STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505318	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Skagit Valley	1462 West State Route 20 Sedro Woolley, WA 98284

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to obtain and/or maintain Advance Directives (AD) for 1 of 2 sampled residents (Resident 24) reviewed for AD. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . Resident 24 admitted to the facility on [DATE] with diagnoses that included fracture of the right femur, chronic heart failure, and kidney disease. Review of Resident 24's care plan dated 07/22/2024 documented they had a Power of Attorney (POA) for healthcare and their daughter was specified as their POA. Review of Resident 24's electronic medical record showed no POA paperwork. In an interview on 09/11/2024 at 12:45 PM Staff W, Licensed Practical Nurse, stated a resident's POA should be documented on the face sheet and located in the chart. Staff W stated Resident 24's daughter was their POA. Staff W checked the electronic medical record and was not able to locate POA documentation for the resident. In an interview on 09/11/2024 at 1:03 PM Staff X, Admissions Director, stated prior to admission and at admission they obtain a resident's POA documentation. Staff X stated they did not obtain POA documents at the time of admission for Resident 24. Staff X stated they were unsure if Resident 24 had a POA, their daughter was present at the time of admission, and they had their own decision-making ability and only wanted their daughter to sign paperwork on their behalf. Staff X stated at times it will take family a few days after admission to bring in POA paperwork and was not sure of the process to follow up if they did not. In an interview on 09/11/2024 at 1:10 PM Staff Z, Medical Records Director, stated if the POA document for Resident 24 was not in the electronic medical record and not in their chart, then it was not given to them. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/11/2024 at 1:14 PM Staff AA, Registered Nurse (RN)-Staff Development Coordinator stated they did not know how to locate the document after reviewing Resident 24's medical record. Staff AA stated Resident 24's daughter had signed the Physician's Order for Life Sustaining Treatment (POLST) as the POA. In a follow up interview on 09/11/2024 at 2:10 PM with Staff AA, RN-Staff Development Coordinator, stated they had contacted Resident 24's daughter, and they would be bringing in the POA documentation. Refer to WAC 388-97-0240 (3)(a)(b)(i-iii)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation and interview, the facility failed to ensure a homelike environment for 3 of 3 sample residents' (11, 28, 17) rooms reviewed for a homelike environment and for unclean windows and screens in the facility conference room. The failure to provide homelike decor/furnishings and to ensure clean room windows and screens placed the residents at risk for living in an institutionalized environment and for having to look through soiled windows and screens. This failed practice also placed staff and the public at risk for having to look out soiled windows and screens in the facility conference room. Findings included . <RESIDENT 11> Resident 11 admitted to the facility on [DATE]. According to the admission Minimum Data Set (MDS) assessment, dated 07/05/2024, the resident had severe cognitive impairment. In an observation on 09/09/2024 at 12:11 PM, Resident 11's room had no personal belongings or decor at all, there were no pictures, and the walls were bare. In an interview and observation on 09/10/2024 at 12:40 PM, Resident 11's room was very stark with no furnishing or decorations. Staff S, Social Services Director, was asked about the resident's room, they stated I see what you mean though, there's not much in there, we'll see what we can do. In an observation on 09/10/2024 at 1:58 PM, Resident 11's room had furnishings to include a sign on the wall that read I will push the call button for help, there were two televisions in the room, there were some latex glove boxes in glove box holders on the wall, there was a bedside commode that was covered with plastic wrap, there was a fan, an empty bulletin board, a hand-sanitizer dispenser, three garbage cans, some trash bags hanging from a trash bag dispenser, two 3-drawer dressers, two wall lights hanging that hang behind beds, three sets of privacy curtains, and one bedside table. <RESIDENT 28> Resident 28 most recently admitted to the facility on [DATE]. According to the quarterly MDS, dated [DATE], the resident had no cognitive impairment. In an interview on 09/09/2024 at 8:52 AM, Resident 28 stated they would like their room windows cleaned, and they had mentioned it to staff several times, but no one had done anything about it. In an interview/observation on 09/10/2024 at 12:16 PM, Staff T, Maintenance Assistant, was asked about Resident 11's soiled room windows and screens and the wall behind the resident's bed that had two areas of about one foot by one foot where the paint was scraped off down to the drywall, they stated the windows were cleaned quarterly and that the wall behind the resident's bed was scraped off because the nurses and nursing assistants placed the bed too close to the wall and then raised and lowered the bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/11/2024 at 10:15 AM, Resident 28 stated they had lived there over two years, and their windows had never been cleaned. In an observation on 09/12/2024 at 1:58 PM, the conference room windows and screens had extensive dirt and debris build-up. 50725 <Resident 17> Resident 17 was admitted to the facility on [DATE]. According to the quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 08/16/2024, the resident was hearing impaired, but able to understand and communicate needs. In an observation and interview on 09/12/2024 at 1:20 PM, Resident 17's window was dusty and have streaks on them. According to the resident, the staff don't clean it well. They stated that even their TV screen was dirty. Surveyor looked closer and the TV screen had streaks on them. Refer to WAC 388-97-0880 (1)(2)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47047 Based on interview and record review, the facility failed to initiate a grievance from 1 of 1 resident groups (Resident Council) reviewed for grievances. The facility's failure to initiate, log, investigate verbalized concerns, and inform the resident of their findings and the actions taken, precluded the facility from identifying grievance trends and placed the residents at risk of feeling frustrated, unimportant, and with a decreased self-worth and quality of life. Findings included . <Facility Policy> Review of the facility policy titled Grievance Program (Concern and Comment) revised 09/15/2022 showed the program was utilized to address concerns of the residents, family members and visitors. The procedure included any staff member could help in the completion of the Concern and Comment form if a concern or comment was expressed. The administrator was responsible for collaborating with the interdisciplinary team to identify and address repeated concerns from residents and families. In the Resident Council Meeting on 09/10/2024 at 12:15 PM, three out of seven residents voiced concerns about call light wait times during nights and weekends. In a review of Resident Council Minutes for 05/14/2024 showed one resident stated their call light take longer at night and on 07/22/2024 residents stated their call lights are being turned off if they are asleep. Residents requested they be woken up and they would like to be checked on even if their call light was not on. In a review of the Grievance Logs for May 2024 and July 2024 showed no entries from Resident Council Meetings related to the concern and comments noted in the resident council minutes for call light wait times. In an interview on 09/11/2024 at 1:30 PM, Resident 36 stated they no longer participated in the grievance process because they were either not logged or lost, and not taken seriously. In an interview on 09/13/24 at 12:08 PM, Staff BB, Activities Director, when asked how grievances discussed in resident council were handled, stated they direct the resident with the concern or comment to submit a blue form (concern or comment form). Staff BB statd they do not complete a concern or comment forms and rely on residents to complete them. Staff BB stated they provide resident council minutes to the administrator and director of nursing and if there were concerns or comments about call lights, a call light audit would be done. Staff BB stated they talk about call light wait times in resident council and the residents have said it probably has something to do with staffing and it's out of their hands. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/13/2024 at 12:00 PM, Staff A, Administrator, stated grievances from resident council were tricky because they wanted the experience to be positive, solution oriented and collaborative. Staff A stated if a resident was not willing to participate in the solutions then they, the facility, could not do much in way of a solution. Staff A stated they encourage residents to utilize the grievance process, but the process was voluntary and if a resident refused to participate then it limits what is able to be done. Refer to WAC 388-97-0460(1)(2)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review, the facility failed to identify a Significant Change in Status for 1 of 2 sampled residents (Resident 43), reviewed for Hospice services. Failure to identify and complete a Significant Change in Status assessment, according to the Resident Assessment Instrument (RAI) requirements, placed residents at risk for inadequate care planning and a diminished quality of life. Findings included . Record review of the Long-Term Care Facility Resident Assessment Instrument, User's Manual, Version 3.0, dated October 2019, showed that a Significant Change in Status Assessment (SCSA) (A comprehensive assessment), must be conducted within two weeks of the resident's election of their Hospice benefit. Review of Resident 43's medical record showed they admitted on [DATE] and were not receiving Hospice services. The record showed the resident elected their Hospice benefit on 08/10/2024. The RAI manual required the facility to conduct a SCSA within 14 days (by 08/24/2024). Review of Resident 43's Minimum Data Set (MDS) assessments on 09/10/2024, showed no SCSA had been completed for Resident 43. In an interview on 09/11/2024 at 10:10 AM, Staff O, Licensed Practical Nurse/Minimum Data Set (MDS) Nurse, stated the only thing that was different for Resident 43 was that now they were on Hospice services and their care plan had not changed. Staff O was not aware that per the RAI manual, the election of Hospice alone was a Significant Change requiring a SCSA. Refer to WAC 388-97-1000(3)(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview, observation and record review, the facility failed to develop and implement a comprehensive person-centered care plan for six of 18 sampled residents (Residents 5, 6, 8, 49, 53 and 168) reviewed for care planning. This failure placed residents at risk for unidentified outcomes or goals, inconsistent or lack of interventions, and diminished quality of life. Findings included . Review of the facility policy titled: Comprehensive Care Plan and Revisions (dated 03/22/2022) showed the comprehensive care plan would be developed within seven days of the comprehensive assessment. <RESIDENT 6> Resident 6 admitted [DATE] with diagnoses which included a stroke with left sided weakness, diabetes and a history of bilateral (both sides) below the knee amputations. The Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 04/11/2024 showed the resident had limb prosthesis marked yes. Review of the resident's current care plan on 09/10/2024 showed the resident's history of amputations and interventions related to limb prosthetics had not been developed on the resident's comprehensive care plan. All of Resident 53's care plan goals were in red font which indicated them as late. <RESIDENT 53> Resident 53 admitted [DATE] with diagnosis which included tobacco use disorder with an order for nicotine patches for smoking cessation treatment. Review of the resident record on 09/11/2024 showed the resident's comprehensive care plan did not include the resident's risk of smoking, smoking history or current treatment. In an interview on 09/13/2024 at 8:39 AM, Staff J, Licensed Practical Nurse (LPN), Resident Care Manager (RCM), stated the whole team worked on the care plans but the RCMs were responsible for ensuring the care plans were completed. Staff J stated they felt they did not have enough time for all of their RCM duties due to staffing. 44110 <RESIDENT 5> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 5 admitted to the facility on [DATE] with diagnoses including osteoarthritis (chronic condition of cartilage and bone breakdown in the joints, causing pain, stiffness, and swelling), major depression disorder, and muscle weakness. The quarterly Minimum Data Set (MDS, an assessment tool) assessment dated [DATE] showed the resident had severe impaired cognition, impairments to both their lower extremities and were dependent on staff for transfers, toileting and required maximum assistance for mobility. Review of Resident 5's care plan on 09/10/2024 showed that the staff were instructed to place resident's call light within reach, and that the resident preferred the call light to be clipped to bed linens or on their chest when in bed. In an observation on 09/09/2024 at 10:14 AM, Resident 5 was observed sitting in a wheelchair in their room. The call light was placed on the bed, not within reach of the resident. In a continuous observation on 09/11/2024 at 8:23 AM - 12:31 PM, the resident was observed sitting in their wheelchair in their room. The call light was observed to be clipped to the privacy curtain behind the resident, and out of reach. <RESIDENT 8> Resident 8 admitted to the facility 09/29/2023 with diagnoses including history of kidney stones, surgery to the urinary system with nephrostomy (artificial opening in the skin to allow urine to drain from the kidney), and antibiotic-resistant bacterial infection. The quarterly MDS, dated [DATE] showed the resident had intact cognition. Review of Resident 8's physician orders showed an order dated 05/08/2024, monitor output for nephrostomy tube every shift, and to do a dressing change to left side nephrostomy every night shift. Review of Resident 8's care plan showed a focus dated 05/08/2024 for the resident that they had kidney stones, with an intervention that the resident had a nephrostomy. The care plan did not reflect the care that the nephrostomy required. In an observation on 09/09/2024 at 9:46 AM, 09/10/2024 at 8:35 AM, 09/11/2024 at 9:29 AM, and 09/12/2024 9:12 AM, Resident 8 was observed to have a nephrostomy bag attached to the draw sheet of the bed on the left side of the resident. In an interview on 09/12/2024 at 9:53 AM, Staff F, Nursing Assistant Certified (NAC) stated they were to ensure all residents had access to their call light when they were in their room or restroom. Staff F stated they follow the care plan for what type of care they were to implement with each resident. In an interview on 09/12/2024 at 10:26 AM, Staff I, NAC stated that they rely on the care plan in the electronic medical record to guide and instruct what type of care should be implemented for each resident. Staff I stated NACs were responsible for emptying the nephrostomy bag on their shift. Staff I stated they were aware that Resident 8 had a nephrostomy bag, and that they would empty on their shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/12/2024 at 2:31 PM, Staff N, Registered Nurse (RN) stated the care plan was what guided and directed the care of the resident. Staff N stated they usually did not have to empty the nephrostomy bag for Resident 8, however they were responsible for monitoring the output. In an interview on 09/13/2024 at 8:39 AM, Staff J, LPN/RCM, stated that the call light for Resident 5 should always be within reach. Staff J stated the whole Interdisciplinary Team (IDT) contributes to the care plan, ultimately it was the RCM's who oversee that the care plan was updated, revised and implemented. Staff J was not aware there was minimal information on the care plan for Resident 8's nephrostomy, and the care plan lacked any individualized care for the nephrostomy. In an interview on 09/13/2024 at 10:59 AM, Staff B, Director of Nursing Services (DNS) stated that the call light for all residents should always be within reach. Staff B was advised of observations made that call light had not been in reach for Resident 5, Staff B was not aware. Staff B stated it was their expectation that any resident with a device should have it addressed on the care plan. Staff B was not aware that Resident 8's care plan was lacking information regarding their nephrostomy. 47047 <RESIDENT 49> Resident 49 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-lung disease that causes breathing problems and restricted airflow), enterocolitis (inflammation of the digestive tract) due to clostridium difficile (an infection of the colon), and muscle weakness. In an interview on 09/09/2024 at 8:56 AM Resident 49 stated they had pain in their left knee when they used it to get out of bed or when they walked. In a review of Resident 49's provider progress note dated 08/19/2024 showed they were seen for back pain and prescribed pain medication to address their back pain. In a review of Resident 49's provider progress note dated 08/31/2024 showed they were seen for chronic left lower extremity pain. In a review of Resident 49's care plan dated 08/26/2024 showed they had pain related to recent hip surgery. The care plan did not contain Resident 46's expressed pain in their left knee or their lower back. Review of Resident 49's September 2024 Medication Administration Record showed they were being monitored for pain; the location of their pain was not identified. In an interview on 09/12/2024 at 12:36 PM Staff G, RN-RCM, stated Resident 49 had not complained of any pain to them during their stay. Staff G stated they were not aware of the location of Resident 49's pain and the location should have been on the care plan. <RESIDENT 168> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 168 was admitted to the facility on [DATE] with diagnoses that included fracture of the hip, fall, respiratory failure, and COPD. Review of Resident 168's August 2024 Medication Administration Record (MAR) showed they had been prescribed an anitbiotic on 08/29/2024 for presumed pnemonia (infection in the lungs). Review of Resident 168's progress notes dated 08/29/2024 showed they had been prescribed an antibiotic for presumed pnemonia. Review of Resident 168's care plan dated 08/26/2024 showed no identified problem or potential problem related to the presumed pnemonia and prescribed antibiotics. In an interview on 09/13/2024 at 9:11 AM, Staff B, DNS, stated the care planning process included a baseline care plan and as the facility has their new admit meetings more information is put into the care plan that is resident specific. Staff B stated they have noticed some items missing on the care plan of residents, care plans were reviewed as an interdisciplinary team, and changes to the care plan were made as a team. Refer to WAC 388-97-1020 (1)(2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview, and record review, the facility failed to ensure Care Plans (CPs) were accurately reviewed and revised to reflect current resident status and needs for 4 of 18 sample residents (Residents 2, 6, 43, 53) reviewed for care planning. This failure left residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled: Comprehensive Care Plan and Revisions (dated 03/22/2022) showed the comprehensive care plan would be developed within seven days of the comprehensive assessment and reviewed and revised after each assessment, including comprehensive and quarterly assessments and the facility would monitor the resident to idenify changes that would warrant updates to the care plan. <RESIDENT 6> Resident 6 admitted [DATE] with diagnoses which included a stroke with left sided weakness, diabetes and a history of bilateral (both sides) below the knee amputations. Review of Resident 6's medical record on 09/11/2024 showed they were receiving skilled therapies on admission which were discontinued on 07/20/2024 stating the resident had met their highest practicable level. Resident 6 was transitioned to restorative services. Review of Resident 6's care plan on 09/11/2024 showed the care plan had not been updated to reflect the current restorative therapy services and goals. <RESIDENT 43> Resident 43 admitted on [DATE] and were not receiving Hospice services at the time of admission. Review of Resident 43's record on 09/11/2024 showed the resident elected their Hospice benefit on 08/10/2024. Review of Resident 43's care plan on 09/11/2024 showed the care plan had not been updated to include Hospice and care coordination with the resident's hospice care team. <RESIDENT 53> Resident 53 admitted [DATE] with diagnosis which included tobacco use disorder with an order for nicotine patches for smoking cessation treatment. Review of the resident's progress notes on 09/11/2024 showed a progress note dated 09/05/2024 showing that Resident 53 was witnessed by staff outside of the facility smoking and found to have smoking materials. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident record on 09/11/2024 showed the resident's comprehensive care plan did not include the resident's risk of smoking, smoking history or current treatment and was not updated after the known smoking incident on 09/05/2024. In an interview on 09/13/2024 at 8:39 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated the whole team worked on the care plans but the RCMs were responsible for ensuring the care plans were completed and updated with changes. Staff J stated they felt they did not have enough time for all of their RCM duties due to staffing. 50725 <Resident 2> Resident 2 admitted on [DATE] with diagnoses to include Cerebrovascular Accident (medical term for stroke which occurs when blood flow cannot reach a part of the brain), left hemiparesis (weakness or the inability to move on one side of the body), dysphagia (difficulty swallowing), and Type 2 Diabetes Mellitus (long term medical condition in which your body does not use insulin properly, resulting in unusual blood sugar level). According to the quarterly Minimum Data Set (MDS - an assessment tool) dated 08/27/2024, Resident 2 was cognitively intact. In an observation on 09/11/2024 at 11:12 AM, Resident 2 was sitting on their wheelchair in front of their table with a glass of milk with a straw, 1/3 of the milk left. There was also a water pitcher, filled with water with a straw. On 09/11/2024 at 11:30 AM, reviewed Resident 2's care plan and under intervention tab it stated that resident should not have straws and resident agreed to having brightly colored sign posted in their room to remind visitors and staff of this precautions. In an observation on 09/11/2024 at 11:40 AM, Resident 2's room did not have any signs that show resident can not use a straw. There was a sign about [NAME] Free Water with instructions. In an observation and interview on 09/11/2024 at 12:03 PM, observed a staff brought resident a cup of white drink with lid and straw. Staff U, Hospitality Aide, stated the drink was milk. In an interview on 09/11/2024 at 12:05 PM Staff I, Certified Nursing Assistant (CNA) stated, they have worked in the facility for a year and have served Resident 2 with milk with a straw. They stated they were not aware the resident should not have a straw. In an interview on 09/11/2024 at 12:17 PM, Resident 2 stated they didn't want thickened drinks and preferred to have straws with their milk. They stated they have never had a problem drinking using a straw. In an interview on 09/11/2024 at 1:16 PM, Staff J, LPN/RCM, stated that staff checked on Resident 2 periodically during mealtimes. They stated the resident should not have a straw with their drink, but the resident got upset if the staff took the straw away. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/11/2024 at 2:07 PM, Staff R, LPN, stated that Resident 2 wanted a straw with their drinks. Staff R added that they checked on resident frequently during mealtimes to monitor them. Refer to WAC 388-97-1020(1)(2)(b)(4)(b)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to complete a discharge summary, including a recapitulation of the resident's stay as required, for 1 of 3 sampled residents (Resident 65), reviewed for discharge. These failures placed residents at risk of post-discharge complications, delayed treatment, and decline in their overall condition by not having the necessary information and services established to ensure continuity of care for a successful discharge to the community. Findings included . Review of the facility policy titled Discharge Summary dated 05/06/2019 showed the social service and nursing staff participate in developing the discharge summary. The discharge summary included a recapitulation of the resident's stay, a final summary of the resident's status to include cognitive patterns, customary routine, psychological well-being Resident 67 admitted to the facility on [DATE] with diagnoses that included neutropenia (low count of a type of white blood cell), pulmonary fibrosis (scarring and thickening of the tissue in the lungs), and high blood pressure. Review of Resident 67's discharge summary dated 07/01/2024 showed they discharged to an assisted living facility. The discharge summary did not contain a recapitulation of the resident's stay, a final summary, or the required final summary of the resident's status. In an interview on 09/13/2024 at 11:46 AM Staff S, Social Services Director, stated they complete a portion of the discharge summary and nursing completes the nursing components of the summary. Staff S stated they ensure the resident has a follow up appointment with their primary care provider, order any durable medical equipment (DME), coordinate home health, and send a copy of all the discharge paperwork with the resident to include the last provider note. Staff S, when asked to review the discharge summary for Resident 67, stated it was not complete and they could not recall if there was any DME or home health services needed. Staff S stated they were trained only to complete certain portions of the discharge summary (demographics, location of discharge, physician appointments, home health information, and reason for discharge) and not the recapitulation of stay or physical assessment on discharge and instructions as this was covered in the physician last visit note. In an interview on 09/13/2024 at 12:47, PM Staff A, Administrator and Staff B, Director of Nursing Services, stated there should be a discharge note in the resident's progress notes to include what supplies/services the resident required and if their goals were met, the discharge summary should be done on the day of discharge, and the one for Resident 67 was started and was incomplete. Refer to WAC 388-97-0080(7)(a)(b)(c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review the facility failed to provide the assistance with activities of daily living (ADL's) for 5 of 8 sampled dependent residents (7, 8, 23, 24, and 28) reviewed for ADL's. The facility failed to provide showers/bathing assistance to residents (7, 8, 23, and 28), who were dependent on staff for bathing, and failed to ensure Resident 24 who was dependent for assistance with toileting was provided the necessary assistance. These failures placed the residents at risk for embarrassment, poor hygiene, unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Activities of Daily Living (ADLs), reviewed 09/10/2024 states all residents will receive assistance as needed to complete activities of daily living (ADLs). Any change in the ability to perform will be reported to the nurse. <TOILETING CARE> Resident 24 admitted to the facility on [DATE] with diagnoses that included fracture of the right femur, chronic heart failure, and kidney disease. In an interview on 09/09/2024 at 9:28 AM Resident 24 stated they were continent of bowel prior to their hospitalization , were able to identify when they needed to have a bowel movement and they were currently using a mechanical lift to be transferred in/out of bed, and if they need to have a bowel movement, they use their brief. Review of Resident 24's Admission Minimum Data Set (MDS-An assessment tool) dated 07/26/2024 showed they were always incontinent of bowels. Review of Resident 24's Care Area Assessment (CAA- a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned) dated 08/02/2024 showed they had fecal incontinence with a goal to maximize continence through assisted toileting. Review of Resident 24's care plan dated 07/22/2024 showed they were totally dependent on two staff to transfer between surfaces. The care plan did not address Resident 24's continence or incontinence of their bowels. In an interview on 09/12/2024 at 1:03 PM, Staff H, Nursing Assistant Certified, stated Resident 24 was incontinent of bowels, but the resident was aware of when they needed to have a bowel movement. Staff H stated they had offered Resident 24 a bed pan, but they had refused. Staff H stated they were unable to transfer Resident 24 to the bathroom toilet as the mechanical lift they used did not fit into the bathroom. Staff H stated they had not, but could offer Resident 24 a bedside commode. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/13/2024 at 9:15 AM Staff B, Director of Nursing Services, stated when a resident was admitted they developed a baseline care plan based on information from the hospital, therapy, and the resident. Staff B stated Resident 24's toileting preferences and abilities was not captured in the process. 33954 <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses to include paralytic syndrome (a condition that causes neuromuscular weakness and paralysis), generalized muscle weakness, and paralytic poliomyelitis (a condition where the poliovirus attacks the brain and spinal cord causing paralysis). According to the admission Minimum Data Set (MDS) assessment, dated 08/06/2024, the resident had moderate cognitive impairment. In an interview on 09/09/2024 at 11:01 AM, Resident 7 stated they only got to bathe every two or three weeks, and they wanted to bathe once weekly. In a review on 09/10/2024 of 30 days of bathing documentation, Resident 7 had been bathed three times in 30 days and had no refusals. The bathing documentation indicated the resident preferred to bathe one time weekly. In an interview on 09/13/2024 at 8:05 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated they did not know why the resident was not being bathed weekly. <RESIDENT 28> Resident 28 most recently admitted to the facility on [DATE] and had diagnoses to include a stroke and hemiplegia (a condition that causes partial or complete paralysis of one side of the body)/hemiparesis (muscle weakness or partial paralysis of one side of the body) affecting their left non-dominant side. According to the quarterly MDS assessment, dated 06/27/2024, the resident had no cognitive impairment. In an interview on 09/09/2024 at 8:47 AM, Resident 28 stated they were supposed to be being bathed twice a week, but that was hit and miss, as it depended on if they had enough shower room workers. In a review on 09/12/2024 of 30 days of bathing documentation, Resident 28 had been bathed five times in 30 days and had no refusals. The bathing documentation indicated the resident preferred showers twice weekly. 44110 <RESIDENT 8> Resident 8 admitted to the facility 09/29/2023 with diagnoses including history of a stroke with right side weakness, and muscle weakness. The quarterly MDS assessment, dated 08/08/2024, showed the resident had intact cognition, no refusal of care, had impairments to the upper and lower extremities, and was dependent on staff for bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8's care plan showed a focus dated 10/10/2023 that the resident had an ADL self-care deficit due to activity intolerance, fatigue, and impaired balance after a surgery. Interventions were to provide a sponge bath when a full bath or shower was not possible, that the resident required 1-2 staff for bathing and used a mechanical lift for all transfers, dated 10/10/2023. Review of Resident 8's documentation report for bathing dated 07/01/2024 - 09/10/2024 showed the following: - July 2024: showers given on 07/03, 07/10, and 07/26, - August 2024: showers given 8/21, - September 2024 (till 10th): shower given 9/05. There were no documented refusals, or make-up showers. In an observation and interview on 09/09/2024 at 9:46 AM, Resident 8 was observed to have hair that appeared greasy, and uncombed. Resident 8 stated they were bed bound most days unless they must go to an appointment due to the staff have to use the mechanical lift, and it takes too long, and they need two staff to use the lift, so they just stay in bed. Resident 8 stated they were hoping they get a shower before Wednesday, as they had an appointment to go to. Resident 8 stated they get a shower about once a week, depending on if there was a shower staff. Resident 8 stated they really wished they could have a shower twice a week since they are in bed all the time. Resident 8 stated they had mentioned it to a staff member but could not recall who that was. <RESIDENT 23> Resident 23 admitted to the facility on [DATE] with diagnoses including bi-polar disorder (mental health disorder that causes extreme shifts in mood, energy, and activity levels), cognition communication deficit. The quarterly MDS dated [DATE] showed the resident had moderate impaired cognition, no refusal of care, impairment to one side of their lower extremity, and the resident was dependent on staff for bathing. Review of Resident 23's care plan showed a focus revised on 05/19/2022 that the resident had an ADL self-care performance deficit related to activity intolerance, fatigue, and inability to walk or stand on their right leg. Interventions were the resident required extensive assist with one staff for showering, the resident preferred the shower bed versus a shower chair with two staff assist, and to provide sponge bath if shower did not occur, dated 04/14/2022, and revised 09/10/2022. Review of Resident 23's documentation report for bathing dated 07/01/2024 - 09/10/2024 showed the following: - July 2024: bed bath on 07/05, shower 07/19, 07/26, - August 2024: 08/09, - September 2024 (till the 10th): bed bath 09/03. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no documented refusals, or make-up showers. In observations done on 09/09/2024 at 9:34 AM, 11:11 AM, 09/10/2024 at 8:37 AM, and 09/10/2024 at 1:51 PM the resident was observed in bed, hair disheveled, uncombed and appeared greasy, wearing hospital gown. In an interview on 09/12/2024 at 9:53 AM, Staff F, Nursing Assistant Certified (NAC) stated that the floor staff are not responsible for showers, the facility has scheduled shower aids that do the showers. If the shower aid was pulled or callouts then the shower will get done another day. In an interview on 09/12/2024 at 10:26 AM, Staff I, NAC, stated the facility will usually schedule two shower aides during the week, the floor staff are given a list, so we know who they are showering that day. Staff I stated the floor staff rarely have time to assist with a shower, they are too busy, they possibly could assist a resident that was independent and only needed set up but that would be rare to happen. Staff I stated they were not aware of Resident 8 refusing showers, and Resident 23 will refuse meals but was not sure about showers. In an interview on 09/12/2024 at 11:21 AM, Staff L, NAC/Central Supply stated they do showers Monday - Friday, they try to have at least one shower aide on every day of the week. Staff L stated the floor staff do not do showers, and all showers or refusals are documented in the electronic medical record. Staff L stated if a resident refused or was unavailable they were to offer a shower every day until it gets made up. Staff L stated all the offers should be documented in the electronic medical record. Staff L stated if a shower was refused or was not completed the nurse was also supposed to document in the progress notes that it was not completed. All residents are placed on shower for once a week unless they prefer otherwise then they refer that to the Director of Nursing (Staff B). In an interview on 09/13/2024 at 8:39 AM, Staff J, LPN/RCM, stated they were not responsible for showers, some staff would mention to them when a resident refuses and I refer them to the nurse. Staff J stated they were not sure who was responsible for showers, but that social services were to review with the residents on the preferences. In a joint interview on 09/13/2024 at 10:59 AM, Staff A, Administrator and Staff B, Director of Nursing Services (DNS), Staff B stated that on admission the shower aide or social services was to approach the resident about their preferences and then that was added in the task menu of the electronic medical record. Staff B stated the expectation was that the staff were reapproaching or adding them to the schedule the next day. Staff A stated they were trying to add a shower aide on Saturdays to assist with makeup showers, and moving forward the Staff Development Coordinator will be managing showers. Staff B stated their expectation was if a resident was refusing care that was documented in the medical record, and there was notification to the appropriate parties, i.e. POA, family, and provider. Staff A and Staff B were not aware there have been missed showers for Resident 8 and 23. Refer to WAC 388-97-1060(1)(2)(a)(i)(iii)(c)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview, and record review, the facility failed to ensure 3 of 4 residents (5, 17, and 23) reviewed for limited Range of Motion (ROM) received necessary care and services to maintain level of functioning and/or prevent decline. The facility failed to ensure residents was evaluated and were provided the appropriate care and services, they failed to ensure consistent use of braces/splints were implemented as ordered and failed to ensure residents received appropriate restorative nursing services programs as ordered. This failure placed residents at risk for decline in mobility and function, increased dependence on staff, and a decreased quality of life. Finding included . Review of the facility policy titled, Restorative Nursing, revised 08/20/2024 states a restorative program may be developed by proactively identifying, care planning and monitoring of resident assessments and indicators. The facility will assess the residents' needs, develop a specific program, provide the care and services, and monitor and evaluate on a routine basis. Review of the facility policy titled, Splints and Braces, issued 01/16/2024 showed the facility will provide splints and braces in accordance with professional standards of practice. Review of the facility policy titled, Activities of Daily Living ADLs, reviewed 09/10/2024 states residents should be repositioned as necessary to promote good body alignment and prevent skin breakdown. <RESIDENT 17> Resident 17 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block the airflow and make it difficult to breath), Reynaud's Syndrome (a disorder that causes decreased blood flow to the fingers), Gangrene (type of tissue death caused by lack of blood supply) in the fingers, Rheumatoid Arthritis (a chronic inflammatory disorder that is usually affecting the small joints in the hands and feet) and washout of left shoulder (a procedure that treats shoulder infection or other condition using a minimally invasive approach) with concern for prosthetic joint infection According to the quarterly Minimum Data Set (MDS - an assessment tool) dated 8/16/2024, the resident was hearing impaired but able to understand and communicate needs. In an observation on 09/09/2024 at 12:24 PM, Resident 17 was wearing a sling on their left arm. In an interview on 09/11/2024 at 8:23 AM, Resident 17 stated that they always wear the sling and the only time it comes off was when they have showers. Resident stated they are not getting any exercises and they would be interested in doing that. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 09/11/2024 at 9:44 AM Staff P, Certified Nursing Assistant (CNA), assisted Resident 17 transfer to the bedside commode. The resident required assistance to sit up at the edge of the bed and was able to transfer self to the bedside commode without any assistive device and their gait was steady. Staff P then took the sling off, then the gown and placed a clean shirt on the resident starting on the left arm first. Resident 17 was able to help put the shirt and the resident did not complain of pain or discomfort. The sling was placed back on. In a record review on 09/12/2024 at 10:04 AM, there was no order seen for the sling that Resident 17 was wearing. There was an order dated 05/09/2024 for Occupational Therapy (OT) to assess the Range of Motion (ROM). In an interview on 09/12/2024 at 11:24 AM Staff Q, Director of Rehab, stated that Resident 17 was discharged from skilled services in December 2023. Staff Q stated they did not see any OT notes after December of 2023. They think that the OT order that was put in on 05/9/2024 may have been put in error. They stated that the rehab department have their way of pulling resident's data to see who has potential declines or have declined in their activities of daily living (ADL). Also, the nurses or CNA's were good at notifying them if there were changes in the long term care residents. When they were made aware of any declines or potential for declines in the ADL's of a resident then the Rehab department will schedule to see and assess residents. In an interview on 09/13/2024 at 8:00 AM with Staff J, Resident Care Manager (RCM)/Licensed Practical Nurse (LPN), Staff J stated that Resident 17 was at risk of developing a contracture and their process was to have a physical therapist or occupational therapist assess the resident and give recommendations to prevent contractures. They confirmed that the OT order to assess the resident for ROM placed on 05/09/2024 was not an error and they will follow up on that. 44110 <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses including osteoarthritis (chronic condition of cartilage and bone breakdown in the joints, causing pain, stiffness, and swelling), major depression disorder, and muscle weakness. The quarterly MDS assessment, dated 08/10/2024, showed the resident had severely impaired cognition, impairments to both their lower extremities and was dependent on staff for transfers, toileting and required maximum assistance for mobility. Review of Resident 5's last comprehensive MDS dated [DATE] showed a focused care area assessment (CAA) had triggered for the resident that they were at risk for skin breakdown due to the resident's limited ability to participate with position changes and offloading of boney prominences. The goal was to minimize risk factors through frequent assisted mobility. The MDS showed the resident was at risk for skin breakdown with treatments for pressure reducing device for the bed, and applications of ointments. Review of Resident 5's care plan showed an intervention for comfort, dated 11/25/2022, that instructed staff to assist the resident with activities of daily living by turning and repositioning the resident every two hours. Review of Resident 5's medical record showed no refusals by the resident to reposition or turn. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 09/09/2024 the resident was observed up in their wheelchair with no change in position from 7:33 AM - 10:17 AM. The resident was observed to not have a pressure reducing cushion on their wheelchair. In a continuous observation on 09/11/2024 starting at 8:23 AM, Resident 5 was observed to be sitting in their room in their wheelchair, behind the privacy curtain and room door closed. At 9:09 AM, no staff had entered the room, the resident was seated in the same position. At 10:05 AM, a staff member entered room and left one minute later, there was no change in the resident's position in the wheelchair. At 11:04 AM, the resident remained behind privacy curtain with the door to room open, there had been no change in the residents' position. At 12:31 PM, the resident was observed to still be in their room in their wheelchair, no staff had been present and there had been no change in the resident's position. <RESIDENT 23> Resident 23 admitted to the facility on [DATE] with diagnoses including a contracture (permanent or temporary tightening of muscles, tendons, skin, and nearby tissues that limits movement of a joint or body part) of the right knee and right hip, bi-polar disorder (mental health disorder that causes extreme shifts in mood, energy, and activity levels), and a cognitive communication deficit. The quarterly MDS dated [DATE] showed the resident had moderately impaired cognition, no refusal of care, impairment to one side of their lower extremity, and the resident required substantial to maximum assistance for mobility and positioning. Review of Resident 23's physician orders showed an order for a Splint/Brace/Medical Device to be applied to the right knee for four to six hours daily, every dayshift for contractures, document in the progress notes if there were any changes and notify the physician if appropriate dated 07/24/2024. Review of the order documentation showed the following: - July (07/25/2024 - 07/31/2024): the brace/splint was administered for 4 - 6 hours, - August: the brace/splint was administered for 4 - 6 hours 30 days of the month except 08/27/2024 was marked refused, - September (09/01/2024 - 09/09/2024): brace/splint administered 4 - 6 hours for seven of the nine days, refused twice. Review of Resident 23's care plan showed a focus, revised date of 05/19/2022, that the resident had a self-care performance deficit due to activity intolerance, fatigue, and inability to walk or stand. Interventions included a restorative nurse program, dated 08/28/2024, that called for the brace to be placed on the residents' right knee and a splint on the right ankle for 4 -6 hours a day as tolerated, report any changes to the nurse. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's restorative nursing documentation showed the following in July 2024 (31 days total) the resident refused three times, wore the brace and splint for 2 hours or less for 19 days, and for nine days there was no documentation provided. August 2024 (31 days total) the resident refused ten times, wore the brace and splint for 3 hours or less for 12 days, and nine days there was no documentation provided. September 2024 (through 09/12/2024) resident refused twice, wore the brace and splint for 3 hours or less for five days, and for five days there was no documentation provided. The documentation also showed when the restorative aides (RA) were pulled to the floor: 07/03/2024 for five hours, 08/17/2024 for four hours, 08/31/2024 for three hours, and 09/07/2024 for one hour. Review of Resident 23's medical record from July 1st - September 11th showed one nursing progress note dated 07/09/2024 the resident had refused range of motion exercises and devices due to pain. The progress note stated the resident was medicated with pain medication and reapproached and participated in the restorative program. There was no other documentation for any refusals, reason why the splint or brace was not applied for the recommended duration or other missing documentation. In an observation on 09/09/2024 at 9:34 AM, and 11:11 AM, Resident 23 was observed to be lying in bed on their back, their right leg was visible with their upper leg extended out, knee bent, and lower leg tucked in, the bent knee was propped up by a pillow. There was no brace or splint observed. In an observation on 09/10/2024 at 8:27 AM, 11:13 AM, and 1:51 PM, Resident 23 was observed to be lying in bed on their back, their right leg was visible with upper leg extended out, knee bent, and lower leg tucked in, the bent knee was propped up by a pillow. There was no brace or splint observed. In a continuous observation on 09/11/2024 from 8:49 AM to 12:03 PM, Resident 23 was observed to be lying in bed on their back, their right leg was visible with upper leg extended out, knee bent, and lower leg tucked in, the bent knee was propped up by a pillow. There was no brace or splint observed. In interview on 09/12/2024 at 10:26 AM, Staff I, Nursing Assistant Certified (NAC), stated the process for anytime a resident refused care was to reapproach, try to accommodate them and if they continue to refuse, we are to notify the nurse. Staff I stated they have worked at the facility for approximately two years and was familiar with the care provided to Resident 23. Staff I stated the restorative aides (RA) were the staff responsible to place the brace and/or splint on the resident. Staff I stated it had been quite some time since they had seen the resident wear a brace or splint. Staff I stated Resident 5 usually will get up in the morning and stay up in their wheelchair all day. In an interview on 09/12/2024 at 1:13 PM, Staff M, NAC/RA stated the facility had two RA's that were able to provide the restorative nursing programs to residents. Staff M stated they have not really had a true restorative nursing program for a while and just recently started it back up. Staff M stated that Resident 23 will only wear the brace for a short time and will sometimes just refuse. In an interview on 09/12/2024 at 2:31 PM, Staff N, Registered Nurse (RN) stated that Resident 23 had an order for a brace and splint placement, and that it was done during the day shift as they usually worked evenings, so they had never seen the resident wearing either. Staff N stated Resident 5 had fragile skin and was at risk for skin breakdown, they try to ensure they were up for meals. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/13/2024 at 8:39 AM, Staff J, LPN/RCM stated Resident 23 had a history of refusal of care, including their restorative nursing program. Staff J confirmed the resident had contractures to their right hip and right knee and was encouraged to wear a brace and splint to prevent further deterioration of those joints. Staff J stated that the restorative nursing program had been on hold for some time, and they were not sure who was overseeing the programs. Staff J stated the physician order for the brace and splint was only for the nurse to ensure the activity was completed, the RAs are placing the brace and splint on the resident. Staff J was not aware the nurse documentation did not reflect what the RA's had done. Staff J stated the staff should inform the nurse every time the resident refused, and the nurse on the floor should document in the medical record. Staff J stated that Resident 5 was at risk for skin breakdown, and was refusing to get out of bed, so they had placed a pressure reducing mattress on their bed. Staff J acknowledged that Resident 5 now was up in their wheelchair more often and they had not placed a pressure reducing cushion on the chair. Staff 5 stated that Resident 5 required frequent repositioning and was unaware that the resident had been left in the same position for over five hours. In an interview on 09/13/2024 at 10:59 AM, Staff B, Director of Nursing Services (DNS) stated their expectation for refusal of care was that staff were reapproaching the resident, reporting to the nurse of the refusal, and the nurse would document the refusal and notification to the physician and family/Power of Attorney (POA) was completed. Staff B stated any resident that was chronically refusing care should be incorporated into the care plan for staff to have interventions to provide the care that was needed. Staff B stated Resident 23 had behavioral issues that they believed were linked to their refusal of care. Staff B stated they were not aware that the resident's refusal of care for restorative and range of motion exercises was not a part of the plan of care, or that there had been notification to the physician or family/POA. Staff B confirmed that Resident 5 was a risk for skin breakdown. Staff B was not aware that the resident had been up in their wheelchair for extended periods of the day, and stated there should be a pressure cushion on their chair as well. Staff B was acknowledged the resident should be repositioned frequently and was not aware that the resident had been left in the same position for over five hours. Refer to WAC 388-97-1060(1)(2)(b)(3)(d)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to develop and implement nutritional interventions, and evaluate the effectiveness of the interventions for 1 of 5 residents (Resident 23) reviewed for nutritional needs. The facility failed to consistently obtain weights and re-weights, notify appropriate parties, and implement Registered Dietician's (RD) recommendations. This failure placed the residents at risk for delayed identification of weight loss and failed to implement appropriate interventions to prevent continued weight loss and decreased quality of life. Findings include . Review of the facility policy titled, Residents at Risk (RAR), revised 04/30/2024, states the facility conducts weekly resident at risk meetings to review residents identified with problems or concerns related to their nutritional status .the facility will establish a consistent method for weighing residents, monitoring weights over time to identify weight loss, determining interventions and reassessing as appropriate .all resident with a significant weight change will be reviewed weekly .documentation will be recorded in the medical record . facility will ensure physician and responsible parties are notified of any changes. Resident 23 admitted to the facility on [DATE] with diagnoses including malnutrition, bi-polar disorder (mental health disorder that causes extreme shifts in mood, energy, and activity levels), and cognitive communication deficit. The quarterly Minimum Data Set assessment (MDS - an assessment tool), dated 07/23/2024 showed the resident had moderate impaired cognition, no refusal of care, impairment to one side of their lower extremity, and that the resident had no weight loss. Review of Resident 23's medical record showed the following weights: - 04/03/2024 152.8 pounds (lbs.) - 08/05/2024 139.8 lbs. - 08/15/2024 138.4 lbs. - 09/05/2024 135.6 lbs. Review of Resident 23's physician orders showed no orders for monitoring of the resident's weight. Review of Resident 23's care plan showed a focus updated on June 7th, 2024, that the resident had a potential nutritional problem and was at risk for weight loss related to their malnutrition and bipolar disorder, as resident routinely refuses to get out of bed or use the mechanical lift for weights. The goals were updated by the RD on 07/25/2024 for a goal weight will be within 5% of 165 lbs., on 07/30/2024 for goal weight will be within 5% of 155 lbs., and 09/05/2024 for goal weight withing 5% of 140 lbs. There was no update to any interventions after the known weight loss occurred. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's progress note, dated 06/07/2024 at 2:56 PM, showed the resident had refused to be weighed, risk and benefits given. There was no notification to the power of attorney (POA) or physician. Review of Resident 23's progress note dated 06/29/2024 by the RD stated resident continued to refuse weights, no weights documented since April/2024, resident barely meeting weight goal. Recommendation to get reweight, and to refer to their quarterly nutritional assessment for further details. Review of Resident 23's quarterly nutritional assessment dated [DATE] by the RD showed that they were unable to fully assess the resident's proper weight trends due to the inconsistency of the weights. Recommendation would be to re-weigh. Review of Resident 23's progress note dated 07/05/2024 at 11:50 AM, showed the resident had refused to be weighed, education was provided to the resident. There was no notification documented to the physician or POA. Review of Resident 23's progress note dated 09/04/2024 at 2:07 PM, showed the resident had refused to be weighed, education was provided to the resident. There was no notification documented to the physician or POA. Review of Resident 23's medical record on 09/11/2024 showed no other documentation related to refusal of weights, or if the physician or POA were notified of the refusals and weight loss. In an interview on 09/12/2024 at 9:53 AM, Staff F, Nursing Assistant Certified (NAC) stated the cart nurse was responsible for letting the NAC's which resident needed to be weighed. If a resident refused, they would refer that to the nurse. In an interview on 09/12/2024 at 10:26 AM, Staff I, NAC stated the nurses are responsible for tracking weights, and they will let the NACs know who needs to be weighed that day. If a resident refuses they would refer to the nurse. Staff I stated that they were not aware if Resident 23 had lost weight, however they refuse their meals often so that would not surprise them if the resident has had weight loss. In an interview on 09/12/2024 at 2:31 PM, Staff N, Registered Nurse (RN) stated Resident 23 will usually refuse care related to if they are in pain or not. Staff N stated they try to ensure the resident was medicated adequately before attempting cares. Staff N stated they were unaware if the resident had weight loss, and stated they are on alert for weight loss so we should monitor that closely. In an interview on 09/13/2024 at 8:39 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated the facility policy was to do weights monthly unless the resident had weight gain or loss then they would be monitoring more often. Staff J stated when a resident has weight loss they will refer to the RD, await their recommendations, notify the physician and responsible parties. Staff J stated getting more frequent weights would be an intervention put in place to monitor that. Staff J stated they were aware that Resident 23 has had weight loss. Staff J stated they had not contacted the residents POA to discuss options or inform them of the changes. Staff J stated the care plan should have been assessed and updated to reflect the resident's refusal of obtaining their weights, and the interventions should have been looked at more. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview on 09/13/2024 at 10:59 AM, Staff A, Administrator, and Staff B, Director of Nursing Services (DNS), Staff B stated their process for obtaining weights was monthly unless they were a new admission or the resident needed to be weighed more often due to other reasons, weight gain/loss, medications, etc. Staff B stated they have a weekly meeting to discuss the residents that are at risk for nutrition, the meeting consists of the DNS, the RCM's, the assistant DNS, and the RD. They discuss as a team the goals, and interventions for each resident they are reviewing. Their expectation was the care plan with be updated to reflect those changes. Staff B stated they were aware that Resident 23 had weight loss and was refusing to get weighed. Staff B stated they usually defer to the RD to interview the resident and make recommendations for preferences and weight loss, Staff B stated they were not sure how much had been done for Resident 23. Staff A stated that the resident's POA was not that involved in their care and that was more than likely why they had not been contacted. Staff B was able to confirm that the resident had been refusing meals, refusing to get weighed and none of that was reflected in the care plan, and acknowledged they needed to look at that more closely. Refer to WAC 388-97-1060(3)(h)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services related to enteral tube feeding (a medical device used to provide nutrients through a tube directly into the stomach) were followed for 1 of 1 resident (Resident 8), reviewed for tube feeding management. The failure to label/date and discard tube feeding supplies, and syringes placed the resident at risk for infection and related complications. Findings included . Resident 8 admitted to the facility 09/29/2023 with diagnoses including history of a stroke with right side weakness, dysphagia, and malnutrition. The quarterly Minimum Data Set (MDS, an assessment tool) assessment dated [DATE] showed the resident had intact cognition, no refusal of care, had a percutaneous endoscopic gastrostomy (PEG) tube for nutrition that delivered more than 51% of the residents' calories, and more that 501milliliters (ml) of fluid for their overall intake. Review of Resident 8's admission paperwork and hospital discharge summary dated 09/29/2023 showed the resident had a PEG tube placement during their hospital stay between 08/22/2023 and their admission to the facility. Review of Resident 8's physician orders showed Jevity 1.5 calorie/fiber oral liquid (nutritional supplement delivered through the PEG tube with a revised date of 08/27/2024. Instructions read to give 500 ml through the PEG tube every evening at 8:00 PM to 1:00 AM at a rate of 100ml/hour, and flush with 150 ml of water before and after. There were no orders related to labeling, dating of syringe, tubing or other tube feeding supplies. Review of Resident 8's medical record showed no documentation for labeling, dating of syringes, tubing or other tube feeding supplies. Review of Resident 8's care plan showed a focus area dated 09/09/2024 that the resident required a PEG tube related to their dysphagia. Interventions stated the head of the bed was to be elevated at least 45 degrees, and the resident was on enhanced barrier precautions. The care plan did not provide guidance on replacement and labeling of tubing feeding supplies. In an observation on 09/10/2024 at 8:35 AM, Resident 8 was observed lying in bed, tube feeding bag was observed hanging from a pole, the tubing was still attached to the resident. The bag on the pole had small amount of light tan substance on the bottom of the bag, the bag was labeled 09/09 7:30 PM. Hanging next to the bag was another bag with clear substance, that appeared to be water, it was unlabeled. In an observation on 09/11/2024 at 8:56 AM, Resident 8 was observed lying in the bed, the tubing for the enteral nutrition was hanging across the pole. The bag was dated 09/09 7:30 PM, it appeared to be the same bag from the day before. The water bag hanging next to it was undated and unlabeled. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 09/12/2024 at 9:12 AM, Resident 8 was observed lying in bed, on the over the bed table in front of them was an enteral syringe (used to assist at administration of liquids or medication into the PEG tube directly) with a date of 09/10/2024. In an interview on 09/12/2024 at 2:31 PM, Staff N, Registered Nurse (RN) stated that the evening shift nurse was responsible for obtaining new supplies every day for Resident 8's tube feeding including tubing, bags, and syringe. Staff N stated everything should be dated and labeled accordingly. In an interview on 09/13/2024 at 8:39 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated all tube feeding supplies should be good for 24 hours, and the nurse should be replacing daily. The expectation was they were dated and labeled. Staff J was not aware there was no orders or direction on the care plan for replacement of tube feeding supplies daily. Staff J was asked why the PEG tube was not placed on the care plan till almost of year after the resident had been admitted , Staff J was unable to provide an answer. In an interview on 09/13/2024 at 10:59 AM, Staff B, Director of Nursing Services (DNS) stated that Resident 8 has had their PEG tube since their admission in September 2023. Staff B stated it was their expectation that that any resident with enteral feeding would have that incorporated into their plan of care, as well as there should be physician orders for replacement and labeling of all tube feeding supplies. Staff B was not aware there was not orders for the tube feeding supplies, and that the care plan had not been updated till recently. Staff B confirmed that all of tube feeding supplies should have been replaced every 24 hours. Refer to WAC 388-97-1060(1)(3)(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview and record review, the facility failed to ensure 2 of 3 residents (Residents 17 and 24) reviewed for respiratory care and services were provided care consistent with professional standards of practice. The facility failed to ensure the concentrator was set to the ordered dosage for Resident 24's Continuous Positive Airway Pressure (CPAP) (a machine that delivers pressurized air through a mask to the airway allowing a resident to breathe easily and regularly when asleep) and daily oxygen therapy through a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) while awake and failed to ensure an order was in place for the use of oxygen for Resident 17. These failures placed residents at risk for health complications, receiving care and services that were not physician ordered, unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Oxygen Administration (Safety, Storage, Maintenance) showed the policy was to assure that oxygen was administered and stored safely within the healthcare centers. The procedure for oxygen administration was to ensure an order was written for specific liter flow required for the resident. <RESIDENT 24> Resident 24 admitted to the facility on [DATE] with diagnoses that included fracture of the right femur, chronic heart failure, and Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block the airflow and make it difficult to breath). Review of Resident 24's September Medication Administration Record (MAR) showed they had physician orders, which started 07/22/2024, for two liters of oxygen while awake and four liters bled into the home CPAP for sleep. Review of Resident 24's care plan dated 07/22/2024 showed they were at risk of altered respiratory status, difficulty breathing related to COPD and used oxygen therapy. Care plan interventions included the use of CPAP when sleeping. In an observation on 09/09/2024 at 7:10 AM, Resident 24 was laying in bed and was not wearing a nasal cannula or CPAP mask. In an observation on 09/11/2024 at 1:22 PM, the resident was laying in bed and was not wearing a nasal cannula or CPAP mask. The concentrator was set at zero liters and was not running. In an observation on 09/12/2024 at 9:05 AM, the resident was laying in bed and was not wearing a nasal cannula or CPAP mask. The CPAP mask was draped over the top of the bed. The concentrator was set at zero liters and was not running. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/12/2024 at 9:08 AM Staff W, Licensed Practical Nurse, stated Resident 24 used their CPAP at night and had orders for continuous oxygen therapy while awake at two liters. Staff W stated they had checked on Resident 24 earlier when they provided them their medications and the concentrator was set at zero and was not running, was not wearing their nasal cannula, and was not wearing their CPAP mask. In an interview on 09/13/2024 at 9:22 AM Staff B, Director of Nursing Services, stated they expected the nursing staff to follow the facility oxygen policy and physician orders for administration for oxygen. 50725 <RESIDENT 17> Resident 17 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block the airflow and make it difficult to breath), Reynaud's Syndrome (a disorder that causes decreased blood flow to the fingers), Gangrene (type of tissue death caused by lack of blood supply) in the fingers and atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). According to the quarterly Minimum Data Set (MDS - an assessment tool) dated 08/16/2024, the resident was hearing impaired but was able to understand and communicate their needs. In an observation and interview on 09/09/2024 at 12:22 PM, Resident 17 has an oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) at bedside that was turned on and the resident stated they used oxygen at night. In an observation on 09/10/2024 at 9:33 AM, Resident 17 had an oxygen tubing laying on the floor on the left side of the resident and the oxygen concentrator was turned on and was on 2 liters per minute. In record review on 09/10/2024 at 10:30 AM, Resident 17's electronic chart did not show an order for oxygen use. In an interview on 09/11/2024 at 8:23 AM, Resident 17 stated that they use oxygen at night time for sleep apnea. In an interview on 09/11/2024 at 8:08 AM,Staff R, Licensed Practical Nurse (LPN), stated Resident 17 used oxygen as needed. Staff R was unable to show me where the oxygen order was in resident's chart. Refer to WAC 388-97-1720 (1)(a)(ii)(2)(c)(i)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview and record review, the facility failed to provide necessary pain management for 1 of 4 sampled residents (Resident 16) reviewed for pain management. This failure placed residents at risk for avoidable pain and a diminished quality of life. Findings included . <RESIDENT 16> Resident 16 admitted to the facility on [DATE] with diagnoses to include chronic pain syndrome. According to the admission Minimum Data Set assessment (MDS- an assessment tool), dated 08/12/2024, the resident had no cognitive impairment, and they had frequent pain that frequently affected their sleep. The pain care area assessment indicated they had chronic pain and were dependent on opiate medication use for pain relief. In an interview on 09/09/2024 at 9:21 AM, Resident 16 stated they had chronic pain in their back and neck and their pain was usually 8 out of 10, and they also had pain in their left shoulder. In an observation/interview on 09/12/2024 at 11:18 AM, Resident 16 had a grimace on their face, and they stated their pain level was a 10/10 and they had not yet received their morning pain medicine. Review of the undated facility medication administration times schedule showed the AM Med Pass was scheduled for 6:00 AM - 10:00 AM. Review of Resident 16's care plan, dated 09/12/2024, showed an intervention under the Pain/Discomfort/Chronic Opiate Dependent Pain Syndrome Focus area that they would administer Pain meds as ordered. Review of Resident 16's Medication Administration Records (MAR) on 09/12/2024 at 11:41 AM, showed the resident had not yet received their morning pain medications that were scheduled to be given between 6:00 AM - 10:00 AM. The medications that had not been given included Gabapentin (medication being given for nerve pain), Acetaminophen (a non-narcotic pain medication), and Suboxone (a potent opioid medication used to treat narcotic dependence) being given for chronic pain syndrome. In an interview on 09/12/2024 at 11:46 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager, stated they had not yet given Resident 16 their morning medications as they were late with the medication pass. In an interview on 09/13/2024 at 9:53 AM, Resident 16 stated they had not yet received their morning pain medications, and their pain was a 10/10. In an interview on 09/13/2024 at 10:03 AM, Staff Y, LPN, stated they had not yet given Resident 16 their morning medications due to the medication pass taking so long. Refer to WAC 388-97-1060 (1)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview and record review, the facility failed to have sufficient staff to provide and supervise care as evidenced by information provided by 6 (8, 13,17,20, 42 and 51) resident interviews; Resident Council (3, 9, 20, 36) and as evidenced by failed practice in many identified quality of life and quality of care areas. The facility had insufficient staff to ensure residents received assistance with activities of daily living (ADL) including grooming and showers, assessments, care planning, care plan revision, respiratory care, restorative services, pain management, medication administration and call light response in accordance with established clinical standards, and resident needs and preferences. These failures placed residents at risk for unmet care needs and negative outcomes. Findings Included . Review of the Facility Assessment on 07/24/2024, showed: -Nurse staffing was that it was sufficient to meet resident needs. -CNA staffing was somewhat variable as there have been isolated concerns regarding call light response times which were resolved. -The facility continues to focus on recruiting and retention efforts to address concerns. -Staffing needs are determined by census and adjustments are made based on acuity of care. -Staffing of units and assignments of caregivers are determined by the relative acuity of the care needs. <RESIDENT INTERVIEWS> In an interview on 09/09/2024 at 6:02 AM Resident 8 stated they used to get out of bed more and attend activities, but since they require a mechanical lift to get out of bed, it takes a long time. Resident 8 stated they don't want to be a bother to staff. In an interview on 09/09/2024 at 11:41 AM Resident 13 stated they call for help and the staff don't come for a long time. Resident 13 stated they believe there to be a lot of staff that work on computers not the kind that come into the room to help them. In an interview on 09/09/2024 at 12:31 PM Resident 17 stated their call light was answered 20-30 minutes after pushing their button. Resident 17 stated the call light response time had been up to two hours in the past. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/09/2024 at 7:12 AM Resident 20 stated they are short staffed often, more in the evening. Resident 20 stated there should be at least four to five nursing assistants on the hall, but there had only been three. Resident 20 stated in the evening they eat in their room due to being short staffed and then the aides can't get them to bed. Resident 20 stated there had been times they don't get to bed until 9:30 PM. In an interview on 09/09/2024 at 10:44 AM Resident 51 stated they had concerns awhile back and they had to wait forever to get care. Resident 51 stated they were told the facility was short handed and working doubles all the time. Resident 51 stated they complained, and it had not happened again. In an interview on 09/09/2024 at 9:27 AM Resident 42 stated the facility overall does not have enough staff and had taken a long time to answer the call button. <RESIDENT COUNCIL> In the Resident Council Meeting, 09/10/2024 at 12:15 PM, three residents out of seven voiced concerns about call light wait times during nights and weekends. Resident 3 stated there are ongoing complaints about call light wait times. Resident 36 stated call lights are still and issue and stated it was all related to staffing. Resident 36 stated staffing is an ongoing issue and there is not enough staff to cover all the care residents need. Resident 36 stated they hire contract staff, and they are not the same and do as little as possible. Resident 36 stated that staffing was worse on nights and the weekends. Resident 9 stated their room was located at the end of the hall, often forgotten by staff, no one checks on them and does not know the name of their aide. Resident 9 stated they had seen nursing assistants walk by rooms with call lights on and had to track down other aides to help other residents even though it is not their responsibility. Resident 20 stated they had to wait up to three hours to get the help they needed. Staff 20 stated they placed their call light on, and the nursing aides come into the room and turn it off without helping and they would be back. Staff 20 stated the staff do not return to help them and they must put the call light back on. Resident 20 stated they can not get in and out of bed without assistance. In a review of Resident Council Minutes for 05/14/2024 showed one resident stated their call light takes longer at night and on 07/22/2024 residents stated their call lights were being turned off if they were asleep. Residents requested they be woken up and they would like to be checked on even if their call light is not on. <OBSERVATIONS> On 09/12/2024 at 9:00 AM observed Staff J, Resident Care Manager (RCM), at the medication cart for the 100 halls, passing medications to residents. On 09/13/2024 at 9:00 AM observed Staff G. Resident Care Manager (RCM), at the medication cart for the 100 hall passing medications to residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<STAFF INTERVIEWS> In an interview on 09/12/2024 at 9:53 AM, Staff F, Nursing Assistant Certified (NAC) stated that the floor staff are not responsible for showers, the facility has scheduled shower aids that do the showers. If the shower aid was pulled or callouts then the shower will get done another day. In an interview on 09/12/2024 at 10:26 AM, Staff I, NAC stated the facility will usually schedule two shower aids during the week, the floor staff are given a list, so we know who they are showering that day. Staff I stated the floor staff rarely have time to assist with a shower, they are too busy, they possibly could assist a resident that was independent and only needed set up but that would be rare to happen. In an interview on 09/12/2024 at 11:21 AM, Staff L, NAC/Central Supply stated they do showers Monday - Friday, they try to have at least one shower aid on everyday of the week. Staff L stated the floor staff do not do showers, all showers or refusals are documented in the electronic medical record. Staff L stated if a resident refuses or was unavailable they are to offer a shower every day until it gets made up. Staff L stated all the offers should be documented in the electronic medical record. Staff L stated if a shower is refused or is not completed the nurse is also supposed to document in the progress notes that it was not completed. All residents are placed on shower for once a week unless they prefer otherwise then they refer that to the Director of Nursing (Staff B). In an interview on 09/12/2024 at 11:59 AM, Staff B, Director of Nursing Services, stated they were aware of medication errors, pertaining to Resident 16 and their routine pain medication that had not been given within the physician ordered time frame. Staff B stated there were holes in their schedule and Staff J, RCM, was covering. Staff B stated the facility is not using agency staff at all and the RCM's/administration was covering for an opening for a day shift nurse. Staff B related the medication errors to their lack of a day shift nurse. In an interview on 09/13/2024 at 8:39 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated they were not responsible for showers, some staff would mention to them when a resident refuses. Staff J stated they were not sure who was responsible for showers. In a follow up interview with Staff J, RCM, on 09/13/2024 8:39 AM they stated orders for were incomplete because they were busy and missed some. Staff J stated the root of it all is the staffing, they were working on the cart, and had a huge patient load. Staff J stated there is lack of time to get the work done. In an interview on 09/13/2024 at 10:07 AM, Staff DD, Staffing Coordinator, stated the facility had openings for four nursing assistants and they had just hired for the open nurse position who was in training. In an interview on 09/13/2024 at 12:00 PM Staff A, Administrator, stated they were aware of shower and restorative aides being pulled to the floor as the priority is resident care and some cares will not be provided as a result. Staff A stated they are working hard on evaluating call ins, conducting interviews, and job postings with bonuses attached. <RECORD REVIEW> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of restorative documentation showed when the restorative aids (RA) were pulled to the floor: 07/03/2024 for five hours, 08/17/2024 for four hours, 08/31/2024 for three hours, and 09/07/2024 for one hour. 37890 <RESIDENT 16> Resident 16 admitted to the facility on [DATE] with diagnoses to include chronic pain syndrome. According to the admission Minimum Data Set assessment (an assessment tool), dated 08/12/2024, the resident had no cognitive impairment, and they had frequent pain that frequently affected their sleep. The pain care area assessment indicated they had chronic pain and were dependent on opiate medication usage for pain relief. In an observation/interview on 09/12/2024 at 11:18 AM, Resident 16 had a grimace on their face, and they stated their pain level was a 10/10 and they had not yet received their morning pain medicine. Review of the undated facility medication administration times schedule showed the AM Med Pass was scheduled for 6:00 AM - 10:00 AM. In a review of Resident 16's Medication Administration Records on 09/12/2024 at 11:41 AM, the resident had not yet received their morning pain medications that were scheduled to be given between 6:00 AM - 10:00 AM, to include their Gabapentin (medication being given for nerve pain), Acetaminophen (a non-narcotic pain medication), and Suboxone (a potent opioid medication used to treat narcotic dependence) being given for chronic pain syndrome. Other late medications included: Buproprion (an antidepressant medication), Ferrous Gluconate (an iron supplement medication) which was ordered to have been given with breakfast), QVar Redihaler (inhaled medication being given for breathing problems). In an interview on 09/12/2024 at 11:46 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated they had not yet given Resident 16 their morning medications as they were late with the medication pass because that unit had a heavy medication pass. In an interview on 09/12/2024 at 11:59 AM, Staff CC, Corporate Nurse, stated there were two other residents that also did not receive their morning medications on time. In an interview on 09/13/2024 at 9:53 AM, Resident 16 stated they had not yet got their morning pain medications, and their pain was a 10/10. In an interview on 09/13/2024 at 10:03 AM, Staff Y, LPN, stated they had not yet given Resident 16 their morning medications due to the medication pass taking so long. Staff Y stated their morning medication pass can sometimes take them until after 12:00 PM to finish and that most residents have between 15 - 20 medications and they must also do blood sugars. Staff Y stated they still had not finished their medication pass for Resident 16, Resident 1 and Resident 38. In an interview on 09/13/2024 at 2:24 PM, Staff B, Director of Nursing, was unable to provide any information what measures the facility had taken since the day prior when residents also had many late medications. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 28> Resident 28 most recently admitted to the facility on [DATE] and had diagnoses to include a stroke and hemiplegia (a condition that causes partial or complete paralysis of one side of the body)/hemiparesis (muscle weakness or partial paralysis of one side of the body) affecting their left non-dominant side. According to the quarterly MDS assessment, dated 06/27/2024, the resident had no cognitive impairment. In an interview on 09/09/2024 at 8:47 AM, Resident 28 stated they were supposed to be being bathed twice a week, but that was hit and miss, as it depended on if they had enough shower room workers. In a review on 09/12/2024 of 30 days of bathing documentation, Resident 28 had been bathed five times in 30 days and had no refusals. The bathing documentation indicated the resident preferred showers twice weekly. In an interview on 09/13/2024 at 8:18 AM, Staff J, LPN/RCM, stated there had been an issue with staffing, especially on the weekends when they had call outs and they didn't have anyone to call in, so the shower aides had to work the floor and bathing didn't get done. Refer to: Fed - F - 0641 - 483.20(g) - Accuracy Of Assessments Fed - F - 0656 - 483.21(b)(1) - Develop/implement Comprehensive Care Plan Fed - F - 0657 - 483.21(b)(2)(i)-(iii) - Care Plan Timing And Revision Fed -F - 0677 - 483.24(a)(2) - Adl Care Provided For Dependent Residents Fed - F - 0697 - 483.25(k) - Pain Management Fed - F - 0688 - 483.25(c)(1)-(3) - Increase/prevent Decrease In Rom/mobility Refer to WAC 388-97-1080 (1) 33954

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview and record review, the facility failed to advocate and assist 1 of 1 sampled resident (Resident 13) in advocating for their rights within the facility. The failure to assist the resident in having care planning meetings to ensure their voice was heard regarding their care and preferences placed residents at risk for unmet care needs and diminished quality of life. Findings included . <RESIDENT 13> Resident 13 admitted to the facility on [DATE] and they had diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement). According to the quarterly Minimum Data Set assessment (an assessment tool), they had moderate cognitive impairment. In an interview on 09/09/2024 at 11:29 AM, Resident 13 stated they were not being bathed according to their preferences as they were only able to bathe once a week, but they wanted to bathe twice a week. In an observation on 09/10/2024 at 12:15 PM, Resident 13 was observed sitting in their wheelchair that had no right legrest or footrest, the resident was sitting askew with their right hip up off the seat, and their right leg was not resting on the wheelchair at all and was basically suspended in the air. In a joint interview on 09/11/2024 at 10:40 AM, Staff S, Social Services Director, stated they were supposed to be doing quarterly care conferences for the resident. Staff V, Social Services Assistant, stated they had been trying to do quarterly care conferences for the resident, but their power of attorney had declined. Staff S and Staff V were unable to provide any information about how the facility assessed the resident's care when they did not have any care meetings, and they stated they did not know the resident had concerns about not being bathed often enough. In a record review on 09/11/2024, the resident's progress notes were reviewed for the last 12 months and no documentation of any care conferences for Resident 13 could be found. In an interview on 09/11/2024 at 11:38 AM, Resident 13 stated No, when asked if the facility had ever offered to have a care conference regarding their care, bathing preferences, or their wheelchair comfort/fit. Refer to WAC 388-97-0960 (1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview and record review, the facility failed to ensure timely administration of scheduled medications for 4 of 4 sample residents (Residents 16, 1, 38, 7) reviewed who had not yet received their morning medications though the facility's AM Medication Pass times had elapsed. This failure resulted in residents not receiving timely pain medications, anticoagulant medications, medication ordered to be given with breakfast not given until hours after breakfast, diabetic medication, and medication for breathing problems. This failed practice resulted in Resident 16 reporting 10/10 pain two consecutive mornings in a row and it placed residents at risk for adverse medication-related outcomes and for diminished quality of life. Findings included . Review of the undated facility medication administration times schedule showed the AM Med Pass was scheduled for 6:00 AM - 10:00 AM. <RESIDENT 16> Resident 16 admitted to the facility on [DATE] with diagnoses to include chronic pain syndrome. According to the admission Minimum Data Set assessment (an assessment tool), dated 08/12/2024, the resident had no cognitive impairment, and they had frequent pain that frequently affected their sleep. The pain care area assessment indicated they had chronic pain and were dependent on opiate medication usage for pain relief. In an interview on 09/09/2024 at 9:21 AM, Resident 16 stated they had chronic pain in the back and neck and their pain was usually 8/10, and they also had pain in their left shoulder. In an observation/interview on 09/12/2024 at 11:18 AM, Resident 16 had a grimace on their face, and they stated their pain level was a 10/10 and they had not yet received their morning pain medicine. In a review of Resident 16's Medication Administration Records on 09/12/2024 at 11:41 AM, the resident had not yet received their morning pain medications that were scheduled to be given between 6:00 AM - 10:00 AM, to include their Gabapentin (medication being given for nerve pain), Acetaminophen (a non-narcotic pain medication), and Suboxone (a potent opioid medication used to treat narcotic dependence) being given for chronic pain syndrome. In an interview on 09/12/2024 at 11:46 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager, stated they had not yet given Resident 16 their morning medications as they were late with the medication pass. In an interview on 09/12/2024 at 11:59 AM, Staff CC, Corporate Nurse, stated there were two residents that had not yet received their morning medications yet that morning. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an incident investigation, dated 09/12/2024, showed Resident 16 received 10 late medications on 09/12/2024, and the facility concluded there was an opportunity for improvement related to the efficiency of medication administration. In an interview on 09/13/2024 at 9:53 AM, Resident 16 stated they had not yet got their morning pain medications, and their pain was a 10/10. In an interview on 09/13/2024 at 10:03 AM, Staff Y, LPN, stated they had not yet given Resident 16, Resident 1, and Resident 38 their morning medications due to the medication pass taking so long. <RESIDENT 38> Review of an incident investigation, dated 09/12/2024, showed Resident 38 received seven morning medications at 12:07 PM, these medications included pain medication, antipsychotic medication, antihistamine medication, and laxative medications. The investigation indicated the facility educated the nurse that had administered the medications over two hours after the flex pass medication window for morning medications. <RESIDENT 7> Review of an incident investigation, dated 09/12/2024, showed Resident 7 received their morning medications as late as 12:15 PM, though they were due between 6:00 AM - 10:00 AM. The investigation indicated late medications included antidiabetic medication, anticoagulant medication, and a pain medication used for nerve pain. The investigation indicated the facility educated the nurse that administered the late medications. Refer to WAC 388-97-1300 (1)(b)(i)(ii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33954 Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in 1 of 1 facility kitchens. The failure to ensure staff wore hair restraints placed residents at risk for receiving food contaminated by hairs from staff not utilizing hair restraints. Findings included . Review of the facility policy titled Associate Conduct and Dress Code, revised date 04/30/2024, showed Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. In an observation on 09/09/2024 at 5:55 AM, Staff C, Dietary Manager, was working in the kitchen without their hair restrained. In an observation on 09/10/2024 at 1:28 PM, Staff D, Dietary Aide, was observed working in the kitchen without their hair restrained. In an interview on 09/10/2024 at 1:50 PM, Staff C was asked about Staff D not wearing a hair restraint while working in the kitchen, they stated Staff D had just started two days ago and they were still working on training them. In an observation on 09/11/2024 at 11:51 AM, Staff E, Dietary Aide was observed working in the kitchen without their beard restrained. In an interview on 09/12/2024 at 8:20 AM, Staff C stated staff were supposed to wear hair and beard restraints as soon as they entered the kitchen. Refer to WAC 388-97-1100 (3) and -2980

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview and record review, the facility administration failed to obtain and use resources to manage the facility effectively and efficiently to maintain substantial compliance with federal and state regulatory requirements and to meet the significant health needs of their residents. The administration failed to provide needed administrative oversight and monitoring of facility personnel, systems, and policies and practices related to care planning, the resident environment, provision of activities of daily living for dependent residents, range of motion services, respiratory cares, sufficient nursing staff, provision of medically related social services, pharmacy services and procedures, food service procedures, infection control and prevention, and in tuberculosis two-step skin testing. This failed practice placed all residents at risk for unmet care needs and diminished quality of life. Findings included . Review of the facility's last annual recertification Statement of Deficiencies (SOD), dated (08/22/2023) showed the facility had repeat deficiencies cited regarding the environment (F584), comprehensive assessments after a significant change (F637), care plan timing and revision (F657), activities of daily living (ADL) provision for dependent residents (F677), increase/prevent decrease in range of motion/mobility (F688), respiratory care (F695), sufficient nursing staff (F725), provision of medically related social services (F745), pharmacy services, procedures, records (F755), food procurement, store, prepare, serve, sanitary (F812), infection control procedures (F880), and in tuberculosis two-step skin testing (WAC 388-97-1480). Review of a complaint SOD, dated 07/02/2024, showed the facility had a repeat deficiency cited regarding pharmacy services, procedures, and records (F755). Review of a complaint SOD, dated 11/08/2023, showed the facility had a repeat deficiency cited regarding developing and implementing the comprehensive care plan (F656). <SAFE CLEAN COMFORTABLE HOMELIKE ENVIRONMENT (Refer to F584)> Administration failed to ensure resident rooms were homelike and that necessary maintenance was done for windows/wall repairs. <COMPREHENSIVE ASSESSMENT AFTER SIGNIFICANT CHANGE (Refer to F637)> Administration failed to ensure the resident's Minimum Data Set (MDS) assessment was properly coded after they experienced a significant change in condition, placing the resident at risk for inadequate care planning and a diminished quality of life. <CARE PLAN TIMING AND REVISION (Refer to F657)> (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administration failed to ensure residents' care plans were reviewed and revised and accurately reflected current resident status placing them at risk for unmet care needs. <ADL PROVISION FOR DEPENDENT RESIDENTS (Refer to F677)> Administration failed to ensure multiple dependent residents received needed care regarding bathing and toileting placing them at risk for embarrassment, poor hygiene and unmet care needs. In an interview on 09/13/2024 at 8:39 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated they were not responsible for managing resident showers, and they were not sure who was responsible for the resident showers. <RANGE OF MOTION/SPLINT CARE AND SERVICES (Refer to F688)> Administration failed to ensure residents were evaluated for and received needed range of motion and splint care and services. In an interview on 09/11/2024 at 1:16 PM, Staff Q, Director of Rehabilitation, stated they didn't currently have a restorative program, so they were not able to add any residents to that program. Staff Q stated most of their residents could benefit from a restorative program. <RESPIRATORY CARE (Refer to F695)> Administration failed to ensure staff had an order for oxygen administration and they failed to ensure staff administered oxygen per the ordered dosage. <INSUFFICIENT NURSING STAFF/LACK OF STAFF SUPERVISION (Refer to F725)> Administration failed to ensure there was adequate nursing staff to provide necessary care for residents in multiple care areas to include bathing, toileting, and medication administration. Additional failed practice regarding nurse staffing is the facility failure to provide necessary supervision of nursing staff in the provision of care which resulted in multiple residents with unmet care needs. <RESIDENT 16> Resident 16 admitted to the facility on [DATE] with diagnoses to include chronic pain syndrome. According to the admission Minimum Data Set assessment (MDS- an assessment tool), dated 08/12/2024, the resident had no cognitive impairment, and they had frequent pain that frequently affected their sleep. The pain care area assessment indicated they had chronic pain and were dependent on opiate medication usage for pain relief. In an interview on 09/09/2024 at 9:21 AM, Resident 16 stated they had chronic pain in the back and neck and their pain was usually 8/10, and they also had pain in their left shoulder. In an observation/interview on 09/12/2024 at 11:18 AM, Resident 16 had a grimace on their face, and they stated their pain level was a 10/10 and they had not yet received their morning pain medicine. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated facility medication administration times schedule showed the AM Med Pass was scheduled for 6:00 AM - 10:00 AM. Review of Resident 16's care plan, dated 09/12/2024, showed an intervention under the Pain/Discomfort/Chronic Opiate Dependent Pain Syndrome Focus area that they would administer Pain meds as ordered. Review of Resident 16's Medication Administration Records (MAR) on 09/12/2024 at 11:41 AM, the resident had not yet received their morning pain medications that were scheduled to be given between 6:00 AM - 10:00 AM, to include their Gabapentin (medication being given for nerve pain), Acetaminophen (a non-narcotic pain medication), and Suboxone (a potent opioid medication used to treat narcotic dependence) being given for chronic pain syndrome. In an interview on 09/12/2024 at 11:46 AM, Staff J, Licensed Practical Nurse (LPN)/Resident Care Manager, stated they had not yet given Resident 16 their morning medications as they were late with the medication pass. In an interview on 09/13/2024 at 9:53 AM, Resident 16 stated they had not yet received their morning pain medications, and their pain was a 10/10. In an interview on 09/13/2024 at 10:03 AM, Staff Y, LPN, stated they had not yet given Resident 16 their morning medications due to the medication pass taking so long. Staff Y stated their morning medication pass can sometimes take them until after 12:00 PM to finish and that most residents have between 15 - 20 medications and they must also do blood sugar checks. Staff Y stated at the time of this interview they still had not finished their medication pass for Resident 16, Resident 1 and Resident 38. In an interview on 09/13/2024 at 2:24 PM, Staff B, Director of Nursing, was unable to provide any information on what measures the facility had taken since the day prior when residents also had many late medications and experienced untreated pain, and then the pattern was repeated the next day. <PROVISION OF MEDICALLY RELATED SOCIAL SERVICES (Refer to F745)> Administration failed to ensure the provision of medically related social services as it related to conducting care planning meetings and ensuring resident needs were being assessed in an ongoing manner and met according to resident needs and preferences. <PHARMACY SERVICES AND PROCEDURES (Refer to F755)> Administration failed to ensure residents received medications as scheduled resulting in avoidable pain and medication ordered to be administered with breakfast not being administered until hours after breakfast. Medications not administered as scheduled included pain medications, anticoagulant medications, diabetic medications, and medications for breathing problems. <FOOD, STORE, PREPARE AND SERVE SANITARY (Refer to F812)> Administration failed to ensure dietary staff stored, prepared and served food under sanitary conditions. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<INFECTION PREVENTION AND CONTROL (Refer to F880)> Administration failed to ensure staff were compliant with infection prevention guidelines and standards of practice when staff failed to use appropriate hand hygiene during dining service, during care of resident genital and anal areas and they failed to ensure the appropriate type of transmission-based precautions were used for a resident with Clostridium Difficile, a pathogen that can cause diarrhea and inflammation of the colon. <TUBERCULOSIS, TWO-STEP SKIN TESTING (Refer to WAC 388-97-1480) Administration failed to ensure tuberculosis two-step skin testing was done as required. In a joint interview on 09/13/2024 at 2:24 PM, Staff A, Administrator, and Staff B, Director of Nursing Services, were interviewed about the facility's repeat failed practices, Staff A stated this building is very different from other facilities because they take residents other facilities won't take and wacky stuff happens, and they deal with that when it happens. Staff A stated they were doing a performance improvement program for bathing, and they were supervising that program. Staff B stated they've done everything they can regarding staffing, and they are trying to find the right staff that want to work for the right reasons, and they've decreased their nursing staff turnover from last year. Refer to WAC 388-97-1620 (1)(2)(b)(i)(ii)(5)(6)(a)(b)(i)(ii)

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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** 44110 Based on observation, interview, and record review the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and standard of practice for 1 of 4 meal carts (Cart 2) during dining service, 1 of 1 staff (Staff P) during peri-care (cleaning the genital and anal areas of a resident), and 1 of 3 resident rooms (room [ROOM NUMBER]) for transmission-based precautions (TBP). The facility failed to ensure the staff were compliant with appropriate hand hygiene practices while serving meals, and while they assisted a resident with toileting needs. The facility failed to ensure the appropriate type of TBP was initiated for a resident on contact enteric isolation precautions for Clostridium difficile [(c. diff) spore-producing pathogen that can cause diarrhea and inflammation of the colon]. These failures place all residents and staff at risk for potential infections. Findings include . Review of the facility policy titled, Hand Hygiene, revised on 06/03/2024 stated the facility staff will perform hand hygiene (even if gloves are used) in the following situations: before and after contact with the resident, after contact with blood, body fluids, or visibly contaminated surface, after contact with objects and surfaces in the resident's environment, and after removing personal protective equipment (e.g., gloves, gown, eye protection, facemask). Hand washing with soap and water when alcohol based hand rub (ABHR) was not appropriate should be done before eating, after using restroom, when hands are visibly soiled, and when caring for a resident with known or suspected c.diff infection. Review of the facility policy titled, Transmission-based Precautions and Isolation Procedures, revised on 06/03/2024, stated the facility will implement and utilize transmission-based precautions to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. The facility will utilize [NAME] Contact Precautions procedures. Review of [NAME] Manual of Nursing Practice 11th Edition stated when caring for a resident with a spore-producing pathogen such as C. difficile-associated disease (CDAD), then use hand hygiene with soap and water applying friction for 15 seconds, as the spores this organism forms are resistant to alcohol hand gel. <HAND HYGIENE> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a continuous observation on 09/09/2024 at 8:04 AM, Staff F, Nursing Assistant Certified (NAC) was observed to remove a breakfast tray from the meal cart, knocked on the door of room [ROOM NUMBER] and entered the room. Staff F was observed to place the tray on to the residents over the bed table, remove the lid and exit the room, Staff F did not perform hand hygiene. Staff F then opened the meal cart and grabbed another breakfast tray without performing hand hygiene and entered room [ROOM NUMBER] where they moved some of the residents' personal items to make room for the breakfast tray. Staff F was observed to exit the room, without performing hand hygiene. Staff F proceeded to remove another breakfast tray from the meal cart and enter the resident room [ROOM NUMBER]. They were observed to place tray on the over the bed table, move some of the residents' personal items, turn on the over the bed light and exit the room without performing hand hygiene. Staff F went to the meal cart and retrieved another tray and entered resident room [ROOM NUMBER] bed B, placed tray on the resident over the bed table, moved it closed to the resident with her bare hands, and exited the room without performing hand hygiene. Staff F was observed to retrieve a second tray and enter room [ROOM NUMBER], place tray down for Bed A on the over the bed table, and adjusted items on their table. Staff F was observed to exit the room, without performing hand hygiene, push the meal cart down the hall to the next area of rooms. Staff F then opened the meal cart door, retrieved a breakfast tray and entered room [ROOM NUMBER] without performing hand hygiene. Staff F then exited the room, no hand hygiene was observed, walked into the main dining room, retrieved items from a cupboard, walked back to room [ROOM NUMBER] where they gave the item to the resident, exited the room again without performing any hand hygiene. Staff F then opened the meal cart and removed another breakfast tray and entered room [ROOM NUMBER], no hand hygiene was performed. Staff F was observed to help set up the resident in room [ROOM NUMBER] for breakfast, they were observed to adjust the bed controls, and the resident's pillow, they exited the room, no hand hygiene performed. Staff F was observed to retrieve another breakfast tray from the meal cart and walk into room [ROOM NUMBER], no hand hygiene was performed. Staff F exited room [ROOM NUMBER], grabbed another tray from the meal cart, no hand hygiene was performed. Staff F walked into room [ROOM NUMBER] and delivered a meal tray to the resident, adjusted the over the bed table, and moved some of the residents' personal items for them. Staff F exited the room, no hand hygiene was performed. In an observation on 9/11/2024 at 9:44 AM, Staff P, NAC, was observed providing peri care to Resident 17. When finished Staff P used the same gloves to put on the resident's briefs and pants. Staff P then removed their gloves and moved the bedside commode and placed resident's wheelchair close to the resident to sit on without washing hands or using alcohol-based hand rub (ABHR). In an interview on 09/12/2024 at 9:53 AM, Staff F, NAC stated that they are responsible for performing hand hygiene before and after they take a meal tray into a resident's room. Staff F was not aware they had not performed hand hygiene during the breakfast meal tray pass on 09/09/2024. In an interview on 9/13/2024 at 8:00 AM with Staff J, Licensed Practical nurse (LPN)/Resident Care manager (RCM) stated that they just had a skills fair where the staff were taught how and when to do handwashing and staff had to return demonstrations on handwashing. <TRANSMISSION BASED PRECAUTIONS> Resident 49 admitted to the facility on [DATE] with diagnoses including enterocolitis (inflammation and infection of the bowels) due to c. diff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In observation and interview on 09/09/2024 at 9:02 AM, room [ROOM NUMBER] had a contact isolation sign outside the door that advised all that entered to wear a gown and gloves prior to entering the room and educated them to perform hand hygiene with an ABHR. Resident 49 was unsure why there was a sign outside of their room, or what the isolation precautions were for. In an interview on 09/09/2024 at 9:04 AM, Staff G, LPN/RCM stated that Resident 49 was on precautions for c. diff. In multiple observations on 09/10/2024 at 10:41 AM, 09/11/2024 at 2:48 PM, and 09/12/2024 at 9:19 AM the contact isolation sign outside of room [ROOM NUMBER], where Resident 49 was observed inside the room, instructed all staff and visitors to perform hand hygiene with ABHR. In an observation and interview on 09/12/2024 at 1:08 PM, Staff H, NAC was observed to enter room [ROOM NUMBER] to provide care to Resident 49. When Staff H exited the room they removed their gown, and gloves, then performed hand hygiene with the alcohol gel hand rub outside of the room. The staff was not observed to wash their hand with soap at water. Staff H stated they follow what the sign outside the room says for the type of isolation precautions they need to initiate. In an interview on 09/13/2024 at 10:46 AM, Staff K, Infection Preventionist/LPN stated anytime a resident had any type of communicable disease they follow the Center for Disease and Control and Prevention (CDC) guidance on what appropriate TBP's they are to use. Staff K stated that Resident 49 had been positive for c. diff which was contact enteric precautions. Staff K stated that all staff or visitors that enter the room need to ensure they are washing their hands with soap and water, and not using the ABHR as it will not kill the spores of c-diff. Staff K was not aware that the directions outside of Resident 49's room were incorrect and had instructed staff and visitors to use ABHR. Staff K stated their expectation was all staff were performing hand hygiene before and after they deliver meal trays to a resident, and before and after all glove changes. In an interview on 09/13/2024 at 10:59 AM, Staff B, Director of Nursing Services stated their expectation for all staff was they were following the facility policies. Staff B was not aware of the hand hygiene issues observed and stated that was not their expectation. Staff B confirmed that any resident that was on isolation precautions for c. diff, required all who enter the room to wash their hands with soap and water. Staff B was not aware the TBP sign was not appropriate for Resident 49. Refer to WAC 388-97-1320(1)(a)(c)(2)(a)(b) 50725

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to ensure the infection prevention and control Antibiotic Stewardship Program (ASP, a system-wide implementation of measures for monitoring/tracking of antibiotics along with reducing the risk of unnecessary antibiotic use) was implemented for 1 of 1 resident (Resident 8). This failure increased the resident's risk for development of multidrug-resistant organisms (a bacteria that are resistant to many antibiotics) along with the potential for unidentified nursing care trends that identify risk related to infection prevention. This failure had the potential for adverse outcomes associated with unnecessary or inappropriate antibiotic use and a decrease in quality of life for all facility residents. Findings included . Review of the facility document titled, Statement of Leadership Commitment for Antibiotic Stewardship in a Skilled Nursing Facility, signed by the Medical Director, Director of Nursing Services, Executive Director, Infection Preventionist, and pharmacist on 08/20/2024. The document states the facility will be embracing and executing the Center for Disease Control and Prevention (CDC) core elements of antibiotic stewardship. The document states those elements are leadership, commitment, accountability, drug expertise, action tracking, reporting and education. The infection preventionist will serve as the chair of the team and ensure to improve nurse - prescriber communication. Resident 8 admitted to the facility 09/29/2023 with diagnoses including history of kidney stones, surgery to the urinary system with nephrostomy (artificial opening in the skin to allow urine to drain from the kidney), and antibiotic-resistant bacteria infection. The quarterly Minimum Data Set (MDS, an assessment tool) assessment dated [DATE] showed the resident had intact cognition. Review of Resident 8's physician orders showed an order dated 05/28/2024 for Bactrim DS (an antibiotic) oral tablet 800-160 milligrams (mg) to take one tablet twice a day, with a note that read need stop date. Review of Resident 8's electronic medication administration record (eMAR) for July 2024 through September 11th, 2024, showed the resident had received the antibiotic medication twice a day, every day. Review of Resident 8's medical record showed that the residents' infection was to be managed by an off-site infectious disease provider. Review of the medical record showed no documentation there had been any communication with the infectious disease provider related to a stop date for the antibiotic. In an interview on 09/12/2024 at 10:45 AM, Staff B, Director of Nursing Services was asked what the status was on Resident 8's antibiotic. Staff B stated they would need to look more into the matter, as they were not locating any information in the medical record. In a follow up interview on 09/12/2024 at 12:37 PM, Staff B stated they contacted the Infection Disease providers office and was able to obtain some documentation that showed the following: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 06/18/2024: a note with the facility and communication about the status of the resident, - 06/24/2024: a note that there had been communication with the facility regarding the use of the antibiotic. The documentation was not part of the medical record until Staff B, requested it on 09/12/2024. In an interview on 09/13/2024 at 10:46 AM, Staff K, Licensed Practical Nurse (LPN)/Infection Preventionist stated the facility had an antibiotic stewardship program. Staff K stated they discuss antibiotic stewardship during the Quality Assurance and Performance Improvement (QAPI) meeting monthly. Staff K stated they were aware that Resident 8 was on an antibiotic, and that they were under the impression that the antibiotic was to be continued if the resident had a nephrostomy tube. Staff K was not aware there was no documentation or follow up in the medical record regarding the usage of the antibiotic, or when the stop date was. Staff K stated they had not completed any follow-up on Resident 8's antibiotic and acknowledged as the infection preventionist they should be aware. Refer to WAC 388-97-1320(1)(a)