STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505324	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Puyallup	511 10th Avenue Southeast Puyallup, WA 98372

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 46067 Based on observation and interview, the facility failed to ensure the survey results were posted in a place readily accessible to all residents and to post notices regarding the availability of the survey reports in areas that were prominent. These failures prevented residents and resident representatives the opportunity to use past survey results to evaluate the quality of care provided by the facility. Findings included . During a group interview on 02/25/2025 at 1:18 PM, Residents 10 and 41, both cognitively alert, stated they did not know survey results were available for their review nor where the survey results were located. Observations on 02/25/2025-02/26/2025 showed a binder labeled State Survey Results on a small corner table in the conference room on the 100-hall. The facility had 4 hallways where residents resided. Observation showed no notices about the availability or location of the binder throughout the resident-occupied areas. During an interview on 02/26/2025 at 11:36 AM, Staff J, Licensed Practical Nurse (LPN), stated the survey book was usually kept at the nurse's station or in the social services office. During an interview on 02/26/2025 at 11:38 AM, Staff K, Receptionist, stated they thought the survey book was located at the front desk but stated they needed to check with the Administrator. During an interview on 02/26/2025 at 11:40 AM, Staff A, Administrator (ADM), stated the binder was in the conference room with signage on the door so residents could have privacy viewing the results. Staff A stated there were no additional signs in the facility informing residents/visitors of the binder's location. Reference: WAC 388-97-0480

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

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

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide written notification of the reason for transfer to the hospital to the resident and/or resident representative for 3 of 4 sampled residents (Residents 21, 54, and 72) reviewed for hospitalization . This failure placed the residents at risk for not knowing rights regarding transfer and discharge from the facility and diminished protection from being inappropriately discharged . Findings included . Resident 21 Review of the electronic health record (EHR) showed Resident 21 initially admitted to the facility on [DATE] with diagnoses that included heart failure, kidney failure, and diabetes (high blood sugar levels). Resident 21 was able to make needs known. Review of Resident 21's EHR showed a transfer to the hospital on 11/12/2024 and on 12/19/2024. The EHR did not show a notice of transfer was provided to Resident 21 or their representative for either of their transfers to the hospital. During an interview on 02/26/2025 at 10:15 AM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated Resident 21, or their representative, did not receive a written notice of transfer; however, they were informed verbally for transfers to the hospital on 11/12/2024 and on 12/19/2024. Resident 54 Review of the EHR showed Resident 54 initially admitted to the facility on [DATE] with diagnoses that included heart failure, diabetes, and respiratory failure. Resident 54 was able to make needs known. Review of Resident 54's EHR showed a transfer to the hospital on 09/09/2024. The EHR did not show a notice of transfer was provided to Resident 54 or their representative. During an interview on 02/26/2025 at 10:04 AM, Staff C, LPN/UCC, stated Resident 54 was informed verbally for transfer to the hospital on 09/09/2024 and was not provided a written notification. Resident 72 Review of the EHR showed Resident 72 initially admitted to the facility on [DATE] with diagnoses that included heart failure and diabetes. Resident 72 was able to make needs known. Review of Resident 54's EHR showed a transfer to the hospital on 07/16/2024 and on 08/05/2024. The EHR did not show a notice of transfer was provided to Resident 72 or their representative for either of their transfers to the hospital. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 02/26/2025 at 9:42 AM, Staff C, LPN/UCC, stated Resident 72, or their representative, did not receive a written notice of transfer; however, they were informed verbally for transfers to the hospital on 07/16/2024 and on 08/05/2024. During an interview on 02/27/2025 at 1:31 PM, Staff A, Administrator, stated the expectation was for the nurses to complete an interact transfer form and provide a written Nursing Home Transfer or Discharge Notice form to the resident and/or their responsible party for transfers to the hospital. Staff A stated a copy of the form should be sent to the hospital with the resident and a copy should go to Medical Records to be scanned into the resident's EHR. Reference WAC 388-97-0120 (2)(a-d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to develop comprehensive care plans to include all provided nursing services for 2 of 19 sampled residents (Residents 10 and 80) when reviewed for care planning. This failure placed residents at risk for not receiving needed care, a decline in condition, and a diminished quality of life. Findings included . Resident 10 Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses of paraplegia (inability to move lower limbs), diabetes (too much sugar in the blood), and a pressure ulcer to the lower back. Resident 10 was able to make needs known. During an interview on 02/24/2025 at 10:07 AM, Resident 10 stated they had a pressure ulcer and facility staff were treating it with the help of an outside wound provider. Review of the care plan, initiated 04/07/2020, showed no focus area for Resident 10's pressure ulcer, no intervention for nursing staff to treat the pressure ulcer, and no intervention for an outside wound provider to assist with treatment. During an interview on 02/27/2025 at 11:37 AM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated residents with a pressure ulcer should have a care plan focus area and interventions on what nursing care was being provided to treat the wound. Staff C stated Resident 10 did not have a focus area for the care of their pressure ulcer and this did not meet expectations. During an interview on 02/27/2025 at 1:05 PM, Staff B, Director of Nursing Services (DNS), stated residents with skin issues, such as a pressure ulcer, should have a care plan focus area addressing the care of the wound. Staff B stated Resident 10's lack of care plan for their pressure ulcer did not meet expectation. 49926 Resident 80 Review of the EHR showed Resident 80 was admitted to the facility on [DATE] with diagnoses to include hydrocephalus (build-up of fluid in the brain), dysphagia (difficulty swallowing) and respiratory failure. Resident 80 was able to communicate needs. Observation on 02/25/2025 at 11:04 AM, showed Resident 80 in their bed watching TV. There was a medical pole near the bed that was holding a feeding pump machine (a machine that pumps formula into artificial feeding tube). There was unopen can of soda pop on the over bed table and chocolates by the TV. Resident 80 stated they got the tube feeding at nighttime only. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provider's orders, dated 01/08/2025, showed Resident 80 had an order for regular diet with puree texture. Review of the care plan focus area for nutrition and weight fluctuation, revised on 12/12/2024, showed a diet intervention of nothing by mouth (NPO). During an interview on 02/26/2025 at 2:08 PM, Staff B, DNS, stated when the orders were changed the nurse should update the care plan to current diet and NPO status. Staff B stated Resident 80's care plan was inaccurate and did not meet expectations. Reference WAC 388-97-1020 (1), (2)(a)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to obtain and/or follow provider's orders (Resident 1, 72, and 6), failed to monitor medication side effects (Resident 6), and failed to provide catheter care per professional standards (Resident 75) for 4 of 19 sampled residents (Residents 1, 75, 72, and 6) reviewed for professional standards of care and services. These failures placed residents at risk of avoidable fall injury, unintended medication side effects, medical complications, and a diminished quality of life. Findings included . Resident 1 Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses to include Crohn's disease of small intestine (bowel disease), autistic disorder (affects how people interact with others, communicate, learn, and behave), and dementia (decline in memory, thinking, reasoning, and judgment). Resident 1 was unable to make needs known. Review of the provider's orders showed Resident 1 was to have orthostatic blood pressure (blood pressure reading in different positions) measured while laying and sitting every month. Review showed Resident 1 was prescribed midodrine (treats low blood pressure that causes severe dizziness and fainting) and was to be held when systolic blood pressure (top number of blood pressure reading) was greater than 130. Review of the November 2024, December 2024, and January 2025 medication administration record (MAR) showed Resident 1's orthostatic blood pressure reading for sitting were labeled NA. Review of the February 2025 MAR showed Resident 1 had NA recorded for both laying and sitting orthostatic blood pressure reading. Review of the December 2024 MAR showed Resident 1's midodrine was provided outside the provider's parameters for 10 of 93 opportunities. Review of the January 2025 MAR showed Resident 1's midodrine was provided outside the provider's parameters for 4 of 93 opportunities. Review of the February 2025 MAR showed Resident 1's midodrine was provided outside the provider's parameters for 14 of 78 opportunities. During an interview on 02/27/2025 at 11:37 AM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated the expectation was for nursing staff to follow provider's orders. Staff C stated Resident 1 was not provided orthostatic blood pressure monitoring per provider's orders and this did not meet expectation. Staff C stated Resident 1's midodrine was provided outside provider's parameters, this constituted a medication error, and it did not meet expectation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 1:05 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was for nursing staff to follow provider's orders. Staff B stated Resident 1's lack of orthostatic blood pressure monitoring and midodrine provided outside of parameters did not meet expectation. 34567 Resident 75 Review of the quarterly minimum data set (MDS, a required assessment tool), dated 01/16/2025, showed Resident 75 readmitted on [DATE] with multiple diagnoses to include stroke, muscle weakness, cancer, dementia, neurogenic bladder (a loss of bladder control due to damage in the brain, spinal cord, or nerves), anxiety and depression. The MDS showed the resident had a foley catheter (a thin flexible tube inserted into the bladder through the urethra to drain urine) and was dependent on staff for assistance with activities of daily living (ADLs). Review of Resident 75's provider's order summary, dated 07/02/2024, showed for licensed staff to place an indwelling (foley) catheter 16 French (FR, diameter size of the catheter) and to change for infection, obstruction or when closed system was compromised as needed related to the resident's neuromuscular dysfunction of the bladder. Review of Resident 75's care plan, revised on 11/14/2024, showed the resident had a catheter 16 FR for their neurogenic bladder. Interventions included for licensed staff to observe and report to the provider for signs and symptoms of urinary tract infection to included cloudiness, foul smelling urine and deepening of urine color. Review of Resident 75's EHR clinical notes, dated 02/11/2025, showed a Licensed Nurse (LN) had documented the resident's family member was concerned with the appearance of the resident's urine and the family reported the resident complained of abdominal pain to them. A follow-up clinical note, on 02/12/2025, showed a LN documented the resident's foley catheter was clogged and changed during the shift with a 14 FR. During an interview and observation on 02/26/2025 at 9:07 AM, Staff E, LPN, was asked whether they had assessed Resident 75's foley catheter and if it was the correct size that the provider had ordered. Staff E explained to the resident they were there to conduct an assessment and check their foley catheter. The size of the foley catheter was revealed to be 14 FR and not 16 FR as indicated in the provider's orders. Staff E stated they were unaware that the resident had the 14 FR foley catheter. During an interview on 02/26/2024 at 9:28 AM, Staff B, DNS, stated it was their expectation the LN would have placed the correct size foley catheter as per the provider's order if the resident required it to be changed. 38344 Resident 72 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR showed Resident 72 readmitted to the facility on [DATE] with diagnoses that included anxiety disorder, psychotic disorder, and depression. The annual MDS, dated [DATE], showed Resident 72 received antipsychotic and antidepressant medications and was able to make needs known. Review of the provider's order dated 11/16/2024 showed Resident 72 was prescribed to have orthostatic blood pressures (BP) obtained and monitored monthly every 30 days. Review of Resident 72's MAR of ordered monthly orthostatic BP showed the following: ---December 2024 MAR documentation on 12/17/2024 showed the area to document BP for lying and sitting had incomplete results, a BP result of 151/77 did not show what the position it was taken, and there was no BP documented for standing. ---January 2025 MAR documentation on 01/16/2025 showed the area to document BP for lying showed NA (not applicable), the BP result for sitting was incomplete, a BP result of 141/74 did not show what position the BP was taken, and there was no BP documented for standing. ---February 2025 MAR documentation on 02/15/2025 showed the area to document BP for lying and sitting had incomplete results, a BP result of 160/74 did not show what position the BP was taken, and there was no BP documented for standing. During an interview on 02/26/2025 at 10:25 AM, Staff C, LPN/UCC, stated Resident 72's December MAR orthostatic BP documentation on 12/17/2024 had incomplete results for lying and sitting, BP result of 151/77 did not indicate what position it was taken, and it did not have a standing BP documented. Staff C stated Resident 72's January and February MAR orthostatic BP documentation on 01/16/2025 and 02/15/2025 had NA (not applicable) documented for lying BP and/or had incomplete BP documented, BP results documented did not indicate position they were taken, and no standing BP was documented. During an interview on 02/26/2025 at 12:21 PM, Staff B, DNS, stated orthostatic BP were to be obtained while a resident was lying, sitting, and standing per provider's order and documented in the resident's MAR. Staff B stated Resident 72's orthostatic BP MAR documentation for December 2024, January 2025, and February 2025 were missing appropriate documentation and did not meet expectations. 49926 Resident 6 Review of the EHR showed Resident 6 was admitted to the facility on [DATE] with diagnoses to include fracture of sacrum (bone at the end of the spine), diabetes (high blood sugar) and dementia (loss of memory, and thinking abilities). Resident 6 was able to communicate needs. Review of the provider order, dated 12/20/2024, showed Resident 6 was taking quetiapine (a mind-altering medication). Review of the abnormal involuntary movement scale (AIMS, a test that shows abnormal movements when taking mind-altering medications), dated 12/23/2024, showed the test was not completed. Review of the EHR did not showed documentation of orthostatic blood pressures for Resident 6. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/2025 at 9:50 AM, Staff B, DNS, stated the process for monitoring adverse side effects for mind-altering medications was to complete AIMS test and take orthostatic blood pressures. Staff B stated Resident 6's monitoring of adverse side effects did not meet expectations. Reference WAC 388-97-1620 (2)(b)(i)(ii), (6)(b)(i)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to provide the necessary grooming services to maintain hygiene for 2 of 4 sampled residents (Residents 49 and 61) when reviewed for activities of daily living. This failure placed the residents at risk of feelings of indignity, decreased social interaction, and diminished quality of life. Findings included . Resident 49 Review of the electronic health record (EHR) showed Resident 49 was admitted to the facility on [DATE] with diagnoses to include right humerus (upper arm bone) fracture, diabetes (high blood sugar) and depression. Resident 49 was able to communicate needs. During an interview on 02/24/2025 at 11:47 AM, Resident 49 stated they liked to shave, but the facility did not offer to help. Observation on 02/25/2025 at 11:22 AM, showed Resident 49 sat in the wheelchair in their room with facial hair about an inch long. Review of the care plan focus area on self-performance, revised on 12/31/2024, showed Resident 49 required one staff assistance with personal hygiene. There was no specific instructions or directives about shaving in the care plan. During an interview on 02/26/2025 at 11:58 AM, Staff F, Certified Nursing Assistant (CNA), stated they offered shaving to resident, and the shower CNA did it. During an interview on 02/26/2025 at 12:01 PM, Staff G, CNA, who was assigned duties to provide showers, stated they offered shaving, but the CNA on the floor should also provide them. During an interview on 02/26/2025 at 2:04 PM, Staff B, Director of Nursing Services (DNS), stated the process was for staff to offer and shave the residents. Staff B stated Resident 49's lack of shaving did not meet expectations. 38344 Resident 61 Review of the EHR showed Resident 61 admitted to the facility on [DATE] with diagnoses that included rheumatoid arthritis (a disease that causes painful inflammation of the joints), respiratory failure, and heart failure. Resident 61 was able to make needs known. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission minimum data set assessment (MDS), an assessment tool, dated 12/05/2024 showed Resident 61 had upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot) impairments on both sides. Resident 61 required substantial/maximal assistance with personal hygiene. Observation and interview on 02/24/2025 at 2:24 PM showed Resident 61 laid in bed and both feet exposed from under the covers and had thick, long toenails. Resident 61 stated they told staff they wanted to see a podiatrist (a person who treats the feet and their ailments) and was told they would be put on a list to be seen but still had not been. During a follow-up interview on 02/25/2024 at 12:32 PM, Resident 61 stated the last time they had their toenails trimmed was about two or three months ago by their family member; however, now their nails were too thick, and family did not want to attempt to cut them because they did not want to hurt them. Review of the referral binder located at the nurse's station showed a document titled, Referrals, dated February 2025, which did not have Resident 61's name on the list to be seen by the podiatrist. During an interview on 02/26/2025 at 11:02 AM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated residents that needed to be seen by a podiatrist got put on a list to be seen and the podiatrist came once a month. Staff C stated Resident 61's name was not on the current podiatry list in the referral binder at this time. Staff C stated Resident 61's toenails were long and thick and should have been cut by a podiatrist. During an interview on 02/26/2025 at 11:53 AM, Staff B, DNS, stated they were aware Resident 61's toenails were long and thick. Staff B stated Resident 61's toenails should have been cut by a podiatrist prior to now and this did not meet expectations. Reference WAC 388-97 -1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure the necessary interventions were in place for residents with a history of a fractured humerus (a bone in the upper arm) for 1 of 2 sampled residents (Resident 75) when reviewed for positioning and mobility. The facility also failed to consistently monitor and document bowel movements and implement the bowel program as needed for 2 of 7 sampled residents (Residents 6 and 49) when reviewed for bowel protocol. These failures placed the residents at risk for worsening condition, discomfort, and a decreased quality of life. Findings included . <Position/Mobility> Resident 75 Review of the quarterly minimum data set (MDS), a required assessment tool, dated 01/16/2025, showed Resident 75 readmitted on [DATE] with multiple diagnoses to include stroke, muscle weakness, cancer, dementia, anxiety and depression. The electronic health record (EHR) showed the resident had a history of a left humerus fracture and was dependent on staff for assistance with activities of daily living (ADLs). Review of Resident 75's care plan, revised on 11/08/2024, had impaired mobility and ADLs deficit and required assistance related to a history of a left humerus fracture and stoke with left side weakness. Interventions included for staff to always apply a sling (a device that supports and immobilizes an injured body part) to the resident's left arm, do not pull-on left arm, reposition, and may apply pillow for comfort. Observation on 02/22/2025 at 1:59 PM showed Resident 75 asleep in their bed. Observation showed a sign affixed to the wall behind the bed which showed, Don't pull left arm. No sling was observed being worn by the resident or their left arm positioned on a pillow. During an interview on 02/26/2025 at 9:07 AM, Staff E, Licensed Practical Nurse (LPN), stated the resident had the sling order discontinued on 02/03/2024 and they no longer applied the left shoulder sling. Review of Resident 75's EHR showed a provider's order to wear a sling, dated 11/19/2024, and was discontinued on 02/03/2025. The order showed the licensed staff had documented the sling was applied for the resident to wear to the left shoulder for a history of fracture and to wear when out of bed for comfort. An additional provider's order dated 02/03/2025 showed the left shoulder sling was to be applied when the resident was out of bed and for comfort as necessary (PRN); however, the order was not transcribed into the medication administration record (MAR) for the licensed staff to apply as per the provider's order. Review of Resident 75's MAR for February 2025 showed the PRN shoulder sling order was not transcribed into the resident's MAR until 02/26/2025 for the licensed staff to apply as ordered. (continued on next page)

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	505324	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Puyallup	511 10th Avenue Southeast Puyallup, WA 98372

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/2025 at 10:04 AM, Staff B, Director of Nursing Services (DNS), stated Resident 75's daughter wanted the resident to wear their left shoulder sling; however, they stated the resident frequently refused, so the order was changed from every shift to as necessary. Staff B was then informed the PRN sling order had not been transcribed yet into the MAR for the licensed staff to apply as necessary. Staff B was then observed to access the resident's EHR to update the order correctly into Resident 75's MAR. 49926 <Bowel Management> Resident 6 Review of the EHR showed Resident 6 was admitted to the facility on [DATE] with diagnoses to include fracture of sacrum (bone at the end of the spine), diabetes (high blood sugar) and dementia (loss of memory, and thinking abilities). Resident 6 was able to communicate needs. During an interview on 02/24/2025 at 10:23 AM, Resident 6 stated, I have bad constipation. They don't give me anything. Review of EHR's bowel documentation showed Resident 6 did not have bowel movements on 02/13/2025 through 02/16/2025 (four days). Review of the provider's orders showed Resident 6 had an order a medication for constipation to be administered when there were no bowel movements after three days. Review of the MAR for February 2025 showed no administration record for the constipation medication for the dates 02/15/2025 or 02/16/2025. Resident 49 Review of the EHR showed Resident 49 was admitted to the facility on [DATE] with diagnoses to include right humerus (upper arm bone) fracture, diabetes (high blood sugar) and depression. Resident 49 was able to communicate needs. Review of the EHR bowel documentation showed Resident 49 did not have bowel movements on 02/14/2025 through 02/17/2025 (four days). Review of the provider's orders showed Resident 49 had order a constipation medication to be administered when there were no bowel movements after three days. Review of the MAR for February 2025 showed Resident 49 had no administration the constipation medication for the dates of 02/16/2025 or 02/17/2025. During an interview on 02/25/2025 at 12:25 PM, Staff F, Certified Nursing Assistant, stated the process was to document the bowel movements in the record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/2025 at 9:44 AM, Staff B, DNS, stated the system flagged for staff to follow up when there was no bowel movements documented and Licensed Nurses were to implement the bowel protocol. Staff B stated that Residents 6 and 49's lack of constipation medications after three days of constipation did not meet expectations. Reference WAC 388-97-1060(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure fall mats were in place to minimize the risk for injury during a fall for 1 of 4 sampled residents (Residents 75) when reviewed for accident hazards. This failure placed residents at risk for potential injury, negative outcomes and decreased quality of life. Findings included . Review of a facility's policy titled, Fall Management, dated 09/25/2024, showed the facility would assess the resident upon admission/readmission, quarterly, with change in condition and with any fall event for any fall risks and would identify appropriate interventions to minimize the risk of injury related to falls. In addition, the policy included for staff to implement interventions to include adequate supervision, and use assistive devices, consistent with resident needs, goals, care plan and current professional standards of practice. Review of the quarterly minimum data set (MDS), a required assessment tool, dated 01/16/2025, showed Resident 75 readmitted on [DATE] with multiple diagnoses to include stroke, muscle weakness, cancer, dementia, anxiety and depression. The MDS showed the resident was able to make needs known and was dependent on staff for assistance with activities of daily living (ADLs). Review of the facility's incident report log showed Resident 75 had falls on 11/03/2024 and 12/17/2024. Review of Resident 75's witness reports for fall incidents on 11/03/2024 and 12/17/2024 showed the fall scene investigation reports of drawings of the post fall scene, whereas the aide drew the area and position in which the resident was found (i.e. face down, on back, right of left side, position of the arms and legs, furniture, equipment and devices nearby). The document showed no falls mat were in place or documented in the report. Review of Resident 75's care plan, revised 08/04/2024, showed the resident had falls related to impaired mobility, weakness, and stoke with left sided weakness. Interventions included for staff to place the bed into lowest position and add floor mats at the side of the bed when asleep. Review of a multiple facility documents titled Fall Risk Evaluation, dated 04/22/2024, 07/01/2024, 07/29/2024, 11/03/2024, 12/20/2024, showed the facility staff had conducted several fall assessments and indicated Resident 75 was at a high risk for falls. During an interview on 02/26/2025 at 9:15 AM, Staff E, Licensed Practical Nurse (LPN), stated they did not see any fall mats being used for Resident 75. Staff E stated if the resident had a care plan intervention for mats to be in place for falls then it should be in place and on the floor next to the resident's bed while they slept. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/26/2025 at 12:14 PM, showed Resident 75 asleep in bed. The bed was observed to be positioned at normal height and no fall mats were observed next to the resident's bed or within the room. During an interview and observation on 02/26/2025 at 12:22 PM, Staff D, Certified Nurse Aide (CNA), stated they would check to see if Resident 75's care plan/Kardex required the resident's bed to be placed into a low position and if floor mats were needed while the resident was asleep. Staff D was then observed to review Resident 75's electronic health record (care plan/Kardex). Staff D stated they noted the resident's bed was to be in a low position and floor mats were required while the resident slept. Staff D stated they would contact the maintenance staff to get the floor mats placed at the side of the resident's bed. During an interview on 02/26/2025 at 1:00 PM, Staff B, Director of Nursing Services (DNS), was asked about the missing falls mat not being used in Resident 75's room while they slept. Staff B stated the fall mats were remove earlier because they were frayed, and the facility had ordered new mats. During an interview on 02/26/2025 at 1:38 PM, Staff A, Administrator (ADM), stated their expectation would be if the interventions were on Resident 75's care plan then the fall mats should be in place. Reference WAC 388-97-1060(3)(g)

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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** 40817 Based on interview and record review, the facility failed to provide pain management to adequately control residents pain for 1 of 6 sampled residents (Resident 3) when reviewed for pain management. This failure put residents at risk of uncontrolled pain and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 3 admitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood), paraplegia (inability to move lower limbs), and anxiety. Resident 3 was able to make needs known. During an interview on 02/24/2025 at 11:09 AM, Resident 3 stated the facility staff would provide pain medication, but sometimes it did not control their pain. Resident 3 stated they would ask facility staff for additional pain medication but would be told by staff they could not have more yet. Review of Resident 3's January 2025 medication administration record (MAR) showed Resident 3 was prescribed two over the counter (OTC) pain medications and one narcotic pain medication. Review showed all three pain medications were as needed (PRN) and had no parameters for nursing staff to follow for which pain medication to be provided based on the resident's pain level. Further review of the January 2025 MAR showed Resident 3 received one OTC pain medication for pain levels 7 to 8, one OTC pain medication was unused, and the narcotic pain medication was used for pain levels 6 to 8. Review of the February 2025 MAR showed Resident 3 received one OTC pain medication for pain levels 4 to 8, one OTC pain medication was unused, and the narcotic pain medication was used for pain levels of 5. During an interview on 02/27/2025 at 11:37 AM, Staff C, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated when more than one PRN pain medication was prescribed it was up to nursing judgement on which to provide. Staff C stated providers would sometimes provide parameters for PRN pain medications and other times would not. During an interview on 02/27/2025 at 1:05 PM, Staff B, Director of Nursing Services (DNS), stated PRN pain medications should include a pain scale parameter to inform nursing staff which medication to provide. Staff B stated Resident 3's PRN pain medications did not have these parameters, and this did not meet expectation. Reference WAC 388-97-1060 (1)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment in 1 of 4 hallways (300 hallway) reviewed for Environment. Failure to ensure Resident 21's and 72's wheelchair armrests were in good repair placed residents at risk for injury, medical complications, and decrease quality of life. Findings included . Resident 21 Review of the electronic health record (EHR) showed Resident 21 readmitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar levels), heart failure, and muscle weakness. It showed Resident 71 utilized a manual wheelchair for mobility and was able to make needs known. Observation and interview on 02/24/2025 at 12:25 PM, showed Resident 21's wheelchair left armrest had cracked/torn vinyl with exposed beige material underneath (not a cleanable surface). Resident 21 stated the left armrest was rough to the touch and they would not put their arm on the armrest if they did not have a long-sleeved shirt on. Resident 21 stated staff had seen them in their wheelchair; however, they had not offered to fix or replace the armrest. During an interview on 02/27/2025 at 12:15 PM, Staff H, Registered Nurse (RN), stated Resident 21's wheelchair left armrests were cracked/torn, rough to the touch, and was not a cleanable surface. Staff H stated Resident 21's wheelchair issue was not logged from 01/02/2025 through 02/27/2025 in the 300 and 400 hall maintenance binder log and should have been. Staff H stated the armrest needed to be fixed or replaced. During an interview on 02/27/2025 at 12:30 PM, Staff A, Administrator, stated Resident 21's wheelchair left armrest was cracked/torn, rough to the touch, and not a cleanable surface. Staff A stated Resident 21's wheelchair issue was not logged in the maintenance book and should have been. Staff A stated Resident 21's wheelchair condition did not meet expectations. Resident 72 Review of the EHR showed Resident 72 readmitted to the facility on [DATE] with diagnoses to include diabetes, heart failure, and muscle weakness. It showed Resident 72 utilized a manual wheelchair for mobility and was able to make needs known. Observation and interview on 02/24/2025 at 11:40 AM showed Resident 72's wheelchair right armrest had cracked/torn vinyl with exposed beige material underneath (not a cleanable surface) and the left armrest was not stable when Resident 72 placed their arm or hand on it (wobbly). Resident 72 stated they had told staff about the wobbly left armrest and the cracked/torn right armrest quite a while ago but did not recall who. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 11:57 AM, Staff H, RN, stated Resident 72's wheelchair right armrest was cracked/torn, rough to the touch, and was not a cleanable surface. Staff H stated Resident 72's left armrest was slightly loose/wobbly and may be missing a screw underneath the armrest. Staff H stated Resident 72's wheelchair issues were not logged from 01/02/2025 through 02/27/2025 in the 300 and 400 hall maintenance binder log and should have been. Staff H stated Resident 72's wheelchair armrests needed to be fixed and/or replaced. During an interview on 02/27/2025 at 12:22 PM, Staff A, Administrator, stated the process was for equipment/wheelchairs with issues were logged in the maintenance book/binder and if needed should be referred to therapy to fix and/or be replace. Staff A stated the condition of Resident 72's wheelchair armrests did not meet expectations. Reference WAC 388-97-0880