STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505355	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Post Acute	414 - 17th Southeast Auburn, WA 98002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44295 Based on observation, interview, and record review the facility failed to ensure residents were provided a comfortable homelike environment for 3 of 5 residents (Resident 1,12, 6) reviewed. The failure to ensure the facility boiler was repaired timely and water temperatures were maintained at comfortable levels, placed all residents at risk for decreased cleanliness, quality of life, dignity, and a homelike environment. Findings included . Review of the facility policy titled, Safe and Homelike Environment, dated 04/2023, showed the facility would provide a safe, clean, comfortable, and homelike environment. This included ensuring the residents received care and services safely. In an interview on 04/17/2024 at 2:07 PM, Staff A (Administrator) stated the facility had two boilers upstairs that supplied hot water to the shower and resident rooms, one of the boilers was leaking. Staff A stated one side of the facility's upper level was affected. Only warm water was available to wash hands, faces, provide showers, and baths. Staff A stated on Friday 04/12/2024 there was no hot water available for less than an hour while a vendor came to assess the malfunctioning boiler. Staff A stated three different vendors came to assess the boiler and a part needed to be replaced. Staff A stated the facility was waiting on an electrician to give a quote to complete the electrical portion of work on the boiler. During an interview on 04/17/2024 at 2:25 PM Staff N (Maintenance) stated on 04/01/2024 a vendor came to the facility to service the boiler and on 04/06/2024 one of the two boilers was observed leaking. Staff N stated the north and east part of the upper level hot and cold water were available but the south and west part of the upper level had warm and cold water was available. In an interview on 04/17/2024 at 3:32 PM Staff I (Licensed Practical Nurse) stated they worked over the weekend and the water was lukewarm. Staff I stated the staff was able to use the lukewarm water to wash their hands and provide care. <Resident 1> (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 04/17/2024 at 4:20 PM, Resident 1 was observed sitting in their bed. Resident 1 stated there is something wrong with the water, it is not getting hot. Resident 1 stated they were not sure why the water wasn't getting hot. Temperature readings of Resident 1's sink water showed 73.7 degrees Fahrenheit, 26.3 degrees cooler than the required temperature range. <Resident 12> In an observation and interview on 04/17/2024 at 4:25 PM showed Resident 12 resting in bed. Resident 12 stated the water from their room sink was cold and they could not wash their face. Resident 12 stated they could not wash their hands after toileting and did not receive a shower in over two weeks. Resident 12 stated they heard that the facility boiler broke. Temperature readings of Resident 12's sink water showed 77.4 degrees Fahrenheit, 22.6 degrees cooler than the required temperature range. During an interview on 04/23/2024 at 4:15 PM, Staff A stated Resident 12 was offered a room move to a different room with hot water available but declined to move rooms. Review of a Nursing Progress Note (NPN), dated 04/18/2024 at 10:11 AM showed Staff G (Administrative Assistant) documented they went to speak to Resident 12 about a room move but the resident did not feel well and asked if Staff G could return later. Review of NPN's between 04/18/2024-05/08/2024, showed no documentation that facility staff returned to speak to Resident 12 about a room move. In an interview on 05/02/2024 at 1:55 PM Staff G stated when they went to speak to Resident 12 it was not a good time, they were off the next day, and did not follow up with Resident 12 on a room move. During an interview on 05/02/2024 at 2:05 PM Resident 12 stated facility staff did not offer them a room move due to no hot water available in their room. <Resident 6> In an observation and interview on 04/18/2024 at 5:35 PM Resident 6 stated they were not able to participate with Physical Therapy (PT) because there was a water leak that made it's way to the outside of their door. Resident 6 stated they attempted to walk with PT but their foot kept slipping on the water that was on the floor. Observations of Resident 6's room showed right outside the doorway was a wet floor sign and a saturated towel on the floor. Water was observed seeping through the wood floor when pressure was applied. Resident 6's room was located on the upper level of the facility next to the boiler room. In an interview of 04/18/2024 at 5:40 PM Staff A stated the electrician had not gotten back to the facility with their quote, they had authorization to purchase the needed parts, and was told the electrician had to consult with their partner and the boiler leak would potentially be repaired next week. During an interview on 04/23/2024 at 4:00 PM Staff A stated the boiler was still leaking a little and the facility was still waiting for the electricians quote. Staff A acknowledged that 17 days passed since the boiler leak was discovered and the lack of hot water on one side of the upper level did not create as a homelike environment for the residents affected by no hot water. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/25/2024 at 2:00 PM, Staff A stated the boiler will be replaced starting tomorrow and the leak has stopped. In an electronic mail (e-mail) communication on 04/30/2024 at 4:53 PM with Staff B (Director of Nursing) showed Staff B confirmed the new boiler was in, the contractors were completing their work, and the work would be completed today. The boiler was replaced after 24 days without hot water to one side of the upper level of the facility. In an interview on 05/02/2024 at 3:10 PM Staff A stated water temperatures should be maintained at 110 degrees Fahrenheit plus or minus 10 degrees. Staff A stated maintenance performed water temperatures after the boiler was replaced. Documentation of water temperatures after the boiler was replaced and no documents were received. Refer to F677- ADL Care provided for dependent residents REFERENCE: WAC 388-97-0880(1)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review the facility failed to ensure residents who were dependent on staff for assistance with Activities of Daily Living (ADLs-bathing, grooming, eating) received the assistance they required for 6 of 6 residents (Residents 12, 14, 9, 1, 3, & 10) reviewed for bathing and showers. The failure to provide bathing or showers placed all residents at risk for poor hygiene, embarrassment, and diminished quality of life. Findings included . Review of a facility Shower policy, date 05/2024, showed the facility would offer residents the preference of shower days and times and the resident's preference would be documented on the Care Plan (CP). When a resident refused a shower staff would re-approach the resident and notify the nursing leadership. <Resident 12> Review of an Annual Minimum Data Set (MDS, an assessment tool) dated 02/14/2024, showed Resident 12 was able to make their own decisions and had diagnoses including a neurological disease, cancer, diabetes, anxiety, depression, and history of a brain bleed. The MDS showed Resident 12 experienced delusions (misconceptions or beliefs, contrary to reality) and had behaviors of rejecting care. The MDS showed Resident 12 used a wheelchair and required maximum assistance from staff for showering. Review of an ADL self-care deficit CP, revised 10/01/2023, showed Resident 12 required one-person extensive assistance with showers and preferred showers twice weekly on Monday and Wednesday. In an observation and interview on 04/17/2024 at 4:25 PM Resident 12 was observed lying in bed and stated they did not receive a shower in over two weeks. Resident 12 stated they liked to take a shower two times weekly but staff did not offer them a shower in the past two weeks because they heard the boiler was out. During an observation and interview on 05/02/2024 at 2:05 PM Resident 12 was observed sitting in their wheelchair and stated staff did not offer them showers but they would like to be asked and offered a shower twice weekly. Review of ADL bathing documentation, dated 04/01/2024-04/30/204, showed Resident 12 received a shower on 04/01/2024 and 04/22/2024 and refused a shower on 04/03/2024. The ADL documentation showed 3 instances where staff offered or provided a shower but no documentation that Resident 12 was offered or provided a shower six out of nine opportunities. <Resident 14> Review of an Admission MDS, dated [DATE], showed Resident 14 admitted to the facility on [DATE], had no behaviors, and was able to make their own decisions and needs known. The MDS showed Resident 14 had medically complex conditions and diagnoses including heart failure, anxiety, and depression. The MDS showed Resident 14 was assessed to require maximum assistance with showers and transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an self-care deficit Care Plan (CP), dated 04/04/2024, showed Resident 14 required one person assistance with a shower or bath and preferred a shower or bath at least one time weekly on Thursday day shift. In an observation and interview on 05/02/2024 at 2:25 PM, Resident 14 was observed in bed, their hair appeared greasy and unwashed. Resident 14 stated they were not receiving showers and after a month at the facility they have only had one shower. Resident 14 stated staff did not offer them showers or bed baths and they would prefer a shower twice a week. Resident 14 stated going without showers made them feel gross especially when they were sweating after working with physical therapy or sometimes woke up sweaty after sleeping. Review of ADL bathing documentation, dated 04/01/2024-04/30/2024, showed Resident 14 received a shower on 04/23/2024, 19 days after admitting to the facility, and refused a shower on 04/21/2024. The ADL documentation showed the facility staff did not offer or provide Resident 14 with the option for bathing four out of six opportunities. <Resident 9> Review of a quarterly MDS, dated [DATE], showed Resident 9 had no behaviors and was able to make their own decisions and needs known. The MDS showed Resident 9 had medically complex conditions and diagnoses including chronic respiratory failure, heart failure, diabetes, anxiety, and depression. The MDS showed Resident 9 had impairments to both lower extremities, used an electric wheelchair, and was assessed to require moderate staff assistance with showers and bathing. Review of an self-care deficit Care Plan (CP), revised 10/21/20236, showed Resident 9 preferred showers two times weekly and required physical help of one staff member with bathing. In an observation and interview on 05/02/2024 at 2:25 PM, Resident 9 was observed sitting on their bed and stated they didn't received their showers twice weekly as they preferred. Resident 9 stated they were a larger person and not having showers made them feel dirty. Review of ADL bathing documentation, dated 04/01/2024-04/30/2024, showed Resident 9 received a shower on 04/10/2024, 04/23/2024, and 04/24/2024, and was not available for a shower on 04/19/2024. The ADL documentation showed the facility staff did not offer or provide Resident 9 with the option for bathing four out of four opportunities. <Resident 1> Review of quarterly MDS, dated [DATE], showed Resident 1 had some impairments to their decision making and had no behaviors. The MDS showed Resident 1 had dementia, a story of a traumatic brain injury, anxiety, and lung disease. The MDS showed Resident 1 had no impairments to their upper or lower extremities, used a wheelchair for mobility and was assessed to require maximum assistance from staff for showers. Review of an self-care deficit Care Plan (CP), dated 11/23/2023, showed Resident 1 required one person extensive assistance with showers. The CP did not show how many showers Resident 1 preferred weekly. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 05/02/2024 at 2:40 PM, Resident 1 was observed sitting on their bed eating a snack. Resident 1 stated staff did not offer them showers, they preferred to shower daily, and stated they liked to maintain a clean body. Resident 1 stated they were not sure how they felt about not getting showers and stated they just have to wait for staff to offer. Resident 1's facial hair was observed to be long and Resident 1 stated they preferred a shorter beard or shaved off but did not have a razor to manage their facial hair. Review of ADL bathing documentation, dated 04/01/2024-04/30/2024, showed Resident 1 received only two showers on 04/19/2024 and 04/23/2024, during a 30 day period. The ADL documentation showed the facility staff did not offer or provide Resident 1 with a shower six out of six opportunities. <Resident 3> Review of a quarterly MDS, dated [DATE], showed Resident 3 had impairments to their decision making and had behaviors of wandering that placed Resident 3 in potentially dangerous places. The MDS showed Resident 3 had medically complex conditions and diagnoses including a seizure disorder, dementia, and chronic pain syndrome. The MDS showed staff assessed Resident 3 to required one person assistance with showers. Review of an self-care deficit Care Plan (CP), dated 04/23/2024, showed Resident 3 required assistance of one staff member for showers and preferred showers or bathing twice weekly. In an observation and interview on 05/02/2024 at 2:00 PM, Resident 3 was observed sitting in a common area socializing with other residents and stated they used to shower twice daily when working but since being retired would prefer a shower every other day. Review of ADL bathing documentation, dated 04/01/2024-04/30/2024, showed Resident 3 received five showers in thirty days on 04/05/2024, 04/08/2024, 04/11/2024, 04/18/2024, and 04/24/2024. The ADL documentation showed facility staff did not offer or provide a shower to Resident 3 three out of three opportunities. <Resident 10> Review of a quarterly MDS, dated [DATE], showed Resident 10 was able to make their own decisions, needs known, and had no behaviors. The MDS showed Resident 10 had vascular disease, an amputation of the left leg , weakness, anxiety, and depression. The MDS showed Resident 10 was assessed with an impairment to the left lower extremity, used a wheelchair to ambulate, and required assistance of one staff member for showering. Review of an self-care deficit Care Plan (CP), dated 04/26/2024, showed Resident 10 required extensive assistance of one staff member for showers and preferred showers twice weekly. In an attempt to interview Resident 10 on 05/02/2024 at 2:30 PM, they were observed sleeping in bed and did not want to participate in the interview at that time. Resident 9, who was Resident 10's roommate stated Resident 10 liked to have their showers religiously. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of ADL bathing documentation, dated 04/01/2024-04/30/2024, showed Resident 10 had four showers in 30 days on 04/10/2024, 04/17/2024, 04/23/2024, and 04/26/2024. The ADL documentation showed facility staff did not offer or provide Resident 10 with a shower four out of four opportunities. In an interview on 05/02/2024 at 2:10 PM Staff O (Staff Scheduler) stated the facility used two shower aides Monday through Friday. Staff O stated the facility has not pulled the shower aides to work as aides on the floor because they had to catch up on showers. During an interview on 05/02/2024 at 2:50 PM, Staff B (Director of Nursing) stated they would expect showers be completed per the residents preference, if a resident refused staff should document the refusal, and inform a nurse manager. Staff B stated they would expect the documentation to be in the resident's record that they were offered or provided with a bath and acknowledged six out of six residents relived did not receive showers per their preference. REFERENCE: WAC 388-97-1060(1)(c)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review the facility failed to provide consistent supervision and ensure a safe environment that was free from dangerous accident hazards for 6 of 14 residents (Resident 1, 4, 8, 3, 9 & 5) reviewed for smoking. The failure to: timely and accurately assess resident's ability to safely smoke; secure smoking paraphernalia; implement, and enforce the facility smoking policy when Resident 1 was found smoking in the facility and a common area repeatedly, including near a resident who required and was wearing oxygen, placed all residents at risk for serious adverse outcomes with the potential for fire and an explosion and/or serious bodily injury, and constituted an Immediate Jeopardy (IJ). On 04/18/2024 an IJ was identified in F-689 and the provider was informed. The IJ was determined to begin on 04/13/2024. The facility removed the immediacy that was confirmed with an on-site visit by ensuring all residents were accurately assessed to smoke, educated all residents who smoked on the facility smoking policy, consequences for not abiding to the policy, and secured all smoking paraphernalia. Findings included . Review of the facility's undated policy titled, Smoking Policy, showed the facility would provide a safe environment while ensuring resident safety as it related to the residents who smoked. The policy showed smoking was prohibited in all areas of the facility except the designated smoking area. The policy showed residents who wished to smoke would be assessed to determine if they were safe to smoke by using the resident safe smoking assessment, all safe smoking measures would be documented on the resident's Care Plan (CP), and communicated to staff. Review of the facility's undated policy titled, Accidents and Supervision showed the resident environment would remain free of accident hazards and each resident would receive adequate supervision to prevent accidents. All facility staff would be involved in the observation and identification of potential hazards in the environment. The policy showed the facility would use specific interventions to reduce the risk from hazards in the environment that included; communicating the interventions to all relevant staff, provide training, document, and ensure interventions were put into place. The interventions would be monitored and modified to ensure interventions were implemented correctly, consistently, and evaluated for effectiveness. Review of the facility, Smoking Tobacco and Marijuana Notice and Agreement, that was part of the resident admission agreement, showed residents are permitted to smoke cigarettes, marijuana, and the use of any/all tobacco products, as well as electronic cigarettes and vaping devices in certain designated outdoor areas of the facility. The smoking agreement showed the resident must be assessed first to safely smoke, assessed to safely go outside independently, and the assessment would verify if the resident was capable of maintaining their own smoking supplies, if not deemed safe to maintain their smoking supplies the resident would agree to have smoking supplies stored at the nurse station. The agreement showed if a resident failed to adhere to the policy, they may be issued a 30-day discharge notification. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<Resident 1> Review of the 01/11/2024 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 1 admitted to the facility on [DATE], was not able to make their own decisions, and had a decision maker to assist with decisions. The MDS showed Resident 1 had medically complex conditions and diagnoses including a traumatic brain injury, pneumonia (respiratory infection) that required intermittent oxygen use, adult failure to thrive, altered mental status, and restlessness with agitation. The MDS showed Resident 1 used a wheelchair to ambulate, had behaviors of delusions (misconceptions or beliefs), was prescribed an antipsychotic (used to treat mental disorders) medication and, an antidepressant (used to treat depression). Review of an admission assessment, dated 11/16/2023, showed Resident 1 had a history of smoking one pack of cigarettes daily for [AGE] years and smoked marijuana. Review of a Nursing Progress Note (NPN), dated 03/07/2024 at 4:16 PM, showed Staff C (Registered Nurse, RN) documented another staff member found Resident 1 smoking marijuana in their room, the room smelled of marijuana but Resident 1 denied smoking in their room. The NPN showed Resident 1's roommate requested to be out of the room, and Staff C notified the Physician, Director of Nursing (DON), and the Resident Care Manager (RCM) of Resident 1's incident. A NPN on 03/07/2024 at 5:28 PM showed Staff C found a lighter and marijuana on Resident 1 who gave Staff C the lighter but refused to provide staff with the marijuana, instead put it in their mouth when staff tried to confiscate the marijuana. Staff C documented they informed Staff B (DON) of the incident and placed Resident 1 on alert monitoring. Review of a NPN, dated 03/08/2024, showed Staff E (RN) documented Resident 1's roommate stated they witnessed Resident 1 smoking in the room and when staff asked Resident 1, they denied smoking in their room. Review of a NPN, dated 03/16/2024, showed Staff D (Licensed Practical Nurse, LPN) was called to Resident 1's room because smoke was observed coming from the room and found Resident 1 smoking marijuana in the bathroom. Staff D explained the fire risks related to smoking indoors and Resident 1 refused to give Staff D the lighter but did relinquish the marijuana to staff. Staff D documented they informed Staff A (Administrator) and the Physician. Review of a NPN, dated 03/17/2024 11:49 AM, showed Staff C found Resident 1 smoking in their room and initially refused to give up their lighter. Staff C documented they informed their supervisor of Resident 1's behavior. An additional note on 03/17/2024 at 1:15 PM showed Staff C asked Resident 1 who provided the cigarette. Resident 1 stated, Resident 3 gave it to them. Staff C asked Resident 3 why they gave Resident 1 a cigarette and Resident 3 replied, they said they wanted to smoke. Review of a NPN, dated 03/28/2024 at 12:12 PM, showed Staff E documented they smelled smoke coming from Resident 1's room. Resident 1 was asked if they were smoking. Resident 1 denied smoking in their room but gave Staff E their lighter. Review of a NPN, dated 03/29/2024 at 7:56 PM, showed Staff C was notified that Resident 1 and their roommate were seen smoking in the atrium (common area) of the facility. Staff C documented they informed Staff A, Staff B, and the facility Social Worker (SW). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a smoking assessment, dated 04/10/2024, showed Resident 1 indicated: they wished to smoke; was assessed as cognitively intact to smoke independently; had a history of smoking in their room and other areas of the facility; and a history of non-compliant behavior regarding the smoking policy. The assessment showed the recommendations based on the data gathered was the resident denies smoking, according to the RN there have been reports of the resident and roommate smoking in room unwitnessed. There were no adjustments made to Resident 1's Care Plan (CP) to reflect the resident's smoking. Review of a NPN, dated 04/12/2024, showed Staff F (RN) documented they caught Resident 1 smoking a cigarette in their bathroom. Staff F documented they reminded Resident 1 not to smoke inside the building due to fire hazards and other residents using oxygen. Review of a NPN, dated 04/13/2024 at 9:31 AM, showed Staff G (Administrative Assistant) documented they found Resident 1 smoking a cigarette in the atrium. When Staff G told Resident 1 they could not smoke in the atrium, Resident 1 responded, I'm not. Staff G observed a lit cigarette Resident 1 had dropped on the ground. Resident 1 apologized to Staff G, and Staff G educated Resident 1 about the dangers of smoking with other residents using oxygen nearby. Staff G stated they informed Staff A and Staff B that Resident 1 was found smoking in the atrium. An additional note on 04/13/2024, four minutes later at 9:35 AM, Staff G found Resident 1 smoking again in the atrium area with another resident, possibly Resident 2 who was actively receiving oxygen from an oxygen tank with a nasal cannula delivering oxygen to their nose. Staff G stated the charge nurse was aware and went and removed the lighter from Resident 1. During an interview on 04/17/2024 at 2:07 PM Staff A (Administrator) stated that another resident might be sharing their cigarettes with Resident 1 because they had no way to get cigarettes. Staff A stated residents were allowed to keep cigarettes on them but lighters were stored in a locked box in the resident's room. In an interview on 04/17/2024 at 3:20 PM Staff J (Infection Preventionist/RN) stated they did not see Resident 1 smoking in the atrium but Resident 1's roommate (Resident 5) was seen sneaking out to smoke in the atrium. Staff J stated Resident 5 had a Collateral Contact (CC) bringing them cigarettes and when staff tried to remove the cigarettes or lighter, Resident 5 would become combative with staff. During an interview on 04/17/2024 at 3:32 PM Staff I (LPN) stated when a resident smoked their lighter and cigarettes should be kept secured on the nurse's cart but it was hard to regulate because the residents could sign out and return with more smoking supplies than staff knew about. In an interview on 04/17/2024 at 3:55 PM Staff H (Certified Nursing Assistant, CNA) stated the facility did not store resident cigarettes or lighters. During an interview on 04/17/2024 at 4:20 PM Staff C stated Resident 1 did not have access to get cigarettes from outside the facility, they were not sure where Resident 1 obtained cigarettes, but last week Staff C smelled smoke coming from Resident 1's room. Staff C could not be sure if it was Resident 1 or their roommate (Resident 5) smoking. In a follow up interview on 04/18/2024 at 5:25 PM Staff C stated they were not sure where Resident 1 obtained marijuana or smoking supplies. Staff C stated Resident 1 continued to ask staff to go outside to smoke. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/17/2024 at 5:45 PM Staff A stated the smoking agreement was in the admission paperwork that informed residents upon admission of the smoking policies. Review of the admission smoking agreement showed the smoking assessment would determine if the resident was able to maintain their own smoking supplies. Review of the smoking assessment showed no area to address where or if a resident could maintain their own smoking supplies. Staff A stated the admission smoking agreement was not correct, residents were not allowed to smoke marijuana in the smoking area, and the facility needed to change the smoking admission agreement. Staff A stated the admission agreement paperwork was not always completed timely and the residents were not always informed of the smoking policies in a timely manner. Staff A stated after Resident 1 was found smoking in the facility numerous times the Interdisciplinary Team (IDT) had conversations about Resident 1's non-compliance with smoking and discussed a plan. Staff A was asked to provide that documentation, as Resident 1's medical record did not show any IDT notes discussing the resident's non-compliance with the smoking policy, and no documents were provided. During an interview on 04/18/2024 at 5:15 PM Staff A stated they believed the other resident who was wearing oxygen when Resident 1 was in the atrium smoking was possibly Resident 2 who worked with Physical Therapy (PT) and would walk through the atrium when exercising with PT. Staff A stated the stated the staff that witnessed Resident 1 smoking in the atrium did not get a good look at the other resident but could see their oxygen tank on the back of the wheelchair and the nasal cannula around the resident's ears and was connected to the oxygen tank. In an interview on 04/18/2024 at 5:32 PM Staff I stated they have never seen lock boxes in rooms of residents who smoked. In an observation and interview on 04/18/2024 at 5:31 PM Resident 1 was observed sitting on their bed and stated yes, they smoked. Resident 1 stated facility staff told them they had to smoke outside and off the facility property. Resident 1 stated they never smoked in the facility and asked if they could go buy cigarettes or have someone buy them cigarettes as they reached and pulled cash out of their shirt pocket. During an interview and observation on 04/18/2024 at 5:35 PM Resident 6's room was observed with a window that looked out into the atrium. Resident 6 stated they observed Resident 1 smoking in the atrium three or four times. Resident 6 stated they observed Resident 1 with another resident one time but was not sure if the resident had oxygen on, and stated they could not always see who was out in the atrium smoking but could smell the smoke. Review of a smoking assessment, dated 04/19/2024, showed staff assessed Resident 1 as not safe to smoke independently. Review of a Smoking Cessation CP, dated 04/19/2024, showed Resident 1 is on a smoking cessation medication due to being assessed as not safe to smoke and the charge nurse should be notified immediately if Resident 1 violates the smoking policy. In an interview on 05/02/2024 at 2:45 PM Staff B stated smoking assessment should be completed upon admission if the resident was identified as a smoker, should be re-assessed every 90 days, and a CP in place to ensure safe smoking. <Resident 4> (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Admission MDS, dated [DATE] showed Resident 4 was admitted to the facility on [DATE], had some impairments with their decision making ability, and had verbal behaviors directed towards others. The MDS showed Resident 4 had medically complex conditions including chronic obstructive lung disease, end stage renal disease that required dialysis (process of removing excess toxins when kidneys no longer work), depression, and tobacco use. The MDS showed Resident 4 was dependent on staff for transfers and used an electric wheelchair to move around the facility. Review of an admission assessment, dated 01/30/2024, showed Resident 4 was assessed as a current smoker and used alcohol. Review of a smoking assessment, dated 01/30/2024, showed Resident 4 wished to smoke, was assessed to be cognitively intact to smoke, had no disease or medical conditions that disqualified them from smoking per the assessment, and was assessed as able to safely smoke independently. The smoking assessment showed when a resident had certain medical conditions, such as neuropathy, the resident may not smoke at that time. Review of Resident 4's Physicians Orders (PO) showed Resident 4 was prescribed a medication for neuropathy. Review of an Active Smoker CP, dated 01/31/2024, showed Resident 4 was instructed about the facility policies on smoking locations, times, and safety concerns. Review of a NPN, dated 02/04/2024, showed Staff K was informed that staff could not enter Resident 4's room because their motorized wheelchair was blocking the door. Staff K documented they observed Resident 4 unresponsive with irregular breathing. Emergency responders were able to gain access into Resident 4's room and while working on Resident 4, a crack pipe, lighter, used foil pieces, used cut straws, a baggie with what appeared to be crack, and six tablets of a narcotic 30 milligram medication were found. Staff K documented Resident 4 transferred to the hospital, informed Staff A of the incident, and requested instructions on what to do with the drug paraphernalia. Review of a signed behavior contract between the facility and Resident 4, dated 02/09/2024, showed Resident 4 would; refrain from the possession or use of illicit drugs and paraphernalia while residing in the facility, if there was concern about paraphernalia Resident 4 would agree to their belongings and room being searched, no smoking in the community, and no smoking in the with oxygen on. The behavior contract showed if Resident 4 failed to meet these expectations it would result in an immediate termination of the relationship between the facility and Resident 4. Review of a NPN, dated 02/26/2024, showed staff observed Resident 4 in the front lobby, with a cigarette and lighter in their hand. Resident 4 was observed with a runny nose, a white residue above their lip, and constricted eye pupils. The NPN showed Resident 4 consented to have their bag being searched, no items were found, but Resident 4's clothing and jacket pockets were not searched. The NPN did not mention if the cigarette or lighter was removed from Resident 4 at that time. Review of a NPN, dated 02/29/2024, showed Resident 4 appeared to be under the influence of a recreational substance and gave consent for staff to search their room. Upon searching Resident 4's room, an electrical heating pad, heat gun, cut pieces of aluminum foil, a cut straw, and a cigarette butt were found. The documentation showed no further interventions were indicated at this time. Review of Resident 4's NPN's showed no documentation to support the facility enforced Resident 4's behavior contract after being found with drug paraphernalia twice in three days. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations and interviews on 04/17/2024 at 2:45 PM showed Resident 11 self-propelling in the hallway, upset, screaming, and swearing that they wanted their lighter back so they could go smoke. At this time Staff B came into the hallway and stated Resident 11 was new to the facility and was not able to safely smoke or go outside independently. Observations and interviews on 04/17/2024 at 4:50 PM showed two working lighters, one with a torch like flame sitting on Resident 4's bedside table. Resident 4 was not observed in their room or in the facility. On 04/17/2024 at 4:55 PM Staff B stated lighters should be stored in the lock box and should not be accessible to other residents because it was a safety issue, especially when Resident 11 was previously looking for a lighter earlier that day. Staff B was not able to locate a lock box or key in Resident 4's room and stated they would expect Resident 4 to have a lock box and key to secure their smoking supplies. During an interview on 04/24/2024 at 4:10 PM Staff B acknowledged the smoking assessment for Resident 4 was not marked for neuropathy although they were being treated with medication for neuropathy and stated the nursing management and administration reviewed and revised the resident smoking assessments eliminating certain medical diagnoses, such as neuropathy. Staff B stated because a resident was treated for neuropathy does not mean they are not safe to smoke. Staff B stated the smoking assessment included a visual assessment to watch the resident smoke to determine if they were safe. <Resident 8> Review of a 04/12/2024 significant change MD'S showed Resident 8 admitted to the facility on [DATE], was able to make their own decisions and needs known. The MDS showed Resident 4 had medically complex conditions including cancer, diabetes, anxiety, and bipolar disorder. The MDS showed Resident 8 used a wheelchair to ambulate and had no behaviors. Review of an Admission Assessment, dated 03/15/2024, showed Resident 8 was identified as a current smoker on admission to the facility. Review of a NPN, dated 03/16/2024 at 2:35 AM, showed Resident 8 demanded staff take them outside to smoke. Staff documented they informed Resident 8 of the facility smoking policy and that staff cannot assist in facilitating smoking. An additional NPN, dated 03/16/2024 at 6:17 PM showed Resident 8 was found smoking cigarettes in their bed. Resident 8 put their cigarette out and gave staff one pack of cigarettes, 1/2 smoked cigarette, and a lighter. Review of a smoking assessment, dated 04/04/2024, showed Resident 8 wished to smoke, was unable to access the smoking area independently, was dependent on staff for all smoking needs, and should not smoke unassisted. A second smoking assessment was completed on 04/19/2024 showed Resident 8 preferred not to smoke and was currently prescribed a smoking cessation to stop smoking. Review of a NPN, dated 04/16/2024, showed Resident 8 was heard yelling about wanting to go outside to smoke. The NPN showed staff reminded Resident 8 that it was past the smoking time. Staff were able to re-direct the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and observation on 04/17/2024 at 4:45 PM Resident 8 stated they were a current smoker and kept their cigarettes and lighter on their person. Resident 8 was observed with a pack of cigarettes and a lighter on them and stated they did not have a lock box with a key to store their cigarettes and stored their smoking supplies in their pocket. Observations showed no lock box in Resident 8's room to secure smoking supplies. Review of Resident 8's CP showed on 04/19/2024, a smoking cessation CP was initiated and directed staff to notify the nurse immediately if Resident 8 violated the facility smoking policy. During an interview on 04/24/2024 at 4:22 PM Staff B stated all smokers were re-assessed and Resident 8 was assessed as no longer safe to smoke independently, wished not to smoke, and was started on a smoking cessation medication. Staff B stated they would expect all residents who smoked to have a lock box and key in their room to secure smoking supplies. <Resident 3> Review of a quarterly MDS, dated [DATE], showed Resident 3 admitted to the facility on [DATE], was not able to make their own decisions, and had behaviors of wandering that put Resident 3 at significant risk of getting to a potentially dangerous place. The MDS showed Resident 3 had medically complex diagnoses including epilepsy (brain disorder that causes seizures), dementia, and nicotine dependence. Review of an admission assessment, dated 12/12/2023, showed Resident 3 was identified as a current smoker with a history of smoking for [AGE] years and currently used smokeless tobacco. Review of Resident 3's CP, initiated 12/13/2023, showed no CP in place that addressed Resident 3's smoking or a smoking assessment completed upon Resident 3's admission after being identified as a current smoker. Review of a NPN, dated 12/15/2023, showed Resident 3 went outside to smoke with their roommate and later returned to the unit. Additional NPN's dated 12/30/2023 and 12/31/2023 showed Resident 3 was reminded not to go smoke by themselves and a staff member assisted them outside to smoke a cigarette. A NPN, dated 01/02/2024 showed Resident 3 triggered the wanderguard alarm (a system to alert staff if a resident attempted to exit the facility) because they wanted to go outside to smoke. Staff C documented they were informed by staff that another resident gave Resident 3 a cigarette and Resident 3 made multiple attempts to go outside to smoke, eventually staff escorted Resident 3 outside to smoke their cigarette. Review of a Social Services Assistant (SSA) note, dated 02/04/2024, showed Staff L (SSA) spoke with Resident 3 and requested they be supervised when leaving the building to go smoke or go to the corner store. Staff L documented Resident 3 had a history of confusion and wandering. Review of a NPN, dated 02/17/2024, showed Staff D was notified by a staff member leaving the building that the wanderguard alarm was ringing and they saw Resident 3 walking down the street towards the facility. Resident 3 told Staff D they went to the corner store to have a cigarette. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a smoking assessment, dated 03/06/2024, showed Resident 3 preferred not to smoke, was independent with their cognition, judgement, and safety decision making. The smoking assessment showed staff documented that Resident 4 was able to smoke independently, acknowledged the smoking policy, and agreed to follow the smoking policy. Review of a NPN, dated 03/16/2024, showed Resident 3 requested to go outside to smoke but when staff brought Resident 3 outside the resident wanted to go to the corner store. A NPN, dated 04/15/2024, showed Staff M (Resident Care Manager, RN) documented a smoking assessment was completed supporting Resident 3 was assessed as not safe to smoke unassisted. Staff M requested an order for nicotine patches for Resident 3. During an observation and interview on 04/17/2024 at 4:34 PM, Resident 3 stated they were a current smoker and they usually had a lighter on them, was unable to locate one, and stated that it was probably in their room. Review of a smoking assessment, dated 04/19/2024, showed Resident 3 wished to smoke, had impaired cognition, judgement, and unsafe decision making. The assessment showed Resident 3 was deemed unsafe to smoke and smoking cessation was in progress. Review of a NPN, dated 04/20/2024, showed Staff C documented they were informed that Resident 3 got money from another resident and left the facility to go to the corner store and returned with a pack of cigarettes, a lighter, and three cans of beer. A staff member found Resident 3 smoking a cigarette in the parking garage, Resident 3 refused to give staff the cigarettes and lighter, and was difficult to re-direct. The documentation did not include any reassessment to new interventions the facility would take to ensure the resident's safety and non-compliance with smoking. Review of Resident 3's PO showed a 04/24/2024 PO for a smoking cessation medication was ordered five days after Resident 3 was deemed unsafe to smoke on 04/19/2024. In an interview on 04/25/2024 at 3:00 PM Staff B stated if a resident was assessed not safe to smoke, they should not be smoking. <Resident 9> Review of a quarterly MDS, dated [DATE], showed Resident 9 readmitted to the facility on [DATE], was able to make their own decisions, and had no behaviors. The MDS showed Resident 9 had medically complex diagnoses including chronic respiratory failure, heart failure, history of brain bleed, anxiety, schizophrenia, and post traumatic stress disorder. The MDS showed Resident 9 had impairments to both lower extremities and used an electric wheelchair to move around the facility. Review of an admission assessment, dated 01/09/2024, showed staff documented Resident 9 was a current smoker. Review of a smoking CP, initiated on 01/31/2024, showed Resident 9 had a history of smoking marijuana and used a vape pen (electronic cigarette). The CP directed staff to instruct Resident 9 on the facility smoking policy and to notify the charge nurse if the resident violated the facility smoking policy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a smoking assessment, dated 03/06/2024, showed staff documented Resident 9 indicated they did not wish to smoke, they were assessed cognitively intact to smoke independently, and had diagnoses that included neuropathy that automatically disqualified them from being able to smoke at that time, per the smoking assessment directions. The smoking assessment concluded that Resident 9 continued to smoke, had plans to stop in the future, and declined smoking cessation medications. Review of a smoking assessment, dated 04/19/2024, showed staff documented Resident 9 wished to smoke, was assessed to be safe to smoke independently, and had diagnoses that included neuropathy that automatically disqualified them from being able to smoke at that time, per the smoking assessment directions. The smoking assessment concluded that Resident 9 continued to smoke at this time. Review of a smoking assessment, dated 04/24/2024, showed Resident 9 wished to smoke, was assessed as cognitively intact, able to smoke independently, and the smoking assessment no longer contained the section that reviewed conditions or medical diagnoses automatically disqualifying a resident to smoke if they had one or more of those conditions. Review of a NPN, dated 03/06/2024, showed staff spoke with the physician about Resident 9 continuing to smoke while having a PO for a nicotine patch, the physician discontinued the order for the nicotine patch. A NPN, dated 04/18/2024, showed Resident 9's lighter was removed from them and put in the nurses cart to keep secure. During an observation and interview on 04/23/2024 at 3:18 PM, Resident 9 was observed sitting on the edge of their bed and stated they had not smoked a cigarette in a week but did still use a vape pen to smoke. Review of a NPN, dated 04/24/2024, showed staff documented that Resident 9 was aware they could not keep marijuana or any smoking paraphernalia in their room, and if they did not abide by the facility smoking policy they may be subject to a 30 day discharge notice. <Resident 5> Review of the admission MDS, dated [DATE], showed Resident 5 admitted to the facility on [DATE], was not able to make their own decisions, and had no behaviors. The MDS showed Resident 5 had a non-traumatic brain dysfunction, dementia with behavioral disturbances, restlessness with agitation, and tobacco use. The MDS showed Resident 5 was able to ambulate independently with no assuasive devices. Review of an admission assessment, dated 03/21/2024, showed Resident 5 was assessed as a previous smoker. Review of a smoking assessment, dated 03/21/2024, showed Resident 5 did not wish to smoke, was not cognitively independent to safely smoke. The assessment concluded that an order for smoking cessation medications were ordered. Review of Resident 5's history of tobacco use CP, dated 04/15/2024, directed staff to monitor for non adherence to the smoking policies and report to the provider with each occurrence. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a NPN, dated 03/29/2024 at 4:08 PM, showed Resident 5's Collateral Contact (CC) requested staff look at Resident 5's belongings and staff found a lighter on Resident 5, who was not willing to have their smoking items secured. An additional NPN, dated 03/29/2024 at 4:45 PM showed Staff C was informed that Resident 5 had a lighter in their hand, refused to give Staff C the lighter, and Staff C informed Staff B. Staff C documented they were notified after an hour that Resident 5 was smoking in the atrium with their roommate (Resident 1), and Resident 5 gave Staff C the cigarettes but refused to give them the lighter. A NPN, dated 03/30/2024 showed Resident 5's CC came to the facility and staff were able to obtain and secure the lighter in the nurses cart. Review of a NPN, dated 04/09/2024, showed Staff K documented at 7:45 PM Resident 5 was observed smoking a cigarette in the atrium, was educated not to smoke in that location, put their cigarette out, and refused to relinquish their lighter to staff. Staff K re-attempted to obtain the lighter but Resident 5 became aggressive and refused to give up their lighter. Staff K documented they informed Staff A, Staff G, and Staff B of the incident. Resident 5 continued on 15 minute checks for safety. Review of a NPN, dated 04/14/2024 at 11:00 PM, Resident 5 was observed pacing the hallway with clenched fists and stated I want out, just out!. Staff K asked Resident 5 if they had cigarettes and Resident 5 stated, you can't have mine. Staff K escorted Resident 5 outside and the resident pulled out a cigarette lit their cigarette with their lighter. The NPN did not indicate if staff removed or attempted to remove Resident 5's smoking supplies from them as they were not assessed to be able safely to smoke independently. During an interview on 04/17/2024 at 3:20 PM Staff J stated Resident 5 was new to the facility and was sneaking out to the atrium to smoke. Staff J stated there was no clear directions from management on how to manage Resident 5's non-compliant behaviors. In an observation and interview on 04/17/2024 at 4:22 PM, Resident 5 stated yes they were a smoker, kept their cigarettes in their pocket as they pointed at their pocket and a shape of a small box was observed. Resident 5 stated they had a lighter but it was almost empty. No lock box was observed in Resident 5's room. In an observation and interview on 04/18/2024 at 5:30 PM, Resident 5 was observed in their room, was unable to answer questions due to increased confusion, and pulled out a Ziploc baggie from their pocket that contained three cigar [TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary environment to prevent placing residents at risk for facility acquired infections. The failure to have an effective system of surveillance to identify possible contagious infections, prevent the spread of infection to there residents and staff, reporting a suspected outbreak, and controlling the spread of a Gastrointestinal (GI) infection to other residents for 3 of 3 residents (Residents 15, 18, & 19) reviewed for infections. The failure to ensure staff used appropriate Personal Protective Equipment (PPE), to ensure proper Hand Hygiene (HH) was performed, and failed to have an effective Water Management Policy (WMP), plan, and implementation of that plan placed all residents at risk for facility-acquired or healthcare-associated infections and related complications. Findings included . Review of the facility policy titled, Transmission-Based Isolation Precautions, dated ,d+[DATE], showed the facility would take appropriate precautions to prevent transmission of pathogens (germs), based on the pathogens mode of transmission. The policy showed contact precautions referred to measures that were intended to prevent transmission of infectious agents that were spread by direct or indirect contact with the resident or the environment. The policy showed that nursing placed residents with suspected or confirmed infectious diarrhea on transmission-based precautions while waiting for confirmation. The policy showed the signage would include and specify the specific Personal Protective Equipment (PPE, used to protect staff from infectious disease), would be placed in a conspicuous location outside the resident's room, near the entrance of the residents room. The policy showed facility staff would don (put on) appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. Review of the facility policy, titled Hand Hygiene, dated ,d+[DATE], showed facility staff would perform hand hygiene when indicated, using proper technique, and consistent with accepted standards of practice. The policy showed a hand hygiene table that directed staff to use soap and water for instances of suspected or likely Clostridium Difficile (C.diff, contagious loose stools and abdominal symptoms) and when caring for a resident with known or suspected infectious diarrhea. <Gastrointestinal (GI) Outbreak> Review of a facility GI Outbreak Line List, dated ,d+[DATE], showed a list of all residents and staff, including symptoms, onset date, and if the person was hospitalized . The line list included a total of 33 residents and 5 staff members with GI like illness, for a total of 38 people affected by the facility GI outbreak. <Resident 15> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an admission Minimum Data Set (MDS, an assessment tool), dated [DATE], showed Resident 15 admitted to the facility on [DATE] and was able to make their own decisions and needs known. The MDS showed Resident 15 had diagnoses including the history of a brain bleed, weakness to the right side of the body, heart failure, diabetes, and a history of a Urinary Tract Infection (UTI) with sepsis (infection moves into the bloodstream). The MDS showed Resident 15 received antibiotics while residing at the facility. Review of a facility provided GI Outbreak line list, dated [DATE], showed Resident 15 was the first resident identified with loose stools, cramps, and vomiting on [DATE]. The line list showed Resident 15 went to the emergency room (ER) for abdominal pain on [DATE] and was sent out to ER again on [DATE] where they passed with a GI bleed and pneumonia with sepsis. Review of Resident 15's comprehensive Care Plan (CP), dated [DATE], showed no documentation of a CP developed for Resident 15's diarrhea, cramping, or vomiting related infection or antibiotic use. Review of a Nursing Progress Note (NPN) dated [DATE], showed Staff K (Licensed Practical Nurse, LPN) documented for Resident 15, reviewed labs drawn on [DATE] for CBC with Diff (Complete Blood Count with Differential) and CMP (Complete Metabolic Profile). Values noted within range. An additional NPN, dated [DATE], showed Staff J (Infection Preventionist) spoke with the Resident 15's physician who ordered a stool sample to be collected to rule out Clostridium Difficile (C. diff, an inflammation of the colon caused by the bacteria c.diff and results in abdominal pain, loose stools, and was contagious), because Resident 15 was having loose stools. Staff J documented Resident 15 was placed on contact precautions (intended to prevent transmission of infections which are spread by direct or indirect contact with the resident or the environment). Review of Resident 15's lab results, dated [DATE], showed the lab report was flagged for abnormal results inconsistent with Staff K's reporting. Resident 15's labs showed indication of abnormal values for liver and kidney malfunctioning, and elevation of white blood cells which was an indication of a possible infection. The lab results showed Resident 15 was negative for C.diff. Review of a NPN, dated [DATE], showed Resident 15, at their request, was sent to the emergency room (ER) the night of [DATE] to be evaluated for lethargy (deep unresponsiveness), low blood oxygen saturation levels at 80%, coughing up bloody mucous NPN notes dated [DATE] showed Resident 15 was given Morphine (pain medications) in the emergency room . The NPN showed Resident 15 returned to the facility. A NPN, dated [DATE] at 11:53 AM showed staff documented that Resident 15 was barely arousable, took their medications, and shortly after became nauseous and vomited. The NPN showed the physician placed an order for intravenous fluids for hydration for Resident 15. Review of a NPN, dated [DATE] at 12:50 AM showed staff documented that Resident 15 was experiencing lethargy, had brown discolored vomit, and diarrhea that was black in color. Resident 15 was sent out to the ER to be evaluated. An NPN, dated [DATE] at 12:03 PM showed staff documented that Resident 15 was admitted to the Intensive Care Unit with sepsis. A NPN, dated [DATE], showed staff documented they were informed that Resident 15 passed away on [DATE]. (continued on next page)

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	505355	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Post Acute	414 - 17th Southeast Auburn, WA 98002

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 15's Activities of Daily Living (ADLs, bathing, eating, toileting) documentation for bowel movements, dated [DATE]-[DATE], showed Resident 15 had loose stools on [DATE], [DATE], [DATE], and no bowel movements were documented for [DATE]. There was no documentation to support the facility initiated infection control measures when Resident 15 first presented with diarrhea. Review of [DATE] Physician's Orders (PO) showed after nine days of diarrhea, Resident 15 was to ordered be started on contact precautions and to rule out C.diff. <Resident 18> Review of a quarterly MDS, dated [DATE], showed Resident 18 had some impairments to their decision making ability, had no behaviors, and was incontinent of bowel. The MDS showed Resident 18 had medically complex conditions and diagnoses including malnutrition and lung disease. Review of a facility provided GI Outbreak line list, dated [DATE], showed Resident 18 was the second of four residents with GI symptoms including diarrhea, vomiting, and cramps that started on [DATE]. Review of Resident 18's comprehensive CP, dated [DATE], showed showed no CP developed for Resident 18's suspected GI infection or isolation precautions. Review of NPNs, dated [DATE] through [DATE], showed no documentation of when Resident 18 experienced symptoms, when the resident was isolated, who was notified, daily monitoring of symptoms or Resident 18's response. There was no NPN entry to indicate when Resident 18's symptoms resolved, if isolation precautions were implemented, or when isolation precautions were removed. Review of Resident 18's PO's dated [DATE]-[DATE] showed no PO for contact isolation or for stool testing to rule out infectious pathogens. Review of Resident 18's Activity of Daily Living (ADL) documentation for bowel movements, dated [DATE]-[DATE], showed Resident 18 had loose stools on [DATE], and not [DATE] as indicated on the facility GI line list. This data supported staff did not implement infection control for a minimum of five days after development of symptoms. <Resident 19> Review of a quarterly MDS, dated [DATE], showed Resident 19 was rarely or never understood, had a decision maker, no behaviors, and used a wheelchair to self propel around the facility. The MDS showed Resident 19 had medically complex conditions including dementia, weakness, and heart failure. The MDS showed Resident was assessed as frequently incontinent of their bowels. Review of a facility provided GI Outbreak line list, dated [DATE], showed Resident 19 was the third resident on [DATE] to present with symptoms of diarrhea. Review of Resident 19's ADL documentation for bowel movements, dated [DATE]-[DATE], showed Resident 19 had loose stools that started on [DATE], not [DATE] as indicated on the facility GI line list. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 19's comprehensive CP, dated [DATE], showed Resident 19 had behaviors of wandering but there was no CP developed for Resident 19's suspected GI infection or isolation precautions. Review of NPN's dated [DATE] through [DATE], showed no documentation when Resident 19 experienced symptoms, when the resident was isolated, who was informed, or when the responsible party or physician were notified. There was no documentation staff daily monitored Resident 19's symptoms or the resident's response. There was no documentation to support when Resident 19's symptoms resolved or when isolation precautions were removed. Review of Resident 19's PO's dated [DATE]-[DATE] showed no PO for contact isolation or for stool testing. During an interview on [DATE] at 3:00 PM Staff J stated 20 or more residents and staff experienced GI illness symptoms. Staff J stated the diarrhea, nausea, and vomiting started on [DATE], despite clear evidence residents experienced diarrhea on [DATE], and was told to put symptomatic residents on contact precautions. Staff J stated Resident 15 was tested for C.diff, which was negative and one other resident had a stool culture (a test that detects and identifies bacteria that cause infections of the lower digestive tract) that results were still pending. Staff J stated they did not feel it was a foodborne illness and did not complete Norovirus (the most common cause of infectious diarrhea, characterized by diarrhea, vomiting, and stomach pain) testing because it had a short duration of ,d+[DATE] hours and it usually wouldn't show up. Staff DJ stated they first identified the increase of GI illness when reviewing a 24 hour nursing report, they were directed by management to report to the local health jurisdiction but was not aware they had to make a state report which was why the GI outbreak was not reported until 10 days after it was identified. <PPE Use, and Handwashing> In an interview on [DATE] at 2:40 PM Staff N (Maintenance) stated the ice machine was cleaned last month, they did not know often the ice machine was emptied and cleaned. Staff N stated they were newly hired and needed to learn how to empty and clean the ice machines. In an observation and interview on [DATE] at 3:45 PM, showed an ice machine behind a closed door, that was not locked, and accessible to anyone who tried to enter the room. A sign was posted on the ice machine that showed, Please wait for employee assistance. No gloves were observed in the ice machine room. An ice scoop was observed sitting in a plastic container on a shelf. At 3:47 PM Staff B stated they did not see any gloves in the ice room and would expect staff to always wear gloves when scooping ice. Staff B did not know how often the ice scoop or the container holding the ice scoop was cleaned. No additional information was provided. Observations on [DATE] at 3:40 PM, showed room [ROOM NUMBER] with a posted contact precautions sign that directed staff to put on an isolation gown and gloves before entering the room. Observations of the isolation cart supplies showed no gloves available for staff use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on [DATE] at 3:47 PM, showed room [ROOM NUMBER] with a posted contact precautions sign that directed staff to put on an isolation gown and gloves before entering the room. Observations of the isolation cart supplies showed no gloves available in the cart. Observations at 3:48 PM showed Staff P (Certified Nursing Assistant, CNA) in room [ROOM NUMBER], with no isolation gown, only gloves assisting Resident 17 out of the bathroom. Staff P removed their gloves in the room, exited and used hand sanitizer in the hallway instead of washing their hands in the resident's room before exiting. During an interview on [DATE] at 3:50 PM Staff P Resident 17 was not on isolation precautions. When asked about the contact isolation sign, Staff P stated they did not see that and yes, if the resident was on isolation an isolation gown and gloves should be worn. During an interview on [DATE] at 3:12 PM Staff B (Director of Nursing) stated if a resident was symptomatic with illness they would expect staff to place the resident on isolation precautions when the diarrhea started, document the resident's symptoms, what actions were taken to decrease the spread of infection, who was notified, and put them on alert charting. Staff B stated if a resident was on posted isolation precautions they would expect the isolation carts to have necessary supplies and expected staff to follow the posted signs for directions on what PPE to wear. <Water Management Program (WMP)> Review of facility Water Management [DATE]-[DATE] documents, provided [DATE], showed a table of contents that included; inspect eyewash stations, Legionella water management plan review-upload your plan to TELS (a platform designed specifically for senior care living to create a safe environment), and testing and monitoring of water management plan for Legionnaires disease. The documents showed a generic step by step instructions on how to create a WMP that included establishing a water management team, have a written plan, a charted plan, a risk assessment, a water monitoring plan, verification and validation of the program, and documentation and communication of the water management team activities. The documents provided did not include any specific information for the facility and documentation of a water management plan as specified in the provided documents. In an interview on [DATE] at 2:07 PM Staff A (Administrator) stated the facility had two water boilers upstairs and one was leaking. One side of the upper level of the building had cold and hot water, while the other side had cold and luke warm water. Staff A stated on [DATE] or [DATE] the facility had no hot water for less than a half hour. During an interview on [DATE] at 2:25 PM Staff N (Maintenance Director) stated they were new to the facility, Legionella water testing should be completed weekly, and water temperatures she be at 110 degrees Fahrenheit, give or take 10 degrees Fahrenheit. Staff N looked for documentation of previous water testing, did not found anything. Staff N stated they were not educated on water testing policy. Staff N stated they were not sure if the facility koi pond/water feature was tested for Legionella in the past, they were educated by the previous maintenance man to clean the koi pond when needed. In an interview on [DATE] at 3:15 PM Staff DJ stated they were not involved or familiar with the WMP and not sure if they were supposed to be involved. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations of water temperature testing on [DATE] at 4:25 PM, showed room [ROOM NUMBER] with sink water at 77.4 degrees Fahrenheit, room [ROOM NUMBER] with sink water at 91.4 degrees Fahrenheit, and room [ROOM NUMBER] with sink water at 93.8 degrees Fahrenheit, During an interview on [DATE] at 5:00 PM Staff A stated facility water temperatures should be checked and documented weekly and if a problem existed with water temperatures residents should be notified. The facility did not notify resident representatives of the hot water being out and affecting one side of the resident rooms Review of a facility policy titled, Legionella Water Management Program, undated, and provided on [DATE]. The policy showed the facility was committed to the prevention, detection and control of water-borne contaminants, including Legionella (a bacteria that caused Legionnaires disease (lung infection) when small contaminated droplets are breathed in and can be found in human man-made water systems, such as showerheads, sink faucets, decorative fountains, and water features. The water management team would consist of the Infection Preventionist (IP), administrator, medical director, and the director of maintenance. The purpose of the WMP was to; identify areas in the water system where Legionella bacteria could grow and spread, and to reduce the risk of Legionnaires disease. The WMP would include a detailed description and diagram of the water system in the facility, identification of areas in the water system that could encourage growth and spread of water borne illness, identification of situations that could lead to Legionella growth, such as water temperature fluctuations, inadequate disinfectant, and construction. The WMP would use specific measures to control the introduction and/or spread by use of a disinfectant or temperature control, a diagram of where the control measures are applied, a plan when the control measures were not met, and documentation of that plan. The policy showed the facility would conduct annual testing and active management of biological populations (including Legionella). Review of additional WMP documents, provided [DATE] showed the facility had a map of the water flow diagram, areas where Legionella could grow, and controls measures used included checking temperatures and disinfectant levels. The documentation did not include a risk assessment, a written plan, and verification validation of the program. Review of a facility document titled, Tap Water Temperature checks dated [DATE] and [DATE], showed the requirement was; water temperature gauges and the temperature of the tap water in each water heater circuit would be checked weekly; random check of 10 sources (resident room, shower); temperatures shall be no more than (left blank) degrees Fahrenheit, and discrepant findings would be remedied immediately. The documentation showed on [DATE] a resident room temperature read 100 degrees Fahrenheit, and on [DATE] two separate room, one being the shower room had lower temperatures at 102 degrees Fahrenheit. In comparison to previous months water temperatures was at the lowest 108 degrees Fahrenheit or above. The document showed after [DATE] through [DATE] weekly water temperatures were not completed. In an interview on [DATE] at 3:10 PM Staff A stated when water temperatures were identified lower on [DATE] the maintenance man should have done an assessment to identify the cause and notify them abut the temperature. Staff A stated they were not sure but would check to see about additional water testing such as pH (a measure of how acidic water is) levels and disinfectants, if used. No additional documents were provided. Staff A stated after the facility had a new water boiler replaced the facility did perform monitor checks but did not conduct any water testing after the construction and interruption of water. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 44295 Based on interview and record review, the facility failed to ensure direct care staff were provided the mandatory effective communication training. Failure to ensure the required effective communication training was provide placed all residents at risk of unmet care needs and diminished quality of life. Findings included . Review of the facility policy titled, training Requirements, undated, showed the facility would develop, implement, and maintain an effective training program for all new and existing employee's consistent with their role. Training would include at a minimum, effective communication for all direct care staff. Review of a facility Licensed Nurse (LN) 2024 training/inservice proposal showed no documentation of a communication training required or provided for LN's. Review of a facility Nursing Assistant Certified (NAC) 2024 training/inservice proposal showed no documentation of a communication training required or provided for NAC's. During an electronic mail (e-mail) communication on 05/10/2024, Staff A documented staff received Communication tracing as part of their Relias (health care education provider) training. Review of received education documents showed no documentation of Effective Communication tracing provided to direct care staff through the facilities training. Reference WAC 388-97-1680(2)(a)(b)(ii)