STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505344	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury House	502 29th Street Southeast Auburn, WA 98002

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on interview and record review, the facility failed to ensure 3 (Resident 1, 12, 3) of 6 residents or resident representatives reviewed were fully informed orally and in writing of the potential risks associated with the use of psychotropic medications (medications that alter the thought process). In addition, based on interview and record review the facility failed to obtain informed consent for devices used for 1 (Resident 1) of 4 residents reviewed for devices. These failures prevented residents and/or legal representatives from making informed decisions about the use of multiple antidepressant medications, and precluded them from exercising their right to refuse/decline the proposed medications. Findings included . Review of the facility policy titled, Informed Consent for Psychotropic Drugs, updated 09/2017, showed the facility would obtain informed consent form the resident or resident representative before the drug prescribed is administered. The licensed nurse would review the drug, dosage and frequency, discuss the rationale/benefits for the order and discuss the potential risk factors of taking the prescribed drug with the resident or resident representative, and obtain their signature if they agree to take the prescribed drug. The policy showed the psychotropic drug consent would be signed and placed in the resident's medical record. Review of a facility policy, titled, Devices, updated 09/2017, showed devices were implemented after consent was obtained addressing the risks and benefits with the resident or the resident representative. The policy showed an individual consent would be obtained for each device. <Resident 1> <Psychotropic Medications> (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly Minimum Data Set (MDS, an assessment tool), dated 10/23/2024, showed Resident 1 admitted to the facility on [DATE], had severe impairments to their decision making, was rarely or never understood, and had a Collateral Contact (CC) for decision making. The MDS showed Resident 1 had verbal behavioral symptoms directed at others that occurred 1 to 3 days of the 7 day look back period that significantly disrupted care and the living environment. The MDS showed Resident 1 had no physical behaviors directed towards others and did not refuse care. The MDS showed Resident 1 had medically complex conditions, including, a brain dysfunction that caused confusion and memory loss, anxiety, and depression. Review of section N, medications of the MDS, showed Resident 1 used an antipsychotic, antianxiety, and antidepressant medications. Review of an antipsychotic Care Plan, (CP), revised 11/09/2024, showed Resident 1 used an antipsychotic for behavior management and directed staff to monitor the effectiveness of the medication. The CP directed staff to discuss with the physician and the family the need for on-going use of the medication and review behaviors, interventions, and alternate therapies attempted to determine the effectiveness. Review of a Nursing Progress Note (NPN), dated 12/04/2024 at 10:54 AM, showed Staff F (Licensed Practical Nurse, LPN) documented Resident 1 was screaming at the top of their lungs, kicking, swinging arms and legs. Staff F documented multiple attempts to redirect were unsuccessful, a call was placed to the behavioral health support, and a new physician order was received for a one time dose of an antipsychotic and to increase Resident 1's an antidepressant (a class of depressant drugs used to treat anxiety, insomnia, and seizures) medication from every six hours to every four hours as needed for an anxiety. The NPN showed Staff F left a message with Resident 1's CC to call the facility. Review of Resident 1's December 2024 Medication Administration Record (MAR), showed Staff J (Registered Nurse, RN) administered the one time dose of the antipsychotic medication at 11:00 AM. Review of Resident 1's record showed no documentation of informed consent was obtained from Resident 1's CC before facility staff administered the one time dose of antipsychotic medication and increased the frequency of Resident 1's antidepressant medication. In an interview on 12/12/2024 at 10:45 AM, Resident 1's CC stated they received a call from the facility on 12/04/2024 that Resident 1 had crawled out of bed and stated no one discussed medications with them at this time. During an interview on 12/12/2024 at 4:18 PM, Staff B (Director of Nursing) stated medications that require informed consent should not be given before consent obtained so the resident or resident representative can make an informed decision about the medication. Staff B stated no documentation could be found that showed Resident 1's CC was informed and consented to the medications before given by staff. <Devices> Review of Resident 1's fall CP, revised 11/05/2024, showed Resident 1 had seven devices including; a bed alarm, a chair alarm, tilt-n-space (a wheelchair that reclines) wheelchair, a perimeter mattress, bed in lowest position, fall mat, and bed against the wall. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's record from admission, dated 07-24-2024-12/09/2024, showed no consent was obtained from resident 1's CC for the use of a fall mat at the bedside, bed against the wall, or perimeter mattress. In an interview on 12/12/2024 at 4:20 PM, Staff B stated all devices should have informed consent before being implemented. <Resident 12> Review of a significant change MDS, dated [DATE], showed Resident 12 was not able to make their needs known, not able to make own decisions, rarely made themselves understood, and rarely understood others. The MDS showed Resident 12 had no behaviors, and medically complex conditions that included dementia, anxiety, depression, and paraplegia (an impairment in motor or sensory function of the lower extremities). The MDS showed Resident 12 was dependent on staff for all care, including toileting, dressing, eating, and transfers. Review of hospital transfer orders and documents, dated 12/03/2024, showed Resident 12 was being treated under hospice care with comfort as the goal. A physician's order, dated 12/03/2024, showed Resident 12 was prescribed an antipsychotic medication to be given every two hours as needed. Review of Resident 12's December 2024 MAR, showed on 12/05/2024 at 1:15 PM and 9:30 PM, and on 12/06/2024 at 9:28 AM, Resident 12 received the antipsychotic medication. Review of Resident 12's medical record from readmission on 12/04/2024 to 12/06/2024, showed no consent was obtained from Resident 12's CC before staff administered the antipsychotic medication. During an interview on 12/12/2024 at 4:25 PM, Staff B stated all antipsychotic medications should have informed consent before medication was administered. <Resident 3> Review of the quarterly MDS, dated [DATE], showed Resident 3 was able to make needs known, own decisions, spoke a different primary language, and could understand and be understood by others. The MDS showed Resident 3 had no behaviors, and medically complex conditions including' end stage renal disease, diabetes, and high blood pressure. The MDS showed Resident 3 was dependent on staff for toileting and lower extremity dressing, and maximum assist for personal hygiene, and bed mobility. Review of a physicians order, dated 11/15/2024, showed Resident 3 was prescribed an antianxiety medication as needed every six hours for adjustment disorder with anxiety. Review of Resident 3's MAR, dated November 2024, showed Resident 3 received the antianxiety medication five times from 11/15-11/25/2024. Review of Resident 3's medical record, dated 11/15/2024-12/12/2024, showed no documentation consent was obtained for Resident 3's antianxiety medication before staff administered the medication. In an interview on 12/12/2024 at 4:27 PM, Staff B stated they would expect staff to obtain consent and document before administering the antianxiety medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	WAC: REFERENCE 388-97-0260

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review the facility failed to implement their abuse and neglect policies and procedures regarding identification, investigation, protecting, and reporting of abuse and neglect incidents. The facility failed to thoroughly investigate incidents and allegations of abuse, sexual abuse, and neglect for 7 of 9 residents (Resident 2, 1, 4, 3, 5, 6, 7) reviewed for incidents, failed to identify and report incidents as potential for abuse or neglect related to falls and bruises for 2 of 2 residents (Resident 2, 8), and failed to ensure facility staff implemented abuse policies and procedures and protected residents from further abuse by staff for 1 (Staff D) of 6 staff involved in incidents, when Staff D went back to Resident 4 and Resident 5's room despite an allegation of verbal abuse, and failed to timely report allegations of sexual abuse to local authorities as required for 1 of 2 residents (Resident 2) reviewed for sexual abuse allegations. These failures placed the residents at risk for abuse by caregivers, and placed all residents at risk for for unidentified and on-going abuse/neglect, and a diminished quality of life. Findings included . Review of the facility policy, Abuse Investigations, dated 10/2022, showed the facility would conduct a thorough investigation of potential or suspected allegations of abuse and neglect in accordance with state and federal rules. The policy showed staff would identify and interview all persons involved, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The facility would protect the alleged victim during the investigation, determine if abuse or neglect occurred and maintain complete and thorough documentation of the investigation. Review of the facility policy, Investigations of Alleged Sexual Abuse, dated 10/2022, showed sexual abuse was defined as non-consensual sexual contact of any type with a resident. The policy directed staff to immediately protect the resident, report to the facility administrator, supervisor, state survey agency, and the local police department. The policy showed the facility would conduct a thorough abuse investigation to determine if sexual abuse occurred by conducting a physical exam for potential injuries of sexual abuse. The policy showed the facility would provide additional medical follow-up including sending the resident to the hospital emergency room for a rape kit as indicated. <Resident 2> Review of Resident 2's quarterly Minimum Data Set (MDS, an assessment tool), dated 10/14/2024, showed Resident 2 had impairments to their thought process, had adequate hearing, vision, clear speech, and was able to make themselves understood, and able to understand others. The MDS showed Resident 2 had no behaviors, had no impairments to their extremities, and was dependent on facility staff for toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS showed Resident 2 had medically complex conditions, including; anxiety, schizophrenia, and adult failure to thrive. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Activities of Daily Living (ADL) Care Plan (CP), dated 10/30/2024, showed Resident 2 was dependent on two staff members to turn, reposition, and provide incontinence care. Review of an at risk for trauma/re-traumatization CP, dated 09/12/2024, showed Resident 2 was at risk for re-traumatization due to past and current trauma the resident experienced. The CP directed staff to listen to resident concerns and notify the Licensed Nurse (LN) or Social Worker (SW) when the resident reported feelings of re-traumatization or displayed changes in behavior or mood. The CP did not indicate what type of trauma Resident 2 experienced and did not identify what triggered the resident for potential re-traumatization. Review of a facility investigation, dated 11/11/2024, showed Resident 2 told a caregiver (Staff E, Certified Nursing Assistant, CNA/Restorative Nursing Aide) they were raped. Staff F (Licensed Practical Nurse, LPN) interviewed Resident 2 who stated an old man raped them the other day. Resident 2 stated the old man took off my brief that was full of poop and smelled it. Staff F asked Resident 2 if they were touched inappropriately and Resident 2, replied yeah they were wiping down there but denied anything being inserted vaginally. The investigation showed the facility administrator, director of nursing, and Resident 2's collateral contact was notified of Resident 2's allegation of sexual abuse. The investigation showed the facility identified one staff member (Staff G, CNA) that worked with Resident 2. Staff G denied providing bowel incontinence care during that time. The investigation showed local police were notified on 11/14/2024, three days after Resident 2 alleged rape and the Interdisciplinary Team (IDT) concluded that Resident 2 described routine incontinence care, denied anything inserted vaginally or rectally, and it was reasonable to believe the allegation resulted from Resident 2's medical diagnoses and a recent medication change. Review of a late entry Nursing Progress Note (NPN), dated 11/11/2024 and entered on 11/13/2024, showed Staff F documented that Resident 1 stated they were raped by an old man the other day, when Staff F asked Resident 2 what they looked like, Resident replied an old man. The progress note showed Staff F informed the administrator, director of nursing, and Resident 2's collateral contact. Review of Staff E's investigation interview, dated 11/15/2024, showed Staff H (Social Services Assistant, CNA) interviewed Staff F to see if they heard or observed any inappropriate behavior with staff and residents, Staff E stated no. Review of the nursing staff schedule from 11/04/2024-11/11/2024, showed eight other male staff members worked with Resident 2 during the time the allegation was made. The scheduled showed on 11/09/2024, Staff I (LPN) was Resident 2's nurse the night the facility determined Staff G was assigned to Resident 2. In an interview and observation on 11/20/2024 at 10:45 AM, Resident 2 was observed in bed and stated, when I was asleep an old man came into the room, removed their brief and smelled it. Resident 2 stated this made them mad and the old man left. During an observation and interview on 12/12/2024 at 1:36 PM, Resident 2 stated the old man was average height, Caucasian with black hair that walked in the room with no devices. Resident 2 stated they had never seen this old man before and has not seen them since the incident. Resident 2 stated the old man did not say anything during the incident and repeated the same encounter as the previous interview. Resident 2 stated they had trauma in their past and did not want to discuss their trauma. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2024 at 1:50 PM, Staff A (Administrator) stated when a resident alleged sexual abuse they would expect staff to report to the state hotline, the resident's provider, resident representative, and police. The staff should perform a physical assessment, suspend the alleged perpetrator, and monitor the resident for psychological harm. Staff A stated the police should have been notified immediately after the allegation was made and acknowledged the facility waited four days to report to the police. Staff A stated Resident 2's provider was notified the next day (11/12/2024) of the allegation, would expect staff to notify the provider immediately after the allegation, and would expect staff to document the notifications in the investigation. Staff A stated they determined Staff G as the perpetrator because he was the only male assigned to Resident 2 a few days prior that could fit the description of an old man. Staff A stated the investigation was not thorough, should have but did not include the possibility of a resident in the facility or other male staff that cared for Resident 2. Staff A was not sure if Resident 2's collateral contact was asked if they would like Resident 2 to be evaluated further at the emergency room and would expect staff to document thoroughly on the investigation. Staff A stated they were not sure who the other aides were when Staff G was providing incontinence care to Resident 2 as they required two staff members for bed mobility and incontinence care. Staff A stated they would expect staff to follow the CP if the resident required two aides they would expect two aides for bed mobility and incontinence care. Staff A would expect the other aides to be identified in the investigation and interviewed about the incident. Staff A stated Staff H helped with interviews, asked very broad questions, and did not seek further information or details specific to the event. <Resident 1> Review of Resident 1's quarterly MDS, dated [DATE], showed Resident 1 had impairments to their decision making ability and thought process, was rarely understood by others, had adequate hearing, vision, and clear speech. The MDS showed Resident 1 had no physical behaviors directed towards others, had verbal behaviors directed at others occurring one to three days of the seven day look back period, and had no other behavioral symptoms, such as disrobing, screaming, rejecting care or throwing food. The MDS showed the behaviors did not put the resident at significant risk of injury, did not interfere with their care or with the resident's participation in activities, and the behaviors significantly disrupted the living environment. The MDS showed Resident 1 required maximum assistance from staff with toileting, personal hygiene, bed mobility, and transfers. The MDS showed Resident 1 had medically complex conditions including a brain dysfunction that caused confusion and memory loss, anxiety, and depression that required treatment with antipsychotic, antianxiety, antidepressant, and pain medications. Review of facility fall assessment, dated 11/05/2024, showed Resident 1 was assessed as a high fall risk due to severe impairments to their decision making, poor safety awareness, and balance problems. Review of a facility fall CP, revised 11/05/2024, showed Resident 1 had a history of crawling on the floor. The CP showed Resident 1 had a bed and wheelchair alarm to alert staff of Resident 1 rising from the bed or chair. The CP directed staff to keep Resident 1 in high visible areas when awake, provide activities that promote exercise, and when a fall occurred monitor, document, and report the fall to the provider. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a NPN, dated 11/30/2024, showed Staff J (Registered Nurse, RN) documented Resident 1 was trying to get out of their wheelchair during the day shift, Resident 2 wanted to be laid down, and was put into bed. Staff J documented at 2:35 PM Resident 2 crawled out of bed and almost by the door when another resident called and reported Resident 2 was crawling on the floor. Staff J documented Resident 2 was placed in the wheelchair by the nurse station so they could be closely monitored. The NPN showed no indication the provider, Resident 1's collateral contact, administrator or Director of Nursing (DON) were notified Resident 2 was found crawling on the floor into the hallway. The NPN note showed no indication Resident 1 was assessed for an injury after they were found crawling in the hallway. Review of a NPN, dated 12/4/2024, showed Staff J documented Resident 1 was yelling and trying to jump out of their wheelchair and was laid down at 1:00 PM. Staff J documented Resident 1 crawled out of bed to the doorway, into the hallway, and was transferred into the wheelchair in the middle of the hallway. The NPN showed no indication Resident 1 was assessed for an injury or Resident 1's CC was notified of Resident 1 crawling out of bed into the hallway. Review of a NPN, dated 12/8/2024, showed Staff J documented Resident 1 was given medications at 7:00 PM, by 7:30 PM crawled out of bed to the room doorway an started screaming. The NPN showed no indication the provider, Resident 1's collateral contact, administrator or Director of Nursing (DON) was notified of Resident 2 found crawling on the floor into the hallway. The NPN note showed no indication Resident 1 was assessed for an injury after found crawling in the hallway. Review of the facility abuse log, dated November 2024 and December 2024, showed Resident 1's crawls out of bed were not observed on the log. During an interview on 12/12/2024 at 10:45 AM, Resident 1's CC stated on 12/11/2024 Resident 1 crawled into the bathroom and then out into the hallway where they had a bowel movement. The CC stated they were aware that a bed and chair alarm was used with Resident 1. The CC suspected the bed alarm was turned off if the staff didn't realize the resident was out of the bed and already in the hallway. During an observation and interview on 12/12/2024 at 1:39 PM, Resident 1 was observed sleeping in bed with their eyes closed. Observations showed no bed alarm or chair alarm. Staff J was asked where the bed and chair were located, looked under Resident 1 in the bed, and no bed alarm was observed under Resident 1. Staff J did not find the chair alarm for Resident 1. Staff A and Staff B (DON) confirmed no bed or chair alarm was observed in the room or being used on Resident 1 as ordered by the provider. Staff A stated they would expect Resident 1's bed and chair alarms to be in use and functioning. During an interview on 12/12/2024 at 2:35 PM, Staff A stated Resident 1 had behaviors of crawling out of bed, they were not able to tell the staff if they fell , and this behavior should be treated as a fall to rule out injury. Staff A stated all falls should be on abuse log, reported to provider and resident's responsible party, and investigated. Staff B stated they would expect staff to assess the resident for injury after found crawling on the ground. Staff A acknowledged Resident 1's crawls out of bed on 11/30/2024, 12/04/2024, and 12/08/2024, were not logged, investigated or reported to the provider or CC as they would expect. <Resident 4> (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's admission MDS, dated [DATE], showed Resident 4 was able to make their needs known, own decisions, could understand, and be understood by others. The MDS showed Resident 4 had diagnoses including; chronic respiratory failure, difficulty walking, and chronic lung disease. The MDS showed Resident 4 required maximum staff assistance with dressing toileting, and personal hygiene. Review of a facility investigation documents, dated 11/21/2024, showed Resident 4 reported a few nights ago that Staff D (CNA) yelled at them stating you are going to get my mom (Staff K, CNA) fired. Resident 4 denied reporting Staff D or Staff K. Review of the incident report showed blank areas for mental status, predisposing situation factors, and statements. The incident report did not indicate the provider was notified of the incident and the investigation did not rule out abuse and neglect. Per the investigation, no other residents had concerns about Staff D or Staff K, Resident 4 did not express psychosocial harm during monitoring, and both alleged staff members would not be allowed to work with the resident. Review of a resident interview, dated 11/21/2024, showed Resident 9 had concerns about Staff K stating they made excuses or said they were busy when Resident 9 needed help. Review of a typed note from Staff L (Social Services Director) showed when they revisited Resident 4, the resident reported that Staff D came back into their room with another CNA to make the bed while they were in the bathroom. Review of Resident 4's NPN's showed no documentation of the incident, no psychological monitoring, and no follow up or monitoring for Staff D returning to Resident 4's room after the incident. In an interview and observation on 12/04/2024 at 3:00 PM, Resident 4 was observed in the room, sitting on the bed with their phone. Resident 4 stated they had concerns about Staff D and Staff K. Resident 4 said Staff D yelled at them about going to get their mom fired and was not sure why Staff D was yelling at them because they did not report anything to staff. Resident 4 stated Staff D and Staff K have not provided care after the incident but Staff D came into the room to talk to the CNA that was making their bed. Resident 4 stated Staff D didn't say anything to them but they felt uncomfortable and went into the bathroom. Resident 4 stated they were told that Staff D would not be allowed back in my room. During an interview on 12/12/2024 at 2:45 PM, Staff A stated both Resident 4 and their roommate (Resident 5) had issues with Staff D, and Resident 4 was targeting Staff D. Staff A stated there was no documentation about the incident, that the provider was notified, and no monitoring for psychological harm to support the investigation conclusion of no psychological harm during monitoring. Staff A stated Staff D went into Resident 4's room because Resident 4 was care in pairs (two staff at all times with care) and they were the second caregiver. Staff A stated Staff D should not have gone back in the room, there was no staff follow-up after Staff L was informed that Staff D returned to the room, and no staff followed up on Resident 9's concerns about Staff K. Staff A stated the investigation should rule out abuse and neglect and acknowledged the investigation did not rule out abuse or neglect. <Resident 5> Review of the admission MDS, dated [DATE], showed Resident 4 was able to make needs known own decisions, and had no behaviors. The MDS showed Resident 5 had medically complex conditions including depression, renal insufficiency, and lymphedema (swelling in an extremity). The MDS showed Resident 5 was dependent on staff for toileting, and required max assistance with upper extremity dressing. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility investigation, dated 11/21/2024, showed Resident 5 requested help with changing their gown when Staff D tossed the gown to the resident and told Resident 4 to figure out themselves how to put it on. The incident report documents provided, did not include all pages, blank areas for mental status and predisposing environmental, physiological, and situation factors. The investigation documents did not show indication the provider was notified of the incident and showed Staff D denied tossing a gown at the resident and assisted them to put on the gown. Review of the investigation documents showed Staff D would no longer work with the resident, the resident had no psychological harm, and discharged the day after the incident. The investigation did not rule out abuse and neglect. In an interview and observation on 12/04/2024 at 3:42 PM, Resident 5 was observed in their bed, and stated they had concerns with Staff D, they did not like how they talked on their phone in a different language while providing care. Resident 5 stated they were told Staff D would not come to their room after the incident and Staff D came back in the room with another CNA who was changing the bed. Resident 5 stated their roommate Resident 4 went into the bathroom. In an interview on 12/12/2024 at 2:50 PM Staff A stated Resident 5 had issues with Staff D, the provider should have been notified of the incident, and the investigation should rule out abuse and neglect. Staff A stated Staff D went into Resident 5's room because Resident 4 was care in pairs (two staff at all times with care) and they were the second caregiver. Staff A stated Staff D should not have gone back into Resident 5's room. <Resident 6> Review of a admission MDS, dated [DATE], showed Resident 6 was able to make needs known, own decisions, and had no behaviors. The MDS showed Resident 6 had diagnoses including orthopedic after care, osteoporosis, anxiety, and diabetes. The MDS showed Resident 6 was dependent on staff for toileting and required max assistance with bed mobility. Review of a facility investigation, dated 11/22/2024, showed Resident 6 reported a staff member put three briefs on them during the night and told Resident 6 they would be changed when the third brief was wet. The investigation showed Staff M (CNA) was identified as the staff providing this care. Staff M denied putting three briefs on Resident 6. The investigation showed that Staff N (CNA) did not observe multiple briefs on Resident 6 although their statement showed they only helped reposition the resident. The investigation showed other residents were interviewed and had no concerns for their care. The investigation concluded that Staff M would no longer work with Resident 6 and did not rule out abuse or neglect. Review of the resident interview questions for the investigation, undated showed two residents (Resident 7 and Resident 10) had concerns for staff not changing their brief when needed and when Resident 7 requested help they were told everyone was gone. Resident 10's CC had concerns with how long Resident 10 was up in the wheelchair, staff didn't know how to use the mechanical lift, and it took an hour for staff to help the resident. Review of resident interviews, dated 11/22/2024, showed residents were asked if they had any issues with their care on night shift. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/2024 at 3:42 PM, Resident 5 stated staff used multiple briefs on the resident before. Resident 5 stated it happened more often in the evening and during the night shift and staff would double the briefs to make it look like one brief. Resident 6 was not available for an interview. In an interview on 12/12/2024, at 3:00 PM, Staff A stated the incident report should be thorough, when asked if residents were asked about staff applying multiple briefs, they were not sure. Staff A stated the resident interview questions should be more specific to the allegation, Staff N should have additional follow up questions to determine if they provided care or changed Resident 6's brief. Staff A stated the investigation did not but should have ruled out abuse and neglect. Staff A stated an investigation was started for Resident 7's concern but would have to look into Resident 10's concerns. <Resident 3> Review of the quarterly MDS, dated [DATE], showed Resident 3 was able to make needs known, own decisions, spoke a different primary language, and could understand and be understood by others. The MDS showed Resident 3 had no behaviors, and medically complex conditions including' end stage renal disease, diabetes, and high blood pressure. The MDS showed Resident 3 was dependent on staff for toileting and lower extremity dressing, and maximum assist for personal hygiene, and bed mobility. Review of a facility investigation, dated 11/22/2034 showed Resident 3 reported that Staff N (CNA) pushed them, they started to fall, and Staff N refused to help prevent Resident 3 from falling. Resident 3 reported Staff N pulled them up by the waist and put them back in bed. The investigation showed Staff N stated they found Resident 3 crying, wanted help to be pulled up in bed but was a two person assist and Staff N needed to get help. Staff N stated Resident 3 started to pull themselves up in bed and Resident 3's legs started to fall off the bed and slid to the point that Staff N had to stop the resident and put their feet back in bed. Staff L followed up with Resident 3 who was uncomfortable stating Staff N was rough, did not listen to them, and was scared. The investigation showed Staff N would not provide care to Resident 3, no other resident interviews showed concerns with care, and the investigation did not rule out abuse or neglect. Review of investigation resident interviews, dated 11/22/2024, showed Resident 11 answered, no staff did not treat them with respect or dignity. In an observation and interview on 12/12/2024 at 1:18 PM, Resident 3 was observed in bed and stated Staff N passed by their room and looked upset and annoyed that they needed to be changed after a bowel movement. Resident 3 stated Staff N started to change them, and pushed them as they were turning, causing their legs to fall out of bed. Resident 3 said their knees were on the ground with their belly and upper body on the bed. Resident 3 stated they asked why they pushed them and Staff N was quiet and quickly put them in the bed. Once in the bed Resident 3 stated Staff N got really close to their face and was aggressive. Resident 3 stated they told Staff N they would report them and Staff N replied, do it. Resident 3 stated they felt insulted, discriminated against, and didn't understand what they did to make Staff N mad. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a social services progress note, dated 11/26/2024, showed Staff L documented they followed up with Resident 3 who stated they had psych harm related to the care received at the facility and did not want to receive care from Staff N. Staff L documented Resident 3 was offered behavioral health services but declined. Review of progress notes showed no staff follow up on Resident 3's psych harm statements. In an interview on 12/12/2024 at 2:55 PM, Staff A stated the investigation should have documentation that abuse and neglect was ruled out. Staff A stated they believed Resident 3 had prior issues with Staff N and did not like them. Staff A stated they think a grievance was made for Resident 11's CC's concern and would have to look. Staff A stated facility staff should have but didn't follow up with Resident 3's statement of experiencing psych harm. <Resident 7> Review of quarterly MDS, dated [DATE], showed Resident 7 was able to make needs known, own decisions, and no behaviors. The MDS showed Resident 7 had diagnoses including chronic obstructive pulmonary disease, diabetes, anxiety, and depression. The MDS showed Resident 7 was dependent on staff for toileting, dressing, bed mobility, and transfers. Review of a facility investigation, dated 11/25/2024, showed Resident 7 complained that on two separate occasions they waited three hours to be changed by facility staff. The facility conducted an investigation that showed abuse and neglect was ruled out. The investigation documents showed five residents were asked if they experienced long call light wait times, all five of five residents replied yes. Two out of five residents stated they were not able to be toileted when they asked facility staff. In an observation and interview on 12/04/2024 at 2:49 PM, Resident 7 was observed in bed and stated the staff the facility identified in the investigation were not the staff involved. When asked who staff were, Resident 7 replied name tags are not always visible and stated they didn't want to go there. When asked about the staff the facility identified, Resident 7 stated they had not seen them since the incident. During an interview on 12/12/2024 at 3:10 PM Staff A stated the investigation information should be reviewed for further concerns. Staff A stated they would expect staff to follow up on the resident interviews gathered during the investigation to get more details about concerns with toileting and call light response. <Resident 8> Review of a quarterly MDS, dated [DATE], showed Resident 8 was not able to make their needs known, not able to make own decisions, was non-verbal with severely impaired vision and hearing. The MDS showed Resident 8 had medically complex conditions including dementia, schizophrenia, and diabetes. The MDS showed Resident 8 self propelled in a wheelchair for mobility, was dependent on staff for toileting, dressing, personal hygiene, bed mobility, and transfers. In an observation on 12/04/2024 at 2:27 PM Resident 8 was observed sitting in their wheelchair in the hallway, a large dark purple area was observed on their forehead near the hairline. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/2024 at 2:33 PM Staff J stated they did not know about a bruise on Resident 8's forehead and stated the bruise was not there earlier when Staff J gave Resident 8 their medications. Review of the facility December 2024 abuse log, showed the facility logged Resident 8's bruise as a bruise of deep color and depth. The facility did not report to the state hotline as the bruise was in an area not generally vulnerable to trauma, such as the face or neck. In an interview on 12/12/2024 at 4:00 PM, Staff A stated Resident 8 is very vulnerable because they prefer to self propel around the facility with impaired vision. Staff A stated the facility had tried a helmet with Resident 8 but they refused to wear it. Staff A stated the facility should have but didn't report the bruise to Resident 8's forehead. WAC: REFERENCE 388-97-0640(2)(b)(5)(6)(a)(b)(7)(b)(i)(ii)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on interview and record review, the facility failed to ensure 5 of 6 residents (Resident 1, 3, 12, 14, 15) reviewed for unnecessary medications were free from unnecessary psychotropic (affect mind, emotions and/or behaviors) medications. Facility staff failed to document identified target behaviors, monitor all target behaviors, document when behaviors occurred, implement and document behavioral interventions before administering medications, assess the effectiveness of the interventions before increasing medications, and to have as needed psychotropic medication (affects behavior, mood, thoughts, or perception) orders with stop dates and physician reassessment for extended use. These failures left residents at risk for unnecessary medications, adverse side effects, unmet needs, and diminished quality of life Findings included . Review of the facility policy titled, Psychotropic Drugs, updated 10/2022, showed the facility would evaluate and implement interventions for residents on psychotropic medications. Treatment would include the use of environmental and/or behavioral interventions prior to initiating psychotropic medications. Prior to initiating any psychotropic medication the Interdisciplinary Team (IDT) would review the resident's medical record, including behavior monitoring, investigate the causal factors triggering the behavior symptoms, and evaluate the resident's medication regime to validate the resident was not receiving duplicate drug therapy. The policy shoed the IDT would hold at a minimum a monthly psychotropic review to ensure residents had appropriate diagnosis, consent, and supporting documentation for resident's taking psychotropics. As needed psychotropic drugs were limited to fourteen days except when the physician believed it was appropriate to extend treatment. The physician would document their rationale in the resident's medical record. The policy showed the physician would be onsite to reevaluate the resident for the continued use and did not include just replacement of the current order <Resident 1> Review of a quarterly Minimum Data Set (MDS, an assessment tool), dated 10/23/2024, showed Resident 1 admitted to the facility on [DATE], had severe impairments to their decision making, was rarely or never understood, and had a Collateral Contact (CC) for decision making. The MDS showed Resident 1 had verbal behavioral symptoms directed at others that occurred one to three days during the seven day look back period that significantly disrupted care and the living environment. The MDS showed Resident 1 had no physical behaviors directed towards others and did not refuse care. The MDS showed Resident 1 had medically complex conditions, including, a brain dysfunction that caused confusion and memory loss, anxiety, and depression. Review of section N, medications of the MDS, showed Resident 1 used an antipsychotic, antianxiety, and antidepressant medications, kicking and hitting (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's medical record, dated 07/17/2024 through 12/06/2024, showed six Care Plans (CP) for antipsychotic, antianxiety, and antidepressant medication use and three behavior CP's. Resident 1's CP for antipsychotic use showed Resident 1 used an antipsychotic for behavior management. The CP's directed staff to monitor and record the number of occurrences of target behaviors that included screaming, throwing items, disrobing, inappropriate response to verbal communication, violence or aggression towards staff, anxiousness/agitation, restlessness, impulsivity, and poor safety awareness, yelling, crawling out of bed, refusing care, showers, and medications. The CP directed staff to administer medications as ordered and monitor the effectiveness of the medications, monitor the behavior episodes, attempt to determine the underlying cause, and consider the location, time of day, persons involved, and the situation. Review of Resident 1's physician orders showed Resident 1 was prescribed seven psychotropic medications including an antipsychotic medication twice daily, an antidepressant to treat depression, another antidepressant to treat insomnia, and an antianxiety medication to treat anxiety as needed. Review of Resident 1's as needed antianxiety medication, dated 11/14/2024, showed Resident 1 was prescribed an antianxiety medication 2 milligrams (mg) as needed for agitation, restlessness related to anxiety, every six hours for fourteen days. The antianxiety medication was re-ordered on 11/29/2024 for an additional fourteen days and on 12/04/2024 was changed to as need every four hours and routinely twice daily. Review of a physician progress notes, dated 11/12/2024, showed the physician discontinued the as needed antianxiety medication for Resident 1. No additional progress notes were observed to indicate why Resident 1's as needed anti-anxiety medication was re-started on 11/14/2024. Review of a 12/04/2024 nursing progress note showed the physician was called because Resident 1 was screaming, kicking and hitting, attempts to re-direct the resident were unsuccessful, and the physician ordered a one time dose of antipsychotic medication and to increase the antianxiety medication from every six hours to every four hours as needed for anxiety. Review of Resident 1's Medication Administration (MAR), dated November 2024 showed two behavior monitors that directed staff to monitor behaviors of crying, withdrawn, refusing care or medications, yelling, and anxious/agitated. The behavior monitoring directed staff to implement interventions of providing a calm space, encourage family visits, one on one socialization, sensory stimulation/activities, and counseling/therapy. The MAR showed on 11/14/2024 at 6:32 PM, 11/15/2024 at 6:00 PM, 11/19/2024 at 4:45 PM, 11/21/2024 at 8:05 AM, 11/26/2024 at 3:31 PM, 11/27/2024 at 3:31 PM, 11/28/2024 at 3:46 PM , 12/02/2024 at 3:24 PM, and 12/05/2024 at 1:05 PM, facility staff administered Resident 's as needed antianxiety medication without documenting behaviors or when staff did document behaviors, did not document non-medicinal interventions attempted, or their effectiveness before medicating Resident 1. During an interview on 12/12/2024 at 4:25 PM, Staff B (Director of Nursing) stated Resident 1 had behaviors of crying, withdrawn, refusing medications, refusing care, yelling, and crawling. Staff B reviewed Resident 1's CP and stated staff were not but should be monitoring all of Resident 1's identified behaviors. Staff B stated they would have to look into because they were not sure if there was a transcription error with the as needed antianxiety medication when reviewing the MAR, the medication showed as needed every fours and to be given twice daily. Staff documentation showed the antianxiety medication was increased to every fours as needed, and did not mention that it was to be given twice daily. Staff B stated there should be documentation to support why the medication was reordered on 11/14/2024, two days after another physician discontinued it. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 3> Review of the quarterly MDS, dated [DATE], showed Resident 3 was able to make needs known, made their own decisions, spoke a different primary language, and could understand and be understood by others. The MDS showed Resident 3 had no behaviors, and had medically complex conditions including' end stage renal disease, diabetes, and high blood pressure. The MDS showed Resident 3 was dependent on staff for toileting and lower extremity dressing, and maximum assist for personal hygiene, and bed mobility. Review of a physician's order, dated 11/15/2024, showed Resident 3 was prescribed an antianxiety medication as needed every six hours for adjustment disorder with anxiety. The as needed antianxiety physician's order had no stop date. Review of Resident 3's MAR, dated November 2024, showed Resident 3 received the antianxiety medication five times from 11/15-11/25/2024. The MAR showed no medication side effect monitoring or behavior monitoring for Resident 3's anxiety. Review of Resident 3's medical record, dated 11/15/2024-11/25/2024, showed no consent was obtained from Resident 3 for the antianxiety medication. In an interview on 12/12/2024 at 1:30 PM, Staff P (Certified Nursing Assistant) sated Resident 3 cried all the time, usually from pain from a medical issue. Staff P stated they worked with the resident often because they spoke the same language. During an interview on 12/12/2024 at 4:27 PM, Staff B stated Resident 3 had behaviors of crying and heightened emotions. Staff B stated, staff were not but should be monitoring Resident 3's behaviors and interventions to ensure the medication was effective. Staff B stated they would expect the as needed antianxiety medication to have a stop date of 14 days, and physician documentation for any extended use in the resident's record. <Resident 12> Review of the significant change MDS, dated [DATE] showed Resident 12 was not able to make needs known, had no speech, rarely made self understood, and rarely understands. The MDS showed Resident 12 had impairments to all extremities and was dependent on staff for toileting, personal hygiene, bathing, dressing, and bed mobility. The MDS showed Resident 12 had medically complex conditions including; soft tissue disorder, paraplegia (no feeling or use of lower extremities), dementia, anxiety, and depression. Review of Resident 12's MAR, dated December 2024, showed Resident 12 had an order for an as need antianxiety medication every two hours as needed for agitation. Review of the MAR showed Resident 12 was administered the medication three times. The MAR showed no stop date for the as needed antianxiety medication, no behavior monitoring, or interventions developed for staff to implement before medicating Resident 12. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2024 at 4:28 PM, Staff B stated they would expect the as needed antianxiety medication to have a stop date of 14 days. Staff B stated staff were not but should be monitoring behaviors, attempting interventions before administering medications, and documentation in the resident's medical record. <Resident 14> Review of a quarterly MDS, dated [DATE], showed Resident 14 was able to make needs known, own decisions, had no behaviors, clear speech, made self understood, and was able to understand others. The MDS showed Resident 2 needed moderate assistance with toileting and dressing, and was independent with transfers. The MDS showed Resident 14 had medically complex conditions that included; cancer, high blood pressure, anxiety, and depression. Review of Resident 14's MAR, dated November 2024 and December 2024, showed Resident 14 was started on an as needed antianxiety medication on 10/11/2024 for 14 days. Review of the MAR showed the as needed antianxiety medication was re-ordered on 10/25/2024, 10/29/2024, 11/15/2024, and 12/01/2024, to be extended an additional 14 days. The MAR's showed Resident 14 received the antianxiety medication almost daily or twice a day. Review of the behavior monitoring, dated November 2024, showed staff were directed to monitor the resident for anxiety and staff documented Resident 14 had no behaviors in the month of November. Review of the behavior monitoring, dated December 1st through the 6th 2024, showed Resident 14 had no behaviors during that time. Review of Resident 12's medical record, dated 10/25/2024 through 12/06/2024, showed one note from the physician, dated 11/26/2024, that Resident 14 was on chronic antianxiety medications, facility staff were monitoring the resident for target symptoms including restlessness, hitting staff or others, verbal aggression with staff, cussing, using racial slurs, delirium, and refusal if care. The physician progress note showed to continue the antianxiety medication as needed for anxiety but did not give a rationale for extended use. No other physician notes were observed in Resident 12's record for the extended use of the antianxiety medication that was reordered four times. During an interview on 12/12/2024 at 4:29 PM, Staff B stated they would expect staff to be monitoring the identified target behaviors, implementing interventions, and documenting before the medication was administered. Staff B stated the as needed medication should only be renewed when the physician did an onsite visit and documented their rationale for continued use in the resident's record. <Resident 15> Review of an admission MDS, dated [DATE], showed Resident 15 discharged from the facility on 12/07/2024. No additional information from the MDS was observed. Review of Resident 15's record showed they had diagnoses including; liver failure, kidney failure, and a recent skin surgery/ Review of Resident 15's physician's orders, dated 11/30/2024, showed an order for an as needed antianxiety medication, with no stop date. Review of the physician's orders showed no behavior monitoring. During an interview on 12/12/2024 at 4:30 PM, Staff B stated they would expect the as needed medication to have a stop date of 14 days, and staff were not but should have monitored behaviors, implemented intervention, and document before the as needed antianxiety medication was administered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2024 at 4:32 PM, Staff B stated resident's on psychotropics should be monitored for medication side effects, effectiveness of medication, and behavior monitoring. Staff B stated behavior monitoring should include all behaviors observed and identified by staff, and when a resident had behaviors they would expect staff to document behaviors, attempt interventions, if interventions were not effective, try something different, and document. Staff B stated they would expect staff to attempt interventions before medicating the resident. Staff B stated as needed psychotropic medications are only valid for fourteen days, after fourteen days the physician should review the resident's record and make a decision to discontinue or extend the medication and document the reason in the resident's record. WAC: REFERENCE 388-97-1060(3)(k)(i). Refer to F-552