STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to ensure a call light (an alerting device for staff to assist residents in need) was within reach for 1 of 4 residents (Resident 35), reviewed for accommodation of needs. This failure placed the resident at risk for delayed care, accidents/falls, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, SNF [skilled nursing facility] Clinic, Answering the Call Light, showed a guideline for staff to ensure that the call light is accessible to a resident in bed. Resident 35 readmitted to the facility on [DATE] with diagnoses that included hemiparesis (weakness or inability to move one side of the body) following cerebral infarction (a type of stroke that occurs when blood flow to the brain is disrupted) affecting left non-dominant side. Review of Resident 35's activities of daily living care plan, revised on 03/23/2023, showed an intervention for soft touch call light is to be within [Resident 35's] reach & [and] situated on [their] R-side [right side] near [their] R-hand [right hand] so that [they] can access/use it. Observation on 09/20/2024 at 9:30 AM, showed Resident 35 was in bed with their call light placed next to their left hand. Observation on 09/24/2024 at 8:30 AM, showed Resident 35 was in their bed with their call light placed below their left hand. Observation on 09/25/2024 at 8:46 AM, showed Resident 35 was in bed with their call light placed on the bedside table. Joint observation and interview on 09/26/2024 at 8:58 AM, with Staff F, Resident Care Manager, showed Resident's 35's call light was placed on their bedside table. Staff F stated that Resident 35's call light was not within reach. Staff F further stated they expected the call light to be placed near Resident 35's right hand, where Resident 35 was able to reach it. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/2024 at 2:44 PM, Staff B, Director of Nursing, stated they expected staff to place call lights within reach of residents in accordance with the residents' own needs and preferences. Reference: (WAC) 388-97-0860 (2)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 45146 Based on observation, interview and record review, the facility failed to ensure survey results were posted in a place readily accessible to residents and residents' legal representatives. In addition, the facility failed to ensure the survey result binder included the results for 8 of 9 (04/26/2021, 06/15/2021, 07/27/2021, 09/07/2021, 01/24/2022, 04/12/2022, 10/19/2023 & 12/06/2023) complaint surveys that resulted in citations. These failures prevented residents, residents' representatives and visitors from exercising their right to review past survey results and the facility's plan of correction. Findings included . Review of the facility's document titled, Notice of Resident Rights Under Federal Law, updated in November 2016, showed, The resident has the right to examine the results of the three preceding years' survey, of the Center conducted by Federal or State surveyors, and any plan of correction in effect with respect to the Center. During a Resident Council meeting on 09/23/2024 at 11:59 AM, Resident 29 and Resident 19 stated they were not aware of their right to read the facility's survey results or where the survey result was located. Observation of the facility's second floor's post on 09/23/2024 at 1:45 PM, showed that the annual inspection survey report could be found on the main floor across the reception desk. Observation on 09/23/2024 at 1:59 PM, on 09/24/2024 at 10:45 AM, and on 09/25/2024 at 9:53 AM, showed there was no annual inspection survey report found on the main floor across the reception desk in the front lobby. On 09/25/2024 at 10:10 AM, Staff Q, Receptionist, stated that the survey result binder was kept on the small shelf behind the receptionist desk. Staff Q further stated that when a resident asks for the survey result binder, they would hand to them. Review of the survey binder labeled Annual Survey showed that the binder did not contain 9 of 10 complaint surveys that resulted in citations during the three preceding years. Review the binder showed that there was a written note that stated, No survey in 2021, last survey conducted on 03/13/2019. Further review of the binder showed the following complaint surveys results, and associated plans of corrections were missing for 04/26/2021, 06/15/2021, 07/27/2021, 09/07/2021, 01/24/2022, 04/12/2022, 10/19/2023, and 12/06/2023. During an interview and joint record review on 09/25/2024 at 11:50 AM, Staff A, Executive Director, stated the survey result binder should be readily accessible to residents, and family members and legal representatives of residents. Joint record review of the survey result binder showed it did not contain complaint survey results and associated plan of corrections for the year of 2021, 2022, and two complaint survey results for the year of 2023. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview on 09/26/2024 at 12:50 PM, Staff A stated that the facility survey result binder should include all complaint survey results, and associated plan of correction of the three preceding years. Reference: (WAC) 388-97-0480(1)(b)(5)(a)(b)

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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** 45146 Based on observation, interview and record review, the facility failed to ensure resident rooms were maintained for 4 of 6 rooms (Rooms 301, 303, 223 and 215) and 1 of 3 halls (Second floor hall), reviewed for environment. The failure to ensure resident rooms were free of wall scrapes, loose baseboards, holes in the walls, and the failure to ensure hall handrails were in good condition placed residents at risk for a less than homelike environment and diminished quality of life. Finding included . Review of the facility's policy titled, Preventative Maintenance published July 2008, showed that all areas of the Center and equipment therein, are inspected and maintained in accordance with the scheduled maintenance system (SMS). The maintenance department is responsible for the condition and function of the Center's physical plant including utilities, grounds, and equipment. room [ROOM NUMBER] Observations of room [ROOM NUMBER] on 09/20/2024 at 12:18 PM, on 09/23/2024 at 8:22 AM, and on 09/24/2024 at 8:26 AM, showed the wall by Resident 48's head of bed was scraped, damaged and exposed drywall. Further observations showed the room wall had multiple white patches, and a loose part of the baseboard was laying on the floor on the left corner side of the room. room [ROOM NUMBER] Observations of room [ROOM NUMBER] on 09/20/2024 at 8:36 AM, on 09/23/2024 at 8:45 AM, on 09/24/2024 at 8:33 AM and 11:18 AM, showed the wall by Resident 56's head of bed was scraped, damaged, and exposing the drywall. Further observations showed that the room walls had multiple white patches that were not repainted. On 09/24/2024 at 11:43 AM, Staff I, Maintenance Director, stated that they were not aware of the damage walls and loose baseboard in room [ROOM NUMBER] and room [ROOM NUMBER]. During a joint observation and an interview on 09/24/2024 at 11:46 AM with Staff I, showed room [ROOM NUMBER]'s wall behind the head of bed of Resident 56 was scraped, damaged and had multiple white patches that were not repainted. Staff I stated that the wall by the resident's head of bed would be patched, and texture painted. During a joint observation and an interview on 09/24/2024 at 11:48 AM, with Staff I, showed room [ROOM NUMBER]'s wall behind the head of bed of Resident 48 was scraped and damaged. Further joint observation showed the room wall had multiple white patches that were not repainted, and a loose part of the baseboard was laying on the floor on the left corner side of the room. Staff I stated these should have been repaired. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/25/2024 at 11:56 AM, Staff A, Executive Director, stated that their expectation was resident rooms in disrepair would be communicated to the maintenance department and repairs would be done in a timely manner. 47680 room [ROOM NUMBER] Observations on 09/19/2024 at 2:36 PM, on 09/20/2024 at 9:25 AM, on 09/23/2024 at 10:48 AM and on 09/24/2024 at 11:04 AM, showed a hole in the wall below the bathroom light switch that measured five inches long by two inches tall in room [ROOM NUMBER]. In an interview on 09/24/2024 at 11:19 AM, Staff V, Certified Nursing Assistant (CNA), stated that if something needed to be repaired, they had a maintenance log where they would log it, and that if it was an emergency, they would page maintenance immediately. Review of the second floor maintenance log on 09/24/2024 at 11:25 AM, did not show a log for the hole in the wall for room [ROOM NUMBER]. In an interview and joint observation on 09/24/2024 at 11:52 AM, Staff I stated that if anything was emergent like a burst pipe, staff would call them and anything that was not emergent, staff would log it in the maintenance log. Staff I stated that they would check the maintenance log daily and that high priority items were done first. Joint observation in room [ROOM NUMBER], showed a hole in the wall below the bathroom light switch. Staff I stated that they were not aware of the hole in the wall and that they expected the care staff, or housekeeping would log it in the maintenance log. In an interview on 09/25/2024 at 2:50 PM, Staff A stated that if the facility environment was in disrepair, they expected that it was communicated to the maintenance director through the maintenance log so they can address it in a timely manner. 46912 room [ROOM NUMBER] Observations of room [ROOM NUMBER] on 09/23/2024 at 8:34 AM, on 09/23/2024 at 10:21 AM, and on 09/24/2024 at 8:42 AM, showed Resident 14's headboard, detached from their bed and found on the floor behind their bed. Further observation showed a hole in the wall behind Resident 14's bed. In a joint observation and interview on 09/24/2024 at 1:03 PM, with Staff LL, CNA, showed Resident 14's headboard was on the floor behind their bed. Staff LL stated that it's off the bed and it should be on the bed, not the floor. Further observation of Resident 14's room showed a hole in the wall behind their bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint observation and interview on 09/24/2024 at 1:32 PM with Staff I, showed Resident 14's headboard was on the floor. Staff I stated that the headboard was on the floor and it should be recorded in the maintenance log so it can be fixed. Staff I stated that there was missing hardware for the headboard and that they should replace the bed. Further observation of Resident 14's room showed a hole in the wall behind the resident's bed. Staff I stated that there was some damage caused by the bed frame and it definitely needs to be repaired. On 09/26/2024 at 3:21 PM, Staff A stated they expected staff to communicate to maintenance staff if a resident's room was in disrepair. Staff A further stated they expected that the facility was following our preventative maintenance policy and making sure things are done in a timely manner. HANDRAILS Observation on 09/23/2024 at 10:51 AM, showed the handrail on the second-floor hallway, by room [ROOM NUMBER], was loose and when pulled on, the nails would come out of the wall. Observation on 09/23/2024 at 2:05 PM, showed the handrail on the second-floor hallway, by room [ROOM NUMBER], was loose and coming away from the wall. Observation on 09/24/2024 at 9:12 AM, showed the handrail on the second-floor hallway, by room [ROOM NUMBER], was coming away from the wall and showed exposed screws. Joint observation and interview on 09/24/2024 at 12:13 PM with Staff I, showed the handrail by room [ROOM NUMBER] was loose. Staff I stated, looks like it needs to be re-anchored for sure and the anchors have come out of the wall. Further observation of the handrail by room [ROOM NUMBER] showed that it was loose. Staff I stated that the handrail needs to be re-anchored and the anchors have lost their grip. Additional observation showed the handrail by room [ROOM NUMBER] was loose. Staff I stated, it's coming off and it needs to be re-anchored. Interview on 09/26/2024 at 3:21 PM, Staff A stated they expected the handrails in the hallways to be in working condition and if I go and grab it, it won't come off the wall. Staff A stated they expected them to be in good repair and secured to the wall. Reference: (WAC) 388-97-0880 (2)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 47680 Based on interview and record review, the facility failed to implement their abuse policy and procedure by not ensuring reference checks were conducted prior to hire for 1 of 5 staff (Staff W), reviewed for reference checks. This failure placed the residents at risk for abuse, neglect, exploitation, and misappropriation of property. Findings included . Review of the facility's policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated October 2022, showed, The Center screens prospective staff for a history of abuse, neglect, exploitation or misappropriation of resident property in order to prohibit abuse, neglect, and exploitation, or misappropriation of resident property. (Refer to Screening Policy). Review of the facility's policy titled, Screening, updated October 2022, showed, The Center screens prospective employees by reviewing .information from employers (at least two reference checks), whether favorable or unfavorable. Review of employee records for Staff W, Certified Nursing Assistant, showed a hire date of 09/15/2023. There was no evidence that two reference checks were conducted by the facility prior to Staff W's employment. In an interview on 09/24/2024 at 1:14 PM, Staff A, Executive Director, stated that they had no reference checks to provide for Staff W. Another interview on 09/26/2024 at 2:56 PM with Staff A, stated that reference checks were to be completed prior to staffs start date, during their onboarding process. Staff A confirmed that Staff W did not have any reference checks and further stated that it should have been completed during Staff W's onboarding process. Reference: (WAC) 388-97-0640(2)(a)

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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** 48298 Based on interview and record review, the facility failed to provide written notices of transfer/discharge to the residents and/or their representatives and failed to notify the Office of the State Long Term Care (LTC) Ombudsman (an advocacy group for residents), describing the reason for transfers/discharge for 4 of 4 residents (Resident 9, 75, 52 & 15), reviewed for hospitalization and discharge. These failures placed the residents at risk for not having opportunities to make informed decisions about transfers/discharges. Findings included . Review of the facility's policy titled, Transfer and Discharge, updated in October 2022, showed, When the transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge which includes the following items: date of notice is given, effective date of the transfer/discharge, reason for the transfer/discharge, where the resident is to be moved, contact information for the state Long-Term Care Ombudsman . It further stated, The Center sends a copy of the notice to the State Long-term Care Ombudsman. The notice is provided at least 30 days before the transfer or discharge; the following are exceptions such as when a resident's urgent medical needs require more immediate transfer. In these cases, notice must be given as soon as practical before or at the time of transfer or discharge. RESIDENT 9 Resident 9 admitted to the facility on [DATE]. Review of the discharge Minimum Data Set (MDS-an assessment tool) dated 06/24/2024 showed Resident 9 was discharged to the hospital. A review of the entry MDS dated [DATE] showed Resident 9 was readmitted back to the facility on [DATE]. Review of the nursing progress note dated 06/24/2024 showed Resident 9 had a change in condition and was transferred to the hospital for further evaluation. Review of the clinical health record (electronic chart) did not show documentation that a written notice of transfer/discharge was provided to Resident 9 and/or their representative. Further review of the clinical health record did not show documentation that the Ombudsman was notified of Resident 9's transfer/discharge to the hospital. In an interview on 09/26/2024 at 2:53 PM with Staff F, Resident Care Manager (RCM), stated Resident 9 had CIC (Change in Condition) completed prior to [their] transfer. When asked if Resident 9 was given a written notice of transfer/discharge, Staff F replied, There was a CIC done. And given a notice of bed hold policy. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/27/2024 at 9:52 AM, with Staff J, Social Services Director, stated they sent notices of transfer/discharge to the Ombudsman via fax (facsimile). When asked if the Ombudsman was notified about Resident 9's discharge to the hospital on 06/24/2024 and to provide related documentation, Staff F stated they did not have the document to show that the Ombudsman was notified about Resident 9's transfer/discharge to the hospital on 06/24/2024. In an interview on 09/27/2024 at 9:59 AM with Staff B, Director of Nursing, stated they expected staff to follow the facility's policy and the State requirement regarding written notice of transfer/discharge and Ombudsman notice. 46912 RESIDENT 75 Review of the discharge MDS dated [DATE] showed that Resident 75 admitted to the facility on [DATE] and discharged to an acute hospital on 09/09/2024. Review of the nursing progress note dated 09/09/2024, showed Resident 75 was transferred to the hospital for further evaluation. Review of the clinical health record did not show documentation that a written notice of transfer/discharge was provided to Resident 75 and/or their representative. In an interview on 09/24/2024 at 1:56 PM, Staff G, RCM, stated that nurses will call families and notify them when residents were transferred to the hospital. Staff G stated that the nurses did not provide written notices. In an interview on 09/26/2024 at 10:36 AM, Staff J stated that nurses notified families by phone when residents were transferred to the hospital. Staff J stated that there was nothing written that I provide to families. Staff J further stated that they notified the ombudsman by fax when a resident was transferred to the hospital. Staff J did not provide documentation that this was done for Resident 75's transfer to the hospital. In an interview on 09/26/2024 at 3:21 PM, Staff A, Executive Director, stated they expected staff to follow our policy and provide verbal and written notices when a resident transferred to the hospital. Staff A further stated that the ombudsman should be notified. 47680 RESIDENT 52 Review of the discharge MDS dated [DATE] showed Resident 52 was discharged to an acute hospital on 08/11/2024. Review of the nursing progress note dated 08/11/2024, showed Resident 52 was sent to the emergency department for evaluation. Review of the discharge MDS dated [DATE], showed Resident 52 was (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharged to an acute hospital on 09/10/2024. Review of the nursing progress note dated 09/10/2024, showed Resident 52 was sent out to the hospital due to abnormal laboratory work/results. Review of Resident 52's electronic health record (under assessments, nursing progress notes, and documents) did not show documentation that a written notice of transfer/discharge was provided to Resident 52 and/or their representative. In an interview on 09/24/2024 at 12:12 PM, Resident 52's representative stated that they were not given a written form of the reason for Resident 52's transfer to the hospital in August 2024 and September 2024. Resident 52's representative further stated that they were just notified by phone. In an interview on 09/24/2024 at 11:26 AM, Staff AA, Licensed Practice Nurse (LPN), stated when a resident was transferred to the hospital, they would notify the doctor, Director of Nursing, and the resident's family/representative. Staff AA stated that they notified the family over the phone and would write a progress note. Staff AA further stated that they did not provide the resident's representative with a written notice of transfer/discharge. In an interview on 09/25/2024 at 9:44 AM, Staff G stated that they sent a packet when the resident went to the hospital which included the transfer/discharge form. Staff G stated that they did not provide a copy of the written notice of transfer and did not mail anything out to the resident's representative. In an interview on 09/25/2024 at 9:48 AM, Staff J stated that a transfer discharge form was completed and would be provided to the resident as able. Staff J stated a copy was faxed monthly or in a reasonable amount of time to the Ombudsman. In a follow-up interview at 12:15 PM, Staff J stated that they were not able to find documentation that a written notice was provided to Resident 52 and/or their representative. In another follow-up interview on 09/26/2024 at 11:02 AM, Staff J stated that they were not able to provide documentation that a copy of the written notice of transfer/discharge was sent to the Ombudsman. On 09/27/2024 at 12:48 PM, Staff A stated that they expected staff to follow the regulation. 51090 RESIDENT 15 Resident 15 readmitted to the facility on [DATE]. Review of the discharge nursing progress note dated 09/13/2024 showed Staff P, LPN, documented that Resident 15 was discharged to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint record review and interview on 09/27/2024 at 11:26 AM with Staff P, showed that they had written the discharge progress note for Resident 15 dated 09/13/2024. Staff P stated they were not aware of the process to provide a written notice for discharges. Staff P further stated that they did not provide Resident 15 a written notice of transfer on 09/13/2024. On 09/27/2024 at 12:03 PM, Staff J stated that the facility's process for providing notice to a resident and/or their representative, when a resident who transferred, or discharged was that the floor nurse would notify the resident representative via phone. Staff J stated they could not provide a copy of Resident 15's written notice of discharge when requested. On 09/27/2024 at 12:09 PM, Staff A stated that their expectation is that [the facility] follow the regulation and policy and that [the facility] would notify [residents] in writing as well. Reference: (WAC) 388-97-0120 (2)(a)(b)(c)(d)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to ensure admission Minimum Data Set (MDS-an assessment tool) was completed within 14 days of admission for 1 of 21 residents (Resident 26), reviewed for comprehensive assessment. This failure placed the resident at risk for delayed and/or unmet care needs, and a diminished quality of life. Findings included . Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.18.11, revised in October 2023, showed that, at a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility (admitted + [plus] 13 days). Resident 26 admitted to the facility on [DATE]. Review of Resident 26's admission MDS dated [DATE], showed it was completed on 07/08/2024 (four days late). In an interview and joint record review on 09/26/2024 at 3:17 PM with Staff L, MDS Coordinator, stated they used the RAI manual for MDS assessment completion. Joint record review of Resident 26's admission MDS dated [DATE] showed it was completed on 07/08/2024. Staff L stated Resident 26's admission MDS was completed late. In a joint record review and interview on 09/27/2024 at 10:08 AM with Staff B, Director of Nursing, showed Resident 26's admission MDS dated [DATE] was completed on 07/08/2024. Staff B stated they expected residents MDS assessments to be completed, transmitted, submitted as required. [Resident 26's] MDS assessment should have been completed within 14 days from [their] admission. Reference: (WAC) 388-97-1000(5)(a)

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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** 47680 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS- an assessment tool) was completed timely for 1 of 3 residents (Resident 61), reviewed for significant change in condition. The failure to complete a SCSA within 14 days placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed that a significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting,' 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary [involving two or more different subjects or areas of knowledge] review and/or revision of the care plan. The RAI manual further showed that the assessment should be completed no later than 14 days after the determination was made (determination date plus 14 calendar days). Review of the admission MDS dated [DATE], showed that Resident 61 admitted to the facility on [DATE]. It further showed under Section K (Swallowing/Nutritional Status), Resident 61 received 51 percent or more of their total calories via tube feeding (the delivery of nutrients through a tube directly into the stomach to provide nutrition for those who cannot obtain nutrition by mouth, are unable to safely swallow, or need nutritional supplementation). Review of the progress note dated 08/27/2024 showed, Resident S/P [status post] G-Tube [gastrostomy tube- a medical device used to provide nutrients through a tube directly into the stomach] removal. Review of Resident 61's SCSA MDS dated [DATE] showed that it was completed on 09/26/2024, 16 days late. In an interview and joint record review on 09/27/2024 at 8:37 AM, Staff L, MDS Coordinator, stated that they followed the RAI Manual for MDS completion. Staff L stated that a SCSA MDS was due to be completed within 14 days from the determination date. Staff L stated that a SCSA assessment was completed for Resident 61 due to G-tube removal and that the resident was now eating. Staff L stated that the determination date was on 08/27/2024. Joint record review of a nursing progress note dated 08/27/2024 showed Resident 61 was S/P G-tube removal. Staff L stated Resident 61's SCSA MDS was late and should have been completed within 14 days of the determination date on 09/10/2024. In an interview on 09/27/2024 at 11:50 AM, Staff B, Director of Nursing, stated that they expected staff to complete the SCSA MDS per policy and per the RAI requirements. Joint record review of Resident 61's SCSA MDS showed that it was completed on 09/26/2024. Staff B stated that they expected the SCSA MDS to be completed in the required time frame. Reference: (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** 51090 Based on interview and record review, the facility failed to accurately assess 3 of 21 residents (Residents 84, 82 & 26), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding hospice care, pressure ulcer (injury to the skin and the tissue below the skin that are due to pressure on the skin for a long time) care, and comatose status (deep sleep-like state where a person is unconscious, unresponsive, and unable to be awakened) placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 84 Resident 84 admitted to the facility on [DATE] with diagnosis that included malignant neoplasm of larynx (cancerous tumors affecting the throat). Review of the quarterly MDS dated [DATE], Section O (Special Treatments, Procedures, and Programs), showed Resident 84 was marked to have no hospice care while a resident at the facility. Review of Resident 84's hospice Comprehensive Assessment and Plan of Care Update Report, dated 08/28/2024, showed Resident 84's start of care under hospice was on 03/13/2024. Joint record review and interview on 09/27/2024 at 11:35 AM, with Staff L, MDS Coordinator, showed Resident 84's quarterly MDS dated [DATE], Section O, was not marked for hospice care while a resident in the facility. Staff L stated, This time it was missed and that hospice services should have been coded. Joint record review and interview on 09/27/2024 at 1:35 PM with Staff B, Director of Nursing, showed Resident 84's quarterly MDS dated [DATE] was not coded for hospice care. Staff B stated that MDS assessments should be coded accurately based on the resident's status and condition. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45146 RESIDENT 82 Resident 82 was admitted to the facility on [DATE]. Review of the admission MDS dated [DATE], showed under Section M (Skin Conditions), pressure ulcer/injury (bed sore) was not marked for Resident 82. Further review of the MDS assessment showed pressure ulcer/injury care was marked as provided for Resident 82 during the assessment period. Review of the Admission-Readmission Nursing Evaluation dated 08/27/2024 showed Resident 82 had no pressure ulcer/injury. Review of the Treatment Administration Record for August 2024 and September 2024 showed that no pressure ulcer/injury treatment was provided for Resident 82. During a joint record review and interview on 09/26/2024 at 11:18 AM with Staff L, showed the admission MDS assessment dated [DATE], pressure ulcer/injury (bed sore) was not marked, however, the MDS also showed that pressure ulcer/injury treatment was marked as provided for Resident 82. Staff L stated they followed the RAI manual as a guideline to complete MDS assessments. Staff L further stated Resident 82 had no pressure ulcer/injury and they would find out why the pressure ulcer/injury was marked as treatment was provided. In another interview on 09/26/2024 at 2:07 PM, Staff L stated Resident 82's admission MDS assessment dated [DATE], the pressure ulcer/injury care was marked incorrectly. On 09/27/2024 at 8:35 AM, Staff B stated they expected staff to complete MDS assessments accurately. Staff B further stated the MDS assessment should reflect the resident's assessment and treatment provided during the assessment period. 48298 RESIDENT 26 Review of the RAI 3.0 User's Manual Version 1.18.11 dated October 2023 defined persistent vegetative state as, Sometimes residents who were comatose (a pathological [diseased] state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; they do not open their eyes, do not speak and do not move their extremities on command or in response to noxious stimuli (e.g., pain) .Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movement. It further showed coding instruction to Code 1, yes if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Resident 26 admitted to the facility on [DATE] with diagnoses that included Encephalopathy (a disease that affects brain function) and pressure ulcers. (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 Resident 26's admission MDS with an ARD of 06/27/2024, showed persistent vegetative state was coded 1 [one] or yes. Further review of the admission MDS showed Resident 26 had one Stage 3 (full-thickness skin loss with may or may not visible subcutaneous [innermost layer of the skin] fat but bone, tendon or muscle was not exposed) pressure ulcer and one Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer. Review of the admission nursing evaluation dated 06/21/2024, showed Resident 26 was marked as alert, awake, oriented to person and response to touch/voice. Review of Resident 26's face sheet printed on 09/19/2024 and nursing progress notes dated 06/21/2024 to 06/27/2024 did not show diagnosis of coma or persistent vegetative state that was applicable during the 7-day look-back period or observation period. Review of the wound health progress note dated 06/26/2024, showed Resident 26 had two Stage 4 pressure ulcers, one on their right heel and one on their sacrum (lower back). In a joint record review and interview on 09/26/2024 at 3:17 PM with Staff L, showed Resident 26's admission MDS Section B0100 [Comatose- Persistent vegetative state/no discernible consciousness] was coded a 1 and Section M0300 [Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage] showed the following: - Section M0300C1 (Number of Stage 3 pressure ulcers) was coded 1 (presence of one Stage 3 pressure ulcer). - Section M0300C2 (Number of Stage 3 pressure ulcers that were present upon admission/entry or reentry) was coded 1. - Section M0300D1 (Number of Stage 4 pressure ulcers) was coded 1 (presence of one Stage 4 pressure ulcer). - Section M0300D2 (Number of Stage 4 pressure ulcers that were present upon admission/entry or reentry) was coded 1. Staff L stated Resident 26 was not comatose or persistent vegetative state. Staff L further stated Resident 26's MDS was not coded accurately. [They] had no Stage 3 but two Stage 4 pressure ulcers. In an interview on 09/27/2024 at 10:08 AM, Staff B stated they expected to code the MDS accurately based on the resident's medical condition. Reference: (WAC) 388-97-1000(1)(b)

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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** 48298 Based on interview, and record review, the facility failed to revise comprehensive care plan for 1 of 21 residents (Resident 28), reviewed for care plan revision. The failure to revise the care plan to include current and specific restorative nursing program services placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.18.11, revised in October 2023, showed that the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Resident 28 admitted to the facility on [DATE] with diagnoses that included traumatic brain injury and right-sided weakness. Review of Resident 28's mobility/ Restorative Nursing Program (RNP) comprehensive care plan printed on 09/24/2024 at 9:58 AM, showed an RNP intervention for Passive Range of Motion (PROM) to their right arm that was initiated and revised on 01/12/2024. Further review of the mobility/ RNP care plan did not include the RNP recommendation by Physical Therapy (PT) and Occupational Therapy (OT) dated 09/11/2024. Review of the Restorative Program referral by PT dated 09/11/2024, showed a recommendation for Resident 28 to have Passive/Active Range of Motion (P/AROM) to their bilateral [both] lower extremities [legs and feet] and joints for three to five times a week to maintain their ROM and current strength. Review of the Restorative Program referral by OT dated 09/11/2024, showed a recommendation for Resident 28 to have a right palm splint for one to two hours or as they tolerated. It further showed Resident 28 to have left upper extremity [left arm] exercises using three to four pounds dumbbell and PROM exercises to their right upper extremity [right arm] for three to five times a week. During a joint record review and interview on 09/24/2024 at 9:41 AM with Staff F, Resident Care Manager, showed Resident 28's mobility/RNP comprehensive care plan did not include the RNP recommendations by PT and OT dated 09/11/2024. Staff F stated Resident 28 had an RNP intervention that was initiated and revised on 01/12/2024 and that there were no other RNP recommendations by PT and OT documented in Resident 28's mobility/RNP comprehensive care plan. (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 record review and interview on 09/24/2024 at 1:24 PM with Staff B, Director of Nursing, showed Resident 28's mobility/RNP comprehensive care plan did not include the 09/11/2024 RNP recommendations by PT, and that the OT recommendations were just added/or initiated on 09/24/2024. Staff B stated Resident 28's mobility/RNP comprehensive care plan was not updated or revised to include the RNP recommendations by PT/OT on 09/11/2024. Reference: (WAC) 388-97-1020 (2)(a)(5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 48298 Based on observation, interview, and record review, the facility failed to ensure 1 of 3 licensed staff (Staff GG) followed professional standards for proper medication administration via a gastrostomy tube (G-tube - a medical device used to provide nutrients through a tube directly into the stomach) and follow insulin (a hormone to lower blood sugar) order for 2 of 9 residents (Resident 54 & 36), reviewed for medication administration. In addition, the facility failed to ensure a urine specimen was properly labeled/stored in accordance with standard of practice for 1 of 1 specimen refrigerator (second floor specimen refrigerator), reviewed for environment. These failures placed the residents at risk for potential adverse effects and a diminished quality of life. Findings included . Review of the facility's policy titled, Enteral Feeding [or tube feeding, is the delivery of nutrients through a tube directly into the stomach], updated in April 2017, showed the licensed nurse administers the enteral feeding and medications per physician order using best practice. It further showed water flushes before, after, and between each medication administration. Review of the facility's policy titled, Medication Administration, dated January 2024, showed, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Review of Chapter 17 Nursing Enteral Tube Management-Nursing Skills 2nd Edition, published in 2023 by National Library of Medicine, showed, After tube placement is checked, a clean 60-mL [milliliter (ml)-unit of measurement] syringe [a medical device used for administering or withdrawing fluids, consisting of a barrel and a plunger] is used to flush the tube with a minimum of 15 mL of water before administering the medication. Follow agency policy regarding flushing amount. Liquid medication, or appropriately crushed medication dissolved in water, is administered one medication at a time. Medication should not be mixed because of the risks of physical and chemical incompatibilities, tube obstruction, and altered therapeutic drug responses. Between each medication, the tube is flushed with 15 mL of water, keeping in mind the patient's fluid volume status. After the final medication is administered, the tube is flushed with 15 mL of water. MEDICATION ADMINISTRATION VIA G-TUBE Review of Resident 54's September 2024 Medication Administration Record (MAR) showed physician orders to check residuals [stomach contents] and to check the tube feeding placement prior to each tube feeding. It further showed to administer water flushes before, in between, and after each medication administration. Observation on 09/25/2024 at 8:31 AM, showed Staff GG, Registered Nurse, prepared medications to give to Resident 54. Staff GG crushed Resident 54's tablet medications, placed them in one plastic cup, mixed and dissolved them in water, and administered them using a 60 ml syringe via tube feeding. Resident 54's medications crushed and mixed altogether were the following: -Two tablets of Acetaminophen (for pain) 500 milligrams (mg-unit of measurement) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One tablet of Calcium Carbonate (antacid) 750 mg -One and a half tablet of Midodrine (for low blood pressure) 15 mg -One tablet of Citalopram (used for anxiety and depression) 30 mg. Further observation on 09/25/2024 at 8:41 AM, showed Staff GG administered Resident 54's medications that were mixed altogether in half a cup of water via G-tube. Staff GG did not check for the Gastric Residual Volume (GRV- fluid/contents that remain undigested in the stomach) or verify the feeding tube placement prior to administering Resident 54's medications. Staff GG did not administer water flushes before, in between, and after medication administration via G-tube. INSULIN ADMINISTRATION Review of Resident 36's September 2024 MAR showed a physician order for insulin, eight units (type of measurement) to be administered under the skin every six hours. The physician order further showed, Hold if CBG [Capillary Blood Glucose-level of blood sugar measured using a glucometer (a device that includes a test strip where blood is collected from a fingertip prick, and the blood sugar level is displayed within seconds)] is < [less than] 100 [mg/dL-milligrams per deciliter {unit of measurement}]. In an interview and observation on 09/25/2024 at 12:04 PM, Staff GG stated they would give Resident 36 their insulin medication due for 12 noon [12:00 PM]. Staff GG was observed withdrawing eight units of insulin from a vial using a syringe. Staff GG went inside Resident 36's room, pricked the tip of Resident 36's left middle finger, seconds after applying alcohol swab and checked their blood sugar using a glucometer. Staff GG proceeded to apply alcohol swab over Resident 36's left upper arm and administered eight units of insulin. When asked about Resident 36's blood sugar level, Staff GG showed glucometer result and stated 81 mg/dL. Staff GG then connected Resident 36's feeding tube to their enteral formula (liquid nutritional products used for tube feeding). In an interview on 09/25/2024 at 1:03 PM, Staff GG stated they mixed and dissolved Resident 54's medications in one cup and administered them altogether through their G-tube. When asked about their process regarding medication administration through the G-tube, Staff GG stated, to flush with each medication administration. Staff GG did not mention each medication should be administered separately. Staff GG stated they should have followed the physician order and should not have administered Resident 36's insulin. Staff GG further stated, I tried to follow the order and perform professionally but I get anxious. In an interview and joint record review on 09/25/2024 at 2:12 PM, Staff F, Resident Care Manager (RCM), stated, Each medication should be given separately in a cup, crushed, mixed with water and given by gravity. Water flushes before, in between and after each medication administration. Joint record review of Resident 36's September 2024 MAR showed a physician order to hold insulin Lispro (a brand) if CBG is <100 mg/dL. It further showed Resident 36's blood sugar level was 81 mg/dL, and that Staff GG administered the insulin. Staff F stated Staff GG should not have administered the insulin and should have followed the standard of practice for medication administration via G-tube. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/27/2024 at 10:20 AM, Staff B, Director of Nursing, stated they expected the staff to follow the physician order and standard of practice in relation to medication administration via tube feeding. 46912 Review of the facility provided document titled, Specimen Collection and Transport Guide, dated 2018-2019, showed, all specimens should be labeled at the time of collection with at least 2 [two] patient [resident] identifiers. SECOND FLOOR SPECIMEN REFRIGERATOR Observations of the clean utility room on the second floor on 09/20/2024 at 1:00 PM, on 09/23/2024 at 1:57 PM, on 09/24/2024 at 9:13 AM, on 09/25/2024 at 2:51 PM, and on 09/26/2024 at 1:56 PM, showed a specimen refrigerator that had one unlabeled urine specimen in it. A joint observation of the specimen refrigerator on the second floor and interview on 09/27/2024 at 9:25 AM with Staff G, RCM, showed one unlabeled urine specimen. Staff G stated it was not labeled and that a urine specimen should not be held for more than 24 hours. Staff G further stated that they did not expect the urine sample to be in a refrigerator for longer than 24 hours and the urine specimen should be labeled. In an interview on 09/27/2024 at 12:18 PM, Staff B stated they expected urine specimens to be labeled, sealed in a bag, and placed in the specimen refrigerator. Staff B further stated that they did not expect the urine sample to be kept for more than 24 hours. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to provide necessary assistance with Activities of Daily Living (ADL) for 1 of 4 residents (Resident 14), reviewed for ADLs. The failure to provide residents who were dependent on staff for assistance with getting out of bed placed the resident at risk for unmet needs, pressure related complications, and a diminished quality of life. Findings included . Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 06/30/2024, showed Resident 14 admitted to the facility on [DATE]. It further showed that Resident 14 was dependent for transferring to and from a bed to a chair or wheelchair. Review of Resident 14's Devices care plan printed on 09/19/2024, showed, patient [resident] to be up in wheelchair, initiated on 02/02/2023. It further showed, reclining/tilt-in-space [a wheelchair that can tilt and can be used to redistribute pressure] WC [wheelchair]. Used for positioning and to allow [Resident 14] to get out of bed safely. It also provides potential pressure reduction. Review of the facility's document, Care Conference, dated 02/12/2024, showed that the resident's representative would like resident to have chair time. Observations on 09/19/2024 at 2:08 PM, on 09/20/2024 at 1:42 PM, on 09/23/2024 at 11:01 AM and at 1:48 PM, on 09/24/2024 at 8:40 AM and at 1:32 PM, and on 09/25/2024 at 8:49 AM and at 2:14 PM, showed Resident 14 laying in their bed. It further showed a tilt-in-space wheelchair was in their room. In an interview on 09/19/2024 at 2:47 PM, Resident 14's representative stated that they wanted the resident to be up in their wheelchair, that they have a special wheelchair, and that it had been over a year since the resident had been up in the wheelchair. In an interview on 09/25/2024 at 10:56 AM, Staff KK, Certified Nursing Assistant, stated that Resident 14 was dependent for transfers. In an interview and joint record review on 09/25/2024 at 2:20 PM with Staff P, Licensed Practical Nurse, stated that they had not seen Resident 14 be transferred to their wheelchair. A joint record review of Resident 14's Devices care plan, showed that the resident was to be up in wheelchair. Staff P stated, they want her to be up in a wheelchair and the care plan should be followed. In an interview on 09/25/2024 at 10:13 AM, Staff G, Resident Care Manager, stated that ADLs included transfers if residents were dependent. Staff G stated that Resident 14 has not used the wheelchair, but has the option. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 09/27/2024 at 12:18 PM, Staff B, Director of Nursing, stated they expected staff to provide ADLs for dependent residents, including transfers. Staff B stated they expected staff to follow and implement the care plan. A joint record review of the care conference document dated 02/12/2024, showed that the resident's representative would like the resident to have chair time. Staff B stated that clearly the care conference shows that the resident [Resident 14] should be up in the wheelchair. Reference: (WAC) 388-97-1060 (2)(c)

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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** 46912 Based on observation, interview, and record review, the facility failed to ensure services were consistently provided to increase Range of Motion (ROM) and/or to prevent decrease in ROM for 6 of 6 residents (Residents 14, 59, 37, 28, 35 & 10), reviewed for restorative services. This failure placed the residents at risk for a decline in ROM, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Restorative Program, updated in March 2019, showed, Restorative services are provided by Restorative Nursing Assistants (RNA) .or other staff .trained in restorative techniques. The Restorative Program is under nursing supervision. It further stated, Each restorative service is recorded .each time the program is implemented/completed. RESIDENT 14 Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 06/30/2024, showed Resident 14 admitted to the facility on [DATE] with diagnoses that included hemiplegia (complete or severe loss of strength, stiffness, or paralysis in one side of the body). Review of the Nursing Rehab (Rehabilitation)/Restorative care plan initiated on 01/11/2024, showed Resident 14 was on a restorative program, which included wearing a left elbow splint and left-hand splint up to six hours daily. Review of the facility's document titled, Nursing Rehab/Restorative: Splint/Brace Program LUE [Left Upper Extremity], printed on 09/25/2024, showed missing documentation of splint use for 11 out of 30 days. Two of the days that were missing documentation included 09/19/2024 and 09/24/2024. Observation on 09/19/2024 at 2:08 PM and on 09/24/2024 at 8:51 AM, showed Resident 14 had no left elbow splint or left-hand splint on their left upper extremity. RESIDENT 59 Review of Resident 59's face sheet printed on 10/02/2024, showed Resident 59 admitted to the facility on [DATE] with diagnosis that included anoxic brain damage [brain injury by a complete lack of oxygen to the brain]. Review of the Nursing Rehab/Restorative care plan initiated on 01/10/2024, showed Resident 59 was on a restorative program, which included wearing bilateral (both sides) hand/wrist splints six to eight hours daily. Review of the facility's document titled, Nursing Rehab/Restorative: Splint/Brace Program bilateral hand/wrist, printed on 09/24/2024, showed missing documentation of splint use for 11 out of 30 days. Two of the days that were missing documentation included 09/19/2024 and 09/24/2024. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/19/2024 at 12:18 PM and 09/24/2024 at 9:15 AM, showed Resident 59 had no splints on their hands/wrists. In an interview on 09/23/2024 at 10:52 AM, Staff JJ, Restorative Aide, stated they were responsible for placing splints on residents receiving restorative services. In another interview on 09/25/2024 at 9:10 AM, Staff JJ stated that they had been off work the day before and that no one covers for them. In an interview on 09/25/2024 at 10:56 AM, Staff KK, Certified Nursing Assistant (CNA), stated that the restorative aide was responsible for putting splints on residents and if they were not working, no one else was assigned to cover for them. In an interview on 09/25/2024 at 2:20 PM, Staff P, Licensed Practical Nurse (LPN), stated that the restorative aide provided the restorative program and was responsible for putting on the splints for residents. Staff P further stated that they did not put on the splints but would check for skin integrity under and around the splints. In an interview on 09/26/2024 at 10:13 AM, Staff G, Resident Care Manager (RCM), stated that they expected the restorative program to be done and that the restorative aides were responsible for putting splints on residents. In an interview and joint record review on 09/27/2024 at 12:18 PM, Staff B, Director of Nursing, stated they expected the restorative aides to follow and implement the plan of care for residents' restorative programs. Staff B stated that if the program stated to put splints on daily, they have to be put on daily. A joint record review of Resident 14's restorative care plan showed splints should be used up to six hours daily. Joint record review of the Nursing Rehab/Restorative: Splint/Brace Program LUE form, showed missing documentation of splint use during the last 30 days. Staff B stated, it appears it was not done daily. A joint record review of Resident 59's restorative care plan showed splint use should be done six to eight hours daily. Joint record review of the Nursing Rehab/Restorative: Splint/Brace Program bilateral hand/wrist, form, showed missing documentation of splint use during the last 30 days. Staff B stated, documentation doesn't show daily. Staff B further stated they expected the restorative program to be followed. 47680 RESIDENT 37 Review of the annual MDS dated [DATE] showed Resident 37 readmitted to the facility on [DATE]. Further review of the annual MDS in Section G (Functional limitation in ROM) showed Resident 37 had impairment on their upper extremity on both sides. Additionally, it showed under Section O (Restorative Nursing Programs), Resident 37 received Passive ROM (PROM-in which a part of your body can move when someone or something is creating the movement). Review of Resident 37's impaired mobility care plan revised on 01/12/2024, showed an intervention for the following: - PROM to Bilateral Upper Extremities (BUE) three to six times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Splint/Brace Program to BUE hands two to four hours daily as tolerated. Observations on 09/19/2024 at 2:56 PM, on 09/23/2024 at 1:47 PM, on 09/24/2024 11:14 AM and at 2:21 PM and on 09/26/2024 at 9:22 AM, showed Resident 37 had no splint/brace on their upper extremity. Review of the Nursing Rehab/Restorative: Passive ROM to BUE task form from 08/27/2024 through 09/24/2024, showed Resident 37 received PROM three out of 29 days. Review of the Nursing Rehab/Restorative: Splint/Brace Program BUE hand task form printed on 09/25/2024, showed no data for the last 30 days. In an interview on 09/25/2024 at 11:30 AM, Staff N, Restorative Aide, stated that they provided Resident 37 with their restorative program and when Resident 37 moved to the second floor, it was hard for them to manage their time. Staff N stated that the last time it was documented that Resident 37 received their restorative program was on 09/03/2024 and that they had not seen Resident 37 since then. Staff N stated that Resident 37 does not like to use the splints/brace and declined to wear them. Staff N further stated that they should have seen Resident 37 three to six times a week. In an interview on 09/25/2024 at 1:09 PM, Staff G stated that they have a restorative aide that does the treatment and that they expected the restorative aide to follow the restorative program. In an interview on 09/25/2024 at 2:21 PM, Staff B stated that they expected staff to follow and implement the restorative program or care plan they have in place. Staff B reviewed Resident 37's record and confirmed that Resident 37 received their last PROM restorative program on 09/03/2024. Staff B stated that they expected staff to follow and implement the restorative program and what was in the care plan. Staff B further stated that if a resident refused, they expected staff to document it. 48298 RESIDENT 28 Resident 28 admitted to the facility on [DATE] with diagnoses that included traumatic brain injury, contracture (stiffening or tightening of muscles) of their right elbow and right wrist. Review of the annual MDS dated [DATE] showed Resident 28 had intact cognition and used a communication board. Review of the Restorative Program referral by Physical Therapy (PT) dated 09/11/2024 showed a recommendation for Resident 28 to have Passive/Active (when you move a part of your body using your muscles) ROM to their Bilateral Lower Extremities (both legs and feet) and joints for three to five times a week to maintain their ROM and current strength. Review of the Restorative Program referral by Occupational Therapy (OT) dated 09/11/2024 showed a recommendation for Resident 28 to have a right palm splint for one to two hours or as they tolerated. It further showed recommendation for Resident 28 to have LUE exercises using three to four pounds dumbbell and PROM exercises to their Right Upper Extremity for three to five times a week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Restorative Nursing Program (RNP) Point of Care (POC-documentation of care provided to the residents) task form printed on 09/24/2024 at 11:01 AM, showed the RNP recommendation by PT dated 09/11/2024 was not written/documented on the RNP POC. In an interview on 09/23/2024 at 8:14 AM, Resident 28 stated that it had been two or three weeks since they were provided ROM exercises. In an interview on 09/24/2024 at 8:30 AM, Staff N stated that they could not remember the last time they provided Resident 28 their ROM exercises. Staff N stated, Am pulled quite often on the floor. Nobody takes over my work doing ROM [exercises]. Staff N stated they documented the ROM exercises provided to the residents on their tablet (electronic device) under POC Restorative program task. Staff N then proceeded to show Resident 28 had ROM exercises on 09/20/2024. When asked if they could show the September 2024 RNP exercises and documentation for Resident 28, Staff N stated they did not have that information. Staff N further stated that they did not do restorative for residents when they were pulled to the floor. In an interview on 09/24/2024 at 9:41 AM, Staff F, RCM, stated that Staff B was responsible for the RNP and that questions about ROM exercises can very well explained by them or the Rehab therapists. In a joint record review and interview on 09/24/2024 at 1:24 PM with Staff B, showed Resident 28's RNP recommendation by PT dated 09/11/2024 was not included in the RNP POC task. Staff B stated Resident 28 did not receive the recommended RNP by PT and that they expected the restorative staff to provide ROM exercises based on PT referral and recommendation. 51090 RESIDENT 35 Resident 35 readmitted to the facility on [DATE] with diagnoses that included hemiparesis (weakness or inability to move one side one side of the body) following cerebral infarction (a type of stroke that occurs when blood flow to the brain is disrupted) affecting left non-dominant side, contracture, unspecified joint and muscle wasting and atrophy (the thinning or loss of muscle tissue). Review of the restorative nursing care plan dated 01/12/2024, showed Resident 35 had a treatment for a left elbow splint, to be worn for two hours daily, as tolerated. Review of Resident 35's quarterly MDS dated [DATE], Section O (Restorative Nursing Programs) was coded for one day of splint or brace assistance from 08/17/2024 through 08/23/2024. Observations on 09/20/2024 at 9:30 AM, on 09/24/2024 at 8:30 AM and on 09/25/2025 at 8:46 AM, showed Resident 35 did not have a left elbow splint in place. In a joint record review and interview on 09/25/2024 at 8:54 AM with Staff N, showed Resident 35's restorative POC task had no documentation for the amount [sic (number)] of minutes spent providing [left elbow] splint assistance on 09/19/2024, on 09/20/2024, on 09/21/2024, on 09/22/2024, and on 09/23/2024. Staff N stated Resident 35's left elbow splint was not provided daily in accordance with Resident 35's restorative nursing care plan. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/25/2024 at 1:40 PM, Staff F stated that the restorative aids were responsible for putting Resident 35's left elbow splint. In a joint record review and interview on 09/27/2024 at 1:35 PM with Staff B, showed Resident 35's restorative POC task had no documentation for the amount [sic] of minutes spent providing [left elbow] splint assistance on 09/19/2024, on 09/20/2024, on 09/21/2024, on 09/22/2024 and on 09/23/2024. Staff B stated the restorative program services were not provided daily, as outlined in Resident 35's plan of care. Staff B further stated that their expectation for staff was to follow the restorative nursing program. RESIDENT 10 Resident 10 was readmitted to the facility on [DATE] with diagnoses that included contractures of the left wrist, right hand, multiple sites and persistent vegetative state (a chronic condition that describes a person who is in a state of wakefulness but is unaware of their surroundings). Review of the impaired mobility care plan dated 01/12/2024, showed Resident 10 had a treatment for a nursing restorative splint program with bilateral elbow and bilateral resting hand splints to be worn for two hours daily. Review of Resident 10's quarterly MDS dated [DATE], showed Section O was coded for one day of splint or brace assistance from 08/11/2024 through 08/17/2024. Observations on 09/19/2024 at 11:17 AM, on 09/20/2024 at 1:04 PM, on 09/23/2024 at 10:50 AM and on 09/24/2024 at 8:25 AM, showed Resident 10 did not have bilateral elbow and bilateral resting hand splints in place. Joint record review and interview on 09/24/2024 at 12:50 PM with Staff N showed Resident 10's nursing restorative splint program was not provided on 09/19/2024 via restorative POC task documentation. Staff N stated Resident 10's splint program was not provided on 09/19/2024 because they were pulled to the floor. In an interview on 09/25/2024 at 1:40 PM, Staff F stated that the restorative aids were responsible for putting on Resident 10's bilateral elbow and bilateral hand splints, as part of Resident 10's restorative nursing care plan. Review of the August 2024 and September 2024 Nursing Rehab/Restorative Splint/Brace Program for bilateral elbow/resting hand splints showed the following dates had an N/A [not applicable] documentations from 08/30/2024 to 8/31/2024, from 09/02/2024 to 09/04/2024, from 09/7/2024 to 09/10/2024, from 09/12/20204 to 09/13/2024, from 09/15/2024 to 09/19/2024, on 09/21/2024 and on 09/23/2024. In a joint record review and interview on 09/27/2024 at 1:35 PM with Staff B, showed Resident 10's restorative POC task documentation printed on 09/27/2024, was documented as not applicable for Resident 10's bilateral elbow and bilateral resting hand splints. Staff B stated the not applicable documentation did not indicate that Resident 10 refused their bilateral splints. Staff B further stated the restorative program services for bilateral elbow and bilateral resting hand splints were not provided daily in accordance with Resident 10's restorative nursing care plan. Additionally, Staff B stated that their expectation was for staff to follow and implement their restorative nursing program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1060 (3)(d)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services related to enteral tube feeding (TF-the delivery of nutrients through a tube directly into the stomach) were followed for 2 of 3 residents (Residents 54 & 36), reviewed for TF management. The failure to check TF placement or check the gastric residual volumes (GRV - fluid/contents that remain undigested in the stomach) prior to TF and medication administration placed the residents at risk for medical complications and a diminished quality of life. Findings included . Review of the facility's policy titled, Enteral Feeding, updated in April 2017, showed the licensed nurse administers the enteral feeding and medications per physician order using best practice. It further showed additional procedure for enteral feeding which included residuals check. RESIDENT 54 Resident 54 admitted to the facility on [DATE] with a diagnosis of laryngeal cancer (cancer of the throat). Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 09/10/2024, showed Resident 54 had a gastrostomy tube (G-tube - a medical device used to provide nutrients through a tube directly into the stomach). Review of Resident 54's September 2024 Medication Administration Record (MAR) showed physician orders to check residuals [stomach contents] and to check feeding tube placement prior to each TF or flush (by visual inspection and aspiration). Observation on 09/25/2024 at 8:41 AM, showed Staff GG, Registered Nurse, administered Resident 54's 8:00 AM medications via G-tube and did not check GRV or verify feeding tube placement prior to Resident 54's medication administration. RESIDENT 36 Resident 36 admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty in swallowing). Review of the quarterly MDS dated [DATE], showed Resident 36 had a feeding tube (a flexible tubing that delivers nutrients directly into the stomach). Review of Resident 36's September 2024 MAR showed physician orders to check residuals and feeding tube placement prior to each TF or flush (by visual inspection and aspiration). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/25/2024 at 12:10 PM, showed Staff GG connected Resident 36's feeding tube to their enteral formula (liquid nutritional products used for tube feeding). Staff GG did not check for GRV or check for TF placement prior to connecting Resident 36 to their enteral formula. In an interview on 09/25/2024 at 1:03 PM, Staff GG stated that they check TF placement by the start of their shift or once during [their] shift by visual inspection. Staff GG stated, If I suspect that it [feeding tube] is not in place or it moves then I will verify it using the stethoscope (a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener through rubbing tubing connected with a piece placed upon the area to be examined). Staff GG stated they did not check or verify TF placement for Resident 36 prior to connecting their enteral formula. Staff GG further stated they did not check or verify TF placement prior to Resident 54's medication administration. In an interview on 09/25/2024 at 2:12 PM, Staff F, Resident Care Manager, stated staff were expected to check proper feeding tube placement prior to TF and medication administration. In an interview on 09/27/2024 at 10:14 AM, Staff B, Director of Nursing, stated they expected staff to check TF placement and to follow the standard of practice in relation to tube feeding and medication administration. Reference: (WAC) 388-97-1060 (3)(f)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 50891 Based on interview and record review, the facility failed to complete required annual performance evaluation for 2 of 3 staff (Staff T & MM), whose personnel files were reviewed for Certified Nursing Assistant (CNA) performance evaluations. The failure to complete a performance review of every nurse aid at least once every 12 months placed residents at risk for receiving care from underqualified care staff, unmet care needs and a diminished quality of life. Findings included . STAFF T, CNA Review of Staff T's personnel file showed they were hired on 01/22/2022. Their last performance review was completed on 02/23/2022. STAFF MM, CNA Review of Staff MM's personnel file showed they were hired on 02/23/2022. Their last performance review was completed on 12/08/2022. In an interview on 09/27/2024 at 1:09 PM, Staff A, Administrator, stated that they expected performance evaluations were completed annually. Reference: (WAC) 388-97-1680 (2)(b)(i)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 50891 Based on observation and interview, the facility failed to ensure the daily nurse staffing form was posted 2 of 9 days and failed to post daily nurse staffing in prominent locations for 3 of 4 floors (First floor, Second floor & Third floor). This failure placed the residents, the residents' representatives, and visitors at risk of not being fully informed of the current staffing levels. Findings included . Observations on 09/19/2024 at 8:48 AM showed there was no nurse staffing posted that was visible on the Third floor. Observation on 09/19/2024 at 10:00 AM showed there was no nurse staffing posted that was visible on the Second floor. Observation and interview on 09/23/2024 at 8:16 AM, showed that the Daily Nurse Staffing Information Form for 09/20/2024 was posted in a glass case by the reception desk. Staff S, Staffing Coordinator, stated that they would have today's posting up in a minute. Observation on 09/24/2024 at 9:22 AM showed there was no Daily Nurse Staffing Information Form on the Third floor. Observation on 09/24/2024 at 9:24 AM showed there was no Daily Nurse Staffing Information Form on the Second floor. Observation on 09/24/2024 at 9:45 AM showed there was no Daily Nurse Staffing Information Form on the First floor. In an interview on 09/27/2024 at 12:39 PM, Staff S stated that they would create the nursing staff forms after checking for call outs. Staff S stated that they would prepare the schedules for Saturday, Sunday and Monday for the weekend supervisor to post. Staff S stated that the weekend supervisor had the last two weekends off. Staff S further stated that they posted the Daily Nurse Staffing Information Form in a glass case by the reception desk and did not post it anywhere else in the building. In an interview on 09/27/2024 at 1:08 PM, Staff A, Administrator, stated that their expectation was to have the nurse staffing posted daily. Staff A stated that the weekend supervisor was off over the weekend. No associated WAC

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services related to enteral tube feeding (the delivery of nutrients through a tube directly into the stomach) were followed for 2 of 3 residents (Residents 54 & 36), reviewed for tube feeding management. The failure to check tube feeding placement for gastric residual volumes (GRV - fluid/contents that remain undigested in the stomach) prior to tube feeding and medication administration placed the residents at risk for medical complications and a diminished quality of life. Findings included . Review of the facility's policy titled, Enteral Feeding, updated in April 2017, showed the licensed nurse administers the enteral feeding and medications per physician order using best practice. It further showed additional procedure for enteral feeding which included residuals check. RESIDENT 54 Resident 54 admitted to the facility on [DATE] with a diagnosis of laryngeal cancer (cancer of the throat). Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 09/10/2024, showed Resident 54 had a gastrostomy tube (G-tube - a medical device used to provide nutrients through a tube directly into the stomach). Review of Resident 54's September 2024 Medication Administration Record (MAR) showed physician orders to check residuals [stomach contents] and to check feeding tube (a flexible tubing that delivers nutrients directly into the stomach) placement prior to each tube feeding or flush (by visual inspection and aspiration). Observation on 09/25/2024 at 8:41 AM, showed Staff GG, Registered Nurse, administered Resident 54's 8:00 AM medications via G-tube and did not check the GRV or verify feeding tube placement prior to Resident 54's medication administration. RESIDENT 36 Resident 36 admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty in swallowing). Review of the quarterly MDS dated [DATE], showed Resident 36 had a feeding tube. Review of Resident 36's September 2024 MAR showed physician orders to check residuals and feeding tube placement prior to each tube feeding or flush. Observation on 09/25/2024 at 12:10 PM, showed Staff GG connected Resident 36's feeding tube to their enteral formula (liquid nutritional products used for tube feeding). Staff GG did not check for GRV or check for tube feeding placement prior to connecting Resident 36 to their enteral formula. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/25/2024 at 1:03 PM, Staff GG stated that they check tube feeding placement by the start of their shift or once during [their] shift by visual inspection. Staff GG stated, If I suspect that it [feeding tube] is not in place or it moves then I will verify it using the stethoscope (a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener through rubber tubing). Staff GG stated they did not check or verify tube feeding placement for Resident 36 prior to connecting their enteral formula. Staff GG further stated they did not check or verify tube feeding placement prior to Resident 54's medication administration. In an interview on 09/25/2024 at 2:12 PM, Staff F, Resident Care Manager, stated staff were expected to check proper feeding tube placement prior to tube feeding and medication administration. In an interview on 09/27/2024 at 10:14 AM, Staff B, Director of Nursing, stated they expected staff to check tube feeding placement and to follow the standard of practice in relation to tube feeding and medication administration. Reference: (WAC) 388-97-1060 (3)(f)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on observation, interview, and record review, the facility failed to appropriately label and store drugs or biologicals (diverse group of medicines made from natural sources) and/or failed to ensure expired medications were disposed of timely in accordance with current accepted professional standards for 2 of 3 medication carts (Second Floor Cart 2 & Third Floor Cart 1) and for 1 of 2 Medication Storage Room (Second Floor Medication Storage Room), reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised and ineffective medications. Findings included . Review of the facility's policy titled, Medication Storage, dated January 2023, showed, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. It further showed, Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal . In addition, Controlled medications should be stored separately from non-controlled medications .must be stored in a separately locked permanently affixed compartment. Review of the facility's policy titled, Medication Administration, dated January 2024, showed, The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. SECOND FLOOR CART 2 In a joint observation and interview on 09/26/2024 at 10:26 AM with Staff BB, Registered Nurse, showed an open and undated bottle of Milk of Magnesia (medication to treat constipation) with an expiration date of 8/24 [August 2024] was found in cart 2 on the second floor unit. Staff BB stated that it had no open date and it should have been discarded. In an interview on 09/26/2024 at 11:05 AM, Staff G, Resident Care Manager (RCM), stated expired medication should be removed from the cart and disposed of properly. THIRD FLOOR CART 1 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint observation and interview on 09/26/2024 at 11:25 AM with Staff II, Licensed Practical Nurse (LPN), showed two open and undated bottles of Chlorhexidine Gluconate (a mouthwash that reduces bacteria in the mouth) labeled with residents' names and an open bottle of Fish Oil gel capsule (a supplement) with an expiration date of 06/23 [June 2023] were found in cart 1 on the third floor unit. Staff II stated that the two bottles of mouthwash had no open date and belonged to the residents who had dental procedures. Staff II stated that the bottle of Fish Oil had not been used because [resident's name] had been taking [NAME] Oil (a supplement). Staff II stated that they should have placed an open date on both bottles of mouthwash when they opened them and that they should have removed the expired bottle of Fish Oil from their cart. In an interview and joint observation on 09/26/2024 at 11:47 AM, Staff H, RCM, stated they expected the staff to remove expired medications from the medication cart and to label with date once they opened the bottle of medication. Staff H stated that they cannot believe there was a 2023 expired medication and asked Staff II to see it. Staff H reached into the cart 1's trash bin and saw the bottle of Fish Oil. In an interview on 09/27/2024 at 10:26 AM, Staff B, Director of Nursing, stated they expected staff to discard expired medication and maintain proper storage and labeling. 46912 SECOND FLOOR MEDICATION STORAGE ROOM In a joint observation and interview on 09/25/2024 at 9:18 AM with Staff P, LPN, showed an unlocked refrigerator in the second floor medication storage room. It showed one unopened bottle of lorazepam (a medication to treat anxiety). Staff P stated that lorazepam was a controlled substance, and that the refrigerator should have been locked. In a joint observation and interview on 09/25/2024 at 9:20 AM with Staff P, showed an open and unlabeled vial of tuberculin (a liquid used to test for tuberculosis). Staff P stated the vial should have been labeled after opening because it was a multi-dose vial. Staff P stated they were unsure how long the vial was good for once it was opened. In an interview on 09/26/2024 at 1:36 PM, Staff G stated that they expected multi-dose vials like tuberculin to be labeled with the date that it was opened. Staff G further stated that lorazepam was a controlled substance and should be stored in a locked refrigerator. In an interview on 09/27/2024 at 12:18 PM, Staff B stated that multi-dose vials should be labeled when they were opened. Staff B further stated that lorazepam was a controlled substance, and they expected the refrigerator to be locked when storing controlled substances. Reference: (WAC) 388-97-1300(2)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on observation, interview, and record review, the facility failed to ensure resident meal preferences for meal services was provided for 1 of 2 residents (Resident 76). This failure placed the resident at risk for not having their food choices honored, dissatisfaction with food served, and a diminished quality of life. Findings included . A record review of Resident 76's face sheet, printed 09/23/2024, showed they admitted to the facility on [DATE] with multiple diagnoses including a fractured lumbar vertebra (broken back). A review of the facility's weekly menu showed the following: -09/22/2024: Oatmeal, fresh fruit, western omelet, and wheat toast -09/23/2024: Cereal cream of Wheat Fresh fruit, sausage patty, pancakes -09/24/2024: Cream of rice, fresh fruit, fried egg sandwich, hashbrown patty, bacon -09/25/2024: Oatmeal, fresh fruit, sausage patty, waffle -09/26/2024: Oatmeal, fresh fruit, fried egg, bacon, bagel -09/27/2024: Cream of rice, fresh fruit, biscuit, sausage gravy -09/28/2024: Oatmeal, fresh fruit, French toast, sausage patty In an interview on 09/19/2024 at 2:00 PM, Resident 76 stated that they had asked the dietician to increase their caloric intake due to their desire to gain weight but had been getting less food instead. Resident 76 stated that for breakfast, they would get one sausage patty and one piece of toast. Resident 76 stated that they would ask staff to get them a real breakfast. Resident 76 further stated that they liked waffles and pancakes but does not get them, so therefore decides not to wake up for breakfast. Observation on 09/25/2024 at 9:20 AM, showed Resident 76 was asleep in bed. Their breakfast tray was untouched and consisted of one sausage patty, toast, and eggs. On that day, the breakfast menu included waffles. Observation on 09/26/2024 at 9:06 AM, showed Resident 76 was asleep in bed. Their untouched breakfast tray consisted of eggs, toast, and fruit. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/2024 at 12:26 PM, Resident 76 stated that activities would come once a week and help residents with their menu order. Resident 76 stated that it was up to the residents to bring the menu order to the kitchen. Resident 76 further stated that no one helped take their menu order during the period when they could not get out of bed. In an interview on 09/26/2024 at 12:33 PM, Staff CC, Certified Nursing Assistant (CNA), stated that the activities department would hand the menu orders out to residents once a week and then would collect them on Fridays. In an interview on 09/26/2024 at 2:37 PM, Staff DD, Activities Director, stated that they provide menu orders for the residents and if residents were independent, they could take their menu order to the CNA station or to the dietary office. In a joint record review and interview on 09/26/2024 at 2:44 PM, with Staff K, Dietary Manager, showed that they were unable to find menu orders for Resident 76 for the last five weeks. Staff K stated activities should have helped this resident. Staff K stated that they did not know why Resident 76 was not getting served pancakes and waffles and that their preference for wheat toast should not have omitted those items. Staff K stated that their expectation was for residents to receive what was on the menu. In an interview on 09/26/2024 at 3:18 PM, Staff A, Administrator, stated that food preferences were collected upon admission and residents should receive what was on the menu. In an interview on 09/27/2024 at 10:22 AM, Staff EE, CNA, stated that Resident 76 had once complained about their breakfast. Staff EE stated that Resident 76 asked them to get them French toast from kitchen because they saw that their roommate had them. Staff EE stated that the kitchen informed them it was not served because Resident 76 had wheat toast as a preference. Reference: (WAC) 388-97-1120 (3)(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 1 of 1 kitchen and 2 of 2 resident personal refrigerators (Resident 6's two personal refrigerators), reviewed for food services. The failure to appropriately thaw food in a manner to provide food safety and failure to check temperature and maintain personal refrigerators, placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Preparation and Service of Foods - Safety Precautions, updated November 2018, showed one of four acceptable methods for thawing food was to completely submerge under cold running potable water (temperature of 70 degrees Fahrenheit [F-unit of measurement] or below), with water that is running fast enough to agitate and float off loose ice particles. According to the Food and Drug Administration's (FDA-a federal agency that protects public health by ensuring the safety and security of food) document titled, 2022 Food Code, January 18, 2023, version, showed that the time/temperature control for safety of food shall be thawed completely submerged under running water for a period of time that does not allow thawed portions of a raw animal food, requiring cooking to be above 41 F, for more than four hours, including the time the food was exposed to the running water and the time needed for preparation for cooking. KITCHEN FOOD PREPARATION Joint observation and interview on 09/19/2024 at 9:00 AM, with Staff K, Dietary Manager, and Staff M, Food and Nutrition Cook, showed raw chicken breasts were being thawed in a sheet pan under running water in the kitchen preparation sink. Staff K stated, [Staff M] put the raw chicken in there [under the running water in the sink] just now. Staff M stated the raw chicken breasts were recently placed in the sink to thaw, but they could not state when thawing of the raw chicken breasts started. Staff K stated there should have been a sticker to indicate the time the raw chicken breast started thawing under the running water. Staff K then used a food thermometer (a tool that measures the internal temperature of food to ensure it's safe to eat) to measure the temperature of a raw chicken breast, from the sheet pan thawing in the sink. The temperature, as displayed on the facility's food thermometer, of the raw chicken breast was 64.9 F. When asked if the raw chicken breast with a temperature of 64.9 F met food safety preparation for consumption, Staff K replied No, we're throwing it away. In an interview on 09/25/2024 at 2:53 PM, with Staff O, Registered Dietician Nutritionist Consultant, stated that the facility followed the 2022 FDA Food Code. Staff O further stated the facility's process when using the running water method for thawing, was to have a sticker placed on the container used to thaw the food item or nearby, to determine how long it's been under the running water. Staff O further stated that they expected thawed raw meat to stay below 41 F, to avoid the danger zone [40 F to 140 F] and the risk for food borne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/26/2024 at 9:16 AM, Staff A, Executive Director, stated that the facility followed the FDA 2022 Food Code, as well as the Federal and State regulations. Staff A further stated they expected staff to follow the FDA 2022 Food Code for ensuring food was prepared and stored safely. 45146 RESIDENT PERSONAL REFRIGERATORS Review of the facility's policy titled, Resident Personal Refrigerators and Foods Brought into Center by Family/Visitors updated August 2020, showed, Refrigerators containing resident food have thermometers and daily temperature logs with temperatures documented. Temperature standards: refrigerator 35 - 40 degrees Fahrenheit, freezer less than zero-degree F. Temperatures outside of these standards are reported to the Dietary Manager or Person in Charge. Resident 6 admitted to the facility on [DATE]. Review of Resident 6's quarterly Minimum Data Set (an assessment tool) dated 06/25/2024 showed Resident 6 was cognitively intact. Observations on 09/19/2024 at 1:56 PM, on 09/23/2024 at 2:07 PM, and on 09/24/2024 at 2:05 PM, showed Resident 6 had two small personal refrigerators in their room. Observation showed both refrigerators' doors would not stay closed due to the ice built-up inside the top shelves of the refrigerators that were pushing the doors out. Further observation showed multiple food items were stored in both refrigerators that included cups of yogurt, a milk cartoon, butter, and multiple jars of salsa. Additional observation showed, temperature logs dated November 2022 and December 2022 were placed on the doors of the refrigerators, and they were blank. Resident 6 stated they were using the refrigerators to store their own food. Resident 6 stated the facility staff never cleaned, maintained or checked their refrigerators' temperature. On 09/25/2024 at 8:46 AM, Staff H, Resident Care Manager, stated that they were not sure who was responsible for maintaining and checking the temperature of Resident 6's personal refrigerators. Joint observation on 09/25/2024 at 9:00 AM with Staff H, showed Resident 6's refrigerators had temperature logs on the door dated November 2022 and December 2022, and they were blank. Further observation showed Resident 6 had food items stored in both refrigerators and the refrigerator doors would not close due to buildup of ice on the top shelves of the refrigerators. On 09/25/2024 at 11:03 AM, Staff K and Staff O stated that the facility had a policy that all refrigerators including residents' personal refrigerators should be checked daily. On 09/25/2024 at 11:57 AM, Staff A stated that they expected the facility's dietary staff to maintain and check the temperature of Resident 6's personal refrigerators daily. Reference: (WAC) 388-97-1100 (3)

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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** 46912 Based on observation, interview, and record review, the facility failed to ensure Contact Precautions (measures put in place to prevent spread of infection by direct or indirect contact with the resident or environment by staff wearing gown and gloves before entering a resident's room or environment) practices were followed for 2 of 5 staff (Staff MM & LL) and failed to implement Enhanced Barrier Precautions (EBP-precaution to protect residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections]) for 1 of 4 residents (Resident 6) reviewed for infection control. In addition, the facility failed to ensure hand hygiene practices and/or proper use of gloves were followed before, during, and after resident care for 2 of 2 staff (Staff BB & GG) and failed to disinfect medical equipment for 1 of 2 staff (Staff R) reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . CONTACT PRECAUTIONS Review of the facility's policy titled, Transmission-Based Precautions, dated May 2015, showed to implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces and staff should wear gloves when entering the room. STAFF MM Observation on 09/19/2024 at 8:34 AM, showed Staff MM, Certified Nursing Assistant (CNA), enter room [ROOM NUMBER] (contact precautions room) to deliver a meal tray and did not put on gloves prior to entering the room. Observation on 09/19/2024 at 9:17 AM, showed Staff MM enter room [ROOM NUMBER] without putting gloves on before entering the room and picking up the meal tray with their bare hands. In an interview and joint observation on 09/19/2024 at 10:24 AM, Staff MM stated they followed what the signage says for residents on contact precautions. A joint observation of the contact precautions sign for room [ROOM NUMBER], showed that staff should put on gloves prior to entering the room. Staff MM stated that the sign says to wear gloves when entering a contact precautions room. STAFF LL Observation on 09/19/2024 at 9:45 AM, showed Staff LL, CNA, entered room [ROOM NUMBER] (contact precautions room) without wearing gloves. Observation on 09/19/2024 at 10:13 AM, showed Staff LL, entered room [ROOM NUMBER] (contact precautions room) without wearing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/19/2024 at 10:46 AM, Staff LL stated that gloves should be worn before going into the room if a resident is on contact precautions. In an interview on 09/27/2024 at 10:52 AM, Staff D, Infection Preventionist (IP), stated that they expected staff to follow the signage for residents on contact precautions, which included wearing gloves prior to entering resident rooms who were on contact precautions. In an interview on 09/27/2024 at 12:18 PM, Staff B, Director of Nursing, stated that they expected staff to put on gloves prior to entering resident rooms who were on contact precautions. 45146 ENHANCED BARRIER PRECAUTIONS According to Centers for Disease Control and Prevention (CDC) website, dated 04/02/2024, showed that nursing home residents with indwelling medical devices (e.g. urinary catheter [a flexible tube inserted into bladder to empty urine]) should be placed on EBP. When implementing EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required Personal Protective Equipment (PPE - protective devices, garments, or coverings like gloves, gown and mask). For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Make PPE, including gowns and gloves, available immediately outside of the resident room. Resident 6 admitted to the facility on [DATE]. Review of Resident 6's quarterly Minimum Data Set (an assessment tool) dated 06/25/2024 showed Resident 6 was cognitively intact. Further review of the MDS assessment showed Resident 6 had an indwelling catheter. Observations on 09/19/2024 at 2:28 PM, on 09/20/2024 at 8:16 AM, on 09/23/2024 at 8:54 AM, and on 09/24/2024 at 8:35 AM, showed no EBP signage on Resident 6's room door or PPE cart was placed outside of the resident's room. During an interview and joint observation on 09/19/2024 at 2:50 PM, Staff FF, CNA, stated that they were not aware of Resident 6's precaution. Joint observation of the resident's room showed that there was no EBP signage on Resident 6's room door or PPE cart was placed outside of the resident's room. During an interview and joint record review on 09/25/2024 at 8:52 AM, Staff H, Resident Care Manager (RCM), stated that Resident 6 had an indwelling catheter, and they should be placed on EBP. Staff H further stated when EBP was initiated there should have been an order and a care plan in place. Joint record review of Resident 6's active physician orders as of 09/24/2024 and care plan printed on 09/24/2024 showed that there was no order or a care plan for EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/25/2024 at 1:43 PM, Staff D stated that when a resident was placed on EBP, there would be an order in place and a care plan initiated. Staff D further stated EBP signage would be placed on the resident's room door and PPE cart would be placed outside of the resident's room. On 09/27/2024 at 8:30 AM, Staff B stated they expected staff to implement EBP for Resident 6 by placing an order, initiating a care plan, placing EPB signage on the resident's door and placing PPE cart outside of the resident's room. 47680 HAND HYGIENE WITH GLOVE USE Review of the facility's policy titled, Handwashing/Hand Hygiene, updated in March 2018, showed to use an alcohol based hand rub containing at least 62 percent alcohol, or, alternatively, soap and water before donning [putting on] sterile gloves and after removing gloves. Observation on 09/26/2024 at 9:03 AM, showed Staff BB, Registered Nurse (RN), perform hand hygiene, applied gown and gloves prior to entering Resident 52's room. Staff BB removed Residents 52's boots on both feet. Staff BB cleaned Resident 52's right foot with the cleanser and gauze. Staff BB then removed their gloves and applied new gloves. Staff BB did not perform hand hygiene between glove use. Staff BB then applied skin prep (a liquid film-forming dressing that forms a protective barrier) to Resident 52's right foot. When Staff BB was done, they removed their gloves and applied new gloves without performing hand hygiene. Staff BB then cleaned the left foot with a cleanser and gauze. When Staff BB was done, they removed their gloves, performed hand hygiene and applied new gloves. In an interview on 09/26/2024 at 9:16 AM, Staff BB stated that their process was to perform hand hygiene before and/or after glove use, and after you touch anything soiled. Staff BB stated that they should have performed hand hygiene between glove use. In an interview on 09/27/2024 at 10:16 AM, Staff E, IP, stated that they expected staff to perform hand hygiene before and after glove use. Staff E further stated that they expected Staff BB to perform hand hygiene between glove use. In an interview on 09/27/2024 at 11:54 AM, Staff B stated that they expected staff to perform hand hygiene before they put their gloves on and after they take them off. 48298 Observation on 09/25/2024 at 8:41 AM, showed Staff GG, RN, wore a PPE gown and entered Resident 54's room to administer their medication. Resident 54 was on EBP and had a feeding tube (a flexible plastic tubing used to deliver nutrients directly to the stomach). Staff GG took a new pair of gloves from Resident 54's room and wore them without performing hand hygiene. Staff GG proceeded to administer Resident 54's medication via their feeding tube. (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 09/25/2024 at 12:04 PM, showed Staff GG wore PPE, a gown then a pair of gloves without performing hand hygiene and entered Resident 36's room to administer their medication. Resident 36 was on EBP and had a feeding tube. Staff HH, RN, asked Staff GG for the keys to their medication cart. Staff GG then removed the glove from their right hand and reached for their pants pocket to give Staff HH their cart keys. Staff GG then took another glove and put it on their right hand. Staff GG did not perform hand hygiene. Staff GG proceeded to wipe Resident 36's left middle finger with an alcohol swab. Staff GG then pricked Resident 36's finger using a retractable lancet (a small blade with a sharp point), and they used a device called glucometer to measure Resident 36's blood sugar level. Staff GG then administered Resident 36 insulin (a hormone that regulates blood sugar level) to their left upper arm. Staff GG then removed their gloves and took another pair of new gloves and proceeded to connect Resident 36's feeding tube to their enteral formula (liquid nutritional products used for tube feeding). Staff GG did not perform hand hygiene between glove use. In an interview on 09/25/2024 at 1:03 PM, Staff GG stated they did not perform hand hygiene between glove use. Staff GG stated they should have performed hand hygiene before, between and after removing their [soiled] gloves. In an interview on 09/25/2024 at 2:36 PM, Staff F, RCM, stated they expected staff to perform hand hygiene before/after and between glove use. In an interview on 09/27/2024 at 10:20 AM, Staff B stated they expected staff to perform hand hygiene as required. 51090 DISINFECTING MEDICAL EQUIPMENT According to the CDC's online document titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, showed under reprocessing of reusable medical equipment to clean and reprocess (disinfect or sterilize) reusable medical equipment (e.g. [for example] blood pressure cuffs, pulse oximeter [a noninvasive device that measures the amount of oxygen in a person's blood]) prior to use on another patient [resident] or when soiled. Observation on 09/25/2024 at 11:04 AM, showed Staff R, CNA, entered room [ROOM NUMBER] with a vital sign (measurement of the body's basic functions, such as breathing rate, heart rate, and blood pressure) equipment. Staff R placed the blood pressure cuff and the pulse oximeter on Resident 286. Staff R then used the vital sign machine on Resident 28. Staff R did not disinfect the vital sign equipment between resident use. In an interview on 09/25/2024 at 11:15 AM, Staff R stated that the facility's process for cleaning and disinfecting shared medical equipment, was that shared medical equipment should be wiped and sanitized. Staff R stated there were no available disinfectant wipes and that they didn't use it. Staff R further stated that they used the regular wipes we clean [residents] with to wipe the vital sign equipment in between use for Resident 286 and Resident 28. On 09/25/2024 at 1:44 PM, Staff F stated they expected vital sign equipment to be disinfected after each use with bleach wipes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/26/2024 at 8:01 AM, Staff E stated that the facility's process for shared medical equipment, such as vital sign equipment, was that shared medical equipment would be disinfected after each use with a disinfectant. Staff E further stated that the facility used microdot [brand] bleach wipes for disinfecting shared medical equipment. On 09/26/2024 at 11:36 AM, Staff D stated that CNAs were trained to disinfect vital sign equipment after each use and that they expected staff to disinfect vital sign equipment after each use. On 09/26/2024 at 2:44 PM, Staff B stated the facility followed CDC's guidance on infection prevention and control practices for cleaning and disinfection. Staff B stated they expected shared medical equipment such as vital sign machine equipment would be cleaned and disinfected with an appropriate disinfectant after each use. Reference: (WAC) 388-97-1320 1(a)(c)(5)(c)(e)