about blood glucose meters, when more staffing would happen, and about pharmacy services, without these concerns filed as grievances. During the 09/17/2024, a grievance was filed on the behalf of the Resident Council, related to wanting to know ahead of time about appointments. The grievance form did not include any notification to the Resident Council on the resolution. During an interview on 11/13/2024 at 11:10 AM, Staff S, Activities Director, confirmed that 05/21/2024, 08/20/2024, and 09/17/2024 meetings had concerns that should have been filed as grievances and were not listed on the grievance log. For the 09/17/2024 grievance that was filed related to appointment notification, Staff S said it did not meet expectations that there were no listed resident council members for notification of the resolution. During an interview on 11/14/2024 at 1:50 PM, Staff B, DNS, stated the 05/21/2024, 08/20/2024, and 09/17/2024 meetings did not meet expectations for filing grievances, and that the 09/17/2024 grievance should have documented who it notified. Reference WAC 388-97-0460

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident and/or their representative for 4 of 4 sampled residents (Residents 18, 40, 16 & 60), reviewed for hospitalization . This failure placed the resident and/or their representative at risk for not having an opportunity to make informed decisions about transfers/discharges. Findings included . Review of the facility's policy section, Admission/Discharge/Transfer, revised in 11/2016, said Information shall be provided to the resident and/or his/her representative in a language they can understand at the time of .transfer to the general acute hospital. 1) Resident 18 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS), an assessment tool, dated 08/05/2024, documented the resident was cognitively intact. A review of Resident 18's progress notes in the electronic health record (EHR) showed Resident 18 transferred to the hospital on 06/11/2024 and discharged from the hospital and returned to the facility on [DATE]. A review of the EHR did not show documentation that Resident 18 was offered and/or provided a transfer/discharge notice. On 11/12/2024 at 12:47 PM Staff K, Resident Care Manager (RCM)/Registered Nurse (RN) said she did not see a transfer notice in Resident 18's chart. At 1:29 PM Staff B, Director of Nursing Services (DNS), said she did not have a transfer notice, and her expectation was that there would be one. 46793 2) Resident 40 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 40 was cognitively intact. Resident 40's EHR showed Resident 40 was transferred to the hospital on 07/01/2024 and discharged from the hospital and returned to the facility on [DATE]. Resident 40's EHR did not show documentation that Resident 40 was offered and/or provided a transfer/discharge notice. On 11/12/2024 at 10:05 AM, Staff E, RCM/RN, said when completing a resident transfer to the hospital, a assessment in the EHR should be completed. Staff E said the resident should be sent to the hospital with a transfer form, most recent orders, progress notes, history and profile, labs results and vitals. Staff E said the transfer notice was not completed for Resident 40, but should have been. At 12:45 PM, Staff B, DNS, said the transfer notification was not completed for Resident 40 and should have been. (continued on next page)

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	505290	A. Building B. Wing	11/14/2024

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50392 3) Resident 16 admitted to the facility 07/17/2019. The Annual MDS dated [DATE], documented that Resident 16 was cognitively intact. Resident 16 was hospitalized from 03/16/2024 until their return on 03/20/2024. The EHR showed no documentation of a transfer notice. 4) Resident 60 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented that Resident 60 was cognitively intact. Resident 60 was hospitalized from 09/13/2024 until their return on 09/19/2024. The EHR showed no documentation of a transfer notice. On 11/08/24 12:37 PM, Staff B, DNS, said she had no transfer notices for Resident 16 and Resident 60, and that the notices should have been completed. Reference WAC 388-97-0120 (2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to provide a bed hold notice to the resident and/or their representative for 3 of 4 sampled residents (Residents 40, 16 &60), reviewed for hospitalization . This failure placed the resident and/or their representative at risk for not having an opportunity to make informed decisions about bed hold and a diminished quality of life. Findings included . 1) Resident 40 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (MDS, an assessment tool), dated 10/17/2024, documented Resident 40 was cognitively intact. Resident 40's Electronic Health Record (EHR) showed Resident 40 was transferred to the hospital on 07/01/2024 and discharged from the hospital and returned to the facility on [DATE]. Resident 40's EHR did not show documentation that Resident 40 was offered and/or provided a bed hold notice. On 11/12/2024 at 10:05 AM, Staff E, Resident Care Manager/Registered Nurse, said Social Services completed bed hold notifications, but could not locate a bed hold notice in the EHR. At 12:45 PM, Staff B, Director of Nursing Services, said the bed hold notification was not completed for Resident 40 and should have been. 50392 2) Resident 16 admitted to the facility 07/17/2019. The Annual MDS, dated [DATE], documented that Resident 16 was cognitively intact. Resident 16 was hospitalized from 03/16/2024 until their return on 03/20/2024. The EHR showed no documentation of a bed-hold notice for the transfer. 3) Resident 60 was admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented that Resident 60 was cognitively intact. Resident 60 was hospitalized from 09/13/2024 until their return on 09/19/2024. The EHR showed no documentation of a bed-hold notice for transfer. On 11/08/24 at 12:37 PM, Staff B, DNS said she had no bed-hold notices for Resident 16 and Resident 60's transfer, and the notices should have been completed. Reference WAC 388-97-0120 (4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS, an assessment tool) accurately reflected the status for 6 of 25 sampled residents (Residents 53, 10, 21, 56, 176 & 23) reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . 1) Resident 53 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 53 was moderately cognitively impaired, had a weight loss of 5% or more and was on a prescribed weight loss program. On 11/12/2024 at 12:45 PM, Staff B, Diretor of Nursing Services (DNS), said when a Resident was on a prescribed weight loss program the facility should be monitoring weights weekly with the interdisciplinary team, the Registered Dietitian should be completing weekly reviews, and there must a Physician order for the diet plan. Staff B said the Resident must be involved in the weigh loss program too. When asked about Resident 53's weight loss program, Staff B said Resident 53 was not on a weight loss program, the resident was expected to lose weight due to diuretic use. When shown the MDS coding, Staff B, said the MDS was incorrect. 50945 2) Review of the EHR showed Resident 10 was admitted to the facility on [DATE]. Resident 10 had diagnoses of heart failure, muscle weakness, and end stage renal disease (kidneys no longer work at a level to keep you alive without medical interventions). Review of the Quarterly MDS, dated [DATE], showed Resident 10 had no identified weight loss. Review of Resident 10's Nutrition and Hydration Risk Evaluation, dated 11/01/2024, showed Resident 10's weight status had either a greater than 5% weight loss in last one month or a greater than 10% weight loss in last six months. During an interview on 11/12/2024 at 11:36 AM, Staff D, MDS Assistant, said that Resident 10 did have weight loss and it should have been coded on the MDS assessment. During an interview on 11/12/2024 at 4:25 PM, Staff B, DNS, said that it did not meet expectations that Resident 10's weight loss was not recognized on the MDS assessment. 3) Review of the EHR showed Resident 21 was admitted to the facility on [DATE]. Resident 21 had a suprapubic catheter (urinary tube that is placed into the bladder through a small hold in the abdomen, the tube carries urine outside of the body and is connected to a drainage bag that collects urine). Review of the Annual MDS, dated [DATE], showed Resident 21 had an indwelling catheter (thin, flexible tube), which included suprapubic catheters. The MDS also had selected ostomy (an artificial opening in an organ of the body creating a stoma, which is a protruding red and round area on the surface of the abdomen). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/08/2024 at 9:06 AM, Staff D, MDS Nurse, said that a suprapubic catheter was not an ostomy. During an interview on 11/12/2024 at 4:29 PM, Staff B, DNS, stated that Resident 21 did not have an ostomy, this was an error, and it did not meet expectations that an ostomy was coded on the 08/26/2024 MDS. 4) Review of the EHR showed Resident 56 was admitted to the facility on [DATE]. Resident 56 had no active diagnosis of depression. Review of Resident 56's 09/19/2024 Medicare 5-Day MDS, showed a diagnosis of depression was selected. During an interview on 11/08/2024 at 8:39 AM, Staff C, RCM, said that Resident 56 did not have a diagnosis of depression on the diagnosis list. Staff C reviewed the MDS for 09/19/2024 and said that they would need to update the MDS due to the miscode. During an interview on 11/12/2024 at 4:14 PM, Staff B, DNS, stated that their expectation for the 09/19/2024 MDS was that it would not say a diagnosis of depression. 37044 5) Resident 176 admitted to the facility on [DATE]. The Admission MDS, dated ,d+[DATE]//2024, showed the resident's pneumococcal vaccination was not up to date and had not been offered. A Resident Consent For Influenza, Pneumococcal, and COVID-19 Vaccination form, dated 10/18/2024, showed Resident 176 was offered and consented to the pneumococcal vaccination. On 11/12/2024 at 3:38 PM, Staff D, MDS Assistant, stated, Yes, [the pneumococcal vaccination] was offered and acknowledged the MDS was incorrectly coded. 6) Resident 23 admitted to the facility on [DATE]. A 08/30/2024 order was obtained to start the resident on Risperdal (an antipsychotic medication) for dementia with psychotic disturbance and severe anxiety. A Level II Preadmission Screening and Resident Review (PASRR) evaluation, dated 06/30/2024, showed the evaluator determined the resident had indicators of serious mental illness including major neurocognitive disorder with underlying psychosis, anxiety and mood disorders. Review of the Quarterly MDS, dated [DATE], showed the resident received antipsychotic medication but did not have active diagnoses of psychosis, anxiety or depressive disorders. On 11/14/2024 at 12:03 PM, Staff D, MDS Assistant, said they should have coded psychotic, anxiety and depressive disorder on Resident 23's MDS, but failed to do so. Reference WAC 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on interview and record review the facility failed to ensure that the Pre-Admission Screening and Resident Review (PASRR, a screening tool used to identify mental health needs) was accurate and a referral for Level II PASRR was sent in a timely manner for 2 of 5 sampled residents (Residents 60 and 56) reviewed for PASRR. This failure placed residents at risk for not receiving specialized mental health services, and a decreased quality of life. Findings included . 1) Resident 60 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool) dated 09/25/2024 documented that Resident 60 was cognitively intact and had a diagnosis of depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.) A Level I PASRR, dated 09/05/2024 documented that Resident 60 was diagnosed with anxiety disorders (mental health disorders characterized by intense, excessive, and persistent worry and fear about everyday situations.) Review of the Electronic Health Record (EHR) documented that Resident 60 was not diagnosed with anxiety but did have a diagnosis of depression. The Level I PASRR indicated that Resident 60 had an exempted hospital discharge which would not require a Level II evaluation due to anticipated stay of less than 30 days at the facility resident was to be transferred to. The Level I PASRR indicated that a Level II evaluation must be completed if discharge does not occur in 30 days. On 11/08/2024 at 12:24 PM, Staff I, Patient Advocacy Resource, said that a Level II PASRR referral was not sent until 11/06/2024 and it should have been sent 30 days after resident's admission on 09/06/2024. On 11/14/2024 at 2:42 PM, Staff C, Resident Care Manager (RCM), said that Resident 60 did not have a diagnosis of anxiety, but did have a diagnosis of depression. When asked if the Level I PASRR was accurate, Staff C said according to the EHR the Level I PASRR was inaccurate and it did not meet expectations that this was not identified. On 11/14/2024 at 2:48 PM, Staff B, Director of Nursing Services (DNS), said she did not see a diagnosis of anxiety in the EHR, but did see a diagnosis of depression and her expectation was for the Level I PASRR to match the diagnosis. 50945 2) Review of the EHR showed Resident 56 was admitted to the facility on [DATE]. Resident 56 had no active diagnosis of depression or mood disorders. Review of Resident 56's admission Level 1 PASRR, dated 09/13/2024, showed no serious mental illness indicators. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 56's updated Level 1 PASRR, dated 09/18/2024, showed Resident 56 had a serious mental illness indicator, with mood disorder- depressive or bipolar selected. During an interview on 11/08/2024 at 8:39 AM, Staff C, RCM, said that Resident 56 did not have a diagnosis of depression on the diagnosis list and the Level 1 PASRR from 09/18/2024 was coded incorrectly. During an interview on 11/12/2024 at 4:14 PM, Staff B, DNS, said that the updated Level 1 PASRR for Resident 56, dated 09/18/2024, was not accurate. Reference WAC 388-97-1915 (1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 25 sampled residents (Resident 56 and 126). This failure placed residents at risk for unidentified/ unmet care and safety needs, and a diminished quality of life. Findings included . 1) Review of the Electronic Health Record (EHR) showed Resident 56 was admitted to the facility on [DATE]. Resident 56 had diagnoses that included surgical amputation (removal of a limb), muscle weakness, and hypertension (high blood pressure). The Medicare 5-day Minimum Data Set Assessment (MDS, an assessment tool), dated 11/04/2024, showed Resident 56 needed assistance from staff for activities such as transferring to and from bed to a wheelchair or going from a sitting to a standing position. <Activities> Review of Resident 56's Activity Assessment, dated 09/26/2024, showed that Resident 56 enjoyed various activities including exercise groups, puzzles, and men's group. During an interview on 11/04/2024 at 2:34 PM, Resident 56 said they liked to exercise and were interested in the facility's more active programs. During an interview on 11/08/2024 at 1:01 PM, Staff C, Resident Care Manager (RCM), said the care plan should include resident specific likes or preferences for certain activities. Staff C said there was not an activity care plan for Resident 56. During an interview on 11/12/2024 at 4:06 PM, Staff B, Director of Nursing Services (DNS), said their expectation was for Resident 56 to have had a care plan for activities. <Edema> Review of Resident 56's progress notes showed that Resident 56 had documented edema. Review of Resident 56's care plans showed there was not a triggered care plan for edema with interventions or goals. During an interview on 11/12/2024 at 9:44 AM, Staff C, RCM, said Resident 56 had edema that was being noted in the progress notes. Staff C reviewed Resident 56's care plan and stated that their expectation was that Resident 56 would have had a care plan on edema, or have had an existing care plan expanded to include interventions for edema. During an interview on 11/12/2024 at 4:06 PM, Staff B, DNS, said a care plan should include sections on focus, interventions, and goals. Staff B said they would expect an edema care plan for Resident 56. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Negative Pressure Wound Treatment> Review of Resident 56's care plan for alteration in skin integrity showed an intervention initiated on 11/06/2024 for negative pressure wound treatment (a technique that uses suction to promote wound healing) to the left plantar foot wound. During an interview on 11/12/2024 at 9:44 AM, Staff C, RCM, said that Resident 56 had a care plan with the wrong extremity listed, and that it was Resident 56's right side (amputation wound) not left side that was receiving negative pressure treatment. During an interview on 11/12/2024 at 4:08 PM, Staff B, DNS, said it did not meet expectation the wrong extremity was listed in the care plan for Resident 56. 2) Review of the EHR showed Resident 126 was admitted to the facility on [DATE]. Resident 126 had diagnoses of sepsis (bloodstream infection) and cellulitis (bacterial skin infection). Review of the Medicare-5 Day MDS, dated [DATE], showed that Resident 126 received intravenous (through a vein) antibiotics. Review of the EHR showed that Resident 126 had a single lumen peripherally inserted central catheter (PICC, a thin long tube that goes through a vein in the arm and goes to the larger veins near the heart for giving medications). During an interview on 11/08/2024 at 7:49 AM, Staff C, RCM, reviewed Resident 126's care plans and said they were unable to find a care plan for Resident 126's PICC. Staff C said their expectation was that there would be a care plan that addressed the PICC. During an interview on 11/12/2024 at 4:30 PM, Staff B, DNS, said their expectation for a resident with a central line was for it to be care planned, and it did not meet expectations that Resident 126 did not have this care planned. 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** 37044 Based on interview and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 7of 35 residents (Residents 62, 176, 376, 67, 23, 28, and 21) whose care plans were reviewed. These failures placed residents at risk for unmet care needs and diminished quality of life. Findings included . 1) Resident 62 admitted to the facility on [DATE]. An Activities of Daily Living (ADL) self-performance CP, revised 04/26/2024, directed staff to provide one person assistance with bathing per the resident's chosen schedule. The care plan did not identify what the resident's chosen bathing schedule was. 2) Resident 176 admitted to the facility on [DATE]. On 11/04/2024 at 3:38 PM, Resident 176 said they wanted a shower at least every three days but was scheduled for only one. An ADL CP, revised 10/30/2024, showed the resident required substantial assistance with bathing. The care plan did not identify the resident's desired type (shower, bath, bed bath, etc.) or frequency of bathing. 3) Resident 376 admitted to the facility on [DATE]. On 11/04/2024 at 2:59 PM, Resident 376 reported they wanted to be showered at least three times a week but was scheduled for only one. An ADL care plan, initiated 10/30/2024, showed the resident required substantial assistance with bathing. The care plan did not identify the resident's desired type (shower, bath, bed bath, etc.) or frequency of bathing. 4) Resident 67 admitted to the facility on [DATE]. An ADL care plan, revised 08/14/2024, showed Resident 67 required one person moderate to maximum assistance with bathing. The CP did not identify the resident's desired type (shower, bath, bed bath, etc.) or frequency of bathing. On 11/12/2024 at 1:18 PM, Staff C, RCM, said initially all residents were assigned one shower a week upon admission, but the frequency could be changed at resident request or during the initial care conference to their desired frequency. When asked where a resident's preferred bathing type and frequency would be documented once obtained, Staff C stated, On the care plan. On 11/13/2024 at 12:41 PM, Staff B, Director of Nursing Services, said residents should be asked their desired method and frequency of bathing. When asked if it should be on the CP Staff B said no, they just care plan bathing per resident's preference, but was unable to indicate how one would know what the resident's preferred bathing type and frequency was. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Resident 23 admitted to the facility on [DATE]. A psychotropic drug use CP, revised 10/15/2024, directed staff to document episodes of visual hallucinations and delusions of grandeur. The care plan did not identify what hallucinations or delusions the resident had previously experienced, the nature or effect of them (were they disturbing or pleasant e.g. seeing an angel in the corner of the room) or what action staff should take, if any, staff should take (other than documenting them). On 11/14/2024 at 12:10 PM, when if Resident 23's CP should identify what their hallucinations and delusions were and the effect they had on the resident, Staff B, DNS, said yes and acknowledged it was not on the CP. 6) Resident 28 admitted to the facility on [DATE]. A Dehydration Fluid Maintenance CP, revised 07/22/2024, directed staff to monitor and document intake & output (I&O, measured amout of fluid consumed and urine output usually compared over a 24 hour period) as per facility policy. Review of the electronic health record (EHR) showed the resident did not have an order for I&O and facility staff were not monitoring the Resident 28's I&O. Similar findings were noted for Resident 176 whose At Risk for Altered Fluid Maintenance CP, initiated 11/1/2024, directed staff to monitor and document intake and output (I&O) as per facility policy Review of the EHR showed the resident did not have an order for I&O and facility staff were not monitoring the Resident 176's I&O. On 11/08/2024 at 11:53 AM, Staff GG, Resident Care Manager (RCM) said if a resident doesn't have an order for I&O and the facility is not monitoring it, it should not be on the CP. Staff GG indicated the CP needed to be revised. 50945 7) Review of the EHR showed Resident 21 was admitted to the facility on [DATE]. Resident 21 had diagnoses of malnutrition (lack of sufficient nutrients in the body), muscle weakness, and gastrostomy status (surgical intervention for a feeding tube that goes through the abdomen into the stomach). Review of the Annual MDS, dated [DATE], showed Resident 21 was dependent on staff for cares. <Activities of Daily Living> Resident 21 had a care plan for decreased ability in activities of daily living (ADL's) self-care performance, with goals of will attain most independent level of ADL's and mobility as his PT/OT/ST [physical therapy, occupational therapy, speech therapy] progresses until next review date and will safely perform Bed, Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene through the review date. The same care plan had an intervention to encourage and assist Resident 21 to get up to a chair daily. During an interview on 11/13/2024 at 10:14 AM, Staff C, RCM, said that Resident 21 was not getting up to the chair daily, was not receiving PT/OT/ST, and that to safety perform bed mobility, transfers, eating, dressing, grooming, toilet use, or personal hygiene were not Resident 21's current abilities or goals. (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 11/14/2024 at 8:45 AM, Staff B, DNS, said it did not meet expectations that Resident 21's care plan was not updated. <Nutritional Status> Review of Resident 21's orders showed an active order, started 07/19/2024, for giving 180 milliliters (ml) of water every six hours. Resident 21 had a care plan on nutritional status with an intervention listed for giving 100 ml of water every six hours. During an interview on 11/13/2024 at 10:22 AM, Staff C, RCM, said Resident 21's care plan had not been updated when the water order was changed. During an interview on 11/14/2024 at 8:53 AM, Staff B, DNS, said Resident 21's care plan for nutritional status was not updated and this did not meet expectations. Reference WAC 388-97-1020(2)(c)(d)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 176) reviewed for communication, were provided appropriate treatment and services to maintain hearing. The failure to complete Resident 176's earwax removal treatment, resulted in Resident 176 indicating their ears remained clogged with wax and they still had difficulty hearing. This placed the resident at risk for feelings of frustration, diminished self-worth and decreased quality of life. Findings included . Resident 176 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), dated 10/24/2024, showed the resident was cognitively intact, had moderate difficulty hearing in some environments and did not have hearing aids or other hearing devices. On 11/04/2024 at 4:05 PM, Resident 176 reported they were experiencing ear pain and could not hear very well due to earwax build-up. The resident said he asked staff to declog their ears. The resident said the nurses put Debrox (ears drops that soften/loosen earwax build-up) drops in their ears for several days, but never flushed their ears when the treatment was completed. Resident 176 said the ear wax was still there and stated, I still can't hear very well. An At Risk For Impaired Communication care plan related to hearing loss, revised 11/01/2024, directed staff to administer ear drops as ordered and to moderately elevate tone and speak directly to Resident 176. The October and November 2024 medication administration records showed a 10/28/2024 order for Debrox (ear drops used to soften and loosen ear wax) three drops in both ears two times a day for seven days alternating with acetic acid ear drops, 3 drops to both ears two times a day. There was no instruction provided to flush the resident's ears when the treatment was completed. Review of the administration instructions on the Debrox (Carbamide Peroxide) package insert read as follows: Step 1- Place 5-10 drops in ear, wait several minutes with head tilted. Step 2- Repeat step one, two times daily for up to four days if needed. Step 3- Gently flush ear with warm water, using soft rubber bulb syringe, to remove remaining wax after final day of treatment. On 11/14/2024 at 7:48 AM, Staff B, Director of Nursing Services, said upon completion treatment with debrox ear drops, the ears should be flushed with warm water. When asked if there was documentation to show that occurred for Resident 176, Staff B said no and indicated facility nurses should have identified the order was incomplete and clarified it. Reference WAC 388-97-1060 (2)(a)(ii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50392 Based on interview and record review the facility failed to ensure dependent residents were provided scheduled bathing/showering opportunities for 6 of 8 residents (Residents 43, 19, 64, 176, 67 and 62) reviewed for activities of daily living (ADL's). This failure placed residents at risk of not having their ADL care needs met and a diminished quality of life. Findings included . 1) Resident 43 was admitted to the facility on [DATE]. The Admission Minimum Data Set, (MDS, an assessment tool) dated 10/22/2024, documented Resident 43 was moderately cognitively impaired and required substantial/maximal assistance with showering/bathing. The Shower Schedule dated 10/6/2024, documented Resident 43's shower day was to occur on Tuesdays during day shift. Resident 43's shower record, dated 10/15/2024 through 11/7/2024, documented no bathing activity was documented from 10/15/2024 until 10/29/2024, for 14 days. There were no refusals documented. On 11/08/24 at 9:59 AM, Staff Q, Certified Nursing Assistant, when informed Resident 43 had not received a shower from 10/15/2024 to 10/29/2024, two weeks, Staff Q said that a resident going two weeks without a shower was not acceptable. 11/08/24 at 12:33 PM. Staff B, Director of Nursing Services, said Resident 43 admitted to the facility on Tuesday 10/15/2024, and the next scheduled shower day should have been Tuesday, 10/22/2024 and a shower should have been done and documented on 10/22/2024 and it wasn't. 46793 2) Resident 19 was admitted to the facility on [DATE]. The Quarterly, MDS, dated [DATE], documented Resident 19 was moderately cognitively impaired. Resident 19 required extensive/total assist with all ADLs. On 11/04/2024 at 2:12 PM, Resident 19 said they wanted to be shaved, but the facility does not shave them. Resident 19 said they have to beg staff for a shave, but staff does not have time. Resident 19 said their family brought in an electric razor to use. Resident 19 was observed with a full beard, long in length. Resident 19's shave schedule in the Electronic Health Record (EHR) documented no entries under the ADL tab. Resident 19's ADL Care Plan documented no information regarding offering or completing the shaving activity. 3) Resident 64 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 64 was moderately cognitively impaired. Resident 64 required extensive/total assistance with all ADL's. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/04/2024 at 2:51 PM, when asked about shaving and a haircut, Resident 64 said staff don't do that. Resident 64 said they have asked staff before for a shave and a haircut, but they are slow to cut my hair or shave me. Resident 64 said they have asked staff multiple times for a haircut and a shave, but it never gets done. Resident 64 said they have a family member shave and cut his hair when they visit. Resident 64 was observed with yellow, thick, long, over 1/4 inch fingernails. Resident 64 toenails were observed to be thick and crusty yellow. Resident 64's had long shaggy unkept facial hair and long, over 2 inches, wiry hair sticking straight up on his head. A Physician's order dated 08/29/2024, documented to check that Resident 64 has been offered a shave every Monday, Wednesday and Friday, to include documentation if the resident refused. Resident 64's ADL Care Plan documented Resident 64 was to be offered a shave every Monday, Wednesday and Friday. Resident 64's Shaving record showed Resident was offered a shave on 10/09/2024- accepted, 10/23/2024 -refused and 10/30/2024 accepted. The EHR showed no documentation that Resident 64 had been offered a shave any other days. On 11/12/2024 at 10:05 AM, Staff E, Resident Care Manager/Registered nurse, said all tasks for CNA's are documented in the EHR, CNA's are able to document when the task was completed. When asked about specific tasks, Staff E, said the system does not break down the specific tasks, instead just documents personal hygiene. When asked about shaving task, Staff E said there is no specific selection in the EHR for shaving. When asked how often staff should be offering shaving, Staff E said some men like long beards, but staff should be asking routinely about cleaning, washing and shaving. When provided information that staff were not offering shaving, Staff E said that is not ok, residents should be getting shaved. When asked about hair cut, Staff E said the facility just hired a new barber yesterday. Staff E said residents should be getting haircuts when asked for. Staff E said if the resident gives the facility permission, staff can cut the resident's hair. At 12:45 PM, Staff B, DNS, said it is the normal standard of care that the facility honors resident preferences for ADL's and staff should be asking about ADL's every shift. Staff B said the facility just hired a person for haircuts, but the facility can also transport residents outside the facility for haircuts too. When provided information regarding lack of resident shaving and haircuts, Staff B said the residents should have been offered shaves and haircuts. 37044 4) Resident 176 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact, required physical assistance with bathing, and choices related to bathing were identified as Very Important. On 11/04/2024 at 3:38 PM, Resident 176 said they were not asked about the type or frequency of bathing they preferred. The resident reported staff just informed them that they would be showered one day per week. Resident 176 said they preferred daily showers but while at the facility, they wanted one at least every three days. An ADL care plan, revised 10/30/2024, showed Resident 176 required substantial assistance with bathing. The care plan did not identify the resident's desired frequency of bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 176's bathing records from 10/18/2024 - 11/08/2024 (21 days), showed the resident was offered/provided bathing once, on 10/29/2024. On 11/14/2024 at 7:43 AM, Staff B, DNS, confirmed Resident 176's bathing documentation showed for the 21-day period between 10/18/2024 - 11/08/2024, the resident was offered /provided bathing once, on 10/29/2024. 5) Resident 67 admitted to the facility on [DATE]. The Admission MDS, dated [DATE], showed the resident was cognitively intact, required substantial assistance with bathing, and choices related to bathing were identified as Very Important. On 11/07/2024 at 11:52 AM, Resident 67 said due to staffing, the shower aid did not always show up on their scheduled shower day(s). An ADL care plan, revised 08/14/2024, showed Resident 67 required one person moderate to maximum assistance with bathing. Review of the Resident 67's bathing record showed the resident went the following periods without being offered/provided bathing: a) 08/01/2024- 08/14/2024 (14 days) b) 08/16/2024- 09/09/2024 (25 days) c) 09/25/2024- 10/07/2024 (13 days) On 11/14/2024 at 7:43 AM, Staff B, DNS, confirmed Resident 67's bathing documentation showed they went the above referenced periods without being offered or provided bathing. 6) Resident 62 admitted to the facility on [DATE]. The Quarterly MDS, dated ,d+[DATE], showed the resident was cognitively intact, required substantial assistance with bathing, and choices related to bathing were identified as Very Important. On 11/05/2024 at 10:50 AM, Resident 62 said they were happy with one shower a week, if the shower aide was always available to provide it, but indicated they were sometimes unavailable due to staffing. An ADL self-performance care plan, revised 04/26/2024, directed staff to provide one person assistance with bathing per the resident's chosen schedule. The care plan did not identify what the resident's chosen bathing schedule was. Review of the Resident 62's bathing record showed the resident went the following periods without being offered/provided bathing: a) 09/13/2024- 10/25/2024 (42 days) b) 09/01/2024- 09/12/2024 (12 days) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/2024 at 7:43 AM, Staff B, DNS, confirmed Resident 62's bathing documentation showed Resident 62 went the above referenced periods without being offered or provided bathing. Reference WAC 388-97-1060 (2)(c)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interviews and record review, the facility failed to consistently provide treatments as ordered, and implement timely and appropriate interventions to prevent the worsening of PU (PU/PI, injury to the skin and underlying tissue due to prolonged pressure) for 1 of 3 sampled residents (Resident 64), reviewed for pressure ulcers. This failure may have contributed to worsening/deterioration of the PU to the sacrum (the triangular bone at the base of the spine that connects the lower back to the pelvis). This failure placed residents at risk for skin injuries, PUs/PIs, and a diminished quality of life. Findings included . <Policy> Facility policy titled, Skin Care Policy/Procedure, revised 06/2016, stated, It is the policy of the facility that: 1. A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and 2. A resident having pressure injuries receives necessary treatment and services to promote healing, prevent infection and prevent new, avoidable pressure injuries from developing. Procedures: Resident Assessment. 1. The nurse responsible for assessing and evaluating the residents' condition on admission and readmission is expected to take the following actions: a. Completed Initial Admission Records and Braden Scale to identify risk and to identify any alterations in skin integrity noted at that time. b. Braden Scale should be completed on admission, quarterly and following a change in the resident's condition. c. Identify risk factors which relate to the possibility of skin breakdown and or the development of pressure injury which include . d. All risk factors identified on assessment should be documented in the resident's clinical record and, when appropriate, be addressed through a care plan designed to minimize the possibility of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Develop comprehensive care plan if indicated following the evaluation/assessment. Care plans must be individualized and designed to meet the needs of the particular resident for whom they are being developed. f. Assessment of wounds upon admission and readmission: g. Assessment of wounds identified after admission: h. A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident, . i. It is understood that a resident may experience pain associated with the presence of a skin injury and/or any form of skin compromise. j. Once an area of alteration in skin integrity has been identified, assessed and documented, nursing shall administer treatment to each affected area as per the Physician's Order. Resident 64 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool), dated 04/22/2024, documented Resident 64 was moderately cognitively impaired and required extensive assistance for some activities of daily living (ADLs). The MDS also documented Resident 64 had one Stage II PU and interventions included a pressure reducing device for the resident's bed and wheelchair and for pressure ulcer/injury care and applications of ointments/medications Review of the LN [Licensed Nurse]-Initial Admission Record, dated 04/15/2024, documented Resident 64 had skin problems, yes and showed two areas, identified as pressure related to the sacrum and documented: 1. Site: 53) Sacrum. Type: Pressure. Length (L) 0.5 x Width (W) 0.5 x Depth (D) 0.1 centimeters (cm). Stage II 2. Site: 53) Sacrum. Type: Pressure. L 1 x W 1.2 x D 0.3 (cm). Stage II. Review of a Braden Scale evaluation (a skin assessment that evaluates the risk of skin breakdown), dated 04/15/2024, documented Resident 64 was at low risk for developing PU. Review of Resident 64's Skin Care Plan, dated 04/15/2024, documented Resident 64 had two open areas on the sacrum but did not identify them as pressure related. Review of a physician's order, dated 04/15/2024, documented Resident 64 had two open areas on the sacrum. The area was to be cleaned with warm soap and water, patted dry and then Zinc ointment applied (treats or prevents skin irritation like cuts, burns or diaper rash), every day and evening shift until resolved. Review of the Electronic Health Record (EHR) had missing entries for completion of the above order on: 04/16/2024 PM shift, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/17/2024 PM shift, 04/22/2024 AM shift, 04/25/2024 PM shift, 04/26/2024 PM shift, 04/30/2024 PM shift, 05/01/2024 PM shift, 05/10/2024 PM shift, and 05/17/2024 AM shift. The physician order was then discontinued on 05/23/2024. Review of the first LN- Skin Pressure Ulcer Weekly, dated 05/08/2024 (started 3 &1/2 weeks after admission), documented: Site 1: Present on Admission: No. Onset date 05/08/2024. Coccyx/buttock. SDTI (Suspected deep tissue injury) 1.2 x 1.2 cm. Site 2: Present on Admission: No. Onset date 05/08/2024. Coccyx/right buttock (No measurements included). No weekly skin check was completed on 05/15/2024. Review of the LN- Skin Pressure Ulcer Weekly, dated 05/23/2024, documented only one PU on the coccyx, and identified it as a SDTI with measurements of 1.8 x 2.7 cm. No second site was documented in the assessment. Review of a physician's order, dated 05/23/2024, documented a Deep Tissue Injury (DTI) was to be cleaned with warm soap and water, patted dry and phytoplex (a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) applied every day and evening shift until wound had resolved. Review of the EHR had a missing entry for completion of the above order on 05/28/2024. The above physician's order was discontinued on 05/29/2024. Review of the LN- Skin Pressure Ulcer Weekly, dated 05/28/2024, documented the left buttock had a 2 x 2 cm round wound with slough (a soft, yellow or white substance that can appear in a wound bed and is made up of dead cells, debris, and other substances) wound bed and draining pus. The adjacent (nearby) wound was beefy red, measured 2 x 4 cm and was identified as unstageable. On 05/28/2024, the physician was notified of the worsening PU. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a wound care provider note, dated 05/29/2024, documented an initial assessment that showed, Location-left buttock. Pressure stage: Stage 4. Review of the LN- Skin Pressure Ulcer Weekly, dated 05/29/2024, documented the area had increased in size and the facility had ordered an air mattress with bolsters. There was no documentation regarding the stage or condition of the wound with this assessment. Review of a physician's order dated 05/29/2024, documented orders for Resident 64's coccyx left buttock to be cleaned with normal saline, patted dry and calcium alginate (is a gelatinous, cream-colored substance with many uses, including wound healing) applied to the open area and covered with a 4 x 8 dressing, every day and evening shift until resolved. Review of the EHR had missing entries for completion of the above order on: 06/01/2024 PM shift, 06/05/2024 PM shift, 06/08/2024 PM shift, 06/10/2024 AM shift, And the resident refused care 06/11/2024 AM shift. The above physician's order was discontinued 06/13/2024. Review of a physician's order dated 06/13/2024, documented orders for Resident 64's coccyx left buttock to be cleaned with normal saline, patted dry, packed with Iodoform gauze packing strip (a sterile, antiseptic, and absorbent gauze that is used to treat infected wounds, reduce bleeding, and remove necrotic/dying tissue) to open area and cover with dressing every day and evening shift until resolved. Review of the EHR had missing entries for completion of the above order on: 06/15/2024 PM shift, 06/16/2024 PM shift, And 06/17/2024 PM shift. The above physician's order was discontinued 06/20/2024. Review of a physician's order dated 06/20/2024, documented orders for Resident 64's coccyx left buttock to be cleaned with normal saline, patted dry, pack with Dakins half strength Kerlix (a diluted solution of Dakin's Solution, used to treat a variety of wounds and infections) and cover with a foam dressing every dayshift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR had a missed entry for completion of the above order on 06/21/2024 and showed Resident 64 refused on 06/25/2024. The above physician's order was discounted on 06/26/2024. Review of the LN- Skin Pressure Ulcer Weekly, dated 06/20/2024, documented no other PU's on Resident 64. Review of wound care provider note, dated 06/26/2024, showed a left ear helix Stage 4 PU and a chronic, non-healing, left buttock wound with significant undermining (tunneling wound under the skin) and documented: Wound 1: (coccyx): Size 6.5 x 4 x 2.3 cm Wound 2: Left Ear Helix Pressure. Stage 4. Size: 0.5 x 0.5 x 0 cm. Review of the LN- Skin Pressure Ulcer Weekly, dated 07/10/2024, documented no other PU's on Resident 64. A Braden Scale evaluation, dated 07/15/2024, documented Resident 64 was at low risk for developing a PU, contrary to how the resident should have scored due to having numerous PUs and risk factors. On 11/14/2024 at 9:54 AM, Staff B, Director of Nursing Services, said when a resident admits with a pressure ulcer, it was the expectation that the facility would treat and monitor the pressure ulcers. Staff B said the facility would add the resident to the wound care provider committee to be discussed and put additional interventions in place. At 11:02 AM, Staff B, said Resident 64 entered the facility with a Stage II pressure ulcer to the sacrum and it progressed and worsened, but their contracted wound provider was treating Resident 64. Staff B provided wound provider notes regarding each visit. Staff B said the notes had not been scanned into the EHR and should have been. Staff B said Resident 64 was assessed to have a Stage II PU, the physician had placed orders for treatment and then the wound specialist providers started following Resident 64 weekly. Staff B said Resident 64's diagnoses turned to Terminal Skin Failure in June. Resident 64 was attending dialysis, but no longer qualified for dialysis and stopped attending. Staff B said a Braden Scale was completed. When asked what the results of the Braden Scale were, Staff B said, the Braden Scale showed Resident 64 was at low risk for pressure ulcers. When asked if the Braden scale was correct, Staff B said the assessments were incorrect due to Resident 64 admitting with a Stage II PU. When asked about interventions for Resident 64, Staff B said medication, physician ordered treatments, monitoring and assessing, and turning and repositioning were used for Resident 64. When asked about Resident 64's change/worsening PU, Staff B said she was unable to provide specifics about the events that caused the PU to worsen. Staff B said the physician was notified on 05/28/2024 regarding the worsening PU. When asked about missing entries in the treatment orders, Staff B said residents did have the right to refuse care. Staff B said the missing entries should have noted why the treatment were not completed. Staff B said it was reported to her that Resident 64 had refused on occasion, but acknowledged the record did not show documentation for follow up with the refusals. Staff B said staff should have been asking why the resident was refusing and should have been documenting it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060 (3)(b) Reference F692.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37044 Based on interview and record review, the facility failed to provide restorative services at the frequency residents were assessed to require for 6 of 7 residents (Residents 48, 22, 55, 46, 25 and 61) reviewed with restorative nursing programs (RNPs). The failure to provide RNPs at the frequency residents were assessed to require, placed residents at risk for decrease in Range of Motion (ROM), development and/or progression of contractures, increased dependance on staff for care needs and a diminished quality of life. Findings included . 1) Resident 48 admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], showed the resident was cognitively intact, and did not receive restorative nursing services during the assessment period. A restorative nursing care plan, initiated 08/15/2024, showed the resident would be provided active ROM restorative program to bilateral (both) upper extremities (UE) and lower extremities (LE) five times a week (5x/wk.), to maintain ROM and prevent contracture formation. Review of restorative documents showed the resident had an Active ROM program to bilateral UE/LEs using the Omni cycle or NuStep (modified and recumbent exercise bike that works UE and LEs) 4-6x/wk., and an ambulation program, with a goal of walking 100 feet using a front wheeled walker 4-6x/wk. On 11/13/2024 at 2:55 PM, when asked for restorative programs written as 4-6x/wk, who decided if the program would be provided four, five or six times in a given week, Staff B, Director of Nursing Services (DNS), stated, the resident and so if the resident shows six times a week, then the program would have to be offered six days a week, and if they declined, a refusal would be documented. Review of the September 2024 restorative records showed staff offered/provided Resident 48's ROM program on 10 of 25 days (Note: 10 is the number of times the program was offered/provided in September and 25 is the number of times at 6x/wk., the program should have been offered) and the ambulation program on 20 of 25 days. Review of the October 2024 restorative records showed Resident 48's ROM and ambulation programs were offered and provided on 7 of 26 days. 2) Resident 22 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, and received restorative nursing services on 3 of 7 days during the assessment period A Restorative program care plan, revised 08/20/2024, showed the resident was to participate in an active ROM program to bilateral UE and LEs using the omni cycle on level two 5x/wk. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2024 restorative record showed the active ROM program was offered/provided on 14 of 21 days. 3) Resident 55 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, and did not receive restorative nursing services. A Restorative Program care plan, revised 08/20/2024, showed the resident would participate in a restorative ambulation program with four wheeled walker and with a goal of ambulating 200 feet 3x/wk. Review of the October 2024 restorative record showed Resident 55 was offered/provided their ambulation program 4 of 13 days. 4) Resident 46 admitted to the facility on [DATE]. Review of the quarterly MDS, dated [DATE], showed the resident was cognitively intact, and did not receive restorative nursing services. Review of Resident 46's restorative documents showed the resident was to participate in a active ROM restorative program four to six times per week utilizing the omni cycle. An ADL care plan, revised 11/12/2024, showed as of 10/31/2024, Resident 46 was to participate in a restorative ambulation program with a two wheeled walker 5x/wk. and active ROM/strengthening program using the omni cycle 5x/wk. Review of the November 2024 restorative records through 11/14/2024 showed the resident was offered/provided their ROM program on 5 of 10 days, and their ambulation program on 4 of 10 days. 5) Resident 25 admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], showed the resident was moderately cognitively impaired, had impaired functional ROM to one lower extremity (LE), and received restorative nursing services on 2 of 7 days during the assessment period. Resident 25's restorative documents showed they were to receive an active ROM program using the omni cycle four to six times a week. Review of the September 2024 restorative documents showed the resident was offered/provided the program 13 of 24 days. On 11/13/2024 at 10:27 AM, when asked if there was anything preventing them from offering/providing resident restorative programs at the frequency they were assessed to require Staff FF, Restorative Aide, said, staffing. Staff FF explained they were the only Restorative Aide and were frequently pulled from restorative to work the floor. On the days they were pulled to the floor Staff FF indicated most of the restorative programs did not get done, although therapy staff would help as able. Staff FF said they did not currently have a Restorative Nurse. Staff FF said they had spoken with Staff A, Administrator, who had acknowledged that more Restorative staff were needed. For the period from 10/16/2024 - 11/01/2024 (16 days), Staff FF worked 13 shifts. Of the 13 shifts worked, Staff FF was pulled from restorative to work the floor seven times. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/2024 at 12:03 PM, Staff A, Administrator, said they were aware that restorative needed more assistance and acknowledged that staffing had detracted from the provision of restorative services at the frequency residents were assessed to require. 46793 6) Resident 61 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 61 was cognitively intact. On 11/04/2024 at 3:29 PM, Resident 61 said the facility is having staffing issues, especially in Physical Therapy (PT). Resident 61 said they were supposed to have PT fivedays a week, but right now they are only getting it 2-3 times a week, because the restorative aides continue to get pulled to work the floor. A Physical Therapy (PT) Evaluation & Plan of Treatment dated 12/01/2023, documented Resident 61 was to have PT 5 times a week, for 4 weeks. Documentation showed Resident 61 attended Rehabilitative services and was discharged [DATE] due to highest practical level achieved. Discharge recommendations included restorative program up to 5 times a week as tolerated. A Progress note, dated 09/26/2024, from Social Services, documented Resident 61 would like more than two days of restorative therapy. Resident was not receiving restorative services due to restorative aides being pulled from assigned job to work the floor tp provide patient care. Reference WAC 388-97-1060 (3)(d), (j)(ix)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview, and record review, the facility failed to ensure residents receiving enteral feedings, were administered enteral formula at the physician ordered rate and volume for 1 of 1 resident (Resident 21) reviewed for enteral feeding. The facility also failed to ensure routine resident weights were obtained, reviewed, weight loss trends identified, and nutritional nutritional interventions were timely identified and implemented for 2 of 2 residents (Resident 64 and 21) reviewed for weight loss. Additionally, the facility failed to have a system in place that ensured fluid intake was accurately monitored, documented, and 24-hour intake totals were calculated and evaluated, and labs were monitored for fluid and electrolyte imbalances for 2 of 2 residents (Resident 58 and 10) reviewed with a fluid restrictions. These failures placed residents at risk for continued weight loss, inadequate nutrition, fluid volume overload, fluid and electrolyte imbalances and other medical complications. Findings included . <Fluid Restriction> Resident 58 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had diagnoses of kidney disease and heart failure, and required diuretic (medication to draw extra fluid from the body through urine) therapy. A nutrition care plan, revised 10/25/2024, showed Resident 58 was on a 1500 milliliter per day (ml/day) fluid restriction, with nursing providing 180 ml per shift and 118 ml health shake for a total of 658 ml/day, and dietary providing 360 ml at breakfast, and 240 ml with lunch and dinner for a total 840 ml/day. A fluid restriction care plan, revised 10/25/2024, showed the resident received diuretic therapy and directed staff to implement fluid restriction per physician orders. Review of Resident 58's EHR showed their fluid intake with meals was recorded on the meal monitor in point of care (computer program), and fluids provided by nursing were recorded on the Medication Administration Record (MAR). Review of the November 2024 MAR showed nurses were recording the amount of fluid they provided each shift, but there was no direction or spot provided for nursing to reconcile the fluid intake recorded on the meal monitor with the fluid intake recorded on the MAR to calculate the resident's 24-hour fluid intake total. On 11/08/2024 at 11:53 AM, Staff GG, Resident Care Manager (RCM), explained the purpose of the fluid restriction was to manage the resident's fluid volume status due to chronic kidney disease. Staff were to record the resident's fluid intake and then assess whether the resident was adherent or non-adherent with the restriction. If the resident was non-adherent, nursing would educate the resident to the risks and benefits and notify the physician. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/08/2024 at 11:53 AM, when asked if there was any documentation to support staff had calculated the resident's 24 hour fluid intake to evaluate if the resident was adherent with the fluid restriction Staff GG, RCM, said no, and acknowledged the fluid restriction had not been effectively implemented or monitored and needed to be corrected. 46793 2) Resident 64 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS, an assessment tool), dated 09/12/2024, documented Resident 64 was moderately cognitively impaired. Resident 64 is an extensive/total assist with all activities of daily living (ADL's). Resident 64 admitted to the facility weighing 237.6 pounds (lbs). A Licensed Nurse (LN) Nutrition/Hydration Risk Evaluation, dated 04/15/2024, documented Resident 64 was able to self-feed, had a stable weight, no dental issues, consumed 50%-75% of meals with more than 2000 cubic centimeters (cc) of fluid intake. Overall score 4.0 (low risk). A Nutrition-Admission Evaluation, dated 04/17/2024, documented Resident 64 was on a restricted concentrated sweets and Renal (kidney) diet. Resident 64 was reported to have a good appetite, no swallowing disorders or gastroenterology issues. Documented target weight was 266 pounds (lbs). A LN Nutrition Interdisciplinary Team review, dated 04/24/2024, documented Resident 64 had end-stage renal disease (ESRD, a permanent condition where the kidneys are no longer able to function and require dialysis or a kidney transplant), weight loss was related to fluids and diuretic (a drug that increases the amount of urine produced by the kidneys, which helps the body get rid of excess water and salt) use. Resident was averaging 63% of meal consumption. Recommendation was to obtain dialysis weights. Weights as followed: 04/17/2024 14:30 244.4 Lbs 04/20/2024 21:08 244.6 Lbs 05/31/2024 09:35 239.8 Lbs 06/18/2024 14:22 226.82 Lbs 06/27/2024 14:21 224.18 Lbs 07/09/2024 14:13 208.12 Lbs 07/11/2024 14:10 211.64 Lbs On 04/15/2024, the resident weighed 237.6 lbs. On 07/11/2024, the resident weighed 211.6 pounds which was a -10.94 % Loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Licensed Nurse (LN) Nutrition/Hydration Risk Evaluation, dated 07/15/2024, documented Resident 64 was able to self-feed, had a stable weight, no dental issues, consumed 50%-75% of meals and more than 2000 cc of fluids. Overall score 4.0 (low risk). A Nutrition Quarterly Evaluation, dated 07/17/2024, documented Resident 64 was taking Nepro (supplement) twice a day and Prosource (supplement) twice a day. Documented target weight was 222 lbs. Per dialysis weight, Resident 64 had a significant weight loss of 6.5% in 1 month and 9.1% decrease in 3 months. At 11:02 AM, Staff B, Director of Nursing (DNS), when asked about Resident 64's nutritional status, said Resident 64 was being seen by the Registered Dietitian, Resident 64 was reviewed 04/17/2024, 07/17/2024 and 09/12/2024 and 10/09/2024. Staff B said the Interdisciplinary Nutrition team reviewed Resident 64's nutrition on 04/24/2024, 08/14/2024, 08/29/2024 and 09/05/2024. When asked about the significant weight loss (more than 7.5% in 3 months) between Resident 64's admission and the quarterly review, Staff B said there was no other reviews and Resident 64's significant weight loss should have been caught before the quarterly review. 50945 3) Review of the Electronic Health Record (EHR) showed Resident 21 was admitted to the facility on [DATE]. Resident 21 had diagnoses inlcuding malnutrition (lack of sufficient nutrients in the body), hyponatremia (low sodium levels) and gastrostomy status (surgical intervention for a feeding tube that goes through the abdomen into the stomach). Review of the Annual MDS, dated [DATE], showed Resident 21 was dependent on staff for cares. <Formula> Review of the EHR showed Resident 21 was ordered to receive 1400 milliliters (ml) of formula (liquid nutrition). Review of Resident 21's October administration record for formula showed: 406 ml on 10/15/2024 and 938 ml on 10/26/2024. Review of Resident 21's progress notes showed no documentation of why volumes were low on these dates. During an interview on 11/13/2024 at 10:22 AM, Staff C, RCM, after looking through the EHR said their expectation regarding the formula being recorded as 406 ml on 10/15/2024 was that there should have been a progress note. During an interview on 11/14/2024 at 8:53 AM, Staff B, DNS, said their expectation was for staff to have notified the provider when a resident did not get the correct formula volume, and should have documented a reason or what the plan was. <Weights> Review of Resident 21's weights record showed none since 08/10/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 21's nutrition progress notes on 09/18/2024 and 10/16/2024 recommended staff obtain an updated weight. Review of Resident 21's progress notes from August to November 2024 showed no mention of any refusals or reason to not obtain a weight. During an interview on 11/13/2024 at 9:16 AM, Staff K, Registered Nurse (RN), said long term residents should receive monthly weights. During an interview on 11/13/2024 at 10:22 AM, Staff C, RCM, said their expectation for Resident 21's weights was to have seen something documented in the progress notes if the resident had refused any. During an interview on 11/14/2024 at 11:36 AM, Staff B, DNS, said after looking at the EHR they were unable to find an updated weight for Resident 21 and a weight should have been done monthly. <Water Flushes> Review of Resident 21's laboratory results showed Resident 21 had a sodium level of 128 (results show normal value is 134-144), on 04/22/2024. Resident 21 was seen at an outside hospital, and review of hospital records showed Resident 21 had sodium levels of 136 on 05/31/2024 and 138 on 06/01/2024. Review of Resident 21's orders showed Resident 21 had an updated order on 07/19/2024 that increased every six-hour water flushes (dose) of the gastrostomy tube, from 100 ml to 180 ml. No laboratory results were found after the updated water flush order on 07/19/2024, until 11/07/2024 when Resident 21's sodium level was 111, a critically low value. During an interview on 11/13/2024 at 9:16 AM, Staff K, RN, said residents with low sodium levels should have less water. During an interview on 11/13/2024 at 12:51 PM, Staff L, Registered Dietician, said for Resident 21 the water flushes were increased to meet hydration needs. Staff L said for residents with low sodium, water flushes should be reduced. When asked to provide documentation that the sodium levels were reviewed in making the decision to increase the water flush, Staff L was unable to provide documentation. During an interview on 11/14/2024 at 8:53 AM, Staff B, DNS, said, regarding Resident 21's increase in water flushes, that the registered dietician recommended the flushes, this change should be discussed and reflected with labs, and this should have been presented to the provider to follow up on what they wanted ordered. 4) Review of the EHR showed Resident 10 was admitted to the facility on [DATE]. Resident 10 had diagnoses of heart failure and ESRD. Resident 10 was requiring dialysis (intervention to filter the blood to remove waste). Review of Resident 10's orders showed they were on a fluid restriction of 1000 ml per day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's fluid intake record of the past 30 days showed: 240 ml on 10/15/2024, 240 ml on 10/16/2024 and 150 ml on 10/17/2024. The nursing administration records were reviewed, and no additional documentation was present for fluid intake on 10/15/2024, 10/16/2024, or 10/17/2024. During an interview on 11/12/2024 at 8:53 AM, Staff C, RCM, said the fluid intake record would be recorded by the nursing aids and would be missing values done by nursing. Staff C reviewed the nursing administration records for Resident 10, said the fluid given by nursing staff was not recorded on the administration record, and this did not meet expectations. During an interview on 11/12/2024 at 4:25 PM, Staff B, DNS, said a resident on a fluid restriction should have documentation on how many fluids they are receiving, and this documentation of fluid intake for Resident 10 did not meet expectations. Reference WAC 388-97-1060 (3)(h)(i)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to administer parenteral (routes other than the digestive system to give fluids or medication) medication in a manner consistent with professional standards for 1 of 1 sampled residents (Resident 126) reviewed for antibiotics. This failure placed residents at risk for complications, infections, and a diminished quality of life. Findings included . Review of the Electronic Health Record (EHR) showed Resident 126 was admitted to the facility on [DATE]. Resident 126 had diagnoses including sepsis (bloodstream infection) and cellulitis (bacterial skin infection). Review of the Medicare-5 Day Minimum Data Set Assessment, dated 10/28/2024, showed Resident 126 received intravenous (IV, through a vein) antibiotics. Review of the EHR showed Resident 126 had a single lumen peripherally inserted central catheter (PICC, a thin long tube that goes through a vein in the arm and goes to the larger veins near the heart for giving medications). Review of the EHR showed Resident 126 did not have orders specific to having a central line (the PICC). The EHR also showed Resident 126 did not have a central line or PICC care plan. Review of Resident 126's IV medications showed the orders did not specify the rate of the antibiotics. Resident 126 was receiving IV vancomycin (antibiotic) every 24 hours and IV piperacillin tazobactam (antibiotic) every 8 hours. During an interview on 11/08/2024 at 7:27 AM, Staff E, Resident Care Manager/Registered Nurse (RCM/RN) said for PICCs, the facility would check the measurement of the external catheter length from the skin to the hub (attachment on the end of the PICC tubing where medications are given). Staff E was unable to find a previous measurement and obtained a new measurement on Resident 126. During an interview on 11/08/2024 at 7:49 AM, Staff C, RCM, said they were unable to find an order for Resident 126 for frequency of dressing change that was per central line guidance. Staff C was unable to find rates on the two IV antibiotic orders. Staff C said their expectation was for staff to confirm the rate with every administration with the order, and the orders should have detailed instructions. During an interview on 11/12/2024 at 4:30 PM, Staff B, Director of Nursing Services, said their expectation for staff on obtaining the external catheter length for a resident with a central line was on admission and with dressing changes, and this should be care planned. Staff B said it did not meet expectations that Resident 126 was admitted on [DATE] and did not have a measurement of the external catheter length of their PICC until 11/08/2024. Staff B said their expectation was for the rate to be listed in the medication order, and central line dressing changes would be ordered and accurate for the central line. Reference F656 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060 (3)(j)(ii)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on interview and record review, the facility failed to ensure orders were followed for 2 of 2 residents (Residents 72 and 10) reviewed for dialysis. This failure put residents at risk for medical complications and a decreased quality of life. Findings included . Resident 72 admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool) documented Resident 72 was cognitively intact. Resident 72's diagnosis included End Stage Renal Disease (ESRD, a condition in which the kidneys lose the ability to remove waste and balance fluids) and dependence on renal dialysis (a treatment that removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly). Resident 72 had a dialysis fistula (a surgically created connection between an artery and a vein that allows for direct access to the bloodstream for dialysis) to their left arm. Review of the Electronic Health Record (EHR) showed that Resident 72 was going to dialysis three times a week from 5 AM to 9 AM. A physician's order, dated 09/21/2024, instructed post dialysis fistula access care to include removal of pressure dressing(s) two hours after dialysis The Renal (kidney) System Care Plan, dated 09/21/2024, instructed staff for post dialysis fistula access care: Remove pressure dressing two hours after dialysis. On 11/04/2024 at 11:15 AM, Resident 72 said after dialysis ended (around 9 AM) they removed the pressure dressing themself and often would wait until 7 or 8 PM to take the pressure dressing off. Resident 72 reported they had removed their own pressure dressing too early one time and there was bleeding from their fistula site resulting in transfer to the hospital. On 11/07/2024 at 3:20 PM, Staff R, Registered Nurse, said Resident 72 liked to wait to remove their own pressure dressing after dialysis, usually removing it themself. On 11/12/2024 at 10:02 AM, Staff C, Resident Care Manager (RCM), said for a resident to remove their own pressure dressing there would need to be training and teaching documented in the EHR. When asked to provide training or teaching documentation for Resident 72's abilities to change their own pressure dressing, Staff C said he could not locate the documentation. At 2:21 PM, Staff B, Director of Nursing Services (DNS), said for Resident 72 to remove their own pressure dressing her expectation was they would have a self-administration form in the EHR, it would be addressed on the care plan and there would be a physician order for Resident 72 to remove their own dressing. No documentation that these steps were taken was provided. Reference WAC 388-97-1900 (1)(6)(a-c)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46793 Based on observation, interviews and record review, the facility failed to have sufficient staff to provide and supervise care as evidenced by information provided by 7 resident interviews (Resident 18, 19, 59, 64, 376, 40 & 58), Resident Council interviews (Residents 40 & 59) and Staff interviews (Staff E, BB, CC, DD, EE & H) and as evidenced by failed practices in many identified quality of life and quality of care areas. The facility had insufficient staff to ensure residents received assistance with Activities of Daily Living (ADL) including grooming and showers, assessments, care planning, care plan revision, restorative services, hospice services and infection control in accordance with established clinical standards, and resident needs and preferences. These failures placed residents at risk for unmet care needs, negative outcomes and a diminished quality of life. Findings included . <Resident Interviews> On 11/04/2024 at 11:03 AM, Resident 18, said staff would come in and tell them they were busy and would have to wait. At 11:18 AM, Resident 19 said staff took a long time to respond, it depended who was on duty on how long we they would have to wait for staff to respond. At 12:15 PM, Resident 59 said my call light was on a least an hour last night, I waited for staff to come and remove the urine tub. Resident 59 said it was upsetting when staff would tell them they would be back and then would not return for hours. Resident 59 said it took staff an hour and half to return to help them last night. At 2:46 PM, Resident 64 said they would have to wait a long time, sometimes up to 30 minutes for staff to respond. Resident 64 said they used the clock on their cell phone to keep time. Resident 64 said sometimes it could be up to an hour for staff to respond and it was across all shifts. At 3:12 PM, Resident 376 said the facility did not have enough staff and stated, I hold it [bathroom use] long enough to where I cannot hold it much longer. On 11/05/2024 at 8:30 AM, Resident 40 said they had concerns that staff were being pulled (restorative and shower aids) to help on the floor, they were not getting restorative services and only one shower a week. At 9:17 AM, Resident 58 stated, I can wait for hours for them to get me out of bed and clean me, I need a hoyer [mechanical] lift, I have sat in my pee until they get me up with the hoyer. <Grievances> On 10/06/2024 a grievance was filed by Resident 59, documenting they had not received a shower in almost two weeks due to shower aides not being available to provide showers. (continued on next page)

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	505290	A. Building B. Wing	11/14/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/2024, Resident 40 filed two grievances: 1) Resident 40 documented residents were not receiving restorative services due to restorative aides being pulled from assigned job, due to staff shortages. 2) Resident 40 documented residents were not getting showers due to shower aides being pulled from assigned job, due to staff shortages. <Resident Council Minutes> Resident Council minutes for May 2024 documented, once again we must bring up informing the residents of appointments ahead of time and a day or two in advance would be better than a few minutes before pickup. Residents who need assistance transferring are still having to wait a half-hour, an hour or more to use the bathroom or go to bed. This seem to be an ongoing problem with lack of sufficient staffing to provide coverage. Resident Council minutes for June 2024 documented, Still concerns about getting light answered timely. Resident Council minutes for August 2024 documented, How can we get notified of appointments? Resident find out the day of the appointment and not told ahead of time. Resident Council minutes for September 2024 documented, a grievance was filed on the behalf of the Resident Council, related to wanting to know ahead of time about appointments. Concerns regarding when more staffing would happen was also brought up. On 11/06/2024 at 1:00 PM, Resident Countil member interviews showed: Resident 17 said sometimes thier needs were not being met until after a long wait time. Resident 17 said shower aides were being pulled and they weren't getting showers. Resident 17 said there had not been a Social Services person. Resident 40 said they felt like residents did not have anyone to go to to get their problems addressed. <Staff Interviews> On 11/12/2024 at 10:05 AM, Staff E, Resident Care Manager, said everything was in transition and the facility was trying to get the new Social Services (SS) team set up and it had been a struggle. Staff E said the facility lost the previous Social Services person and it staffing had been a struggle. On 11/13/2024 at 1:20 PM, when asked if staff had time to answer staffing questions, Staff BB, Certified Nursing Assistant, stated, you have to walk with me, I can't stop. When asked if she felt she had enough time to complete her daily tasks, Staff BB said not really, see how fast I am walking, you have to hurry and go. Staff BB said she had been asked to work overtime a lot lately. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:33 PM, Staff CC, Licensed Practical Nurse (LPN), said when she was working eight hours a day, she was not able to get her daily assignments completed, but since switching to 12 hour days, she has been able to complete her daily assignments. Staff CC said it was worse on weekends because the Administrative staff were not there to help with processing orders, treatments, phones, etc. Staff CC said wound care was hard because the contracted wound services they used would only come in on Wednesdays, and the rest of the time wound care was on the nursing staff. Staff CC said it would be more helpful if there were more nursing assistants helping to answer call lights, pass meal trays and provide care, so the nurses could focus on medication administration and treatment orders. Staff CC said the restorative and shower aides were often pulled from their assignments because people would call out. At 1:52 PM, Staff DD, CNA, said it would depend on how the day was going, if he was able to get all his daily assignments completed. When the facility was busy, he would not be able to complete all his assignments. Staff DD said it was usually pericare and showers that were not completed. Staff DD said the shower aides and restorative aides were often pulled to provide patient care, this would happen 3-4 times a week. Staff DD said he stayed late twice last week. At 2:02 PM, Staff EE, LPN, said it would take her all morning to do medication administration and the only other thing she had time to complete was wound care. 37044 <Restorative Services> On 11/13/2024 at 10:27 AM, when asked if there was anything preventing them from offering/providing resident restorative programs at the frequency they were assessed to require Staff FF, Restorative Aide, said, staffing. Staff FF explained they were the only Restorative Aide and were frequently pulled from restorative to work the floor. On the days they were pulled most of the restorative programs did not get done, although therapy staff would help as able. Staff FF said they did not currently have a Restorative Nurse. Staff FF said they had spoken with Staff A, Administrator, who had acknowledged that more Restorative staff were needed. For the period from 10/16/2024 - 11/01/2024 (16 days), Staff FF worked 13 shifts. Of the 13 shifts worked, Staff FF was pulled from restorative to work the floor seven times. <Bathing Services> On 11/07/2024 at 1:51 PM, when asked if there was anything that prevented them from providing resident bathing/showers as scheduled Staff II, Shower Aide, stated, Yes, the only thing is getting pulled [from showers to provide direct care, due to staffing issues]. At 2:35 PM, Staff H, CNA/Shower Aide, said most of the time she could complete her daily tasks, but was pulled 1-2 times a week to help provide patient care. When asked about making up showers for the residents that missed their shower day, due to staffing, Staff H said she would try to make them up the next day. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/2024 at 12:19 PM, Staff B, Director of Nursing Services, when asked if staffing had affected the ability for staff to provide bathing and restorative services at the frequency residents were assessed to require, Staff B said that staffing may have inadvertently affected the provision of both. At 2:54 PM, Staff A, Administrator, said there had been staffing issues, and they had been trying to address them. Staff A said yes, when asked if the staffing issues had affected resident care. Refer to F578, F623, F625, F676, F684, F688, F804, F849 & F880 50945

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure that the pharmacist's Medication Regimen Review (MRR) recommendations were acted upon for 1 of 5 residents (Resident 21) reviewed for unnecessary medications. This failure placed residents at risk of decreased effects of medication, medication complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, Medication Regimen Review, revised 08/2017, showed the MRR recommendations were to be provided to the responsible physician, facility's Medical Director, and the Director of Nursing within a week of the review. The provider would then document in the resident's medical record what was reviewed and if any actions needed to be taken. Nursing was responsible for providing a written response to the review, to be given to the pharmacist and to the facility to be filed. Review of the Electronic Health Record (EHR) showed Resident 21 was admitted to the facility on [DATE]. Resident 21 had diagnoses of malnutrition (lack of sufficient nutrients in the body) and gastrostomy status (surgical intervention for a feeding tube that goes through the abdomen into the stomach). Review of the Annual Minimum Data Set Assessment, dated 08/26/2024, showed Resident 21 was dependent on staff for cares and experienced constant pain. Review of the MRR binder showed that Resident 21 had a recommendation on 08/28/2024 that said Carafate (forms a coating over ulcers to protect from stomach acid) had the potential to alter the absorption of other medications, should be given on an empty stomach, and should be given two hours before or after other medications. Review of the medication administration record for August and September 2024 showed Resident 21 had oxycodone (opioid pain medication) and Carafate scheduled at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. During an interview on 11/13/2024 at 1:44 PM, Staff C, Resident Care Manager, reviewed the EHR and said they were unable to find documentation of Resident 21's MRR recommendations on 08/28/2024 being implemented, or any documentation saying Carafate and oxycodone were reviewed or could be given together. During an interview on 11/14/2024 at 11:42 AM, Staff B, Director of Nursing Services, said their expectation for Resident 21's MRR recommendations on 08/28/2024 was that the doctor would have confirmed there was a conversation about the medication. Staff B said they were unable to provide documentation the provider was aware of the recommendation, if Carafate was being given with oxycodone was reviewed, or if the two medications were approved to be given together. Reference WAC 388-97-1300 (4)(c)

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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** 50945 Based on on interview and record review, the facility failed to ensure quality of care for 2 of 5 residents (Resident 72 & 56) reviewed for unnecessary medications related to providing ordered medication. This failure placed residents at risk for medical complications and a decreased quality of life. 1) Review of the Electronic Health Record (EHR) showed Resident 10 was admitted to the facility on [DATE]. Resident 10 had a diagnosis of ESRD, required renal dialysis, and had a port (implanted venous access device). Review of the Quarterly Medicare MDS, dated [DATE], showed Resident 10 was cognitively intact. Resident 10 had an order for removing the dressing on Resident 10's port two hours after dialysis on Tuesday, Thursday, and Saturday. Review of the November 2024 administration record showed the dressing was not being removed. Review of the November 2024 progress notes showed staff were not removing the dressing to prevent infection. During an interview on 11/12/2024 at 9:14 AM, Staff C, RCM, said the dressing order was not written correctly for Resident 10's port, and this needed to be fixed. Staff C said their expectation of staff was to report problems with orders to the provider or RCM, and this did not meet expectations. During an interview on 11/14/2024 at 8:34 AM, Staff B, DNS, said their expectation for staff caring for Resident 10 was to clarify the order with the provider. 2) Review of the EHR showed Resident 56 was admitted to the facility on [DATE] and was hospitalized from 10/24/2024 to 10/31/2024. Resident 56 had diagnosis of type two diabetes (trouble regulating sugar in the body). The Medicare 5-day MDS, dated [DATE], showed Resident 56 had a moderately impaired mental status. Resident 56 returned from the hospital on 10/31/2024 and had an ordered dose for dulaglutide (medication for diabetes) for 11/01/2024, ordered for once a week. Review of a 11/01/2024 progress note showed Resident 56's dulaglutide dose was missed due to the medication not being available from pharmacy. The note said pharmacy was advised of the need to send the medication. Review of Resident 56's progress notes for November 2024 did not include documentation of notifying the provider of the missing dose. No additional orders were found. The next administration of the medication was given on 11/08/2024, the week following the missing dose. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/2024 at 8:39 AM, Staff C, RCM, reviewed Resident 56's EHR and said they did not see a makeup dose for the missing dulaglutide dose on 11/01/2024. Staff C said it did not meet expectations that they could not find a progress note saying a conversation happened between staff and the provider, and the provider should have rewritten the dose when it became available from pharmacy. During an interview on 11/12/2024 at 4:14 PM, Staff B, DNS, said it did not meet expectations when Resident 56 returned from the hospital that the dulaglutide dose was not available and there was not a makeup dose. Reference WAC 388-97-1060 (1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic (affecting the mind) medications by ensuring Gradual Dose Reductions (GDR) were attempted for 1 of 5 residents (Resident 27) reviewed for unnecessary medications and that GDR recommendations that included laboratory tests were followed up on for 1 of 5 residents (Resident 21) reviewed for unnecessary medications. This failure placed residents at risk for medical complications, receiving unnecessary medications and a diminished quality of life. Findings included . 1) Resident 27 was readmitted to the facility on [DATE] with diagnoses of Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). The Annual Minimum Data Set, (MDS, an assessment tool) dated 06/25/2024, documented Resident 27 was moderately cognitively impaired. A physician's order, dated 04/22/2022, documented Resident 27 was prescribed duloxetine (an antidepressant used to treat depression). This order was discontinued for Resident 27 and reordered for the same dose and frequency on 08/30/2024. Review of the Medication Regimen Review book showed no evidence any GDRs had been attempted from January 2024 through October 2024. Review of the 02/22/2024, 06/06/2024 and 09/12/2024 behavior/psychoactive medications interdisciplinary team reviews for Resident 27, documented no GDRs were attempted. On 11/13/2024 at 1:11 PM, Staff B, Director of Nursing Services (DNS), when made aware of no documentation of attempted GDRs said her expectation would be that this documentation would be in the Electronic Health Record (EHR), and she would attempt to reach the physician to provide the documentation. No further documentation was provided. 50945 2) Review of the EHR showed Resident 21 was admitted to the facility on [DATE]. Resident 21 had diagnoses of anxiety (abnormal amounts of stress) and depression. Review of the Annual MDS, dated [DATE], showed Resident 21 was dependent on staff for cares. Review of a psychiatry note, dated 09/24/2024, showed Resident 21 was evaluated for a GDR for their medication. The provider recommended decreasing Resident 21's antianxiety medication dose, to decrease the sedation (decreased level of alertness) effects of the medication and to more accurately determine a diagnosis. The note ended with, repeat labs and exclude component of delirium. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR showed that Resident 21 had their antianxiety medication reduced on 09/27/2024. Review of the EHR showed Resident 21's next laboratory blood tests were not done until 11/07/2024, in a response to a change of condition of the resident. During an interview on 11/13/2024 at 1:44 PM, Staff C, Resident Care Manager, said they could not find any evidence of the recommendation from the 09/24/2024 psychiatry note being followed for Resident 21, and if the provider did not give direct orders, that the interdisciplinary team would hopefully review the progress notes and follow up on recommendations. During an interview on 11/14/2024 at 1:33 PM, Staff B, DNS, said they were now following up to find out what laboratory tests the provider wanted, and they should have followed up on the laboratory tests for the 09/24/2024 psychiatry visit. Reference WAC 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50488 Based on observation and interview, the facility failed to ensure expired medications and supplies were removed/discarded in 1 of 2 medication storage rooms (Medicare A and Medicare B medication room) reviewed for medication storage and labeling. This failure placed residents at risk of receiving compromised and/or ineffective medications and medical supplies. Finding included . On 11/04/2024 at 2:50 PM, the following outdated medications and supplies were observed: - Package of blood glucose lancets, label read, facility should use or discard by 06/30/2024 - 3 bottles of blood glucose strips, expired 08/22/2024. - Ibuprofen 200 milligram (mg), opened, expired 09/2024. - Vitamin B-6 100 mg opened, expired 10/2024. - Daily Vitamin formula plus iron, opened, expired 08/2024. - Arexvy (a vaccine to protect against lower respiratory tract disease) 120 micrograms (mcg)/0.5mg vial in fridge, expired, label read, use or discard by 09/25/2024. - Tuberculin Purified Protein Derivative vial in fridge, date accessed 09/13/2024, expired 10/13/2024. - Bottle of Urine Reagent Strips (used to test for specific parameters in urine) read, do not use after 90 days of breaking foil seal, bottle was opened but not dated. On 11/04/2024 at 3:05 PM, Staff C, Resident Care Manager, said nursing staff were responsible for going through medications and supplies to remove and dispose of expired medications and supplies. 42960 On 11/12/2024 at 3:48 PM, Staff B, Director of Nursing, said her expectation would be that those expired medications be destroyed or removed at the expiration date. Reference WAC 388-97 -1300 (1)(b)(ii), (c)(ii-iv)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37044 Based on observation, interview and record review, the facility failed to prepare food in a manner that ensured meals were appetizing, palatable and served at appropriate temperatures for 9 of 15 sampled residents (56, 43, 58, 19, 18, 59, 64, 13 and 126) reviewed for dining. This placed residents at risk for a decreased nutritional intake and dissatisfaction with meals. Findings included . <Resident Interviews> On 11/04/2024 at 2:02 PM, Resident 56 said, the food here stinks, the food texture is pasty, it feels like you are eating glue, like they glued it all together. The soups seem to be leftover stuff from other meals. At 12:14 PM, Resident 43 said the food did not always taste good and was often that the hot was not hot and the cold was not cold. On 11/05/2024 at 9:27 AM, Resident 58 stated, The food is terrible. It is not good. On 11/04/2024 at 11:00 AM, Resident 19 said he wanted a hot meal, the meals were consistently cold, and the bacon always had the taste of oil. Resident 19 said they had sent meals back because it was cold. At 11:05 AM, Resident 18 said the food was cold and it could it happen at any meal. At 12:17 PM, Resident 59 said the food was bland and it had a freezer burnt taste. Resident 59 said they gave them menus and they would check off what you would want and not want, but they wouldn't always give them what they wanted. Resident 59 said it was the same stuff every two weeks and gave the example that they receive Salisbury steak at least twice a week and breakfast was always eggs. At 2:35 PM, Resident 64 said the food was terrible, it doesn't taste good and the temperature was medium, but not hot. At 2:59 PM, Resident 13 said some meals were, mystery meat. Resident 13 said they had spoken to the kitchen, but nothing had changed. Resident 13 said they had a refrigerator in their room where they kept beef soup, if they did not like what was being served. On 11/05/2024 at 8:45 AM, Residents 126 ate less than 25 percent of breakfast, only a few bites of eggs. Resident 126 said they did not like the texture of eggs. Resident 126 said lunch and dinner depended on what was being served. Resident 126 said they would prefer cereal for breakfast. On 11/06/2024 at 8:36 AM, Resident 59 (who had eaten breakfast in the dining room) said the breakfast was not hot, the pancakes were cold and didn't taste the best. Resident 59 said they covered the pancakes in syrup to help. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/07/2024 at 1:52 PM, Resident 59 said lunch was Chicken Almondine and that it tasted good but was cold. <Observations of Meal Delivery> On 11/06/2024 at 8:27 AM, a meal cart was observed sitting in the [NAME] Mountain Hall next to the nurses' cart. No meals delivered at this time. At 8:44 AM, a staff member brought a breakfast meal tray to Resident 61 (17 minutes after arrival of the meal cart to the floor). At 8:45 AM, a staff member brought a breakfast meal tray to Resident 64 (18 minutes later). <Meal Preparation> Observation of meal preparation and tray line on 11/12/2024 from 10:47 AM - 12:23 PM showed dietary had removed all resident beverages (juices and milks) from the refrigerator and placed them on trays in the tray carts by 11:20 AM. At 12:21 PM, after preparing the Garden Room and Medicare A Hall meal cart(s) for delivery staff had not checked the temperature of any of the beverages, which had been sitting out on the carts since 11:20 AM (61 minutes.) Upon request, Staff MM, Dietary Aide, checked the temperature of a cup of cranberry juice which was 57.1 degrees. Staff MM then placed the juice back on the cart for delivery. <Test Tray> On 11/12/2024, a test tray was delivered at 12:54 PM. The temperature of the juice was 58.9 degrees, the milk was 56.3 degrees, and the chocolate pudding was 57.4 degrees. On 11/12/2024 at 3:27 PM, when asked if they always prepared and placed resident beverages on the meal carts 40 minutes to an hour prior to meal service, Staff LL, Dietary Manager, indicated they had to prepare them ahead of time and place them on the trays so tray line would go smoother. No explanation was provided as to why the beverages could not be placed on ice and added to resident trays by the dietary aide while the cook was plating the food. Reference WAC: 388-97-1100 (3) 46793

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 37044 Based on observation, interview and record review, the facility failed to ensure residents' received therapeutic diets as prescribed by the physician, and/or assessed by the interdisciplinary team for 5 of 23 residents whose meals were observed (Residents 46, 24, 10, 50 and 42), and to provide the correct portion size for 6 of 6 residents (Residents 42, 71, 24, 43 64 and 127) observed with orders for small or large portions. Failure to ensure residents' received physician ordered therapeutic diets and/or portion sizes placed residents at risk for medical complications and/or unmet nutritional needs. Findings included . <Therapeutic Diets> On 11/12/2024 at 11:20 AM, dietary staff had already placed beverages and condiments on all resident trays and placed them into the tray carts. Observation of the trays at that time, showed each tray had been provided a container of tartar sauce. Review of the therapeutic menu for the lunch meal, which consisted of cakes, rice pilaf with mushrooms, seasoned green peas with chocolate cream pie, showed the following diet types were not to receive tartar sauce: No added salt (NAS); low fat/low cholesterol; two grams sodium (2 GM Na); renal (low sodium/potassium). During tray line on 11/12/2024 from 11:39 AM - 12:23 PM, the following residents' trays were observed being prepared and sent out for delivery: 1) Resident 46 who was on a renal diet. 2) Resident 24 who was on a NAS diet. 3) Resident 10 who was on a NAS diet. 4) Resident 50 who was on a 2 GM Na diet. 5) Resident 42 who was on a controlled carbohydrate diet with Additional Directions of NAS. Each of the above residents were provided tartar sauce on their meal tray despite the therapeutic menu directing staff not to provide it. On 11/12/2024 at 12:23 PM, Staff LL, Dietary Manager, confirmed all residents, including the above referenced residents, had been provided tartar sauce on their trays and should not have been. After confirming it, Staff LL failed to direct staff to remove the tartar sauce from other residents' trays who were on NAS, low fat/low cholesterol, 2 GM NA or renal diets. <Portion Sizes> (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of tray line on 11/12/2024 from 11:39 AM - 12:23 PM, showed staff had green handled spoodles (4 oz or 1/2 cup) placed in the rice pilaf and seasoned green peas, as the recipe called for. During tray line on 11/12/2024 from 11:39 AM - 12:23 PM, Staff JJ, Cook, was observed plating meals for the following residents: 1) Resident 42 whose diet under Additional Directions, directed staff to provide small portions, but the resident was provided a full serving of seasoned peas, rice pilaf and crab cake. 2) Resident 71's diet ticket directed staff to provide small desert portions, but the residents was provided a full portion of desert. 3) Resident 24's diet ticket directed staff to provide small portions, but the resident was provided full serving of seasoned peas, rice pilaf and crab cake. 4) Resident 43's diet ticket directed staff to provide small desert portions, but the resident was provided a full potion of desert. 5) Resident 64's diet ticket directed staff to provide large protein portions, but the resident was only provided one crab cake. 6) Resident 127's diet ticket directed staff to provide large portions, but the resident was provided one crab cake and 1/2 cup of seasoned peas and rice pilaf. On 11/12/2024 at 12:15 PM, Staff JJ, Cook, and Staff MM, Dietary Aide, both confirmed that the same 1/2 cup spoodle for each of the above referenced residents and agreed each resident received one scoop, despite the ordered portion size. Staff JJ indicated they had visually adjusted the amount they had in the scoop (e.g. filled it halfway for small portions etc.) On 11/12/2024 at 12:23 PM, Staff LL, Dietary Manager, explained that staff usually did use just one spoodle and visually adjust the amount they scooped, rather than using a 1/4 cup scoop for small portions or providing a 1/2 cup and a 1/4 cup scoop for large portions. When asked if small portions of desert meant the resident should get 1/2 desert Staff LL stated, Yes. On 11/12/2024 at 12:58 PM, when asked if dietary staffs' practice of visually adjusting the scoop size of a 1/2 cup spoodle to provide a 3/4 cup serving for large portions and 1/4 cup for serving small portions was acceptable Staff A, Administrator, said no, they should use the appropriate size spoodle. Reference WAC 388-97-1200(1)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 37044 Based on interview and record review, the facility failed to seek/ obtain approval from the Resident Council, and to ensure residents were provided a nourishing snack at bedtime, when the time between the dinner and breakfast meals was increased from 14 hours to 15 hours. These failures precluded residents from having input about extending the time between meals beyond 14 hours and placed them at risk for feelings of hunger and inadequate nutrition. Findings included . a) The Garden Room and Medicare A hall were served dinner at 5:00 PM and breakfast at 8:00 AM, for a total of 15 hours in between meals. b) Medicare B was served dinner at 5:10 PM and breakfast at 8:10 AM, for a total of 15 hours in between meals c) [NAME] Mountain and Mountain View Halls were served dinner at 5:15 - 5:20 PM and breakfast at 8:15 - 8:20 AM, for a total of 15 hours in between meals. On 11/14/2024 at 7:45 AM, Staff B, Director of Nursing Services, said they were unable to find documentation to show they sought approval from the Resident Council prior to extending the time between Dinner and Breakfast meals beyond 14 hours. When asked if the facility was serving residents a nourishing snack at bedtime, Staff B said only diabetic residents were served snacks at bedtime, but indicated snacks were available to other residents if requested. Reference WAC 388-97-1200(1)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to have a system in place that ensured effective communication, collaboration, and coordination of care occurred between the facility and the hospice provider for 2 of 2 residents (Resident 64 & 28) reviewed for hospice services. The facility failed to obtain and/or maintain a copy of a resident's current hospice coordinated plan of care, to have documentation in residents' Electronic Health Records (EHR) that showed what hospice disciplines (e.g. registered nurse, chaplain, certified nursing assistant, massage therapist) had visited, when they visited, and what care was provided. These failures detracted from staffs' ability to effectively collaborate, communicate and coordinate care with the hospice provider and placed residents at risk for not receiving necessary care and services and/or unmet care needs. Findings included . Review of the facility's Hospice Service Agreement, effective date [DATE], showed the facility and hospice would each designate a Registered Nurse responsible for coordinating the implementation of the plan of care for each hospice patient. Additionally, hospice and the facility agreed to develop a plan of communication for each hospice patient and further agreed, as required by state or federal regulations, to enter all necessary information into each Hospice patient's medical chart. 1) Resident 64 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS, an assessment tool), dated [DATE], documented Resident 64 was moderately cognitively impaired. Resident 64 was placed on hospice on [DATE]. Resident 64's Hospice Care Plan, dated [DATE], documented hospice would only provide a bed bath once a week and Activities of Daily Living (ADL's) once a week. The facility was responsible for providing all other ADL assistance, except when hospice staff was present, including wound care. Review of facility/hospice services binder, located at the Long Term Nurses station, only provided information that Resident 64 was no longer receiving the 12 microgram Fentanyl patch. No other information was located in this hospice binder. The facility/hospice service binder at the Medicare A and B Nurses station, provided no documentation for Resident 64's hospice care. The last progress note from hospice was on [DATE], no further documentation was in the EHR. Progress notes on [DATE] and [DATE] showed the facility contacted hospice regarding medications. No other progress notes showed communication with hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:05 AM, Staff E, Resident Care Manager, said the facility currently did not have a designated person for communication with hospice and the nurse who communicated with hospice should document all communication. When asked about the hospice binder, Staff E said every resident on hospice should have a tab in the binder for communication between the facility and hospice. Staff E said Resident 64 should have had a section specific to them. Staff E said any hospice communication documentation should have been given to the nurse, who would process the order and then give the record to medical records to upload into the EHR. At 12:45 PM, when reported there was no documentation from hospice since [DATE], Staff B, Director of Nursing Services (DNS), said there should have been documentation in the hospice binder for Resident 64 and all residents on hospice. 37044 2) Resident 28 admitted to the facility on [DATE]. Review of the [DATE] Quarterly MDS showed the resident had a terminal diagnosis and received hospice services. A Certificate of Terminal Illness showed Resident 28 started on hospice services on [DATE]. Review of the most recent hospice plan of care in Resident 28's record showed it had expired on [DATE]. A recertification visit, dated [DATE], was present in the record but not a copy of the resident's current coordinated plan of care. On [DATE] at 12:03 PM, when asked who the facility designated as the liaison to coordinate and implement hospice residents' plans of care, Staff B, DNS, said that any nurse could communicate and coordinate hospice care and said there was not a specific staff member identified. Staff B then indicted that for further hospice questions Staff X, Registered Nurse, was the best person to speak with. A Hospice care plan, revised [DATE], showed the resident was to receive weekly hospice nurse visits as well as weekly aide visits to provide shower/sponge baths. Review of Resident 28's EHR showed no documentation was present to show what hospice disciplines had visited, when, or what they did. Additionally, it was unclear if the hospice care plan remained accurate as the facility did not have a copy of the resident's current coordinated hospice plan of care. On [DATE] at 12:30 PM, when asked if they could tell what hospice disciplines had visited the resident in the past two weeks, when, and what they did during the visit (e.g. provide bed bath etc.), Staff X said No. Staff X explained that they had identified issues with the communication between hospice and the facility and recently initiated a hospice binder to improve communication but indicated it was in process. Staff X said they had requested hospice aide documentation and hospice nurse after visit summaries. When asked if they could find a current coordinated hospice plan of care for Resident 28, Staff X said no, but indicated they would request it. No Associated WAC

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation, interview, and record review, the facility failed to perform hand hygiene, follow Personal Protective Equipment (PPE, equipment worn to minimize exposure to a variety of hazards requirements for a resident on Enhanced Barrier Precautions (EBP, an infection control method that involves wearing gowns and gloves during high-contact interactions with residents in nursing homes) orders, failed to prevent cross-contamination for food and PPE carts, and failed to prevent medical equipment from touching the floor for 3 of 25 sampled residents (Resident 7, 21 & 56) and 1 of 3 halls (Med Cart B Hall) reviewed for infection control practices. These failures placed residents at risk of developing and transmitting infections and a decreased quality of life. Findings included . <EBP> 1) Resident 7 was admitted to the facility on [DATE] and had diagnoses including dysphagia (difficulty swallowing) and aphasia (a language disorder that affects a person's ability to understand and express written and spoken language) following a cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, resulting in brain tissue death). The Quarterly Minimum Data Set (MDS, an assessment tool), dated 10/03/2024, documented the resident had a gastric feeding tube (it can be used for long-term nutritional support and is often used for people who have difficulty swallowing or can't get enough food by mouth). Resident 7 had an order, dated 10/03/2024, for Enhanced Barrier Precautions. PPE required for high resident contact care activities. Indications: Gastric tube. On 11/08/2024 at 7:27 AM, Staff W, Licensed Practical Nurse (LPN) gave Resident 7 their medications and Staff W said, I should have gowned up when I gave Resident 7 their medications but I forgot this time. At 8:54 AM, Staff X, Infection Preventionist (IP)/Registered Nurse (RN) said when giving medication through a gastric tube the nurse should put on PPE according to the EBP order. At 12:16 PM, Staff B, Director of Nursing (DNS) said her expectation would be for the nurse to follow the order for EBP. 37044 50945 <PPE Carts> Observation on 11/04/2024 at 10:27 AM, showed a resident's half eaten meal tray on the PPE cart across the hall from their room, next to Resident 21's room. At 10:41 AM, the tray was no longer on the PPE cart and staff were observed to place items (brief, absorbent pads) onto the PPE cart as they applied PPE and then entered Resident 21's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/06/2024 at 8:31 AM, showed a PPE cart next to room [ROOM NUMBER] had a half empty mug filled with a dark liquid substance in it on the cart. At 8:44 AM, the PPE cart was observed to have the same mug, with a nursing aid putting new items next to it (milk, orange juice, water, and straws) on the PPE cart. The new items were observed to be brought into the room, the half-filled mug remained on the PPE cart. During an interview on 11/13/2024 at 9:58 AM, Staff C, RCM, said their expectation for PPE carts was staff not put anything on the PPE cart, and if they do then they clean it before putting something else on it. <Food Carts> Observation on 11/07/2024 at 9:29 AM, showed that a food cart labeled Med Cart B contained coffee on the bottom of the cart, and staff were putting used trays (taken from resident rooms) and putting the trays above the coffee that continued being served. A nursing aid was asked about the process and confirmed coffee was stored on one side and cups were stored on the other side of the cart, and that used trays were kept above. On 11/07/2024 at 12:17 PM, the Mountain View: food cart was delivered to the hall. Observation of the food cart at 12:21 PM showed staff were serving coffee/ tea from carafes stored on the bottom of the food cart underneath the residents' trays. Observation on 11/08/2024 at 12:21 PM showed the food cart labeled Med Cart B still had coffee being kept at the bottom of the cart. During an interview on 11/14/2024 at 1:43 PM, Staff B, DNS, said their expectation was for coffee to not be kept on the bottom of the food cart with staff still using the coffee. <Standard Precautions> Observation on 11/08/2024 at 12:34 PM showed Staff T, CNA, put a tray into the food cart labeled Med Cart B, went into an EBP room and took a tray from a resident, left the room, touched the food cart to put tray back into cart. Staff T went into another room and touched the door, left the room, then entered another residents room and was observed to help the resident clean up their chest using a tissue. Staff T then left the room with a bag of linen, went into the soiled linen room for a few seconds, left the room, and then went into a another room where they touched a wheelchair and the resident. No hand sanitizer was used at any point during this observation. During an interview on 11/08/2024 at 12:38 PM, Staff T said they forgot to hand sanitize, and they should have used hand sanitizer when entering a room. At 1:04 PM, Staff C, RCM, said for standard precautions (precautions used for all patient care) you should use hand sanitizer when you enter and leave rooms. During an interview on 11/13/2024 at 9:58 AM, Staff C, RCM, said the observation did not meet expectations, and they would have expected hand hygiene to have been completed several times. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/2024 at 1:43 PM, Staff B, DNS, said the observation did not meet expectations. <Urinary Catheter> Review of the Center for Disease Control and Prevention (CDC) document Guidelines for Prevention of Catheter (thin tube that collects urine)-Associated Urinary Tract Infections dated 2009, recommended staff maintained unobstructed urine flow by keeping the catheter and collection tube free from kinking (bend or twist obstructing flow of urine), the bag should not rest on the floor, and standard precautions should be used during any manipulation of the catheter's collecting system. Resident 21 Review of the Electronic Health Record (EHR) showed Resident 21 was admitted to the facility on [DATE]. Resident 21 had a suprapubic catheter (urinary tube that is placed into the bladder through a small hole in the abdomen, the tube carries urine outside of the body and is connected to a drainage bag that collects urine). Observation of Resident 21's catheter tubing on: 11/04/2024 at 10:25 AM, 11/05/2024 at 8:28 AM & 9:59 AM, 11/06/2024 at 10:34 AM, 12:22 PM & 3:26 PM, 11/07/2024 at 9:09 AM & 10:27 AM, and 11/08/2024 at 8:11 AM showed urine in the dependent part of the catheter tubing that loops down, then the tubing loops up creating a section where the urine has to move against gravity to move up in the tubing, before it loops back down into the urine bag. Observation on 11/06/2024 at 10:38 AM showed Staff Z, CNA, after assisting Resident 21 with cares, went into the bathroom and grabbed a urinal, came out and emptied the urine bag attached to the catheter. Staff Z did not change gloves or perform hand hygiene before emptying the urine bag, and did not empty the urine tubing into the urine bag before emptying it. Observation on 11/06/2024 at 10:34 AM showed Resident 21's catheter tubing and bag were touching the floor. During an interview on 11/13/2024 at 2:29 PM, Staff C, RCM, said their expectation was for staff to use hand hygiene before emptying the urine bag into the urinal, and this did not meet expectations that the urine bag and tubing had touched the ground. During an interview on 11/14/2024 at 9:13 AM, Staff B, DNS, said their expectation was the catheter tubing would be drained into the urine bag before emptying, staff would follow hand washing techniques when they emptied the urine bag, and the catheter tubing would not touch the ground. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Negative Pressure Wound Treatment> Resident 56 Review of the EHR showed Resident 56 was admitted to the facility on [DATE]. Resident 56 had a diagnoses of surgical amputation (removal of a limb) and muscle weakness. The Medicare 5-day MDS, dated [DATE], showed Resident 56's mental status was moderately impaired. Observations on 11/06/2024 at 12:33 PM and 11/12/2024 at 9:33 AM showed the tubing from the negative pressure wound treatment (a technique that uses suction to promote wound healing) was on the floor. During an interview on 11/12/2024 at 9:44 AM, Staff C, RCM, confirmed the tubing was on the floor and said their expectation was the tubing would not be on the floor and be lifted off the floor when it happened. At 4:08 PM, Staff B, DNS, said it did not meet expectations that the negative pressure wound treatment tubing was on the ground. Reference WAC 388-97-1320 (1)(c), -1320 (2)(b), -1320 (1)(a)

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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** 37044 Based on interview and record review, the facility failed to provide pneumococcal vaccines for 3 of 6 residents (Residents 176, 10 and 21) reviewed for vaccinations. This failure placed the residents at a higher risk for contracting pneumococcal infections, related complications, and a decreased quality of life. Findings included . 1) Resident 176 admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool), dated 10/24//2024, showed the resident's pneumococcal vaccinations were not up to date and documented the pneumococcal vaccination had not been offered. A Resident Consent For Influenza, Pneumococcal, and COVID-19 Vaccination form, dated 10/18/2024, showed Resident 176 consented to the vaccination and checked the box on the form that stated, Yes, I wish to receive the pneumococcal vaccine according to the CDC's recommended schedule. Review of the Electronic Health Record (EHR) showed the resident was not provided the pneumococcal vaccination despite giving written consent to receive it. Resident 176 subsequently discharged home on 11/11/2024 without receiving the requested vaccination. On 11/12/2024 at 11:08 AM, Staff X, Infection Preventionist, indicated they were not notified that Resident 176 had consented to the pneumococcal vaccination and acknowledged that the resident did not receive it. When asked if they would have expected the vaccination to be administered given the resident was in the facility for 25 days after providing consent, Staff X stated, Yes. 50945 2) Review of the EHR showed Resident 10 was admitted to the facility on [DATE] and consented to receive the pneumococcal vaccination on 10/29/2024. During an interview on 11/13/2024 at 8:51 AM, Staff C, Resident Care Manager (RCM), stated the pneumococcal vaccinations were not previously ordered from the supplier, and now the infection control nurse was made aware and would be ordering. During an interview on 11/14/2024 at 8:34 AM, Staff B, Director of Nursing Services (DNS), stated it did not meet expectations that Resident 10 signed consent and the pneumococcal vaccine was not ordered. 3) Review of the EHR showed Resident 21 was admitted to the facility on [DATE] and consented to receive the pneumococcal vaccination on 06/03/2024. During an interview on 11/13/2024 at 8:53 AM, Staff C, RCM, stated that Resident 21's pneumococcal vaccine was not ordered with the supplier, and this did not meet expectations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/2024 at 1:43 PM, Staff B, DNS, stated their expectation since Resident 21 consented to the pneumococcal vaccination, was that it would be completed. 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
	505290	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard Bremerton, WA 98310

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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 - Few	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** 50945 Based on record review and interview, the facility failed to ensure residents received COVID-19 vaccines that were consented for, for 2 of 7 residents (Residents 10, 21) reviewed for vaccinations. This failure placed residents at risk for a decreased immune response to COVID-19, related complications if infected, and a diminished quality of life. Findings included . 1) Review of the Electronic Health Record (EHR) showed Resident 10 was admitted to the facility on [DATE] and consented to receive the COVID-19 vaccination on 05/13/2024 and 10/29/2024. During an interview on 11/13/2024 at 8:51 AM, Staff C, Resident Care Manager (RCM), said the COVID-19 vaccinations were not previously ordered from the supplier, and now the infection control nurse was aware and would be ordering. During an interview on 11/14/2024 at 8:34 AM, Staff B, Director of Nursing (DNS), said it did not meet expectations that Resident 10 signed consent and the COVID-19 vaccine was not ordered from the supplier. 2) Review of the EHR showed Resident 21 was admitted to the facility on [DATE] and consented to receive the COVID-19 vaccination on 06/03/2024. During an interview on 11/13/2024 at 8:53 AM, Staff C, RCM, said Resident 21's COVID-19 vaccine was not ordered with the supplier, and this did not meet expectations. During an interview on 11/14/2024 at 1:43 PM, Staff B, DNS, said their expectation was that if Resident 21 consented to COVID-19 vaccination, then it would have been completed. No Associated WAC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505290	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard Bremerton, WA 98310

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on observation and interview the facility failed to maintain the emergency fire doors in 1 of 3 main halls (outside room [ROOM NUMBER]) reviewed for maintenance were in working order. This failure placed residents and staff at risk for falls, avoidable injury, and a diminished quality of life. Findings included . During an observation on 11/04/2024 at 1:00PM, a square metal piece in the floor of Medicare A and Medicare B hallway was loose and sticking up. Facing north, the right fire door was closed to test whether or not the metal piece would hold the door and then allow the door to be opened. The exit bar had to be pushed upward and with a moderate amount of force in order to open the door. Staff P, Licensed Practical Nurse, walked by as the door was being tested and stated, oh good, that's back again, pointing to the metal piece. On 11/05/2024 at 9:31 AM, the fire door was observed to be closed. Staff O, Certified Nursing Assistant (CNA) attempted to open the door, pushing against the exit bar with one hand and could not open the door. It took several attempts and the use of both hands to successfully open the door. At 9:52 AM, a resident was observed ambulating with a walker towards the closed fire door. The resident attempted to push against the exit bar but was unable to open the door. At 11:41 AM, the double doors in the hallway near room [ROOM NUMBER] required two hands and significant force to be opened. At 3:45 PM, Staff M, Maintenance Supervisor, said he tried to glue the metal piece the day before but the glue had not cured. He said he would try to drill some type of screw through the bottom that would go into the pavement. On 11/12/2024 at 4:19 PM Staff A, Administrator, said it was their understanding that the little square, in the floor, that catches the door, had come loose and they repaired it, so it was no longer a tripping hazard. Reference WAC 388-97- 2100 50488