STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505362	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
View Ridge Care Center	5129 Hilltop Road Everett, WA 98203

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review the facility failed to identify a significant change and complete a timely Significant Change in Status Assessment (SCSA) within the required 14-day timeframe for 1 of 4 residents (Resident 7) reviewed for Hospice Services. Failure to complete the SCSA timely placed the resident at risk for unmet care needs, decreased quality of care and diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.18.11, dated October 2023, stated a Significant Change in Status Assessment must be completed no later than 14 days from the Assessment Reference Date and no later than 14 days from the determination date of the significant change in status. (For purpose of this section, a significant change means a major decline in status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of a resident's health status). SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains in the nursing home. Resident 29 admitted to the facility on [DATE] with diagnoses including pressure ulcer (bed sore) to right buttock, long term use of anticoagulants (blood thinners), and osteomyelitis (bone infection). The admission Minimum Data Set (MDS - an assessment tool) assessment, dated 07/05/2024 showed the resident had intact cognition. Review of Resident 29's clinical record on 08/26/2024 showed that the resident had been placed on hospice services on 08/06/2024. Review of the MDS assessments showed no significant change assessment was completed. In an interview on 08/28/2024 at 2:00 PM, Staff O, Licensed Practical Nurse/MDS Coordinator stated whenever there was a change in condition, they are required to complete a significant change MDS assessment. Staff O stated that they usually receive communication from the nurse manager in the morning clinical meeting if there are any residents that have had a change in condition. Staff O stated that Resident 29 did not receive a significant change assessment when they were placed on hospice services. (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 11:15 AM, Staff J, Registered Nurse/Patient Care Coordinator stated all residents that are experiencing a change in condition are discussed in the morning clinical meeting every Monday - Friday. Staff J stated they were out of facility on vacation during the first two weeks that Resident 29 was on hospice services and was not sure who had been responsible in their absence, nor why that information was not communicated to the MDS coordinator. In an interview on 08/29/2024 at 12:33 PM, Staff B, Director of Nursing Services stated they discuss any residents with a change in condition at the morning clinical meetings. Staff B stated they were aware of who was covering for Staff J while they were out on vacation but ultimately the responsibility fell with them, and they did not get that communication regarding Resident 29 to the MDS coordinator to complete a significant change assessment for the resident. Refer to WAC 388-97-1000(3)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were completed accurately for 1 of 4 residents (Resident 14) reviewed for Activities of daily living and 1 of 1 resident (Resident 6) reviewed for dental care. This failure placed residents at risk for inaccurate care planning and decreased quality of care. Findings included . <Resident 14> Resident 14 admitted [DATE] with diagnoses that included Schizophrenia and Bipolar disorder. Review of Resident 14's Medication Administration Records for the prior six months showed the resident frequently refused ordered medications and treatments. Review of Resident 14's progress notes from April 1, 2024, through August 26, 2024, showed Resident 14 exhibited behaviors such as yelling, cursing and refusing cares. Review of the Annual Minimum Data Set (MDS-an assessment tool) assessment dated [DATE] showed Resident14 exhibited no behaviors or refusals of care in the reference period. Review of the Quarterly MDS dated [DATE] showed the resident exhibited no behaviors or refusals of care. In an interview on 08/29/2024 at 12:05 PM, Staff O, Licensed Practical Nurse (LPN)/MDS Coordinator, stated the MDS' for Resident 14 were incorrect. Staff O stated they had signed those sections (behaviors/refusals of care); however, the facility social worker usually completed those sections. Staff O stated they had reviewed nursing assistant documentation which did not show refusals but had not reviewed progress notes or licensed staff documentation for the resident. 50725 <Resident 6> Resident 6 admitted to the facility on [DATE] with diagnoses that included Congestive Heart Failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should), Chronic Obstructive Pulmonary Disease (COPD - a group of diseases that block airflow and make it difficult to breath), Diabetes Mellitus Type 2(a disease that occurs when your blood sugar is too high). According to the admission MDS dated [DATE], showed Resident 6 was cognitively intact. In an interview on 08/26/2024 at 1:25 PM, Resident 6 stated that they were interested in getting dentures. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 08/27/2024 at 1:38 PM, Resident 6 stated that they have missing teeth and cavities on the right side of their mouth and that they have a difficult time chewing hard food. Resident 6's mouth was observed and cavities were observed on their teeth, and they were missing teeth on the top and bottom of the right side of their mouth. Resident 6 was unable to recall the last time they saw a dentist. Review of the Admission MDS dated [DATE] showed that Resident 6 did not have dental issues. Review of the current care plan on 08/27/2024 showed the care plan did not address Resident 6's dental issues, goals or interventions. Review of a dietician progress note dated 07/30/2024 showed Resident 6 had complained of chewing difficulties due to broken teeth and recommendations were made for Resident 6 to have easy to chew food. Resident 6's current diet order was general diet with downgraded texture due to broken teeth. In an interview on 08/27/2024 at 2:54 PM, Staff J, Registered Nurse/Patient Care Coordinator stated they were going to put Resident 6 on the list to be seen by the dentist. Staff J stated they were going to assess the resident's diet and texture. Staff J stated that any licensed staff can update the care plan as needed. In an interview on 08/28/2024 at 12:48 PM, Staff O, LPN/MDS Coordinator, stated they were not able to explain why Resident 6's MDS assessment showed no dental issues. Staff O stated that they don't look at the resident's mouth, and the admission nurse was the one that completes that assessment. Refer to WAC 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR - a federally required screening of all individuals who has both an Intellectual Disability (ID) or Related Condition (RC) and a serious mental illness (SMI) prior to admission to a Medicaid-certified nursing facility or a significant change of condition) form was completed prior to admission and according to the guidelines specified for 2 of 5 sampled residents (Resident 5 and 47) reviewed for unnecessary medications. Incomplete or inaccurate PASRR's placed residents at risk for inappropriate placement and/or lack of access to specialized services for residents with identified mental health diagnoses or disability. Findings included . Review of the facility's PASRR policy dated 07/11/2024 showed the policy was in place to assure that the facility has reviewed a PASRR and determined if a potential resident was acceptable for admission into this facility. <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses to include Major Depressive Disorder. Resident 5 admitted to the facility on Sertraline, an anti-depressant medication. A Level 1 PASRR (a screening to determine if a resident may have a SMI/ID related condition and if positive a Level II PASRR is required), dated 09/01/2023 showed Resident 5 had no mood disorders (depressive or bipolar) on preadmission. Review of Resident 5's clinical record showed there were no other PASRR assessments, or any conducted at the facility. In an interview on 08/29/2024 at 1:00 PM, Staff B, Director of Nursing acknowledged the PASRR error and said Staff Q, Social Services could speak more to the specifics. In an interview on 08/30/2024 at 9:03 AM, Staff O, stated that Resident 5's PASRR was incorrect. Staff O said they talked to the PASRR evaluator and started to do a revision on Resident 5's PASRR but did not follow through with the paperwork. 44110 <RESIDENT 47> Resident 47 admitted to the facility on [DATE] with diagnoses to include depression. The admission Minimum Data Set (MDS - an assessment tool) assessment, dated 08/06/2024 showed the resident had intact cognition, and was prescribed an antidepressant. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 47's medical record showed, a Level 1 PASRR, dated 07/30/2024, under section four services needs and assessor date (required section to be completed) was left blank and incomplete. Review of Resident 47's medical record on 08/27/2024 showed no other PASRR assessment was conducted at the facility. In an interview on 08/28/2024 at 11:48 AM, Staff O stated that prior to admission the clinical team will review the admission paperwork to ensure everything was accurate. Staff O stated the clinical team consists of the unit nurse manager, the admission coordinator, the Director of Nursing Services and them. Staff O confirmed that prior to admission the PASRR must be completed, and accurate. Staff O confirmed that Resident 47 was admitted to the facility with an incomplete PASRR. Refer to WAC 388-97-1915(1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview, observation and record review the facility failed to develop a comprehensive care plan for 1 of 2 sampled residents (Resident 6) reviewed for comprehensive care planning. Failure to ensure person centered care plans were developed and implemented placed residents at risk for unmet care needs and diminished quality of life. Findings included Resident 6 was admitted to the facility on [DATE] with diagnoses that included Congestive Heart Failure (CHF- a chronic condition in which the heart doesn't pump blood as well as it should), Chronic Obstructive Pulmonary Disease (COPD - a group of diseases that block airflow and make it difficult to breath), Diabetes Mellitus Type 2 (a disease that occurs when your blood sugar is too high), Cataract (clouding of the normally clear lens of the eye), displacement of intraocular lens (a lens implanted in the eye usually as part of a treatment for cataracts). According to the admission Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], the resident was cognitively intact. In an interview and observation on 08/27/2024 at 10:55 AM, Resident 6 stated they had limited vision and could only read large prints. Observed a printed menu on the resident's table and according to the resident they could not read the paper. Resident 6 stated staff brings in the menus and they just eat whatever the facility serves them. Resident 6 stated they were not aware that they had meal options. In an interview on 08/27/2024 at 11:25 AM, Staff M, Licensed Practical Nurse (LPN) stated that they did not know that Resident 6 had limited vision. They stated that if they knew that a resident had limited vision, they would make sure to accommodate their needs such as, making sure to describe what they are doing prior to providing care. Staff M stated Resident 6 had not complained about not being able to see. In an observation on 08/27/2024 at 11:35 AM, Staff N, Dietary Staff, was observed reading the menu for Resident 6 and they choose what they wanted to eat for lunch and dinner. Review of Admission MDS assessment dated [DATE] showed that Resident 6 had impaired vision and needed eyeglasses. Review of the Care Area Assessment (CAA - are triggered responses to items coded on the MDS specific to resident's possible problems, needs or strengths), showed the resident had vision impairment and may need documents /labels to be large print and/or read out loud. Review of the current care plan on 08/27/2024 showed the care plan did not address Resident 6's vision issues, goals or interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/28/2024 pm 12:48 PM, Staff O, LPN/MDS Coordinator, stated that their process when completing MDS's included gathering information by reviewing resident records, admission assessments, interview staff and/or the resident. Staff O stated the admission nurse was the staff responsible for initiating the care plan and if something triggered in the MDS then they would add those issues to the care plan. Staff O was unable to provide any information as to why Resident 6's care plan did not include information regarding their visual impairments, when there was documentation regarding vision in the CAA. Refer to WAC-388-97-1020(1)(2)(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview, and record review, the facility failed to ensure resident-centered care and treatment was provided in accordance with professional standards of practice when the facility failed to ensure consistent communication and collaboration of care occurred between the facility and hospice care for 1 of 2 resident's (Resident 29) reviewed for hospice services. The facility failed to ensure the management of a high-risk medication (anticoagulant used to regulate how much the blood clots), including when to test for appropriate dose of the medication were communicated appropriately between the facility provider and the hospice provider. The facility failed to ensure the comprehensive care plan was revised and updated consistent with the residents' goals and choices for end-of-life care. This failure placed residents at risk for not receiving necessary comfort care services, unmet care needs, and a diminished quality of life. Findings included . Review of the facility contract with Glacier Peak Healthcare, Inc. Alpha Home Health & Hospice dated 07/27/2021, and signed on 09/01/2023 states the hospice provider and facility will notify the other promptly with any changes. Hospice provider will develop the plan of care and coordinate that with the facility for implementation into the care plan. Physician orders will be communicated promptly with the facility between hospice provider and in the event the hospice provider was unavailable the facility provider may issue orders to direct care. Review of the facility policy titled, Coumadin (anticoagulant medication) Policy and Procedure, revised August 2024 states the facility will monitor residents who receive coumadin therapy per provider orders, Prothrombin time (PT)/ international normalized ratio (INR) (blood test to measure how fast the blood was clotting) will be monitored by the provider. Any new order or dose changes facility was to obtain order and document including dose, frequency, and next time to check the PT/INR. Facility was directed to document in the medical record, in the coumadin binder, and place on alert charting for new dose. Resident 29 admitted to the facility on [DATE] with diagnoses to include pressure ulcers to right buttock, long term use of anticoagulants, and osteomyelitis (bone infection). The admission Minimum Data Set (MDS - an assessment tool) assessment, dated 07/05/2024 showed the resident had intact cognition, and had received anticoagulation medication therapy. Review of Resident 29's medical record on 08/26/2024 showed that the resident had been placed on hospice services on 08/06/2024. Review of Resident 29's physician orders on 08/26/2024 showed an order for warfarin (generic medication for coumadin) to give 1 milligram (mg) by mouth in the evening every Monday, Wednesday, and Friday and 2 mg my mouth in the evening every Tuesday, Thursday, Saturday, and Sunday dated 08/08/2024. The physician orders showed no order for the resident to have their PT/INR lab checked to ensure adequate dosing of the anticoagulant. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 29's care plan on 08/26/2024 showed the resident had a terminal prognosis related to serve protein calorie malnutrition dated 08/02/2024. The resident's goals had a target date of 07/17/2024 and were marked as overdue. Review of Residents 29's progress note dated 08/01/2024 at 3:32 PM, showed that the resident's anticoagulant medication was on hold for two days related to an elevated INR of 4.7. The note stated the therapeutic range should be between 2.0 - 3.0 (the higher the number the higher the risk of bleeding). The note did not indicate when the next INR check was to be completed. Review of Resident 29's hospice visit documentation dated 08/06/2024 lacked any documentation related to the residents elevated INR level on 07/30/2024. The documentation did not indicate when the residents PT/INR (blood clotting levels) lab should be checked again. Review of Resident 29's progress note dated 08/08/2024 at 11:04 AM, showed the residents INR had been checked and the level was 5.2. The note indicated a provider was notified, but did not specify whether that was hospice or the in-house facility physician. There was no other documentation in the resident's progress notes indicating the residents INR levels were being monitored. Review of Resident 29's facility provider note dated 08/08/2024 showed that the resident had an elevated INR of 5.2. The physician assistant (PA), Collateral Contact 1 (CC1) documented they would discuss treatment with the hospice nurse. Review of Resident 29's medical record for 08/08/2024 through 08/26/2024, showed no further documentation related to the management, dosing, or monitoring of the anticoagulant for the resident. Review of Resident 29's electronic medication administration record (EMAR) on 08/27/2024 showed that the resident had received 2mg of coumadin daily 08/01/2024 - 08/06/2024, 1mg was given on 08/07/2024, and on 08/08/2024 and 08/09/2024 the medication was held. On 08/10/2024 - 08/26/2024 2 mg was given every Tuesday, Thursday, Saturday, and Sunday and 1mg given every Monday, Wednesday and Friday. Review of facility document titled, Coumadin PT/INR Flow Sheet, showed the last entry for Resident 29 was a PT/INR checked on 7/30/2024 with a result of 4.7, and the next check would be on 8/1/2024. The note stated to hold medication for two days and restart the medication after the next check was completed. In an interview on 08/28/2024 at 8:17 AM, Staff K, Registered Nurse (RN) confirmed that Resident 29 was currently receiving an anticoagulant medication daily. Staff K stated they were not clear as to why a resident that was on end-of-life services was taking an anticoagulant that required frequent blood check monitoring. Staff K reviewed the residents medical record and confirmed there was no order to monitor the resident blood clotting levels. Staff K stated the there was a machine in the facility that was able to read INR levels, licensed staff had the ability to prick the finger of a resident, obtain a blood sample and check the INR levels within a few minutes in the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/28/2024 at 8:31 AM, Staff J, RN/Patient Care Coordinator (PCC) confirmed that Resident 29 was currently taking an anticoagulant. Staff J stated that the INR check frequency was driven by the hospice provider. Staff J stated that the hospice nurse was in the facility every Monday, Wednesday and Friday and that their documentation should be scanned into the medical record. Staff J confirmed there was no documentation from hospice in the medical record addressing the monitoring and management of the resident's anticoagulant medication after 08/08/2024. Staff J stated they would reach out to hospice to review. In an interview on 08/28/2024 at 8:35 AM, Staff R, Medical Records confirmed all the documentation they had received from hospice had been scanned into Resident 29's medical record. Staff R stated they had recently given the hospice nurse access to directly chart into the electronic medical record, and confirmed there was no documentation from the hospice nurse in Residents 29's medical record. In an interview on 08/28/2024 at 8:40 AM, Staff J stated they had located some hospice notes for Resident 29, that were on the fax machine. Staff J stated they needed to review the notes prior to medical records scanning them into the record. Staff J stated they were not able to locate when the last time Resident 29 had their INR checked, and confirmed the resident was currently on an antibiotic that could increase the resident's risk for adverse effects such as bleeding. In a follow-up interview at 10:13 AM, Staff J stated the hospice nurse and facility PA would be in this afternoon to assess the resident. In an interview on 08/28/2024 at 11:19 AM, Staff J stated they had obtained a physician order to check the residents INR. Staff J was not clear as to why there had been no monitoring of Resident 29's INR since 08/08/2024. Staff J stated the expectation was the staff were entering a PT/INR progress note in the resident's medical record as well as completing the coumadin flow sheet in the binder at the nurse's station every time the INR was checked and there was a change in the medication dosage. Staff J stated they believed the facility PA had deferred the coumadin management to hospice. In an interview on 08/28/2024 at 12:44 PM, CC1, PA stated they will default to the secondary backup provider when a resident goes on hospice at the facility. CC1 stated when Resident 29 went on hospice they did a hand off with the hospice nurse (CC2, RN). CC1 stated they recalled the resident had an elevated INR of 5.2 and had discussed with CC2 about possible discontinuation of the anticoagulant at that time. CC1 stated that CC2 told them they would discuss that issue with the hospice physician. CC1 stated it appeared that hospice may have not followed up on the anticoagulant medication or elevated INR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/28/2024 at 1:04 PM, CC2, RN for contracted Hospice provider stated Resident 29 had started on hospice services with their company on 08/06/2024. CC2 confirmed they are in the facility three times a week to see residents receiving hospice services. CC2 stated when they took responsibility of care over for Resident 29, the physician had discontinued some medications. CC2 stated that they believed the physician had discussed the anticoagulant yesterday (08/27/2024) in their meeting with possibly discontinuing the medication. CC2 stated they were recently (08/16/2024) given direct access to the EMAR system so they could document care provided, and orders with the facility. CC2 stated they had not yet used the EMAR system at the facility. CC2 stated they document all orders and care provided in their internal system, and stated the facility did not have access to that information. CC2 was asked how they communicate and coordinate care of the residents to the facility, CC2 stated I believe some of the notes are faxed to the facility. CC2 was asked when they had discussed the management, dosing and monitoring of the anticoagulant with the facility since the 08/08/2024 reading of 5.2, CC2 stated they discussed with CC1, PA today about discontinuation of the medication. CC2 was unable to provide any documentation that the contracted hospice provider and the facility had coordinated and communicated on the care of Resident 29 for the management of their anticoagulant. In an interview on 08/29/2024 at 11:15 AM, Staff J, RN/PCC stated the designated hospice care coordinator was the nurse manager for each floor, they were responsible for communicating care for Resident 29. Staff J stated they usually speak to the hospice nurse 1 - 3 times a week. Staff J stated their documentation was faxed over to the facility and was aware that they were recently given access to document directly into the EMAR system. Staff J stated they were out of facility on vacation during the first two weeks Resident 29 was on hospice services and was not sure who had been responsible in their absence. In an interview on 08/29/2024 at 12:33 PM, Staff B, Director of Nursing Services confirmed the nurse manager for each unit was the designated staff member to communicate and coordinate care with hospice. Staff B stated the contracted hospice provider was faxing their communication to the facility, the nurse managers would review for any new orders, then pass on to medical records for scanning into the medical record. Staff B stated Resident 29's contracted hospice provider would now start documenting directly into the EMAR system. Staff B stated their expectation was that after each visit they would have that documentation within 24 hours. Staff B was not aware there was a lack of communication between the contracted hospice provider and the facility. Staff B stated their expectation for anticoagulation therapy was licensed staff were to check orders for INR testing, complete the testing as ordered, document any results and changes in the medical record and on the flow sheet. Staff B stated for Resident 29 it was their understanding that the facility had deferred care to hospice, and the facility never received any other orders after 08/08/2024. Staff B stated when it was identified they addressed it, Staff B confirmed it was not identified until 08/28/2024. Refer to WAC 388-97-1060(1)(3)(k)(i)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview, and record review the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 2 residents (Resident 29) reviewed for hospice services. The failure to ensure medications were acquired and administered as ordered, and follow facility processes for medications not available, placed residents at risk for adverse events related to missed medications. Findings included . Review of the facility policy titled, Ordering and Receiving Non-Controlled Medications, dated January/2023 states all medications should be reordered in advance. All medications orders must be communicated to the pharmacy timely to provide the correct quantity. Resident 29 admitted to the facility on [DATE] with diagnoses to include major depressive disorder, and insomnia. The admission Minimum Data Set (MDS - an assessment tool) assessment, dated 07/05/2024 showed the resident had intact cognition. Review of Resident 29's physician orders showed an order for Trazadone HCL (antidepressant medication) 100 milligrams (mg), give 200 mg by mouth at bedtime for depression as evidence by poor sleep habits. Review of Resident 29's electronic medication administration record (EMAR) for August/2024 showed on 08/11/2024, 08/12/2024, 08/14/2024, 08/20/2024, 08/21/2024, 08/25/2024, and 08/26/2024 the documentation reflected a 9 which indicated the medication was not given as ordered and to see progress notes. Review of Resident 29's progress notes showed the licensed staff documented the following: - 08/11/2024 - trazadone not given, medication not available, - 08/12/2024 - trazadone not given, medication not available, - 08/14/2024 - trazadone not given, medication not available, - 08/20/2024 - trazadone not given, waiting for delivery, - 08/21/2024 - trazadone not given, medication not available, - 08/25/2024 - trazadone not given, medication not available, - 08/26/2024 - trazadone not given, medication not available. There was no documentation that the physician or pharmacy had been notified, or that the resident was assessed for depression related to lack of medication being administered as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/26/2024 at 12:56 PM, Resident 29 stated they were very tired as they had not been able to sleep. Resident 29 stated the nurse had not been able to give them their antidepressant that they take at night because they did not have the medication available. In an interview on 08/27/2024 at 8:30 AM, Resident 29 stated they did not sleep well the last few nights as they were told the facility was still out of the medication they take at bedtime. Resident 29 stated they did not know why the facility was out of the medication. In an interview on 08/28/2024 at 12:44 PM, CC1, Physician Assistant stated they will default to the secondary backup provider when a resident goes on hospice at the facility. CC1 stated when Resident 29 went on hospice they did a hand off with the hospice nurse (CC2, Registered Nurse [RN]). CC1 was unaware the resident had not received their antidepressant as the physician had prescribed. In an interview on 08/28/2024 at 1:04 PM, CC2, Hospice RN stated Resident 29 had started on hospice services with their company on 08/06/2024. CC2 confirmed they are in the facility three times a week to see residents receiving hospice services. CC2 stated they had not been notified Resident 29 had not received their antidepressant medication until today. CC2 stated they was a problem with the amount ordered per the pharmacy and they would get it corrected. In an interview on 08/29/2024 at 11:15 AM, Staff J, RN/Patient Care Coordinator (PCC) stated the designated hospice care coordinator was the nurse manager for each floor, and they were responsible for communicating care for Resident 29. Staff J stated if a medication was unavailable the licensed staff should contact the pharmacy to see why, they should be notifying the physician, request any new orders and place the resident on alert charting to monitor. Staff J stated they were unaware Resident 29 was out of their antidepressant until yesterday (08/28/2024), there was a discrepancy with the prescription, and they updated the order yesterday with hospice. Staff J stated they were not clear as to why there had been no follow-up for the missing medication. In an interview on 08/29/2024 at 12:33 PM, Staff B, Director of Nursing Services stated the expectation for all licensed staff was if a medication was unavailable and not in the automated medication dispensing system (PYXIS), the staff were to notify the provider, and obtain a new order or replacement if possible. Staff B confirmed Resident 29's medication was not in the PYXIS and it was not clear as to why nothing had been done to get the missing medication for Resident 29. Refer to WAC 388-97-1300(1)(a)(b)(i)(ii)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review, the facility failed to ensure 1 of 5 Residents (Resident 22) reviewed for unnecessary medications were free from unnecessary psychotropic medications. Facility staff failed to identify/monitor target behaviors for antipsychotic medication and attempt a Gradual Dose Reduction (GDR) for an Antipsychotic medication. These failures placed residents at risk to receive unnecessary psychotropic medications and experience adverse side effects. Findings included . Resident 22 readmitted to the facility on [DATE] with diagnoses to include dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). According to the Quarterly Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], the resident was rarely or never understood due to severely impaired cognition, exhibited no hallucinations or delusions, exhibited physical behaviors such as grabbing, hitting 1 to 3 days in the reference period. Resident 22 was admitted on hospice services on 07/26/2024. Review of Resident 22's physician's orders dated 06/22/2024 showed an order for Risperdal, (an antipsychotic medication for treatment of psychosis) twice a day for dementia with behavior issues . Review of a June 2024 pharmacy form showed a recommendation was given for a GDR of Risperdal which was signed by the provider on 06/13/2024 documenting, OK to GDR. As of 08/26/2024, a GDR had not been done. Review of Resident 22's physician's orders dated 07/26/2024 showed the addition of a second antipsychotic medication, Quetiapine Fumarate 25 MG, give 1 tablet by mouth every 4 hours as needed for anxiety/agitation Related to dementia with behavioral disturbance. This medication order had been active greater than 14 days although it had not been documented as administered. In an interview on 08/28/2024 at 12:31 PM, Staff S, Registered Nurse, Resident Care Manager, stated Resident 22 tended to grab people. Staff S stated Resident 22 had no hallucinations or delusions that they were aware of, and the Seroquel was added because Resident 22 had scratched or grabbed a hospice aid, and needed something to Calm down. Staff S stated they were supposed to call hospice first before they started the Seroquel, so it was available but had not been used yet. Review of the resident's Medication Administration Records (MAR) on 08/26/2024 showed no psychotic behavior monitoring was in place for antipsychotic medications. Resident 22's behavior monitors were related to dementia behaviors such as grabbing, resisting care, agitation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/29/2024 at 12:24 PM, Staff B, Director of Nursing Services, stated the facility team met to discuss residents' psychotropic medications monthly as well as reviewing the pharmacy recommendations. Staff B stated Resident 22 had notes showing behaviors such as sadness, anger, social isolation, depressed mood and agitation but did not have further information regarding the specific behaviors or diagnosis which supported the use of antipsychotics for Resident 22 and acknowledged that the monitoring did not include psychosis specific target behaviors. Staff B acknowledged that dementia was not an approved diagnosis for antipsychotic medications. Staff B did not recall discussions regarding the reason there had not been a GDR for Resident 22's antipsychotic in June. In an interview on 08/30/2024 at 8:59 AM, Staff Q, Social Services, stated Resident 22 was a long-term resident since 2016 who initially admitted with other inappropriate behaviors which may no longer be relevant due to their dementia progression. Staff Q stated that was likely where the psychosis behavior had originated from. Staff Q stated the only current behaviors were the involuntary responses while giving care (the grabbing and hitting during cares.) Staff Q stated that Resident 22 admitted to hospice and the goal is comfort and to get the resident off antipsychotics. Refer to WAC 388-97-1060(3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42927 Based on observation, interview and record review, the facility failed to ensure 2 of 3 medication carts (Carts 3 and 4) and 1 of 1 medication rooms (first floor medication room) had unexpired medications and/or biologicals and medications were stored at the proper temperature. These failures placed residents at risk of receiving compromised medications and biologicals. Findings included . Review of a facility policy titled, Medication Storage in the Facility, dated 03/30/2023, showed: Outdated medications were to be removed from inventory; Facility should maintain a temperature log in storage area and record temperatures at least once a day; If vaccines are stored in the refrigerator the temperature should be checked at least two times a day.; When the original seal of a multidose vial is broken, the container will be dated; Expiration date of a vial will be 30 days once opened. <CART 4> During an observation on 08/28/2024 at 9:42 AM, Medication cart 4 was reviewed with Staff M, Licensed Practical Nurse (LPN). An opened bottle of acidophilus probiotic was in the top drawer of the cart. The label showed refrigerate after opening. In addition, there was a box of glucometer (meter to check sugar level in the blood) control solution which contained level 1 solution with an expiration date of 06-13-2024 and level 2 solution that expired 05-27-2024. During an interview on 08/28/2024 at 10:03 AM, Staff M stated the bottle of acidophilus probiotic was in the cart when they arrived, and it had not been stored in the refrigerator as the label showed. Staff M stated that the glucometer control solution was no longer good as the bottles were expired. <CART 3> During an observation and interview on 08/28/2024 at 10:12 AM, Medication cart 3 was reviewed with Staff K, Registered Nurse (RN). A bottle of calcium polycarbophil was found in the cart. The label showed an expiration date of 05/2024. Staff K stated the medication was no longer good as it had expired and would remove it from the cart. <FIRST FLOOR MEDICATION ROOM> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 08/29/2024 at 10:02 AM, the contents of the refrigerator in the first-floor medication room were reviewed. Inside the refrigerator were several vaccines. There were two individual dose vials of Flucelvax quad (influenza) vaccine, a vial of Prevnar 20 (pneumonia vaccine) and a multidose vial of Flucelvax quad. The multidose vial of Flucelvax quad vaccine was dispensed on 11/17/2023. The vial was open, but it was not dated when it was opened, and the label showed an expiration date of 06/16/2024. There was also an open vial of tubersol (solution to test for tuberculosis) that was not dated to show when it had been opened. Affixed to the front of the refrigerator were the temperature logs for August 2024 and July 2024. The temperature log showed that temperatures should be done twice a day but had several missing entries: August 2024 log (from August 1st- [DATE]th) showed missing 14 of 56 entries (2nd- PM, 3rd-PM, 12th- AM and PM, 13th- AM and PM, 14th- AM, 17th-PM, 18th-PM, 19th-PM, 20th-PM, 25th-PM, 26th-PM, and 27th-PM). July 2024 log showed missing 23 of 62 entries (2nd- AM and PM, 5th - AM, 7th - PM, 8th - PM, 9th- PM, 12th- AM and PM, 13th-PM, 14th- AM, 15th- AM and PM, 16th- AM and PM, 17th- AM, 21st- PM, 22nd- PM, 23rd- PM, 25th- AM, 27th-AM, 28th- PM, 30th- PM, and 31st- PM). During an interview on 08/29/2024 at 10:12 AM, Staff J, Patient Care Coordinator/RN, stated they could not find an open date on either the multidose vial of Flucelvax quad or the vial of tubersol. Staff J stated the Flucelvax quad vaccine also was expired so they would discard those vials. Staff J stated the nursing staff were supposed to check the refrigerator temperature in the morning and evening, but it did not look like they had been checking it twice a day. Refer to WAC 388-97-1300 (2)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. 42927 Based on observation, interview, and record review, the facility failed to ensure residents with physical impairment and/or swallowing difficulty were fed by staff that were properly trained for 1 of 2 staff (Staff L) observed providing feeding assistance to residents in the second-floor assisted dining room. This failure placed residents at risk of choking and aspiration (inhalation of food or fluid into the lungs) and a diminished quality of life. Findings included . During the entrance conference meeting on 08/26/2024 at 11:20 AM, Staff A, Administrator, and Staff B, Director of Nursing Services, stated they did not have paid feeding assistants in the facility. During an observation on 08/28/2024 during the breakfast meal, six residents were sitting at individual tables. One staff member was present assisting residents. At 8:22 AM, Staff L, Activities Manager, entered the dining room and sat beside Resident 22. Staff L was observed giving Resident 22 several bites of food and drinks of a beverage. Review of Resident 22's care plan, print date 08/28/2024, showed the resident required assistance of 1 staff for eating, had a swallowing problem and was on a minced (cut up or ground up) and moist texture diet. On 08/28/2024, Review of the Washington State provider credential search for healthcare workers showed Staff L did not have any type of nursing license. During an interview on 08/28/2024 at 8:41 AM, Staff B confirmed that the facility did not use paid feeding assistants. During an interview on 08/28/2024 at 8:56 AM, Staff L stated they did not have a nursing assistant or nurse's license. Staff L stated they had not received specialized training to provide feeding assistance to residents. During an interview on 08/29/2024 at 11:05 AM, Staff B stated non nursing staff could pass trays and hand residents items from their tray, but non nursing staff should not be providing feeding assistance to residents. Refer to WAC 388-97-1060

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 33954 Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in 1 of 1 facility kitchens, 1 of 2 dining rooms (1st floor) and 2 of 2 nourishment refrigerators (1st and 2nd floors). The facility failed to ensure the dishwashing machine maintained adequate hot water temperature, to ensure the kitchen and dining room ceilings were free of dust and lint, to ensure the nourishment refrigerators were clean and sanitary, to ensure food preparation equipment surfaces were sanitary, and to ensure overhead light fixtures were sanitary and in good repair. These failed practices placed residents at risk for foodborne illnesses. Findings included . In an observation on 08/27/2024 at 9:50 AM, the 2nd floor nourishment room refrigerator and freezer were observed to have sticky residue and scattered food/debris, and the freezer had approximately 1/2 inch of ice on the walls and upper and lower surfaces. In an observation on 08/27/2024 at 10:02 AM, the 1st floor nourishment room refrigerator and freezer units were soiled with food residue and the refrigerator had a layer of frozen water on the bottom surface of the refrigerator. The overhead light fixture in the nourishment room was broken and was observed to have many dead insects. In an interview on 08/27/2024 at 10:02 AM, Staff D, Housekeeper, stated housekeeping was supposed to clean the nourishment room counters, cupboards and refrigerator every morning and maintenance was responsible for defrosting the freezer. Review of the Low Temperature Dish Machine Log showed the minimum acceptable wash cycle temperature was 120 degrees Fahrenheit (F). Unacceptable low temperatures were logged at lunch on 08/17/2024 (115F), 08/23/2024 (119F), 08/24/2024 (116F), 08/25/2024 (119F), 08/26/2024 (119F), and Breakfast on 08/21/2024 (115F) and 08/22/2024 (118F). In an observation and interview on 08/27/2024 at 10:43 AM, the dishwashing machine wash cycle temperature was observed to be 115F, Staff C, dietary manager, stated the machine needed to be warmed up, and they restarted another load, and the temperature was observed to be 124F for the wash cycle. In observations on 08/27/2024 from 11:02 AM to 11:06 AM, the dishwashing machine wash cycle temperatures ranged from 103 - 118 degrees F. In an observation/interview on 08/27/2024 at 11:13 AM, the kitchen ceiling in the food preparation area had lint blowing back and forth from the air coming out of the ceiling air conditioner. The flooring in front of the dishwashing area was missing approximately 6 feet by 8 feet of linoleum, Staff C stated they had plans to replace the kitchen flooring, but they were uncertain of the replacement dates. The food preparation shelving under the kitchen overhead air conditioning vents had a layer of dust and debris. The coffee maker in the kitchen had a layer of dust and coffee grounds. Several overhead light fixtures in the kitchen food preparation area had dead insects. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In observations on 08/28/2024 from 12:47 PM to 1:39 PM, the dishwashing machine wash cycle temperatures varied from 111F - 127F. In an observation on 08/28/2024 at 1:46 PM, Staff C was observed assisting dishwashing staff to set up the sinks for manual washing of dishes. In an interview on 08/29/2024 at 10:30 AM, Staff F, Corporate Operations, stated they had scheduled the kitchen flooring to be replaced after they had completed repairs of other parts of the building. In an observation on 08/29/2024 at 10:35 AM, the first-floor dining room ceiling had four overhead vents that were surrounded by ceiling tiles that had a build-up of lint and dust in approximately two to three feet in all directions around the vents. In an observation on 08/29/2024 at 10:40 AM, Staff G, Environmental Services Manager, stated they were not sure who was responsible for cleaning the ceiling around the overhead vents, but they would take the hit and make sure it got cleaned. In an interview on 08/29/2024 at 12:45 PM, Staff E, Corporate Operations, stated they had the dishwashing machine repair company come out and they changed the settings on the dishwashing machine, and they think the dishwashing machine temperature issue had been fixed. Staff E stated they were looking at getting a different dishwashing machine to replace their current machine. Refer to WAC 388-97-1100 (3) and -2980 51312

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview and record review, the facility failed to ensure staff followed procedures to prevent the spread of disease for 2 of 3 rooms (room [ROOM NUMBER] and 216) reviewed for Transmission Based Precautions (TBP) and failure to store respiratory equipment in sanitary conditions for 1 of 2 residents (Resident 252) reviewed for respiratory care. Failure of staff to follow appropriate use of Personal Protective Equipment (PPE), perform hand hygiene consistently and properly store respiratory equipment, placed residents and staff at risk of transmitting a communicable disease and a decreased quality of life. Findings included . Review of facility policy titled Enhance Barrier Precautions review date 03/22/2024, defined Enhanced Barrier Precautions (EBP) as the use of gown and gloves for use during high-contact resident care activities. High-contact resident care activities included dressing, changing linens, changing briefs, and wound care. Review of the facility policy titled Nebulizer - Administering Medications through a Small Volume (Handheld) Nebulizer, review date 08/28/2024, stated when treatment is complete: Disconnect T-Piece, mouthpiece and medication cup. Wash pieces with warm, soapy water daily. Allow to air dry completely on paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and date on it. Review of a Washington State Hospital Association sign, titled, Contact Precautions, dated 04/16/2019, showed: Everyone must clean hands when entering and leaving room Everyone must wear gown and gloves Clean and disinfect equipment prior to removing from room <room [ROOM NUMBER]> In an observation on 08/26/2024 at 9:30AM, an Enhanced Barrier Precaution sign was seen on top of a cart that contained PPE, next to the sink in room [ROOM NUMBER]. Resident 252 was the only resident currently residing in the room. Review of Resident 252's current care plan, on 08/27/2024, showed they were on EBP. (continued on next page)

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View Ridge Care Center	5129 Hilltop Road Everett, WA 98203

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 08/27/2024 at 2:57 PM, Staff P, Registered Nurse, was observed applying gloves upon entering the room [ROOM NUMBER] but did not put on a gown. Staff P was observed to perform a dressing change to Resident 252's legs. In an interview on 08/24/2024, at 3:15 PM, Staff P, stated they did not wear a gown while performing the dressing change because they were not aware that resident 252 was on EBP. In an interview on 08/29/2024 at 11:24 AM, Staff H, Licensed Practical Nurse (LPN)/Infection Preventionist Nurse stated that Resident 252 was on EBP. Surveyor informed Staff H that Staff P had performed wound care and dressing change without wearing a gown. Staff H stated Staff P was new to the facility. <Respiratory Equipment> In an observation on 08/26/2024 at 12:28 PM, Resident 252's breathing treatment equipment and facemask, medication cup and tubing was on top of a gray basin on the bedside table, uncovered. Inside the basin were eyeglasses, recharger, deodorant and a Ziplock bag with hairbrush and mirror inside. In an observation on 08/27/2024 at 12:16 PM, Resident 252's breathing treatment equipment were on top of the gray basin at the bedside table not covered. In an observation on 08/28/2024 at 08:10 AM, Resident 252's breathing treatment equipment were on top of the gray basin at the bedside table not covered. In an interview on 08/29/2024 at 08:56 AM, Staff K, LPN, stated the nurse should disconnect the mouth piece and medication cup, wash with warm, soapy water, air dry and place in plastic bag with the date. 42927 <room [ROOM NUMBER]> During an observation on 08/26/2024 at 12:30 PM, Staff I, Maintenance Supervisor, was noted standing outside room [ROOM NUMBER] with a large metal cart. At the doorway of room [ROOM NUMBER] was an orange sign from the Washington State Hospital Association that showed the room had contact precautions. There was a plastic three drawer bin outside the doorway, stocked with N95 respirators (specialized face mask that filters 95% of particles), disposable gowns, gloves, and disinfectant. Staff I was observed to apply a N95 respirator and gloves. Staff I entered room [ROOM NUMBER] with the metal cart. Staff I did not perform hand hygiene prior to putting on the N95 respirator or gloves and did not apply a gown before entering the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff I was observed removing the phone from the nightstand and putting it on top of the metal cart while they installed new batteries. Staff I then removed their gloves and N95 respirator, picked up the phone and brought it to the room across the hall, tried the phone in the phone jack, and then returned to room [ROOM NUMBER]. Staff I did not perform hand hygiene after they removed the N95 respirator and gloves or before they entered the room across the hall. Staff I did perform hand hygiene and reapplied gloves prior to reentering room [ROOM NUMBER] but did not apply a gown. Staff I returned the phone to the nightstand, removed their gloves and exited the room with the metal cart. Staff I performed hand hygiene when exiting the room but did not disinfect the metal cart that they had touched inside the room with contaminated gloves. During an observation and interview on 08/26/2024 at 12:47 PM, Staff I reviewed the contact precaution sign with surveyor outside of room [ROOM NUMBER]. Staff I stated the sign meant the resident in room [ROOM NUMBER] had an infection or Covid (respiratory illness caused by a virus that is spread through the air). Staff I stated they did not wear a gown when they were in the room because they were not aware it was needed. Staff I stated that they did not do hand hygiene or disinfect the metal cart because they did not realize it was that type of precaution room. During an interview on 08/29/2024 at 12:45 PM, Staff H, stated everyone that enters a room that had contact precautions was to wear a gown and gloves, regardless of what the person would be doing in the room. Staff H stated staff were to perform hand hygiene after removing gloves and before entering another room. Staff H stated any equipment brought into a room with contact precautions should not be removed from the room unless it was sanitized. Refer to WAC 388-97-1320 (1)(a)(c), (5)(e)