STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505367	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Springs Care and Rehabilitation	4007 Tieton Drive Yakima, WA 98908

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on interview and record review, the facility failed to ensure funds were reimbursed to the State Office of Financial Recovery (OFR), within 30 days of a resident's discharge or death, for 4 of 4 residents (Residents 252, 253, 254, and 255), reviewed for personal funds. This failure placed the state department at risk for loss of funds and interest accumulated. Findings included . Review of the undated policy titled, Resident Trust Funds, showed within 30 days of death of the resident, the facility would return the resident's personal funds. If the resident received long-term care services paid by the department, the personal funds would be sent to the Office of Financial Recovery. <Resident 252> Review of Resident 252's medical record showed they were admitted to the facility on [DATE] and passed away on 06/08/2024. The resident had $100.08 personal funds remaining in their trust account. Review of Resident 252's trust account showed the balance of $100.08 had not been returned to the Office of financial Recovery, (OFR) within 30 days of the resident's death as required. Additional review of the account showed the check for $100.08 was returned to the OFR on 08/21/2024, 44 days after the required conveyance of funds timeframe. <Resident 253> Review of Resident 253's medical record showed they were admitted to the facility on [DATE] and passed away on 05/12/2024. The resident had $40.33 personal funds remaining in their facility held trust account. Review of Resident 253's trust account showed the balance of $40.33 had not been returned to the OFR within 30 days of the resident's death as required. Additional review of the account showed a check for $40. 33 was returned to the OFR on 08/21/2024, 71 days after the required conveyance of funds timeframe. <Resident 254> (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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 254's medical record showed they were admitted to the facility on [DATE] and passed away on 02/17/2024. The resident had $70.79 personal funds remaining in their facility held trust account. Review of Resident 254's trust account showed the balance of $70.79 had not been returned to the OFR within 30 days of the resident's death as required. Additional review of the account showed a check for $70. 79 was returned on 04/18/2024, 31 days after the required conveyance of funds timeframe. <Resident 255> Review of Resident 255's medical record showed they were admitted to the facility on [DATE] and passed away on 05/17/2024. The resident had $1678.83 personal funds remaining in their facility held trust account. Review of Resident 255's trust account showed the balance of $1678.83 had not been returned to the OFR within 30 days of the resident's death as required. Additional review of the account showed a check for $1678.83 was returned to the OFR on 08/21/2024, 66 days after the required conveyance of funds timeframe. During an interview on 09/06/2024 at 9:43 AM, Staff F, Business Office Manager, stated the process was to return remaining funds in resident accounts within 30 days to the OFR upon a resident's death and these refunds should not have been delayed. Reference: WAC 388-97-0340(5)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of hospital transfer for 2 of 3 residents (Residents 7 and 9) reviewed for hospital transfers. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold while in the hospital. Findings included . Review of the policy titled, Bed Hold Policy Notification 2024, updated 01/11/2024, showed residents were able to retain their bed when they were discharged to the hospital or on a therapeutic leave. The resident and/or their representative must sign and return the Bed Hold Policy Notification 2024 form to the business office within 24 hours of receipt of the form if they chose to retain their bed. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory disease and depression. The 07/01/2024 comprehensive assessment showed Resident 7 required substantial assist of two staff members for activities of daily living (ADLs) and was cognitively intact. Further review of the medical record showed Resident 7 was transferred to the hospital on 08/02/2024. There was no notice of a bed hold in the medical record. During an interview on 09/10/2024 at 10:52 AM, Resident 7 stated the facility did not give them a bed hold policy to review when they transferred to the hospital to sign. <Resident 9> Review of the medical record showed Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including a stroke, respiratory disease and heart disease. The 06/15/2024 comprehensive assessment showed Resident 9 required substantial assist of one to two staff members for ADLs and had difficulty making decisions regarding daily care needs. Review of the medical record showed Resident 9 was transferred to the hospital on 06/05/2024 and the resident's power of attorney was notified of the transfer though there was no notice of a bed hold in the medical record. During an interview on 09/09/2024 at 10:11 AM, Staff B, Director of Nursing Services, stated that if residents were transferred emergently a bed hold wasn't always completed, though one should have been completed by the resident or sent to a resident's representative within 24 hours of the transfer. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-0120(4)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on interview and record review, the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were corrected on admission, had the required level 2 referral sent if residents had a positive Level 1 PASARR nor corrected/updated resident PASARR as needed for 4 of 9 residents (Resident 21, 27, 47 and 49) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR or PASRR) Level 1 Screening Process, dated 07/06/2024, showed a positive level one PASARR screen (that would then require a referral for a level two PASARR) was Any of the questions in Section 1A (1, 2, and/or 3) are marked Yes: or Sufficient evidence of SMI is not available, but there is a credible suspicion that a SMI may exist; and the requirements for exempted hospital discharge do not apply . Additionally, nursing facilities will ensure residents with a positive level one PASARR screen have been evaluated by the designated state-authority through the level two PASARR process and approved for admission prior to admitting to the nursing facility. Review of the facilities undated policy titled PASARR showed all residents PASARR would be reviewed and updated as needed. <Resident 21> Review of Resident 21's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), insomnia (trouble sleeping), and anxiety (a feeling of worry, nervousness, or unease). Review of the quarterly comprehensive assessment, dated 08/02/2024, showed the resident's cognition was moderately impaired and required extensive assistance of two staff members for ADLs. Review of Resident 21's PASARR, dated 04/02/2024, showed under section I, SMI/ID had one marked yes to include the diagnosis of depression. The resident had diagnoses of anxiety disorder and insomnia that were not included. No evidence of a Level 2 referral was sent for review in the resident's medical record. <Resident 27> Review of Resident 27's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include depression, insomnia and anxiety. Review of the quarterly comprehensive assessment, dated 06/29/2024, showed the resident's cognition was severely impaired and required extensive assistance of two staff members for ADLs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 27's PASARR, dated 06/21/2024, showed under section I, SMI/ID had one marked yes to include the diagnosis of anxiety. The resident had diagnoses of depression and insomnia that were not included. The medical record showed no documentation that a Level 2 referral was sent for review in the resident's medical record. 43280 <Resident 47> Review of the resident's medical record showed they were admitted to the facility on [DATE] with a diagnosis including heart failure and depression. Review of the 08/01/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Review of Resident 47's PASARR, dated 07/21/2024, showed that the PASARR was completed outside of the facility and no SMI had been checked even though the resident had a diagnosis of depression. <Resident 49> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnosis including bipolar disorder, anxiety, delusional disorders (a mental health condition where an individual is unable to tell what is real from what is imagined), and schizoaffective disorder (a mental illness that has schizophrenia symptoms and mood disorders symptoms). Review of the 08/16/2024 comprehensive assessment showed the resident had a severely impaired cognition and was taking a psychotropic medication for their mental health conditions. Review of Resident 49's undated PASARR, showed that SMI indicators were check marked for schizophrenia, mood disorder (like bipolar or depression) and other disorders, but was not checked for anxiety. The PASSAR section for service needs showed a Level 2 evaluation would be needed. There was no documentation of a referral sent for review in the resident's medical record. During an interview on 09/04/2024 at 11:00 AM, Staff E, Social Service Director and Staff R, Social Service Assistant, stated they did not know about a resident's PASARR until they were admitted to the facility and were unaware that any SMI marked on a resident's PASARR would have required a Level 2 evaluation prior to a resident's admission to the facility. Staff E stated they checked to make sure a resident had a completed PASARR on admission but that none of the facility's resident's PASARR had been reviewed for accuracy. Staff E stated that no Level 2 PASARR referral was sent for Resident 49, nor other residents that might have needed one sent. Staff E and Staff R stated they did not have a good process in place and would need to audit all facility resident's PASARR documents for accuracy. During an interview on 09/09/2024 at 7:38 AM, Staff B, Director of Nursing Services, stated they were unaware of the PASARR process in the facility and the SSD was responsible for PASARR review. Staff B stated the expectation would be that all regulations regarding PASARR would be followed and all Level 1 PASARR's needing a Level 2 referral should have been completed and sent for review. Reference: WAC 388-97-1975 (1)(2)(3)(4), -1915 (1)(2)(a-c)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to ensure culturally competent, trauma-informed care, related to assessing for trauma and identifying trigger-specific (a psychological stimulus that prompts recall of a previous traumatic event) interventions for residents with a history of trauma for 1 of 3 residents (Resident 14) reviewed for trauma informed care. This failed practice placed the resident at risk for unidentified triggers, re-traumatization and psychological harm. Findings included . Review of the facility's undated policy titled Trauma Informed Care Purpose, showed that social services staff were trained on screening, trauma assessment and how to identify triggers associated with re-traumatization. <Resident 14> Review of Resident 14's medical record showed the resident was admitted to the facility on [DATE] with diagnoses including insomnia (trouble sleeping) and Post Traumatic Stress Disorder [(PTSD) a mental health condition that's triggered by a terrifying event-either experiencing it or witnessing it]. The comprehensive assessment, dated 06/09/2024, showed the resident had a severely impaired cognition and required extensive assistance of two staff members for activities of daily living (ADLs). Review of Resident 14's care plan, dated 05/08/2024, showed that the resident was at risk of depression PTSD, their goal was to be free of depression. The care plan did not show trigger-specific interventions or identify Resident 14's triggers. Review of Resident 14's trauma screenings dated 02/09/2024 and 09/05/2024, showed no documented discussion of the resident's diagnosis of PTSD nor their person-centered triggers that would cause them re-traumatization. During an interview on 09/10/2024 at 9:49 AM, the Resident Representative, (RR), stated Resident 14's PTSD had resulted from their military service in the Vietnam War and the resident suffered from nightmares, night terrors, and had a lot of anger. Resident 14's physician had started medicating them with an antidepressant, which helped for a while. The RR stated as the resident aged, they had those recall moments which were horrifying for them. During an interview on 09/10/2024 at 9:19 AM, Staff E, Social Services Director, stated the trauma screening was completed on admission, quarterly, changes in condition, and on discharge. Staff E stated their process for trauma screening included interviewing or completing an assessment using trauma related questions. When residents did not open up, Staff E would reapproach in a week or more to complete the screening. Staff E stated Resident 14 said they did not have trauma or tell me anything about their trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/10/2024 at 9:32 AM, Staff B, Director of Nursing Services, stated the expectation was for staff to ensure the trauma screenings were completed timely and followed up on as needed. Reference: WAC 388-97-1060(3)(e)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent. Three medication errors were identified for 2 of 6 residents (Residents 21 and 43) observed during 25 medication administration opportunities that resulted in an error rate of 12%. The failed practice had the potential to place residents at risk for not receiving the full therapeutic effect of the medication and possible adverse side effects. Findings included . Review of the policy titled, Medication and Flexible Pass Time, dated 10/2023, showed nurses would follow the general guidelines for safe and accurate medication administration. Review of the Instructions for use (IFU) by the U.S. Food and Drug Administration (USFDA) revised 07/2023, stated to prime the insulin pen (a pre-filled disposable device containing insulin) with a new needle prior to each injection administration. To prime the insulin pen was to turn the dose knob to two units, hold pen and needle upright, tap pen slightly to remove air bubbles and push the dose knob until stopped and 0 was seen in the dose window. Priming was meant to remove air from the needle and the cartridge that may collect during usages. In addition, the IFU stated to insert the needle into the skin, press plunger all the way down, and continue to hold the plunger and slowly count to six prior to removing the needle. These steps were to ensure the insulin pen worked correctly and the proper dosage of medication was administered. <Resident 21> Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses including diabetes and dementia (a progressive disease that destroys memory and other important mental functions). The comprehensive assessment, dated 08/02/2024, showed Resident 21 required substantial/maximal assistance of one to two staff for activities of daily living (ADLs) and had a moderately impaired cognition. Review of Resident 21's physician orders, dated 04/11/2024, showed the resident's insulin was to be administered on a sliding scale based on the resident's current blood glucose result. The sliding scale showed based on a blood glucose of 251-300 mg/dl the resident was to have eight units of insulin. Resident 21's blood glucose was 262 milligrams/deciliter (mg/dl, unit of measure). An observation on 09/06/2024 at 10:57 AM, showed Staff I, Licensed Practical Nurse (LPN), administered eight units of insulin with the insulin pen to Resident 21. Staff I held the needle into the resident's lower abdomen for three seconds. <Resident 43> Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), heart disease and depression. The comprehensive assessment, dated 06/23/2024, showed Resident 43 required supervision of one staff member for ADLs and had an intact cognition. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 43's physician orders, dated 05/21/2024, showed the resident's insulin was to be administered on a sliding scale based on the resident's current blood glucose (sugar) result. The sliding scale showed based on a blood glucose of 150-199 mg/dl, (a normal blood glucose level is between 70 and 100 mg/dl) the resident was to have two units of insulin. Resident 43's blood glucose was 187 mg/dl. An observation and interview on 09/06/2024 at 11:44 AM, showed Staff H, LPN, prepared the insulin pen by attaching the disposable needle to administer the insulin. Staff H dialed the insulin pen to two units and proceeded to Resident 43's room. Staff H inserted the needle into the resident's left lower abdomen, pressed the plunger and removed the needle at three seconds. Staff H did not prime the needle of the insulin pen prior to the administration. Staff H stated the process for using an insulin pen was to dial the dose needed, administer to the resident and hold the needle in the skin for 10 seconds. Staff H further stated they were unaware of the requirement to prime the insulin needle prior to each use, and they did not count how long they held the needle into the resident's skin. An interview on 09/09/2024 at 1:05 PM, Staff B, Director of Nursing Services, stated the nurses should be priming the insulin pen for each use and leaving the needle in the resident's tissue for the required length of time to ensure the resident received the accurate dose. Reference: WAC 388-97-1060(3)(k)(ii)

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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. 46722 Based on observation, interview, and record review the facility failed to ensure medications were discarded when expired for 2 of 3 medication carts (Team 1 and Team 3). The facility also failed to ensure consistent monitoring of temperature for the medication storage refrigerator located in the medication storage room. These failures placed residents at risk for receiving expired medication and/or experiencing compromised or ineffective medications and vaccines. Findings included . Review of the policy titled, Medication Storage in the Facility, dated 07/2021, showed outdated, contaminated, or deteriorated medications are immediately removed from inventory and disposed of according to facility procedures for medication disposal. The policy also showed medications, biologicals and vaccines were stored at their required temperatures. Additionally, vaccines stored in the medication refrigerator were to be monitored twice daily per the Center for Disease Control (CDC). Review of the CDC guidance titled, Vaccine Storage and Handling, dated 04/03/2024, showed to ensure safety of vaccines, the refrigerator must have a reliable temperature monitoring device with the recommended use of a recording device called a digital date logger (DDL-a device that records temperatures at least every 30 minutes). The guidance further showed when a DDL was not used, then the facility should monitor and record the vaccine refrigerator temperature at a minimum of twice daily. <Medication Carts> During an observation and interview on 09/09/2024 at 12:17 PM, with Staff I, showed the Team 1 medication cart contained the following expired medications: Four Albuterol inhalers (medication that is inhaled to increase airflow to the lungs), expired on 04/16/2024, 06/19/2024, 07/03/2024, and 07/21/2024. Two tubes of Arthritis (joint pain) pain gel expired 06/13/2024 and 06/19/2024. Staff I, Licensed Practical Nurse, (LPN), stated nurses were to dispose of expired medications and reorder when required. During an observation and interview on 09/09/2024 at 12:53 AM, with Staff H, showed the Team 3 medication cart contained the following expired medications: Two bottles of ondansetron (anti-nausea) medication, expired on 07/28/2024 and 08/06/2024. One pack of Ipratropium (a drug taken to increase airflow to the lungs) medication, expired 08/04/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff H, LPN, stated when expired medications were found, nurses were to dispose of the expired medication in the medication storage room. <Medication Storage Room Refrigerator> During an observation and interview on 09/09/2024 at 11:03 AM, with Staff D, showed the medication storage room refrigerator contained the following vaccines: 20 vials of influenza vaccine. Eight syringes of pneumococcal vaccine. Staff D, Resident Care Manager, stated the refrigerator temperature were checked and recorded on the log sheet by the night shift nurses. Review of the documents titled, Refrigerator Temperature Chart, for the months of July 2024 through September 2024, showed an area for one time a day temperature documentation. Further review showed the facility received 10 pneumococcal vaccines on 07/22/2024 and 20 vials of influenza vaccine on 09/06/2024. Additionally, after the date the facility received the vaccine there was no documentation that twice daily temperature monitoring was being completed. During an interview on 09/09/2024 at 1:05 PM, Staff B, Director of Nursing Services, stated the medication carts should be reviewed by nurses and expired medications should be removed and taken to the medication storage room to be destroyed. Staff B stated the facility had one medication refrigerator that held medications and vaccines. Staff B stated the facility's process was the night shift nurses were to monitor, record the temperature, and record onto the log sheet. Staff B stated this process was done once a day. Reference: WAC 388-97-1300(2)

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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** 43280 Based on observation, interview and record review the facility failed to ensure staff maintained components of an infection prevention control program to prevent the development and transmission of infections with, 1) hand hygiene for 4 of 8 staff (Staff P, G, H and O) reviewed during medication administration and entering/exiting isolation precautions (a process used to reduce the transmission of infectious bacteria and organisms in the healthcare setting), 2) implementing appropriate transmission based precautions (TBP, safeguards put in place to help prevent staff and residents from spreading infectious diseases) when providing care for 2 of 3 residents (Resident 33 and 34) reviewed for standard precautions, 3) cleaning/disinfecting of resident equipment and furniture for 3 of 4 types of equipment (chairs, sofa and mechanical sit-to-stand devices) and residents general/isolation precaution rooms with an Environmental Protection Agency (EPA) registered disinfectant for 3 of 3 staff (Staff G, P, O) reviewed for environmental cleaning and disinfection. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included . Review of an undated facility policy titled, Handwashing/Hand Hygiene, showed hand hygiene was to be implemented to help prevent harmful spread of infections in the nursing home. The policy showed common situations that required staff to perform hand hygiene were before/after contact with a resident, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, before/after assisting a resident with meals, after touching the resident's environment, before/after preparing or handling medications, before/after entering isolation precaution settings and immediately after glove removal. Review of the undated facility guidelines titled, Enhance Barrier Precautions (EBP, indicated with high contact resident care activities with an infection, a long-term wound, central line device or colonization [the presence of a bacteria that has not yet started its infection process] of an multi drug resistant organism), showed that all staff were to perform hand hygiene before entering and when leaving a room. Staff were to . wear gloves and a gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line (a tube for medications to be administer right by the heart), urinary catheter (a tube that drains urine from the bladder), feeding tube (a tube that delivers food to the stomach), tracheostomy (a tube and/or opening made in the neck to help with breathing), wound care: any skin opening requiring a dressing. Review of the facility guidelines titled, Contact Enteric (related to or occurring in the intestines of the body) Precautions (a specific type of TBP), dated 05/30/2019, showed anyone that entered the enteric, also known as Clostridium Difficile (C. diff, a type of bacterium that causes an infection of the colon, the longest part of the large intestine and when outside of the body they become inactive and are known as spores) must clean hands with sanitizer when entering room .wash with soap and water upon leaving room . Additionally, the guidelines stated that when cleaning a room that was on contact enteric precautions a Sporicidal-based (a specific type of substance or chemical that kills the C. diff spores) disinfectant was to be used. (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 the undated facility guidelines titled, Contact Precautions (a specific type of TBP), showed that everyone must clean their hands before entering and exiting the room. The guidelines stated that staff must also put on a gown and gloves before entering the contact precaution room. Review of Centers for Disease Control and Prevention (CDC) recommendations titled, Guidelines for Environmental infection control in Health-Care Facilities, updated July 2019, showed that cleaning and disinfecting environmental surfaces is fundamental in reducing their potential for transmission of diseases. Environmental surfaces can be medical equipment surfaces or .housekeeping surfaces (e.g., floors, walls, and tabletops), and need to go through a cleaning and disinfecting process. Environmental surface disinfectants are regulated by the EPA and labeled with an EPA registration number. Review of facility's policy titled, Cleaning and Disinfecting Residents' Rooms, dated June 2023, showed that environmental surface would be clean/disinfected on a regular basis (e.g., daily, three times per week) ., and the facility's environmental service director, Infection Preventionist (IP) and administrator would select appropriate disinfectants. Additionally, the policy showed when cleaning a resident room .utilize disinfectant solution based on type of precaution, and that all high-touch areas would be disinfected. <Hand Hygiene> During a concurrent observation and interview on 09/03/2024 at 3:44 PM, Staff P, Housekeeper, was cleaning a contact enteric precaution room, with Staff G, Housekeeping Supervisor, in the hallway outside the TBP room. When Staff P exited, they did not perform hand washing and instead used hand sanitizer. When inquired about specific hand hygiene requirements when exiting a contact enteric precaution room, Staff P and Staff G both were unaware of the requirement to wash their hands after exiting a C. diff positive TBP room. During an observation on 09/06/2024 at 8:28 AM, Staff H, Licensed Practical Nurse (LPN), exited room [ROOM NUMBER] after administering medications to a resident without performing hand hygiene. Staff H returned to the medication cart and began to document in the computer. Staff H proceeded to unplug the computer power cord from the wall and moved the medication cart down the hall. Staff H plugged the power cord back into the wall and resumed documenting in the computer. Once Staff H completed their documentation, they obtained a new medication cup and dispensed medications for another resident into the medication cup. These medications were then placed into a small pouch, crushed, and mixed with applesauce. Staff H walked down the hall with the medication mixture, entered room [ROOM NUMBER], and administered the medications to the resident with a spoon. They obtained the resident's drink on their bedside table and assisted them with a drink. Staff H then performed hand hygiene prior to exiting the resident's room. During an interview on 09/06/2024 at 11:15 AM, when asked their process for hand hygiene when exiting a contact enteric precaution room, Staff O, Housekeeper, stated they would use hand sanitizer and not perform hand washing. During an interview on 09/06/2024 at 1:03 PM, Staff B, Director of Nursing Services (DNS), stated they expected staff to follow TBP guidelines that were placed on the contact enteric precaution room door and when exiting the room to perform the required hand washings. <TBP> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 33> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including Multidrug-resistant Organism (MDRO-bacteria that is resistant to multiple antibiotics) right hip surgical wound that required a Peripherally Inserted Central Catheter [(PICC) - a thin, soft tube that is inserted into a vein in the arm, leg, or neck for long-term administration of antibiotics, medication, nutrition, and blood draws] for antibiotic therapy. The 08/01/2024 comprehensive assessment showed the resident required substantial/maximum assistance of one to two staff members with activities of daily living (ADLs) and had an intact cognition. Resident 33 was on Contact precautions. <Resident 34> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of stroke and obstructive uropathy (urine cannot drain from the urinary tract) with an indwelling catheter (a flexible tube that drains urine from the bladder into a drainage bag). The 08/02/2024 comprehensive assessment showed the resident required moderate assistance of one staff member for eating and had a moderately impaired cognition. Resident 34 was on EBP. An observation and interview on 09/05/2024 at 8:24 AM, showed Staff M, Nursing Assistant (NA), in a resident room that was designated as Contact Precautions and Enhanced Barrier Precautions (EBP) for two separate residents (Resident 33 and 34). Staff M sat bedside Resident 34 assisting them with their breakfast. Staff M provided the resident's fluid cup to drink and wiped their face after they coughed and cleared their throat. Staff M was not wearing personal protective equipment (PPE). Staff M stated they were supervising and assisting Resident 34 with their meal. Staff M stated the yellow sign (Contact Precautions) was for Resident 34 and the orange sign (EBP) was for Resident 33. Staff M stated they were required to wear a gown when providing catheter care, peri-care, and transfers for both residents. During and observation on 09/06/2024 at 8:18 AM, Staff N, Director of Rehabilitation, was sitting at Resident 34's bedside, assisting with their meal. Staff N was not wearing the required PPE for the room that was designated as Contact precautions and EBP. A concurrent observation and interview on 09/09/2024 at 5:16 AM, showed the signage posted on the entrance to the resident's room as Contact precautions and EBP. Staff L, LPN, entered the resident's room with gloves and no gown and administered medication to Resident 33. Staff L stated they were following the instructions for both signs, as they had not been informed of which precaution sign to follow. <Environmental Cleaning and Disinfection> <Furniture> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 09/05/2024 at 8:57 AM, showed three chairs located in the hall across from the dining room, that had stains on the seat cushions. One chair had multiple dark stains, varying in size on the seat cushion and a two inch (unit of measure) black/brown smear down the right arm of the chair. A second chair had an eight-inch by seven-inch dark stain on the seat cushion and the third chair had four one-inch stains that were dark in color and contained a white crusty substance. During a follow up observation on 09/09/2024 at 5:32 AM, the three chairs continued to show the same stains and black/brown smear. During an interview on 09/09/2024 at 6:32 AM, Staff K, Housekeeper, stated they were responsible for cleaning breakrooms, offices, therapy rooms and hallways. Staff K stated they did not clean furniture, and the evening housekeeping staff were responsible for cleaning furniture. During an interview on 09/09/2024 at 7:07 AM, Staff G, stated Staff K was responsible for cleaning breakrooms, offices, therapy and hallways. Staff G stated Staff K should clean the furniture in the hallways at least once per week and as needed. An observation on 09/09/2024 at 11:58 AM, showed a black, smooth surfaced sofa located in the television area on the Team 1 Hallway, that had peeling and cracked arm rests with exposed white fabric. The seam of the right arm rest had a six-inch by two-inch tear with peeled edges that exposed the white fabric with worn fibers. The right arm rest showed two two-inch by three-inch areas with peeling black sofa material and exposed white fabric. During an interview on 09/10/2024 at 8:43 AM, Staff G stated the stained chairs did not look clean and had not attempted to remove the stains. Staff G stated they were unaware of the worn black sofa, and it did not look professional for the facility. Staff G stated the exposed white fabric was not cleanable and was unable to be disinfected. During an interview on 09/10/2024 at 9:14 AM, Staff B, DNS, stated there were stains on the chairs and if they were unable to be cleaned, they would need replaced. The fabric on the sofa was worn and was now an uncleanable surface. The sofa should be replaced with furniture that was cleanable. <Resident Equipment> In an observation on 09/04/2024 at 10:03 AM, a white colored sit-to-stand machine (a device that helps people get from a seated position to a standing position) had a pleather (an imitation of leather) knee pad with splits in the pleather that exposed the fabric of the inside of the knee pad and the pleather had worn out areas of discoloration. On top of the sit-to-stand machine there was a visibly stained, worn-out white sling with Velcro that had old hair and dirt woven throughout it. Further observation of another sit-to-stand machine with a blue footrest which had dark brown debris and white substance all over the footrest, on top of the sit-to-stand machine there was an unsanitary blue and red sling lying across it. An observation on 09/05/2024 at 10:24 AM, a blue colored sit-to-stand with blue footrest was visibly soiled with dark brown debris and white substance, an unkempt, worn-out blue and red sling was lying on top of the machine. The white colored sit-to-stand continued to have the visibly soiled and worn-out white sling lying over it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 09/09/2024 at 5:07 AM, the white colored sit-to-stand with the white sling that had Velcro on it was observed in the same soiled condition as noted on 09/04/2024. An observation on 09/09/2024 at 6:42 AM, showed Staff J, NA, push a sit-to-stand with a sling into a resident's room that was designated as EBP. After use of the sit-to-stand lift, Staff J placed the sit-to-stand lift into a lift device holding area in the Team 1 hall. Staff J placed the used sling on top of the lift device and walked away without cleaning the lift device. The lift device foot plate (an area for resident's feet during transfers) was visibly soiled with dirt, debris and thick food particles. The white sling had multiple areas of discoloration and shredded fabric. The 10-inch by eight-inch Velcro securement area was filled with hair, black, brown, and yellow debris. During an interview on 09/09/2024 at 8:28 AM, Staff J stated they placed the lift device back into the holding area for other staff to use. Staff J stated they did not clean the lift device after each use. During an interview on 09/10/2024 at 9:14 AM, Staff B stated the sit-to-stand lift should be cleaned and slings changed and laundered in between use of residents. Staff B stated when the sling was unable to be cleaned or was in disrepair, then it would need to be replaced. <General/Isolation Precaution Resident Rooms> During an interview on 09/03/2024 at 3:16 PM, Staff G, stated that all housekeeping staff utilized a Multi-Surface Peroxide (tables, dressers, nightstands, bedside tables and other surfaces) and a Floor Rejuvenator chemical when cleaning/disinfecting all resident rooms and throughout the facility. During an observation on 09/03/2024 at 3:37 PM, in facility's housekeeping closet, showed the Multi-Surface Peroxide nor the Floor Rejuvenator were labeled as an EPA registered disinfectant. Review of EPA registered chemicals titled, List K: EPA's Registered Antimicrobial Products Effective against Clostridium difficile Spores, dated 06/15/2016, showed the Multi-Surface Peroxide nor the Floor Rejuvenator were registered disinfectants nor were they effective against C. diff. During a concurrent observation and interview on 09/03/2024 at 3:44 PM, showed Staff P, cleaning a contact enteric precaution room without an EPA registered disinfectant. Staff P and Staff G both stated they used the Multi-Surface Peroxide and Floor Rejuvenator for cleaning/disinfecting all resident rooms, including the TBP rooms, like the C. diff positive resident room. During an interview on 09/06/2024 at 11:15 AM, Staff O, stated they used Multi-Surface Peroxide and Floor Rejuvenator for cleaning/disinfecting all resident rooms, including all the TBP rooms (including C. diff positive rooms), and throughout the whole facility. During an interview on 09/06/2024 at 1:03 PM, Staff B, and Staff C, Infection Preventionist Nurse, stated they were unfamiliar with the chemicals, utilized by housekeeping staff, to clean and disinfect resident rooms. Staff B stated they would expect housekeeping staff to have used the correct EPA registered disinfectant when cleaning/disinfecting rooms on TBP's and throughout the whole facility they should be disinfecting everywhere. Staff B stated they were unsure if the Muli-Surface Peroxide and Floor Rejuvenator were EPA registered disinfectants. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/10/2024 at 1:29 PM, Staff B stated the Muli-Surface Peroxide and Floor Rejuvenator chemicals utilized by housekeeping were not registered disinfectants. Reference: WAC 388-97-1320 (1)(a)(c)(2)(b)(3)(5)(d)(e) 45642 46722