STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505309	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Coupeville Rehab and Nursing Center	311 Northeast 3rd Street Coupeville, WA 98239

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 36787 Based on observations and interviews, the facility failed to ensure the residents environment was clean and sanitary, and failed to identify and provide the necessary housekeeping services to ensure privacy curtains were laundered or replaced in resident (Residents 4 and 7) rooms on 1 of 2 units. These failures placed residents at risk for infectious disease and diminished quality of life. Findings included . <RESIDENT 4> In an interview and observation on 10/22/2024 at 11:43 AM, Resident 4 was in bed with both privacy curtains pulled around them. Both privacy curtains were heavily soiled with an 18 inch by 2-inch vertical brown stain on the left curtain and multiple brown and black areas on the right curtain. In multiple observations the privacy curtains remained unchanged on 10/23/2024 at 1:07 PM, 10/24/2024 at 9:55 AM, 10/25/2024 at 8:23 AM and 10/28/2024 at 9:30 AM. In an interview and observation on 10/29/2024 at 9:00 AM, Resident 4 was observed in bed behind both privacy curtains that remained soiled. Resident 4 stated they did not know when their privacy curtains were laundered or changed. <RESIDENT 7> In an interview and observation on 10/23/2024 at 10:07 AM, Resident 7's privacy curtains had multiple brown or black soiled areas approximately 1 centimeter in size. In multiple observations the privacy curtains remained unchanged on 10/24/2024 at 8:41 AM, 10/28/2024 at 9:34 AM and 10/29/2024 at 9:30 AM. In an interview and observation on 10/29/2024 at 9:00 AM, Resident 7 was lying in bed behind both privacy curtains that remained soiled. Resident 7 stated they did not know when their privacy curtains were laundered or changed. In an interview and observation on 10/29/2024 at 11:13 AM, the soiled privacy curtains remained in place. Resident 7 stated they were unsure when privacy curtains had been changed out or laundered. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/28/2024 at 12:54 PM, Staff C, Housekeeping Supervisor, stated that they don't have a schedule for replacing privacy curtains. Staff C stated if the housekeeper had time, they would change the privacy curtains out when they have a new resident coming into the room. In a joint interview on 10/29/2024 at 10:03 AM, Staff A, Administrator and Staff D, Director of Clinical Services were informed of Resident 4 and 7's soiled privacy curtains and both long term residents reported they did not know when the curtains had been laundered or replaced. Staff A reported they just ordered a lot more privacy curtains for this purpose. Staff A said the facility had no policy in regard to privacy curtains. Refer to WAC 388-97-0880 (1)(2)(4)(b)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 33954 Based on observation, interview and record review, the facility failed to promptly resolve and document resident grievances for 2 of 3 sampled residents (Residents 67 and 4) reviewed for grievance resolution. The failure of staff to document, investigate, and resolve resident grievances resulted in delays in grievance resolution and an extended period where a resident went without their missing clothing, and placed residents at risk for frustration and diminished quality of life. Findings included . Review of the facility policy titled Grievance Procedure, revised date of October 2021, showed the facility would have a process in place for identification, investigation, and follow-up of resident grievances in a timely manner. The policy indicated they facility would identify a Grievance Officer to oversee the grievance procedure and coordinate the facility system for collecting, tracking, and responding to grievances. The policy indicated staff were trained on the facility's grievance procedure including the need to take all grievances seriously, what to do with grievances and when to put grievances in writing. The policy indicated when immediate resolution of grievances was not possible, the individuals receiving the grievance were to fill out a grievance/comment form and forward it to the Grievance Officer and/or designee, and the Grievance Officer would log the grievances on the grievance log. <RESIDENT 67> Resident 67 admitted to the facility on [DATE]. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 09/11/2024, the resident had no cognitive impairment. In an interview on 10/22/2024 at 1:47 PM, Resident 67 stated they were missing a nightgown, pajamas, and a pair of pants, and they had been missing for three weeks. Review of the facility grievance log for 10/01/2024 - 10/23/2024 showed no grievances were logged for Resident 67. In an interview on 10/24/2024 at 9:25 AM, Staff H, Registered Nurse/Resident Care Manager, stated Resident 67 had mentioned yesterday to nursing that they were missing clothing, but the resident had not told anyone except laundry and the nursing assistants until recently. Staff H stated they gave Resident 67 a copy of the facility grievance form to fill out yesterday, but they didn't know if it got filled out. In an interview on 10/24/2024 at 1:31 PM, Resident 67 stated the missing property had been going on close to a month, and initially they had told a housekeeper and a nursing assistant. Resident 67 stated two days earlier a unit nurse manager had brought them a grievance form to fill out, but they had not yet heard anything back. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/25/2024 at 9:52 AM, Resident 67 stated they had not received any of their missing clothing back, but the facility had brought some donated clothes in and told them those were their clothes now, and they were not happy about that because some of their missing clothes had cost over $100. In an interview on 10/25/2024 at 10:00 AM, Staff C, Housekeeping/Laundry Supervisor, stated a nursing assistant told laundry last week that Resident 67 was missing clothing, and they looked and could not find any of the items. Staff C stated if clothing was not labeled it could go out to just about any resident and that is what they think happened to the resident's missing clothing. Staff C didn't know if any staff had filled out a grievance form, they stated they could have, but they didn't and they didn't know if any other staff had. In an observation on 10/25/2024 at 10:45 AM, observed 18 items of clothing hanging in Resident 67's closet, the clothing items had multiple names on them, and only one item had Resident 67's name. Review of a grievance form, signed by Resident 67, and it had two dates, 10/18/2024 and 10/23/2024, it indicated the grievance was Resolved. Items found and returned. In an interview on 10/25/2024 at 10:33 AM, Staff A, Administrator, was asked about the resident's grievance form that indicated the grievance was resolved, they stated they had gone to laundry and saw the clothes laundry was going to provide to the resident so they thought the missing items had been found, but they would re-open the grievance. Staff A stated they would also investigate why staff didn't fill out a grievance form earlier, as they didn't find out until 10/23/2024 when the resident themselves filled out a grievance form. 36787 <RESIDENT 4> Resident 4 admitted [DATE] with diagnoses to include Cerebrovascular Accident (CVA, a condition that affects blood flow to the brain) with hemiparesis (weakness on one side of the body), hemiplegia (paralysis on one side of the body) and mild cognitive impairment. In an interview on 10/23/2024 at 8:48 AM, Resident 4 was frowning and stated their aide (NAC, Nurse's Aide Certified) yesterday was awful, just awful. I won't elaborate she just didn't take good care of me. She didn't turn me. On 10/23/2024 at 9:00 AM, this surveyor reported Resident 4's concern to Staff A, Administrator. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a grievance dated 10/23/2024 showed that Resident 4 reported to Staff B, Director of Nursing Services The NAC that cared for me yesterday did not provide good care. Didn't change me enough. Not a good caregiver. Action taken on the grievance showed was the agency was contacted, and the NAC removed from facility schedule so further investigations was able to be completed. The follow up section of the grievance showed the resident validated no concerns of abuse/neglect and would prefer a different caregiver moving forward. Action recommendations listed the facility would continue to monitor resident care, communicate any concerns and validate appropriate care and the caregiver was to receive education prior to returning to the facility. The outcome showed the grievance was resolved, the resident confirmed satisfaction and there were no signs of harm or psychosocial distress. There were no additional statements or documents included with the grievance. Review of Resident 4's clinical record showed no entry about the resident's concern or monitoring in place for the allegation of poor care. Review of the incident reporting log showed no entry for Resident 4. In an interview on 10/29/2024 at 9:00 AM, Resident 4 said they not seen the NAC they had concerns with and had not heard if there was any resolution to the matter. In a joint interview on 10/29/2024 at 9:38 AM Staff A, Administrator and Staff D, Director of Clinical Services were informed Resident 4's grievance was not escalated to an incident. The grievance was not investigated. Staff A and Staff D were informed there was no alert charting/ progress notes, interviews with staff, and other residents or the involved staff to ascertain if other residents or staff had similar concerns. Staff A said this issue had not been addressed in Quality Assurance Performance Improvement (QAPI). No additional information was provided. Refer to WAC 388-97-0460 (2)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51312 Based on interviews and record reviews, the facility failed to ensure a Significant Change in Status (SCSA) Minimum Data Set (MDS- an assessment tool) was completed for 1 of 3 sampled residents (Resident 12) reviewed for decline in Activity of daily living (ADL). This failed practice placed residents at risk for inadequate care planning and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.18.11, dated October 2023, stated a Significant Change in Status Assessment must be completed no later than 14 days from the Assessment Reference Date and no later than 14 days from the determination date of the significant change in status. (For purpose of this section, a significant change means a major decline in status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of a resident's health status). <RESIDENT 12> Resident 12 admitted to the facility on [DATE] with diagnoses to include muscle weakness, major depressive disorder, abnormalities of gait and mobility, anxiety disorder, and alcoholic cirrhosis of the liver. Review of Resident 12's current care plan print date 10/24/2024, showed the resident did not have an ADL care plan in place with interventions or goals. In an interview on 10/22/2024 at 1:59 PM, Resident 12 stated, I have lost muscle strength and would like to regain it. Resident 12 indicated that they feel like they are getting weaker, and staff does not exercise with them. Review of the Quarterly MDS assessment dated [DATE] showed Resident 12 had a significant decline in their ADL ability. In an interview on 10/28/2024 at 11:15 AM, Staff I, Nursing Assistant Certified (NAC) stated that Resident 12 is not standing or walking, and it seems they are getting weaker. In an Interview on 10/28/2024 at 11:28 AM, Staff V, Licensed Practical Nurse (LPN) stated that when a resident has a decline, nursing should let the staff know, so all floor staff are aware. Staff V stated that a residents' treatment plan should be updated if a decline happens. In an interview on 10/28/2024 at 11:40 AM, Staff J, LPN/Resident Care Manager, stated that Resident 12 had COVID 19, and that could have been part of their decline, but feels that Resident 12 is refusing care and has mentioned that their legs are weak. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/28/2024 , Staff F, Registered Nurse (RN)/MDS, stated that when an MDS showed a decline in ADL function, a significant change assessment should be completed and it was for completed for Resident 12. In an interview on 10/28/2024 at 1:40 PM, Staff B, Director of Nursing stated they rely on physical therapy to know if residents need restorative services. Staff B felt like there was a program in place for Resident 12, but the resident had chosen not to follow the program. Refer to WAC 388-97-1000 (3)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview and record review, the facility failed to accurately assess 2 of 3 sample residents (Residents 67 and 65) reviewed for devices and 1 of 2 residents (Resident 4) reviewed for pressure injuries. This failure placed the residents at risk for not receiving the care and service required to meet the residents' needs and for inaccuracies in care planning of the residents' care. Findings included . <RESIDENT 67> Resident 67 admitted to the facility 09/07/2024 with diagnoses to include a colostomy (colostomy - a surgery to create an opening for the colon (large intestine) through the abdominal wall). According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 09/11/2024, the resident had no cognitive impairment, and they had no ostomy, and they were coded they were always continent of bowels. In an observation/interview on 10/24/2024 at 1:10 PM, Resident 67 stated they had a colostomy that was used for them to have their bowel movements, and they showed the surveyor their colostomy supplies they used to manage their colostomy to empty their bowels. In an interview on 10/25/2024 at 1:00 PM, Staff B, Registered Nurse/Director of Nursing, stated the MDS was not correct regarding Resident 67's colostomy and it was also not correct regarding the resident's bowel continence as they were obviously not continent of bowels if they had an ostomy. 36787 <PRESSURE ULCERS> Review of the RAI (Resident Assessment Instrument), manual of requirements for completing MDS assessment) directs MDS nurses to examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer development .Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e. g., ears from oxygen tubing). <RESIDENT 4> Resident 4 admitted [DATE] with diagnoses to include Cerebrovascular Accident (CVA, a condition that affects blood flow to the brain) with hemiparesis (weakness on one side of the body) , hemiplegia (paralysis on one side of the body), facility acquired pressure ulcers and mild cognitive impairment. Review of the contracted wound provider visit note from 07/25/2024 at 9:19 PM, showed the resident had a Stage IV pressure ulcer to their right buttock and a stage IV to their medial sacrum. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE] showed Resident 4 had a pressure ulcer determined by formal assessment tool and clinical assessment. The MDS showed the resident had one- stage III and one- stage IV pressure ulcers that were not present on admission or reentry. In an interview on 10/28/2024 at 12:16 PM, Staff F, MDS nurse said they code the pressure ulcer section by looking at the wound notes in the chart then they decipher from there how to code the wounds. Staff F acknowledged they coded Resident 4's wounds as a stage III and IV. Staff said they interviewed staff and reviewed the medical record but did not examine the resident to visualize the wounds. Staff F said they were unsure how they had determined the staging as different from the provider visit on 07/25/2024 and that they had not made a note about their coding for Resident 4. In an interview on 10/28/2024 at 9:17 AM, Staff D, Director of Clinical Services said the facility did not have a policy and procedure for MDS assessments and the MDS nurse utilized RAI manual for their process. <ENTERAL FEEDING> <RESIDENT 65> Resident 65 admitted [DATE] with diagnoses to include cerebral infarction (a condition that affects blood flow to the brain) with hemiparesis, hemiplegia, and dysphagia (difficulty swallowing) requiring enteral feeding (nutrition through a tube into the stomach). Review of the admission note on 08/08/2024 at 5:49 PM, showed Resident 65 received enteral feeding and nothing by mouth. Review of the admission MDS on 08/13/2024 showed Resident 65 had no swallowing disorder or feeding tube. In an observation on 10/23/2024 at 2:21 PM, Resident 65 was resting in bed with their tube feeding running at 65 milliliters (ml) per hour. In an interview on 10/28/2024 at 12:10 PM, Staff F, MDS nurse stated their interview with Resident 65 was limited on admission. The admission MDS was reviewed with Staff F. Staff F stated they were not sure why they coded the resident as having no difficulty swallowing and no tube feeding as they coded the MDS wrong. In a joint interview on 10/29/2024 at 9:44 AM, Resident 4 and 65's MDS inaccuracies were discussed with Staff A, Administrator and Staff D, Director of Clinical Services. No additional information was provided. Refer to 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** 36787 Based on interview and record review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) screening for residents for a serious mental illness (SMI), intellectual disability (ID) or a related condition was completed if the scheduled discharge did not occur for 1 of 5 sampled residents (Resident 18) reviewed. Additionally, the facility failed to ensure a resident with a Level 1 PASRR screening form was accurate prior to admission to the nursing facility for 1 of 5 sample residents (Resident 38) reviewed. These failures placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health and/or intellectual disability care needs. Findings included . <RESIDENT 18> Resident 18 was admitted to the facility on [DATE] with diagnoses to include depression, anxiety disorder and a history of delirium (a serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings) with agitation. Review of Resident 18's Level I (pre-screen to determine if a resident may have a SMI, ID, or related condition and is typically completed by the referring entity) PASRR form dated 01/18/2024 showed no Level II (an in-depth evaluation to determine if a resident has a SMI, ID, or related condition and is completed by a representative from the state intellectual disability authority or a representative from the state mental illness authority) evaluation was indicated due to exempted hospital discharge, but a Level II must be completed if scheduled discharge did not occur. Review of Resident 18's medical record showed no Level II PASRR was completed after the resident had been in the facility greater than 30 days. In an interview on 10/28/2024 at 1:41 PM, Staff G, Social Services Director (SSD) confirmed the last PASRR in Resident 18's clinical record was in January pre-admission and the assessment was exempted as the resident was to discharge in 30 days. Staff G said they notified the PASRR evaluator on 09/20/2024 for review and informed them the resident was staying at the facility long term now. Staff G said the assessment was definitely late and their policy stated that if the PASRR was marked 30 days and they stay then they need a referral. Staff G said they did update everyone's PASRR but this one with an exempt was over looked. Review of PASRR audit documentation received from the facility on 10/29/2024 at 10:57 AM, the PASRR evaluator was faxed on 02/14/2024 and 08/15/2024 and an email was sent on 10/28/2024 at 4:31 PM for Resident 18. In a joint interview on 10/29/2024 at 9:47 AM, Staff A, Administrator and Staff D, Director of Clinical Services said they had identified Resident 18's PASRR was exempt in September 2024 and sent a message to the PASRR evaluator at that time. 50725 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<RESIDENT 38> Resident 38 admitted to the facility on [DATE] with diagnoses to include dislocation of right hip prosthesis and dementia unspecified with behavioral disturbance. In a record review on 10/23/2024, Resident 38's PASRR under Section IV, No Level II evaluation indicated was marked. PASRR form was signed and dated 01/03/2024. In a record review on 10/24/2024, Resident 38's Medication Administration Record for October and September 2024 showed resident was taking Seroquel, an antipsychotic (a medication to treat psychosis [refers to collection of symptoms that affect the mind, where there has been some loss of contact with reality]), 50 milligrams daily at bedtime. In an interview on 10/28/2024 at 1:12 PM, Staff J, Licensed Practical Nurse/Resident Care Manager, stated that Resident 38 started taking Seroquel on 01/08/2024 after resident was discharged from the hospital on 01/07/2024. In an interview on 10/28/2024 at 1:28 PM Staff G, SSD, stated that if the hospital started a psychotropic medication (any drug that affects brain activities associated with mental processes and behaviors) then the hospital staff should have provided an updated PASRR prior to sending a resident back to their facility. Staff G stated that Resident 38 does not have an updated PASSR to reflect their Seroquel medication. Refer to WAC 388-97-1975 (1)(5)(9)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36787 Based on observation, interview and record review, the facility failed to ensure that care plans were revised to reflect changes or current status of 3 of 7 sample resident (Residents 4, 7, and 17) reviewed for care plans. These failures placed residents at risk of less-than-optimal care, staff not knowing how to properly care for a resident, a decreased quality of life with potential for harm. Findings included . <RESIDENT 4> Resident 4 admitted to the facility on [DATE] with diagnoses to include Cerebrovascular Accident (CVA, a condition that affects blood flow to the brain) with hemiparesis (weakness on one side of the body), hemiplegia (paralysis on one side of the body) and mild cognitive impairment. In a review of Resident 4's care plan dated [DATE] and most recently updated [DATE] showed a care plan focus of potential alteration in skin integrity related to decreased mobility following CVA with hemiparesis. The care plan showed Resident 4 preferred to remain up in their wheelchair throughout the day increasing their risk for breakdown/poor healing. The care plan reflected a history of recurring skin breakdown to coccyx/sacrum, paraplegia, indwelling Foley catheter. The care plan showed current wounds as a Stage IV (Stage IV pressure ulcer - full thickness tissue loss with exposed bone, tendon or muscle) to right gluteal fold and moisture associated skin damage (MASD) pressure areas to sacrum and right buttock. On observations on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE], the resident was observed in bed on all observations with the exception of a shower on [DATE] at 2:11 PM. In an interview on [DATE] at 12:36 PM, Resident 4 stated they didn't really get out of bed anymore, but they should. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident 4 had a pressure ulcer determined by formal assessment tool and clinical assessment. The MDS showed the resident had one- stage III (Stage III pressure ulcer - full thickness tissue loss and subcutaneous fat may be visible, but bone, tendon or muscle is not exposed) and one- stage IV pressure ulcers that were not present on admission or reentry. Review of the contracted wound provider visit note from [DATE] at 8:36 AM, showed the resident had a Stage IV pressure ulcer to their right buttock and a stage IV to their medial sacrum. <RESIDENT 7> Resident 7 admitted on [DATE] with diagnoses to include multiple sclerosis (MS, a debilitating neuromuscular disease), quadriplegia, chronic fatigue and muscle spasms. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 9:47 AM, Resident 7 stated that this past January, their electric wheelchair died and the company that it was purchased had closed so the facility contracted the repairs out. Resident 7 said that almost 10 months later there was no resolution. They told me they were waiting for a code. The tilt function did not work anymore but I would like to just sit in it. If I could just use it in manual mode, it was a decent chair to sit in and it was a lot more comfortable. Resident 7 said they had asked staff about it, and they got lots of excuses. The resident said they now lay flat in the standard wheelchair the facility provided. Resident 7 said this wheelchair had no seatbelt like their custom one and they slid in this one. The resident reported the wheelchair was uncomfortable and painful when riding on the bus. Review of Resident 7's care plan created on [DATE], showed the resident was at risk for falls related to impaired mobility, poor sitting balance due to MS, poor body trunk balance, altered cardiorespiratory status, chronic pain, use of high-risk medications, incontinence, quadriplegia, and weakness. The last revision was on [DATE]. The care plan directed staff to provide an appropriate adaptive electric wheelchair. The resident was able to have their electric wheelchair tilted back when the seatbelt was fastened for comfort and proper seated alignment. In an observation on [DATE] at 11:52 AM, Resident 7 was up in a manual wheelchair being pushed by Staff M, Agency NAC while on their cell phone by the nurses station. Resident 7 was leaned back in the wheelchair and looked uncomfortable. In an interview on [DATE] at 12:00 PM, Staff F, Registered Nurse/MDS nurse said the nurse managers revised the care plans. Staff F said social services updated the care plan for discharge planning. Staff F said they were unaware Resident 7 was in a manual wheelchair now. <RESIDENT 17> Resident 17 admitted on [DATE] with diagnoses to include right artificial hip, chronic kidney and lung disease. Review of the clinical record showed one social service note entry since admission. The entry was about exposure to COVID. Review of the care plan initiated on [DATE] showed the discharge plan was for Resident 17 to return home with daughter, resident's barriers to discharge were balance and to be independent with safety awareness. The interventions listed were community referrals as needed and to evaluate and discuss with the resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss and address limitations, risks, benefits and needs for maximum independence. The care plan did not specify the resident's goals and interventions to accomplish them. In an interview on [DATE] at 8:56 AM, Staff G, Social Services Director, stated the resident, and their daughter did not feel they were ready for discharge yet. Staff G said they did not complete the care plan as they did not do the psychosocial care plan which would have triggered them to complete the discharge care plan. Staff G said they tried to make changes in the discharge plan during care conferences. In an interview on [DATE] at 9:16 AM, Resident 17 said staff had not talked to them about discharge planning. The resident said their goal was to be home by Thanksgiving. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview on [DATE] 9:35 AM, Staff A, Administrator and Staff D, Director of Clinical Services were informed about the care plan revision issues for Resident 4, 7 and 18. Staff A stated they were unaware of the issues. This is a repeat deficiency from [DATE]. Refer to WAC [DATE] (1)(5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review, the facility failed to ensure staff followed professional standards of practice for 2 of 2 sampled residents (Residents 7, 17) reviewed for physician's orders on medication parameters and 1 of 1 sample residents (Resident 38) reviewed for admission orders. The failure to implement and follow physician prescribed orders placed residents at risk for adverse effects, unmet care needs and diminished quality of life. Findings included . <RESIDENT 38> Resident 38 was admitted to the facility on [DATE] with diagnoses to include dislocation of right hip prosthesis and dementia unspecified with behavioral disturbance. Resident 38 was sent to the emergency room (ER) on 09/08/2024 for hip dislocation. In a record review on 10/28/2024 at 9:14 AM, Resident 38's hospital discharge note, dated 09/09/2024, the Emergency Department (ED) note stated, the ED provider recommended palliative care (a specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness)/hospice care (a specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life) and since the resident was going back to the nursing home facility, the staff at the facility would follow up on this recommendation. Record review on 10/28/2024 of Resident 38's progress notes from 09/09/2024 through 10/28/2024 did not show any documentation that they had addressed the ED provider recommendation for palliative/hospice care. In an interview on 10/28/2024 at 1:05 PM, Staff J, Licensed Practical Nurse/Resident Care Manager (RCM) stated that when a resident came back from the emergency room , the licensed nurse assigned to the resident would review the after-visit summary (AVS) for any new orders. If the nurse was too busy with other residents, then they assigned this task to the RCM to do, and a copy of the AVS would be given to the house provider for review. Staff J was unable to provide any documentation staff had discussed the ED provider's recommendation for palliative care/hospice with the resident or their spouse. In an interview on 10/29/2024 at 9:10 AM, Staff B, Director of Nursing, stated when a resident came back from the hospital, the licensed nurse would compare the discharge orders to what they currently had at the facility and if there were changes, they reached out to the house provider for clarification. Staff B was unable to provide documentation that staff had talked to Resident 38 and/or their spouse about the palliative/hospice care recommendation from the ED provider. 36787 <RESIDENT 7> Resident 7 was admitted on [DATE] with diagnoses of heart failure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician orders, dated 10/01/2024, directed nurses to administer diuretic medication Lasix one time a day for congestive heart failure, ascites and pedal edema but hold the medication when the systolic blood pressure (SBP, top reading of a blood pressure) was less than 100. Review of the October 2024 Medication Administration Records (MAR) showed that Lasix was administered 10/01/2024 to 10/29/2024. The MAR did not have an area to document the blood pressure prior to administering the dose. Review of the October blood pressures in the clinical record under the vital sign tab showed Resident 7's blood pressure was not obtained daily to ascertain if the medication could be given as the physician ordered. The blood pressures documented were on 10/11/2024, 10/13/2024, 10/18/2024, 10/19/2024, 10/20/2024, 10/25/2024, 10/26/2024 and 10/27/2024. In an interview on 10/29/2024 at 11:13 AM, Resident 7 said that staff do not check their blood pressure prior to administering their morning pills. <RESIDENT 17> Resident 17 admitted on [DATE] with diagnosis to include hypertension (elevated blood pressure). Review of the physician orders directed nurses to administer Hydralazine (mediction to rapidly reduce blood pressure in hypertensive emergency) every six hours as needed for severe hypertension when the systolic BP was > 180 or the diastolic blood pressure (DBP, lower number of blood pressure) was over 110 beginning 10/20/2024. Review of the October 2024 MAR showed that Hydralazine was administered 10/21/2024 at 11:24 AM when the last blood pressure was 158/66 at 10:33 AM. The blood pressure before the 10/23/2024 at 12:45 AM dose was 126/70 at 10/23/2024. The MAR did not have an area to document the blood pressure every six hours prior to administering the dose. The blood pressures were not obtained four times a day to ascertain if the medication could be given as the physician ordered. In an interview on 10/28/2024 at 9:17 AM, Staff D, Director of Clinical Services said the facility did not have a policy on medication parameters and said parameters were a standard of practice. In an interview on 10/28/2024 at 12:05 PM, Staff F, Registered Nurse said the best practice for medication parameters was to obtain the BP before BP dependent meds were given so you would know when to hold it. In an interview on 10/28/2024 at 2:11 PM, Staff R, Licensed Practical Nurse said If someone had an order to hold a medication for a certain blood pressure, they would take their vital signs before administration to see if they should administer the medication. Staff R said the vital signs should be documented in the MAR. In a joint interview on 10/29/2024 at 9:54 AM , Staff A, Administrator and Staff D, Director of Clinical Services were notified of the physician order concerns for Resident 7 and 17. Staff A said they were unaware of this issues and it was not addressed in Quality Assurance Performance Improvement (QAPI). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This is a repeat deficiency from 11/22/2023. Refer to WAC 388-97-1620 (2)(b)(ii)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to ensure nursing assistant competencies were assessed and completed yearly, for 5 of 5 staff (L, N, O, P and Q) employee files reviewed. This failed practice had the potential to negatively affect the competency of the nursing assistants and impact the quality of care provided to residents. Findings included . Staff L, Nursing Assistant Certified (NAC) was hired 09/29/2023. Review of the employee file showed no documentation of a yearly skills checklist having been performed in the last year. In an interview on 10/28/2024 at 11:41 AM, Staff L, NAC, confirmed they had been at the facility over a year and had not had competencies or skill checks done other than someone watched them do hand hygiene a couple months back. Staff N, NAC, was hired 05/12/2023. Review of the employee file showed no documentation of a yearly skills checklist having been performed. Staff O, NAC, was hired 07/17/2023. Review of the employee file showed no documentation of a yearly skills checklist having been performed in the last year. Staff P, NAC, was hired 09/25/2023. Review of the employee file showed no documentation of a yearly skills checklist having been performed in the last year. Staff Q, NAC, was hired 07/26/2023. Review of the employee file showed no documentation of a yearly skills checklist having been performed in the last year. Review of the facility assessment dated [DATE], showed the facility required staff competencies for activities of daily living , daily care, bed mobility, transfers, walking in room, toilet use, eating, bathing, dressing, hygiene, grooming, ambulation and contractures. The facility analysis showed these areas had been evaluated. Review of an email received from Staff A, Administrator on 10/28/2024 at 3:06 PM, showed the facility did not have competencies for Staff L, N, O, P or Q. In a joint interview on 10/29/2024 at 9:52 AM, Staff A, Administrator and Staff D, Director of Clinical Services said they did not have a performance improvement plan in place for competencies. This is a repeat deficiency from 11/22/2023. Reference: (WAC) 388-97-1680 (2)(b)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 36787 Based on interview and record review, the facility failed to ensure annual Nurse Aide Certified (NAC) performance reviews were completed for 5 of 5 employees (Staff L, N, O, P, and Q) files reviewed who had been employed longer than 1 year. This failed practice had the potential to negatively affect the competency of these NACs and the quality of care provided to residents. Findings included . Review of the facility handbook dated May 2023, showed the performance management system is designed to provide employees with specific feedback on their job performance for the previous evaluation periodm and to establish new objectives and goals for the upcoming review period. Employees and supervisors are encourged to provide mutual feedback and communication about performance, expectations, and other work issues on a regualr basis. You also may request performance feedback from your supervisor at any time. Staff L was hired on 09/29/2023. Review of Staff L's employee file showed there was no current employee evaluation done. There was no evidence the evaluator completed this evaluation nor if it was reviewed/discussed with Staff L. In an interview on 10/28/2024 at 11:41 AM, Staff L, NAC, confirmed they had been there over a year. Staff L said they had not yet had a performance evaluation. Staff N was hired on 05/12/2023. Review of Staff N's employee file showed there was no current employee evaluation done. There was no evidence the evaluator completed this evaluation nor if it was reviewed/discussed with Staff N. Staff O was hired on 07/17/2023. Review of Staff O's employee file showed there was no current employee evaluation done. There was no evidence the evaluator completed this evaluation nor if it was reviewed/discussed with Staff O. Staff P was hired on 09/25/2023. Review of Staff P's employee file showed there was no current employee evaluation done. There was no evidence the evaluator completed this evaluation nor if it was reviewed/discussed with Staff P. Staff Q was hired on 07/26/2023. Review of Staff Q's employee file showed there was no current employee evaluation done. There was no evidence the evaluator completed this evaluation nor if it was reviewed/discussed with Staff Q. Review of the facility assessment reviewed in March 2024 showed education, competencies and training plans were sufficient to address the care needs of the facility's resident population. Review of an email received from Staff A, Administrator on 10/28/2024 at 3:06 PM, showed the facility did not have performance evaluations for Staff L, N, O, P or Q. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview on 10/29/2024 at 9:52 AM, Staff A, Administrator and Staff D, Director of Clinical Services said they did not have a performance improvement plan in place for performance evaluations. This is a repeat deficiency from 11/22/2023. Refer to WAC 388-97-1680 (2) (a-c)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review, the facility failed to advocate and assist 1 of 1 sampled residents (Resident 38) with their rights within the facility. The failure to assist the resident in having care planning meetings to ensure their voice was heard regarding their care and preferences placed residents at risk for unmet care needs and diminished quality of life. Findings included . Review of the facility policy titled: Interdisciplinary Care Conference Revised date 11/2016 stated, the Interdisciplinary Care Conference is completed upon admission, quarterly and following a significant change in condition. The resident and/resident representative will be invited to care conference. Resident 38 was admitted to the facility on [DATE] with diagnoses to include dislocation of right hip prosthesis and dementia unspecified with behavioral disturbance. Review of Resident 38's quarterly Minimum Date Set (MDS -an assessment tool) assessment dated [DATE] showed the resident rarely/nevererstood, has short-term and long-term memory loss. In an interview on 10/22/2024 at 12:42 PM, with Resident 38 and CC1, the resident's spouse, CC1 stated that they had not had any care conference since January 2024. In an interview on 10/24/2024 at 12:15 PM, CC1, spouse stated the facility was not telling them anything about resident 38's care. In a record review on 10/25/2024, Resident 38's chart under Assessments, showed Interdisciplinary Care Conference dated 01/24/2024, in attendance were Social Services, Therapy, resident care manager, and CC1. In an interview on 10/28/2024 at 11:23 AM Staff G, Social Services Director, stated care conferences were held at a minimum quarterly or it can be often as once a month or yearly depending on what the family or resident preferred. The family also had the option not to attend if they preferred. Staff G stated the electronic health records would notify them 14 days in advance if a resident was due for a care conference and that's when they set up the appointment with the resident and/or family. Staff G was unable to provide any documentation they had a care conference with Resident 38 or their spouse after 01/24/2024. Staff G stated they were not sure why they had not had any other care conferences with Resident 38. Refer to WAC 388-97-0960(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** 50725 Based on record review and interview the facility failed to ensure 2 of 5 sampled residents (Resident 38 and Resident 58) reviewed for unnecessary medications, were free from unnecessary psychotropic medications (any drug that affects brain activities associated with mental processes and behaviors). The facility failed to ensure there were valid diagnoses for use of psychotropic medications, behavior monitoring and to attempt gradual dose reductions (GDR). These failures placed residents at risk for receiving unnecessary psychotropic medications, for adverse events, and diminished quality of life. Findings included . According to the FDA Boxed Warning: Elderly patients with dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities)-related psychosis (symptoms that happen when a person is disconnected from reality) treated with antipsychotic drugs (prescribed medication to treat psychosis) are at an increased risk of death. Seroquel is not approved for elderly with dementia-related psychosis. Review of the facility policy titled: Behavior Management/Psychotropic Medication Overview, revised date 10/2022, showed, when psychotropic medications were ordered, an appropriate diagnosis must have been obtained and psychotropic medication use will be reviewed at least quarterly to determine appropriateness of continued use, effectiveness of current treatment plan and whether gradual dose reductions was indicated. <RESIDENT 38> Resident 38 was admitted to the facility on [DATE] with diagnoses to include dementia unspecified with behavioral disturbance. Review of Resident 38's quarterly Minimum Data Set (MDS -an assessment tool) assessment, dated 08/13/2024, showed the resident was rarely/never understood, had short-term and long-term memory problems, no Indicators of Psychosis, hallucinations, delusions, and no behavioral symptoms. The MDS did not indicate that resident had any psychotic disorder, schizophrenia or bipolar disorder, but did list non-Alzheimer's dementia. In a record review on 10/24/2024, Resident 38's physician orders showed Seroquel (an antipsychotic medication), given at bedtime daily for unspecified dementia with other behavioral disturbance. This was an inappropriate indication for use of Seroquel. In a record review on 10/24/2024 Resident 38's October 2024 Medication Administration Records showed the resident received Seroquel 50 milligram (mg) at bedtime daily related to unspecified dementia, unspecified severity, with other behavioral disturbance. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident 38's spouse, CC1, on 10/24/2024 at 12:15 PM, they were aware the resident was taking Seroquel, an antipsychotic medication. They stated that when the resident was at the hospital in January 2024 and was being treated for urinary tract infection (UTI) with a very resistant drug, the resident was very mad, confused and combative. They were not sure if the Seroquel helped improve the resident's mood/behavior or because Resident 38's UTI had resolved. In an interview with Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) on 10/28/2024 at 1:12 PM, they were not sure if the diagnosis of dementia was appropriate for Seroquel use. Staff J was unable to provide any documentation regarding recommendations for GDR, or notes from the doctor of contraindications for a GDR. In an interview on 10/28/2024 at 1:28 PM, Staff G, Social Services Director (SSD), stated that they review psychotropic medications quarterly with the Interdisciplinary team (IDT) which consisted of the RCM, Director of Nursing (DON), Assistant DON (ADON), SSD and pharmacist. The pharmacist reviewed medications and their corresponding diagnosis to ensure it was appropriate for the resident. Staff G showed that they did reviewed Resident 38's psychotropic medication on 04/17/2024, but not since. They were not sure why they did not review the resident again. Staff G stated that dementia was not an appropriate diagnosis for Seroquel use. In a record review on 10/28/2024, Resident 38's Psychotropic Medication Review, dated 04/17/2024 showed the last GDR and last Doctor of Medicine documentation regarding GDR contraindication were blank. In an interview on 10/29/2024 at 9:10 AM, Staff B, DON, stated that the pharmacist and IDT reviewed the medications and their diagnosis to check for accuracy. Staff B stated that due to Resident 38's behavior such as punching staff, justified Resident 38's need for Seroquel. Staff B was unable to provide any documentation of attempts of a GDR or a doctor's note showing contraindications for GDR. 33954 <RESIDENT 58> Resident 58 admitted to the facility on [DATE]. According to the admission MDS, dated [DATE], the resident had no psychiatric or mood disorders, they had no behaviors directed towards self or others, and they did not receive any antipsychotic drugs. Review of Resident 58's Medication Administration Records/Treatment Administration Records/Behavior Monitors from 10/08/2024 - 10/24/2024, showed the facility administered the resident Olanzapine (an antipsychotic medication) twice daily for a psychotic disorder, and there was no associated behavior monitor to show what the facility was monitoring for the Olanzapine treatment. In a review of Resident 58's clinical record on 10/28/2024, no indications necessitating the need for treatment with an antipsychotic medication could be found. In an interview on 10/28/2024 at 10:45 AM, Staff H, Registered Nurse/RCM, stated they didn't know of any signs or symptoms of psychosis as the nurses had not reported any to them, but they thought the resident had been hallucinating. (continued on next page)

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	505309	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This is a repeat deficiency from 11/22/2023. Refer to WAC 388-97-1060 (3)(k)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interviews, observations, and record review, the facility failed to assist with access to preventative (and emergency) dental services for 2 of 3 sampled residents (Residents 44 and 15) reviewed for dental services. Failure to follow up on dental referrals and ensure the coordination of dental services for residents who had missing, and broken teeth placed the residents at increased risk for continued dental problems, difficulty chewing, associated health complications, and diminished quality of life. Findings included . <RESIDENT 44> Resident 44 admitted to the facility on [DATE], with diagnoses including heart failure, history of stroke, and difficulty swallowing. The Annual Minimum Data Set (MDS - an assessment tool) assessment, dated 09/04/2024 showed the resident had intact cognition, and required substantial to maximum assistance for oral hygiene care assistance. The dental section was documented as unable to examine. Review of Resident 44's current care plan showed a focus area initiated on 09/07/2023 that showed the resident had dental care needs related to their paralysis (loss of muscle function) to the resident's left side, as the resident was noted to have dental caries (decay/cavities). In an observation and interview on 10/22/2024 at 12:06 PM, Resident 44 was observed lying in their bed, chewing gum. Resident 44 was observed to have missing and broken teeth, the partial teeth were observed to have dark spots on them. Resident 44 stated they had never seen a dentist since being admitted to the facility. Resident 44 stated they would like to go to a dentist, but I did not know that was an option, here. In an interview on 10/28/2024 at 10:27 AM, Staff I, Nursing Assistant Certified (NAC) stated when a resident requested to see a dentist they referred them to the nurse. In an interview on 10/28/2024 at 11:21 AM, Staff J, Resident Care Manager (RCM)/Licensed Practical Nurse (LPN), stated when a resident requested to see a dentist, they notified the health unit coordinator to schedule an appointment with a dentist. Staff J stated they did not have any routine dental processes or procedures at this time, only if a resident requested to see a dentist, did they seek out dental services. Staff J stated they were not aware that Resident 44 not aware the resident had missing, broken teeth and needed to see a dentist, or that their care plan stated they had dental caries. In an interview on 10/29/2024 at 9:35 AM, Staff A, Administrator, stated they were not aware the facility did not have a process for preventative dental services. 51312 <RESIDENT 15> (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 15 was a long-term care resident admitted to the facility on [DATE]. In an interview on 10/23/2024 at 9:58 AM, Collateral Contact 2 (CC2- Resident 15's representative), reported they asked the facility to make a preventative dental appointment during the last care conference a few months ago, and they had not heard back from the facility about a dental appointment being scheduled for the resident. A review of Resident 15's care conference note, dated 10/07/2024, showed CC2 asked that they be contacted after the facility had scheduled a dental appointment for the resident. In an interview on 10/28/2024 at 11:15 AM, Staff I, NAC, reported that The resident doesn't have the best teeth. In an interview on 10/28/2024 at 11:40 AM, Staff J, (LPN/RCM), reported they were responsible for obtaining a dental order when dental need came up. Staff J stated they had not attended Resident 15's care conference and were not notified of the need for a routine dental appointment. Review of Resident 15's clinical record showed there was no order for the resident to be seen by a dentist or that Resident 15 needed a dental appointment. This is a repeat deficiency from 11/22/2023. Refer to WAC 388-97-1060(1)(3)(j)(vii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33954 Based on observation, interview and record review, the facility failed to ensure food was prepared and stored under sanitary conditions in 2 of 2 nourishment rooms (East and [NAME] units) and 1 of 1 facility kitchens. The failure to ensure overhead light fixtures, toasters, microwave ovens and refrigerator/freezer units were sanitary placed residents at risk for foodborne illnesses and diminished quality of life. Findings included . <UNIT NOURISHMENT ROOMS/REFRIGERATORS/FREEZERS/MICROWAVE OVENS/TOASTERS> In an observation on 10/23/2024 at 11:09 AM, the East unit nourishment room refrigerator/freezer units in the clean utility room were soiled with food matter and spillage. The microwave oven in the nourishment room was very soiled with food splattering and debris inside and out. In an observation on 10/23/2024 at 11:16 AM, the [NAME] unit nourishment refrigerator/freezer units with very soiled with spilled food matter, and the freezer unit had lots of ice buildup. The microwave oven was very soiled. In an observation/interview on 10/23/2024 at 1:40 PM, the toasters in the East and [NAME] nourishment rooms were all observed to be quite soiled, Staff K, Dietary Manager, stated kitchen staff were responsible for cleaning the refrigerator/freezer units and housekeeping was responsible for cleaning the toasters and microwave ovens. In an observation on 10/28/2024 at 11:10 AM, the overhead light fixtures in the East and [NAME] nourishment rooms/clean utility rooms were visibly soiled. <FACILITY KITCHEN> In an observation/interview on 10/23/2024 at 1:05 PM, the overhead lights in the facility kitchen food preparation area and the dishwashing area were soiled with extensive splattering, debris, and dead insects, Staff K stated they didn't know if the overhead light fixtures were on a cleaning schedule, they stated they would have to ask. In an observation/interview on 10/28/2024 at 11:10 AM, the six overhead light fixtures in the kitchen food preparation area were still very soiled with debris/dead insects, and the three overhead light fixtures in the dishwashing area were still very soiled. Staff K stated they didn't know about any cleaning schedule for the overhead light fixtures, but they would ask. Refer to WAC 388-97-1100 (3)(-2980)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 33954 Based on interview and record review, the facility administration failed to ensure the facility maintained substantial compliance with federal and state regulatory requirements and to meet the significant needs of the residents. The administration failed to provide sorely needed administrative oversight and monitoring of facility personnel, systems, policies and practices related to residents' care plan timing and revision, professional standards of care, ensuring competency of nursing staff and completion of required nursing assistants performance reviews, psychotropic medication management, infection control and coordination of dental services. This failed practice placed all residents at risk for unmet care needs and diminished quality of life. Findings included . Review of the facility Administrator position description, dated May 2015, showed the administrator was responsible for the daily operation of the facility and they were to utilize resources effectively and efficiently to attain and maintain the highest level of care for residents in accordance with regulatory standards. Review of the facility's last annual certification Statement of Deficiencies, dated 11/22/2023, showed the facility had repeat deficiencies cited regarding care plan timing and revision (F657), services meet professional standards (F658), competent nursing staff (F726), nurse aide performance reviews (F730), free from unnecessary psychotropic medication use (F758), infection prevention and control (F880), and coordination of dental services (F791). <CARE PLAN TIMING AND REVISION (Refer to F657)> Administration failed to ensure residents' care plans were reviewed and revised and accurately reflected current resident status placing them at risk for unmet care needs. <SERVICES MEET PROFESSIONAL STANDARDS (Refer to F658)> Administration failed to ensure nurses complied with physician orders regarding medication administration parameters and admission orders regarding hospice/palliative (end of life care) care recommendations. <COMPETENT NURSING STAFF (Refer to F726)> Administration failed to ensure nursing assistants were able to demonstrate competency in skills and techniques necessary to care for residents' needs. <NURSE AIDE PERFORMANCE REVIEWS (Refer to F730)> Administration failed to ensure nurse aides received required performance reviews necessary to determine which in-service education was necessary based on the outcome of the reviews. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<UNNECESSARY PSYCHOTROPIC DRUGS (Refer to F758)> Administration failed to ensure residents received only psychotropic medications with adequate indications for use, and they failed to ensure staff monitored residents' behaviors for which they were placed on the antipsychotic medications. <INFECTION PREVENTION AND CONTROL (Refer to F880)> Administration failed to ensure staff were knowledgeable, trained, and compliant with infection prevention and control standards of practice necessary to prevent cross-contamination. <DENTAL SERVICES (Refer to F791)> Administration failed to ensure staff coordinated necessary dental cares for residents. In an interview on 10/29/2024 at 9:35 AM, Staff A, Administrator, stated the facility had not done any quality assurance or performance improvement projects for care planning timing and revision, professional standards of practice, competencies for nursing staff, nurse aide performance reviews, unnecessary psychotropic medications, or dental services. Refer to WAC 388-97-1620 (1)(2)(b)(i)(ii)(5)(6)(a)(b)(i)(ii)