STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505326	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Extended Healthcare	1649 East 72nd Tacoma, WA 98404

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to provide risks/benefits and obtain consent for the use of a psychotropic (affecting the mind) medication for 1 of 5 sampled residents (Resident 72) when reviewed for unnecessary medications. This failure placed residents at risk of avoidable side effects, chemical restraint, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 72 admitted to the facility on [DATE] with diagnoses to include fracture of the spine, quadriplegia (inability to move arms and legs), and depression. Resident 72 was able to make needs known. Review of the current provider orders, Feburary 2025, showed Resident 72 received an antidepressant medication. Review of the EHR showed Resident 72 had not been provided risks/benefits for the use of the antidepressant and had not given consent to receive the antidepressant. During an interview on 02/12/2025 at 1:03 PM, Staff K, Staff Development /Licensed Practical Nurse (SD/LPN), stated when a resident admitted to the facility with an order for an antidepressant the facility would provide risks/benefits and obtain consent for use. Staff K stated Resident 72 received an antidepressant, but the facility had failed to provide risks/benefits and obtain consent for its use. During an interview on 02/12/2025 at 1:26 PM, Staff B, Director of Nursing Services, stated when a resident admitted to the facility with an order for an antidepressant the facility would provide risks/benefits and obtain consent for use. Staff B stated they could not locate a consent for the use of an antidepressant for Resident 72. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to initiate, investigate, and resolve a grievance for 1 of 4 sampled residents (Residents 67) reviewed for personal property and grievances. This failure placed the residents at risk for emotional distress and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 67 admitted to the facility on [DATE] with diagnoses that included contracture (reduction in movement) of the right hand, muscle weakness, congestive heart failure (condition that happens when your heart is unable to pump blood well enough to give your body a normal supply) and chronic kidney disease (condition where the kidneys are damaged and unable to filter blood). Resident 67 was able to make needs known. During an interview on [DATE] at 11:55 PM, Resident 67 stated they were unhappy staff came into their room that morning and threw away multiple condiments purchased by a family member. Review of a progress noted, dated [DATE], showed two staff removed all open and expired food products from Resident 67's room. Resident 67 was provided a copy of the facility food policy but stated they did not agree with the policy. During an interview on [DATE] at 10:35 AM Resident 67 stated they did not recall receiving the facility food policy prior to the disposal of their items. Review of the grievance log for February 2025 showed no grievances filed for Resident 67 related to the food items. During an interview on [DATE] at 12:32 PM Staff A, Administrator, stated the expectation was that staff would initiate a grievance for concerns expressed by residents. Reference WAC [DATE]

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to conduct an assessment for the use of a low bed for 1 of 1 sampled resident (Residents 39) reviewed for use of physical restraints. This failure placed the resident at risk for injury, unmet needs and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 39 was admitted to the facility on [DATE] with diagnoses to include hemiplegia (complete loss of strength or paralysis on one side of the body) and hemiparesis (mild loss of strength in a leg, arm, or face). Resident 39 was assessed to be a fall risk and required the assistance of staff for mobility. Observation on 02/10/2025 at 11:09 AM and 02/11/2025 at 1:54 PM showed Resident 39 in their room lying on a bed that was lowered to the floor. Review of Resident 39's care plan showed an intervention place bed in low position initiated on 08/27/2022. During an interview on 01/28/2025 at 10:19 AM, Staff B, Director of Nursing Services, stated a low bed could be considered a restraint and needed to have consent, assessment, order and care plan. Staff B stated the lack of this on the above-mentioned resident did not meet expectations. Reference WAC 388-97-0620

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to identify and investigate allegations of abuse/neglect for 1 of 7 sampled residents (Resident 56) when reviewed for abuse/neglect. This failure placed the resident at risk of continued abuse/neglect and a diminished quality of life. Findings included . Review of a facility policy titled, Abuse Investigation and Reporting, dated July 2017, showed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Review of the quarterly minimum data set assessment (MDS), an assessment tool, dated 08/08/2024, showed Resident 56 admitted on [DATE] with multiple diagnoses to include muscle weakness, anxiety and depression. The MDS showed Resident 56 was able to make needs known and was dependent on staff for activities of daily living. During an interview on 02/07/2025 at 11:05 AM, Resident 56 stated a couple weeks ago, during a night shift, a Certified Nurse's Aide (CNA) had provided rough care to them, and they felt like they were being man handled. Resident 56 stated they reported the incident, and the CNA was no longer working at the facility. Resident 56 stated they were satisfied that the aide was let go after the rough handling; however, a couple days later during similar care by two other facility CNAs an aide stated, You know you got that CNA fired, don't you? Resident 56 stated they felt like they were being retaliated against because they reported the rough treatment. Resident 56 stated they reported this CNA's comment to another facility staff (Staff C, CNA) later in the day but did not know whether it (retaliation comment) was addressed or not. During an interview 02/11/2025 at 9:27 AM, Staff D, CNA, stated Resident 56 had made a comment to them that they (Resident 56) felt they were being retaliated against after the CNA who had provided them rough treatment was fired. Staff C stated they did not think much of the resident's comment because they recalled the resident did not want to keep this going. Staff C stated they were a mandated reporter and the resident's comment of retaliation was not reported up the chain. During an interview on 02/11/2025 at 9:42 AM, Staff D, Licensed Practical Nurse/Care Coordinator, stated the comment Resident 56 made regarding the potential retaliation was a reportable event and should have been reported so a thorough investigation could be conducted. During an interview on 02/11/2025 at 9:51 AM, Staff B, Director of Nursing Services, stated the comment Resident 56 made regarding retaliation was a reportable event and should have been reported by Staff C and investigated due to potential psychosocial harm. Reference WAC 388-97-0640(5)(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46067 Based on interview and record review, the facility failed to provide written notification of the reason for hospital transfer to the resident or responsible party for 1 of 3 sampled residents (Resident 291) reviewed for hospitalization . This failure placed the resident at risk for not knowing rights regarding transfer and discharge from the facility and diminished protection from been inappropriately discharged . Findings included . Review of the electronic health record (EHR) showed Resident 291 admitted to the facility on [DATE] with diagnoses that included polyneuropathy (nerve disorder that affects multiple nerves) and bipolar disorder (condition that causes extreme mood swings). Resident 291 was able to make needs known. Review of Resident 291's EHR showed a transfer to the hospital on 02/08/2025. The EHR did not show documentation a notice of transfer was provided to Resident 291 or their representative. During an interview on 02/13/2025 at 12:12 PM, Staff B, Director of Nursing Services, stated Resident 291 or their resident representative did not receive a written notice of transfer as they should have. Staff B stated nursing should have provided notice upon transfer. During an interview on 02/13/2025 at 12:19 PM, Staff A, Administrator, stated the expectation was that residents received written notification at the time of transfer. Reference WAC 388-97-0120 (2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide written bed hold notice at the time of transfer to the hospital for 1 of 3 sampled residents (Resident 291) reviewed for hospitalization . This failure placed the residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 291 admitted to the facility on [DATE] with diagnoses that included polyneuropathy (nerve disorder that affects multiple nerves) and bipolar disorder (condition that causes extreme mood swings). Resident 291 was able to make needs known. Review of Resident 291's EHR showed a hospitalization on [DATE]. The EHR did not show documentation or progress notes that a bed hold was offered to the resident. During an interview on 02/13/2025 at 12:16 PM, Staff R, Business Office Manager, stated the Resident 291 or their resident representative was not offered a bed hold. During an interview on 02/13/2025 at 12:19 PM, Staff A, Administrator, stated the expectation was that bed holds were done at the time of the resident transfer or within 24 hours. Reference WAC 388-97-0120 (4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to accurately complete the comprehensive assessment for 3 of 21 sampled residents (Residents 79, 18, and 88) when reviewed for accuracy of comprehensive assessment. This failure placed residents at risk of not receiving needed care, a decline in ability, and a diminished quality of life. Findings included . Resident 79 Review of the electronic health record (EHR) showed Resident 79 admitted to the facility on [DATE] with diagnoses of chronic ulcer of the left thigh and diabetes. Resident 79 was able to make needs known. Review of the admission minimum data set assessment (MDS), an assessment tool, dated 12/31/2024, showed Resident 79 had two pressure ulcers which were not present on admission. During an interview on 02/12/2025 at 12:56 PM, Staff K, Staff Development /Licensed Practical Nurse (SD/LPN), stated Resident 79 admitted to the facility with two pressure ulcers and did not acquire any while in the facility. Staff K stated Resident 79's admission MDS, dated [DATE], was inaccurate. During an interview on 02/12/2025 at 1:24 PM, Staff B, Director of Nursing Services (DNS), stated all MDS assessments should be accurate. Staff B stated Resident 79's admission MDS was inaccurate, and this did not meet expectation. 49926 Resident 18 Review of the EHR showed Resident 18 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (condition where the kidney reaches advanced state of loss of function), acute respiratory failure (condition that results from inadequate gas exchange by the respiratory system), chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe) and cirrhosis (scarring) of the liver. Resident 18 was able to make needs known Observation and interview on 02/07/2025 at 11:03 AM showed Resident 18 sat in the bed using oxygen with multiple broken teeth. Resident 18 stated, My teeth are broken, and the staff are not doing anything about it. Resident 18 stated they used the oxygen, and it made it easier to breathe. Review of the clinical admission note, dated 01/25/2025, showed Resident 18 had broken natural teeth. Review of the admission MDS, dated [DATE], showed Resident 18 had no broken teeth, no natural teeth, and no obvious cavity or broken natural teeth. Review showed Resident 18 did not use oxygen. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 88 Review of the EHR showed Resident 88 was readmitted to the facility on [DATE] with diagnoses to include multiple sclerosis (disease in which the immune system eats away at the protecting covering of the nerves, resulting in damage in the communication between brain and the body), dementia (disease that affect memory, thinking, and the ability to perform daily activities) and hospice (care provided at end of life) services. Review of the EHR showed Resident 88 discharged home on 11/12/2024. Review of the significant change/discharge MDS, dated [DATE], showed Resident 88 had an unplanned discharge in section A0310F. During an interview on 02/11/2025 at 1:48 PM, Staff U, MDS Nurse, stated the MDS was coded inaccurately for Residents 18 and 88 and needed to be modified. During an interview on 02/13/2025 at 9:00 AM, Staff B, Director of Nursing Services, stated Residents 18 and 88's MDS coding did not meet expectations. Reference WAC 388-97-1000(1)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed conduct timely care planning meetings with residents or responsible party for 1 of 2 sampled residents (Residents 31) reviewed for care planning. These failures placed residents at risk for unmet needs, care not provided as directed, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 31 readmitted to the facility on [DATE] with diagnoses to include respiratory failure (condition in which your blood doesn't have enough oxygen), paraplegia (paralysis or loss of ability to move legs) and depression. Resident 31 was able to make needs known and was dependent on staff for activities of daily living. During an interview on 02/11/2025 at 11:21 AM, Resident 31 stated they did not recall having a recent care conference. Review of the EHR showed Resident 31 was last offered a care conference on 06/08/2024. During an interview on 02/12/2025 at 2:59 PM, Staff S, Social Service Director, stated they could not locate the date of Resident 31's last care conference. Staff S stated this did not meet expectations as care conferences should be held quarterly. During an interview on 02/11/2025 at 12:05 PM, Staff A, Administrator, stated the expectation was that care conferences were to be offered every three months. Reference WAC 388-97-1020(2)(c)(d)

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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** 49926 Based on interview and record review, the facility failed to ensure the discharge summary was completed and included recapitulation (overview) of the residents stay, a final summary of the resident's status, and the resident and/or their representative signature for 1 of 3 sampled residents (Resident 88) reviewed for discharge. This failure placed the resident at risk for unsafe discharge, complications and diminished quality of life. Findings included . Review of policy titled Discharge Summary and Plan, revised December 2016, showed 1. When the facility anticipates a resident's discharge [.] a discharge summary and a post-discharge plan will be developed [.]. Review of the electronic health record (EHR) showed Resident 88 was readmitted to the facility on [DATE] with diagnoses to include multiple sclerosis (disease in which the immune system eats away at the protecting covering of the nerves, resulting in damage in the communication between brain and the body), dementia (disease that affects memory, thinking, and the ability to perform daily activities) and hospice (care provided at end of life) services. Review of the EHR showed Resident 88 discharged home on 11/12/2024, and there was no discharge summary completed with instructions describing post discharge care. During an interview on 02/11/2025 at 12:21 PM, Staff T, Licensed Practical Nurse, stated the planned discharge process should be completed by the nurse manager and the floor nurse should gather the medications for discharge. During an interview on 02/13/2025 at 8:53 AM, Staff B, Director of Nursing Services, stated Resident 88 did not have the summary completed and that did not meet expectation. Reference WAC 388-97-0080(7)(a-b)

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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 to ensure correct positioning for 1 of 5 sampled residents (Resident 17) 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 4 sampled residents (Residents 4 and 82) reviewed for bowel protocol. These failures placed the residents at risk for worsening conditions, discomfort, and a decreased quality of life. Findings included . <Position/Mobility> Resident 17 Review of the quarterly minimum data set (MDS), a required assessment tool, dated 01/06/2025, showed Resident 17 admitted on [DATE] with multiple diagnoses to include heart and lung disease, diabetes, anxiety, depression, and muscle weakness. The electronic health record (EHR) showed Resident 17 had a stroke, had a contracture (tightening or lose of movement) of muscle to the left ankle/foot, was able to make their needs known and was dependent of staff for activities of daily living (ADLs). Review of Resident 17's focus care plan, dated 05/01/2024, for activities of daily living showed the resident required assistance with ADLs. Interventions included Licensed Nurses (LNs) and Certified Nurse Aides (CNAs) were to monitor, document and report, when necessary, any changes in self-care performance, declines in ability or refusal of care and decline in function. An additional intervention included for staff to apply a Prevalon (a device worn on the resident's foot that floats the heel off the surface on the mattress) boot to the left foot and to be on while in bed. During an interview and observation on 02/07/2025 at 10:59 AM, Resident 17 stated they (facility) were supposed to get them a splint for their elbow and a boot for their foot, but they never got one or had worn one. No Prevalon boot or elbow splint was observed to be worn by the resident nor observed to be present in the resident's room. Review of Resident 17's providers order, dated 10/24/2024, showed the provider had ordered a referral to a local orthotics (a branch of medicine that deals with the provision and use of artificial devices such as splints and brace), for a left upper extremity contracture and would benefit from an elbow extension splint. During an interview on 02/11/2025 at 12:47 PM, Staff H, Licensed Practical Nurse (LPN), stated they did not have any orders for Resident 17 to wear a boot or splint. During an interview on 02/11/2025 at 12:48 PM, Staff D, LPN/Care Coordinator (LPN/CC), stated if there was an order for the resident get a referral (to orthotics), medical records staff would receive that order and they were to call to get an appointment. (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 02/11/2025 at 12:44 PM, Staff V, Medical Records, stated they had received the order but they were unsure the resident's representative had refused or not due to the expense or lack of insurance. Staff V stated they would call again to get the referral if the resident still wanted to go. Review of Resident 17's EHR showed no documentation of refusal for the orthotics referral. During an interview on 02/11/2025 at 1:41 PM, Staff B, Director of Nursing (DNS), stated they had been trying to get residents in for an orthotics appointment, but it was difficult; however, Staff B stated their expectation would be for the medical records staff to continue to reach out and connect with this orthotics provider or call another one if necessary. 49926 <Bowel Management> Review of a policy titled, Bowel Protocol, undated, showed, The policy is that bowel protocol is initiated when a resident does not have a bowel movement by the end of the 3rd shift on the 3rd day following their previous bowel movement. Resident 4 Review of the EHR showed Resident 4 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (progressive disease that destroys memory and other mental functions), heart failure and chronic pain. Resident 4 was not able to communicate needs. Review of the bowel record showed Resident 4 had no bowel movements documented for 01/18/2025, 01/19/2025, 01/20/2025 and 01/21/2025. Review of the January 2025 medication administration record (MAR) showed no documentation for medication administered for constipation per the bowel protocol policy. Resident 82 Review of the EHR showed Resident 82 was admitted to the facility on [DATE] with diagnoses to include cirrhosis (scaring) of the liver, abdominal bleeding and heart failure. Resident 82 was able to make needs known. Review of the bowel record showed Resident 82 had no bowel movements documented on the dates 01/24/2025 through 01/28/2025 (four days) and 01/30/2025 through 02/07/2025 (nine days). Review of the January and February 2025 MARs showed no documentation of laxative (relieving constipation) medications administered per the bowel protocol policy. During an interview on 02/12/2025 at 11:18 AM, Staff D, LPN/CC, stated the facility should have documented the bowel protocol, and should have asked Resident 82 about their bowels. (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 02/12/2025 at 12:57 PM, Staff B, DNS, stated the facility had a bowel protocol and Resident 4 and 82's bowel management documentation did not meet expectation. Reference WAC 388-97-1060(1)(2)(3)(b)(c)

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	505326	A. Building B. Wing	02/13/2025

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Heartwood Extended Healthcare	1649 East 72nd Tacoma, WA 98404

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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** 46067 Based on observation, interview, and record review, the facility failed to ensure care and services to ensure residents increased or maintained range of motion (ROM) were provided for 1 of 5 sampled residents (Resident 67) reviewed for position, range of motion/mobility. This failure placed the residents at risk for worsening mobility, developing of contractures (permanent tightening of muscle, tendons and skin, leading to deformity), and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 67 admitted to the facility on [DATE] with diagnoses that included contracture of the right hand (reduced range of motion), muscle weakness, congestive heart failure (condition that happens when your heart is unable to pump blood well enough to give your body a normal supply) and chronic kidney disease (condition where the kidneys are damaged and unable to filter blood). Resident 67 was able to make needs known. Observation and interview on 02/12/2025 at 9:29 AM showed Resident 67 laid in bed with their right fingers slightly bent. Resident 67 stated they had been waiting on a splint to be ordered but had not heard anything from therapy. Review of a provider note, dated 11/22/2025, showed, Referral for resting hand splint. Patient educated on resting hand open palm down and to perform hand/finger exercises to prevent contracture from worsening. Review of Resident 67's care plan showed no interventions for a restorative nursing program for splint/brace assistance. During an interview on 02/12/2025 at 12:39 PM, Staff W, Restorative Nursing Aide, stated Resident 67 was not receiving services for splint assistance. During an interview on 02/13/2025 at 10:27 AM, Staff D, Licensed Practical Nurse/Care Coordinator, stated nursing staff should have followed up on the referral but did not. During an interview on 02/13/2025 at 12:03 PM, Staff B, Director of Nursing Services, stated the expectation was that the referral would have been followed up on in a timely manner. Reference WAC 388-97-1060 (3)(d)

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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** 40817 Based on observation, interview, and record review, the facility failed to ensure resident environments were free from accident hazards for 1 of 3 sampled shower rooms (200 Hall) and failed to ensure fall interventions were implemented for 1 of 1 sampled residents (Resident 67) reviewed for accident hazards. These failures placed residents at risk of having access to dangerous items, repeated falls, and a diminished quality of life. Findings included . Observations on 02/07/2025, 02/11/2025, and 02/12/2025 showed the shower room on the 200 Hall was unlocked. Observation showed inside the shower room was an electric razor, disposable razors, and nail clippers. During an interview on 02/12/2025 at 12:33 PM, Staff P, Registered Nurse, stated electric razors, disposable razors, and nail clippers were locked in the medication cart as residents were not to have access to these items. Staff P stated the 200 Hall shower room door was unlocked and these items were unsecured within the shower room. During an interview on 02/12/2025 at 2:12 PM, Staff B, Director of Nursing Services (DNS), stated electric razors, disposable razors, and nail clippers should be locked in a cupboard in the shower room. Staff B stated the door to the 200 Hall shower room was unlocked and the electric razor, disposable razors, and nail clippers were unsecured within. Staff B stated this did not meet expectation. 46067 Resident 67 Review of the electronic health record (EHR) showed Resident 67 admitted to the facility on [DATE] with diagnoses that included contracture of the right hand, muscle weakness, congestive heart failure (condition that happens when your heart is unable to pump blood well enough to give your body a normal supply) and chronic kidney disease (condition where the kidneys are damaged and unable to filter blood). Resident 67 was able to make needs known. Review of Resident 67's care plan showed the Resident was at risk for falls due to impaired balance and impaired mobility. Review of a provider's note dated 12/16/2024 showed Resident was a high fall risk. - Contributing factors: poor safety awareness, generalized weakness, vision, postural blood pressure. Fall mat ordered for side of bed and bed to be placed in low and locked position. Observation from 02/07/2025-02/12/2025 showed Resident 67's bed was not in the low or locked position and there was no fall mat on either side of the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2025 at 10:27 AM, Staff D, Licensed Practical Nurse Care Coordinator, stated nursing staff should have followed up on the provider's recommendation, but did not. During an interview on 02/13/2025 at 12:03 PM, Staff B, DNS, stated the expectation was that the provider recommendation would have been implemented. Reference WAC 388-97-1060(3)(g)

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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** 46067 Based on interview and record review, the facility failed to ensure the facility's Registered Dietician's (RD) recommendations were administered as ordered for 1 of 5 sampled residents (Resident 31) and ensure fluid restrictions were followed for 2 of 5 sampled residents (Residents 18 and 82) when reviewed for nutrition/hydration. This failure placed the residents at risk for unmet nutritional needs, dehydration, medical complications, and continued weight loss. Findings included . Review of the electronic health record (EHR) showed Resident 31 readmitted to the facility on [DATE] with diagnoses to include respiratory failure (condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), paraplegia (paralysis or loss of ability to move legs) and depression. Resident 31 was able to make needs known and was dependent on staff for activities of daily living. Review of a quarterly nutrition note, dated 12/17/2024, from the RD showed Resident 31 had significant weight loss of 10%. RD recommended Arginaid (powdered drink supplement) two times a day and Medpass 2.0 (nutrition supplement) three times a day. Review of the EHR showed a provider's order, dated 12/16/2024, for Arginaid two times a day for supplement, mix with 6 oz to 8 oz of fluids. The EHR did not show a provider's order for Medpass 2.0. Review of Resident 31's January 2025 and February 2025 medication administration records (MARs) showed the Arginaid was not administered in January 2025 and was not administered until 02/11/2025. During an interview on 02/12/2025 at 2:38 PM, Staff B, Director of Nursing Services, stated the expectation was the providers orders were implemented as recommended and the Arginaid should have been administered as ordered and documented on the MAR. 49926 Review of the facility policy titled, Encouraging and Restricting Fluids, revised in October 2010, showed Record the amount of fluid consumed [.]. Resident 18 Review of EHR showed Resident 18 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (condition where the kidney reaches advanced state of loss of function), acute respiratory failure (condition that results from inadequate gas exchange by the respiratory system), chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe), and cirrhosis (scarring) of the liver. Resident 18 was able to make needs known. Observation and interview on 02/07/2025 at 11:11 AM showed Resident 18 sat on their bed in their room. Resident 18 stated they were on fluid restriction of 1500 milliliters (ml) per day because of their kidney failure and heart failure, and they were four liters over. (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 January 2025 and February 2025 medication administration record (MAR) showed an order for fluid restriction of 1500 ml but did not show the amount of ml Resident 18 received. Review of the care plan, dated 11/06/2024, did not show Resident 18 had a fluid restriction. Resident 82 Review of the EHR showed Resident 82 was admitted to the facility on [DATE] with diagnoses to include cirrhosis (scarring) of the liver, abdominal (stomach) bleeding and heart failure. Resident 82 was able to make needs known. Review of the January 2025 MAR showed an order for a fluid restriction of 1500 ml per day but did not show the amount of ml Resident 82 received. During an interview on 02/12/2025 at 11:18 AM, Staff D, Licensed Practical Nurse/Care Coordinator, stated the process was to have an order and the licensed nurses would document the amount of ml consumed every shift. Staff D was not able to locate where the documentation was for the 1500 ml per day fluid restriction for Residents 18 and 82. During an interview on 02/12/2025 at 12:59 PM, Staff B, Director of Nursing Services, stated the fluid restriction documentation for Residents 18 and 82 should have been documented in a measurable amount, and currently did not meet expectation. Reference WAC 388-97-1060(3) (h-i)

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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** 49926 Based on observation, interview, and record review, the facility failed to have order and monitor oxygen services to meet professional standards for 1 of 2 sampled residents (Resident 18) reviewed for respiratory services. This failure placed the resident at risk for oxygen toxicity, injury, infection and diminished quality of life. Findings included . Review of policy titled, Oxygen Administration, revised October 2010, showed 1. Verify that there is a physician's order for this procedure [.] 2. Review the resident's care plan [.]. Review of electronic health record (EHR) showed Resident 18 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (condition where the kidney reaches advanced state of loss of function), acute respiratory failure (condition that results from inadequate gas exchange by the respiratory system), chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe) and cirrhosis (scarring) of the liver. Resident 18 was able to make needs known. Observation and interview on 02/07/2025 at 11:16 AM showed Resident 18 sat on a bed in their room with oxygen tubing on their face. Resident 18 stated they used the oxygen, and it made it easier to breathe. Review of the EHR showed Resident 18 had no provider's orders for the use of the oxygen, and there was no care plan that directed staff about using oxygen. During an interview on 02/12/2025 at 11:27 AM, Staff D, Licensed Practical Nurse/Care Coordinator, stated oxygen services should be provided per provider's orders, should be monitored each shift, and should be care planned. During an interview on 02/13/2025 at 9:00 AM, Staff B, Director of Nursing Services, stated Resident's 18 oxygen services did not meet expectations. Reference WAC 388-97-1060(3)(j)(vi)

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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** 34567 Based on interview and record review, the facility failed to ensure staff conducted pain assessments for 1 of 3 sampled residents (Resident 9) who received an as necessary pain medication (oxycodone, a narcotic pain medication used to treat moderate to severe pain) when reviewed for pain management. This failure had the potential for the residents to not receive the necessary pain medication as ordered, a diminished quality of life and unmet needs. Findings included . Review of a document titled, Pain Assessment and Management, dated October 2022, showed the purpose of the procedures were to help the staff identify pain in the resident, and to develop interventions consistent with the residents that addressed the underlying causes of pain. The pain management program was based on facility-wide commitment to an appropriate assessment and treatment of pain, on professional standards of practice, and the comprehensive care plan. The facility staff were to assess the resident's pain and to use a consistent approach and standardized pain assessment instrument appropriate to the resident's cognitive level. Review of Resident 9's admission minimum data set (MDS), a required assessment tool, dated 01/06/2025, showed the resident admitted on [DATE] with multiple health conditions including chronic pain, spinal stenosis (a narrowing of the spaces in the spinal column that puts pressure on the spinal cord and nerve roots), bipolar (a mental health condition characterized by extreme mood swings between periods of elevated mood and depression), muscle weakness, anxiety and depression. The MDS showed the resident was dependent on staff for assistance with activities of daily living and was able to make their needs known. Review of Resident 9's care plan, dated 01/02/2025, showed the resident had a potential or actual chronic pain by how the resident described pain or how nonverbal resident exhibited signs of pain. Interventions included staff to conduct pain assessments. Review of a document titled, Pain Assessment Interview, dated 01/09/2025, showed Resident 9 was last evaluated by Licensed Nurse (LN) and documented the resident indicated verbally their pain was described as moderate, no signs of non-verbal or facial expressions of pain were observed by staff and no pain intensity scale was documented which indicated a 0 score no pain to 10 as the worst pain imagined. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's January and February 2025 medication administration record (MAR) showed multiple provider orders for pain medications to be administered by the LNs that included oxycodone for pain. The oxycodone orders throughout the month of January and February 2025 were as follows: Providers ordered 01/02/2025 and discontinued 01/28/2025 oxycodone 5 milligrams (mg) every 4 hours (hrs.) as needed for pain, providers order 01/28/2025 and discontinued 01/28/2025 to administer 5 mg every 4 hrs. and give 5 mg every 6 hrs. as needed for pain. On 01/28/2025 the oxycodone order was changed again for the LN to administer 5 mg as needed every 6 hrs. On 01/28/2025 the provider changed the oxycodone order back to just 5 mg every 6 hrs. but was discontinued on 02/03/2025. On 02/03/2025 oxycodone 5 mg was ordered to be administered every 4 hrs. and was discontinued on 02/10/2025. On 02/10/2025 the provider changed the oxycodone order for the LN to administer the narcotic to every 3 hrs. as needed for pain. The orders for oxycodone were shown to be frequently changed by the provider that decreased or shortened the timeframe for the LN to administer the narcotic; however, no additional pain assessment was conducted after the initial pain assessment was completed 01/09/2025. During an interview on 02/13/2025 at 9:08 AM, Staff B, Director of Nursing Services, stated it was their expectation the residents care managers (RCMs) conducted pain assessments; however, the facility was currently short of RCMs and they changed the requirement for the staff LNs, who administered the pain medication, to conduct the on-going pain assessments as directed. Reference WAC 388-97-1060 (1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on interview and record review, the facility failed to provide dialysis (a process to remove waste from blood) care consistent with professional standards for 1 of 1 sampled resident (Resident 18) when reviewed for dialysis care. This failure placed the resident at risk for receiving substandard dialysis care, injury, infection and diminished quality of life. Findings included . Review of the policy titled, Hemodialysis Access Care, revised September 2010, showed The general medical nurse should document in the resident's medical record every shift as follows: 1) Location of catheter 2) Conditions of dressing 3) If dialysis was done during the shift 4) Any part of report from dialysis nurse post-dialysis being given 5) Observations post-dialysis Review of electronic health record (EHR) showed Resident 18 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (condition where the kidney reaches advanced state of loss of function), acute respiratory failure (condition that results from inadequate gas exchange by the respiratory system), chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe) and cirrhosis (scarring) of the liver. Resident 18 was able to make needs known. Interview on 02/07/2025 at 11:11 AM Resident 18 stated they went to dialysis every Saturday, Tuesday, and Thursday, and they took a binder with them to communicate between their care teams. Review of the care plan, initiated on 11/06/2024, with focus area of hemodialysis showed interventions to include maintain dialysis flowsheet post-dialysis. Review of the EHR showed one post-dialysis evaluation completed on 02/13/2025 and 3 pre-dialysis evaluations completed on 02/08/2025, 02/11/2025 and 02/13/2025. During an interview on 02/12/2025 at 1:00 PM, Staff D, Licensed Practical Nurse/Care Coordinator, stated the process was for the nurses to complete pre- and post-dialysis evaluations and if the communication form was not entirely completed nurses were to call the dialysis center. Review of the dialysis binder with Staff D on 02/12/2025 showed the 02/11/2025 flow sheet. Staff D stated that this did not meet expectations. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/2025 at 9:11 AM, Staff B, Director of Nursing Services, stated Resident's 18 dialysis care did not meet expectations. Reference WAC 388-97-1900(1)(6)(a-c)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34567 Based on observation, interview, and record review, the facility failed to post the actual nursing staffing hours daily for 30 of 30 days when reviewed for nurse staff posting. This failure prevented the residents, family members, and visitors from exercising their rights to know the actual numbers of available nursing staff in the facility. Findings included . Review of a policy titled, Posting Direct Care Daily Staffing Numbers, dated August 2022, showed the facility would post daily for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The information recorded on the form would include the following: the name of the facility, the actual time worked during that shift for each category and type of nursing staff. Observation and record review on 02/13/2025 at 8:45 AM showed the nursing staff posting, located in the facility's main hallway area, was dated 02/13/2025, did not document the name of the facility, nor the actual adjustments were documented that reflected the nursing staff absences on each shift due to call-offs, illness or show that it was being reconciled to show actual hours worked. The documents reviewed for the past 30-day staff posting showed no calculated totals or actual hours was documented. During an interview on 02/13/2025 at 12:21 PM, Staff E, Staffing Coordinator (SC), stated they were unaware that they needed to post the actual hours worked for the nursing staff daily. During an interview on 02/13/2025 at 12:24 PM, Staff A, Administrator, stated it was their expectation the staffing coordinator post the nursing staff actual hours worked on the document. No reference WAC

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to ensure an as needed or as the situation demands (PRN) psychotropic medication (drugs that affect the brain and central nervous system, that alter mood, thoughts, emotions and behavior) was limited to 14 days for 1 of 5 sampled residents (Resident 9) when reviewed for unnecessary medications. This failure had the potential to place the resident at risk for increased medical complications and decreased quality of life. Findings included . Review of a policy titled, Psychotropic Medication Use, dated July 2022, showed psychotropic medications were not to be prescribed or given on a PRN basis unless that medication was necessary to treat a diagnosed specific condition that was documented in the clinical record. Psychotropic orders were limited to 14 days and if psychotropic medications were prescribed and the attending provider believed that it was appropriate to extend the PRN order beyond 14 days a rationale was to be documented and the appropriateness for extending the use and included the duration for the PRN order. Review of Resident 9's admission minimum data set (MDS), a required assessment tool, dated 01/06/2025, showed the resident admitted on [DATE] with multiple health conditions including chronic pain, spinal stenosis (a narrowing of the spaces in the spinal column that puts pressure on the spinal cord and nerve roots), bipolar (a mental health condition characterized by extreme mood swings between periods of elevated mood and depression), anxiety, and depression. The MDS showed the resident was dependent on staff for assistance with activities of daily living and was able to make needs known. Review of Resident 9's current Feburary 2025 care plan showed the resident had a decline in mood due to anxiety and multiple interventions were for staff to monitor, document and evaluate the resident's anxiety and to encourage the use of PRN medication to alleviate symptoms. The pharmacy was to review the medication regimen as necessary and psychotropic committee was to review as indicated. Review of Resident 9's electronic health record (EHR) showed an order for clonazepam (a psychotropic medication used to treat anxiety), dated 01/28/2025, to be administered every 8 hours as needed with no end date; ordered as indefinite. No additional rationale was noted in the EHR by the provider to extend the medication beyond 14 days. During an interview on 02/13/2025 at 9:08 AM, Staff K, Staff Development/Licensed Practical Nurse, stated they were unaware of Resident 9's PRN psychotropic medication (clonazepam) was ordered greater than 14 days, but would check with the provider to see if there was a rationale to extend the order. During an interview on 02/13/2025 at 10:22 AM, Staff B, Director of Nursing Services, stated their expectation would be for the provider to document a rationale for extending the psychotropic greater than 14 days as needed. Reference WAC 388-97-1060 (3)(k)(i)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to provide routine dental services for 1 of 3 sampled residents (Resident 18) when reviewed for dental services. Failure to provide routine dental services placed the resident at risk for infection, pain, decrease ability to eat and diminished quality of life. Findings included . Review of electronic health record (EHR) showed Resident 18 was admitted to the facility on [DATE] with diagnoses to include acute respiratory failure (condition that results from inadequate gas exchange by the respiratory system) and chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe). Resident 18 was able to make needs known. Observation and interview and on 02/07/2025 at 11:03 AM, showed Resident 18 with multiple broken teeth. Resident 18 stated, My teeth are broken, and the staff are not doing anything about it. Review of the care plan, dated 11/06/2024, showed Resident 18's broken teeth were not included. Review of the clinical admission note, dated 01/25/2025, showed Resident 18 had broken natural teeth. Review of the Nutrition Evaluation Form, e-signed on 02/04/2025, showed Resident 18 had obvious cavities and/or broken teeth. During an interview on 02/12/2025 at 11:25 AM, Staff D, Licensed Practical Nurse/Care Coordinator, stated staff should make a dental appointment and the oral status should be addressed in the care plan. During an interview on 02/13/2025 at 9:00 AM, Staff B, Director of Nursing Services, stated Resident's 18 dental care/services did not meet expectations. Reference WAC 388-97-1060 (3)(j)(vii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505326	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Extended Healthcare	1649 East 72nd Tacoma, WA 98404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to ensure staff: consistently applied Personal Protective Equipment (PPE) in accordance with the Enhanced Barrier Precautions/Transmission Based Precaution (EBP/TBP, implement precautions based on the means of transmission in order to prevent or control infection) signs posted outside of resident rooms for 1 of 3 sampled residents (Resident 47) and consistently ensure respiratory care equipment (an aerosol machine and oxygen tubing) were stored in a clean and sanitary manner for 1 of 2 sampled residents (Resident 18) when reviewed for infection control. These failures placed residents and staff at risk for contracting and/or spreading infections and a decreased quality of life. Findings included . Review of a document titled, Personal Protective Equipment - Using Gowns, dated September 2010, showed gowns were to be used to prevent the spread of infections, soiling of clothing with infectious material, and to prevent splashing or spilling blood or body fluids onto clothing or exposed skin. <Transmission Based Precautions> Review of the quarterly minimum data set (MDS), an assessment tool, dated 10/15/2024, showed Resident 47 admitted on [DATE] with multiple diagnoses to include anoxic brain damage (occurs when the brain is completely deprived of oxygen, which leads to brain cell death), obstructive uropathy (a condition where the flow of urine is blocked causing urine to back up into the kidneys), dysphagia (swallowing difficulties) and had a percutaneous endoscopic gastrostomy tube (PEG, a thin flexible tube inserted through the skin of the abdomen directly into the stomach to provide nutrition, fluids and medicine). The electronic health record (EHR) showed the resident had a disturbance of their salivatory secretions (a condition where the salivary glands did not produce saliva normally and/or produced too much saliva) and was dependent on staff for activities of daily living (ADLs). Review of Resident 47's providers order, dated 10/28/2024, showed an order for staff to use EBP related to the resident's PEG and a foley catheter (a thin flexible tube inserted into the urethra and bladder to drain urine). Review of the EHR showed several provider orders for staff to provide the resident oral care every shift, flush the PEG tube four times a day for medication administration and to flush the resident's foley catheter every shift with renacidin (a sterile irrigation solution used to remove kidney stones and aids in the prevention of encrustations of foley catheters). (continued on next page)

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	505326	A. Building B. Wing	02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 47's focus care plans, dated 11/14/2024, showed EBP related to the resident's indwelling foley catheter, PEG feedings and to use appropriate PPE when entering the resident's room to include gown and gloves when providing high contact resident care. Additional focus care plans showed the resident was at risk for aspiration (breathing in fluid/food) due to their dysphagia diagnosis. Interventions included providing oral care and the licensed nurses (LNs) with the use of a Yankauer (a rigid plastic tube to assist in removing excessive oral secretions) suction device and required a foley catheter related to the resident's obstructive uropathy and to provide catheter care and use contact precautions to prevent urinary tract infections. Observation on 02/07/2025 at 12:16 PM, showed a laminated sign posted at the entrance to Resident 47's room. The signage showed it was a U.S. Department of Health and Human Services / Centers for Disease Control and Prevention sign and was labeled STOP, Enhanced Barrier Precautions. The signage directed providers and staff must wear gloves and a gown for the following high-contact resident care activities including dressing, bathing / showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. In addition, gown and gloves were to be worn for any device care or the use of urinary catheters. Observation on 02/07/2025 at 12:17 AM showed Resident 47 laid in bed within their room. A foley catheter was observed attached draining urine to a collection bag and hung to the lower end bed frame. Staff F, Certified Nurse's Aide (CNA), entered Resident 47's room wearing only a surgical mask and a pair of exam gloves and proceeded to use a plastic portable urinal to collect the urine from the resident's drainage collection bag. After collecting the resident's urine, Staff F walked to the resident bathroom and emptied the urinal in the resident's toilet. During an interview on 02/07/2025 at 12:28 PM, Staff F stated they should have followed the sign posted outside the door to wear gown, but they forgot to do so. Observation on 02/07/2025 at 2:15 PM, showed Staff J, Licensed Practical Nurse (LPN), within Resident 47's room and wore only a face mask and gloves and no hospital gown was observed while they flushed Resident 47's urinary catheter. Observation and interview on 02/10/2025 at 12:56 PM, showed Staff H, LPN, in Resident 47's room and wore only a face mask and gloves and no hospital gown was observed being worn as they provided oral care while they used the Yankauer suction device. Staff H stated they should have worn a hospital gown during the oral care and suctioning of the resident since they were on EBP. During an interview on 02/11/2025 at 9:02 AM, Staff D, LPN/Care Coordinator (CC), stated it was their expectation the LNs and CNAs wore hospital gowns during any direct care for residents on EBP. During an interview on 02/11/2025 at 10:03 AM, Staff G, Infection Preventionist (IP), stated it was their expectation that staff who had direct contact with residents on EBP should wear hospital gowns along with gloves and mask. 49926 <Respiratory Care Equipment> Resident 18 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of EHR showed Resident 18 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (condition where the kidney reaches advanced state of loss of function), acute respiratory failure (condition that results from inadequate gas exchange by the respiratory system), chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe), and cirrhosis (scarring) of the liver. Resident 18 was able to make needs known. Observation and interview on 02/07/2025 at 11:16 AM, showed Resident 18 sat on their bed in their room using oxygen via nasal canula (tubing into the nose). A nebulizer (machine that turns liquid medicine into a mist that can be inhaled) machine and the nebulizer mouthpiece were on the floor next to the bed. Resident 18 stated they used oxygen, and it made it easier to breath. Observation on 02/12/2025 at 2:20 PM, showed Resident 18 sat on their bed and their nasal cannula was on the floor. The portable green tank tubing hung from their wheelchair and was on the floor, and the nebulizer machine and tubing with mouthpiece was on the floor. During an interview on 02/12/2025 at 2:29 PM, Staff D, Licensed Practical Nurse/Care Coordinator, and Staff T, Licensed Practical Nurse, stated the tubing should not be on the floor, and this practice did not meet expectation. During an interview on 02/13/2025 at 9:00 AM, Staff B, Director of Nursing Services, stated tubing should not be on the floor, and that did not meet expectation. Reference WAC 388-97-1320 (2)(b)