STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505349	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willapa Harbor Care	1100 Jackson Street Raymond, WA 98577

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or resident representatives were informed and provided consent before administering a psychotropic medication (medications capable of affecting the mind, emotions, and/or behaviors) for 1 of 5 sampled residents (Resident 14) reviewed for unnecessary medications. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about medications, and a diminished quality of life.Findings Included . Review of the facility's policy titled, Psychoactive [a drug affecting the mind] Medication Management, revised 08/2024, documented, .10. Complete the Psychopharmacologic [drugs used to treat mental health conditions] Medication Information Evaluation with the resident/resident representative. a. Review the Psychopharmacologic Medication Information Evaluation with the resident/resident representative when psychoactive medication is prescribed. Resident 14 was admitted to the facility on [DATE] with multiple diagnoses including depression and dementia. The End of PPS (Prospective Payment System) Minimum Data Set, an assessment tool, dated 06/20/2025, documented Resident 14 was severely cognitively impaired, taking antidepressant (used to treat depression) medication, and an antipsychotic (a class of psychotropic medications used to treat symptoms of various mental disorders) medication. Record review of Resident 14's physician orders, dated 05/12/2025, documented Resident 14 was prescribed Sertraline (a medication used to treat depression) 50 mg (milligrams) daily. The August 2025 Electronic Medication Administration Record (EMAR) showed Resident 14 was receiving Sertraline 50 mg daily. Review of Resident 14's Electronic Health Record (EHR) Psychopharmacologic Medication Informed Consent, dated 05/30/2025, showed Resident 14's representative gave consent for Sertraline on 05/30/2025, 18 days after the medication was started. Record review of Resident 14's physician orders, dated 05/12/2025, documented Resident 14 was prescribed Bupropion (a medication used to treat depression) 150 mg two times a day. Further review of Resident 14's EHR, showed the Bupropion dose ordered and administered was decreased to 100 mg two times a day starting 06/12/2025, decreased to 50 mg two times a day on 07/12/2025, and decreased to 25 mg two times a day on 08/02/2025. Review of Resident 14's EHR Psychopharmacologic Medication Informed Consent, dated 05/12/2025, showed Resident 14 gave consent for Bupropion on 05/12/2025. Review of Resident 14's EHR did not show documentation of consent or notification of change in dose from the resident or resident's representative for dose changes of the Bupropion on 07/12/2025 and 08/02/2025. In an interview on 08/07/2025 at 8:48 AM, Staff C, Infection Preventionist/Registered Nurse (RN) said they got consent from the resident and/or the resident's representative prior to administering psychotropic medications. Staff C said if there was a dosage change to psychotropic medications; they would notify the resident and/or the resident representative. When asked about Resident 14's Sertraline consent signed on 05/30/2025, Staff C said it was signed late, it should have been signed before Resident 14 started the medication. Staff C said she did not see a consent signed prior to starting Sertraline. When asked about Resident 14's Bupropion consent, Staff C said the original consent should not have been signed by Resident 14, it should have been signed by a representative or power of attorney (POA), stating, Her BIMS [Brief Interview for Mental Status, a screening tool used to assess cognitive function) is so low. Staff C said she did not find documentation Resident 14's representative was notified for the start of Bupropion and the dose changes on 07/12/2025 and 08/02/2025. In an interview on 08/07/2025 at 9:39 AM, Staff B, Director of Nursing/RN, said it was her expectation consents were signed by the resident or POA prior to the start of psychotropic medications. Staff B said the resident and/or the POA needed to be notified, and it documented in the EHR, if there was a change in dose for psychotropic medication. Staff B said if a resident had a low BIMS score, they needed to get consent from the POA for psychotropic medications. Reference WAC 388-97-0260 (1)-(3)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete an accurate comprehensive dental/oral assessment for 1 of 1 resident (Resident 8) reviewed for dental status. This failure placed the residents at risk for unmet care needs and a diminished quality of life.Findings included .Resident 8 was admitted to the facility on [DATE]. The Medicare 5-day Minimum Data Set (MDS), an assessment tool, dated 02/17/2025, documented the resident was alert and oriented.Record review of Resident 8's oral/dental status MDS assessment, dated 02/17/2025, documented Resident 8 did not have broken or loose natural teeth. In an observation on 08/04/2025 at 10:48 AM, Resident 8 was observed to have broken and loose teeth.In a joint observation on 08/06/2025 at 10:44 AM, Staff G, Licensed Practical Nurse, assessed Resident 8's mouth and stated, his teeth are loose, and he has broken teeth. Resident 8 was observed to be able to push his front teeth back and forth using his tongue. In an interview on 08/07/2025 at 9:37 AM, Staff C, Infection Preventionist/Registered Nurse reviewed the oral/dental status MDS assessment dated [DATE]. Staff C said Resident 8 did have broken teeth therefore the MDS assessment was incorrect. Staff C said it was the expectation that an accurate physical assessment was completed and documented in the MDS assessment. Reference WAC 388-97-1000 (1)(b)(2)(K)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a resident care plan for 1 of 3 sampled residents (Resident 37) reviewed for activities of daily living (ADL). This failure placed residents at risk for unmet needs and inappropriate plans of care.Findings included.Record review of the facility's policy titled, Care Planning Process, revised date 05/19/2023, stated the care plan must be reviewed and revised according to the RAI (resident assessment instrument) process at a minimum upon admission, quarterly and with significant change in condition and services provided or arranged must be consistent with each resident's written Care Plan.Resident 37 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS), an assessment tool, dated 06/25/2025, documented Resident 37 was dependent with oral care, and needed substantial/maximal assistance with personal hygiene. Resident 37 was moderately cognitively impaired. Review of Resident 37's ADL self-care performance deficit care plan, revised date 08/23/2022, documented, Personal Hygiene/Oral Care: The resident requires set up assist of (1) staff for personal hygiene and oral care.During an interview on 08/06/2025 at 2:17 PM, Staff I, Certified Nursing Assistant (CNA), said dependent meant the staff provided the full care doing everything for the resident with personal care and teeth. Staff I said personal care was head to toe, brush hair, teeth, dress and wash face and hands. Staff I said partial/moderate assistance was setting up and helping residents with something the residents could not do themselves. During an interview on 08/06/2025 at 2:55 PM, Staff C, Infection Preventionist/Registered Nurse, said partial assistance meant staff should encourage residents to do as much of their own care as possible. Staff C said if the MDS documented a resident was dependent with ADLs the care plan should be updated to reflect the change. During an interview on 08/06/2025 at 3:02 PM, Staff B, Director of Nursing/Registered Nurse, said if the resident's care needs changed the MDS should reflect the change, and the care plan should be updated. During an interview on 08/06/2025 at 3:10 PM, Staff B said she spoke with the CNA and was told Resident 37 did have a change with her care needs. Reference WAC 388-97-1020(2)(c)(d)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide resident centered activities that incorporated the resident's preferences for 1 of 3 residents (Resident 37) reviewed for activities. This failure placed residents at risk for a diminished quality of life.Findings included .Resident 37 was admitted to the facility on [DATE]. The Annual Minimum Data Set, an assessment tool, dated 06/25/2025, documented it was very important for Resident 37 to listen to music she liked. Resident 37 was moderately cognitively impaired. Review of The Life Enrichment quarterly progress notes dated 02/15/2025 and 03/21/2025, documented music became more important to her. Review of Resident 37's care plan, revised date 02/12/2025, showed Resident 37 prefers the following TV channels: news, sports, drama, etc. Resident 37 sometimes joins in a JW (Jehovah's Witness) meeting on Zoom [a platform that provides video and audio conferencing and online meetings]. Review of Resident 37's Planned Activities task, dated 07/08/2025 to 08/05/2025, documented Resident 37 had five of 27 days of one-on-one visits. No other activities were documented. In an observation on 08/05/2025 at 9:27 AM, Resident 37 was lying in bed, eyes closed head slightly turn to left shoulder. The TV was on. In an observation on 08/05/2025 at 10:08 AM, Resident 37's eyes were closed, her head slightly turned to her left. Resident 37 did not respond to knocks on the door or calling out to her. In an interview on 08/06/2025 at 11:10 AM, Resident 37 said she loved country music. When asked if she listened to music here, she stated no! Resident 37 said if they had music television she would listen to it, but she preferred a radio. In an interview on 08/06/2025 at 2:25 PM, Staff J, Life Enrichment Director, said if a resident had a preferred activity, they would do what they could to meet that resident's preferences. Staff J said they had two cd (compact disc) players and a variety of music to include country. Staff J said they did not have any radios. Staff J said he had offered Resident 37 the opportunity to use the cd player a few times, but she declined. Staff J said they don't document how often residents decline or refuse. In an interview on 08/06/2025 at 3:12 PM, Staff A, Administrator, said if a resident refused a program staff should document. Reference WAC 388-97-0940 (1)(2)

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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** Based on interviews and record review, the facility failed to initiate bowel interventions for 3 of 6 residents (Resident 1, 3 & 30) reviewed for quality of care. This failure placed residents at risk of unmet care needs and a diminished quality of life. Findings included . Record review of the facility policy, titled, “Management of constipation,” revision date, November 2023, documented, “when a resident is identified with no/small BM (bowel movement) documented for 64 hrs (hours), the LN (licensed nurse) will assess the resident and determine if the bowel protocol will be initiated.” The facility policy outlined standard bowel protocol based on providers’ orders which included: “Milk of magnesia 30 ml (milliliters) PO (by mouth) HS (at hour of sleep) after eight shifts of no BM. Bisacodyl Suppository rectally if no results from the milk of magnesia. Fleets Enama rectally if no results from the Bisacodyl Suppository.” Resident 1 Resident 1 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 07/30/2025, documented the resident was alert and oriented. Review of Resident 1's the Bowel Movement (BM) task sheet, undated, showed documentation of Resident 1’s BM activity on 07/13/2025 at 2:48 PM. Resident 1’s next BM was documented on 07/18/2025 at 06:42 AM, approximately 118 hours since the last BM. Record review of Resident 1’s physician’s order, dated 06/22/2025, documented, “Milk of Magnesia [MOM- medication for constipation] Suspension 400 MG [Milligrams]/5ML [Milliliters] (Magnesium Hydroxide) Give 30 ml by mouth every 8 hours as needed for Constipation Give at bedtime or at resident preferred time if no BM on 3rd day.” Review of Resident 1’s physician’s order, dated 06/22/2025, documented, “Dulcolax Suppository (Bisacodyl) [medication for constipation] Insert 1 suppository rectally every 24 hours as needed for Constipation If no results from MOM after 12 hours.” Review of Resident 1's Electronic Medication Administration Record (EMAR), dated July 2025, did not show documentation of medication intervention for no BM after 64 hours from 07/13/2025 to 07/18/2025. Review of Resident 1’s physician’s order, dated 06/22/2025, documented, “Fleet Enema Enema 7-19 GM [Grams]/118ML (Sodium Phosphates) Insert 1 application rectally every 24 hours as needed for Constipation If no results from Dulcolax in 4-6 hours. If no results from enema, notify MD [Doctor]. ” Resident 3 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 was admitted to the facility on [DATE]. The Medicare 5-day MDS, an assessment tool, dated 06/27/2025, documented the resident was alert and oriented. Record review of the Bowel Movement task sheet, undated, showed documentation of Resident 3’s BM activity on 07/22/2025 at 12:08 PM. Resident 3’s next BM was documented on 07/27/2025 at 01:55 PM, approximately 121hours since the last BM. Record review of Resident 3’s physician’s order, dated 06/23/2025, documented, “Milk of Magnesia Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ml by mouth every 8 hours as needed for Constipation Give at bedtime or at resident preferred time if no BM on 3rd day.” Record review of Resident 3’s physician’s order, dated 06/23/2025, documented, “Dulcolax Suppository (Bisacodyl) Insert 1 suppository rectally every 24 hours as needed for Constipation If no results from MOM after 12 hours.” Record review of Resident 3’s physician’s order, dated 06/23/2025, documented, “Fleet Enema Enema 7-19 GM(grams)/118ML (Sodium Phosphates) Insert 1 application rectally every 24 hours as needed for Constipation If no results from Dulcolax in 4-6 hours. If no results from enema, notify MD.” Record review of Resident 3’s Electronic Medication Administration Record (EMAR), dated July 2025, did not show documentation of medication intervention for no BM after 64 hours from 07/25/2025 to 07/26/2025 In an interview on 08/06/2025 at 1:39 PM, Staff B, Director of Nursing Services/Registered Nurse (RN), said the bowel protocol should be initiated 64 hours after the last BM. Staff B said after reviewing the medical records the bowel protocol for Resident 3 had not been initiated 64 hours after the last BM on 07/22/2025. Resident 30 Resident 30 was admitted to the facility on [DATE]. The Medicare 5- Day MDS, dated [DATE], documented the resident was alert and oriented. Review of Resident 30's Bowel Movement task sheet, undated, showed documentation of Resident 30’s BM activity on 07/23/2025 at 5:21 AM. Resident 30’s next BM was documented on 07/28/2025 at 03:21 PM, approximately 130 hours since the last BM. Record review of Resident 30’s physician’s order, dated 07/22/2025, documented, “Milk of Magnesia Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ml by mouth every 8 hours as needed for Constipation Give at bedtime or at resident preferred time if no BM on 3rd day.” Review of Resident 30’s physician’s order, dated 07/22/2025, documented, “Dulcolax Suppository (Bisacodyl) Insert 1 suppository rectally every 24 hours as needed for Constipation If no results from MOM after 12 hours.” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 30’s physician’s order, dated 07/22/2025, documented, “Fleet Enema Enema 7-19 GM(grams)/118ML (Sodium Phosphates) Insert 1 application rectally every 24 hours as needed for Constipation If no results from Dulcolax in 4-6 hours. If no results from enema, notify MD.” Review of Resident 30’s EMAR, dated July 2025, did not show documentation of medication intervention for no BM after 64 hours from 07/23/2025 to 07/28/2025. In an interview on 08/07/2025 at 10:03 AM, Staff N, Licensed Practical Nurse stated, “There should be something in the records from that stretch of time. There are no BM interventions for both.” In an interview on 08/07/2025 at 10:26 AM, Staff B, said it was her expectation to follow the bowel protocol. Staff B stated, “we have a problem with documentation. That is unacceptable to not have started the bowel protocol.” Reference WAC 388-97-1060 (1)(3)(c)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an order was in place prior to the administration of oxygen, for 1 of 2 sampled residents (Resident 30) reviewed for respiratory services. This failure placed residents at risk for complications in respiratory health and a diminished quality of life. Findings included . Record review of the Facility's Oxygen Management Policy, revised on 12/2022, documented, The center requires that a physician's order be obtained prior to the administration of oxygen. Resident 30 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- lung disease making it difficult to breathe) and pulmonary fibrosis (condition in which scare tissue builds up in the lungs, making it difficult to breathe). The Medicare 5- Day Minimum Data Set, an assessment tool, dated 07/22/2025, documented Resident 30 was alert and oriented. In an observation on 08/04/2025 at 1:06 PM, and at 3:23 PM Resident 30 was observed in bed with continuous oxygen on. Record review of Resident 30's physician order, dated, 08/05/2025, documented, 2lpm [liters per minute] n/c [nasal canula] oxygen continuously. Review of Resident 30's Electronic Health Records (EHR) did not contain any documentation of physician's order for oxygen prior to 08/05/2025. In an interview on 08/07/2025 at 12:21 PM, Staff C, Infection Preventionist/Registered Nurse, said Resident 30 had been using oxygen since her admission on [DATE]. Staff C stated, she has been on it ever since she has been here. In an interview on 08/07/2025 at 12:36 PM, Staff C stated, Yes, she admitted with oxygen. We checked and there was no order in until the 5th. In an interview on 08/07/2025 at 2:08 PM, Staff B, Director of Nursing Services, said that oxygen must be ordered by a physician. Staff B said she would expect oxygen to be administered per facility policy. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure nursing hours were accurately posted and updated daily for 30 of 31 days reviewed for nurse staff postings. This failure placed residents, resident representatives, and visitors at risk of not being fully informed of the current staffing levels and census information.Findings included.Record review of the Daily Nursing Staffing Report postings, prior to being edited, from 07/05/2025 to 08/04/2025 were not provided for review. Review of the Daily Nursing Staffing Report postings provided by the facility, from 07/05/2025 to 08/04/2025, showed changes for every day, except for 07/21/2025, to columns titled Hours Scheduled, Staffing Total, and Actual Hours Worked daily.In an interview on 08/05/2025 at 11:05 AM, Staff H, Staffing Coordinator, said she had only done staffing since May and was still learning. Staff H said she had not been updating the staffing numbers for each shift on the posted Daily Nursing Staffing Report. Staff H said yesterday's updated staffing did not get added to the daily posting during the day and that happened a lot.In an interview on 08/07/2025 at 9:49 AM, Staff B, Director of Nursing/Registered Nurse, said staffing was a new role for Staff H and she was still learning the process. Staff B said Staff H would only post the daily staffing numbers that were scheduled. Staff B said Staff H did not know she had to update the postings with changes each shift, and Staff H did not have a process to update them. Staff B said they would need a process to figure out who would be updating them. Staff B said the Daily Nursing Staffing Report needed to be updated with changes throughout the day.In an interview on 08/07/2025 at 10:42 AM, while looking at the Daily Nursing Staffing Reports provided by the facility with Staff H, Staff H said the postings provided to the surveyors had changes to them because she reviewed and corrected the postings the next day after they were taken down. Staff H said she would take the previous posted day down, review and correct it, and post a new one for the current day. Staff H said she did not know it needed to be updated to reflect current staffing throughout the day.No WAC Reference

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered by professional standards of practice for 1 of 5 residents (Resident 20) reviewed for medication administration. This failure placed residents at risk for medication errors, negative outcomes, and a diminished quality of life. Findings Included. Review of the facility's policy titled, Medication Administration, revised 12/2024, documented, .15. Remain with the resident until all medication is taken. Resident 20 was admitted to the facility on [DATE]. The End of PPS (Prospective Payment System) Part A Stay Minimum Data Set, an assessment tool, dated 07/08/2025, documented Resident 20 was cognitively intact. In an observation and interview on 08/04/2025 at 10:47 AM, Resident 20 was observed lying in bed with no staff present in the room. A medication cup with 9 pills in the cup was observed in front of Resident 20 sitting on the bedside table. When Resident 20 was asked about the pills in the cup, she said she wasn't ready to take them when the nurse brought them in. Resident 20 said she was still sleepy, so the nurse left them there for her to take. Resident 20 said she did not know what they all were for. Resident 20 said some were for nausea, dizziness, and some for high blood pressure. Record review of Resident 20's electronic health record did not show a self-medication administration evaluation had been completed. In an interview on 08/04/2025 at 10:51 AM, Staff B, Director of Nursing/Registered Nurse, said she did not think there were any residents on a self-medication program. Staff B said medications should not be left at the bedside if a resident was not on a self-medication program. In an observation and interview on 08/04/2025 at 10:55 AM, Staff B went to Resident 20's room to observe the medication cup at bedside. Resident 20 was observed to be swallowing and then set the empty medication cup down on bedside table. Resident 20 said she just swallowed her medications. When asked if the nurse left the medications there for her, Resident 20 stated, Yes. In an interview on 08/04/2025 at 11:01 AM, Staff B said Resident 20 was not on a self-medication program. Staff B said she talked to Resident 20's nurse. Staff B said Resident 20's nurse said she handed Resident 20 her pills and thought Resident 20 would take them, so she left the room. Staff B said the nurse should have stayed and watched Resident 20 take her medications. Reference WAC 388-97-1300 (1)(b)(i), (3)(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505349	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willapa Harbor Care	1100 Jackson Street Raymond, WA 98577

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food items were labeled and dated when opened in 1 of 2 kitchen refrigerators, reviewed for food storage. This failure placed residents at risk for food borne illness, and a diminished quality of life.Findings included .During an observation on 08/04/2025 at 10:03 AM, the kitchen refrigerator on the left, was observed with the following expired, opened items: 1. Metal Tupperware Jar of Butter Pasta- labeled with use by date of 08/03/20252. Metal Tupperware Jar of Meatballs - labeled with use by date of 08/02/20253. Metal Tupperware Jar of Diced Carrots - labeled with use by date of 08/03/20254. Plastic Ziplock bag of Bulk Ham- labeled with use by date of 07/25/20255. Plastic Ziplock bag of Deli Ham- labeled with use by date of 07/29/20256. Plastic Ziplock bag of Parmesan Cheese- labeled with use by date of 08/02/2025In an interview on 08/04/2025 at 10:05 AM, Staff M, Dietary Manager, said the items in the refrigerators should be kept until the use by date, and then disposed of. Staff M stated, they should be tossed out, and proceeded to throw away the expired items. In an interview on 08/07/2025 at 10:26 AM with Staff B, Director of Nursing, said she expected food items in the refrigerators and freezers to be discarded by the use by date. Reference WAC 388-97-1100 (3) & 2980

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505349	A. Building B. Wing	08/08/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to distribute resident meal trays in a sanitary manner in 1 of 2 hallways reviewed for infection control. This failure placed residents at risk of infection transmission and a diminished quality of life.Findings included .In an observation on 08/04/2025 at 12:46 PM, Staff F, Certified Nurse Assistant, was observed carrying a meal tray from the food cart into room [ROOM NUMBER] and placed it on a bedside table. room [ROOM NUMBER] had an orange-colored sign at the room entrance indicating the resident in room [ROOM NUMBER] was on enhanced barrier precautions (infection control precautions). Resident in room [ROOM NUMBER] declined the meal tray. Staff F proceeded to pick up the tray from the bedside table and returned it into the meal cart in the hallway which had other meals trays due to be served. In an interview on 08/04/2025 at 1:01 PM, Staff F was asked where she would keep residents meal trays if the resident refused it. Staff F stated, we typically put them back in the meal cart. In an interview on 08/07/2025 at 9:36 PM, Staff C, Infection Preventionist/Registered Nurse, said it was the expectation when a resident declined their meal tray, staff were expected to leave the meal tray in the room and not return the tray into the meal cart thus preventing contamination of the other trays in the cart. Reference WAC 388-97-1320 (1)