STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505346	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheney Care Center	2219 North 6th Street Cheney, WA 99004

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 46115 Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (25), reviewed for unnecessary medications, were informed of the potential risks and benefits associated with the use of psychotropic medications (medications that can affect the mind, emotions, and behaviors). Failure to obtain the informed consents resulted in the resident and/or representative not being informed. Findings included . <Resident 25> Per the 02/29/2024 quarterly assessment, Resident 25 had diagnoses which included hallucinations and received psychotropic medications daily. A review of the Order Summary Report documented on 11/24/2023, Resident 25 was prescribed psychotropic medication (Trazodone) to treat depression, and Seroquel to treat the hallucinations. Review of the November 2023 Medication Administration Record documented Resident 18 received the first doses of Trazodone on 11/24/2023 and Seroquel on 11/25/2023. Review of the Psychoactive Medication Informed Consent, a form used to provide education related to the potential risks and benefits of psychotropic medications, the dose, and the reason the medication was being prescribed, documented Resident 18 signed the consent for Seroquel on 11/28/2023, three days after the medication was started and Trazodone on 11/28/2023, four days after the medication was started. Further review of Resident 25's record did not show any additional documentation, either verbally or written, that education related to the psychotropic medication with regards to the reason for being prescribed, risks or the benefits expected from taking the medication had occurred. In an interview on 06/04/2024 at 11:05 AM, Staff N, Resident Care Manager, stated psychotropic medication informed consents should be obtained prior to the first dose given. In an interview on 06/04/2024 at 3:59 PM, Staff B, Director of Nursing confirmed it was important for consents for psychotropic medications to be obtained prior to giving the first dose of medication, so residents were aware of the side effects and risks of the medication. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1020(4)(a-b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46115 Based on observation, interview, and record review, the facility failed to provide a clean, comfortable, homelike environment for 1 of 2 sampled resident (25), reviewed for environment. This failure placed Resident 25 at risk for possible illness from unclean equipment, a lack of dignity, and a decreased quality of life. Findings included . Resident 25 had diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). A 02/29/2024 quarterly assessment documented Resident 25 was moderately cognitively impaired, required partial to maximum assistance for activities of daily living and used a wheelchair for mobility. On 05/28/2024 at 11:13 AM, Resident 25 was observed in the dining room sitting in the wheelchair. The wheelchair was unclean with food smeared on the sides of the chair. On 05/30/2024 at 9:48 AM, Resident 25 was observed in bed asleep. The wheelchair was unclean with food smeared on the sides and foot pedals of the wheelchair. Additional observations of the wheelchair being unclean were made on 05/30/2024 at 9:48 AM, and 05/31/2024 at 8:51 AM. The resident was not able to be interviewed related to their disease progression. During an interview on 05/31/2024 at 2:21 PM, Staff O, Nursing Assistant, stated when wheelchairs needed a deep cleaning, maintenance was notified, otherwise sanitization wipes were used to clean the chairs when food or debris was found. When Staff O observed the wheelchair, they verified it was unclean. During an interview on 06/05/2024 at 2:55 PM, Staff B, Director of Nursing, stated wheelchairs were cleaned weekly on night shift and as needed and the expectation was to keep the wheelchairs clean. Reference: WAC 388-97-0880

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to complete a discharge summary, including a recapitulation of the resident's stay as required, for 1 of 1 sampled residents (40), reviewed for discharge. This failure placed the resident at risk for having an incomplete medical record. Findings included . The 12/30/2023 admission assessment documented Resident 40 was cognitively intact to make decisions regarding care, needed moderate to maximum assistance from staff to complete activities of daily living, and had received physical therapy for four days during the assessment period. A discharge assessment dated [DATE] documented the resident had discharged and was expected to return to the facility. A progress note dated 03/16/2024 at 6:45 PM documented Resident 40 had informed a nursing assistant that they were looking for plastic bags so they could suffocate themselves. The resident was assessed for depression and safety interventions were implemented to include increased supervision. Review of the progress notes from 03/17/2024 through 03/19/2024 documented Resident 40 continued to express suicidal thoughts and informed staff that they were just waiting for the right opportunity. After additional assessment from the provider and a mental health clinician, the resident was sent to the hospital on 03/19/2024 to be evaluated. The 03/19/2024 discharge summary completed by Staff C, Physician Assistant, documented the resident discharged to the hospital due to suicidal thoughts, but no other information was documented, nor did the summary provide a recapitulation of the care and services the resident received while at the facility. In an interview on 05/30/2024 at 12:51 PM, Staff B, Director of Nursing, stated a recapitulation of stay/discharge summary needed to be done by the provider when a resident discharges from the facility. Reference (WAC) 388-97-0080(7)(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on interview and record review the facility failed to implement bowel management protocol when indicated for 3 of 7 sampled residents (2,18,193), reviewed for constipation. These failures placed residents at risk for complications, worsening conditions, and diminished quality of life. Findings included . Review of the facility policy titled, Bowel Protocol, dated 05/10/2023, instructed nursing staff to implement the bowel program if a resident did not have a bowel movement (BM) for two days. The policy documented nursing staff was to administer Milk of Magnesia (MOM) on day two of no BM, Miralax on day three, Senna on day four, a suppository on day five, and if no BM on day six, the provider was to be notified. <Resident 2> According to the 04/18/2024 quarterly assessment, Resident 2 required maximal to total assistance for most activities of daily living including dressing, transfers, and toileting. Resident 2 was incontinent of bowel. The assessment further documented Resident 2 had severe cognitive impairments and was able to make their needs known. Review of the 11/28/2023 at risk for constipation care plan documented interventions for Resident 2 to have increased fiber and fluid intake, monitor side effects of medications, monitor/document/report to provider any signs and symptoms of constipation and to record BM's. Review of Resident 2's provider orders documented active orders for: - 11/24/2023 MOM (liquid laxative) to be given as needed on day two of no BM - 11/24/2023 Miralax (powder laxative mixed with water) to be given as needed on day three of no BM - 11/24/2023 Senna (stimulant laxative) to be given as needed on day four of no BM - 11/24/2023 Bisacodyl suppository (stimulant laxative) tablet to be given as needed on day five of no BM Review of Resident 2's March 2024 through May 2024 bowel record documented resident had no BMs on the following days: 04/03/2024 through 04/06/2024 (four days) 04/11/2024 through 04/15/2024 (five days) 04/17/2024 through 04/19/2024 (three days) 05/19/2024 through 05/21/2024 (three days) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/24/2024 through 05/26/2024 (three days) Review of Resident 2's March 2024 through May 2024 Medication Administration Record (MAR) documented bowel medications were not administered when needed for constipation, as ordered. Nor was there any documentation found that bowel medications were offerred and/or refused. <Resident 18> According to the 05/13/2024 annual assessment, Resident 18 required substantial to total assistance for most activities of daily living including dressing, transfers, and toileting. Resident 18 was incontinent of bowel. The assessment further documented Resident 18 had severe cognitive impairments. Review of the 04/20/2023 at risk for constipation care plan, documented interventions for Resident 18 to monitor side effects of medications, monitor/document/report to provider any signs and symptoms of constipation, record BM's and instructed nursing staff to follow the facility bowel protocol. - 06/09/2022 Bisacodyl to be given every twenty-four hours as needed - 11/24/2023 MOM (liquid laxative) to be given as needed on day two of no BM - 11/24/2023 Miralax (powder laxative mixed with water) to be given as needed on day three of no BM - 11/24/2023 Senna (stimulant laxative) to be given as needed on day four of no BM - 11/24/2023 Bisacodyl suppository (stimulant laxative) tablet to be given as needed on day five of no BM Review of Resident 18's March 2024 through May 2024 bowel record documented resident had no BMs on the following days: 03/07/2024 through 03/09/2024 (three days) 03/13/2024 through 03/17/2024 (five days) 03/19/2024 through 03/22/2024 (four days) 03/30/2024 through 04/01/2024 (three days) 04/06/2024 through 04/08/2024 (three days) 04/20/2024 through 04/22/2024 (three days) 05/04/2024 through 05/06/2024 (three days) 05/09/2024 through 05/11/2024 (three days) 05/16/2024 through 05/19/2024 (four days) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/21/2024 through 05/23/2024 (three days) 05/30/2024 through 06/01/2024 (three days) Review of Resident 18's March 2024 through June 2024 MAR documented bowel medications were not administered when needed for constipation, as ordered. Nor was there any documentation found that bowel medications were offerred and/or refused. In an interview on 06/04/2024 at 10:15 AM, Staff U, Nursing Assistant, stated BMs are monitored every shift and a small BM does not count. In an interview on 06/04/2024 at 10:19 AM, Staff D, Registered Nurse, reviewed Resident 2's bowel pattern and stated the resident should have been given the as needed bowel medications to assist with their constipation. In an interview on 06/04/2024 at 4:03 PM, Staff B, Director of Nursing, stated the bowel protocol needed to be followed and medications given when indicated for constipation. <Resident 193> According to the assessment dated [DATE], Resident 193 was able to direct their care and required extensive assist with most activities of daily living (ADL's) including walking with a walker and transferring to/from bed, chair, and toilet. Resident 193 received most of their nutrition from a feeding tube (a device that delivers liquid nutrition to the stomach or intestine when a person can't eat normally) and had diagnoses including malnutrition, Adult Failure To Thrive, (when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal) and Diverticulosis (a condition of having small pouches or pockets in the inside walls of the intestines in which undigested food or stool can get stuck and cause pain and/or infection.) Per the May 2024 bowel record, Resident 193 had only 1 small BM in 4 days from 5/19/2024 - 5/22/2024. Per the May 2024 Medication Administration Record (MAR) the bowel protocol was not followed for Resident 193 from 5/19/2024-5/22/2024. A progress note dated 5/22/2024 at 08:00 AM by Staff N, Resident Care Manager (RCM), documented Resident 193 was triggering on the bowel list, and the floor nurse was notified to offer bowel protocol intervention. In an interview with Staff P, Licensed Practical Nurse (LPN) on 06/05/2024 at 10:44 AM, they stated BMs were monitored by the night shift nurses and a list was left in the medication room for the day shift nurses to follow up on and then the evening shift nurses followed up on the day shift intervention. They stated, the facility bowel protocol was on the MAR, and personalized as needed. When asked if it was a problem if bowel protocol/orders were not followed they replied yes, because it could cause a resident to develop pain and discomfort and/or a bowel impaction, if not followed and because it would be a medication error. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff B Director of Nursing on 06/05/2024 at 12:58 PM they stated the nursing assistants document the resident's BMs on the bowel record, the nurses reviewed the bowel record, and the RCM followed up and talked to the nurses about which residents needed to start the bowel protocol. They stated the facility's medical director developed the bowel protocol and updated it last year. When asked if it was a problem if the bowel protocol wasn't followed, they stated yes because it was a Medical Doctor (MD) order. Reference: WAC 483.25 -1060 (1) 47728

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728 Based on observations, interview, and record review the facility failed to document a detailed nutritional assessment at time of admission, for a resident identified as being at risk for compromised nutritional status. This failure resulted in potential impaired nutrition, and an increased risk of: mortality, impairment of anticipated wound healing, decline in function, fluid and electrolyte imbalance/dehydration, and unplanned weight change. Findings included . Review of undated nutritional management policy, a comprehensive nutritional assessment would be completed upon admission, and the dietitian would use data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake was adequate to meet those needs. According to the 04/11/2024 assessment Resident 10 had cognitive impairment and was unable to direct their care. They required assistance for most activities of daily living (ADL's) including transfers, toileting, and mobility. Resident 10 had diagnoses which included malnutrition, Diabetes and obesity Per the Malnutrition Risk Identification form dated 04/11/2024 Resident 10 was noted to be at risk for malnutrition due to need for a therapeutic diet related to diabetes, infection, taking three or more medications, reduced physical function and need for assistance with ADLs, and diagnosis impacting appetite or ability to eat. Per the care plan dated 05/24/2024, Resident 10 admitted to the facility on [DATE] with a new right above knee amputation (AKA) with a stapled surgical incision and a wound vac, a treatment that applies gentle suction to a wound to help it heal. Review of the resident record documented no nutritional assessment had been completed by the Dietetic Technician or the Registered Dietitian (RD). In an interview on 05/28/2024 at 03:36 PM Resident 10 stated they wanted to lose weight, and had not been talked to by the dietician. During an interview on 06/05/2024 at 10:44 AM, Staff P, LPN, stated upon admission to the facility dietary preferences were assessed and communicated to the kitchen by the admission nurse or resident care manager (RCM). In an interview on 06/04/2024 at 01:01 PM, Staff V, Dietetic Technician (Diet Tech) stated the dietary manager did the initial visit with a resident to determine food preferences at time of admission. They stated the nutritional assessment was to be completed by the Diet Tech with-in seven days of a resident admission to the facility then the Registered Dietitian (RD) would review it and make changes as needed. Staff V stated the RD came into the facility on ce per week and met with residents. Staff V acknowledged there was no nutritional assessment completed for Resident 10 and stated it got missed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 483.25(g)(1)-(3) -1060 (3)(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observation, interview and record review, the facility failed to ensure that 2 residents (3, 11) had current and complete oxygen orders and failed to ensure that oxygen equipment was maintained in a clean manner for 5 of 5 residents (3, 11, 14, 17, 28) reviewed for respiratory care. These failures placed the residents at risk for respiratory complications and infection. Findings included . A facility policy, reviewed on 01/20/2024, titled Oxygen Administration documented that orders for oxygen should include the flow rate (level of oxygen, usually measured in liters/minute.) In addition, the policy documented to change the oxygen tubing and mask weekly and as needed, and to follow the manufacturer recommendation for cleaning the filters. <Resident 3> According to an annual assessment dated [DATE], Resident 3 made their needs known and had diagnoses that included dementia and chronic respiratory failure. A review of Resident 3's Electronic Medical Record (EMR) showed an order dated 07/28/2022, that documented oxygen may be used if the resident was short of breath or requested it. A liter flow was not included in the order. Further review of Resident 3's record documented their oxygen saturation level (an estimated reading of oxygen in the blood, measured using a finger probe) was recorded without documentation of the liter flow of oxygen at the time. During an observation on 05/28/2024 at 12:05 PM, Resident 3 had their oxygen on. The setting on the concentrator (oxygen machine) was set at 2 liters. The concentrator's external filter was dusty and had a whitish powder/residue. During an observation on 05/29/2024 at 10:52 AM, Resident 3's oxygen was set at 2 liters. Similar observation of Resident 3 wearing oxygen at 2 liters were made on 05/30/2024 at 9:00 AM, 12:28 PM, 3:03 PM and on 05/31/2024 at 9:09 AM. Observations of Resident 3 wearing oxygen at 2.5 liters were made on 06/03/2024 at 9:54 AM, 12:55 PM and on 06/04/2024 at 8:32 AM <Resident 11> According to a comprehensive assessment, dated 02/29/2024, Resident 11 was alert, oriented and had diagnoses which included quadriplegia (paralysis of all four limbs.) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 11's medical record showed an order dated 12/27/2023, that documented Oxygen 1-2 liters by nasal cannula as needed. This order was discontinued on 05/15/2024. During the survey time, there was no current order for oxygen. On 05/29/2024 at 11:19 AM, Resident 11 was observed with oxygen on at 1.5 liters. There was no label on the tubing, that indicated when it was last changed. Resident 11 stated that it had been a while since they last changed the tubing, and thought it was supposed to be changed weekly. Their concentrator's external filter was dusty and had a whitish powder/residue visible. In subsequent observations, Resident 11 was not wearing oxygen. During an observation and interview on 06/04/2024 at 2:21 PM, Resident 11 stated that they wore their oxygen mostly when sleeping. The filter on their concentrator still showed visible dust and white residue. During an interview on 06/04/2024 at 9:03 AM, Staff T, Nursing Assistant (NA) stated that Resident 3's oxygen was usually set at 2 liters. When asked to show where that was documented, they were unable to find in the electronic medical record (EMR) and stated they were not sure why, but it should be there. During an interview on 06/04/2024 at 9:14 AM, Staff S, Registered Nurse (RN) stated that oxygen orders should contain a liter flow. They confirmed that it was not in the EMR for Resident 3. During an interview on 06/04/2024 at 10:24 AM, both Staff N, Resident Care Manager (RCM) and Staff Q, Infection Preventionist, stated that there must be an order for oxygen, and it must include the liter flow. On 06/05/2024 at 9:17 AM, Staff B, Director of Nursing, was shown the filter on Resident 11's concentrator. Staff B confirmed that the filter was dirty and removed the filter to clean it. <Resident 17> According to the 04/18/2024 quarterly assessment, Resident 17 had diagnoses which included chronic respiratory failure, chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and utilized oxygen. The 05/03/2023 care plan documented Resident 17 used supplemental oxygen. The care plan and the provider's orders did not include interventions for the maintenance or cleaning of the oxygen filters. On 05/28/2024 at 9:42 AM, Resident 17 was observed in their bed wearing oxygen. The oxygen concentrator had two filters that were covered with thick dust. During an interview on 06/04/2024 at 11:00 AM, Staff N, Resident Care Manager, stated an outside company comes twice a month to perform maintenance on the oxygen concentrators. Staff N stated nursing needed to check and clean the filters when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/2024 at 4:07 PM, Staff B, Director of Nursing stated the oxygen filters needed to be cleaned weekly when the oxygen tubing was changed. <Resident 28> Per the 04/16/2024 quarterly assessment, Resident 28 had diagnoses which included heart failure (when the heart muscle doesn't pump blood as well as it should), circulation problems, lung disease, and needed oxygen due to those conditions. The physician order, dated 10/05/2023, prescribed oxygen to be used continuously. There were no orders for the oxygen tubing to be changed. During an observation on 05/28/2024 at 09:18 AM, Resident 28 was observed wearing oxygen while in their bed. Staff F, Nurse Tech affixed the resident's oxygen tubing to their face due to it falling from their left ear and slightly out of their nose. On 05/28/2024 at 11:44 AM, an interview and observation were conducted while Resident 28 was in bed wearing their oxygen. Resident 28 stated they had consistently complained to the staff about their oxygen tubing not lasting and that the tubing got too hard. An inspection of the oxygen concentrator showed the concentrator filter was unclean with visible thick and heavy dust. There was no date on the resident's tubing as to when it had last been changed. Subsequent observations to the oxygen concentrator filter being dirty and undated oxygen tubing were made on 05/29/2024 at 11:09 AM and 05/30/2024 at 2:18 PM. On 06/05/2024 at 9:03 AM, Staff H, Nursing Assistant, stated they informed the nurse when a resident's oxygen tubing needed to be replaced. Staff H stated that if the nurse was unavailable, they would have provided the resident with new tubing and informed the nurse thereafter. Staff H confirmed that they had not changed Resident 28's tubing. During an interview on 06/05/2024 at 10:10 AM, Staff D, Registered Nurse, stated that nursing management entered the physician orders into the residents' charts. Staff E, Licensed Practical Nurse, stated oxygen tubing should be changed weekly and when soiled or oversaturated with water from the hydrator. Staff E also stated that oxygen tubing was dated when changed and documented on the medication or treatment administration record. Staff E confirmed there was no order in the resident's record to change their oxygen tubing until today when the order had been added. Reference: WAC 388-97-1060 (3)(j)(vi) 46115 50027

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42802 Based on observation, interview and record review, the facility failed to accurately reconcile all controlled medications in 1 of 2 medication carts (Cart 1), reviewed for medication storage. This failure placed residents at risk for misappropriation of their controlled medications and placed the facility at increased risk for controlled substance drug diversion. Findings included . During an inspection of the narcotic drawer on Cart One on 06/05/2024 at 10:49 AM with Staff D, Registered Nurse (RN), a bottle of narcotic pain pills labeled for a current facility resident, was observed. The cap of this bottle was wrapped in clear plastic tape, with the number 56 in black marker, half on the tape and half on the side of the bottle. Staff D stated that the medication was from the resident's home supply. Staff D further stated that the 56 was placed that way, so it would be noticeable if anyone removed the tape to access the medication. In addition, Staff D stated they had been going by the pill quantity written on the tape, rather than counting the actual pills, during the narcotic count at change of shift. During an observation of the same narcotic drawer on 06/05/2024 at 11:26 AM with Staff B, Director of Nursing, acknowledged the bottle of pills with the tape. Staff B removed the tape from the pill bottle and counted the pills, before they put them back in the drawer. There were 56 pills, which matched the quantity logged in the narcotic book. Staff B stated that nurses should have counted the pills with every change of shift. Reference: WAC 388-97-1300 (1)(b)(ii), (c)(ii-iv)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46115 Based on interview and record review, the facility failed to ensure recommendations from the pharmacist were addressed, for 1 of 5 sample residents (25), reviewed for unnecessary medications. These failures placed residents at risk for receiving medications at inappropriate times and a diminished quality of life. Findings included . The Consultant Pharmacy Report, dated 04/2024, documented Resident 25 received Melatonin (a medication to assist with sleep) and it was recommended the time the medication was administered be changed to be given 60 to 90 minutes before the resident's bedtime. Review of the April and May 2024 medication administration records documented the medication was to be given at bedtime. Resident 25 received the Melatonin from 7:00 PM to 10:53 PM A review of Resident 25's record documented no response from the provider or nursing regarding the recommendation. During an interview on 06/04/2024 at 3:50 PM, Staff G, Nursing Assistant, stated Resident 25 went to bed after dinner, between six to seven o'clock. During an interview on 06/04/2024 at 3:29 PM, Staff B, Director of Nursing stated the recommendation for the Melatonin should have been followed up on and the resident should have received the medication as suggested by the pharmacist. Reference: WAC 388-97-1300 (4)(c)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728 Based on observation, interview and record review, the facility failed to ensure dietary staff had the required qualifications (current Food Worker Cards) for 2 dietary staff (W, X). This failed practice had the potential risk for unsafe food handling practices and placed all residents at risk for developing foodborne illness. Additionally, the facility failed to ensure there were enough staff in the dining room during meals to assist residents timely. This failure had the potential risk for residents being served food at unappetizing temperatures, decreased appetite and decreased quality of life. Findings included . <Dietary Staff> A review of the dietary cards on [DATE] at 09:28am showed Staff W, dietary aide (hire date [DATE]) had a Washington State Food Workers card with an effective date of [DATE] and Staff X, Prep [NAME] (hire date [DATE]) did not have a current Washington State Food Workers card. Observations were made of both Staff W and Staff X preparing and/or serving food on [DATE] at 09:28AM and [DATE] at 11:05AM. During an interview on [DATE] at 11:27 AM, Staff W stated they did not have a Washington State Food Workers card prior to [DATE]. During an interview on [DATE] at 11:30AM, Staff Y, Dietary manager, stated a Washington State Food Workers card was required for all kitchen staff working with food and acknowledged Staff W did not have this prior to [DATE] and Staff X's card had expired but was unable to provide proof of a prior card and when it expired. <Dining> On [DATE] at 11:46AM it was observed that Resident 15 was brought into the dining room in their wheelchair and pushed up to a table. At 12:09 PM a kitchen staff member placed an ice cream bar on the table by Resident 15's place setting but did not interact with the resident. At 12:15 PM Resident 15's uncovered plate of food was set in front of them. At 12:18 PM Staff O, Nursing Assistant (NA) began assisting another resident with their meal, at the same table as Resident 15. During this meal-time observation there was a total of three nursing staff members in the dining room assisting residents with their meals. At 12:26 PM Resident 15 reached toward their food but was unable to reach it, no one intervened to assist the resident. Resident 15 received no assistance with their meal or interaction from staff until 12:27 PM, 41 minutes after being brought into the dining room. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] it was observed that residents in the dining room started being served the lunch meal at 12:07 PM. At 12:21PM Staff O, Nursing Assistant, who was helping Resident 15, told Staff Z, Human Resources Director/Nursing Assistant (HR) that help was needed in the dining room for the residents who could not feed themselves. At that time there were two nursing assistants in the dining room helping residents with their meals. Staff Z then began to assist a resident with their meal. Additionally, at 12:21 PM Resident 17's uncovered plate of food was set in front of them. At 12:32PM Staff O stopped assisting Resident 15 to assist resident 16. At 12:34 PM Resident 15 attempted to pick-up their utensils and was pointing at their plate but there was no staff at or by the resident to assist them. At 12:36 PM, Staff O used a pager and requested help in the dining room. No staff responded to page for help. At 12:45 PM Staff O began assisting Resident 17, who was unable to feed themselves independently and whose meal had been sitting in front of them for 19 minutes. In an interview on [DATE] at 12:58 PM Staff B, Director of Nursing (DON) stated there should be at least one nursing assistant in the dining room during meals and that there were typically two to three nursing assistants in the dining room. Staff B acknowledged that ,d+[DATE] minutes with an uncovered plate of food. The food would get cold and it would contribute to an unpleasant dining experience and a lack of dignity for the resident. Reference: WAC 483.60(a)(3)(b)-1160

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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. 47728 Based on observation and interview the facility failed to ensure meals were served to residents at an appropriate and appetizing temperature. This failed practice resulted in the potential risk for decreased quality of life for all residents. Findings inculded . According to the Washington State Food Handlers Guide Website, The Washington State Department of Health, Safety and Licensing Division recommends that all potentially hazardous foods be held at a temperature of 41 F or below in commercial refrigerators and freezers. This includes meats, fish, poultry, eggs, dairy products, cooked vegetables, cooked rice and pasta, cut melons, and other perishable items. All frozen foods should be stored at 0 F or below. Hot food items should be held at a temperature of 140 F or above. On 06/04/2024 while the lunch meal was being served, it was observed that periodic checks of the temperature of the foods being held on the steam table was not completed. During an observation on 06/04/2024 at 12:10 PM, Staff CC, Cook, was heating up soup in the microwave oven, and when they removed the soup from the microwave, they checked the temperature and then put it back into the microwave to cook longer. At 12:11 PM, Staff CC removed the soup from the microwave and without checking the temperature, put it on a tray to be served. When asked why they did not recheck the temperature of the soup before serving it, Staff CC stated it was close to the correct temperature when they checked it the first time, so they assumed it was the correct temperature after cooking it for another minute. In an interview on 06/04/2024 at 11:37 AM, at the start of lunch service, Staff CC, [NAME] stated they had checked the temperatures of the foods on the steam table prior to starting the meal service. On 06/04/2024 at 12:40 PM (63 minutes after the food tempurature was last checked by Staff CC) temperatures of a sample tray were taken by the surveyor, immediately after taken from the kitchen. The temperatures (in degrees Fahrenheit) were as follows: LoMein Noodles = 120 Mixed Vegetables = 110 Orange Chicken = 80 Cranberry juice = 56 Milk = 46 Tuxedo cake = 50 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These temperatures do not meet the requirments that hot food must be 140 degrees or greater and cold foods must be less than 41 degrees or less, when served. Reference: WAC 483.60(d)(1)(2-1100 (1), (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47728 Based on observation and interview the facility failed to ensure food in the snack/nourishment refrigerators was labelled and dated, expired foods were removed, and the snack/nourishment refrigerators were monitored routinely for proper temperature. This failure resulted in a potential risk of food borne illness for all residents. Findings included . During an observation on [DATE] at 09:37 AM of the Snack/Nourishment refrigerator on the Transitional Care Unit (TCU), there was an open apple and open grape juice container with no opened date, a foil covered container labelled with a name and room number but not dated, an open half full gallon jug of Kikkoman soy sauce with date of ,d+[DATE] but no year, and sugar free coffee creamer with an expiration date of [DATE]. There was a temperature log for March, April and [DATE] taped to the front of the refrigerator with only 5 temperature readings recorded in March, no April temperature readings recorded, and only 1 temperature reading recorded in May. No temperature log was present for [DATE]. Staff O, Nursing Assistant (NA) was present during this observation and removed the undated and expired food from the refrigerator. Staff O stated whoever put something into the refrigerator was supposed to label and date it, and the kitchen checked for expired and old food. During an observation on [DATE] at 01:28 PM of the Snack/Nourishment refrigerator in the main nurses station, no temperature log was found. In an interview on [DATE] at 01:28 PM Staff E Licensed Practical Nurse (LPN) stated night shift was responsible for checking the temperatures in the snack/nourishment refrigerators. In an interview on [DATE] at 04:19 PM Staff DD, Dietary Aide, stated monitoring of the temperatures of the snack/nourishment refrigerators was the responsibility of the kitchen staff. Staff DD stated they were supposed to do it when checking/filling the snack/nourishment refrigerators but did not always remember and they usually did not fill or check the snack/nourishment refrigerators every day, so it was not done daily. They stated the temperature log should be hanging on the outside of each snack/nourishment refrigerator. When informed that neither the TCU snack/nourishment refrigerator nor the nurses station snack/nourishment refrigerator had a temperature log for June and only the TCU refrigerator had a temperature log for May, but it was not filled out Staff DD stated they were not aware. Reference: WAC 483.60(i)(1)(2) -1100 (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46115 Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene and wore gloves during the meal service when indicated, maintained a resident's nails in a sanitary manner prior to and after meals, and not cleansing a resident's skin prior to an injection. These failures placed the residents at risk for infection, transmission of communicable diseases and diminished quality of life. Findings included . Review of the facility policy titled, Handwashing/Hand Hygiene revised 01/20/2024, documented hand hygiene was the means to prevent the spread of infections. The policy instructed staff to perform hand hygiene with alcohol-based hand rub or soap and water before and after direct contact with residents; before performing any non-surgical invasive procedure; before and after handling an invasive device; before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care; after contact with object in the immediate vicinity of a resident; before and after handling food; before and after assisting a resident with meals; and after glove removal. The website CDC.gov - in which CDC refers to Centers for Disease Control and Prevention- with regard to hand hygiene showed, healthcare personnel should use alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing an aseptic (free from living viruses, bacteria, and other germs that may cause disease) task, before moving from a soiled boy site to a clean body site on the same patient, after touching a patient or the patient's immediate environment and immediately after glove removal. <Dining Room> <Resident 25> During a lunch observation on 05/28/2024 at 12:38 PM, Resident 25 was observed sitting in the dining room with brown matter under their nails. The resident picked up their potatoes and ate them with their hands. During an observation on 05/28/2024 at 2:44 PM, Resident 25 was observed with brown matter under their nails. During a lunch observation on 05/31/2024 at 12:21 PM, Resident 25 was observed sitting in the dining room with brown matter under their nails. A nursing assistant asked the resident if they were hungry, and the resident picked up their potatoes with their fingers and ate them. During an observation on 05/31/2024 at 12:46 PM, Resident 25's nails remained unclean with brown matter under them. The resident's nails were not cleaned after the noon meal service. In an interview on 06/04/2024 at 3:59 PM, Staff B, Director of Nursing stated nail care was performed during showers and when needed. Staff B stated nail care was important to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 7> During a noon meal observation on 05/30/2024 at 12:25 PM, Resident 7 was sitting in the dining room and had requested a sandwich. Staff G, Nursing Assistant cut the resident's sandwich in half with ungloved hands and fed the sandwich to the resident. In an observation on 05/30/2024 at 12:36 PM, Staff G opened a straw with ungloved hands and placed it into the resident's milk. In an observation on 5/30/2024 at 12:54 PM, Staff G touched Resident 7's arm and continued to feed the resident the sandwich with ungloved hands without performing hand hygiene. During an interview on 05/30/2024 at 12:54 PM, Staff G stated that they did not need to wear gloves to feed the resident a sandwich if their hands were clean. During an interview on 06/05/2024 at 12:26 PM, Staff Q, Infection Preventionist, stated gloves needed to be worn when touching residents' food to prevent bacteria. 47728 <Hall Trays> On 05/28/2024 at 12:07 PM Staff T, Nursing Assistant was observed delivering a meal tray to a resident in their room, after delivering the tray and before leaving the room, Staff T used a pen to update the resident's tray card. Staff T then proceeded, without performing hand hygiene, to deliver another meal tray to a different resident and picked up the coffee mug the resident had been drinking from, prepared coffee for the resident, then returned the mug to the resident. In an interview on 05/28/2024 at 12:17 PM Staff T stated when passing meal trays they should perform hand hygiene when they came out of a resident room. They acknowledged they had not performed hand hygiene as indicated and stated they should in order to prevent the spread of germs and bacteria. <Dining> During an observation on 05/31/2024 at 12:06 PM Staff BB, Dietary Aide, lifted the lid of a trash can with their hand and without performing hand hygiene put on gloves. They then delivered beverages to residents, removed the lids from the cups the residents were to drink from and then proceeded to deliver a lunch plate to a resident. <Kitchen> On 06/04/2024 during food being prepared and served for the lunch meal by kitchen staff, the following observations were made: * 11:42 AM Staff W, Dietary Aide placed uncovered desserts on trays to be delivered to resident rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 12:07 PM Staff CC used a handheld can opener to open a can of food, heated the food in a bowl in the microwave oven and without changing gloves or performing hand hygiene, picked up a lid, touching it on the side that faced the food, and placed it on the bowl. *12:12 to 12;22 PM Staff CC took a meal tickets from other staff, touched oven controls, cleaned a food thermometer with an alcohol wipe and did not change gloves or perform hand hygiene afterwards. *12:22 PM Staff CC began plating food wearing the same gloves that they had been wearing since 12:07 PM, and their thumb was touching the plates where food was being placed. *12:27PM Staff CC without changing gloves or performing hand hygiene reached into a bag of sandwich buns and brought one bun out of the bag and set it on a plate. *12:31PM Staff CC pushed their glasses up on their face with gloved hand then, without changing gloves or performing hand hygiene proceeded to take another sandwich bun out of package of buns and place it on a plate. In an interview on 06/04/2024 at 12:56 PM, Staff W stated they needed to wash hands before serving food, when they touched doors, and when changed gloves. Staff W stated they had not been covering the dessert for trays to be delivered to resident rooms and stated they were unaware they needed to do so. In an interview on 06/04/2024 at 12:58 PM, Staff Y, Dietary Manager stated desserts were supposed to be covered when placed on trays to be delivered to resident rooms to order to protect the food from possible contamination during transit. In an interview on 06/04/2024 at 1:08 PM, Staff CC stated hands were supposed to be washed when leaving the cooking area of kitchen and when returning, between glove changes, and after touching their face and/or other surfaces. Staff CC stated this was important to prevent the spread of bacteria. When asked, Staff CC did not acknowledge the observations of lack of hand hygeine, and repeated that they had washed their hands. <Medication Administration> During an observation on 06/04/2024 at 07:44 AM Staff D, Registered Nurse, RN, administered the injectable medication, insulin, to resident 14's abdomen without first cleaning the area with alcohol. In an interview on 06/04/2024 at 08:29 AM Staff D stated it was the resident's preference to not use alcohol on their skin prior to injections because it caused a burning sensation. Staff D stated they had not considered using a different cleaning method. They stated the area should have been cleaned prior to the injection to prevent transmission of bacteria with the injection. Staff D stated there was no documentation of the resident's preference to not have alcohol on their skin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/04/2024 at 10:59 AM, Resident 14 stated some of the nurses swabbed the injection area with alcohol prior to the injection of insulin. The resident stated they did not have a preference either way. When asked if it stung or burned after swabbing the area with alcohol, Resident 14 stated they thought it had in the past, but rarely. When asked if they told the nurses they preferred not to have alcohol on their skin to clean the area prior to injection Resident 14 said, no they had never told that to any of the nurses. In an interview on 06/05/2024 at 12:26 PM, Staff Q, Registered Nurse, Infection Preventionist stated an alcohol wipe should be used prior to giving a resident insulin or else the outcome could be an infection at the site of the injection. Reference: WAC 483.80(g)(1)(i)-(iv)(2)(i) -1320 (1)(c)