

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Arlington Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  620 South Hazel Street Arlington, WA 98223	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725</b></p> <p>Based on observation, interview, and record review the facility failed to ensure 2 of 2 residents (Resident 5 and 263) were properly assessed for the safety of self-medication administration. This failed practice placed residents at risk for medical complications and medication errors.</p> <p>Findings included .</p> <p>Review of a facility policy titled, Self-Medication Administration dated 09/16/2022 showed: Residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer.</p> <p>&lt;RESIDENT 263&gt;</p> <p>Resident 263 was admitted on [DATE] with diagnoses to include left hip fracture with surgical repair. Resident was alert, oriented and can verbalize needs.</p> <p>In an observation and interview on 01/30/2025 at 9:30 AM, an eye drop container labeled Pataday Ophthalmic Solution (eye drop to treat itching and redness in the eyes due to allergies) was observed on Resident 263's overbed table. The resident stated that they self-administered the eye drops every day. Resident stated staff were aware that they had and used the eyedrops.</p> <p>In an observation on 01/31/2025 at 9:40 AM, a bottle of Pataday eye drop was observed on Resident 263's bedside table.</p> <p>Review of Resident 263's current physician orders on 01/31/2025, showed no order was in place for Pataday eye drops.</p> <p>In a record review on 01/31/2025, Resident 263's care plan did not show that resident was on a self-medication program.</p> <p>In an interview on 02/03/2025 at 2:07 PM, Staff I, Licensed Practical Nurse (LPN) stated that the facility did not allow self-medication administration to residents and if they saw medications in the resident's room, they remove them. They were not aware that Resident 263 had an eye drop in their room.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/03/2025 at 3:42 PM, Staff G, LPN/Resident Care Manager (RCM), stated that if a resident wanted to self-administer their own medication, the resident needed to be assessed for safe storage of medication and pass a self-medication assessment. Staff G stated staff should remove medications that were brought to the facility by the resident or family. Staff G was not aware that Resident 263 had an eye drop at bedside.</p> <p>In an interview on 02/04/2025 at 3:15 PM, Staff G stated that they noted the eye drop in Resident 263's room after it was reported by surveyor.</p> <p>51312</p> <p>&lt;RESIDENT 5&gt;</p> <p>Resident 5 was a long-term resident of the facility. Review of MDS dated [DATE] showed Resident 5 had no cognitive issues.</p> <p>During an observation on 1/30/2025 at 2:30 PM, Resident 5 returned from a doctor's appointment with an inhaler (A portable device for administering a drug to be breathed in). Staff DD, LPN, brought the resident to the room. Resident 5 had the inhaler in their hand.</p> <p>In an observation on 1/30/2025 at 2:42 PM, the inhaler was observed at the bedside of Resident 5.</p> <p>During an observation and interview on 1/31/2025 at 8:34 AM, Resident 5 stated that I only used the inhaler when needed. Resident 5 then showed surveyor inhaler on the bedside table.</p> <p>During an interview and observation on 1/31/2025 at 2:01 PM, Resident 5 stated that they had only used their inhaler once that day. The inhaler was observed on the bedside table.</p> <p>Review of Resident 5's clinical record on 01/31/2025 at 2:20 PM, showed no self-medication assessment was present in the record.</p> <p>Review of Resident 5's care plan, print date 01/31/2025, showed no documentation of a self-medication program or keeping inhaler at bedside.</p> <p>During an interview on 02/03/2025 at 1:58 PM Staff O, Registered Nurse (RN) stated that residents may have medication in their rooms after being evaluated for safety and if the medication was in a lock box.</p> <p>During an interview on 02/03/2025 at 1:48 PM, Staff GG, RN, stated that the facility would have to have an agreement with the resident in order for residents to have medications at the bedside. No, this was all the staff member GG could say about meds. I can take it out.</p> <p>During an interview on 02/03/2025 at 2:15 PM, Staff B, Director of Nursing Services, stated that for residents to have medications at the bedside, they would need a doctor's order and an evaluation for safety. Staff B stated that if a resident was self-administering medications, nursing staff should assess whether they administered their medications accurately. Staff B stated they were aware that Resident 5 had medication at the bedside and had not been evaluated and were planning on removing the drug until the procedure could be followed.</p> <p>(continued on next page)</p>		

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F 0554  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Refer to WAC 388-97-0440		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50725</p> <p>Based on interview and record review the facility failed to provide the required beneficiary notice for 2 of 3 residents (Residents 47 and 265) reviewed for liability notices. Failure to provide the appropriate form for the beneficiary notice and failure to give the Notice of Medicare Non-Coverage (NOMNC) 48 hours before the Medicare Part A's last covered day placed the residents at risk for not being fully informed of their rights to appeal the decision to end skilled services and/or the potential costs of continued services if the residents wished to stay longer at the facility.</p> <p>Findings included .</p> <p>&lt;RESIDENT 47&gt;</p> <p>Resident 47 was discharged on [DATE]. Last covered day of Medicare Part A service was 01/01/2025.</p> <p>Review of the Advance Beneficiary Notice of Non-coverage (ABN) form signed by Resident 47's spouse showed the facility used Centers for Medicare and Medicaid Services (CMS) form R-131. Per CMS guidelines, Skilled Nursing Facilities (SNF) should be using CMS-10055 forms for SNF ABN.</p> <p>In an interview on 01/31/2025 at 2:33 PM, Staff F, Social Service Director, stated that they were not aware that there was a new SNF ABN form. They added moving forward, they will start using the new form.</p> <p>&lt;RESIDENT 265&gt;</p> <p>Resident 265 was discharged from the facility on 09/26/2024.</p> <p>Review of the NOMNC form showed that Resident 265's Skilled Nursing Services ended on 09/25/2024. Signature of resident or representative was signed on 09/24/2024.</p> <p>In an interview on 01/31/2025 at 2:33 PM, Staff F stated that they were the primary person that gives the NOMNC and ABN notices to residents. Staff F stated they did not know why the NOMNC was given 24 hours prior to Medicare Part A last covered day instead of 48 hours per guidelines for Resident 265.</p> <p>Refer to WAC 388-97-0300 (1)(e)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51551</p> <p>Based on interview and record review, the facility failed to promptly initiate, resolve and document resident grievances for 2 of 4 sampled residents (Resident's 45 and 25) reviewed for grievance resolution. The failure of staff to initiate resident grievances resulted in delays in grievance resolution and an extended period where a resident went without their missing clothing, broken furnishing and placed residents at risk for frustration and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy, titled, Grievance Policy and Procedure for Residents, revised date 04/15/2024, showed grievances were resolved immediately when possible, by the individual receiving the grievance. The policy showed grievances would be completed within 5 days and the resident would be notified and updated if the grievance took longer than 5 days.</p> <p>&lt;RESIDENT 45&gt;</p> <p>Resident 45 admitted to the facility on [DATE]. According to the Minimum Data Set (MDS-an assessment tool) assessment, dated 12/15/2024, the resident was cognitively intact.</p> <p>In an interview on 01/29/2025 at 11:48 AM, Resident 45 stated they were missing two pairs of socks and one pair of pants since last September. Resident 45 stated they told nurses and laundry staff about the missing items, and the clothes had still not been found yet.</p> <p>Review of the facility grievance logs for 08/03/2024 through 01/27/2025 showed no grievances were logged for Resident 45 regarding missing clothes.</p> <p>In an interview on 01/30/2025 at 2:40 PM, Staff D, Certified Nurse Assistant (CNA), stated Resident 45 had some socks and pants missing quite a while ago and laundry staff were still looking for the missing clothes. Staff D stated they did not know if a grievance form was filled out.</p> <p>In an interview on 01/30/2025 at 2:53 PM, Staff E, Laundry Assistant, stated they were aware that Resident 45 had missing pants since Thanksgiving and Christmas time, and they were still looking for the items. Staff E stated they were not sure if a grievance form was filled out, but the laundry manager knew about it.</p> <p>In an interview on 02/03/2025 at 1:39 PM, Staff F, Social Service Director, stated they were not aware that Resident 45 had missing clothes, and they were not sure if a grievance form was filed. Staff F stated everyone in the facility could fill out a grievance form as soon as possible when the resident reported missing items.</p> <p>In an interview on 02/04/2025 at 12:24 PM, Resident 45 stated no one had communicated with them about their missing clothes yet and they had not received reimbursement or replacement.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the updated facility grievance logs received on 02/04/2025 showed no grievances were logged for Resident 45 for missing clothes.</p> <p>50725</p> <p>&lt;RESIDENT 25&gt;</p> <p>Resident 25 admitted to the facility on [DATE]. Resident was alert and can make needs known but is forgetful.</p> <p>During a Resident Council meeting on 01/31/2025 at 11:00 AM, Resident 25 stated that the blinds in their room have holes in them.</p> <p>In an observation and interview on 01/31/2025 at 3:05 PM, Resident 25's window blinds had blinds that were cut off on the edges creating holes in the blinds. The resident stated the Maintenance Manager came in and looked at their blinds and informed them that they will order new blinds and replace them.</p> <p>In an interview on 02/03/2025 at 9:16 AM, Staff Y, CNA stated that in each nurse's station, they have a clipboard to write issues down for maintenance to follow up. The Maintenance Director looks at the list and initials it if it was fixed or work was done.</p> <p>Review of the maintenance log from 10/21/2024 to 02/03/2025 did not show Resident 13's broken blinds.</p> <p>Review of the facility grievance log from September 2024 to February 2025 did not show Resident 13's concern regarding their broken blinds.</p> <p>In an observation and interview on 02/03/2025 at 2:58 PM, the blinds in Resident 25's room had not been replaced. Staff X, Maintenance Director stated when there are things that need to be fixed, staff or resident will notify them. They stated that there were 3 window blinds that needed to be replaced, and they ordered replacements, but it will take up to two weeks to get delivered.</p> <p>Refer to WAC 388-97-0460(2)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</b></p> <p>Based on interview and record review, the facility failed to ensure policies and procedures for timely reporting of alleged financial exploitation of 1 of 2 residents (Resident 16) reviewed for abuse/neglect. The facility failed to report to the state agency and law enforcement when a resident voiced concerns related to their financial affairs. This failure by the facility to identify, report, and investigate an allegation of potential abuse or neglect placed residents at risk of being victims of unidentified and uninvestigated abuse and/or neglect and limited the thoroughness of investigations.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Abuse and Neglect, dated 08/2024 stated the facility will report allegation(s) of abuse and neglect to the appropriate authorities. Allegations of abuse and neglect will be reported to the Department of Social and Health Services (DSHS) following the nursing home reporting guidelines the Purple Book.</p> <p>Review of the Nursing Home Guidelines, The Purple Book, October 2015 (sixth edition) showed an immediate report was required to be made to the department when there is a reasonable cause to believe that financial exploitation occurred in addition a report to law enforcement.</p> <p>Resident 16 admitted to the facility on [DATE] with diagnoses that included hypertension, history of stroke, and type two diabetes mellitus (a chronic condition that affects how the body uses sugar for energy).</p> <p>In an interview on 01/29/2025 at 3:03 PM Resident 16 stated the social worker at the facility had told them they should protect their money. Resident 16 stated they believed that they had paid the mortgage of their child.</p> <p>Review of Resident 16's electronic medical record, showed a document titled Outcome Report from Adult Protective Services (APS), dated 10/04/2024, documenting an allegation of neglect was found to be inconclusive. There was no notation regarding financial exploitation.</p> <p>In an interview on 01/29/2025 at 3:14 PM Staff F, Social Service Director, stated there had been concerns about Resident 16's child using the resident's funds to pay for their mortgage in addition to allegations of neglect. Staff F stated they did not know if a report was made to the department but they would look into it.</p> <p>In a follow up interview on 01/30/2025 at 9:34 AM Staff F stated there was not a report made to the department regarding concerns of financial exploitation of Resident 16. Staff F stated they had spoken to the APS investigator (who had been investigating allegations of neglect) about concerns of financial exploitation of Resident 16. Staff F stated they did not document their conversation with the APS investigator in Resident 16's progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/05/2025 at 9:15 AM Staff A, Administrator, stated the facility communicates with APS investigators when there is an active case open. Staff A stated if there was new or additional information about a resident, a report would need to be completed.</p> <p>This is a repeat deficiency from 08/23/2024.</p> <p>Reference (WAC) 388-97-0640(5)(a)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51551</p> <p>Based on interview and record review, the facility failed to ensure the Resident Assessment Instrument (RAI), an assessment of a resident's needs, strengths, goals, and preferences, and included thorough summaries of the Care Area Assessments (CAA's), an assessment of a specific resident care or medical issue, to holistically analyze the plan of care for 5 of 16 residents (Residents 1, 12, 16, 22, and 32) reviewed for comprehensive assessments. This failure placed the residents at risk of not having appropriate services provided based on the resident's individualized needs and placed all other residents at risk of their needs and preferences not met.</p> <p>Findings included .</p> <p>Review of the Centers for Medicare &amp; Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1, dated October 2024, showed the Care Area Assessment process reflects conditions, symptoms, and other areas of concern that are common in nursing home residents. The CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors, some of which may be reversible and obtaining input from the resident and/or family. It is important that the CAA documentation include the causal or unique risk factors for decline or lack of improvement.</p> <p>&lt;RESIDENT 1&gt;</p> <p>Resident 1 admitted on [DATE]. Review of the significant Minimum Data Set (MDS-an assessment tool) assessment, dated 01/22/2025, showed the psychotropic drug use CAA did not contain comprehensive summaries or analysis that included the resident's current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's care plan was needed.</p> <p>In an interview on 02/03/2025 at 11:23 AM, Staff N, Licensed Practical Nurse (LPN)/MDS Coordinator stated the psychotropic CAA should be completed with a summary and they were not sure why the CAA was not completed for Resident 1. Staff N stated social services had taken over the responsibility for psychotropic medication reviews as well.</p> <p>In an interview on 02/03/2025 at 1:39 PM, Staff F, Social Service Director, stated they were not responsible for completing the psychotropic medication CAA's.</p> <p>In an interview on 02/04/2025 at 9:23 AM, Staff B, Director of Nursing, stated social services was responsible for parts of the MDS assessment and the MDS Coordinator needed to check and make sure all CAAs were completed. Staff B stated they expected the triggered CAAs should be filled out and completed.</p> <p>47047</p> <p>&lt;RESIDENT 16&gt;</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 16 admitted to the facility on [DATE] with diagnoses that included stroke, and diabetes (a chronic condition that affects how the body uses sugar for energy).</p> <p>Review of Resident 16's significant change MDS assessment, dated 09/25/2024, showed the pressure ulcer/injury CAA did not contain comprehensive summaries or analysis that included the resident's current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's care plan was needed.</p> <p>In an interview on 02/05/2025 at 11:05 AM Staff N, stated they typically complete CAA's and the care plan review right after submitting and finalizing the MDS. Staff N described gathering information to complete the MDS solely through review of the resident's medical records with some sections left for social services to complete.</p> <p>&lt;RESIDENT 22&gt;</p> <p>Resident 22 admitted to the facility on [DATE] with diagnoses that included dementia.</p> <p>Review of Resident 22's significant change MDS assessment, dated 11/13/2024, showed the cognition/dementia and communication CAA did not contain comprehensive summaries or analysis that included the resident's current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's care plan was needed.</p> <p>In an interview on 02/05/2025 at 11:05 AM Staff N, stated they typically complete CAA's and the care plan review right after submitting and finalizing the MDS. Staff N described gathering information to complete the MDS solely through review of the resident's medical records with some sections left for social services to complete.</p> <p>51312</p> <p>&lt;RESIDENT 32&gt;</p> <p>Resident 32 was a long-term care resident of the facility.</p> <p>A review of Resident 32's significant change MDS assessment, dated 03/27/2024, showed the Resident was severely cognitively impaired, and had communication issues due to difficulty hearing. Review also showed that the communication CAA did not contain comprehensive summaries or analyses that included the resident's current goals, preferences, strengths, or needs for the specific care areas, which were necessary to determine whether updates to the resident's care plan were needed.</p> <p>In an interview on 1/29/2025 at 1:32 PM, Resident 32 could not hear questions without loud and significant voice raising.</p> <p>In an interview on 2/3/2025 at 2:15 PM, Staff B stated that when they speak to Resident 32, the resident understands if they talk loudly, but Resident 32 should be assessed for a whiteboard or another way to communicate.</p> <p>In an interview on 2/3/2025 at 2:20 PM, Staff N, indicated that Resident 32's hearing CAAs were completed, and that Staff N was only required to fill out the first and last portion of the worksheet.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&lt;RESIDENT 12&gt;</p> <p>Resident 12 was a long-term care resident of the facility.</p> <p>Review of Resident 12's significant change MDS assessment, dated 10/04/2024, showed the pressure ulcer/injury CAA did not contain comprehensive summaries or analysis that included the resident's current goals, preferences, strengths, or needs for the specific care areas, which were necessary to determine if updates to the resident's care plan were required.</p> <p>During record review of a document titled 'Brayden Scale' (a scale that indicates a risk of pressure ulcers) with a print date of 1/29/2025 indicated that Resident 12 was at high risk for pressure ulcer injury.</p> <p>In an interview on 2/3/2025 at 2:20 PM, Staff N stated that they needed to complete the last area of the CAA worksheet. Staff N stated they had a paragraph written for them to copy and paste into that box. Staff N stated they were unaware that other areas needed to be addressed.</p> <p>Reference: (WAC) 388-97-1000 (b)(c)(ii)(2)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47047</p> <p>Based on observations, interviews and record review, the facility failed to review, revise and implement a comprehensive plan of care to included resident specific information for 6 of 18 sampled residents (Residents 12, 22, 34, 40, 16, &amp; 33) reviewed for care plans. The failure to establish and implement care plans that were individualized, accurately reflected assessed care needs and provided direction to staff, placed residents at risk to receive inappropriate and inadequate care to meet their individualized needs and preferences.</p> <p>&lt;RESIDENT 22&gt;</p> <p>Resident 22 admitted to the facility on [DATE] with diagnoses that included dementia.</p> <p>&lt;WANDERING&gt;</p> <p>Review of Resident 22's care plan dated 05/11/2022 showed they were at risk for wandering. Interventions for Resident 22's wandering included assessing for fall risk, ensuring needs were met, identifying a pattern of wandering, use of a wander guard and the use of the fenced patio if they were looking for sun.</p> <p>Review of Resident 22's Document Survey Report for 1/01/2025 through 02/05/2025 showed a single documented instance of wandering on 01/03/2025 at night. There were no documented interventions used.</p> <p>In an observation on 02/04/2025 at 12:31 PM, Resident 22 was using their feet and the handrail to self-propel in the hallway of the unit. Resident 22 was seen entering a room other than their own. Staff S, Nursing Assistant Certified (NAC) stated aloud that it was their second time removing the resident from another room.</p> <p>In an observation on 01/31/2025 at 9:33 AM Resident 22 was in their room, the room number outside their door, significantly larger than any other room, handwritten.</p> <p>&lt;DEMENTIA CARE&gt;</p> <p>Review of Resident 22's Care Area Assessment (CAA) for cognition/dementia, completed as part of a significant change assessment, dated 11/24/2024 showed they had cognitive impairment which had been impacted by being placed on hospice services. Additionally, a CAA was completed for communication which noted Resident 22 was heard talking to someone in their room, but no one was in the room with them.</p> <p>Review of Resident 22's care plan consisted of two separate plans to address their impaired cognition related to their dementia process one dated 05/11/2022 and another dated 06/02/2023. Neither care plan included person-centered information, goals or interventions regarding their dementia, dementia process, or the information found in the CAA.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/05/2025 at 9:26 AM Staff A, Administrator, stated they try to meet regulations associated with care plans. Staff A stated part of the care planning process included lining up diagnosis, behaviors, and interventions and reviewing them at least quarterly. Staff A stated they thought Resident 22's behavior of wandering into other rooms was new.</p> <p>&lt;RESIDENT 16&gt;</p> <p>Resident 16 admitted to the facility on [DATE] with diagnoses that included hypertension, history of stroke, and type two diabetes mellitus (DM- a chronic condition that affects how the body uses sugar for energy).</p> <p>In an observation on 01/29/2025 at 2:06 PM observed a green wedge on the shelving unit in Resident 16's room, across from the foot of their bed. When asked what the purpose of the green wedge was, Resident 16 stated it was used to position under them to take pressure off.</p> <p>Review of Resident 16's care plan dated 07/04/2024 showed they were at risk for skin impairment related to their multiple diagnoses. The goal was for Resident 16 to be cooperative with position changes. Interventions included repositioning, use of ointments, use of an air mattress, and green open heel pressure relieving boots while in bed. There was no intervention for the use of a green positioning wedge.</p> <p>Review of Resident 16's progress notes, dated 11/22/2024, showed resident was resistant to change positions while in bed, wanted to lie on their back to watch television.</p> <p>In an interview on 02/05/2025 at 11:05 AM Staff W, Licensed Practical Nurse (LPN), stated Resident 16 did not like to stay repositioned on their side and would return to lying on their back, but had used wedges. Staff W did not know the care plan lacked the interventions currently being utilized with the wedges and Resident 16's resistance and would update it.</p> <p>&lt;RESIDENT 40&gt;</p> <p>Resident 40 admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses that included DM, chronic obstructive pulmonary disease (group of lung diseases that restrict breathing), and high blood pressure.</p> <p>&lt;BATHING/SHOWER&gt;</p> <p>In an interview on 01/29/2025 at 11:14 AM Resident 40 stated they had not had a shower they thought since before they broke their leg, had a bed bath in their chair, and was due for a shower.</p> <p>In an observation on 01/29/2025 at 11:14 AM Resident 40's lower dentures were observed to be in a candy dish, covered by three black licorice sticks, not stored in a container, and were covered in small pieces of green matter.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 40's care plan dated 03/13/2024 showed they had a deficit in their ability to perform activities of daily living. Interventions included to provide resident a bath/shower, to avoid scrubbing, and to pat dry sensitive skin. There was no person-centered interventions and no resident preferences for when or how they preferred to be bathed.</p> <p>&lt;UNNECESSARY MEDICATIONS&gt;</p> <p>Review of Resident 40's January 2025 Medication Administration Record (MAR) showed they were taking antibiotics prophylactically for a urinary tract infection, insulin (medication used to treat DM), and pain medication.</p> <p>Review of Resident 40's care plan dated 03/14/2024 showed no care plan related to antibiotic use or insulin use. The care plan showed Resident 40 was at risk of pain related to their chronic medical condition however there were not any non-pharmacological interventions.</p> <p>In an interview on 02/05/2025 at 9:26 AM Staff A, Administrator, stated they try to meet regulation associated with care plans. Staff A stated part of the care planning process included lining up diagnosis, behaviors, and interventions and reviewing them at least quarterly.</p> <p>50725</p> <p>&lt;RESIDENT 33&gt;</p> <p>Resident 33 admitted to the facility on [DATE] with diagnoses to include Cholecystitis (inflammation of the gallbladder) with a cholecystostomy drain tube (a thin, flexible tube inserted into the gallbladder to drain bile and infected fluid) and dementia. According to the admission Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], the resident had severely impaired cognition.</p> <p>&lt;FEEDING/NUTRITION&gt;</p> <p>In an observation on 01/31/2025 at 8:44 AM, Resident 33 was in bed eating alone, no staff were present in the room. The head of the bed was elevated, and the resident was leaning toward their right side while trying to reach for the food to eat. A staff member entered the room and asked the resident if they liked the eggs. The staff left and ten minutes later went in to take the tray from the resident's room. Observation of the resident's meal tray showed the food appeared untouched.</p> <p>In an interview on 01/31/2025 at 9:10 AM, Staff D, NAC, stated that Resident 33 feeds themselves but their condition had been declining and does not eat much. Staff D stated occasionally they assist the resident with eating when they are weaker.</p> <p>Review of Resident 33's care plan, with a print date of 1/30/2025, showed there were no mention on how the resident eats and if they required assistance in feeding themselves.</p> <p>In an observation and interview on 02/03/2025 at 8:47 AM, Staff AA, NAC, was sitting beside Resident 33 in the hallway encouraging the resident to eat some more food. When Staff AA took the tray, they stated that resident only ate about 25%. Staff AA stated it was Resident 33's normal intake.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 33's weight record, print date 02/05/2025, showed the resident's weight on 01/11/2025 was 110.2 pounds (lbs.) and their weight on 01/30/2025 was 96.8 lbs. A difference of 13.4 lbs. in less than a month.</p> <p>In an interview on 02/05/2025 at 12:59 PM, Staff G, LPN/Resident Care Manager (RCM) stated that Resident 33 was a one-to-one feed (one staff to feed resident during mealtimes) since admission. When asked how the staff would know that Resident 33 was a one-to-one feed, Staff G stated through shift reports and in the Kardex (a summary of resident's information regarding the care they need based on the care plan). Staff G reviewed the Kardex for the resident but stated that the one-to-one feed was not listed. Staff G stated they were unsure why it was not on the Kardex and they would add that information.</p> <p>&lt;MOBILITY&gt;</p> <p>Review of Resident 33's care plan on 02/03/2025 showed the resident was on a Restorative Program (nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible).</p> <p>In an interview on 02/04/2025 at 12:55 PM, Staff H, Restorative Aid stated that Resident 33 was not on Restorative Program.</p> <p>In an interview on 02/04/2025 at 1:15 PM, Staff G stated that Resident 33 was not on a Restorative Program, they stated that when the resident was admitted , they reactivated their old care plan from the past admission and did not update it.</p> <p>51312</p> <p>&lt;RESIDENT 12&gt;</p> <p>Resident 12 was a long-term care resident at this facility. According to the MDS dated [DATE], the Resident is severely cognitively impaired and required extensive assistance with turning and repositioning in bed.</p> <p>Review of Resident 12's care plan, print date of 01/29/2025, showed the resident should be turned side to side with pillows.</p> <p>In an multiple observations on 01/31/2025 at 8:36 AM, 9:58 AM, 11:20 AM, 12:00 PM, 1:56 PM Resident 12 was observed in bed on their back with their legs slightly elevated. The head of the bed was at a 45-degree angle.</p> <p>In observations on 01/31/2025 at 3:17 PM and 4:37 PM, Resident 12 was observed lying on their left side in bed. The head of bed was at a 45-degree angle.</p> <p>During an interview on 02/03/2025 at 11:03 AM, Staff GG, RN stated that Resident 12 should be repositioned every two hours and that the nursing staff should alert the Nursing Assistants. Staff GG noted that they had repositioned the resident by lifting the head of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/03/2025 at 1:37 PM, Staff D stated when residents are dependent, they should be repositioned every two hours Staff D stated that NACs should look at the care plan, and they would also be told in report that residents should be turned every two hours.</p> <p>During a subsequent interview on 02/03/2025 at 1:48 PM, Staff GG stated that dependent residents should be repositioned every two hours.</p> <p>During an interview on 2/3/2025 at 2:15 PM, Staff B, Director Nursing Services (DNS), stated that residents who are dependent should be turned and repositioned every two hours and that information should be on the care plan. Staff B stated that Resident 12 should be repositioned every two hours.</p> <p>&lt;RESIDENT 34&gt;</p> <p>Resident 34 was admitted to the facility on [DATE]. According to the MDS dated [DATE], the resident had severe cognitive impairment and required extensive assistance with all ADLs.</p> <p>Review of Resident 34's care plan, with a print date of 1/29/2025, showed the resident should always have their heels floated while in bed.</p> <p>In multiple observations on 01/31/2025 at 8:30 AM, 10:02 AM, 11:28 AM, 11:59 AM, 3:22 PM, 4:39 PM, Resident 34 was observed in bed, lying on their back, and their heels were not floated.</p> <p>During an interview/observation on 02/09/2025 at 1:37 PM, Staff D was in Resident 34's room and was asked to look at their heels; they stated Resident 34's heels were not being floated, but they should be.</p> <p>During an interview on 02/03/2025 at 2:15 PM, Staff B stated NACs should be turning/repositioning Resident 34 every two hours, Staff B stated that information should be in the care plan. Staff B was not sure about their heels being floated.</p> <p>Review of Resident 34's care plan, print date of 1/29/2025, showed that the activity interventions included group activities, introduction to other residents, and invitation to scheduled activities.</p> <p>During an interview on 02/03/2025 at 1:37 PM, Staff D stated that Resident 34 dislikes eating in the dining room; they get agitated around big groups of people. Staff D then answered that Resident 34 likes to watch sports on TV, but they were unsure what other activities the resident enjoyed.</p> <p>During an interview on 02/03/2025 at 2:15 PM, Staff B stated that they were unsure what activities Resident 34 enjoyed and that information should be on the care plan.</p> <p>In an interview on 2/3/2025 at 4:17 PM, Staff FF, Activities Director, stated that Resident 34 does not like group activities and gets agitated. Staff FF then stated that Resident 34's activities are 1:1 with staff members 2-3 times a week and that nothing on their care plan reflects their choices.</p> <p>Refer to WAC 388-97-1020 (1), (2)(a)(e)(f)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</b></p> <p>Based on observations, interviews and record reviews the facility failed to review and revise care plans for 2 of 12 residents (Residents 40 and 1) reviewed for care planning. The failure to review and revise care plans by the interdisciplinary team placed residents at risk for unmet care needs, adverse health effects and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Care Plan Policy, revised on 08/16/2024, showed care plans are updated with any status change and revised based on changing goals, preferences, and needs of the resident.</p> <p>&lt;RESIDENT 40&gt;</p> <p>Resident 40 admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses that included diabetes type two (a chronic condition that affects how the body uses sugar for energy), chronic obstructive pulmonary disease (group of lung diseases that restrict breathing), and high blood pressure.</p> <p>&lt;ACCIDENTS/FALLS&gt;</p> <p>In a review of Resident 40's Significant Change Minimum Data Set (MDS- an assessment tool) dated 01/12/2025 showed the resident had moderate cognitive impairment. Review of the Care Area Assessment (CAA-an assessment which directs the care plan development) portion of the MDS related to falls showed the resident had deconditioning related to a recent hospitalization , recalled falling twice in the last year, and could walk to the cafeteria using a four wheeled walker and was a fall risk. There information was incomplete, not person centered, and lacked the components of a comprehensive assessment.</p> <p>Review of Resident 40's incident reports showed they had a total of 6 falls on the following dates: 08/21/2024, 09/04/2024, 10/21/2024, 10/30/2024, 11/01/2024 and 11/20/2024.</p> <p>Review of Resident 40's care plan dated 01/06/2025 showed they were at risk for falls related to decreased mobility and weakness with the goal of them being free of falls. Resident 40 was noted to have falls on 09/04/2024, 10/21/2024 and 10/30/2024 all related to slipping out of their bed. Interventions included encouraging Resident 40 to decrease clutter around their bed, education and encouragement to use the call light, fall mat on the right side of the bed, sign to ensure use of proper footwear, call light within reach and answered promptly, therapy orders, monitor for signs/symptoms of change of condition, night shift to check and change their brief, and they were non weight bearing with use of the Hoyer Lift (mechanical device used to transfer residents from one surface to another). The care plan was in contradiction to information found in the CAA and incomplete based on information found in the incident reports.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/04/2025 at 12:39 PM Staff S, Nursing Assistant Certified (NAC) stated Resident 40 was a fall risk and there were interventions put in place to minimize their fall risk. Staff S stated interventions included the use of a commode, nonskid socks, placement of wheelchair next to their bed, encouraged the resident to use their call light and have staff be there with them for safety, use of a gait belt and to have everything within reach for resident to use. Staff S stated they rely on the Kardex (a guide for nursing assistance to provide care derived from the care plan), which was in the closets of residents.</p> <p>In an interview on 02/05/2025 at 9:26 AM Staff A, Administrator, stated they try to meet regulations associated with care plans. Staff A stated part of the care planning process included lining up diagnosis, behaviors, and interventions and reviewing them at least quarterly.</p> <p>51551</p> <p>&lt;RESIDENT 1&gt;</p> <p>Resident 1 admitted to the facility on [DATE] with diagnosis to include palliative care (an approach that improves the quality of life of terminal ill patient), dementia (progressive decline in cognitive functions, such as memory, thinking, reasoning, and problem-solving, that interferes with daily life and activities) and depression.</p> <p>&lt;PSYCHOTROPIC MEDICATION&gt;</p> <p>Review of MDS assessment, dated 01/22/2025 showed Resident 1 had severe cognitive impairment, received antidepressant and antipsychotic medications and the CAA was triggered for psychotropic medication use.</p> <p>Review of Resident 1's January 2025's Medication Administration Record (MAR) showed the resident was taking antidepressant medications since 02/14/2024 and antipsychotic medications since 03/14/2024.</p> <p>Review of Resident 1's care plan, copy date 01/31/2025 showed a focus area that the resident had psychotropic medication (antipsychotic); the goal was Resident 1 would have decreased number of depressive episodes and interventions were monitor antidepressant medication side effects and monitor target behaviors related to antidepressant use.</p> <p>In an interview on 02/03/2025 at 10:36 AM, Staff O, Registered Nurse, stated it was an error that the care plan had mixed up the two different categories psychotropic medications into one care plan. Staff O stated the care plan showed goal and interventions about antidepressants but was under the wrong medication focus. Staff O stated the care plan needed to be updated.</p> <p>In an interview on 02/03/2025 at 11:26 AM, Staff N, MDS Coordinator, stated they updated care plans after the CAA process when they did comprehensive assessments. Staff N stated the antidepressant medication care plan interventions were listed under antipsychotic medication focus and they would fix it.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a joint interview on 02/04/2025 at 9:23 AM, Staff B, Director of Nursing, and Staff C, Director of Operation stated they expected care plans to be reviewed and revised at least 7 days after a resident had a change.</p> <p>&lt;WANDER GUARD&gt;</p> <p>On all days of the survey, Resident 1 was observed lying in bed or sitting in wheelchair at the side of bed. Resident 1 was observed unable to propel their wheelchair themselves.</p> <p>Review of a Hospice Certification dated 01/17/2025, showed Resident 1 was terminally ill and started hospice care since 01/16/2024.</p> <p>Review of significant change MDS assessment dated [DATE], showed Resident 1 had not attempted to walk and required dependent assistance with wheelchair mobility. The MDS assessment showed Resident 1 did not use a wander/elopement alarm.</p> <p>Review of progress note, dated 01/24/2025 at 3:23 AM, showed wander guard found on the table in room and given to resident care manager (RCM) to see if needed replaced.</p> <p>Review of a progress note dated 01/31/2025 at 12:10 AM, showed no wander guard on resident and was given to RCM two weeks ago.</p> <p>Review of Resident 1's clinical record showed there was no wandering risk assessment completed after 01/10/2025.</p> <p>Review of Resident 1's care plan copy date 01/31/2025, showed an intervention of a wander guard placed for attempt to elope from facility initiated on 02/14/2024.</p> <p>In an interview on 02/03/2025 at 10:21 AM, Staff P, Certified Nurse Assistant, stated Resident 1 had been unable to propel their wheelchair themselves for quite a while.</p> <p>In an interview on 02/03/2025 at 1:39 PM, Staff F, Social Service Director, stated Resident 1 was not able to propel wheelchair to the exit recently.</p> <p>In a joint interview on 02/04/2025 at 9:23 AM, Staff B and Staff C stated they would complete a wander risk assessment and revise the care plan immediately.</p> <p>Refer to WAC 388-97-1020(2)(c)(d).</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50725</p> <p>Based on observation, interview and record review, the facility failed to provide the necessary activities of daily living care (ADL) and services for 1 of 4 residents (Resident 263) reviewed for bathing. This failure placed the resident at risk for hygiene issues and for diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled Bathing revised on 07/01/2017 showed:</p> <p>Bathing schedule will be based on resident's personal requests and physical health needs. Refusal of shower/bath will be documented and reported to Licensed Nurse (LN).</p> <p>Resident 263 was admitted to the facility on [DATE] with diagnoses to include Left hip fracture with surgical repair. The resident was alert and can verbalize needs. According to the resident's care plan, they required 2-person maximum assist with transfers.</p> <p>In an interview on 01/30/2025 at 9:24 AM, Resident 263 verbalized that they had not had a shower since they were admitted at the facility and had asked staff if they can have a shower.</p> <p>Review of Resident 263's clinical record on 01/31/2025, showed no entries on the Task: ADL- Bathing for the last 14 days. There was no documentation in the progress note about the resident receiving or declining shower or bath.</p> <p>In an observation and interview on 01/31/2025 at 9:40 AM, Resident 263's hair appeared to be oily, and the resident stated that they had been asking for a shower every day since they were admitted and staff told them that they were not on the shower schedule.</p> <p>In an interview on 01/31/2025 at 4:24 PM, Staff L, Nursing Assistant Certified (NAC) stated that on admission, the nurses will put the resident on the shower schedule by asking the resident their preferences. Staff L stated that the shower schedule was in the binder at the nurse's station. Review of the shower schedule showed Resident 263's last name documented on Tuesday's and Thursday's. Staff L stated that the NAC assigned to the resident was the one that would provide the shower, they did not have a shower aid. Staff L stated if a resident refused a shower they would notify the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/31/2025 at 4:28 PM, Staff G, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated that on admission they ask the resident their preference of when they want to have a shower, then they update the shower schedule and put the resident's name. Staff G reviewed the shower schedule which showed Resident 263's name documented on Tuesdays and Thursdays. Staff G reviewed the residents clinical record and found no entries or documentation under the Task for Bathing. Staff G was unable to state why Resident 263 did not receive a shower last night (Thursday). Staff G stated they don't audit or check if residents were getting their showers or not. While talking to Staff G, RCM, Staff M, NAC stated that Resident 263 had refused their shower last Tuesday. Both staff stated they did not have a place to document resident refusals for showers. Staff M then went to resident's room and asked if resident wants to have a shower, Resident 263 responded yes and Staff M assisted the resident with having a shower.</p> <p>Refer to WAC 388-97-1060(2)(c)</p>		

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NAME OF PROVIDER OR SUPPLIER  Arlington Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  620 South Hazel Street Arlington, WA 98223	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725</b></p> <p>Based on observation, interview and record review, the facility failed to ensure 5 of 7 resident's (Resident 13, 19, 20, 40, and 260) received care and treatment in accordance with professional standards of practice and received the necessary care and services to attain or maintain their highest practicable level of well-being. This failure placed all residents at increased risk of unmet care needs, medical complications and decreased quality of life.</p> <p>Findings included .</p> <p>Review of the facility Policy titled Notification of Change in Condition dated 08/30/2024 showed the facility shall promptly notify the resident, their provider, and primary contact of changes in the resident's condition and/or status. The care provider would be notified by the nurse when necessary or appropriate in the best interests of the resident.</p> <p>&lt;RESIDENT 13&gt;</p> <p>&lt;WEIGHTS&gt;</p> <p>Resident 13 admitted to the facility on [DATE]. Admitting diagnoses to include Congestive Heart Failure (CHF - a chronic condition in which the heart does not pump blood as well as it should), Peripheral Artery Disease (PAD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), Right foot toe ulcers - between second and third toes.</p> <p>Review of Resident 13's order summary print date 01/30/2025 showed an order for daily weights (wt.) - notify provider if weight up 3 pounds (lbs.) in one day or up to 5 lbs. in three days one time a day for CHF.</p> <p>Review of Resident 13's Medication Administration Record (MAR) dated January 2025 showed the following weights:</p> <ul style="list-style-type: none"> <li>- 01/04/2025- 167.2 lbs.</li> <li>- 01/05/2025- 166.9 lbs.</li> <li>- 01/06/2025- 170 lbs., increase of 3.1 lbs. in one day</li> <li>- 01/16/2025- no weight was recorded</li> <li>- 01/20/2025- 168.8 lbs.</li> <li>- 01/21/2025- 173 lbs., increase of 3.2 lbs. in one day</li> <li>- 01/24/2025- no weight was recorded</li> <li>- 01/30/2025- 173.6 lbs.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 01/31/2025- no weight was recorded</p> <p>Review of Resident 13's February 2025 MAR showed the following weights:</p> <p>- 02/01/2025- 174 lbs.</p> <p>- 02/02/2025- 181.1 lbs., increase of 7.1 lbs. in one day</p> <p>Review if Resident 13's progress note for January 2025 showed no notes that the physician had ben notified of the residents wt. gains on 01/06/2025 and 01/21/2025.</p> <p>Review of Resident 13's progress note for February 2025 showed no notes that the physician was notified of the resident's wt. gain on 02/02/2025.</p> <p>Review of Resident 13's progress note dated 01/24/2025, Staff T, Registered Dietician (RD) documented the resident had a wt. gain of 7 lbs. in the past week and recommended re-weigh, check for increased edema and notify provider if confirmed. There were no notes in resident's chart that staff followed up on the wt. gain and that they notified the doctor.</p> <p>Review of Resident 13's February 2025 MAR showed on 02/01/2024, resident's wt. was 174 lbs. and on 02/02/2025 resident's wt. was 181.1 lbs., that's 7.1 lbs. wt. gain in one day. There were no notes in the progress notes that the doctor was notified of the weight gain on 02/02/2025.</p> <p>Record review of Resident 13's progress note showed, on 02/03 2025 at 2:41 PM, Staff U, Registered Nurse (RN) charted that resident was using accessory muscles to breath and with audible wheezing. Oxygen Saturation (O2 sat - refers to the percentage of oxygen carried by red blood cells in the bloodstream) read 83% on room air, resident required 4 liters (l) of oxygen via nasal cannula. They notified the doctor with order for chest x-ray and antibiotics immediately. On 02/03/2025 at 4:02 PM, Staff V, Licensed Practical Nurse (LPN) charted that resident's wt. on 02/01/2024 was 174 and wt. on 02/03/2025 was 182.6 lbs. Resident had noted edema to extremity, and wet moist cough. Provider was notified of the wt. gain with order to continue to monitor resident. Further review of the progress note showed Resident 13 was having a hard time breathing with O2 sat of 82-85% with 3-5 l of oxygen. Resident was sent to the emergency room and was admitted to the hospital.</p> <p>Review of Emergency Department note dated 02/04/2025 stated that Resident 13's chief complaint was shortness of breath. In the medical decision making note it stated that chest x-ray looked more like pneumonia and possible fluid overload, that they have been holding on fluids due to concerns for pulmonary edema (a condition caused by excess fluid in the lungs). They will continue to hold fluids and had given Lasix (also called water pill, used to treat fluid retention and swelling caused by CHF) instead due to the patient was fluid overloaded and extra fluids will be detrimental to the patient.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/03/2025 at 3:48 PM, Staff G, LPN/Resident Care Manager (RCM) stated that the provider notification for wt. changes should be documented in the progress note. The providers were notified via telephone call, messaging in Point Click Care (program facility uses for electronic charting), faxing or leaving a note in the provider's bin. The doctor comes in once a week and the Advance Registered Nurse Practitioner (ARNP) comes in more often. Staff G went to the provider's bin but did not see any notes regarding wt. They stated if they were the one working on a cart and saw the wt. gain, they would notify the doctor and document in the progress note. Staff G stated they don't micromanage their staff and they expected the staff to notify the provider and document in the progress note.</p> <p>In an interview on 02/04/2025 at 3:00 PM, Collateral Contact 1 (CC1), Medical Director stated they were familiar with Resident 13. They stated that they were notified of wt. gain last Monday (02/03/2025). CC1 reviewed the resident's wt. trends for Januar and they stated that they had only started talking about resident's wt. gain last weekend (02/01/2025 or 02/02/2025.</p> <p>&lt;HEEL BOOTS&gt;</p> <p>According to Resident 13's admission Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], resident had mildly impaired cognition. Skin assessment showed three venous/arterial ulcer with treatment.</p> <p>In an observation on 01/29/2025 at 3:58 PM, Resident 13 was observed in bed wearing non-skid socks. Resident was not wearing heel boots.</p> <p>Review of Resident 13's order summary print date 01/30/2025 showed: Heel boots on while in bed three times a day for skin.</p> <p>Review of Resident 13's care plan and there was no care plan regarding the heel boots.</p> <p>Review of Resident 13's January 2025 Treatment Administration Record (TAR) showed the following treatment: Heel boots on while in bed three times a day for skin. Licensed nurses initialed and placed a check mark (administered) for every shift.</p> <p>In an observation and interview on 01/31/2025 at 9:02 AM, entered Resident 13's room and observed the heel boots on the table close to the foot of the bed, Resident 13 stated that they used to wear boots in the hospital but does not think they need it anymore.</p> <p>In an observation on 01/31/2025 at 9:02 AM, Staff I, LPN attempted to put the boots on Resident 13, but resident declined and stated they have not worn them for two weeks and does not want to wear them.</p> <p>Review of Resident 13's January 2025 TAR print date 02/05/2025 showed Staff I, LPN initialed and placed a check mark (indicating this order was complete) on the heel boots order for the shift they worked on 1/31/2025, when the resident had actually refused to wear the heel boots.</p> <p>Review Resident 13's progress notes, print date 02/05/2025, showed there were no documentation regarding the boots or any refusals from the resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/04/2025 at 1:00 PM, Staff G stated that if Resident 13 refuse to wear the boots, the nurse should document that in the progress note.</p> <p>47047</p> <p>&lt;RESIDENT 19&gt;</p> <p>Resident 19 admitted to the facility on [DATE] with diagnoses that included vascular dementia (brain damage caused by multiple strokes), heart failure, and hearing loss.</p> <p>In an interview on 01/30/2025 at 10:17 AM Staff CC, Nursing Assistant Certified (NAC) stated Resident 19 has had a change in condition related to a recent viral infection and required additional assistance with eating their meals.</p> <p>Review of Resident 19's care plan dated 07/05/2022 showed they were able to feed themselves after set up and to encourage them to eat .</p> <p>Review of a progress note dated 01/28/2025 at 6:51 AM showed Resident 19 had a status change exhibited by being slow to respond, staring into space, and left hand shaking mildly.</p> <p>Review of a progress note dated 01/28/2025 at 7:08 AM showed speech language pathology (SLP) was being requested by the nurse and in the meantime Resident 19 would be assisted with meals.</p> <p>Review of Resident 19's clinical record showed a message dated 01/28/2025 that was sent to their provider informing them of the resident's slow decline and diet downgrade with a request for SLP to assess them.</p> <p>Review of Resident 19's clinical record showed a message dated 01/28/2025 where the resident's provider responded to the message and agreed with SLP evaluation and deferred to another provider for assessment.</p> <p>Review of a progress note dated 01/29/2025 at 11:00 PM showed Resident 19's diet was downgraded to mechanical soft, required one to one assistance with eating/feeding, and liquids were changed to nectar thick consistency.</p> <p>Review of a progress note dated 02/03/2025 at 2:42 PM showed Resident 19 was pocketing their food (storing food inside the mouth without swallowing) at lunchtime.</p> <p>Review of Resident 19's SLP screening assessment form dated 01/29/2025 showed nursing had recommended a screen. There was a check mark in swallowing as the problem area and comments noted no issues and no interventions indicated.</p> <p>In an interview on 02/05/2025 at 10:28 AM Staff BB, Therapy Manager stated a SLP screen was completed for Resident 19 and not an evaluation. Staff BB stated they share the results of the screen in an interdisciplinary team meeting following the outcome of the screen. Staff BB stated they must find out the concerns first before an evaluation. Staff BB stated Resident 19 had no concerns the day of the screen and had no additional concerns noted by nursing staff since the screen and thus an evaluation not indicated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&lt;RESIDENT 260&gt;</p> <p>Resident 260 admitted to the facility on [DATE] with diagnoses that included hip fracture, insomnia (sleep disorder), and history of falling.</p> <p>On 01/31/2025 at 8:47 AM observed Staff D, NAC, tell Staff I, LPN that Resident 260 was asking about their sleep medication, Ambien, and wanted to know if it was out. Staff I responded to Staff D, stated it was a medication used at night, did not know, and would look into it.</p> <p>In a review of Resident 260's January 2025 MAR showed they had an order for Zolpidem Tartrate (Ambien) 5mg, one tablet by mouth as needed for insomnia at bedtime.</p> <p>Review of Resident 260's care plan dated 01/24/2025 showed they were taking Zolpidem for insomnia. Interventions included administering the medication (Zolpidem) as ordered by the physician.</p> <p>Review of Resident 260's progress notes dated 01/30/2025 and 01/31/2025 showed no indication the provider was notified of Ambien not being available.</p> <p>In an interview on 01/31/2025 at 2:10 PM Resident 260 stated they do not sleep very well, had been taking Ambien for the last year. Resident 260 stated that they had slept poorly the night before related to not having the Ambien. Resident 260 stated they had just spoken to the doctor, and they had not ordered it, but the nurses had been giving it to me the whole time. Resident 260 stated the nurse on duty last night had given them another medication, like Tylenol, but it was not effective.</p> <p>In a joint interview on 01/31/2025 at 2:14 PM Staff G stated Resident 260 had admitted with an order for Ambien. Staff I stated there was a pharmacy issue last night and they did not deliver the prescription. Staff G stated the provider should be notified if a medication was not available and they had not read a progress note about the medication not being available. Staff G stated they did not know what had happened because they do not work nights and planned to place a call to the pharmacy. No other information was provided.</p> <p>&lt;RESIDENT 40&gt;</p> <p>Resident 40 admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses that included diabetes type two (a chronic condition that affects how the body uses sugar for energy), chronic obstructive pulmonary disease (group of lung diseases that restrict breathing), and high blood pressure.</p> <p>In an interview on 01/31/2025 at 10:45 AM Resident 40 stated they did not feel good and had been having diarrhea and would not be able to participate in an assessment to have their recliner placed back in their room.</p> <p>In a review of Resident 40's January 2025 MAR showed the resident had an order for a routine stool softer daily, Senna-Docusate Sodium 8.6-50 milligrams (mg) for constipation ordered on 01/07/2025. Resident 40 also had an order for Imodium A-D, 2 mg every eight hours as needed for loose stools. Resident 40 had received daily stool softener, but no Imodium was given.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 40's January 2025 Document V2 Report (resident specific report) showed they had loose stools consistently throughout the month.</p> <p>In an interview on 01/31/2025 at 11:04 AM Staff S, NAC, stated Resident 40 had reported three instances of diarrhea that morning.</p> <p>In an interview on 01/31/2025 at 11:23 AM Collateral Contact 2 (CC 2-Resident 40's Family Member) stated they had asked nursing to stop the use of Senna multiple times due to Resident 40's ongoing diarrhea.</p> <p>In an interview on 02/03/2025 at 2:47 PM Staff B, Director of Nursing Services, stated they expected nursing staff to review the MAR when a resident had complaints of loose stools, check prescribed bowel medications, hold the medications if indicated, and contact the provider.</p> <p>51551</p> <p>&lt;RESIDENT 20&gt;</p> <p>Resident 20 readmitted to the facility on [DATE] with diagnoses to include urinary tract infection.</p> <p>Review of the hospital discharge summary dated 11/04/2024, showed Resident 20 needed to follow up with the infectious disease doctor in two weeks.</p> <p>Review of a progress note dated 12/11/2024 at 2:01 PM, showed Resident 20 was scheduled a follow up infectious disease telehealth appointment on 01/08/2025 at 1:30PM.</p> <p>Review of Resident 20's Electronic Medical Record, showed there was no documentation of having an infectious disease doctor follow up visit.</p> <p>In an interview on 02/03/2025 at 12:56 PM, Staff K, Licensed Practice Nurse/Infection Preventive Nurse, stated they were not sure if Resident 20 was scheduled or attended the infection disease doctor follop up visits and not sure where the documentation from the infectious disease doctor was.</p> <p>In an interview on 02/03/2025 at 2:20 PM, Staff K stated they could not find any documentation of the infectious disease follow up appointment and they were requesting documentation from the clinic and waiting for the notes.</p> <p>In an interview and record review on 02/03/2025 at 4:48 PM, Staff K provided a fax document that had been received on 02/03/2025 at 4:26 PM of the infectious disease clinic note from 11/13/2024. The infectious disease clinic documentation showed Resident 20 needed another infectious disease follow up visit in four weeks. Staff K stated they could not find documentation of the four week follow up with the infectious disease doctor. Staff K stated they expected the resident care manager to follow up with clinic visits and take care of any orders.</p> <p>Review of a progress note dated 02/03/2025 at 5:03 PM, showed Staff K called infectious disease and requested the clinic to fax the documentation of follow up visit on 01/08/2025.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/04/2025 at 3:24 PM, Staff B, Director of Nursing, stated they expected the nurse to follow up on any changes from appointments on the same day or the next morning. Staff B stated they expected the nurse to document any attempts to contact the clinic if the resident did not bring back any documentation and escalate to the resident care manager if they could not get the appointment visit notes. Staff B stated not getting Resident 20's appointment notes from November 2024 until January 2025 was too long and they should get the visit notes sooner in order to follow up any changes or physician orders.</p> <p>Refer to WAC 388-97-1060(1)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</b></p> <p>Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 3 sampled residents (Resident 40) reviewed for respiratory care. Failure to follow provider's orders for oxygen (O2) therapy placed the resident at risk for unmet needs, potential negative outcomes and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Oxygen Administration dated 10/15/2023 showed oxygen would be provided to residents to improve oxygenation and comfort to residents experiencing respiratory difficulties. The procedure included storing cannula's (tubing inserted into the nose to supply oxygen) and add oxygen to be administered by licensed staff and requires a physician order.</p> <p>Resident 40 admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses that included diabetes type two (a chronic condition that affects how the body uses sugar for energy), chronic obstructive pulmonary disease (group of lung diseases that restrict breathing), and high blood pressure.</p> <p>Review of Resident 40's January Medication Administration Record (MAR) showed a physician order for O2 at two liters per minute (lpm) as needed for shortness of breath, comfort, or to keep oxygen saturations (percentage of oxygen in the blood) above 90 percent (%).</p> <p>In an observation on 01/29/2025 at 11:24 AM Resident 40 was lying in their bed, the head of their bed slightly elevated, wearing a nasal cannula without the nose piece in their nostrils, rather on the side of their nose. Observed the oxygen concentrator in Resident 40's room set to 2.5 lpm.</p> <p>In an observation on 01/30/2025 at 1:30 PM Resident 40 was sitting in their wheelchair with visitors, not wearing their nasal cannula. Observed Resident 40's nasal cannula sitting on the floor next to their bed attached to the O2 concentrator which was set at 2.5 lpm.</p> <p>In an interview on 01/30/2025 at 2:34 PM Staff DD, Licensed Practical Nurse (LPN), stated Resident 40's physician orders included O2 at 2lpm as needed to keep O2 saturations above 90%. Staff DD stated the checked Resident 40's oxygen saturations but had not checked the settings on the concentrator. Staff DD stated they were Resident 40's day shift nurse.</p> <p>In an interview on 02/03/2025 at 2:50 PM Staff B, Director of Nurses Services, stated the expectation of nursing staff was to ensure there was an order for oxygen use and the setting checked to ensure the settings on the tank/concentrator were at the ordered rate.</p> <p>Refer to WAC 388-97-1060(3)(j)(vi)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</b></p> <p>Based on observations, interviews, and record review the facility failed to develop a dementia care plan that addressed the physical, mental and psychosocial needs of the resident, established personalized and achievable goals, and identified interventions to promote a person-centered environment for 1 of 4 residents (Resident 22) reviewed for dementia care. These failures placed residents at risk for unmet physical and psychosocial needs, increased behaviors and decreased quality of life.</p> <p>Findings included .</p> <p>Resident 22 admitted to the facility on [DATE] with diagnoses that included dementia.</p> <p>In a review of Resident 22's Care Area Assessment (CAA-an assessment which directs the care plan development) for cognitive loss/dementia dated 11/13/2024 showed they were severely impaired, had a memory problem with confusion, disorientation and forgetfulness. The description of the impact of cognitive loss/dementia on the resident was noted to be, Resident's care plan addresses cognition impairment. Staff will continue to monitor as resident was currently placed on Hospice and their cognition has been impacted.</p> <p>Review of progress note dated 12/27/2024 a late entry for 12/26/2024 showed Resident 22 had22 had been anxious over the last few days with behaviors or self propellingself-propelling up/down halls, and in and out of rooms, bumping into objects and almost running over other resident's toes. Resident 22 was also noted to [NAME] be calling out for their daughter, unable to sleep, and calling into rooms of otheranother resident while they were sleeping. Resident 22 was encouraged to call their daughter which helped them calm for short periods of time.</p> <p>In a review of Resident 22's care plan dated 05/11/2022, showed they had two care plans focused on impaired cognition related to dementia and potential for delirium related to recent back surgery. The focus areas included a goal for resident to be able to communicate their needs daily. Interventions developed for Resident 22 to meet those goals included:</p> <ul style="list-style-type: none"> <li>-Their basic needs would be met.</li> <li>-Their life would be honored.</li> <li>-Administered medications as ordered, monitor/document side effects and effectiveness.</li> <li>-Monitor/document/report as needed any changes in their cognitive function.</li> <li>-They relied on family for significant decision making</li> <li>-Keep resident's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Arlington Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  620 South Hazel Street Arlington, WA 98223	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Monitor for signs and symptoms of possible delirium related to recent back surgery, advanced age and anesthesia clearance, pain medications and increased pain.</p> <p>-Use task segmentation to support short term memory deficits. Break tasks into one step at a time.</p> <p>The care plan did not include any resident specific information about how Resident 22's dementia manifests itself, what types of situations/environments increase stress/anxiety or decrease it, or how their family supports play a role in their overall cognition.</p> <p>In an interview on 02/04/2025 at 5:16 PM Staff EE, Licensed Practical Nurse (LPN), stated interventions in place for Resident 22's dementia included frequent visits by their daughter, the daughter requested that they call them when Resident 22 had difficulties. Additional interventions described by Staff EE included Resident 22 story telling/storytelling, talking with them about anything, listening/anything, listening to the radio/music. Staff EE stated Resident 22 also takes medication, Seroquel (an antipsychotic medication). Staff EE stated Resident 22 had medication to treat their dementia, but mostly did not need it. Staff EE stated Resident 22 was essentially blind, could not really watch television, and music was the most important thing for them.</p> <p>In an interview on 02/03/2025 at 2:23 PM Staff FF, Activities Director, stated Resident 22 was a bit of a wanderer and liked to travel around the facility and to the front office, was friendly, interacted with staff and other residents and had been more confused lately. Staff FF, when asked what activities Resident 22 had been involved in for the last two weeks, stated it was difficult to complete activities due to a viral outbreak in the building. Staff FF stated Resident 22 consistently engaged in the sing along activity scheduled on Wednesdays. When asked about one on one/one-on-one support activities with Resident 22, Staff FF stated they did not believe it was necessary for them as they were socializing with other residents and staff daily. Staff FF stated Resident 22's daughter visited two to three times a week.</p> <p>In an interview on 02/05/2025 at 8:54 AM Staff F, Social Services Director, stated they have had multiple contacts with Resident 22's family members, they are very involved and visit Resident 22 several times a week.</p> <p>On 01/29/2025 at 3:26 PM Resident 22 was observed to be in the hallway of the unit. Resident 22 was not involved in an activity and moved with no purpose.</p> <p>On 01/31/2025 at 2:34 PM Resident 22 was observed outside their room, in their wheelchair, with their hand placed on their forehead and head was down.</p> <p>On 02/03/2025 at 9:03 AM Resident 22 was observed talking on the telephone in their room.</p> <p>On 02/03/2024 at 2:19 AM Resident 22 was observed sitting in their room, in their wheelchair in front of the television/television, which was on, sleeping.</p> <p>Refer to F758</p> <p>Reference WAC 388-97-1040 (1) (a-c)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50725</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 5 sampled residents (1 and 22) reviewed for unnecessary medications, were free from unnecessary psychotropic medications (a drug that affects the brain activities associated with mental processes and behavior). The facility failed to ensure there were valid diagnoses for use of psychotropic medications, implement non-medication and behavioral interventions, accurately monitoring target behaviors and updating care plans. The facility failed to ensure Resident 22's use of an as needed psychotropic medications was limited to 14 days. These failures placed residents at risk for receiving unnecessary psychotropic medications, for adverse events, and diminished quality of care.</p> <p>Findings included .</p> <p>Review of the facility policy titled Psychotropic Medications updated 01/01/2023 showed, residents on psychotropic medications will be reviewed by the psychotropic team quarterly and more frequently, if indicated. During the quarterly review, the team will review the appropriateness and dosage of current psychotropic medications, behaviors, and the care plan associated with behaviors and/or medication.</p> <p>The Federal Drug Administration Boxed Warning which accompanies second generation anti-psychotics states, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death.</p> <p>&lt;RESIDENT 22&gt;</p> <p>Resident 22 was admitted to the facility on [DATE]. Admitting diagnoses to include stroke, vascular dementia (brain damage that causes memory loss from multiple strokes), major depressive disorder. According to the significant change Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], the resident had severely impaired cognition.</p> <p>Resident 22 was admitted to hospice services on 11/13/2024.</p> <p>In an observation on 01/31/2025 at 9:29 AM, Resident 22 was in their room in their wheelchair listening to music. Resident was conversant but very hard of hearing.</p> <p>In an observation on 01/31/2025 at 3:19 PM, Resident 22 was wheeling self in their wheelchair and stated feeling terrible and was asking for lunch. Resident was observed singing and talking to staff.</p> <p>Review of Resident 22's Order Summary with print date of 01/30/2025 showed that the resident was taking an anti- psychotic medication called Seroquel for restlessness, agitation and hallucinations. The diagnoses listed were not appropriate diagnoses for the use of an anti-psychotic medications. Further review of Resident 22's medication orders showed the anti-psychotic medication orders as follows:</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Seroquel oral tablet 50 milligram (mg). Give one tablet by mouth one time a day for restlessness. Ordered on 12/26/2024.</p> <p>- Seroquel oral tablet 25 mg. Give one tablet by mouth in the morning for restlessness. Ordered on 12/26/2024</p> <p>- Seroquel oral tablet 25 mg. Give one tablet by mouth every 4 hours as needed (PRN) for agitation, hallucinations. Ordered on 11/14/2024.</p> <p>Review of Resident 22's November 2024 Medication Administration Record (MAR) showed that on 11/14/2024 an order for a Seroquel 25 mg PRN was started with no stop date. Review showed that the resident received a dose of the PRN Seroquel on 11/21/2024 at 6:05 PM.</p> <p>Review a pharmacist progress note dated 12/05/2024 stated that Resident 22 was taking Seroquel PRN and per CMS guidelines it required a stop date and to add a 14 day stop date unless longer duration is documented. There was a handwritten note at the bottom of the letter which stated, Hospice changed to indefinitely. Unable to read the signature and it was dated 1/17/2025. There were no other notes in resident's chart for follow up.</p> <p>Reviewed Resident 22's MAR for November 2024, December 2024, January 2025 and February 2025, showed that the resident had received PRN doses of Seroquel. There was no documentation indicating that non-medication interventions were done prior to giving the PRN dose of Seroquel. Further review of the February 2025 MAR shows that the PRN Seroquel was discontinued on 02/03/2025.</p> <p>Review of Resident 22's care plan with print date of 01/30/2025 showed the care plan did not address the PRN use of anti-psychotics and there were no non-medication interventions.</p> <p>Review of Resident 22's order summary print date 02/04/2025 showed an anti-anxiety medication as a PRN order with no stop date. Order was dated 01/03/2025.</p> <p>Review of Resident 22's January 2025 MAR showed that resident did not take any PRN medication for anti-anxiety however, the behavior monitoring for anti-anxiety use showed that there were behaviors documented. On 01/11/2025 at 9:00 PM, there was a number 4 documented as the Behavior #, however, the behavior list was only up to number 3. In the chart code at the end of the MAR showed number 4 as vitals outside parameters for administration. There were no behaviors documented on the anti-psychotic behavior monitoring, there were no notes in the progress notes for January 11, and the resident received a PRN dose of Seroquel on 01/11/2025 at 8:32 PM.</p> <p>In an interview on 02/04/2025 at 3:25 PM, Staff EE, Licensed Practical Nurse (LPN) stated that they don't know what the number 4 meant in the Anti-anxiety behavior monitoring. They stated when they document, they pick the numbers that were listed in the MAR.</p> <p>In an interview on 02/04/2025 at 3:32 PM, Staff V, LPN stated that the number 4 was the number of times resident exhibited behaviors and then they document in the progress notes what those behaviors were.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a joint interview on 02/04/2025 at 3:40 PM, when asked what the number 4 meant in the behavior monitoring, Staff C, Director of Operation stated that it probably meant other and then the staff documents it in the progress note. They looked at Resident 22's progress notes but did not see any notes on 01/11/2025. Staff B, Director of Nursing (DON) and Staff G, LPN/Resident Care Manager (RCM) stated that it might be a typo, and it was meant to be a number 1.</p> <p>In a joint interview on 02/04/2025 at 3:40 PM, Staff B stated that when a resident gets started on psychotropic medications, before they even give the medication, they get a consent from resident or the power of attorney or family member, then they review them every quarter and review if the resident will be eligible for the gradual dose reduction (GDR) process. When asked about diagnosis for psychotropic medications, Staff B stated that they just started working with an Advance Registered Nurse Practitioner (ARNP) that specializes in Psychiatry (a branch of Medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders), and they review residents on psychotropic medications to determine if diagnoses and behavior monitoring were appropriate. When asked if restlessness was an appropriate diagnosis for an anti-psychotic medication for Resident 22, Staff C, Director of Operation stated that the hospice agency following Resident 22 were the ones that handles the anti-psychotic medications for the resident. Staff C stated that they have had issues with all their buildings about hospice informing them that they can use their own diagnosis for Seroquel (anti-psychotic medication). When asked about the PRN psychotropic medications, Staff C stated that they have discontinued the medication today and that there were some confusions between the hospice agency and pharmacy. They added that hospice agency staff were the ones that gives the orders, and the facility provider defers things to hospice so it's a battle that the facility cannot fix.</p> <p>51551</p> <p>&lt;RESIDENT 1&gt;</p> <p>Resident 1 admitted to the facility on [DATE] with diagnosis to include palliative care (an approach that improves the quality of life of terminal ill patient), dementia (impairs cognitive functioning and reasoning) and depression. According to the Minimum Data Set (MDS - an assessment tool) assessment, dated 01/22/2025, Resident 1 showed severe cognitive impairment and had no diagnosis of anxiety.</p> <p>Review of a consent form for Lorazepam dated 04/17/2024, showed that the diagnosis section was blank.</p> <p>Review of Resident 1's January 2025 Medication Administration Records (MAR) showed a provider's order for Lorazepam (anxiety medication) as needed for anxiety. The medication was administered on 01/18/2025 at 12:01 AM and 3:48 PM, 01/19/2025 at 2:21AM, and 01/27/2025 at 09:51AM. Review of the progress notes from 01/18/2025 to 01/31/2025, showed no documentation of non-pharmacological interventions were provided before administering the as needed Lorazepam.</p> <p>Review of Resident 1's progress note dated 01/19/2025 at 3:39 AM, showed Resident 1 was given Lorazepam as they were not able to sleep, not for anxiety as the order was written.</p> <p>Review of Resident 1's progress note dated 01/27/2025 at 2:48 PM, showed the nurse administered Lorazepam for pain, not for anxiety as the order was written.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's care plan, print date 01/31/2025, showed the resident used Lorazepam related to terminal agitation. Intervention related to psychotropic medication was to provide non-pharmacological interventions, such as: attempt to redirect by calling daughter, offer activities, offer to assist to library to get a book.</p> <p>Review of Resident 1's medical record showed no assessment, rationale or review for the use of an antipsychotic medication. The medical record showed no duration or stop date for the use of an antipsychotic medication.</p> <p>Review of Resident 1's January 2025 MARs showed a provider's order for Seroquel (used to treat persons that lose contact with reality) as needed for anxiety. Seroquel was initiated on 01/16/2025 with no stop date, and the order continued beyond the 14 days maximum use.</p> <p>Review of a progress note dated 01/18/2025 at 11:42 PM, showed Resident 1 was given Seroquel due to calling out for their daughter and dangling their legs over the side of bed.</p> <p>Review of a progress note on 01/19/2025 at 3:39 AM, showed Seroquel was given due to Resident 1 due to talking to self and calling out for their daughter.</p> <p>Review of Resident 1's progress notes from 01/18/2025 to 01/19/2025, showed no documentation of non-pharmacological interventions were provided before antipsychotic medication was administered.</p> <p>In an interview on 02/03/2025 at 10:26 AM, Staff O, Registered Nurse, stated Resident 1 did not have a diagnosis of anxiety. Staff O stated Lorazepam was ordered for comfort since Resident 1 was on hospice and Seroquel was ordered for delusions. Staff O stated they could not find documentation that non-pharmacological interventions were attempted before staff gave psychotropic medications to Resident 1.</p> <p>In a joint interview on 02/04/2025 at 10:48 AM, Staff B, Director of Nursing, and Staff C, Director of Operation, stated Resident 1 did not have an anxiety diagnosis and the psychotropic medications were for hospice comfort care, delusion and hallucination. Staff B stated non-pharmacological interventions should be provided before psychotropic medications were administered, but they could not find the documentation. Staff C stated the as needed Seroquel order exceeded the 14-day limitation.</p> <p>Refer to WAC 388-97-1060(3)(k)(i)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47047</p> <p>Based on observation and interview the facility failed to ensure drugs and biologicals (diverse group of medicines made from natural sources) were refrigerated after opening from 2 of 2 medication carts (Medicare and North Hall) and expired medications and biologicals were disposed of timely in accordance with professional standards from 1 of 2 medication rooms (Medicare Hall). These failures placed residents at risk to receive expired medications, ineffective medication from lack of refrigeration, to experience adverse side effects and other potential negative health outcomes.</p> <p>Findings Included .</p> <p>On 02/03/2025 at 9:49 AM observed the refrigerator of the medication room to contain 3 vials of lorazepam (an antianxiety medication) in a small, clear bag with the expiration date of 10/2024. In addition, observed a small bag with a label that read, Promethegan, the expiration date printed on the label (2023) was crossed out and replaced by a handwritten date of 04/2025.</p> <p>On 02/03/2025 at 10:45 AM observed an open bottle of Acidophilus, a probiotic, with directions to refrigerate after opening in the medication cart on the Medicare Hall.</p> <p>Staff U stated all nurses, when time allows, should be going through their medication carts for expired medications.</p> <p>In an interview on 02/03/2025 at 9:49 AM Staff U, Licensed Practical Nurse, stated the night shift was responsible for removing and destroying/returning expired medication located in the medication room. Staff U observed the expiration date on the three vials of lorazepam and stated that they were expired in October of 2024. Staff U stated all nurses, when time allows, should be going through their medication carts for expired medications. Staff U stated they did not know who had crossed out the date on the Promethegan and stated it had come from the emergency kit.</p> <p>In an interview on 2/03/2025 at 11:48 AM Staff U stated the night shift was responsible for ensuring the medication in the medication cart was stored as directed on the label. Staff U stated they had checked the medication cart on North Hall and found Acidophulius of the same brand as the Medicare Hall and replaced it with a new manufacturer that did not call for refrigeration after opening.</p> <p>Refer to WAC 388-97-1300(2)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47047</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview and record review, the facility failed to ensure foods were served in a timely manner and were palatable for 1 of 1 Halls (South Hall) and 1 of 1 organized resident groups (Resident Council) who were interviewed about the food palatability and temperatures. Failure to meet these requirements could negatively impact the residents' nutritional status, appetite, and meal acceptance.</p> <p>Findings Included .</p> <p>In a review of facility policy titled Long Term Care Policy &amp; Procedure Manual labeled food temperatures, undated, showed the facility recommended ranges of temperatures for the safe holding, storage and serving of foods such as hot cereal and hot beverages (coffee and tea) was at 165 degrees Fahrenheit or above. These are the standards suggested for food acceptance and palatability as well as safety.</p> <p>On 01/31/2025 at 8:47 AM observed a full cart of meals on trays in the hallway of South Hall. None of the trays had been served.</p> <p>In an interview on 01/31/2025 at 8:47 AM Staff I, Licensed Practical Nurse (LPN), stated the carts had just arrived a few minutes ago. Staff I stated they had two nursing aides working on the South Hall with another one due to come in.</p> <p>In an observation on 01/31/2025 at 8:52 AM Staff D, Nursing Aide Certified (NAC), arrived and started passing meal trays to the residents on South Hall.</p> <p>In an interview on 01/31/2025 at 8:52 AM Staff D stated the other aide they were working with was stuck in a room. When asked how long the trays had been sitting in the hallway, Staff D stated a few minutes. Staff D stated when they need assistance, like this morning, other staff come to assist them such as the nurse. When asked what time the trays are typically delivered to the South Hall, Staff D stated at around 8:00 AM.</p> <p>In an interview on 01/31/2025 at 8:59 AM Staff HH, Dietary Manager, stated they believed the meal trays went out to South Hall at around 8:15 AM. At 8:59 AM observed Staff HH, check the temperature of oatmeal on one of the remaining trays in the cart, the temperature 124 degrees Fahrenheit. When asked if the oatmeal was too cold, Staff HH stated it was not warm enough for the resident and removed the oatmeal from the tray.</p> <p>Review of the dining times provided on 01/29/2025 showed mealtimes for residents eat in their room would be provided between 7:45 AM - 8:45 AM.</p> <p>Review of the facility menu provided on 01/29/2025, breakfast on 01/31/2025 included oatmeal or cream of wheat, waffle, egg, half of banana, margarine/syrup and milk/hot beverage.</p> <p>During Resident Council on 01/30/2025 residents reported the food served was consistently cold and late and was especially bad on the weekends when Staff HH was gone.</p> <p>(continued on next page)</p>		

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F 0804  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Reference: WAC 388-97-1100(1)(2)		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47047</p> <p>Based on observation and interviews, the facility failed to ensure resident meals were prepared and stored in accordance with professional standards of food safety for 1 of 1 facility kitchens, and 1 of 2-nourishment refrigerators. The failure to ensure the kitchen and nourishment refrigerators were free from potential contaminants, maintenance to ensure the kitchen refrigerator and freezer were properly maintained left residents at risk for food contamination, food borne illnesses, and spoiled food.</p> <p>Findings Included .</p> <p>On 01/29/2025 at 9:23 AM observed the following in the facility kitchen refrigerator:</p> <ul style="list-style-type: none"> <li>- applesauce in a container with a green lid-undated and not labeled</li> <li>- opened cottage cheese container with no open date</li> <li>-opened freezer jam with no open date.</li> </ul> <p>Observed a note on the front of the refrigerator which read, all items in the refrigerators/freezers need to have labels with item and date on them no exceptions.</p> <p>On 01/29/2025 at 9:23 AM observed a cabinet which contained a refrigerator labeled Fruit Bar. The lower portion of the cabinet was a refrigerator containing trays with multiple small containers containing salad dressings. Two trays marked as blue cheese, and thousand island dressing contained no date as to when they had been prepared.</p> <p>On 01/29/2025 at 9:23 AM observed the refrigerator located outside of the building which contained four cucumbers on the top shelf, the cucumbers were wrapped in plastic and had visible black circles on them and were mushy to touch.</p> <p>In an interview on 01/29/2025 at 9:50 AM Staff HH, Dietary Manager, stated all open food items in the refrigerators should be dated, if not dated they should be thrown away. Staff HH stated the cucumbers were spoiled, they were delivered about five days prior and they had thrown them away.</p> <p>On 01/29/2025 at 1:10 PM observed the refrigerator/freezer in the small dining room/conference room which contained snacks and sandwiches for residents. The refrigerator contained undated and unlabeled foods items which consisted of the following:</p> <ul style="list-style-type: none"> <li>-an unlabeled/undated fast-food bag with a roast beef sandwich</li> <li>-Egg Nog opened, with no open date</li> <li>-gallon of milk, opened with no open date</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-med pass supplement, opened dated 8-4</p> <p>-coconut drink opened with no open date</p> <p>The freezer had a note on the front which read, no ice packs. The freezer contained an ice pack.</p> <p>In an interview on 02/03/2025 at 1:15 PM Staff II, Dietary Aide, stated they checked and maintained the nourishment refrigerators on a weekly basis, usually on Mondays, and cleans it out. Staff II stated the opened items in the refrigerator could only be kept for three days and then needed to be thrown out.</p> <p>Refer to WAC 388-19-1100 (3)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>47047</p> <p>Based on interview and record review, the facility failed to have a system in place that ensured effective consistent communication, collaboration, and coordination of care occurred between the facility and the hospice provider for 1 of 3 residents (Resident 22) reviewed for hospice services. The facility failed to obtain and/or maintain a copy of a resident's current hospice coordinated plan of care and integrate it into the facility care plan. This failure placed the resident at risk for not receiving necessary care and services and/or unmet care needs.</p> <p>Findings included .</p> <p>Review of the facility contract with hospice, titled Nursing Facility Services Agreement dated 02/04/2020 showed in section 2.1.2 coordination with hospice regarding plan of care included design of plan, modification and monitoring of residential hospice patient. The nursing facility shall coordinate with hospice in development of a plan of care. Nursing facility agreed to abide by the plan of care.</p> <p>In a review of Resident 22's progress notes dated 11/13/2024 showed resident was admitted to hospice care.</p> <p>Review of Resident 22's electronic health record (EHR) showed no hospice plan of care but showed multiple hospice notes.</p> <p>Review of Resident 22's care plan dated 11/14/2023 showed resident had a terminal prognosis related to end stage disease process which included recent hip fracture, labs and decline in condition. The goal showed Resident 22 would be free of depression and anxiety through the review date and their comfort would be maintained through the review date of 01/31/2025. Interventions included encouraging resident to express their feelings, to keep the environment calm with low lighting and familiar objects near, and work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met.</p> <p>Review of hospice notes found in the electronic health records showed no notation they were reviewed by anyone prior to being placed in the record. Review of hospice nursing note dated 12/23/2024 showed Resident 22 was confused and agitated with multiple calls from the evening nurse and resident's daughter coming into the facility to assist resident calm.</p> <p>Review of progress note dated 12/27/2024 a late entry for 12/26/2024 showed Resident 22 had been anxious over the last few days with behaviors or self propelling up/down halls, and in and out of rooms, bumping into objects and almost running over other resident's toes. Resident 22 was also noted to be calling out for their daughter, unable to sleep, and calling into rooms of another resident while they were sleeping. Resident 22 was encouraged to call their daughter which helped them calm for short periods of time.</p> <p>In an interview on 02/05/2025 at 8:54 AM Staff F, Social Services Director, stated hospice care plans are developed by the resident care manager and hospice services are coordinated through nursing.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/05/2025 at 9:10 AM Staff W, Licensed Practical Nurse (LPN) stated hospice sends their care plan and medical records uploads it in the resident's EHR. Staff W stated they would try to find the care plan.</p> <p>In a follow up interview on 02/05/2025 12:05 PM Staff W provided a copy of the hospice care plan, date stamped on the top with the date of 02/05/2025. Staff W stated they did not know why the hospice care plan was not in Resident 22's EMR.</p> <p>No associated WAC</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725</b></p> <p>Based on observation, interview and record review, the facility failed to ensure that staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 3 of 4 hallways with Enhanced Barrier Precautions (EBP), 1 of 1 observations for wound care (Resident 33), 1 of 3 residents observed during personal care (Resident 13) and 1 of 1 housekeeping staff observed for hand hygiene. The facility failed to ensure that staff used the Personal Protective Equipment ([PPE] - specialized clothing worn to protect from infection or illness) during high contact resident care activities and failed to perform proper hand hygiene. These failures placed all residents and staff at risk for the potential transmission of infections. The facility was currently in a gastrointestinal virus outbreak.</p> <p>Findings included .</p> <p>Review of a facility policy titled, Enhance Barrier Precautions, dated 10/03/2022 showed</p> <ul style="list-style-type: none"> <li>- EBP to be implemented for residents with wounds, indwelling medical devices, or residents infected with drug resistant organisms.</li> <li>- Hand hygiene to be performed when entering the room and when exiting the room.</li> <li>- PPE to be used during high contact resident care activities such as toileting, transferring, and use of enteral tube (tube inserted into stomach used for medications and formula).</li> </ul> <p>Review of recommendations from the Centers of Disease Control website, Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009), showed a strong recommendation to maintain unobstructive urine flow to not rest the catheter bag (a urine collection bag attached to the catheter) on the floor.</p> <p>Review of an undated facility policy titled, Hand Hygiene, showed hand hygiene was required after removing gloves.</p> <p>&lt;PERSONAL CARE&gt;</p> <p>Resident 33 was admitted on [DATE] with a cholecystostomy tube (a thin, flexible tube inserted into the gallbladder to drain fluid and relieve pressure).</p> <p>In an observation and interview on 01/29/2025 at 3:53 PM, Staff J, Nursing Assistant Certified (NAC), provided peri-care (the practice of washing the genital and anal area) to resident 33 after applying gloves but did not apply a gown prior to performing this high contact activity. Staff J removed gloves and applied a new pair without doing hand hygiene. Staff J stated they did not do hand hygiene prior to putting on new gloves, as it will take ten minutes to dry their hands.</p> <p>&lt;WOUND CARE&gt;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 13 admitted on [DATE] with a multi drug resistant bacteria in their lungs and a wound to right foot.</p> <p>In an observation and interview on 01/31/2025 at 12:13 PM, Staff I, LPN, placed wound care supplies on the overbed table. The overbed table was not covered and beside the wound care supplies were Resident 33's TV remote and drinking water container. Observed Staff I with mask and gloves, no gown. They took the old gauze between the big toe and second toe in the right foot and used saline and q tip to cleanse the wound, with the same glove, they reached over the package of 4x4 and dried the wound. With the same gloves, Staff I opened an individually wrapped 4x4 and placed the gauze between the first and second toe. Using the same gloves, Staff I took the old dressing on the right outer malleolus, cleansed the wound with saline and using the same gloves reached over to the 4x4 package to dry the wound. Still with the same glove, applied new Opti foam dressing. Staff I then moved to the other side of the bed and with the same gloves, took the old dressing on the left outer malleolus, cleansed the wound with saline reached over the 4x4 gauze package and dried the wound. Using the same glove Staff I, covered the wound with Opti foam dressing. Staff I then took gloves off, covered resident and washed hands. They then took the package of 4x4 gauze and the box of gloves and put them in the treatment cart. When I asked Staff I when were they supposed to change gloves, they stated if their gloves were soiled or if they go from one area of the body to another, such as when they go from the buttocks to another area of the body. They stated since they were doing the feet of the resident and did not go to another area of the body, they did not have to change their gloves.</p> <p>&lt;ENHANCED BARRIER PRECAUTION&gt;</p> <p>&lt;BLUE RECTANGLE&gt;</p> <p>During an interview on 01/30/2025 at 8:00 AM, Staff Y, NAC, stated the blue rectangle on the door jamb for room [ROOM NUMBER] meant the resident in the room required two person assist with care, and the blue rectangle with a flower on the door jamb of room [ROOM NUMBER] meant that resident required two person assist because of behaviors.</p> <p>During an interview on 01/30/2025 at 8:20 AM, Staff S, NAC, stated the blue rectangle on the door jamb to room [ROOM NUMBER] meant the resident was a fall risk.</p> <p>&lt;Resident 12&gt;</p> <p>Resident 12 was a long-term care resident at this facility. According to the MDS dated [DATE], the Resident is severely cognitively impaired and required gastrostomy tube (a tube used to provide nutrition directly into the stomach) for nutrition.</p> <p>During an observation on 02/03/2025 at 9:21 AM, Staff GG entered Resident 12's room, did not perform hand hygiene, then proceeded to lift the resident's bedspread, touched the mattress next to the resident, and adjusted the air mattress controls without donning Personal Protective Equipment (PPE).</p> <p>In an interview on 02/03/2025 at 11:03 PM, Staff GG replied that Resident 12 is not on precautions; the PPE supplies in Resident 12's room were from hospice. Staff GG answered that hand washing should be done before everything, touching residents when they enter or leave the room, and removing their gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 02/03/2025 at 2:10 PM, Staff Z, NAC, replied that Resident 12 is on precautions due to his gastrostomy tube.</p> <p>&lt;RESIDENT 13&gt;</p> <p>Resident 13 admitted on [DATE] with a multi drug resistant bacteria in their lungs.</p> <p>In an observation on 01/31/2025 at 8:43 AM, Resident 13's room did not show any signs that resident was on any transmission based precautions.</p> <p>In a record review on 01/31/2025, Resident 13's physician's orders showed Enhanced Barrier Precautions (EBP) related to history of respiratory MRSA (drug resistant staff aureus/bacteria) dated 01/07/2025.</p> <p>In an interview on 01/31/2025 at 2:04 PM, Staff I, LPN, stated Resident 13 was not on EBP because it was a history of MRSA and resident was not coughing.</p> <p>In an interview on 02/03/2025 at 12:56 PM, Staff K, LPN/Infection Preventionist (IP) Nurse, stated that residents who were on EBP will have a blue rectangular magnet placed by the resident's door frame and inside the room will have the PPE cart with sign that showed EBP. Staff K confirmed that Resident 33 should have been on EBP. Staff K stated that there was a miscommunication between them and the Resident Care Manager.</p> <p>51551</p> <p>&lt;CATHETER CARE&gt;</p> <p>Resident 36 admitted to the facility on [DATE].</p> <p>In an observation on 01/29/2025 at 1:50 PM, Resident 36 was sitting at the edge of the bed. Their catheter bag was attached to the trash bin with the bottom of the catheter bag was touching the floor.</p> <p>In an observation on 01/30/2025 at 9:19 AM, Resident 36's catheter bag was hanging at the edge of trash bin and the catheter bag was inside the trash bin. The bottom of the bag was touching the garbage.</p> <p>In an observation on 01/30/2025 at 2:25 PM, Resident 36's catheter bag was hanging on the edge of the outside of trash bin with the bottom touching the floor.</p> <p>In an observation on 01/31/2025 at 8:22 AM, Resident 36's catheter bag was inside the trash bin at the bedside lying on top of garbage.</p> <p>In an observation and interview on 01/31/2025 at 10:01 AM, Resident 36's catheter bag was lying on the floor in the bathroom. Staff P, Certified Nurse Assistant, stated they were not sure why the catheter bag was on the floor and the catheter bag was not supposed to touch the floor.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 01/31/2025 at 11:14 AM, observed Resident 36's catheter bag attached to the trash bin with the bottom touching the floor. Staff K, Licensed Practice Nurse/Infection Preventive Nurse, stated the catheter bag should not be hanging on the trash bin. Staff K stated the catheter bag, the tubing and the bottom should not touch the floor or garbage. Staff K stated it was infection risk and needed to be corrected.</p> <p>&lt;HAND HYGIENE&gt;</p> <p>In an observation and interview on 01/31/2025 at 11:18 AM, observed Staff R, Housekeeper took off the dirty gloves and put on clean gloves without hand hygiene between glove changes. Staff R stated their usual practice was not to perform hand hygiene between gloves change.</p> <p>In an interview on 01/31/2025 at 11:32 AM, Staff K stated they expected staff to perform hand hygiene before and after changing gloves.</p> <p>42927</p> <p>&lt;ENTERIC CONTACT PRECAUTION&gt;</p> <p>During an observation on 01/29/2025 at 12:07 PM, Staff GG, Registered Nurse, applied a gown and gloves and entered room [ROOM NUMBER]. A sign outside the doorway of room [ROOM NUMBER] showed Enteric Contact Precautions. The sign showed to apply a gown and gloves prior to entering the room, wash hands with soap and water when leaving room and to clean and disinfect equipment before leaving room. Outside the door was a plastic cart with drawers that had disposable gloves and gowns inside.</p> <p>During an observation on 01/29/2025 at 12:13 PM, Staff GG was observed standing at sink just inside room [ROOM NUMBER]. Staff GG removed their gloves and was noted to be holding a blue inhaler (device to deliver medication to lungs by taking a breath) in their bare hands. Staff GG was still wearing a gown but had not done hand hygiene. Staff GG walked to doorway of room and placed the inhaler on top of the plastic bin, which then fell into the open drawer that had disposable gowns inside. Staff GG then removed the disposable gown they had been wearing and discarded in the garbage can. Staff GG exited the room and used hand sanitizer on hands. Staff GG did not use soap and water for hand hygiene as the enteric contact precaution sign stated.</p> <p>During an interview on 01/29/2025 at 12:20 PM, Staff GG reviewed the enteric contact precaution sign with surveyor. Staff GG stated that they had used hand sanitizer instead of washing their hands when leaving room [ROOM NUMBER] and that they did not disinfect the inhaler before leaving the room. Staff GG stated the gowns inside the plastic bin were contaminated since the inhaler had fallen on top of them.</p> <p>51312</p> <p>Refer to WAC 388-97-1320 (1)(c) (2)(a)(b)(5)(c)</p>		