STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505339	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Bend Post Acute	219 Cedar Avenue South North Bend, WA 98045

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43642 Based on observation, interview, and record review the facility failed to provide care and services in a manner that maintained and promoted dignity while assisting with meals for 3 of 13 residents (Resident 27, 112, & 57), reviewed for dining observations. This failure placed residents at risk for a diminished self-worth and over-all well-being. Findings included . <Resident 27> Observations during dining services on 02/28/2025 at 12:39 PM showed staff assisting Resident 27 to the dining room for lunch. The staff member stated to the resident, I'll get you a new bib. The staff member was referring to a clothing protector worn during meals. <Resident 112> Observations during dining services on 02/28/2025 at 12:48 PM showed Resident 112 sitting at a table in the dining room waiting for lunch with two other residents at the table. Staff placed Resident 112's lunch tray down in front of the resident and went back to the cart to continue passing trays. Resident 112 started reaching for the lid covering their food, so staff returned to the table and pulled the tray away from the resident, moving it further to the middle of the table. Staff told the resident they would come help them after they finished passing trays and walked away. Resident 112 tried reaching for the tray again and another resident attempted to push it towards Resident 112 to help. A third resident at the table then pulled the tray back away from Resident 112. At 12:52 PM, Resident 112's behavior was changing, and they appeared frustrated as they started to get out of their wheelchair to reach the tray in the middle of the table. Staff came over to help, assisted Resident 112 to sit back down, and went back to passing trays. Staff did not sit down to assist Resident 112 with their lunch until 12:57 PM, almost 10 minutes after the resident was initially given their tray. <Resident 57> (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations during dining services on 02/28/2025 at 12:55 PM showed Resident 57 in the middle of eating their lunch at a table with other residents. An additional resident entered the area and saw Resident 57 sitting where they usually sit for lunch. Staff went over and moved Resident 57, with their tray, to a different table, with no other residents. Resident 57 was facing away from everyone in the dining room while they resumed eating their lunch. The residents from the previous table stated, you did not have to move [them]. In an interview on 03/05/2025 at 2:56 PM, Staff B (Director of Nursing) stated it was important for staff to promote dignity and be respectful of residents needs. Staff B stated it was their expectation staff not call clothing protectors, bibs. Staff B stated staff should sit down and assist a resident with their meal as soon as they place the tray in front of the resident and attempt alternate interventions to avoid interrupting a resident while they are in the middle of eating. REFERENCE: WAC 388-97-0180(1-4). 46479

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43642 Based on interview and record review, the facility failed to thoroughly investigate and resolve grievances identified through a resident council meeting or provide a grievance log entry for 3 (Residents 14, 39, & 24) of 4 sample residents reviewed and 1 (Resident 35) supplemental resident, reviewed for grievances. The failure to thoroughly investigate a grievance and either resolve the resident grievance timely or provide an explanation the grievance could not be resolved placed residents at risk for frustration and a diminished quality of life. Findings included . <Facility Policy> According to the facility's 2025 Resident and Family Grievances policy, the facility would make prompt efforts to resolve resident or family grievances. The facility would acknowledge a complaint or grievance and actively work towards a resolution. <Resident Council Minutes> The 12/30/2024 Resident Council Minutes included an Old Business section that included a resident concern regarding the ceiling in room North 3. A resident asked when it would be fixed. These Minutes' New Business section showed residents asked about the possibility of better bed mattresses during the meeting. The 01/22/2025 Resident Council Minutes showed Resident 35 attended the meeting. These Minutes showed Resident 35 asked about the possibility of implementing an air mattress during the meeting. The Minute's New Business section also showed residents brought up concerns with aides turning off call lights without providing care, residents requesting water be offered every shift, coffee with every meal, and Resident 24 asked about their incontinence pads. Review of the 02/18/2025 Resident Council Minutes under New Business showed Resident 35 still had questions about getting a better mattress. The Minutes showed Resident 39 was missing a pair of black leggings In an interview on 03/05/2025 at 1:00 PM Staff R (Activities Supervisor) stated they facilitated the monthly Resident Council meetings. Staff R stated after each meeting, they reviewed the Minutes, divvied up the concerns that came up by facility department, and presented the concerns to the appropriate department. Staff R stated they reviewed the Old Business at the beginning of each meeting and if residents remained dissatisfied, they moved the item down to New Business. In an interview on 03/05/2025 at 11:40 AM, Resident 35 stated they had a concern related to their mattress. Resident 35 stated they asked repeatedly for an air mattress since admission but did not know if they would be able to get one and were not informed if there was a reason they could not have one. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/05/2025 at 1:25 PM Staff B (Director of Nursing) stated because Resident 35 did not have an appropriate condition such as a risk for skin breakdown, the resident was not eligible for an air mattress. Staff B stated they discussed the matter with Resident 35 when they admitted but did not discuss it further. Staff B stated they were not informed of Resident 35's repeated requests at Resident Council meetings. Staff B stated they, Staff A (Administrator), and Staff R all played a role in notifying residents on the outcome of grievances. <Grievance Log> Review of the facility's Grievance Log from 09/01/2024 through 02/28/2024 showed nothing logged related to Resident 35's repeated concern with an air mattress. The logs showed a 10/21/2024 entry for Resident 14 related to environmental services. The November 2024 Grievance Log listed 13 individual grievances. Of these 13 grievances, there were five grievances logged on 11/26/2024 or later, and none were assigned to a staff member to investigate and none of the five were concluded. The December 2024 Grievance Log listed 11 individual grievances. Of these 11 grievances only one was assigned to a staff member to investigate. For the 11 grievances on the log, none were concluded. The January 2025 Grievance Log listed 11 grievances. Of these 11 grievances, none were assigned to a staff member to investigate. For the 11 grievances on the log, none were concluded. The February 2025 Grievance Log listed five grievances. These grievances did not include Resident 39's concern regarding their missing black leggings. <January 2025 Grievance Forms> Review of the nine available individual grievance forms related to the 11 logged January 2024 grievances showed on each form: no investigator was assigned, no follow up was documented, no resolution date was added, no department assigned, no grievance official's signature was added, no indication was present showing the resident's representative was notified as necessary. Only four forms had an investigator assigned, and only three forms included a follow-up. These three form were signed by their investigators but did not show the date the grievance was resolved. <Resident 14> Review of the 10/21/2024 grievance form showed Resident 14 complained a housekeeper bumped a drawer in their room causing damage to a charging station, two laptop computers, and a tablet computer. The form showed the charging station was replaced, one laptop was easily fixed once it could be charged, and the other laptop and the tablet would be repaired even though unable to substantiate . The grievance form included an attestation for the replacement charger signed by Resident 14 on 11/25/2024. In an interview on 03/05/2025 at 11:20 AM Resident 14 stated their laptop and tablets were not fixed. Resident 14 stated they did not receive much feedback on the status of their broken electronic items, and added they felt the facility kept them out of the loop. Resident 14 stated it was over a month since the facility provided an update. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 39> In an interview on 03/05/2025 at 10:35 AM Resident 39 stated there was no resolution to their missing black leggings. Resident 39 stated they are in process, I guess. In an interview on 03/05/2025 at 2:05 PM Staff A stated the outcomes of grievance investigations should be documented on the grievance form. Staff A stated any explanation to a resident relating to the resolution of, or the facility's inability to resolve a grievance would be documented on the grievance form. Related to the incomplete Grievance Logs from 11/26/2024 through 01/31/2025 and incomplete grievance forms from January 2025, Staff A stated the facility identified at the end of January 2025 that there was a breakdown in the grievance process following a change in staff responsibilities. Staff A stated both the logs, and the forms should be complete. Staff A stated the facility needed to do a better job of explaining to residents why they could not resolve a grievance to the residents' satisfaction once it was concluded that was the case. REFERENCE: WAC 388-97-0460.

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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. 43642 Based on interview and record review, the facility failed to ensure a system by which residents/representatives received required written notices at the time of transfer/discharge, or as soon as practicable for 4 of 5 residents (Residents 9, 1, 41, & 37) reviewed for hospitalization s. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> According to an undated facility, Transfer and Discharge . policy, the facility's transfer/discharge notice would be provided to the resident and the resident's representative in a language and manner in which they could understand. The form would include the specific reason and basis for the transfer or discharge, effective date, and would include information on how to obtain an appeal form. The policy showed when an immediate transfer was required by the resident's urgent medical needs, the notice must be provided to the resident, resident's representative if appropriate, as soon as practicable before the transfer or discharge. <Resident 9> Review of Resident 9's 11/07/2024 Discharge Minimum Data Set (MDS - an assessment tool) showed the resident was transferred to an acute care hospital on 11/07/2024, with their return anticipated. Record review showed no documentation staff provided written notification to Resident 9 and/or the resident's representative regarding their discharge as required. In an interview on 03/03/2025 at 11:10 AM, Staff C (Social Services Director) stated they did not provide written discharge notices when residents were transferred to the hospital. In an interview on 03/05/2025 at 2:56 PM, Staff B (Director of Nursing) stated a written notification of discharge should be provided to a resident upon transfer to a hospital. Staff B reviewed Resident 9's records and stated they were unable to locate a discharge notice or any documentation a notice was provided to the resident for the 11/07/2024 transfer to the hospital. 45941 <Resident 1> Review of Resident 1's 06/08/2024 Discharge Return Anticipated MDS showed Resident 1 discharged to an acute care hospital on 06/08/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 03/03/2025 showed no documentation staff provided the required written notification to Resident 1 and/or their representative regarding their discharge to the hospital. In an interview on 03/05/2025 at 11:14 AM, Staff B reviewed Resident 1's record and was unable to locate a written notification was provided to Resident 1 when they were transferred to the hospital. Staff B stated it was important to provide a written transfer notification for resident's rights. <Resident 41> Review of Resident 41's 11/13/2024 Discharge Return Anticipated MDS showed Resident 41 discharged to an acute care hospital on 11/13/2024. Record review on 03/03/2025 showed no documentation staff provided the required written notification to Resident 41 and/or their representative regarding their transfer to the hospital. In an interview on 03/05/2025 at 11:18 AM, Staff B reviewed Resident 41's record and was unable to locate a written notification was provided to Resident 41 when they were transferred to the hospital. Staff B stated it was important to provide a written transfer notification for resident's rights. 46479 <Resident 37> Review of Resident 37's 04/02/2024 Discharge Return Anticipated MDS showed the resident was transferred to an acute care hospital on 04/02/2024 with their return anticipated. Review of Resident 37's 04/18/2024 Discharge Return Anticipated MDS showed the resident was transferred to an acute care hospital on 04/18/2024 with their return anticipated. Review of Resident 37's 05/28/2024 Discharge Return Anticipated MDS showed the resident was transferred to an acute care hospital on 05/28/2024 with their return anticipated. Record review showed no documentation staff provided the required written notification to Resident 37 regarding their transfers to the hospital. In an interview on 03/05/2025 at 11:30 AM Staff B confirmed Resident 37 was not provided the written notifications as required. 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** 43642 Based on interview and record review, the facility failed to provide the resident and/or the resident's representative with a written notice of the facility's bed-hold policy, at the time of transfer or within 24 hours, for 3 of 5 sample residents (Resident 9, 1, & 37) reviewed for hospitalization . This failure placed the residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized that was necessary for decision-making. Findings included . <Facility Policy> According to an undated facility, Bed Hold Prior to Transfer policy, it was the policy of the facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital. <Resident 9> Review of Resident 9's 11/07/2024 Discharge Minimum Data Set (MDS - an assessment tool) showed the resident was transferred to an acute care hospital on 11/07/2024, with their return anticipated. Record review showed no documentation or indication the facility provided Resident 9 or their resident representative written information regarding the facility's bed-hold policy upon transfer to the hospital as required. In an interview on 03/05/2025 at 2:56 PM, Staff B (Director of Nursing) confirmed Resident 9 was not provided a bed-hold policy as required when transferred to the hospital on 11/07/2024. 45941 <Resident 1> Review of Resident 1's 06/08/2024 Discharge Return Anticipated MDS showed Resident 1 discharged to an acute care hospital on 06/08/2024. Review of Resident 1's record showed Resident 1 was sent to the hospital on 06/08/2024 and readmitted to the facility on [DATE]. Review of Resident 1's record showed no documentation indicating a bed hold notification was provided to Resident 1 when they discharged to the hospital on 06/08/2024 as required. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/2025 at 11:14 AM, Staff B reviewed Resident 1's record and was not able to locate documentation the resident was offered and/or provided a bed hold as required. Staff B stated nursing staff should offer and documented the bed hold notification for Resident 1's discharge to the hospital, but they did not. 46479 <Resident 37> Review of Resident 37's 04/02/2024 Discharge Return Anticipated MDS showed the resident was transferred to an acute care hospital on 04/02/2024. Resident 37's 05/28/2024 Discharge Return Anticipated MDS showed the resident was transferred to an acute care hospital. Review of Resident 37's records showed no progress notes or documentation that staff offered the resident a bed hold as required for the 04/02/2024 or 05/28/2024 discharges. In an interview on 03/05/2025 at 11:30 AM, Staff B confirmed a bed hold was not offered to Resident 37 for the two discharges as required. 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** 43642 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS -an assessment tool) accurately reflected the status for 4 (Resident 25, 53, 1, & 41) of 17 residents reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 25> According to an 11/27/2025 Admission MDS, Resident 25 had no broken natural teeth. Review of a 11/20/2024 Admit Assessment form showed Resident 25 had their own teeth and included a question asking if the resident had broken teeth, this question was left blank by staff. In an interview on 02/26/2025 at 1:37 PM, Resident 25 stated they had some broken teeth and indicated staff never asked them about their teeth. In an observation at this time Resident 25 showed broken front upper and lower teeth and stated they were broken prior to admission to the facility. In an interview and observation on 02/28/2025 at 11:20 AM, Staff E (Licensed Practical Nurse) confirmed Resident 25 had broken teeth and stated they were aware that the teeth were broken since admission. According to the 11/27/2025 Admission MDS Resident 25 had a diagnosis of respiratory failure with an inadequate supply of oxygen to the body's tissues, but did not require oxygen therapy during the assessment period. Observations on 02/26/2025 at 1:25 PM, 02/28/2025 at 11:20 AM, and 03/03/2025 at 11:25 AM showed Resident 25 lying in bed using oxygen. Review of a 11/20/2024 Admit Assessment form showed Resident 25 used oxygen continuously. Review of November 2024 Treatment Administration Records showed Resident 25 had an 11/20/2024 physician order for oxygen to be administered continuously. Nursing staff documented Resident 25 received oxygen every shift during the MDS assessment period. In a telephone interview on 03/05/2025 at 12:33 PM, Staff F (MDS Nurse) stated an accurate MDS was important in order to provide the full picture of a resident and to establish the care a resident required. Staff F stated they were not physically working in the facility, did their work remotely, and relied on resident records and staff interviews to complete the MDS data. Staff F stated it was their expectation an oral exam be conducted in order for the oral/dental section of the MDS be completed accurately. Staff F reviewed Resident 25's records and stated the oral/dental and oxygen items were inaccurately coded on the 11/27/2025 Admission MDS. <Resident 53> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 01/31/2025 Quarterly MDS, Resident 53 received an anticoagulant (medication used as a blood thinner) medication during the assessment period. Review of Resident 53's January 2025 Medication Administration Record showed the resident was not receiving an anticoagulant medication during the assessment period. Resident 53 was only receiving an aspirin tablet for stroke prevention. In a phone interview on 03/05/2025 at 12:33 PM, Staff F reviewed Resident 53's records and stated the aspirin was inaccurately coded as an anticoagulant medication on the 01/31/2025 Quarterly MDS. 45941 <Resident 1> According to an 11/27/2024 Quarterly MDS Resident 1 admitted to the facility on [DATE]. The MDS showed Resident 1 had no weight loss in last 30 days or 180 days. Review of Resident 1's weight record showed Resident 1's admission weight on 05/26/2024 was 182 pounds and on 11/16/2024 Resident 1's weight was 134.6 pounds. Resident 1's weight record showed Resident 1 had lost almost 48 pounds in last six months since admission. Review of a 05/26/2024 Nutrition risk Care Plan (CP), showed interventions which instructed staff to monitor/record and report to provider for significant weight loss of more than five percent in one month or more than 10 percent in six months. In an interview on 03/03/2025 at 9:45 AM, Resident 1 stated they have lost a few pounds of weight in the last few months. In an interview on 03/05/2025 at 11:46 AM, Staff B (Director of Nursing) stated they were aware of Resident 1's weight loss. Staff B stated the dietitian was following the resident in the nutrition at risk meetings and ordered supplements related to weight loss. Staff B stated it was important for the MDS to be accurate to plan residents care appropriately. <Resident 41> According to the 01/29/2025 Annual MDS, Resident 41 had medical conditions including a stroke (brain injury) resulting in paralysis (loss of function) to one half of their body and affected Resident 41's ability to speak. The MDS showed Resident 41 had no functional limitations in range of motion to their upper or lower extremities. Review of a 02/02/2023 Activities of Daily Living CP showed Resident 41 had a self-care deficit related to right side weakness from the stroke. The CP instructed staff to apply a splint on Resident 41's right hand daily as tolerated and to report any skin issues due to the splint placement to provider. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 02/26/2025 at 9:07 AM and on 03/03/2025 at 1:29 PM showed Resident 41 was lying in bed; their right hand was contracted; and their right foot was turned inwards. Resident 41 was unable to move their right arm, open their right hand, and was unable to move their right leg. Observations at this time showed Resident 41 had to use their left hand to lift their right arm, but could not open their right hand. In an interview on 03/03/2025 at 1:29 PM, Resident 41 stated they had a stroke and since then, they were unable to move their right arm and right leg. In an interview on 03/05/2025 at 2:20 PM, Staff G (Rehab Director) stated Resident 41 had weakness on right side of the body with a contracture on their right hand. In an interview on 03/05/2025 at 10:51 AM, Staff B stated Resident 41 had right side of the body weakness with right hand contracture. Staff B stated the MDS was inaccurate, and staff should assess Resident 41 accurately and document on MDS accurately showing Resident 41 had functional limitations on one side of upper and lower extremities. REFERENCE: WAC 388-97-1000 (1)(b).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the residents' mental health conditions for 3 of 6 (Resident 23, 1 & 27) residents and 1 supplemental resident (Resident 53) reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Facility Policy> Review of a 2024 facility, Resident Assessment - Coordination with PASRR Program policy showed the social services director would be responsible for keeping track of each resident's PASRR screening status, and referring to the appropriate authority. <Resident 23> According to a 12/06/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 23 had multiple medically complex diagnoses including anxiety, depression, and schizophrenia (a chronic mental illness that affects a person's ability to think, feel, and behave clearly). This MDS showed Resident 23 required the use of an antidepressant and antipsychotic medication during the assessment period. Review of a March 2025 Medication Administration Record (MAR) showed Resident 23 was receiving antidepressant and antipsychotic medications daily. Record review showed an undated Level 1 PASRR was uploaded into Resident 23's records on 09/09/2024. This PASRR showed staff marked Resident 23 had the following Serious Mental Illness (SMI) indicators: schizophrenia; mood disorder; psychotic disorder; anxiety disorder; and a delusional disorder. Staff indicated Resident 23 was assessed to require a level II evaluation referral for their SMI indicators. No Level II evaluation was found in Resident 23's records. In an interview on 03/03/2025 at 11:10 AM, Staff C (Social Services Director) stated it was their expectation a Level 1 PASRR would be dated when signed as completed and an assessment be obtained as required for residents with referrals for a Level II assessment. Staff C was unable to provide documentation the referral was made or obtained and stated they had to resubmit the forms. <Resident 53> According to a 01/31/2025 Quarterly MDS, Resident 53 had multiple medically complex diagnoses including anxiety and depression and required the use of an antianxiety medication during the assessment period. (continued on next page)

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	505339	A. Building B. Wing	03/05/2025

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North Bend Post Acute	219 Cedar Avenue South North Bend, WA 98045

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a March 2025 MAR showed Resident 53 was receiving an antianxiety medication daily. Review of a 06/28/2024 admission Level 1 PASRR from the hospital showed Resident 53 had no SMI indicators identified on the form and did not require a referral for assessment. Staff did not identify the Level 1 PASRR was inaccurate, and Resident 53 had diagnoses of anxiety and depression which required the use of medications. In an interview on 03/05/2025 at 1:37 PM, Staff C stated Resident 53's Level 1 PASRR was inaccurate and needed to be redone. 45941 <Resident 1> According to a 11/27/2024 Quarterly MDS, Resident 1 admitted to the facility on [DATE], had multiple medically complex diagnoses including an anxiety disorder and depression, and required the use of an antidepressant and antianxiety medication during the assessment period. Review of the March 2025 MAR showed Resident 1 was receiving an antianxiety medication daily. Review of a 06/11/2024 Level 1 PASRR showed Resident 1 had no SMI indicators identified, and a Level II evaluation was not indicated. In an interview on 03/04/2025 at 3:03 PM, Staff C stated the Level 1 PASRR should be assessed by staff for accuracy. Staff C reviewed Resident 1's record and stated the Level I PASRR was inaccurate and should be, but was not updated as required. 46479 <Resident 27> According to the 02/04/2025 Annual MDS, Resident 27 had diagnoses including dementia (progressive memory loss disorder), anxiety, and depression. The MDS showed Resident 27 received an antipsychotic medication and antidepressant mediation during the assessment period. Review of the undated PASRR in Resident 27's record showed the resident did not have any SMI indicators. The boxes for mood and anxiety disorders were unchecked. The last page of the PASRR document showed all the boxes were left blank. There was no name for the person completing the form, no date, or information regarding the facility or agency. In an interview on 03/04/2025 at 2:33 PM, Staff C reviewed Resident 27's PASRR and confirmed it was inaccurate. Staff C confirmed the PASRR should capture Resident 27's diagnoses but it did not. REFERENCE: WAC 388-97-1915(1)(2)(a-c)(4).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to provide baseline Care Plans (CP) to 6 (Residents 23, 25, 7, 58, 40 & 55) of 17 residents reviewed. The failure to provide the resident and/or their representative with a summary of their baseline CP placed residents and/or their representatives at risk for not being informed of their initial plan for delivery of care and services, and placed residents at risk for unmet care needs. Findings included . <Facility Policy> Review of the facility's 2024 Baseline Care Plan policy showed the baseline CP would be developed within 48 hours of the resident's admission and include the minimum healthcare information necessary to properly care for a resident. The policy showed a written summary of the baseline CP would be provided to the resident and/or their representative in a manner and language they could understand. <Resident 23> According to a 09/10/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 23 admitted to the facility on [DATE] after a recent surgery which required skilled nursing care. In an interview on 02/27/2025 at 11:23 AM, Resident 23 stated they felt staff were not communicating with them about their care or goals. Review of Resident 23's records showed no documentation a baseline CP was provided to the resident and/or their representative as required. <Resident 25> According to an 11/27/2025 Admission MDS, Resident 25 admitted to the facility on [DATE] with multiple medically complex diagnoses including heart failure, a wound infection, and respiratory failure. Review of Resident 25's records showed no documentation a baseline CP was provided to the resident and/or their representative as required. <Resident 7> According to a 02/05/2025 Admission MDS, Resident 7 admitted to the facility on [DATE] with multiple medically complex diagnoses including pressure ulcers and a spinal cord injury resulting in loss of movement to their lower extremities. Review of Resident 7's records showed no documentation a baseline CP was provided to the resident and/or their representative as required. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 58> According to a 02/06/2025 Admission MDS, Resident 58 admitted to the facility on [DATE] with multiple medically complex diagnoses including heart failure, end-stage kidney disease, and stroke. Review of Resident 58's records showed no documentation a baseline CP was provided to the resident and/or their representative as required. 46479 <Resident 40> Review of Resident 40's 01/07/2025 Quarterly MDS showed the resident admitted to the facility on [DATE] with diagnoses including paraplegia, a neurogenic bladder (impaired bladder control caused by nerve dysfunction), pressure ulcers, and a seizure disorder. Review of Resident 40's record showed no documentation that a baseline CP was initiated or provided to Resident 40 for their review. <Resident 55> Review of Resident 55's 02/12/2025 Admission MDS showed the resident admitted to the facility on [DATE] with diagnoses including an amputation, high blood pressure, inability to control their blood sugars, malnutrition, and a stroke. Review of Resident 55's record showed no documentation that a baseline CP was initiated or provided to the resident or their representative for their review. In an interview on 03/05/2025 at 2:11 PM, Staff B (Director of Nursing) stated it was not the facility's current practice to complete baseline CPs. Staff B stated they did not provide baseline CP documentation to the residents or their representatives. REFERENCE: WAC 388-97-1020(3).

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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** 43642 Based on observation, interview, and record review the facility failed to develop the care plans for 3 of 17 sampled residents (Resident 53, 58, & 25) reviewed for care planning. This failure placed the residents at risk for inadequate care, unmet care needs, and a diminished quality of life. Findings included . <Facility Policy> According to the facility's 2025 Comprehensive Care Plans policy, the facility would develop and implement a comprehensive, person-centered Care Plan (CP) for each resident that included measurable objectives and timeframes. <Resident 53> According to a 01/31/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 53 required set up assistance from staff for eating and was on a therapeutic diet. This MDS showed Resident 53 was at risk for developing pressure ulcers. Review of a revised 11/02/2024 nutrition CP showed Resident 53 had the potential for altered nutrition with an identified goal that the resident would maintain adequate nutritional status as evidenced by stable weight. Staff did not identify a measurable goal for Resident 53 to indicate what a stable weight would be for the resident. In an interview on 02/27/2025 at 10:12 AM, Resident 53 stated they had some skin breakdown on their chin that at times would become infected. According to an 08/05/2024 physician order, staff were to monitor Resident 53's skin daily for any new open skin lesions due to the resident's tendency for picking at the skin causing openings. Review of Resident 53's comprehensive CP showed staff did not develop a CP to address the residents skin picking behaviors and recurrent lesions to their face. Review of an 08/10/2024 pressure ulcer care area assessment showed staff documented Resident 53 was at risk for skin breakdown and a CP focusing on preventing development of pressure ulcers, providing good nutrition, and ensuring the facility met resident's needs would be developed. Review of Resident 53's comprehensive CP showed staff did not develop a CP to address the residents pressure ulcer risks. In an interview on 02/27/2025 at 10:17 AM, Resident 53 stated they had broken teeth. Observations at this time showed Resident 53 had broken upper teeth and many missing lower teeth. Resident 53 stated they were seen by a dentist since admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to an 08/21/2024 dental consult, Resident 53 had two identified broken upper teeth and 16 missing lower teeth. Review of Resident 53's comprehensive CP showed staff did not identify the resident's current dental status. In an interview on 03/05/2025 at 2:56 PM, Staff B (Director of Nursing) stated it was their expectation CPs were developed to identify goals and interventions for resident identified conditions. Staff B stated goals should be measurable to know when interventions need to be changed. Staff B stated Resident 53's comprehensive CP needed to include a measurable goal for the resident's nutritional status. Staff B stated Resident 53's dental and skin conditions should be addressed on their comprehensive CP. <Resident 58> According to a 02/06/2025 Admission MDS, Resident 58 was admitted to the facility on [DATE] with multiple medically complex diagnoses including stroke, heart failure, and end stage kidney disease and required a feeding tube for nutritional support. Review of a revised 02/24/2025 nutrition CP showed Resident 58 had the potential for altered nutrition with an identified goal that the resident would maintain adequate nutritional status as evidenced by stable weight. Staff did not identify a measurable goal for Resident 58 to indicate what a stable weight would be for the resident. In an interview on 03/05/2025 at 2:56 PM, Staff B stated Resident 58's nutrition CP should have, but did not include measurable goals. <Resident 25> According to the 11/27/2025 Admission MDS Resident 25 had a diagnosis of respiratory failure with an inadequate supply of oxygen to the body's tissues. Review of a 11/20/2024 Admit Assessment form showed Resident 25 used oxygen continuously. Observations on 02/26/2025 at 1:25 PM, 02/28/2025 at 11:20 AM, and 03/03/2025 at 11:25 AM showed Resident 25 lying in bed using oxygen. Review of Resident 25's physician orders showed an 11/20/2024 order for continuous oxygen to maintain Resident 25's oxygen levels. Review of Resident 25's comprehensive CP showed staff did not address the resident's respiratory failure and oxygen use or identify the goals and interventions to implement. In an interview on 03/05/2025 at 2:56 PM, Staff B stated it was their expectation Resident 25's CP address the resident's respiratory status and oxygen use. REFERENCE: WAC 388-97-1020(1), (2)(a)(b).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation, interview, and record review the facility failed to ensure residents received and/or participated in care conferences for 3 (Residents 23, 58, & 20) of 17 residents reviewed and failed to ensure Care Plans (CP) were updated and/or revised to reflect person-centered care for 5 (Residents 7, 25, 53, 8, & 58) of 17 sample residents. These failures left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 2024 Care Planning - Resident Participation policy, the facility would discuss the resident's plan of care with the resident and/or representative at regularly scheduled care conferences. The facility would obtain a signature from the resident and/or representative after discussion or viewing the CP. According to the facility's 2025 Comprehensive Care Plans policy, the facility would develop and implement a comprehensive, person-centered CP for each resident that included measurable objectives and timeframes. The comprehensive CP would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS - an assessment tool) assessment. <Care Conference> <Resident 23> According to a 12/06/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 23 admitted to the facility on [DATE], had clear speech, made self-understood, and understood others. In an interview on 02/27/2025 at 11:23 PM, Resident 23 stated they felt staff did not communicate with them about their care or goals. Resident 23 stated they did not have any care conferences since their admission. Review of Resident 23's records showed the only documented care conference was on 09/05/2024, six months previously. <Resident 58> According to a 02/06/2025 Admission MDS, Resident 58 was admitted to the facility on [DATE] with multiple medically complex diagnoses including stroke, heart failure, and end stage kidney disease. Review of Resident 58's records showed no documentation a care conference was completed since admission on 01/30/2025, almost two months previously. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/05/2025 at 1:37 PM, Staff C (Social Services Director) stated care conferences were important to establish care, make discharge plans, and resolve any frustrations and/or barriers to care a resident was experiencing. Staff C stated care conferences should be completed within 72 hours of admission, quarterly, and as needed with any significant changes. Staff C stated if a care conference was completed, it would be documented in the resident's records. Staff C reviewed Resident 23 and Resident 58's records and was unable to find the residents had documentation showing a care conference was completed since their admission to the facility. <Resident 20> According to the 01/03/2025 Annual MDS, Resident 20 was understood and could understand others and had minimal cognitive impairment. This MDS showed Resident 20 had diagnoses including high blood pressure, kidney disease, diabetes, and depression. In an interview on 02/27/2025 at 11:26 AM, Resident 20 stated they only had one care conference. Record review showed Resident 20 had a quarterly care conference on 07/15/2024. Resident 20 did not have another care conference until 01/14/2025. In an interview on 03/05/2025 at 1:43 PM, Staff B (Director of Nursing) stated care conferences included the social worker, nursing staff, activities, dietary, and therapy. Staff B stated they expected care conferences to be held quarterly for the residents. <Care Plan Revision> <Resident 7> According to a 02/05/2025 Admission MDS Resident 7 had multiple medically complex diagnoses including a traumatic spinal cord injury with paralysis (inability to move some or all of your body), and pressure ulcers. This MDS showed Resident 7 did not walk or transfer out of bed during the assessment period. Review of a revised 02/07/2025 Activities of Daily Living (ADL) CP showed Resident 7 was at risk for altered ADLs and required, from weight bearing to non-weight bearing assistance. Varies from independent to supervised level and partial to substantial assistance on ADL. The interventions for this CP were for mobility devices as applicable for transfers, gait and locomotion in facility, and to provide assistance with ADLs as indicated. There were no directions to care staff to identify what those mobility devices were or what the level of assistance was required for Resident 7's ADLs. In an interview on 03/05/2025 at 1:19 PM, Staff Q (Certified Nursing Assistant) stated they utilized a resident's CP to determine what care a resident required. Staff Q stated Resident 7 required a two person assist and used a mechanical lift for transfers. Staff Q reviewed Resident 7's CP and stated they were unable to find directions to staff on the resident's care needs. In an interview on 03/05/2025 at 2:56 PM, Staff B stated it was their expectation CPs be updated and revised to reflect a resident's current conditions. Staff B stated Resident 7's CP should indicate the level of care for staff to provide for transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 25> According to an 11/27/2025 Admission MDS, Resident 25 had no broken natural teeth. In an observation on 02/26/2025 at 1:37 PM Resident 25 showed they had broken front upper and lower teeth since and stated they have been broken since before their admission. In an interview on 02/28/2025 at 11:20 AM, Staff E (Licensed Practical Nurse) stated they were aware that Resident 25's teeth were broken since admission. Review of an 11/20/2024 ADL CP showed interventions for: Oral Care: The resident has own teeth, upper/lower dentures, broken teeth, decayed teeth, sore gums, bridgework. This intervention was not revised or individualized to identify which concerns were applicable for Resident 25. In an interview on 03/05/2025 at 2:56 PM, Staff B stated Resident 25's CP should have been updated and individualized to reflect the resident's broken teeth identified by staff. <Resident 53> According to a 01/31/2025 Quarterly MDS, Resident 53 had a progressive neurological condition and heart failure. This MDS showed Resident 53 required set up assistance from staff for eating and was on a therapeutic diet. Review of an 08/25/2024 allergy CP showed Resident 53 was at risk for allergic reaction due to drug allergy to (enter/specify allergy) and medication allergy to (enter/specify allergy). This CP was not revised to reflect the individualized allergies for Resident 53. In an interview on 03/05/2025 at 2:56 PM, Staff B stated Resident 53's CP should be revised to specify what allergies the resident had. <Resident 58> According to a 02/06/2025 Admission MDS, Resident 58 was admitted to the facility on [DATE] with multiple medically complex diagnoses including stroke, heart failure, and end stage kidney disease and required a feeding tube for nutritional support. Review of Resident 58's physician orders showed a 02/21/2025 diet order for the resident to receive Nothing By Mouth (NPO). Review of a 01/30/2025 dehydration CP showed interventions directing staff to offer fluids as tolerated or as indicated per diet order. In an interview on 03/05/2025 at 2:56 PM, Staff B stated the intervention indicated on Resident 58's dehydration CP needed to be updated and revised to reflect the resident's NPO status. 45941 <Resident 8> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 12/25/2024 Annual MDS, Resident 8 admitted to the facility on [DATE], was assessed as cognitively impaired, and required one person assistance with personal hygiene. The MDS showed Resident 8 had indwelling catheter (a thin tube inserted into the bladder to drain urine) and was always incontinent of bowel. Review of a 12/13/2023 ADL self-care deficit CP showed Resident 8 was incontinent of both bowel and bladder; wore incontinent briefs and needed one-to-two-person assistance with care. Review of Resident 8's March 2025 physician orders showed Resident 8 had an indwelling catheter and staff were directed to provide catheter care every shift. Observations on 02/26/2025 at 9:08 AM, on 02/28/2025 at 12:35 PM, and on 03/03/2025 at 11:02 AM showed Resident 8 had an indwelling catheter for bladder needs. In an interview on 03/03/2025 at 9:37 AM, Staff H (Licensed Practical Nurse) stated Resident 8 had indwelling catheter and was incontinent of bowel. In an interview on 03/05/2025 at 10:45 AM, Staff B stated Resident 8 had an indwelling catheter. Staff B reviewed Resident 8's CP and stated the CP was not updated to show Resident 8's status. Staff B stated the CP should be updated but it was not. 46479 REFERENCE: WAC 388-97-1020(2)(c)(d), (2)(f), (4)(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** 45941 Based on observation, interview, and record review the facility failed to clarify diagnoses on physician's orders and to monitor and document resident's behaviors while on antipsychotic medications for 3 (Residents 8, 25, & 61) of 17 sample residents reviewed. These failures left residents at risk for unmet care needs, inappropriate care interventions, and other negative health outcomes. Findings included . <Resident 8> According to the 12/25/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 8 admitted to the facility on [DATE] with medically complex conditions including non-Alzheimer's dementia (group of cognitive disorders that cause memory loss and confusion), depression, and anxiety. The MDS showed Resident 8 received antipsychotic and antidepressant medications every day during assessment period. The MDS showed Resident 8 had no behavior of rejecting care during the assessment period. Observations on 02/27/2025 at 11:29 AM, on 02/28/2025 at 9:24 AM, and on 03/03/2025 at 11:32 AM showed Resident 8 dressed, sitting in their wheelchair in the dining area, calm, and watching TV. No behavior were observed. Review of Resident 8's March 2025 Medication Administration Record (MAR) showed Resident 8 received an antipsychotic medication every day for dementia with behavioral disturbance. Review of Resident 8's record showed no documentation staff monitored Resident 8's behaviors related to the use of the antipsychotic medications that were administered every day. In an interview on 03/04/2025 at 2:55 PM, Staff C (Social Services Director) stated it was very important to monitor resident's behaviors if residents received psychotropic medications. Staff C reviewed Resident 8's record and stated Resident 8 received antipsychotic medication for dementia with behavior disturbance. Staff C was unable to provide any documentation indicating staff monitored Resident 8's behaviors. Staff C stated staff should monitor and document Resident 8's behaviors related to the antipsychotic medication, but they did not. In an interview on 03/05/2025 at 11:02 AM, Staff B (Director of Nursing) reviewed Resident 8's record and was unable to provide documentation indicating why Resident 8 received the antipsychotic medication for dementia and what kind of behaviors Resident 8 exhibited to justify receiving the antipsychotic medication. Staff B stated staff should monitor and document Resident 8's behaviors and the provider should document an appropriate diagnosis for Resident 8 prescription for the antipsychotic medication but they did not. 43642 <Resident 25> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to an 11/27/2025 Admission MDS, Resident 25 was assessed by staff to be at risk for developing pressure ulcers/injuries, had pressure ulcers on admission, and received applications of ointments/medications. Review of an 11/20/2024 physician order showed an order for a castor oil ointment to be applied to Resident 25's pressure ulcer site twice daily for pressure ulcer on buttocks. Observations of wound care on 03/03/2025 at 11:25 AM with Staff K (Licensed Practical Nurse) showed Staff K perform wound care to two areas of Resident 25's bottom area. After the wounds were covered with a dressing, Staff K applied a castor oil ointment to Resident 25's bottom cleft area below the two wounds. Staff K did not apply the castor oil ointment to Resident 25's pressure ulcer as instructed in the physician's order. In an interview on 03/05/2025 at 2:56 PM, Staff B stated the castor oil ointment order needed to be clarified to indicate there were other specific orders for Resident 25's pressure ulcers. <Resident 61> According to a 12/25/2024 Death in Facility MDS, Resident 61 was admitted to the facility on [DATE] from an acute care hospital. Review of Resident 61's records showed the resident was placed on hospice services on 12/24/2025. Review of a 12/25/2024 progress note showed staff documented Resident 61 passed away on 12/25/2024 at 1:15 AM and hospice was notified. Review of Resident 61's records showed no physician order was obtained to release Resident 61's body to a mortuary, no documentation a mortuary receipt was obtained by the facility; and no progress note documenting when Resident 61's body was released. In an interview on 03/05/2025 at 2:56 PM, Staff B stated it was their expectation nursing staff obtain a physician's order to release Resident 61's body, document when the body was released, and obtain records from the mortuary regarding the receipt of Resident 61. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(i).

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to develop and implement a discharge planning process to effectively transition residents to a community setting for 2 residents (Resident 23 & 60) of 17 residents reviewed for discharge planning. This failure placed the residents at risk for an unsafe discharge and diminished quality of life. Findings included <Facility Policy> According to an undated facility, Transfer and Discharge . policy, for anticipated transfers or discharges, a physician's order would be obtained for the transfer or discharge along with instructions or precautions for ongoing care. <Resident 23> According to a 12/06/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 23 admitted to the facility on [DATE], had clear speech, was understood, and could understood others. This MDS showed Resident 23 had a surgical wound and received surgical wound care during the assessment period. In an interview on 02/27/2025 at 11:23 AM, Resident 23 stated they were frustrated they were not discharged home yet. Resident 23 stated they were supposed to go home after their wound healed on their right foot. Resident 23 stated they talked with the nurse and asked them to, get the ball rolling as the resident wanted to go home. Review of a 09/05/2024 Admission Care Conference form showed Resident 23 originally admitted for short term care with a plan to remain in the facility until the resident qualified for a lower-level care and then planned to go to an assisted living/adult family home. Staff indicated Resident 23 may qualify for a program designed to help people with complex, long-term care needs move back into the community. There was no documentation in Resident 23's records to show a quarterly care conference occurred after 09/05/2024. According to a 09/05/2024 Psychosocial History and Discharge Plan, Resident 23 originally admitted for therapy and nursing services for long term care. The discharge plan was to remain in the facility until Resident 23 qualified for lower-level care. Barriers to discharge were impaired mobility. Review of a 09/10/2024 discharge potential care plan showed a goal identified for Resident 23 was to remain at the facility for long-term care and remain at their highest level of functioning in current setting (until/if lesser care facility is indicated). Interventions identified were: community referrals as needed; discharge potential to lesser care discussed with resident- resident to return to independent living in the community, with therapy clearance; evaluate the resident motivation to return to the community as needed; and make arrangements with required community resources to support independence post-discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 02/14/2025 provider progress note showed Resident 23's right foot was healed and the resident wanted to go home. Review of Resident 23's records showed no further documentation by staff regarding the status of discharge or continued level of care required. In an interview on 03/05/2025 at 1:37 PM, Staff C (Social Services Director) stated discharge plans and barriers were addressed at quarterly care conferences. Staff C was unable to locate documents that a care conference occurred for Resident 23 since admission, almost six months previously. Staff C stated they were in process to obtain guardianship services for Resident 23 and the resident would not be discharging to the community. Staff C stated there should be documentation in Resident 23's records regarding the guardianship and if the resident was determined not to qualify for a discharge to lesser care. No documentation showing this occurred was provided. <Resident 60> According to 12/03/2024 Discharge MDS, Resident 60 was discharged on [DATE] to home/community with their return not anticipated. Review of Resident 60's physician orders showed no order was obtained for Resident 60 to be discharged . Review of Resident 60's progress notes showed no documentation by staff regarding any communication between the facility and the adult family home in which the resident was discharged to on 12/03/2024. In an interview on 03/05/2025 at 2:56 PM, Staff B (Director of Nursing) stated it was their expectation a physician's order be obtained prior to a resident discharging from the facility. Staff B stated they would expect a progress note by staff documenting communication with the facility a resident was being discharged to, in order to ensure continuity of care. Staff B reviewed Resident 60's records and was unable to find a physician order for the resident's discharge or progress notes showing communication with the receiving facility. REFERENCE: WAC 388-97-0080.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 45941 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL) related to cleanliness and grooming for 6 (Residents 8, 22, 41, 37, 27, & 55) of 17 sample residents reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with shaving, bathing, and nail care placed the residents at risk for poor hygiene, unwanted long facial hair, embarrassment, and a diminished quality of life. Findings included . <Facility Policy> According to the facility's 08/2024 ADLs policy, a resident who was unable to carry out ADLs would receive the necessary services to maintain good grooming, personal and oral hygiene. <Resident 8> According to the 12/25/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 8 had impairment to their right arm and both legs, was assessed as cognitively impaired, and required one person assistance with personal hygiene. The MDS showed Resident 8 had no behavior of rejecting care during the assessment period. Observations on 02/26/2025 at 10:48 AM and on 02/27/2025 at 9:55 AM, showed Resident 8 was in their wheelchair in the dining area. Resident 8 was not shaved and had long fingernails. Observation on 03/03/2025 at 10:09 AM showed Resident 8 was in their wheelchair in the dining room watching television. Resident 8 had long fingernails. According to the 11/03/2020 ADL self-care performance deficit Care Plan (CP), Resident 8 required one-person extensive assistance with personal hygiene and Resident 8 was dependent on staff for bathing. In an interview on 03/05/2025 at 10:42 AM, Staff B (Director of Nursing) stated they expected staff to check the resident's CPs related to ADLs and provide assistance as needed. If the resident refused, staff should document the refusals. Staff B stated staff should follow the CP and provide assistance to Resident 8 with shaving and clip their fingernails on shower days, but they did not. <Resident 22> According to the 02/05/2025 Quarterly MDS, Resident 22 had right sided weakness, was assessed as cognitively intact, and required one person assistance with personal hygiene. The MDS showed Resident 22 had no behavior of rejecting care during assessment period. Observations on 02/27/2025 at 10:04 AM, on 02/28/2025 at 9:13 AM, and on 03/03/2025 at 8:30 AM showed Resident 22 was lying in bed, was not shaved, had long fingernails, and long toenails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/03/2025 at 10:23 AM showed Resident 22 was not shaved and had long fingernails. Resident 22 stated they could not shave themselves or clip their own nails. Resident 22 stated staff should help them with shaving and nail care during showers, but they did not. According to the 05/31/2023 ADL self-care performance deficit CP, Resident 22 required one-person extensive assistance with personal hygiene and bathing. In an interview on 03/05/2025 at 10:42 AM, Staff B stated they expected staff to check the resident's CPs related to ADLs and provide assistance as needed. Staff B stated Resident 22 had weakness to the right side of their body and required assistance from staff with shaving and nail care. Staff B stated staff should follow the CP and provide assistance to Resident 22 with shaving, trimming fingernails, and toenails on shower days, but they did not. <Resident 41> According to the 01/29/2025 Annual MDS, Resident 41 had medical conditions including a stroke (brain injury) resulting in paralysis (loss of function) to one half of their body and required one person extensive assistance with personal hygiene. The MDS showed Resident 41 was assessed as cognitively impaired and did not reject care during the assessment period. Observation on 02/27/2025 at 9:36 AM showed Resident 41 lying in bed, was not shaved, and had long fingernails. Observation on 02/28/2025 at 9:11 AM showed Resident 41 had long fingernails. According to the 05/31/2023 ADL self-care performance deficit revised CP, Resident 41 required one-person extensive assistance with personal hygiene. The CP instructed staff to offer shaving and nail care to Resident 41 during showers or per Resident 41's preferences. In an interview on 03/05/2025 at 10:42 AM, Staff B stated they expected staff to check the resident's CPs related to ADLs and provide assistance as needed. Staff B stated staff should follow the CP and provide assistance to Resident 41 with shaving and trimming fingernails on shower days, but they did not. 46479 <Resident 27> According to the 02/24/2025 Annual MDS, Resident 27 had severe cognitive impairment and had diagnoses including a progressive memory loss disorder, depression, and anxiety. The MDS showed Resident 27 did not have behaviors or reject care during the assessment period. Review of Resident 27's 09/14/2024 revised ADL self-care performance deficit CP showed the resident often refused bathing/showering assistance. This CP showed Resident 27 preferred showers twice weekly and required assistance from one staff member for showering. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/26/2025 at 10:03 AM showed Resident 27 lying in bed. Resident 27 had several long gray and black hairs on their upper lip and chin. Similar observations were made on 02/28/2025 at 1:05 PM and 03/04/2025 at 2:24 PM. Review of Resident 27's shower task documentation and shower skin sheets on 03/04/2025 showed Resident 27 did not have a shower since 02/19/2025. This task documentation showed staff only documented two instances of Resident 27 refusing care on 02/14/2025 and 02/21/2025. In an observation and interview on 03/04/2025 at 2:38 PM, Staff B confirmed Resident 27 had long hairs to their upper lip and chin. <Resident 55> According to the 02/12/2025 Admission MDS, Resident 55 was moderately impaired for daily decision making and required supervision. This MDS showed Resident 55 had weakness/paralysis to one side of their body and required assistance for personal care. Review of Resident 55's 02/05/2025 ADL CP directed staff to provide bathing assistance to the resident twice weekly. This CP directed staff to offer nail care during showers. Review of Resident 55's February 2025 treatment administration record showed a 02/05/2025 order directing licensed nurses to perform/offer nail care to Resident 55 each week. This record showed staff documented on 02/26/2025 Resident 55 did not need nail care. Observation on 02/28/2025 showed Resident 55 with long, broken, and dirty fingernails on their right hand. Review of Resident 55's 03/02/2025 skin monitoring shower review form showed the resident received a shower that day. The form included an area for the shower aid to document whether the resident needed nail care and if the resident required a nurse to perform nail care. Staff left this portion of the form blank. Observations on 03/05/2025 showed Resident 55's left hand with long, dirty fingernails. <Resident 37> According to the 02/14/2025 Annual MDS, Resident 37 had no cognitive impairment and had diagnoses including a stroke, end stage kidney disease, and a limb amputation. The MDS showed Resident 37 did not reject care during the look back period. Review of Resident 37's 01/08/2024 revised ADL self-care performance deficit CP showed the resident preferred two showers per week and was totally dependent on staff for bathing assistance. Review of Resident 37's January 2025 tasks report showed the resident preferred one shower per week. This report showed no showers were documented for the resident for the month of January. This report showed staff documented Resident 37 did not have any refusals of care during the month. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 37's skin monitoring shower review form showed the resident received one shower for the month of January, on 01/19/2025. There were no shower refusal forms for the month of January. Review of Resident 37's February 2025 tasks report showed the resident preferred one shower per week. The report showed no showers were documented for the resident for the month of February. This report showed staff documented Resident 37 did not have any refusals of care during the month. Review of Resident 37's February skin monitoring shower review form showed the resident received two showers in February, one on 02/26/2025 and on 02/23/2025. There were no shower refusal forms for the month of February. In an interview on 03/05/2025 at 1:49 PM, Staff B stated shower documentation was an issue. Staff B stated it was their expectation shower staff offered to shave and provide nail care to all resident on their shower days. Staff B stated they expected staff to document in the record if a resident refused to be showered/bathed or refused nail care and shaving. Staff B stated if a resident refused, the facility process was to have another staff person approach the resident later. If the resident continued to refuse, Staff B would check in with the resident to see if there was an issue that needed resolving. 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. 43642 Based on observation, interview, and record review the facility failed to monitor and identify changes in a resident's skin condition timely for 1 (Resident 25) of 7 sampled residents reviewed for skin conditions. These failures placed residents at risk for complications, worsening conditions, and a diminished quality of life. Findings included . <Resident 25> According to an 11/27/2025 Admission Minimum Data Set (MDS - an assessment tool), Resident 25 had clear speech, was understood, able to understand others, and had no memory impairment. This MDS showed staff assessed Resident 25 was at risk for developing pressure ulcers/injuries and had pressure ulcers on admission. During observations of wound care on 03/03/2025 at 11:25 AM with Staff K (Licensed Practical Nurse), Resident 25 reminded the nurse about the rash they had under their right-side abdominal fold and their right armpit. Staff K observed the areas which showed large areas of red, inflamed skin with some drainage noted to the areas. Staff K stated they would go get the powder they were using to the skin areas and returned shortly after to apply. In an interview on 03/04/2025 at 8:59 AM, Resident 25 stated they had the skin breakdown to their abdomen and armpit for the last couple of weeks. When asked how often the nursing staff looked at the identified rash areas, Resident 25 stated, not unless I ask them to. Review of Resident 25's physician orders showed an 11/20/2024 order for an antifungal powder to be used under the abdominal fold twice daily that was discontinued on 02/13/2025 due to the rash being resolved and a 01/07/2025 order for a skin evaluation to be completed weekly for prevention of skin breakdown. Record review showed the last skin assessment completed by nursing staff was on 02/19/2025, almost two weeks prior. Resident 25 was scheduled for a skin check to be completed on 02/25/2025, no documentation was found in Resident 25's records showing the skin check was completed as ordered. Review of a 03/03/2025 and 03/04/2025 Daily Skilled Evaluation form completed by staff showed Resident 25 did not have any surgical wounds or any other skin conditions. In an interview on 03/05/2025 at 2:56 PM, Staff B (Director of Nursing) stated it was their expectation that nursing staff completed weekly full skin assessments and document them in the resident records using the skin evaluation form. Staff B stated if a new area was identified, it was their expectation nursing staff documented the findings, notify Staff B, and the provider, and obtain further orders as needed. REFERENCE: WAC 388-97-1060.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review the facility failed to ensure 4 of 9 (Residents 49, 14, 7, & 25) residents reviewed for Pressure Ulcers (PU - injury to the skin and underlying tissue due to prolonged pressure), received necessary care and services, consistent with professional standards of practice, to promote healing, and prevent new ulcers from developing. Failure to timely monitor, assess, implement wound provider recommendations, and preventative skin measures placed all resident's at risk for deterioration in skin condition(s), pain, and diminished quality of life. Findings included . Review of the 2024 facility Pressure Injury Prevention and Management policy, showed the facility would use a systematic approach for PU prevention and management. This included prompt assessment and treatment of the PU, interventions to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions, and modifying the interventions as necessary. The policy showed the Registered Nurse (RN) or designee would review all relevant documentation regarding skin assessments, PU risks, progression towards healing, and compliance at least once weekly, and document a summary of findings in the resident's medical record. The attending physician would be notified of a new PU and any complications with the wound. The policy showed a Care Plan (CP) would be developed that included relevant goals for prevention and management of PU's with appropriate interventions. <Resident 49> Review of a 12/10/2024 Admission Minimum Data Set (MDS - an assessment tool), showed Resident 49 was able to make needs known and required assistance with decision making. The MDS showed Resident 49 was frequently incontinent of bowel and bladder, and had no behaviors of rejecting care. The MDS showed Resident 49 was at risk for PU development, had no PU's, and was dependent on staff for toileting, bathing, and required moderate assistance with bed mobility. The MDS showed Resident 49 had an infectious lung disease, chronic lung disease, memory loss disorder, chronic pain, muscle weakness, malnutrition, and reduced mobility. Review of a 12/03/2024 Braden Scale (a risk assessment tool used to identify risk of developing a PU), showed Resident 49 was assessed to be at risk for developing a PU. Review of Resident 49's CP, initiated 12/03/2024, showed no CP in place with interventions for the resident's high risk of PU development or actual PU that developed on 02/10/2025. Review of 02/10/2025 progress note showed Staff J (RN) documented Resident 49 was assessed with a red area to the upper left buttocks. Staff J documented that Staff B (Director of Nursing) was notified and prophylactic (preventative) treatment orders were placed. Review of Resident 49's 02/10/2025 physician's orders showed no orders placed for prophylactic treatment for Resident 49's new wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 02/10/2025 skin evaluation showed Staff B documented Resident 49 had a Stage 1 PU (intact skin with redness usually over a bony prominence) in the middle of their buttocks (near tailbone) on the right side that was newly acquired at the facility. The PU measured 3.2 centimeters (cm) in length and 2.3 cm in width, with no drainage or pain noted. The skin evaluation showed Staff B documented a treatment dressing was ordered, turning and repositioning schedule initiated, and nutritional supplements added. Review of a skin evaluation, dated 02/17/2025, and signed off on 02/18/2025, showed Staff H (Licensed Practical Nurse - LPN) documented Resident 49 had a pressure sore to the right buttocks. The evaluation did not include measurements of the size of the PU or pain level related to the PU. Review of the February 2025 treatment administration record showed no documentation of treatment orders placed or implemented by facility staff. In an interview on 02/27/2025 at 12:00 PM, Staff B stated Resident 49 had a Stage 1 PU on their sacrum (tailbone) that was not open. Staff B stated the facility was applying a prophylactic wound dressing and cream to the area, Resident 49 had discharged the facility to another facility. In an interview on 03/12/2025 at 2:03 PM, Resident 49's Collateral Contact (CC), stated the resident arrived to the new facility on 02/18/2025, with redness and rash in their groin area, and an open area on their tailbone. In an interview on 03/13/2025 at 11:38 PM, Staff B stated they expected staff to document wound measurements and pain on the weekly wound evaluation and stated they did not include that information on the 02/17/2025 evaluation. Staff B stated Resident 49's PU was closer to the right and not on the left buttocks near the tailbone as Staff J documented. Staff B stated they did not see physicians orders placed in Resident 49's medical record for monitoring and treatment of the PU and would expect staff to put in orders as received by the physician. Staff B stated the wound and wound treatment orders should be but were not included on the transfer discharge summary. <Resident 14> Review of a 01/28/2025 Quarterly MDS showed Resident 14 was able to make needs known, was independent for decision making, and had no memory issues. The MDS showed Resident 14 had no behaviors of rejecting care, had an indwelling catheter (drains urine from the bladder into a bag), and was frequently incontinent of bowel. The MDS showed Resident 14 was at risk for PUs, had three PUs, and a diabetic foot ulcer (open area on the foot related to a blood sugar disorder). The MDS showed Resident 14 did not have a pressure relieving device for the wheelchair and the bed, and did receive PU care and applications of dressings. Resident 14 was dependent on staff for toileting, bathing, dressing, and transfers. The MDS showed Resident 14 had medically complex conditions including diabetes, heart failure, muscle weakness, and muscle wasting, Review of a 02/12/2025 Braden score showed Resident 14 was assessed to be at risk for PUs due to moist skin, inadequate nutrition, and the inability to walk. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a wound CP, revised 02/19/2025, showed Resident 14 had five wounds including a diabetic foot ulcer to the right foot, a Stage 4 PU (extends to muscle, tendon, or bone) to the right ankle, a surgical open area to the tailbone, a Stage 3 PU (full thickness tissue loss with no muscle, tendon, or bone exposed) to the back of the left thigh, and a Stage 3 PU to the right buttocks. The CP directed staff to assess, record, and document wound healing by measuring the length, width, and depth of the wound weekly. The CP directed staff to float the right foot off the bed surface to provide pressure relief on the wound by using off loading boots or pillows. Review of Resident 14's medical record, showed Resident 14 was last seen by a wound specialist at the facility on 10/24/2024. Review of weekly skin and wound evaluation documentation showed Resident 49's multiple wounds were not measured on 10/31/2024, 11/08/2024, 11/23/2024, 11/30/2024, 12/07/2024, 12/11/2024, 12/18/2024, 12/25/2024, 01/01/2025, 01/08/2025, 01/22/2025, 02/05/2025, 02/12/2025, 02/19/2025, 02/26/2025, and 03/05/2025. Review of wound clinic documents, dated 11/19/2024, showed Resident 14 was seen by a wound provider for a diabetic foot ulcer on the right foot, a diabetic ulcer of the right ankle, a stage 4 PU to the sacrum, a Stage 3 PU to the left buttocks, and a Stage 3 PU to the right buttocks. The documentation included measurements for 3 out of 5 wounds. Review of wound clinic documents, dated 12/17/2024, and faxed to the facility on [DATE], showed pictures of wounds with a measuring tape against the wound. The pictures were not clear, and wound measurements were unable to be determined by the quality of the faxed pictures. The wound clinic documents showed, the provider recommended staff should check Resident 14's feet daily, off load pressure by elevating their feet when at rest, appropriate footwear to be worn if resident worked with therapy, such as diabetic shoes, frequent repositioning/turning when in bed, elevate heels, avoid prolonged time in the wheelchair, and appropriate low airloss mattress (distributes body weight over a broad surface area to help prevent skin breakdown). Review of a 01/17/2025 wound clinic documentation showed similar findings with blurry wound images, wound measurements not visible, and the same provider recommendations. During an observation and interview on 02/27/2025 at 2:37 PM, Resident 14 was observed in their wheelchair, on their computer. Resident 14 was wearing gym shoes and observations of their bed showed no air loss mattress was in place. Resident 14 stated they had multiple open wounds on their bottom, two wounds on their right foot, and stated their wounds were becoming progressively worse. Resident 14 stated they were wearing diabetic gym shoes that they purchased. In an interview on 03/13/2025 at 9:52 AM, Resident 14's CC stated Resident 14's wound dressings were saturated upon arrival to the clinic. The CC stated three of the four wounds worsened by measuring bigger in size. The CC stated one of the wounds fluctuated in size but was to be expected due to the location of the wound and contributing factors of moisture. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/13/2025 at 11:08 AM, Staff B stated when a resident was found with a wound, they expected staff to notify them, the provider, and responsible party. The staff should complete an incident report, measure and assess the wound weekly, obtain and implement treatment orders, and notify the provider of any wound changes. Staff B stated they would expect Resident 14's wounds to be assessed and measured weekly. Staff B stated when a resident was not seen by the wound provider at the facility, nursing staff were responsible for measuring and documenting the wounds weekly. Staff B stated they did not see documentation that the wounds were measured weekly as expected. Staff B stated they were not aware of the wound providers recommendations as they were faxed to the facility after the appointment and scanned in the medical record. Staff B stated wound provider recommendations were not carried out as they would expect, and stated Resident 14 did not have an air mattress but the facility did encourage off loading of the right foot, frequent repositioning and limited time in the wheelchair. 43642 <Resident 7> According to a 02/05/2025 Admission MDS, Resident 7 admitted to the facility on [DATE] with multiple medically complex diagnoses including PUs and a spinal cord injury resulting in loss of movement to their lower extremities. Review of a 02/24/2025 progress note by a contracted wound clinic showed Resident 7 had a left buttock PU with significant improvement and a wound VAC (a medical device that used negative pressure to promote wound healing) would be resumed. This progress note gave recommendations and instructions to adjust the wound VAC settings to 120/125 millimeters of mercury (mmHg) intermittent suction and gave additional recommendations for wound treatment until the wound VAC supplies were delivered. Review of Resident 7's physician orders showed a 02/24/2025 order for wound treatment orders to left buttock until wound VAC supplies were delivered. There were no current physician orders for the use of the wound VAC or what the settings should be once initiated. Observations on 03/04/2025 at 10:11 AM showed Resident 7 with a wound VAC machine at the bedside. This wound VAC was set to 125 mmHg. Review of Resident 7's progress notes showed no indication when the wound VAC supplies were received. In an interview on 03/05/2025 at 2:56 PM, Staff B stated nursing staff should have obtained physician orders for the wound VAC once the supplies were received prior to implementing the device. <Resident 25> According to an 11/27/2025 Admission MDS, Resident 25 was assessed by staff to be at risk for developing PUs/injuries, had PUs on admission and received PU/injury care during the assessment period. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 25's physician orders showed the following orders from 02/28/2025 for both the upper and lower buttock wounds: staff were to cleanse the areas with saline, apply a skin prep to the surrounding area around the wound, apply a collagen sheet (a sheet of protein designed to promote wound healing), and cover with a dressing. Observations of wound care on 03/03/2025 at 11:25 AM showed Staff K (LPN) perform wound care to the upper and lower PUs of Resident 25's buttocks. Staff K did not apply the skin prep to the surrounding areas of the PUs for either wound as directed in the physician orders. Staff K used a cotton swab on a stick to insert a strip of an antiseptic dressing into the upper PU, instead of using a collagen sheet to the PU as ordered. Review of Resident 25's records showed the resident's PUs were measured by a contracted wound clinic on 01/31/2025, with no further wound measurements documented until 02/24/2025, over three weeks later. In an interview on 03/05/2025 at 2:56 PM, Staff B stated it was their expectation staff follow the physician orders for wound treatments and wounds be measured and documented weekly by staff in order to determine the progress of a wound's status. REFERENCE: WAC 388-97-1080(1)(3)(b).

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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. 45941 Based on observation, interview, and record review the facility failed to ensure a restorative program was provided for 2 of 5 (Residents 41 & 23) sample residents reviewed for restorative nursing services. These failures placed residents at risk for a decline in Range of Motion (ROM), a reduction in mobility, increased dependence on staff, and decreased quality of life. Findings included . <Resident 41> According to the 01/29/2025 Annual Minimum Data Set (MDS - an assessment tool), Resident 41 had medical conditions including a stroke (brain injury) resulting in paralysis (loss of function) to one half of their body and required one-person extensive assistance with personal hygiene. The MDS showed Resident 41 was assessed as cognitively impaired and did not reject care during the assessment period. Review of a 02/29/2025 revised ADL (Activities of Daily Living) self-care deficit Care Plan (CP) showed Resident 41 had right sided weakness due to a stroke. Staff were instructed to apply a splint on the resident's right hand daily as tolerated and to report any skin issues related to the splint placement to the provider. Observations on 02/26/2025 at 10:02 AM, on 02/27/2025 at 9:41 AM and at 2:12 PM, on 03/03/2025 at 9:24 AM and at 1:29 PM, and on 03/04/2025 at 11:53 AM showed Resident 41 was lying in bed, their right hand was contracted and there was no splint on the resident's right hand or wrist. Review of Resident 41's record showed Resident 41 received Occupational Therapy (OT) from 11/20/2024 through 12/24/2024. Review of the OT discharge summary showed Resident 41 was discharged from OT on 12/24/2024 and referred to a Restorative Nursing Program (RNP). The referral included application of a splint to Resident 41's right hand for four hours daily as tolerated to decrease risk of contractures. The OT discharge summary showed the staff were educated on applying the splint and the splint wearing schedule. Review of Resident 41's record showed Resident 41 had a 09/15/2024 physician order for a restorative functional maintenance program for active ROM, passive ROM, and bed mobility five times per week. In an interview on 03/05/2025 at 2:10 PM, Staff G (Rehab Director) stated Resident 41 had a contracture to their their right hand. Staff G stated Resident 41 was discharged from OT on 12/24/2024 with a RNP referral for splinting to their right hand and the referral was given to nursing staff for implementation of the program. In an interview on 03/05/2025 at 2:33 PM, Staff B (Director of Nursing) reviewed Resident 41's record and stated restorative staff should have implemented the RNP and should have applied the splint to Resident 41's right hand as recommended by OT, but they did not. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43642 <Resident 23> According to a 12/06/2024 Quarterly MDS, Resident 23 had multiple medically complex diagnoses including infection of their bone, obesity, absence of their left leg, and required skilled nursing care after a recent surgery. This MDS showed Resident 23 was assessed to have a functional limitation in ROM to both sides of their lower extremities, utilized a wheelchair for mobility, and received no restorative programs during the assessment period. In an interview on 02/27/2025 at 11:30 AM, Resident 23 indicated they previously asked staff about an exercise program and stated, nothing ever got started. Review of a 09/25/2024 functional abilities care area assessment showed staff documented Resident 23 required staff assistance with mobility, self-care activities for safety, and was at risk for further decline in functioning. Review of a 12/06/2024 provider progress note showed documentation Resident 23 had generalized weakness and would benefit from restorative therapy for transfers, mobility, and balance training. Starting a restorative program was discussed with Resident 23 and the documentation showed the resident was agreeable to starting a restorative program. Review of Resident 23's physician orders showed a 12/09/2024 order to evaluate the resident for restorative therapy to improve mobility/transfers. This order showed the status was completed with an end date of 12/16/2024. There was no documentation in Resident 23's records to show the resident was evaluated or had a restorative program initiated. On 02/14/2025 the provider wrote another progress note indicating Resident 23 was agreeable and would benefit from restorative therapy. No further order was initiated, and no documentation was found in Resident 23's records to show an evaluation for restorative was completed. In an interview on 03/05/2025 at 2:38 PM, Staff G stated a restorative program was important to help continue and maintain the resident's strength and current function to avoid decline in activities of daily living. In an interview on 03/05/2025 at 2:56 PM, Staff B reviewed Resident 23's records and stated they were unable to locate the restorative program evaluation was completed as ordered. REFERENCE: WAC 388-97-1060(3)(d).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45941 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) provided at least eight hours of direct care supervision per day for 5 of 31 days reviewed. This failure placed residents at risk for delay in resident assessments, identification of changes in condition, provision of care and services outside the scope of practice of the Licensed Practical Nurse (LPN), and unmet care needs. Findings included . Review of the facility's Daily Nurse Staff Documentation showed on five days (02/02/2025, 02/08/2025, 02/09/2025, 02/15/2025, and 02/16/2025 - on Saturdays and Sundays) from 01/27/2025 through 02/26/2025 there was no RN on site for eight hours as required by federal regulations. In an interview on 03/04/2025 at 11:21 AM, Staff I (Staffing Coordinator) stated they were responsible for scheduling daily nursing staff. Staff I stated when staff called out, they were responsible for finding a substitute. Staff I stated they started with in-house staffing resources who were off on that day. Staff I stated call outs were most common on the weekends. In an interview of 03/05/2025 at 2:08 PM, Staff H (LPN) stated the facility had RNs and LPNs to work on the floor daily all three shifts and over the weekends. Sometimes, there were call outs and the staffing coordinator was responsible to find another RN or LPN to fill in. Staff H stated their Director of Nursing worked on the floor to cover the shift for any call outs at times. Staff H stated on the weekend, the facility depended on the on-call nurse. If the on-call nurse for that weekend did not hold an RN license, there was no opportunity to fulfill the eight-hour RN requirement. In an interview on 03/05/2025 at 2:35 PM, Staff B (Director of Nursing) stated they were aware the facility did not have RN coverage over the weekend at times. Staff B stated it was hard to fulfill the RN requirement and acknowledged the weekends when the facility failed to meet the eight-hour requirement. REFERENCE: WAC 388-97-1080 (3)(a).

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to provide social services interventions for 1 of 5 residents (Resident 1) reviewed for unnecessary medications. The failure to initiate further assessment and appropriate interventions when the resident answered positively to a self-harm question, placed the resident at risk for unmet care needs and non addressed mental health concerns. Findings included . <Resident 1> According to the 11/27/2024 Quarterly Minimum Data Set (MDS- an assessment tool), Resident 1 admitted to the facility on [DATE], had no memory impairment, and had a diagnosis of depression. The MDS showed Resident 1 received antidepressant and antianxiety medications on seven of seven days during the assessment period. The 11/27/2024 MDS included a PHQ - 9 (an assessment for screening the severity of depression) of Resident 1's mood which identified the presence of multiple symptoms of depression. The section titled, Thoughts that you would be better off dead, or of hurting yourself in some way was marked as present for two to six days of the 14-day look-back period. The PHQ-9 assessment was completed on 11/21/2024 with a score of 09, showing Resident 1 had depressive symptoms. Review of Resident 1's record showed no documentation further assessments, monitoring, or interventions related to the positive response to the above concern about self-harm was considered completed. There was no documentation showing that provider was notified. Observations on 02/26/2025 at 9:32 AM, 02/28/2025 at 12:22 PM, and on 03/03/2025 at 8:33 AM showed Resident 1 lying in their bed with their eyes closed. In an interview on 03/04/2025 at 11:19 AM, Resident 1 stated, I want to go home. I know I cannot take care of myself at this point. Resident 1 stated, I do not have any plans to harm myself and Resident 1 went back to sleep. In an interview on 03/05/2025 at 11:48 AM, Staff C (Social Services Director) stated their process for assessing residents who answered positively to the self-harm question was to ask the resident if they had a plan in place to harm themselves. If the resident had a plan, staff would initiate alert charting, increase supervision, talk to everyone involved in the resident's case, notify the provider, and involve a mental health professional. Staff C reviewed Resident 1's PHQ-9 assessment and stated there was no further assessment and interventions for the response regarding self-harm. Staff C stated, I just took this SSD position recently. I was not aware of this assessment otherwise I would have done the follow up assessment and implement the interventions. On 03/05/2025 at 12:23 PM, Staff C stated they just talked to Resident 1 and Resident 1 stated they did not have a plan to harm themselves. Staff C stated they would follow up with Resident 1 again and implement the interventions. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/2025 at 12:36 PM, Staff B (Director of Nursing) stated they expected staff to interview the resident further about any statements of self-harm and determine if the resident had a plan in place to harm themselves. Staff B stated the resident would be placed on alert charting, monitored closely, the provider would be notified, a mental health professional would be called, and the resident might be sent to the hospital if needed. Staff B stated they expected staff to discuss Resident 1's statement with them but they did not. Staff B stated implementing interventions to protect residents from self-harm was very important for resident safety. REFERENCE: WAC 388-97-0960(1).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43642 Based on observation, interview, and record review the facility failed to ensure planned breakout menus were followed during meal service and 5 (Resident 53, 25, 30, 40, & 20) residents with specialized diets were provided meals that were in alignment with their prescribed diets. These failures placed residents at risk for less than adequate nutritional intake, consuming meal portion sizes and calories other than as planned by a Registered Dietician (RD), and unmet nutritional needs. Findings included . <Facility Policy> Review of the facility's 2023 Menus and Adequate Nutrition policy showed menus were developed and prepared to meet residents choices including their nutritional, religious, cultural, and ethnic needs. This policy showed menus would be followed as posted and the facility would ensure the menus met the nutritional needs of residents. Review of the facility's 02/28/2025 Week 3 breakout menu showed the facility was serving Panko crusted fish with zucchini and tomatoes for lunch. This menu showed residents on large portion diets would receive 1 and 1/2 pieces of the fish. Review of the facility's 03/03/2025 Week 3 breakout menu showed the facility was serving sausage patties for breakfast. This menu showed residents on large portion diets would receive 2 sausage patties. <Resident 53> According to a 01/31/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 53 had multiple medically complex diagnoses including anemia (condition of not having enough protein in the cells to carry oxygen through the body), heart failure, and a progressive movement disorder disease. This MDS showed Resident 53 was on a therapeutic diet. Review of an 08/10/2024 nutritional status Care Area Assessment showed Resident 53 was at risk for weight fluctuations and staff would proceed to the Care Plan (CP) to assure the facility meets the resident's nutritional needs while preventing dehydration and reducing risk of weight loss. Review of Resident 53's nutritional risk CP showed the resident had the potential for altered nutrition and/or hydration status related to their diagnoses and gave directions to staff to provide and serve the diet as ordered. According to a 01/31/2025 quarterly nutrition assessment progress note completed by the RD, Resident 53 was to continue receiving large protein portions as an intervention for resident's recent weight loss. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 53's tray card showed they were on a regular diet with large protein portions and cut up meats. Observations on 02/28/2025 at 12:20 PM showed Resident 53 received their lunch tray. On the tray was a tray card that said the resident was to receive large portions of proteins. On Resident 53's tray was one piece of plain fish, not Panko crusted fish or large portions as directed on the menu. Observations on 03/03/2025 at 8:11 AM showed staff delivering a breakfast tray to Resident 53. This tray included only one cut up sausage patty, instead of large portions as directed. Observations on 03/03/2025 at 12:19 PM showed staff delivering a lunch tray to Resident 53. This tray only had one whole piece of meatloaf, rather than the large portions cut up as directed on the breakout menu. <Resident 25> According to an 11/27/2024 Admission MDS, Resident 25 had multiple medically complex diagnoses including heart failure, pressure wounds, and obesity. This MDS showed Resident 25 had clear speech with no memory impairment and was on a therapeutic diet. Review of Resident 25's tray card showed the resident was on a regular diet, no added salt, and was to receive double protein portions. This tray card listed Resident 25's dislikes which included bacon and tomato. In an interview on 02/26/2025 at 1:25 PM, Resident 25 stated they were frustrated with the kitchen service. Resident 25 stated they do not eat pork and reported they kept getting pork as well as other things they disliked from the kitchen. Resident stated, it just happened a couple days ago, I was served pizza with bacon on it. Observations on 02/28/2025 at 11:28 AM showed Resident 25 received their lunch tray. On the tray was one piece of plain fish, not Panko crusted fish or double portions as directed on the tray card. Resident 25 was also served zucchini with tomatoes when their dislikes listed tomato. The tray also included a packet of salt and pepper, rather than the no added salt directions on Resident 25's meal tray card. Observation of the meal service tray line on 03/04/2025 at 12:07 PM showed kitchen staff placed a salt packet on Resident 25's tray. Review of the tray card showed the resident was not to receive added salt on their meals. In an interview on 03/05/2025 at 2:56 PM, Staff B (Director of Nursing) stated it was their expectation the menu was followed by staff to keep a resident's nutritional status stable. 46479 Review of the facility's 03/04/2025 Week 4 breakout menu showed the facility was serving meatloaf and mashed potatoes with gravy for lunch. This menu specified that a large portion of meat loaf was 4 ounces (oz) and large portion mashed potatoes was equal to a size #16 scoop. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the lunch service tray line on 03/04/2025 at 12:07 PM showed kitchen staff preparing to plate the lunch meal for residents. The mashed potatoes on the steam table had a gray handled scoop staff used to put the potatoes on the resident's plates. The meatloaf was sliced in a variety of sizes and thickness and contained a spatula for serving. <Resident 30> Observation on 03/04/2025 at 12:07 PM showed kitchen staff prepping Resident 30's lunch tray. Review of Resident 30's tray card showed a diet order of no added salt. Staff placed a salt packet on Resident 30's tray. <Resident 40> Observation on 03/04/2025 at 12:12 PM, Staff O (Kitchen Cook) was plating Resident 40's lunch. Resident 40's tray card showed the resident was on a regular diet with large portions. Staff O placed one slice of meatloaf and one scoop of mashed potatoes using the gray handled scoop. A different scoop was not used for large portions as directed by the breakout menu. <Resident 20> Observation on 03/04/2025 at 12:29 PM showed Staff O preparing Resident 20's lunch plate. Staff O placed one slice of meatloaf on Resident 20's plate. Review of Resident 20's tray card showed the resident was to receive large protein portions. In an interview on 03/04/2025 at 1:36 PM, Staff N (Dietary Supervisor) stated it was very important for kitchen staff to follow the menu. Staff N stated residents had expectations of what they were receiving for meals and it was important they received diets as ordered with the right portion sizes for proper nutrition. Staff N confirmed Resident 30 and Resident 25 should not receive salt packets on their trays. Staff N stated large portions meant residents were supposed to get double the amount of food. Staff N was unaware about the scoop sizes and what size kitchen staff should use based on diet orders. In an interview on 03/05/2025 at 1:05 PM, Staff P (RD) stated not following the menu could impact resident nutrition calculations if residents received too much or too little food. Staff P stated they expected kitchen staff to follow menus and use stated scoop sizes as identified in the breakout menu. REFERENCE: WAC 388-97-1160(1)(a)(b).

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43642 Based on observation, interview, and record review the facility failed to serve foods that were appetizing in appearance, palatable, and served at the proper temperature. Observations of meal services, a facility test tray, and interviews with 4 (Residents 25, 23, 12 & 45) sample residents identified concerns about the taste, temperature, and palatability of the food served by the facility. These failures placed residents at risk for less than adequate nutritional intake and dissatisfaction with meals. Findings included . <Resident 25> In an interview on 02/26/2025 at 1:41 PM, Resident 25 stated the food was, almost always cold. Resident 25 stated once in a while it was warm. <Resident 23> In an interview on 02/27/2025 at 11:28 AM, Resident 23 stated the food was not cooked well and reported the food was cold when it is delivered. <Resident 12> In an interview on 02/26/2025 at 10:18 AM, Resident 12 stated the food was not appetizing and reported it was, hit or miss if they got the requested alternatives. Resident 12 stated the toast was either too hard to eat or hardly toasted and the meals were not served hot. <Resident 45> In an interview on 02/26/2025 at 10:30 AM, Resident 45 stated the food was horrible and stated the staff delivering the food are unable to identify what the food was at times. 46479 <Test Tray> Review of the facility's 03/04/2025 lunch breakout menu showed the facility was serving meatloaf, mashed potatoes and gravy, buttered carrots, a roll with margarine, and a winter fruit cup for lunch. Observation of the facility test tray on 03/04/2025 at 12:57 PM showed the meatloaf temperature was 117 degrees Fahrenheit (F). The buttered carrots were 99 degrees F and very difficult to get a fork through the carrot. The carrots were very hard and undercooked. (continued on next page)

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	505339	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Bend Post Acute	219 Cedar Avenue South North Bend, WA 98045

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/05/2025 at 1:05 PM, Staff P (Registered Dietician) stated they were aware of resident concerns regarding cold food. Staff P stated the facility was working to correct this issue for the residents. REFERENCE: WAC 388-97-1100(1), (2). .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 45941 Based on interview and record review, the facility failed to establish an infection prevention and control program that included developing an Antibiotic (ABO) Stewardship Program to promote appropriate use of ABOs and reduce the risk of unnecessary ABO use for 1 sample (Resident 8) and 1 supplemental (Resident 35) of 5 residents reviewed for unnecessary ABOs. This failure placed residents at risk for potential adverse outcomes, associated with the inappropriate/unnecessary use of ABOs. Findings included . <Facility Policy> According to the 2024 facility ABO Stewardship Program policy ABOs would be prescribed and administered to residents under the guidance of the facility's ABO Stewardship Program and in conjunction with the facility's general policy for Medication Utilization and Prescribing. The purpose of this program was to optimize the treatment of infections while reducing the adverse events associated with ABOs. This policy stated nursing staff would monitor the initiation of antibiotics on residents and conduct an ABO timeout within 48-72 of antibiotic therapy, to monitor response to the antibiotic and review laboratory results. Staff would consult with the practitioner to determine if the antibiotic was to continue or if adjustments needed to be made based on the findings. This policy did not indicate which criteria the facility utilized in determining appropriate ABO usage. In an interview on 03/04/2025 at 9:00 AM, Staff B (Director of Nursing) stated facility did not have a full time Infection Preventionist. Staff B stated the facility had Staff D (Offsite Infection Preventionist) who came to the facility on ce a month. Staff B stated they took care of infection control issues in the facility and Staff D had access to resident records, received reports about infections occurring in the facility, and provided guidance to staff every month regarding infection control issues. In an interview on 03/04/2025 at 1:00 PM, Staff B and Staff D (over the phone) stated the facility used the McGeers criteria (a tool used for infection surveillance activities and management of ABO usage). Staff B stated when a resident admitted to the facility with an infection, staff were expected to obtain, from the hospital, the appropriate diagnosis for the prescribed ABO, start and stop date of ABOs, lab results, and data to ensure the resident's condition met McGeer's criteria. Staff B stated when a resident acquired an infection in house, staff were expected to ensure the resident's symptoms met the McGeer's criteria, the prescribed ABO was appropriate and necessary, lab results were communicated to the prescriber to ensure the least invasive ABO was prescribed, and the order was complete with name, dose, length of course, and had an appropriate diagnosis. Staff D stated they reviewed resident's records with new ABOs, indications, doses, labs, and supporting documents, and followed up with Staff B regarding any concerns. <Resident 8> (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the December 2024 physician orders, Resident 8 was prescribed three different ABO courses. A Urinalysis (UA) was obtained on 12/12/2024 and Resident 8 was prescribed a 5 day course of ABOs to be administered twice daily for a possible Urinary Tract Infection (UTI) on 12/14/2024. Resident 8 received the ABO for five days from 12/14/2024 to 12/19/2024. The 12/17/2024 provider note directed staff to start Resident 8 on another ABO by mouth twice daily for 7 days for a UTI based on the preliminary UA report. There was no documentation directing staff to stop the first ABO started on 12/14/2024 for the same infection. Resident 8 received another course of ABO treatment for the UTI twice daily from 12/17/2024 to 12/21/2024. The final UA culture report on 12/18/2024 showed Resident 8 had an infection. A Culture and Sensitivity (C&S - microbiology evaluation of urine showing which ABO's were resistant/susceptible for the treatment of the specific bacteria resident had in their urine) report showed the ABO to treat UTI. Review of Resident 8's medical records showed a 12/19/2024 provider's note directing staff to discontinue the current ABO and start an intravenous ABO every 6 hours for 5 days for the UTI based on the final urine C&S. Review of the ABO line listing showed Resident 8 did not meet McGeer's criteria for the first ABO Resident 8 was given from 12/14/2024 to 12/19/2024. In a joint interview on 03/04/2025 at 1:00 PM with Staff B and Staff D (over the phone), Staff B reviewed Resident 8's record and provided the medical provider's documentation that showed on 12/17/24 and 12/19/2024 progress notes that the UA report was reviewed and an order to start Resident 8 on two different ABOs. Staff B and Staff D were unable to provide documentation explaining the reason why Resident 8 continued the first ABO for five days after the UA report was obtained. <Resident 35> Review of Resident 35's December 2024 medication administration record showed Resident 35 received a seven days course of ABOs prescribed for dysuria (painful urination). According to the December 2024 line listing, Resident 35 received an ABO for dysuria. The line listing showed McGeer's criteria was not met. Review of Resident 35's records showed the facility collected Resident 35's urine on 12/24/2024 and the UA report was back on 12/25/2024 showing the resident did not have an infection. There was no documentation showing staff consulted with the provider regarding the UA results or to discontinue the ABO. In a telephone interview on 03/04/2025 at 1:09 AM Staff D stated they obtained a UA to assess for a UTI but staff did not consult with Staff B or the provider regarding the UA report that showed Resident 35 did not have an infection. Staff D stated Resident 35 did not meet the McGeer's criteria and should not be treated with an ABO. Staff B stated they should have reviewed the ABO order at the time of order to ensure Resident 35 met McGeer's criteria, but they did not. REFERENCE: WAC 388-97-1060(3)(k)(i).

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to ensure and designate a qualified staff person to serve as the Infection Preventionist (IP) and that the IP physically worked onsite in the facility at least part time hours as determined by the Facility Assessment. This failure placed residents at risk for unmet infection control issues and prevented a lack of over site of the facility staff's infection control practices. Findings included . Upon entrance to the facility on [DATE] Staff B (Director of Nursing) stated Staff D (Registered Nurse) was the facility's IP. Staff B provided Staff D's Certificate of Training from the Centers for Disease Control Nursing Home Infection Preventionist Training Course of 19.3 hours completed on 12/14/2020. In an interview on 03/04/2025 at 9:00 AM, Staff B stated Staff D was working as an IP offsite. Staff B stated Staff D did not work physically in the facility at least 20 hours a week according to the facility census, they came to the facility sometimes and reviewed infection control issues. Review of the facility's 08/28/2024 Facility Assessment showed the facility did not assess or determine the amount of time the facility required an IP to fulfill their roll based on resident census and need. The Facility Assessment showed services the facility offered related to infection control included identification of infection, standard/transmission based precautions, and prevention of infection but did not determine the amount of time the IP required in order to ensure residents received these services as offered by the facility. In an interview on 03/04/2025 at 9:07 AM, Staff A (Administrator) stated Staff D worked as an IP offsite and came to the facility on ce a month. Staff A stated the last time Staff D was in the facility was 02/17/2025 for eight hours to review infection control issues. Staff A stated they were aware of the requirement of a qualified staff person to serve as an IP must physically work onsite in the facility at least for 20 hours a week according to the facility census, but they did not have one. Refer to F881, Antibiotic Stewardship. REFERENCE: WAC 388-97-1320(1)(a).