STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505379	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Health & Rehabilitation Center	7411 North Nevada Spokane, WA 99208

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46033 Based on observation, interview and record review, the facility failed to maintain urinary catheters (a tube inserted into the bladder that drains urine into a collection bag) in a dignified manner for 2 of 3 sampled residents (Residents 36 and 154) reviewed for urinary catheter care. This failure placed the residents at risk for public visualization of their urine and possible embarrassment. Findings included . The December 2000 Evaluation for Indwelling Catheters facility policy documented residents admitted to the facility with an indwelling catheter were evaluated at admission and quarterly for catheter usage. The policy did not address concerns regarding a resident's dignity when catheters were required. <Resident 36> A review of the 10/25/2024 quarterly assessment documented Resident 36 had diagnoses that included Parkinson's disease (a disorder of the central nervous system that caused slow, stiff movement, tremors and loss of balance) and kidney disease. The resident had an indwelling urinary catheter and required substantial assistance of staff for toileting. A further review of the record documented on 01/10/2025, Resident 36 reported feeling weak and out of breath and developed a high temperature of 102 degrees Fahrenheit. Blood work and a urinalysis and urine culture were ordered. The resident received one dose of ceftriaxone, an antibiotic, while waiting for the results of the urine culture to return. On 01/14/2025, the urine culture was positive and Resident 36 was ordered to receive a full course of ceftriaxone. On 01/15/2025 at 1:03 PM, Resident 36 was seated in their wheelchair and was positioned in the doorway of their room by Staff B, Director of Nursing. The urine collection bag was hanging on the frame of their wheelchair, was not covered in a dignity bag, and the bag and clamp were dragging on the floor. The collection bag was observed in the same position, uncovered and touching the floor at 1:17 PM. <Resident 154> (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the 01/02/2025 admission assessment documented Resident 154 had diagnoses that included benign prostatic hyperplasia (BPH, age-associated prostate gland enlargement) and urinary retention. The resident had an indwelling urinary catheter and was dependent on staff for toileting. The 12/23/2024 care plan documented Resident 154 had an indwelling catheter. Staff were instructed to position the urine collection bag and tubing below the level of the bladder and away from the door, check for a securement device (secured the tubing to the leg to prevent movement that caused irritation and risk for infection), monitor for signs or symptoms of a urinary tract infection and clean the catheter every shift. On 01/09/2025 at 8:56 AM, Resident 154 was observed lying in bed. The urine collection bag was hung on the bedframe visible from the doorway of the resident's room. The resident's bed was in a low position so that the collection bag and its clamp were resting on the floor. The collection bag was not covered for the resident's privacy (use of a plastic or cloth covering that kept a person's urine from view, also referred to as a dignity bag). On 01/09/2025 at 1:58 PM, Resident 154 was napping. The resident's urine collection bag was hung on the bedframe, part was bunched up on the floor, next to the wheels of the overbed table. There was no dignity bag on it and it was visible from the hall. On 01/13/2025 at 5:30 AM, Resident 154 was sleeping. A dignity bag was hanging on the bedframe on the side of the bed that faced the doorway.Their urine collection bag was lying on the floor on the other side of the bed away from the door. Additional observations of the resident's uncovered urine collection bag were made on 01/14/2025 at 9:57 AM, and on 01/15/2025 at 1:17 PM. During an interview at 01/16/2025 at 1:05 PM, Staff G, Nursing Assistant, observed Resident 154 with the surveyor from the hall. Resident 154 was resting in bed. Their urine collection bag was visible and not covered with a dignity bag. Staff G stated Resident 154 needed a dignity cover over their urine collection bag. Staff G stated it was probably still on the resident's wheelchair when the resident was out of bed earlier. They stated they would put the cover on. Staff G stated any resident's urine collection bag was never to be left touching the floor as doing so could contribute to infections. During an interview on 01/17/2025 at 5:24 PM, Staff B stated urine collection bags were to be kept off the floor, hanging below the level of the bladder to help the flow of urine, and covered in a dignity bag. Reference: WAC 388-97-0180(1-4)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 47328 Based on observation, interview, and record review the facility failed to implement the self-administration of medicaiton policy, ensure the interdisciplinary team (IDT) determined a residents could self-administer medications, ensure only provider approved medications were kept at the resident's bedside and/or safely and securely stored at the bedside for 1 of 3 sampled residents (Resident 24), reviewed for choices. This failure placed residents at risk of access to unsecured medications, potentially avoidable medication errors and/or accidents, and diminished quality of life. Findings included . Review of the facility policy titled, Self-Administration of Medication updated September 2017, showed if a resident desired to self-administer medications they would be evaluated using the self-medication evaluation assessment. If a resident was determined to self-administer medications provider orders that specified specific medications to self-administer would be obtained, a self-administration care plan would be implemented, a bedside self-administration record was to be implemented if medications were stored at bedside, and proper safety mechanisms for bedside medication storage would be implemented. The resident would be re-assessed quarterly and with any changes of condition. The policy further showed the IDT only reviewed when a resident was unable to self-administer medications, to determine if there were areas the resident could complete. According to the 11/16/2024 quarterly assessment, Resident 24 had diagnoses that included chronic obstructive pulmonary disease (COPD, lung disease that made it difficult to breathe), muscle weakness and reduced mobility. Resident 24 was cognitively intact and able to verbalize their needs. Review of the 05/25/2023 self-administration of medication evaluation showed Resident 24 continued to be appropriate for self-administration of saline [solution of salt and water] nasal spray, cough drops, and topicals [medication applied to the body such as creams, lotions, or ointments]. The evaluation further showed Resident 24 was to keep these items at bedside and could administer them per provider orders and no other medications of any kind was to be kept at beside or self-administered. Review of the fall risk care plan showed a 12/05/2023 intervention Resident 24 was approved to purchase and/or keep cough drops, saline nasal spray and topicals in their room for independent use and instructed staff to report any other items to nursing management staff immediately. Review of provider orders showed an 08/28/2024 order for Mentholatum (over-the-counter petroleum-based ointment used to soothe symptoms associated with the common cold) as needed to affected areas, a 03/22/2024 order for lidocaine cream every four hours as needed may keep at bedside and self-administer as able, steroid nasal spray into each nostril daily for allergies, and routine oxygen use to keep oxygen levels greater than 88%. Review of the 06/25/2024, 09/24/2024, and 12/16/2024 care conference assessments showed Resident 24's self-medication program was reviewed without changes made. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 01/07/2025 at 2:35 PM, Resident 24 wore an oxygen nasal cannula in their nose and had Xylitol [natural occurring sweetener] nose sprays, a small opened green jar of Mentholatum ointment, a bag of cough drops, Lidocaine creams and roll on liquids unsecured at their bedside. Similar observations were made on 01/08/2025 at 9:42 AM, on 01/09/2025 at 8:11 AM and 12:20 PM, on 01/10/2025 at 8:18 AM and 11:31 AM. Further review of provider orders showed no provider orders for Resident 24's cough drops, Xylitol nasal spray or the liquid roll-on Lidocaine, observed at their bedside. The as needed Mentholatum order showed no documentation it had been approved for bedside storage. During an interview on 01/10/2025 at 11:31 AM, Resident 24 stated they applied the Mentholatum ointment right under their nose because their nasal passages got dry related to their use of oxygen. According to the National Institute of Health website, NIH.gov The use of petroleum-based products should be avoided when handling patients under oxygen therapy. Whenever a skin moisturizer is needed for lubrication or rehydration of dry nasal passages, the lips or nose when breathing oxygen, consider the use of oil-in water creams or water-based products. During observation and interview on 01/14/2024 at 8:32 AM, Resident 24 laid in their bed with their eyes closed with unsecured over-the-counter medications at bedside, as identified and described above. At 8:35 AM, a confused fell ow resident wandered into Resident 24's room. At 8:36 AM, the confused resident approached Resident 24's bed. At 8:37 AM, the resident exited Resident 24's room. At 8:38 AM, Resident 24 identified the confused resident and stated the resident visited them often. In a follow-up interview on 01/15/2025 at 10:17 AM, Resident 24 stated they were not required to inform staff if, and/or when they used the medications stored in their room. In an interview on 01/15/2024 at 12:38 PM, Staff E, Registered Nurse, stated if/when a resident chose to self-administer medications they would have to be assessed, the order would indicate what medications were to be self-administered and/or allowed to be stored at the bedside, and care planned accordingly. Staff E further stated Resident 24 was not to have medications at the bedside but frequently ordered over-the-counter medications online and kept those items at their bedside. Staff E was unsure how residents were to secure medications at the bedside. In an interview on 01/15/2025 at 12:56 PM, Staff D, Resident Care Manager, stated the provider was to approve a resident to self-administer medications or store medications at the bedside. Staff D explained a resident had to be assessed for their ability to safely self-administer medications and/or store medications at the bedside, the order would indicate what medications were to be self-administered and/or allowed to be stored at the bedside, and care planned accordingly. Staff D stated medications stored at the bedside needed to be secured to prevent other residents from accessing the medications. Staff D reviewed Resident 24's medical record. Staff D acknowledged Resident 24's Mentholatum order did not indicate it was to be stored at the bedside or to be used to moisten dry nasal passages due to oxygen use. Staff D further stated using petroleum-based products while wearing oxygen was a potential safety issue. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/15/2025 at 2:11 PM, with Staff B, Director of Nursing, and Staff C, Assistant Director of Nursing, Staff B stated the provider would approve medications for self-administration and/or to store medications at the bedside which would be documented on the individual medication order. Staff B further stated residents would be assessed, educated, and care planned accordingly. Staff C stated bedside medication storage depended on the medication but was to be stored out of sight to prevent other residents from having unintended access to them and acknowledged it would be a safety concern if a confused resident wandered into a room with unsecured medications. Staff B stated Resident 24 was known to purchase over-the-counter medications online or at the local grocery store. Staff B acknowledged using petroleum-based products when wearing oxygen was a potential safety concern. In an interview on 01/15/2025 at 3:36 PM, Staff A, Administrator, stated they expected staff to ensure medications were safely secured when stored at the bedside. Reference WAC 388-97-0440, -1060 (3)(I)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview and record review the facility failed to maintain a clean, comfortable, safe and homelike environment for 2 of 2 sampled residents (Resident 23 and 28), reviewed for environment. Specifically, Resident 23's personal refrigerator contained expired foods, and the facility failed to ensure an exit door was in good repair and Resident 28 had a large hole in the wall behind the door to their room. These failures placed Resident 23 at risk for a foodborne illness, and all residents at risk for injury and a diminished quality of life. Findings included . Review of the facility policy titled, Resident Personal Refrigerators And Foods Brought Into The Center By Family/Visitors dated [DATE], showed temperatures were to be monitored daily and perishable foods covered, labeled, dated and discarded following use by date guidelines on the Food Labeling Reference Guide. The policy further showed center staff may, at their discretion, discard food items that were not safe to eat nor labeled, after verbally notifying the resident and/or the responsible party. <Personal Refrigerator> During an observation and interview on [DATE] at 11:56 AM, Resident 23 was sitting in their wheelchair in their room. They had a personal refrigerator that contained 3 containers of meat and stuffing that had no expiration date. Resident 23 stated their family had brought them the food. Subsequent observations of the containers of food without a date were made on [DATE] at 12:26 PM, [DATE] at 8:41 AM, [DATE] at 7:07 AM, and [DATE] at 10:49 AM. On [DATE] a glass of tomato juice had been placed in the refrigerator without an expiration date. Per the [DATE] Medication Administration Record, the Licensed Nurse was to check and log the temperature of Resident 23's refrigerator and discard expired food every night shift. A review of the temperature logs in Resident 23's room showed multiple omissions for [DATE] and no temperatures for [DATE]. In an interview on [DATE] at 10:02 AM, Staff E, Registered Nurse, stated daily refrigerator temperatures needed to be obtained, and food monitored for expiration dates. Staff E stated this was important to prevent the food from spoiling. During an interview on [DATE] at 4:31 PM, Staff B, Director of Nursing, stated the nursing assistants and nurses were responsible for labeling and dating food and the nurses were responsible for monitoring the temperature of the refrigerators. Staff B stated this was important to ensure the safety of the food was maintained. 47328 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Drywall Penetration> According to the [DATE] quarterly assessment, Resident 28 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. During observation and interview on [DATE] at 12:58 PM, a large hole was observed in the dry wall behind the door to Resident 28's room. The hole was the length and width of the surveyor's hand and was at door nob level. Resident 28 stated the hole in the drywall had been there a long time, as long as they could remember. Similar observations were made on [DATE] at 7:56 AM, on [DATE] at 8:33 AM, and on [DATE] at 10:21 AM. During observation and interview on [DATE] at 10:26 AM, Staff G, Nursing Assistant (NA), stated if staff noticed something was broken or in disrepair, they would write it down in the maintenance binder. Staff G observed the large hand size hole behind Resident 28's room door. Staff G stated they were unsure how long the hole had been there. During observation and interview on [DATE] at 10:44 AM, Staff BB, Maintenance, stated they checked they maintenance request binder frequently throughout the day. Staff BB observed the large hand size hole behind Resident 28's room door. Staff BB stated they checked the facility for wall penetrations and/or dents that if left unaddressed could lead to potential penetrations monthly. Documentation of wall penetration rounding was requested from Staff BB. Staff BB stated they did not have any documentation. Staff BB further stated the hole in the drywall appeared to be caused by a hard pushing force and the elongated door nob penetrated the wall. Staff BB acknowledged the large hole in the drywall was a potential fire hazard and was not a homelike environment. <Exit Door> During observation on [DATE] at 11:42 AM, the outside door leading to the foyer at the back of the building, outside of 100 hall, was offset, did not latch, and slammed on the outer portion of the door jamb. Similar observations were made on [DATE] at 3:58 AM and on [DATE] at 10:23 AM. During observation and interview on [DATE] at 10:28 AM, Staff G, NA, observed the outside door leading to the foyer at the back of the building, outside of 100 hall, was offset, did not latch, and slammed on the outer portion of the door jamb. Staff G stated they knew the door had been slamming but never noticed the door was offset and did not latch. During observation and interview on [DATE] at 10:44 AM, Staff BB observed the outside door leading to the foyer at the back of the building, outside of 100 hall. Staff BB stated they were unsure how long the door had been offset and did not latch. Staff BB acknowledged the offset door was a potential safety issue. In an interview on [DATE] at 3:49 PM, Staff A, Administrator, stated they would defer to maintenance to determine if a wall penetration was a potential fire hazard or if things in disrepair were a potential safety issue. Reference WAC [DATE]

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47328 Based on interview and record review the facility failed to ensure residents could file grievances without reprisal or fear of reprisal, report grievances consistent with alleged abuse to the State Survey Agency as required, and repeatedly promptly resolve grievances for 4 of 5 sampled residents (Resident 40, 31, 10, 24), reviewed for grievances. This failure placed residents at risk of feelings of powerlessness, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy title, Grievance Procedure revised November 2016, documented residents and resident representatives were informed of their right to voice a grievance orally, in writing, and anonymously regarding the care and treatment/lack of treatment, behavior of staff and of other residents, and other concerns during their stay. The policy further documented residents had the right to voice grievances without discrimination or reprisal and without fear of discrimination or reprisal. Grievances were to be resolved immediately, when possible. If a grievance involved an allegation of abuse, neglect, exploitation, or misappropriation of resident property the executive director was to be notified, an investigation started and the abuse prohibition procedure was to be followed. <Resident 40> According to the 11/02/2024 quarterly assessment, Resident 40 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 40 filed the following grievances: -08/06/2024 the beef tips taste like sawdust with a 08/15/2024 resolution of facility returned to the previous food supplier. -08/06/2024 staff ignored call lights and played on their mobile phones. A 08/26/2024 resolution of staff was educated on leaving phones in lockers and notifying the nurse all resident cares were provided by the end of the shift. -09/03/2024 still having issues with staff ignoring call light never had any follow up from prior grievance in August and staff did not perform hand hygiene prior to handling resident items. A 09/10/2024 resolution of 1:1 staff education on hand hygiene. -12/03/2024 night shift staff using Oak activity room as break room and ignoring call lights. A 12/10/2024 resolution of staff education and signage posted on activity room staff were not to use the resident area as a breakroom. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/08/2025 at 10:38 AM, Resident 40 stated staff still had not answered call lights timely. Resident 40 further stated they received medications around 3:30 AM and often came out in search of the nurse to find staff using the Oak activity room as a breakroom while residents had call lights on in the halls. In a follow-up interview on 01/08/2025 at 11:11 AM, Resident 40 stated they felt staff retaliated against them when they previously voiced concerns. Resident 40 explained Staff F, Nursing Assistant (NA), approached them once and stated Why did you say that? You threw me under the bus and then would not talk to Resident 40 for a while. Resident 40 further stated they felt staff talked down to them and this made them feel they needed to move out. Resident 40 was unaware they could file a grievance anonymously and felt grievances were not addressed timely because they had the same concerns month after month. Review of additional grievances provided by the facility on 01/20/2025 showed: -06/04/2024 an identified nursing assistant (not Staff F, NA) wore their pants low with their underwear exposed. Resident 40 recommended the staff use a belt and staff responded, I don't have one, you are just looking at my **s. -06/10/2024 Resident 40 felt retaliated against when the staff identified in the 06/04/2024 grievance approached the resident and stated, I hope everyone can see that I am doing my job right. <Resident 31> According to the 11/19/2024 quarterly assessment, Resident 31 had diagnoses including chronic (occurring for long period of time or repeatedly) respiratory failure (lungs not working properly to get enough oxygen into the body) with hypoxia (low oxygen levels in body), chronic pulmonary embolism (blood clot that blocks blood flow to lungs), and muscle weakness. Resident 31 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 31 filed the following grievances: -07/02/2024 the night NA was rude, rough and pinched Resident 31's skin when they assisted with a brief change. A 07/03/2024 resolution included staff education and verbal disciplinary action. The grievance did not describe what type of staff education was provided. Review of the July 2024 through December 2024 facility mandatory reporting log showed no entries for this allegation of potential abuse. -09/03/2024 the clam chowder smelled and tasted bad with a 09/04/2024 resolution switched out soup for replacement item. -11/05/2024 waited 45 minutes for staff to assist with personal hygiene after an episode of incontinence. A 11/12/2024 resolution included a staff reminder to answer call lights as soon as possible. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/08/2025 at 10:38 AM, Resident 31 stated staff were still not answering call lights timely. Resident 31 further stated they were not to be taking themselves to the bathroom but did because staff would not respond to their call light timely. Resident 31 explained they typically did not wear their oxygen when in the bathroom, last week they pressed their bathroom call light, after waiting 35 minutes without staff response, Resident 31 began to yell out because they needed their oxygen. Resident 31 stated they left the door to their room open, in case of emergencies, because staff did not response to call lights timely. In a follow-up interview on 01/08/2025 at 11:11 AM, Resident 31 stated they felt ignored, and staff talked down to them. Resident 31 further stated they did not know how to file a grievance until their child informed them how. <Resident 10> According to the 10/19/2024 annual assessment, Resident 10 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of the July 2024 through December 2024 grievance log showed Resident 10 filed the following grievances: -09/03/2024 Teriyaki beef was too tough with a 09/04/2024 resolution of staff were educated on roasting meat. In an interview on 01/08/2025 at 10:55 AM, Resident 10 stated they rarely ate meat served because they could not chew it. Resident 10 further stated the facility did not follow-up on grievances. <Resident 24> According to the 11/16/2024 quarterly assessment, Resident 24 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 24 filed the following grievances: -11/05/2024 waited one and a half hours for staff assistance with a 11/12/2024 resolution of staff re-education on call light response times. In an interview on 01/07/2025 at 2:43 PM, Resident 24 stated the facility did not have enough staff because they often had excessively long call light wait times. In an interview on 01/17/2025 at 9:09 AM, Staff G, Nursing Assistant, stated residents could submit grievances without fear of retaliation and informed residents about the Ombudsman (a person who investigated and resolved complaints, and advocated for resident's rights) if retaliation concerns arose. Staff G further stated staff were not to confront a resident as to why a concern was reported because that could be considered retaliation. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/17/2025 at 9:50 AM, Staff E, Registered Nurse, stated residents could file grievances without fear of retaliation. Staff E explained if they received a grievance that was a potential allegation of abuse, they followed the facility's abuse prohibition policy. Staff E acknowledged staff should not tell a resident they were thrown under the bus when a concern was voiced, that was unprofessional behavior that could potentially be considered retaliation or harassment. In an interview on 01/17/2025 at 10:26 AM, Staff T, Social Service Director, stated Staff A, Administrator was the grievance official. Staff T further stated residents should be able to submit grievances without fear of retaliation, staff should not approach a resident saying they were thrown under the bus as that could be considered retaliation. Staff T explained grievance information was confidential, and some details were not be shared with staff involved. Staff T further stated if they received a grievance that rose to the level of a potential abuse allegation, they followed the abuse prohibition policy. In an interview on 01/17/2025 at 11:33 AM, Staff B, Director of Nursing, stated residents could submit grievances without fear of retaliation and protected residents by not disclosing persons involved to maintain confidentiality. Staff B was unsure the time frame a grievance should be resolved by. Staff B further stated if a grievance sounded like a potential allegation of abuse, they followed the facility's abuse prohibition process. Staff B acknowledged staff should not approach a resident saying they were thrown under the bus when a concern was voiced because it could be considered retaliation that would need to be investigated. In an interview on 01/17/2025 at 3:56 PM, Staff A, Administrator, stated they reviewed grievances for potential allegation of abuse and followed the abuse policy if a grievance appeared to rise to the level of a potential allegation of abuse or neglect. Staff A further stated the facility attempted to resolve grievances within five days, but some grievances might take longer. Staff A acknowledged staff should not approach residents asking them why they were thrown under the bus as that could be considered potential retaliation. Reference WAC 388-97-0460 Refer to F607, F725, and F804 for additional information.

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Royal Park Health & Rehabilitation Center	7411 North Nevada Spokane, WA 99208

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to implement its Abuse and Neglect Policy and Procedure to include the identification of potential allegations of abuse, responding to and reporting the allegation to the State Survey Agency (SA) as required, and thoroughly investigating allegations for 5 of 8 sampled residents (Resident 98, 10, 58, 40, and 31), reviewed for abuse. This failure placed residents at risk for abuse, unmet care needs, and a diminished quality of life. Findings included . Review of the facility policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, updated [DATE], defined different forms of abuse. The policy defined mental abuse as the use of verbal or nonverbal conduct which caused or had the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. The policy further showed new and existing staff would be trained regarding the facility's abuse policies to include identification of abuse and/or neglect, immediately report all suspected and/or allegations of abuse as required, and thoroughly investigate potential, suspected and/or allegations of abuse. <Resident 98> According to the [DATE] admission assessment, Resident 98 admitted to the facility on [DATE] with diagnoses including muscle weakness, reduced mobility, lack of coordination, and chronic pain. Resident 98 required touch assistance to transfer onto the toilet and moderate staff assistance to perform toileting hygiene. Resident 98 had severe cognitive impairment. Review of a [DATE] facility incident report showed Resident 98 experienced an unanticipated death. Resident 98 was found at 6:30 PM slumped over on the toilet with a laceration above their left eyebrow. The incident report further showed Resident 98 was last seen sitting on the edge of their bed at 5:25 PM, on hour and five minutes prior. The incident report only contained two staff interviews and no resident interviews. A [DATE] investigation summary showed Resident 98 had been compliant with use of their call light, but the call light was not on at the time Resident 98 was found on the toilet. The investigation summary did not rule out abuse and/neglect. Review of [DATE] nursing progress notes showed Resident 98 required moderate assistance for toileting. On [DATE] Resident 98 was found sitting on the toilet unresponsive, staff called emergency medical services and initiated cardiopulmonary resuscitation (CPR) per Resident 98's wishes. Resident 98 expired and the medical examiner (ME) was notified of the laceration to the left upper eyebrow. The progress notes further showed the ME was sent pictures of Resident 98's facial laceration and Resident 98 would need to be picked up for further testing. Further review of Resident 98's medical record showed no pictures of Resident 98's facial laceration were found. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 11:00 AM, Staff GG, Nursing Assistant (NA), stated they looked into resident rooms as they walked down the hall to check on residents. Staff GG further stated abuse and/or neglect was ruled out by management interviews of residents and staff interviews on the unit. In an interview on [DATE] at 11:16 AM, Staff LL, LPN, stated they constantly checked on residents as they walk down the hall. Staff LL explained incident investigations were completed by management, everyone filled out statements, and management ruled out abuse and/or neglect by reviewing staff and resident interviews conducted. In an interview on [DATE] at 11:53 AM, Staff Y, Resident Care Manager (RCM), explained investigations were completed by management staff depending on the allegation or incident. Staff Y further stated social service staff conducted interviews of residents in the general vicinity and staff, the interdisciplinary team (IDT) discussed the incident and ruled out abuse by asking questions. In an interview on [DATE] at 3:02 PM, Staff B, Director of Nursing (DNS), explained when an allegation of abuse was received, the staff receiving the report ensured resident safety and started the investigation process. The RCM and/or DNS would then interview staff and resident involved and social service staff would conduct extended interviews that included other resident in the area and staff working the unit at the time. Staff B further stated interviews were reviewed by the IDT to rule out abuse and/or neglect. In an interview on [DATE] at 4:17 PM, Staff A, Administrator, explained the facility ruled out abuse and/or neglect by interviewing residents and staff, if appropriate other staff beyond who was involved would be interviewed to try to get a clear picture of an incident. Staff A stated the facility ruled out abuse and/or neglect related to Resident 98's unanticipated death. Staff A was asked how abuse was ruled out if the investigation only contained two staff statements and no resident interviews. Staff A stated, no other residents were involved in that situation, so why would we interview other residents? <Resident 58> The [DATE] quarterly assessment documented Resident 58 had severe cognitive impairment but was able to understand others and make their needs known. On [DATE] at 8:14 AM, Resident 58 was observed lying in bed, waiting for breakfast. When asked about the care at the facility, the resident stated they did not care for Staff X, Licensed Practical Nurse (LPN). The resident stated Staff X was rude and not nice when they interacted with them. In a follow up interview at 1:14 PM that same day, Resident 58 stated that about two or three weeks ago, they had observed Staff X sleeping at the nurse's station, and when they had mentioned it to Staff X, they denied being asleep, and their manner was rude and condescending. Resident 58 further stated it made them feel terrible, and they would not feel comfortable in approaching Staff X if they needed assistance or had a medical concern. When Resident 58 was asked if they had told any of the other staff of their concern, Resident 58 stated they had kept quiet because they did not want to cause a ruckus and were afraid of retaliation. Resident 58 was then asked if they were comfortable with the surveyor informing the facility of their concerns regarding Staff X, and Resident 58 stated yes. In an interview on [DATE] at 2:16 PM, Staff A, Administrator, was informed of the conversation with Resident 58 and the resident's concerns regarding Staff X. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] a review of the State Agency incident reporting program, STARS, found no documentation that the facility had reported the allegation of possible abuse concerning Resident 58. A report was then made by the surveyor to the SA. An additional review of STARS on [DATE] at 11:49 AM, eight days after the facility was notified of the allegation, found no documentation to show the facility had reported the allegation to the SA as required. Review of the [DATE] facility grievance log which had been provided to the survey team on [DATE] found no entries related to Resident 58. On [DATE] at 12:00 PM, Staff A, Administrator was asked to provide the facility investigation related to Resident 58's allegation, an updated grievance log and the facility reporting log for [DATE]. On [DATE] at 2:38 PM, the updated facility reporting log for [DATE] was reviewed and no entries had been made regarding Resident 58. On [DATE] at 2:39 PM, review of the updated grievance log for [DATE] found an entry dated [DATE] was now present related to Resident 58 which documented the issue as a staff concern which was resolved on [DATE]. On [DATE] at 3:38 PM, a grievance form for Resident 58 was received via email correspondence from Staff A related to the staff concern on [DATE]. The form documented the nature of the concern was expressed by the surveyor and stated Staff X was mean. The form did not include all the information that had been reported to the facility. The form further documented the only steps taken to investigate were to interview the resident. No other documentation or a facility investigation was received. In an interview on [DATE] at 6:14 PM, Staff B, Director of Nursing, was asked if an investigation had been completed regarding the concerns expressed by Resident 58. Staff B stated it was their understanding that the concern was more how Staff X talked, and it was not identified as potential abuse. 47328 <Resident 40> According to the [DATE] quarterly assessment, Resident 40 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of [DATE] through [DATE] grievance log showed Resident 40 filed the following grievances: -[DATE] staff ignored call lights and played on their mobile phones -[DATE] still having issues with staff ignoring call light never had any follow up from prior grievance in August and staff did not perform hand hygiene prior to handling resident items. -[DATE] night shift staff using Oak activity room as break room and ignoring call lights. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 10:38 AM, Resident 40 stated staff were still not answering call lights timely. Resident 40 further stated they received medications around 3:30 AM and often came out in search of the nurse to find Staff X, LPN, sleeping at the nurses' station and other staff using the Oak activity room as a breakroom, while residents had call lights on in the halls. In a follow-up interview on [DATE] at 11:11 AM, Resident 40 stated they felt staff retaliated against them when they previously voiced concerns. Resident 40 explained Staff F, NA, approached them once and stated Why did you say that? You threw me under the bus and then would not talk to Resident 40 for a while. Resident 40 further stated they felt staff talked down to them and this made them feel they needed to move out. In an interview on [DATE] at 12:03 PM, Staff A, Administrator, was informed Resident 40 voiced an allegation of potential abuse related to how staff communicated with them and how it made them feel. In an interview on [DATE] at 12:19 PM, Resident 40 was informed the surveyor reported their concerns about how staff communicated with them and how it made them feel to the facility because it was a potential allegation of abuse the facility needed to investigate. In a follow-up interview on [DATE] at 12:55 PM, Resident 40 stated social services spoke to them. Review of the State Survey Agency Secure Tracking And Reporting System, STARS, on [DATE], showed no entries for Resident 40's [DATE] allegation of potential abuse. The investigation for Resident 40's [DATE] allegation of potential abuse was requested from Staff A, administrator, on [DATE] at 12:00 PM. No documentation was provided. <Resident 10> According to the [DATE] annual assessment, Resident 10 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. In an interview on [DATE] at 11:11 AM, Resident 10 stated staff had poor social skills and ignored residents. Resident 10 explained this made them feel ignored and depressed. Review of the [DATE] depression screening assessment showed Resident 10 scored a one, indicating minimal depression symptoms. Review of the [DATE] depression screening assessment showed Resident 10 scored an eight, indicating mild depression symptoms. In an interview on [DATE] at 12:03 PM, Staff A, Administrator, was informed Resident 10 voiced an allegation of potential abuse related to how staff communicated with them and how it made them feel. In an interview on [DATE] at 12:19 PM, Resident 10 was informed the surveyor reported their concerns about how staff communicated with them and how it made them feel to the facility because it was a potential allegation of abuse the facility needed to investigate. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation for Resident 10's [DATE] allegation of potential abuse was requested from Staff A, administrator, on [DATE] at 12:00 PM. Review of the [DATE] facility incident report showed Resident 10 stated staff was mean and they wanted staff to make them feel like a human being. The investigation contained a [DATE] grievance filed by Resident 58 related to Staff X, LPN, being mean, no staff or other resident interviews were included. A [DATE] investigation summary showed abuse and/or neglect was ruled out through residents' interviews conducted by social services. <Resident 31> According to the [DATE] quarterly assessment, Resident 31 had diagnoses including chronic pulmonary embolism (blood clot that blocks blood flow to lungs) and muscle weakness. Resident 31 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of [DATE] through [DATE] grievance log showed Resident 31 filed the following grievances: -[DATE] night NA was rude, rough and pinched Resident 31's skin when assisting with a brief change. A [DATE] resolution of staff education and verbal disciplinary action. The grievance did not describe what type of staff education was provided, did not include staff or resident interviews, and did not rule out abuse and/or neglect. Review of the [DATE] through [DATE] facility mandatory reporting log showed no entries for the [DATE] allegation of potential abuse. In an interview on [DATE] at 11:11 AM, Resident 31 stated they felt ignored by staff and staff talked down to them. In an interview on [DATE] at 12:03 PM, Staff A, Administrator, was informed Resident 31 voiced an allegation of potential abuse related to how staff communicated with them and how it made them feel. In an interview on [DATE] at 12:19 PM, Resident 31 was informed the surveyor reported their concerns about how staff communicated with them and how it made them feel to the facility because it was a potential allegation of abuse the facility needed to investigate. Review of the State Survey Agency Secure Tracking And Reporting System, STARS, on [DATE], showed no entries for Resident 31's [DATE] or [DATE] allegations of potential abuse. The investigation of Resident 31's [DATE] allegation of potential abuse was requested from Staff A, administrator, on [DATE] at 12:00 PM. Review of documentation provided showed a single piece of paper with Resident 31's vague interview. Resident 31's interview showed they could perform most cares independently, staff thought they did not need to help them but Resident 31 voiced they could use more staff assistance. Abuse and/or neglect was not ruled out. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 9:13 AM, Staff G, NA, stated if they received a report of a potential allegation of abuse, they would ensure resident safety then report the allegation to the nurse and up the chain of command so an investigation could be started. Staff G further stated a report of staff being rude and so rough they pinched a resident's skin, would be considered a grievance, not a potential allegation of abuse. In an interview on [DATE] at 9:54 AM, Staff E, Registered Nurse, stated if a resident reported staff was rude and so rough they pinched a resident's skin, Staff E would complete a skin assessment, speak with the identified staff 1:1, and notify management. Staff E further stated they would ask the resident if they would like to file a grievance with an incident resolution. In an interview on [DATE] at 10:32 AM, Staff T, Social Service Director, explained when an allegation of potential abuse was reported they would ensure resident safety by removing any identified staff from providing resident care, start an investigation, and rule out abuse and/or neglect by completing resident and staff interviews. Staff T acknowledged if a resident reported staff was rude, rough, and pinched their skin, it would be considered a potential allegation that needed to be reported to the State Survey Agency and all steps followed to investigate the potential allegation. In an interview on [DATE] at 11:38 AM, Staff B, Director of Nursing, stated all staff were mandatory reporters and should follow the appropriate steps when an allegation of abuse was received. Staff B acknowledged Resident 31's [DATE] grievance of rude staff with rough care and pinched skin should have been reported as an allegation of abuse and investigated as such. In an interview on [DATE] at 3:56 PM, Staff A, Administrator, stated they reviewed grievances for potential allegations of abuse and/or neglect. Staff A further stated if a grievance appeared as a potential allegation, then it would be reported and investigated following all the steps in the abuse policy. In a follow-up interview on [DATE] at 4:01 PM, Staff A, acknowledged if a resident reported staff was rough and pinched their skin, it would be considered an allegation of potential abuse. Reference WAC [DATE] (2) Refer to F585, F730, and F842 for additional information.

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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. 46115 Based on interview and record review, the facility failed to provide a bed-hold notice, a notice that informed the resident of their right to pay the facility to hold their room/bed while they were hospitalized , to the resident and/or their representative at the time of discharge, or within 24 hours of transfer to the hospital, for 1 of 2 sampled residents (Resident 54), reviewed for hospitalization . This failure placed the residents at risk for a lack of knowledge regarding the right to a bed-hold, while they were hospitalized . Findings included Per the 12/23/2024 significant change in condition assessment, Resident 54 had diagnoses which included high blood pressure, diabetes, and dementia, and had severe cognitive impairments. Review of Resident 54's record showed a 12/12/2024 nursing progress note which documented the resident had a rapid heart rate and their oxygen level was 74 percent (the normal oxygen level is 90-100). The resident was assessed and was sent to the hospital for evaluation. Additional record review found no documentation that showed the resident had been provided a bed-hold notice until 12/16/2024, not within 24 hours as required. In an interview on 01/17/2025 at 8:57 AM, Staff K, Admissions Director, stated bed holds were offered upon admission and within 24 hours of a discharge to the hospital, unless it was on a Friday, then it would have been offered on a Monday. Staff B stated no one offered bed holds when they were gone and it was important to offer bed holds because some residents want to return to their same room. Reference WAC 388-97-0120 (4)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to provide services that ensured a resident's abilities in activities of daily living (ADLs) did not diminish for 1 of 4 sampled residents (Resident 36) reviewed for activities of daily living. This failure put residents at risk for physical decline and decreased quality of life. Findings Included . The Facility assessment dated [DATE] documented the facility offered cares to residents with various types of needs. Services for Mobility and Fall/Fall with injury Prevention included Restorative Nursing care among others in supporting the resident's independence in doing as many of these activities by him or herself. A review of the 10/25/2024 quarterly assessment documented Resident 36 had diagnoses that included Parkinson's disease (a central nervous system disorder that caused slow, stiff movements, tremors and balance difficulties) and muscle weakness. Resident 36 was cognitively intact, did not use assistive devices such as a walker or wheelchair, and required partial assistance from staff for bed mobility and bed to chair transfers and personal hygiene. The resident required substantial assistance for toileting, bathing/showering and dressing. The resident received six days of restorative walking and active range of motion during the look back period. The 09/24/2024 care plan documented Resident 36 had impaired mobility related to decreased strength, ambulation and transfer skills. Interventions included a Restorative (RNA) active range of motion and walking program to include sit to stand to a four-wheeled walker for two sets of three repetitions and to ambulate 50 feet with a four-wheeled walker with a wheelchair following behind. A review of the 12/04/2024 Occupational Therapy discharge summary documented Resident 36 was seen from 11/01/2024 to 12/04/2024. At the time of discharge, the resident required stand-by assistance with cueing to transfer from sitting to standing, met their goal for increased lower abdominal strength and maintained their standing balance. A restorative nursing (RNA) program was established at discharge on 12/04/2024. A report provided from the facility regarding RNA participation for Resident 36 documented the following participation for the following weeks: -12/01/2024 to 12/07/2024 Three 15-minute sessions -12/08/2024 to 12/14/2024 Three 15-minute sessions -12/15/2024 to 12/21/2024 One 15-minute session -12/22/2024 to 12/28/2024 None -12/29/2024 to 01/04/2025 None (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-01/05/2025 to 01/11/2025 Three 15-minute sessions. The resident refused RNA sessions on 01/13/2025 and 01/14/2025. The review of the resident's record documented that the resident had been ill with a urinary tract infection, had an elevated fever of 102 degrees Fahrenheit, and received antibiotics beginning 01/10/2025. A review of daily staffing sheets showed that beginning the week of 12/08/2024 through 01/14/2025, one of three of the Restorative Nursing Aide staff were pulled from their RNA duties and were assigned to direct resident care assignments 16 times on the following dates: -12/11/2024, 12/13/2024, 12/15/2024, 12/20/2024, 12/24/2024, 12/25/2024, 12/26/2024, 12/29/2024, 12/30/2024 and 12/31/2024 in December and, -01/01/2025, 01/02/2025, 01/03/2025, 01/10/2025, and 01/14/2025 in January. A quarterly assessment submitted on 01/13/2025 documented Resident 36 had declined in their ability to perform their ADLs; the resident used assistive devices of a walker and a wheelchair, was dependent on staff for toileting assistance, dressing their upper and lower body, and they required substantial assistance for personal hygiene, bed mobility and bed to chair transfers. The resident received 2 days of restorative walking activity and 1 day of restorative active range of motion during the 7-day look-back period. During an interview on 01/08/2025 at 10:35 AM, Resident 36 stated they no longer received therapy as their insurance benefits ran out. Resident 36 was seated in a recliner, and a four-wheeled walker and wheelchair were positioned at the end of their bed by their closet just past the recliner. When asked what types of activities the resident preferred to participate in, Resident 36 stated they mainly stayed in their room. They stated they were supposed to get restorative therapy, but the restorative aides were usually pulled to direct care assignments. Resident 36 stated their restorative activity was important to them because they did not want to stiffen up. During an interview on 01/15/2025 at 10:46 AM, a staff member that wished to remain anonymous stated when a resident was discharged from therapy, physical therapy determined what restorative program was appropriate for a resident. They stated each RNA had 18-20 residents a piece. They tried to see each resident 4-5 times a week. If a resident refused, the RNA marked refused in their documentation. If the resident participated, but did an activity other than what was in their plan, such as walking instead of doing active range of motion, the RNA documented that the resident did not complete the plan as written with no but the resident still got RNA services. When a Resident was in their window for charting (the look back period for their comprehensive assessments), they were seen 6 times in the week. The staff member stated they worked often with Resident 36, and noticed the resident was not doing as much. They stated they notified therapy the resident was not doing as well. The staff member stated they were often given direct care assignments so were unable to complete RNA activities. Consistency was important for Resident 36 because they lost progress quickly without their restorative work. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/2025 at 1:14 PM, Staff L, Director of Rehabilitation, stated therapy created the restorative plan for a resident when their therapy program ended, but they were unsure how often a resident was seen by the RNA; the restorative program was a nursing program so nursing determined the frequency. Staff L stated they were notified that day, 01/16/2025, that Resident 36 had declined and had trouble transferring so they had done an evaluation and they would be providing therapy to the resident again. Staff L stated when Resident 36 was discharged from therapy services in December of 2024, they required contact guard assistance of one staff with their walker and could walk to their bathroom. During an interview on 01/17/2025 at 3:06 PM, Staff W, Registered Nurse, Minimum Data Set Coordinator, stated Resident 36 had been ill, and once their treatment had been completed, the resident was to be evaluated for a second area of decline to determine if there had been a significant change. Staff W stated restorative services were to be completed 6 days per week. Reference: WAC 388-97-1060(2)(a)(b) Refer to F725 for additional information.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37544 Based on observation, interview, and record review the facility failed to provide adequate assistance during mealtimes for 1 of 4 sampled residents (Resident 90), reviewed for activities of daily living. This failure placed the resident at risk for decreased food and fluid intake, possible unintended weight loss and decreased quality of life. Findings included . Per the 12/17/2024 comprehensive assessment, Resident 90 had diagnoses which included traumatic brain injury (brain damage caused by a sudden forceful bump, blow, or jolt to the head), lack of coordination and muscle weakness. The assessment further documented Resident 90 had no range of motion impairment to their upper extremities, required set-up or clean-up assistance for eating and was cognitively intact for decision making. Review of the 12/09/2024 nutrition care plan showed Resident 90's assistance needs during meals varied from independent up to set -up assistance and instructed staff to refer to physical therapy (PT) and/or occupational therapy (OT) as appropriate. The 12/09/2024 limited physical ability care plan showed Resident 90 had a contracture to their left hand and instructed staff to provide PT/OT as ordered and/or as needed. Review of the 12/12/2024 nutrition evaluation form showed Resident 90 required set up assistance for meals, did not use adaptive equipment, and consumed 0-100% of each meal. Review of nursing progress notes showed Resident 90 was agreeable to therapy on 12/12/2024. During an observation on 01/09/2025 at 12:50 PM, Resident 90 was sitting in the dining room eating their lunch. Resident 90 had slow arm movements while feeding themselves and had difficulty grasping their utensils. Resident 90 used their fingers to eat pieces of cut-up chicken. Resident 90 took long breaks (approximately 5-10-minute intervals or more) between bites and consumed less than 25% of their meal. No staff were present. During an observation on 01/10/2025 at 8:25 AM, Resident 90 was sitting in the dining room eating breakfast. A staff member cut-up Resident 90's biscuit with jelly and then sat down with another resident across the room. Resident 90 was slowly eating using their fork and ultimately began to eat the scrambled eggs with their fingers. No staff was observed providing cues or assistance. During an observation on 01/13/2025 at 7:41 AM, Resident 90 was sitting in their wheelchair eating breakfast in their room. Resident 90 attempted to pick up a full cup of orange juice with their left hand while they simultaneously held a cup of coffee in their right hand. Resident 90 could not grasp the cup of orange juice and drank the coffee instead. Resident 90 did not attempt eating. At 8:16 AM, Resident 90 lightly held the full cup of orange juice with two hands, almost dropped it, and began to slowly drink from the edge of the cup. At 8:33 AM, Resident 90 still had their breakfast tray in front of them. No staff was observed assisting Resident 90 during their meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 01/14/2025 at 12:18 PM, Resident 90 was sitting up in their bed eating lunch extremely slow and showed difficulty manipulating their utensils to feed themselves. During an interview on 01/15/25 at 10:18 AM, Resident 90 stated that they would like to work with the therapy on grasping items with their hands, such as picking up a glass of water. Resident 90 further stated their hand impairment made them feel insecure and would ask for assistance during their meals, if staff was available. During an interview on 01/16/2024 at 4:05 PM, Staff L, Certified Occupational Therapist Assistant, stated nursing staff informed the therapy department Resident 90 was having increased difficulties at meals, on 01/09/2025, and was currently receiving OT to address their activities of daily living skills. Staff L explained Resident 90's gross motor skills (use of large muscle groups in the arms, legs and core to perform coordinated movements) were impaired . Staff L reviewed Resident 90's care plan. Staff L stated stand by assistance during meals was a more appropriate level of care for Resident 90 and the care plan should have been updated to reflect that. Reference WAC 388-97-1060 (2)(C) This is a repeat deficianry from 01/24/2024.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to provide care according to the person-centered care plans and provider orders for 4 of 8 sampled residents (Residents 27, 36, 54 and 89) reviewed for quality of care. Specifically, Resident 27 was on a fluid restriction and their intake was not monitored or maintained, Resident 36's blood sugar monitoring equipment was broken by staff and was not replced timely, Resident 54 did not have their bowel management medications administered to prevent constipation, and Resident 89 had difficulty swallowing and a Speech Therapy evaluation was not completed timely. These failures placed residents at risk for unintended health consequences and decreased quality of life. Findings included . <Resident 36> A review of the 10/25/2024 quarterly assessment documented Resident 36 had diagnoses that included Parkinson's disease (a Central nervous system disease that caused stiffness, tremors and balance difficulty) and diabetes. The resident was cognitively intact and received insulin injections (treated high blood sugar) daily. On 08/07/2024, an order was given by the provider for staff to utilize a continuous glucose monitor (CGM, a sensor inserted under the skin that monitored blood sugar levels continuously and sent the information to a receiver or smartphone application) to monitor Resident 36's blood sugar level twice a day, no finger sticks. During an interview on 01/08/2025 at 11:11 AM, Resident 36 was in their room seated in their recliner. The resident stated they received insulin injections every day to manage their blood sugar. Resident 36 stated they had an implanted blood sugar monitor and it was observed on the back upper portion of the resident's left arm. The resident stated they had a receiver that was held up to their arm and their blood sugar level could be seen. Resident 36 stated their CGM had been broken over a week prior. The resident stated one of the nurses had been unable to get the CGM to work, had tried to replace a cartridge in the sensor and also broke the cartridge. The resident stated ever since, staff were pricking their fingers to obtain their blood sugar and their fingertips were sore. Resident 36 stated their family member had tried to order more cartridges but none had come in yet. Review of the January medication administration record (MAR) documented blood sugar results were obtained twice daily from Resident 36's CGM, with no omissions. There were no progress notes that documented that the CGM was broken, what the status was, or if the provider or other staff had been notified. During a follow up interview on 01/17/2025 at 9:10 AM, Resident 36 stated they were still having their blood sugar results obtained using finger sticks. They stated no one from the facility had talked with them regarding replacing their cartridges or if their family was able to obtain any supplies. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/2025 at 9:33 AM, Staff AA, Certified Medication Technician, stated they performed finger sticks to obtain Resident 36's blood sugar result. Staff AA viewed the order that instructed staff to use the monitor and not use finger sticks and stated the resident's CGM was not working and had been broken for several weeks. Staff AA was not sure if the provider had been notified, or if the Resident Care Manager knew the CGM was broken. During an interview on 01/17/2025 at 1:18 PM, Staff D, Resident Care Manager, stated they had not been notified that Resident 36's CGM was not working. The resident's family had been providing the supplies for the monitor. Staff D stated they expected staff to notify the provider so other arrangements or orders for blood sugar monitoring could be obtained, and they expected staff to follow-up and also write a progress note. 46115 CONSTIPATION <Resident 54> Review of the March 2018 facility bowel protocol, documented residents who were at risk of constipation would have a care plan implemented. A licensed nurse reviewed the bowel monitor daily, and if a resident did not have a bowel movement (BM) for three days, the nurse administered the physician ordered bowel program. Per the 12/23/2024 significant change in condition assessment, Resident 54 was unable to make decisions regarding cares, and needed total assistance from staff for activities of daily living, such as toileting. Review of the 04/27/2023 care plan showed there was no care plan for constipation. Review of the December 2024 MAR documented on 12/17/2024, the physician had ordered a laxative (Milk of Magnesia) to be given on day four of no BM as needed, a suppository was to be given the next shift if no BM and an enema the next shift if no results had occurred. Review of the bowel records from 12/12/2024 through 01/08/2025, documented Resident 54 had no BMs from 12/20/2024 through 12/24/2024 (five days). Additional review of the MARS for December 2024, documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 54's record that stated the reason for the omissions. In an interview on 01/16/2024 at 3:14 PM, Staff B, Director of Nursing, stated the expectation was for bowel medication to be given as ordered and this was important to prevent constipation which could cause pain, discomfort and an obstruction. 47328 FLUID RESTRICTION (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 27> According to the 12/19/2024 quarterly assessment, Resident 27 admitted to the facility on [DATE] with diagnoses including heart failure (HF, heart is not strong enough to pump blood well enough to meet the body's needs), atrial fibrillation (irregular and abnormal heartbeat) and malnutrition. Resident 27 had moderate cognitive impairment and was able to verbalize their needs. Review of the 09/24/2024 nutrition care plan showed Resident 27 had nutritional risks and instructed staff to provide diet per provider orders, provide 120 milliliters (mls) of a house supplement with meals, obtain weights per facility protocol, and follow a 1500 ml/24 hours (hrs) fluid restriction per provider orders. Review of provider orders showed a 12/02/2024 order Resident 27 was on a 1500 ml fluid restriction. The provider order broke down the fluids as dietary was to provide 960 mls/24 hrs with meals and nursing was to provide 540 mls/24 hrs, (180 mls each shift in addition to fluid provided by dietary). A 12/02/2024 order instructed night shift to add all fluids provided by the dietary and nursing departments nightly. Review of the December 2024 through January 2025 MAR showed Resident 27 was provided the following fluids by nursing: -12/02/2024 540 mls on evening shift -12/08/2024 240 mls on day shift -12/12/2024 540 mls on night shift -12/15/2024 360 mls on day, evening, and night shifts -01/01/2025 360 mls on day shift and evening shift -01/08/2025 320 mls on evening shift These amounts exceeded the 180 mls allowed per shift. The January 2025 MAR further showed Resident 27 received 1620 mls fluid total on 01/07/2025 and 2480 mls fluid total on 01/08/2025. Review of the December 2024 through January 2025 fluid intake at meals showed Resident 27 was provided: -12/23/2024 488 mls with breakfast, 440 mls with lunch, and 240 mls with dinner (1168 mls) -12/12/2024 360 mls with breakfast, 240 mls with lunch, and 480 mls with dinner (1080 mls) -01/06/2025 420 mls with breakfast and lunch, 240 mls with dinner (1080 mls) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 01/07/2025 at 9:15 AM, Resident 27 sat in their room with a Fluid Restriction 1500mls, NO water at bedside sign posted above their bed. Resident 27 had a large clear cup of ice water with a straw on their bedside table. Similar observations were made on 01/07/2025 at 12:13 PM, on 01/09/2025 at 8:14 AM and 12:13 PM, on 01/13/2025 at 7:44 AM, and 01/15/2025 at 10:05 AM. In an interview on 01/09/2025 at 1:25 PM, Staff R, Nursing Assistant (NA), stated floor staff passed ice water at least twice daily. Staff R was unsure what size the large clear cups used to pass ice water to the residents were. In an interview on 01/14/2025 at 10:13 AM, Resident 27 stated they could get all the juice, coffee, or other fluids they wanted but sometimes staff limited their water. Resident 27 explained staff removed water from the bedside at night. In a follow-up interview on 01/15/2025 at 12:12 PM, Staff R, NA, stated staff could reference a resident's care plan to see what interventions were implemented for the resident, including a fluid restriction. Staff R further stated fluid restrictions were typically in place related to heart issues and not following a fluid restriction could potentially cause increased swelling and medical complications. During observation and interview on 01/15/2025 at 12:25 PM, Staff E, Registered Nurse, explained when a resident was on a fluid restriction, the daily fluid allotment would be divided up into fluids provided by dietary for meals and fluids provided by nursing throughout the day. Staff E stated fluids consumed would be documented in the resident's medical record. Staff E further stated residents were typically on fluid restrictions related to HF and could fill up with fluid if the restriction was not followed. Staff E stated Resident 27 was on a fluid restriction and had signage posted at the bedside to notify staff. Staff E walked into Resident 27's room to point out the fluid restriction sign that read Fluid Restriction 1500mls, NO water at bedside. Staff E removed a large clear cup of water off the bedside table and acknowledged Resident 27 should not have water at their bedside. Staff E reviewed Resident 27's medical record. Staff E stated Resident 27 was on a fluid restriction because they had HF. In an interview on 01/15/2025 at 1:07 PM, Staff D, Resident Care Manager, explained when a resident was on a fluid restriction, the daily fluid allotment would be divided up into fluids provided by dietary for meals and fluids provided by nursing throughout the day. Staff D stated a resident on a fluid restriction should not receive extra water and typically had signage posted at the bedside for staff to follow. Staff D reviewed Resident 27's medical record. Staff D acknowledged Resident 27 was on a fluid restriction because of their HF. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/15/2025 at 2:22 PM, with Staff B, Director of Nursing, and Staff C, Assistant Director of Nursing, they explained when a resident was on a fluid restriction, the daily fluid allotment would be divided up into fluids provided by dietary for meals and fluids provided by nursing throughout the day. Staff B stated the facility typically posted signage at the bedside when a resident was on a fluid restriction and staff should ask the resident's nurse for approval on fluids prior to providing them to a resident on a fluid restriction. The provider should be notified if a resident took in more fluids than ordered. Both Staff B and C stated if a fluid restriction was not followed it could cause fluid overload and/or a potential flare up of the medical condition the fluid restriction was managing. Both Staff B and Staff C were unsure what size the large clear plastic cups used to pass ice water to the residents were. Staff B reviewed Resident 27's medical record. Staff B acknowledged Resident 27 was on a fluid restriction for HF. In an interview on 01/15/2025 at 3:44 PM, Staff A, Administrator, was unsure what size the large clear plastic cups used to pass ice water to the residents were. Staff A stated they expected staff to read signage posted in a resident's room and follow fluid restrictions when implemented. In an interview on 01/17/2025 at 3:28 PM, Staff S, Registered Dietician, was unsure what size the large clear water cups used to pass ice water to the residents were. Staff S further stated they were not aware staff were not following Resident 27's fluid restriction and were concerned. Reference WAC 388-97-1060 (1) This is a repeat deficiency from 11/13/2024 and 05/13/2024.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 37544 Based on observation, interview, and record review the facility failed to consistently implement a resident's care plan and ensure appropriate treatment and services to restore as much normal bladder and bowel function as possible were received 1 of 3 sampled residents (Resident 81), reviewed accidents. These failures placed residents at risk for a decline in urinary and/or bowel function, embarrassment, and diminished quality of life. Findings included . Per the 11/14/2024 quarterly assessment, Resident 81 had diagnoses including stroke and hemiplegia (muscle weakness on one side of the body). The assessment further showed Resident 81 was dependent for transfers during toileting and was frequently incontinent of bowel and bladder. There was no bowel and bladder training program in place. Resident 81 had moderate cognitive impairment. Review of the 06/04/2024 self-care deficit care plan documented Resident 81 was dependent for toileting and instructed staff to only use a bedpan to use for toileting. The 08/27/2024 bowel incontinence care plan instructed staff to observe pattern of incontinence and initiate a toileting schedule if indicated. Review of the bowel records from 12/16/2024 through 01/14/2025, showed Resident 81 had bowel incontinence for 19 days, bowel continence for 4 days, and no bowel movements at all for 5 days. Review of the bladder records from 12/16/2024 through 01/14/2025, showed Resident 81 had urinary incontinence daily and was continent of urine for 4 days. During an observation on 01/09/2025 at 09:07 AM, staff transferred Resident 81 into bed using a full body lift, provided incontinence care but did not offer or provide Resident 81 with the bedpan, as care planned. Similar observations were made on 01/09/2025 at 1:06 PM and 01/10/2025 at 11:47 AM. In an interview on 01/15/2025 at 3:26 PM, Resident 81 stated they had not used a bed pan for toileting and would prefer to be continent. During an observation and interview on 01/15/2025 at 3:47 PM, Staff DD, Nursing Assistant, entered the resident's room and repositioned them in their wheelchair after the resident stated they were in pain. Resident 81 made a grunting sound, showed facial grimaces and stated they were in pain because they needed to have a bowel movement. Staff DD did not offer or provide Resident 81 with a bedpan. In an interview on 01/16/2025 at 1:49 PM, Staff E, Registered Nurse, stated Resident 81's toileting did not include the use of a bed pan and acknowledged nursing staff only checked and changed Resident 81's brief. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/16/2025 at 03:41 PM, Staff L, Certified Occupational Therapist Assistant, acknowledged a bed pan should be used with Resident 81 due safety during transfers and comfortability when voiding. In an interview on 01/17/2025 at 5:18 PM, Staff DD stated Resident 81 informed staff when they needed to have a bowel movement or be changed after incontinence episodes. Staff DD acknowledged they never used a bed pan with Resident 81 or seen a bedpan in the room. Staff DD stated using a bedpan would be better for the Resident 81's skin integrity and dignity, rather than using a brief. In an interview on 01/17/2025 at 06:05 PM, Staff B, Director of Nursing, reviewed Resident 81's care plan. Staff D acknowledged a bed pan should have been available and offered to the Resident 81 for toileting use, as care planned. Reference WAC 388-97-1060 (3)(c) Refer to F725 for additional information.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview and record review, the facility failed to implement interventions timely to prevent weight loss for 2 of 7 sampled residents (Resident 54 and 77) reviewed for nutrition. This failure placed the residents at risk for further weight loss and a decline in their health. Findings included . <Resident 77> According to the 11/09/2024 annual assessment, Resident 77 admitted to the facility on [DATE] with diagnoses including dysphagia and muscle weakness. The assessment further showed Resident 77 showed no signs and/or symptoms of a swallowing disorder. Resident 77's weight was 159 lbs within the last 30 days. Resident 77 was cognitively intact and able to clearly verbalize their needs. Review of the 01/05/2024 initial nutrition evaluation by the Registered Dietician showed Resident 77's weight was 181.6 lbs on 01/04/2024. The assessment further showed Resident 77 was on a regular texture diet with thin liquids and nourishment supplement ordered at bedtime. Resident 77 consumed 75-100% of all three meals. Nutritional interventions were listed as monitoring with a goal weight of 180 lbs, plus or minus 5%. Review of a 05/01/2024 nutrition hydration skin committee review form showed Resident 77 was reviewed related to weight loss. Resident 77's weight was 165.8 lbs on 04/30/2024 with a 5% weigh loss in the last month from 174.9 lbs on 03/29/2024. Resident 77's average meal intake was 26-100%. An interdisciplinary team evaluation summary showed Resident 77 had an 11 lbs significant weight loss in April 2024 unrelated to intake, no recommendations were made at that time. Review of a 08/22/2024 nutrition hydration skin committee review form showed Resident 77 was reviewed related to weight loss. Resident 77's weight was 158.8 lbs on 08/22/2024 with a 7.5% weight loss in the last three months from 169.2 on 05/09/2024 and a 10% weight loss in the last six months from 179.9 on 02/16/2024. Resident 77's average meal intake was 51-100%. An interdisciplinary team evaluation summary showed Resident 77 had documented weights indicating weight loss, weight were obtained sitting, standing, and in wheelchair and recommended consistent weighing method be used. Review of a 08/23/2024 nutrition note showed Resident 77's body mass index (BMI, calculated weight relative to height) was at the lower end of normal for their age and a calorie dense supplement was added twice daily for calorie and protein support. Review of provider orders showed Resident 77 was ordered a nutritionally enhanced meals (NEM, extra calories added through use of butter, brown sugar and gravy for example) on 08/22/2024 and a calorie dense supplement twice daily on 08/23/2024. Review of the nutrition care plan revised 08/23/2024 instructed staff to provide Resident 77 a diet and calorie dense supplement as ordered, offer liquids between meals, obtain weights per facility protocol, and offer a meal substitute or supplement if 50% or less of a meal was consumed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 09/24/2024 provider progress note showed Resident 77 was concerned about their weight loss. The note further showed Resident 77 had a 15 lbs weight loss in the last six months, moderate protein-calorie malnutrition with muscle wasting in their abdomen, thighs, and face. Resident 77 stated the food is horrible. Review of the 11/06/2024 annual nutrition evaluation form showed Resident 77's weight was 159.2 lbs on 11/04/2024 and their desired body weight was between 170-180 lbs. The assessment further showed Resident 77 was on regular texture NEM diet with thin liquids and calorie dense supplement twice daily. Resident 77 consumed 26-100% of their meals. The dietician evaluation summary showed between 08/14/2024 through 11/04/2024, Resident 77's weights had been stable between 154 and 160 lbs. Review of a 12/04/2024 provider note showed Resident 77 was seen for follow-up on their protein calorie malnutrition. Resident 77 was on nutritional supplements and their weight had stabilized between 157-158 lbs for the last three months. Resident 77 attributed their weight loss to disliking the facility food. In an interview on 01/07/2025 at 2:53 PM, Resident 77 stated the facility food was terrible. Resident 77 further stated they had lost 30 lbs, from 180 lbs down to 160 lbs, and it bothers me. Resident 77 explained they had lost so much weight they could now pull their pants down without having to undo their belt. In a follow-up interview on 01/17/2025 at 9:04 AM, Resident 77 stated their preferred weight was being in the 180 lbs range. Resident 77 again stated their pants were loose and was concerned they had lost so much weight. In an interview on 01/16/2025 at 1:43 PM, Staff G, NA, explained the facility process for obtaining weights. Staff G explained if a weight showed a potential weight loss, a reweigh would be obtained and they would notify the nurse and resident care manager. Staff G was unsure if Resident 77 had weight loss. In an interview on 01/16/2025 at 1:53 PM, Staff E, Registered Nurse, stated if a resident refused a meal or consumed less than 50% of a meal, they would offer them an alternative like a sandwich or pudding. Staff E further stated if potential weigh loss was identified the provider and RD would be notified. Staff E reviewed Resident 77's medical record. Staff E stated Resident 77's weight upon admission was 182 lbs on 12/29/2023, was not on a prescribed weight loss regimen and had weight loss in the facility, Resident 77's lowest weight was 154.8 lbs on 10/01/2024. Staff E further stated Resident 77 was started on a calorie dense supplement on 08/23/2024 after a 23.2 lbs weight loss. Staff E acknowledged Resident 77's stopped losing weight, their weight stabilized, and they started gaining a few pounds after the supplement was added and increased. In an interview on 01/16/2025 at 2:18 PM, Staff Y, Resident Care Manager, reviewed Resident 77's medical record. Staff Y stated Resident 77's weight upon admission was 182 on 12/29/2023, they lost 23 lbs since at the facility, Resident 77's weight was 159 lbs on 01/10/2025. Staff Y stated Resident 77 was ordered calorie dense supplements on 08/23/2024. Staff Y acknowledged if supplements were ordered sooner, it could have potentially prevented Resident 77 from losing so much weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/16/2025 at 2:40 PM, Staff B, Director of Nursing, reviewed Resident 77's medical record. Staff B stated Resident 77's admission weight was on 12/29/2023 and had significant weight loss in May 2024, five months after their admission. Staff B stated Resident 77 was started on a NEM diet and calorie dense supplements in August 2024, after their weight loss. In an interview on 01/17/2025 at 3:03 PM, Staff S, RD, reviewed Resident 77's medical record. Staff S stated Resident 77 began to be followed by the facility nutrition/hydration committee 05/01/2024 for identified weight loss, 165.8 lbs on 04/30/2024, a 16.2 lbs weight loss. Staff S further stated a NEM diet and calorie dense supplements were ordered in August 2024, then their weight stabilized. Staff S reviewed the 09/24/2024 provider progress note that showed Resident 77 had protein calorie malnutrition after a 15 lbs weight loss in six months with muscle wasting. Staff S acknowledged Resident 77's protein calorie malnutrition diagnoses was new during their stay at the facility. In an interview on 01/17/2025 at 4:11 PM, Staff A, Administrator, stated the facility implemented interventions when weight loss was identified, not prior to weight loss. <Resident 54> Per the 12/23/2024 significant change assessment, Resident 54 had diagnoses which included diabetes, high blood pressure, dementia and had severe cognitive impairments. The assessment further showed the resident held food in their mouth or residual food in their mouth after meals, coughed or choked during meals and had no weight loss or gain. A 12/23/2024 physician's order prescribed Resident 54 mildly thickened liquids, supervision for all intake and was to have aspiration precautions [sitting upright at a 90-degree angle, taking small bites and chewing well before swallowing, and eating and drinking slowly] for dysphagia (difficulty swallowing). The order also stated sippy cups (a cup with two handles and a lid that prevented excessive flow of fluids) for all drinks. The 04/24/2024 care plan stated Resident 54 would have no unplanned significant avoidable weight loss or gain, was at risk related to an aspiration event, dysphagia and was on a mechanically altered diet. The interventions included a two handled cup, aspiration precautions, no straws, supervision, refer to the dietician as appropriate and two ounces of no sugar added shakes with lunch and dinner that was added on 12/23/2024. A 10/01/2024 nutritional evaluation by the Registered Dietician showed Resident 54 had a downward trend in weight, lost 10 lbs in the last year but was not significant and food preferences were updated. A 12/23/2024 nutritional evaluation by the Registered Dietician showed Resident 54's weight on 06/12/2024 was 172.4 pounds (lbs), 09/04/2024 170.4 lbs, 11/05/2024 163.2 lbs, and 12/18/2024 157.5 lbs. The resident's average intake was 58 %, current body mass index was 22.6, underweight, and a no sugar added shake was added to meals. Review of Resident 54's record from August 2024 through January 2025 showed a 9.1% weight loss in six months, a 6.57% loss in three months and a 2.3% loss over the past month. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 01/10/2025 at 12:11 PM, Resident 54 sat alone in their room consuming fluids and eating independently (no supervision as ordered). Subsequent observations of the resident without supervision during the meal service were made on 01/10/2025 at 12:31 PM, 01/13/2025 at 7:23 AM, 7:44 AM, 7:55 AM, 01/15/2025 at 12:28 PM, 12:32 PM, 12:37 PM, and 12:45 PM. In an observation on 01/10/2025 at 12:36 PM, Resident 54 had some regular cups and had consumed fluids from them (not all cups were sippy cups as ordered). In a similar observation on 01/13/2025 at 7:05 AM, the resident had a regular cup, and one cup of the fluids contained ice cubes (resident was prescribed thickened liquids). At 7:55 AM, the resident had three cups of fluids, and none were in a sippy cup. On 01/15/2025 at 12:33 PM and 01/16/2025 at 7:58 AM, the resident had consumed fluids out of a regular cup. In an interview on 01/15/2025 at 1:39 PM, Staff OO, Nursing Assistant, stated supervision for meals meant sitting with the resident but they did not have enough staff to do so when the residents ate in their rooms. Staff OO stated they looked at the resident's care plan or meal tickets to know if they needed adaptive equipment for meals. When asked why it was important for the resident to have a sippy cup, Staff OO stated to prevent choking. Staff OO stated any resident that received thickened liquids should not have had ice in their fluids as they could choke or aspirate. During an interview on 01/16/2025 at 2:19 PM, Staff B, Director of Nursing, stated Resident 54 had not triggered for weight loss, but had lost 15 lbs. Staff B added interventions would be placed prior to weight loss. Staff B stated a resident that requires sippy cups should have them for all liquids and this was important to control the flow of the liquids and stated residents on thickened liquids should not have ice cubes unless they have signed a risk/benefit form, and this could cause aspiration. In an interview on 01/17/2025 at 2:41 PM, Staff S, Registered Dietician, stated Resident 54 had a downward trend in their weight. When asked what interventions were put in place for the resident over the past six months, Staff S stated they had a downgrade in their diet, change in adaptive equipment and aspiration precautions. Staff S added house supplement had been added on 12/23/2024. When asked if interventions should have been placed prior to December 2024, Staff S stated it possibly could have helped to start the house supplement sooner or to have increased it. Staff S acknowledged Resident 54 was diabetic and added they did not have sugar free house supplement in stock, and it had to be ordered when needed. 47328 Reference: WAC 388-97-1060 (3)(h) Refer to F804 for additional information.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37544 Based on observation, interview and record review, the facility failed to ensure bi-level positive airway pressure (BIPAP, a machine that helped people breathe by delivering pressurized air into their lungs through their nose, or nose and mouth) was implemented as ordered by the physician for 1 of 3 sampled residents (Resident 81) reviewed for respiratory care. This failure placed the resident at risk for impaired sleep, unmet care needs, and a diminished quality of life. Findings included . The 11/14/2024 quarterly assessment documented Resident 81 was moderately cognitively impaired, was able to make their needs known, and had diagnoses which included stroke and impaired ability to move the upper and lower extremity on one side of their body. In addition, the assessment documented the resident was dependent on nursing staff to complete activities of daily living (ADLS) for getting dressed. Review of Resident 81's care plan showed a respiratory care plan was developed on 12/10/2024 to provide interventions to treat the resident's sleep apnea, a condition that caused breathing to stop during sleeping. The care plan informed nursing staff the resident had a BIPAP machine, and the licensed staff were to ensure the BIPAP was worn by the resident while sleeping, including naps as ordered. Observations of Resident 81 sleeping in bed and/or their wheelchair without the BIPAP being worn were made on the following: - 01/10/2025 at 11:34 AM, 11:42 AM, and 11:58 AM. - 01/13/2025 at 8:01 AM, and 10:41 AM; and 01/14/2025 at 8:34 AM. During the observation on 01/14/2025 at 8:34 AM of Resident 81 not wearing the BIPAP, the resident woke up and stated they didn't get much sleep yesterday. In an interview on 01/15/2025 at 3:38 PM, Resident 81's spouse stated it was important for the resident to wear the BIPAP anytime they were asleep due to the high risk for another stroke and decreased alertness from not sleeping well. In an interview on 01/17/2025 at 5:11 PM, Staff DD, Nursing Assistant, stated Resident 81 used a BIPAP at night, did not use it during the day when they nappped, just when they slept at night to help them breath. When asked how the nursing staff knew what the care needs were for residents, Staff DD, stated the resident's care plans provided information and instructions. In an interview on 01/17/2025 at 6:00 PM, Staff B, Director of Nursing, was informed of the multiple observations of Resident 81 not wearing the BIPAP while sleeping. After review of the residents' orders and record, Staff B confirmed the resident needed to wear the BIPAP whenever sleeping, including naps as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC: 388-97-1060(3)(j)(vi)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to ensure the facility had enough staff to provide care according to facility acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and/or care plans for 5 of 9 sampled resident's (Resident 40, 31, 27, 24 and 28), reviewed for sufficient staffing. This failure placed all residents at risk for potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment reviewed 08/15/2024, showed staffing levels were determined at the facility level to ensure there were enough staff with appropriate competencies and skill set necessary to care for the residents' needs as identified through resident assessments and plans of care. The facility would consider staffing needs for each shift and would adjust as necessary based on any changes to its resident population. The assessment further showed the facility average daily census was 105 over the last six months with an average of 70 long term care and 35 short term/rehabilitation residents. The facility reviewed resident acuity levels to understand potential implications regarding the intensity and complexity of care and services needed. The assessment showed the facility contingency staffing plan included the use of on-call managers who would come into the building to provided coverage as needed and the use of staffing agencies for immediate and long-term staffing needs when needed. <Resident 40> According to the 11/02/2024 quarterly assessment, Resident 40 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 40 filed the following grievances: -08/06/2024 staff ignored call lights and played on their mobile phones. -09/03/2024 still having issues with staff ignoring call light never had any follow up from prior grievance in August. -12/03/2024 night shift staff using Oak activity room as break room and ignoring call lights. In an interview on 01/08/2025 at 10:38 AM, Resident 40 stated staff were still not answering call lights timely. Resident 40 further stated they received medications around 3:30 AM and would often come out in search of the nurse to find staff using the Oak activity room as a breakroom while residents had call lights on in the halls. <Resident 31> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 11/19/2024 quarterly assessment, Resident 31 had diagnoses including chronic (occurring for long period of time or repeatedly) respiratory failure (lungs not working properly to get enough oxygen into the body) with hypoxia (low oxygen levels in body), chronic pulmonary embolism (blood clot that blocks blood flow to lungs), and muscle weakness. Resident 31 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of the 04/17/2024 self-care performance deficit care plan showed Resident 31 required extensive assistance of staff to perform most activities of daily living (ADLs) including toileting hygiene. A 04/17/2024 fall risk care plan showed Resident 31 was at risk for falls and instructed staff to encourage call light use, ensure appropriate footwear was worn, keep the bed at an appropriate transfer level, and anticipate Resident 31's needs. A 04/17/2024 respiratory care plan showed Resident 31 had difficulty breathing and instructed staff to elevate the head of the bed and provide oxygen therapy per provider order, changing from an oxygen mask to a nasal cannula during meals. Review of July 2024 through December 2024 grievance log showed Resident 31 filed the following grievances: -07/02/2024 the night Nursing Assistant was rude, rough and pinched Resident 31's skin when they assisted with a brief change. -11/05/2024 they waited 45 minutes for staff to assist with personal hygiene after an episode of incontinence. In an interview on 01/08/2025 at 10:38 AM, Resident 31 stated staff were still not answering call lights timely. Resident 31 further stated they should not be taking themselves to the bathroom but did because staff would not respond to their call light timely. Resident 31 explained they typically did not wear their oxygen when in the bathroom, last week they pressed their bathroom call light, after waiting 35 minutes without staff response, Resident 31 began to yell out because they needed their oxygen. Resident 31 stated they left the door to their room open, in case of emergencies, because staff did not response to call lights timely. <Resident 27> According to the 12/19/2024 quarterly assessment, Resident 27 admitted to the facility on [DATE] with diagnoses including muscle weakness. Resident 27 required substantial staff assist to transfer onto the toilet and was dependent of staff for toileting hygiene. The assessment further showed Resident 27 did not sustain any falls prior to admission and sustained three falls after their admission. Resident 27 had moderate cognitive impairment and was able to verbalize their needs. Review of the 11/18/2024 self-care deficit care plan showed Resident 27 required extensive assistance of one to two staff to use a mechanical lift for transfers. A 11/18/2024 care plan showed Resident 27 was a risk at risk for falls related to being legally blind and instructed staff to anticipate Resident 27's needs, encourage call light usage, keep bed at a safe transfer level, offer toileting with each interaction, and not to leave Resident 27 unattended on the toilet. Review of the November 2024 through December 2024 facility incident log showed Resident 27 sustained falls on 11/12/2024, 11/17/2024, 12/05/2024, and 12/28/2024. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the 11/17/2024 fall incident report showed Resident 27 was found sitting on the floor in the bathroom. A 11/19/2024 incident summary showed Resident 27 was left on the toilet unattended and attempted to self-transfer back into their wheelchair. Review of the 12/05/2024 fall incident report showed Resident 27 was found lying on the bathroom floor holding the back of their bleeding head. A 12/06/2024 incident summary showed Resident 27 recently had their diuretic (medication that helps the body get rid of excess fluid) increased and fell when they attempted to transfer onto the toilet independently. During observation on 01/10/2025 at 11:51 AM, the call light above Resident 27's room came on. A visitor stuck their head out of the room and said Where is an aide at? [Resident 27] needs to go to the bathroom, last time [Resident 27] fell , [staff] better get down here, we will see how long this takes. At 11:52 AM, Resident 27 now sat in the doorway to their room with the call light still on. At 11:53 AM, the visitor flagged staff down and informed them Resident 27 needed to go to the bathroom. In an interview on 01/14/2025 at 10:10 AM, Resident 27's family friend stated residents had excessively long call light wait times, and they reported their concern to nursing. Resident 27's friend explained they had seen multiple call lights on with no staff around. The friend continued to explain Resident 27 had weakness in their legs and had their diuretic increased which caused Resident 27 to urinate more often. Resident 27's friend further stated Resident 27 attempted to self-transfer because they waited too long for staff to answer their call light. In an interview on 01/14/2025 at 10:13 AM, Resident 27 stated they sustained at least three falls in the facility. Resident 27 explained they took themselves into the bathroom because they did not want to have incontinence accidents while waiting for staff to answer their call light. Resident 27 further stated there was not enough help because they had excessive call light wait times. <Resident 24> According to the 11/16/2024 quarterly assessment, Resident 24 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of the functional abilities care plan revised 12/05/2023 showed Resident 24 required substantial up to dependent staff assistance to perform most ADLs and instructed staff not to rush Resident 24 during ADL cares. Review of July 2024 through December 2024 grievance log showed Resident 24 filed the following grievances: -11/05/2024 the resident waited one and a half hours for staff assistance. In an interview on 01/07/2025 at 2:43 PM, Resident 24 stated the facility did not have enough staff because they often had excessively long call light waiting times. <Resident 28> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 12/16/2024 quarterly assessment, Resident 28 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. In an interview on 01/07/2025 at 11:29 AM, Resident 28 explained they approached the nurses' station after waiting 50 minutes for their call light to be answered and observed staff sitting around while call lights were going off. In an interview on 01/17/2025 at 12:28 PM, Staff G, Nursing Assistant (NA), stated they were unsure how the facility determined staffing levels. Staff G explained when a NA called in the facility pulled staff from another unit or placed the restorative staff on the floor. Staff G acknowledged residents had excessively long call light wait times when not enough staff. In an interview on 01/17/2025 at 12:52 PM, Staff E, Registered Nurse, stated they were unsure how the facility determined staffing levels. Staff E explained when a nurse called in, sometimes the resident care manager (RCM) came in to help. When a NA called in staff would be pulled from another unit or from the restorative nursing program. Staff E stated restorative nursing staff wore dual hats sometimes they were restorative aides and other times they were a floor aide. Staff E further stated the restorative program did not have a big pool of staff to pull from, only 2 or 3 restorative aides, but pulling from restorative staff was the last resort because that staff was not replaced when pulled to the floor. Staff E acknowledged residents had to wait a long time to get help when there was not enough staff. In an interview on 01/17/2025 at 12:59 PM, Staff D, RCM, stated in theory staffing should be based on census and acutely level. Staff D explained when staff called in, they were to call the facility to get the on-call managers number and call the on-call manager. The on-call manager was to attempt to call staff in and if unable to fill the vacancy, the facility would pull the shower aides to the floor or place restorative nursing staff on the floor. Staff D explained if the bathe aide was pulled to the floor each NA would be responsible for completing their own bathes, if the restorative aide was pulled to the floor, no staff replaced restorative because they did not have the training, there was no restorative program. A tracking log of attempts to fill call ins was requested from Staff D. Staff D acknowledged the facility had no tracking log of who was called in an attempt to fill staffing call ins when they occurred. Staff D was asked about facility acuity. Staff D explained Oak hall was long-term care residents, rooms 101 through 120 had lighter care needs while rooms 128 through 146 had heavier care needs with higher use of full body lifts for dependent residents. Staff D explained as the resident care manager they had attempted to readjust the NA section assignments based on resident acuity, but floor staff did not honor managements changes and readjust the assignments. Staff D acknowledged some residents had excessively long call light wait times, especially the back of Oak hall, rooms 128 through 146. During interview and record review on 01/17/2025 at 1:20 PM, Staff U, Staffing Coordinator, explained they followed a handwritten staffing guide. Staff U provided a copy. Review of the form provided by Staff U showed staffing assignments for Oak hall for staffing from three up to eight direct care staff and instructed nurses to adjust assignments based on resident behaviors and use of transfer lifts. Staff U explained Oak hall was long-term care, residents in the front part of Oak required less assistance than the residents toward the back of Oak hall. Staff U stated staff assigned to the front of Oak sometimes cared for more residents because they required less assistance, but that was not consistent. Staff U acknowledged staff who worked the back of Oak hall had voiced concerns about needing more staff in that area. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 01/17/2025 at 1:46 PM, Staff B, Director of Nursing, stated staffing was based on calculations according to the company guidance that determined how many direct care staff were needed based on census. Staff B further stated management also attempted to keep the facility acuity into consideration. Staff B acknowledged residents on the back part of Oak hall were heavier care and attempted to adjust section assignments accordingly. In a confidential interview on 01/17/2025 at 2:00 PM, an anonymous staff stated the back part of Oak hall was heavy care related to a high use of transfer lifts, it was too much for one person to handle. The anonymous staff further stated they had informed management, but nothing had been done yet; the section assignments did not get adjusted. The staff added sometimes it took them 20 minutes to find a peer to assist them with full body mechanical lift transfers because those should not be done with only one staff for safety. In an interview on 01/17/2025 at 4:07 PM, Staff A, Administrator, stated staffing levels were determined based on the facility population. Staff A further stated section assignments were readjusted based on resident acuity nightly. Reference WAC 388-97-1080 (1), -1090 (1) Refer to F585, F676, and F727 for additional information.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47328 Based on interview and record review the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 1 of 5 sampled staff (Staff F), reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, and diminished quality of life. Findings included . Review of Staff F, Nursing Assistant, personnel file showed they were hired on 11/03/2022. The personnel file included a 01/10/2023 verbal warning for not completing training as required and a 07/29/2024 written warning for a verbal altercation with a peer which included use of profanity and threatening language at the nurse's station. No documentation of a performance evaluation was found. In an interview on 01/17/2025 at 12:28 PM, Staff G, Nursing Assistant, stated staff evaluations were done yearly. In an interview on 01/17/2025 at 12:52 PM, Staff E, Registered Nurse, stated staff evaluations were done yearly. In an interview on 01/17/2025 at 12:59 PM, Staff D, Resident Care Manager, stated staff evaluations were supposed to be completed yearly. Staff D stated resident care was a priority and acknowledged staff evaluations were not completed yearly as required. In an interview on 01/17/2025 at 1:46 PM, Staff B, Director of Nursing, stated staff evaluations were to be completed yearly. Staff B acknowledged the facility was behind on completing staff evaluations yearly as required. Reference WAC 388-97-1680 (1), (2)(a-c) Refer to F585 for additional information.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47328 Based on interview and record review the facility failed to timely act upon the pharmacist's monthly medication regimen review recommendations for identified irregularities for 1 of 5 sampled residents (Resident 24), reviewed for unnecessary medications. This failure placed residents at risk of receiving unnecessary medications, medication complications, and diminished quality of life. Findings included . Review of the facility policy titled, Medication Regimen Review published March 2019, showed a pharmacist reviewed the resident's medication regimen monthly and report irregularities to the attending physician, medical director, and Director of Nursing (DNS). The pharmacist was to exit with the DNS or designee prior to leaving the facility and email their report of any irregularities, at the end of their visit. The attending physician was to respond to pharmacist recommendations within 2-4 weeks and provide documentation pharmacy recommendations were reviewed. If a change was made, the facility notified the pharmacy and completed the order. According to the 11/16/2024 quarterly assessment, Resident 24 had diagnoses including high cholesterol. Resident 24 was cognitively intact and able to verbalize their needs. Review of provider orders showed Resident 24 had an active 03/22/2024 order for staff to administer a cholesterol lowering medication daily at bedtime. Review of the 07/31/2024 pharmacy medication review note to attending prescriber showed Resident 24 took a cholesterol lowering medication. The consultant pharmacist recommended obtaining baseline and yearly liver function test (LFT) and lipid panel blood work to monitor the therapeutic effects and side effects of the medication. The form included a handwritten note that indicated Resident 24's primary care physician was from outside the facility's provider group. A 08/22/2024 typed provider response showed LFTs were done on 05/09/2024 and instructed the facility to repeat the LFTs and fasting lipids next time lab rounds at the facility. Review of the 08/31/2024 pharmacy medication review note to the attending prescriber showed Resident 24 took a cholesterol lowering medication. The consultant pharmacist repeated their 07/31/2024 recommendation to obtain baseline and yearly LFTs and lipid panel blood work to monitor the therapeutic effects and side effects of the medication. No documentation of a provider response was found. Review of the 09/30/2024 pharmacy medication review note to attending prescriber showed Resident 24 took a cholesterol lowering medication. The consultant pharmacist made a recommendation for the third month in a row to obtain baseline and yearly LFTs and lipid panel blood work to monitor the therapeutic effects and side effects of the medication. No other documentation of a provider response was found. On 10/18/2024, Resident 24 had blood tests drawn by the lab that included liver function tests. A lipid panel, which was ordered on 08/22/2024, was not included in the blood work. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/2024 a pharmacy medication review note to the attending prescriber showed Resident 24 took a cholesterol lowering medication. The consultant pharmacist again recommended obtaining baseline and yearly LFTs and lipid panel blood work. The form included a handwritten provider response for the facility to obtain a fasting lipid panel and fax results to the outside provider's office. Review of 11/25/2024 blood test results showed results for a lipid panel, 95 days after it was originally ordered by Resident 24's provider. In an interview on 01/15/2025 at 12:37 PM, Staff E, Registered Nurse, stated they were unsure of the facility monthly pharmacy medication review process. In an interview on 01/15/2025 at 12:48 PM, Staff D, Resident Care Manager, stated they were unsure how an outside provider received and/or reviewed the pharmacist monthly medication review recommendations. Staff D acknowledged Resident 24's lipid panel was not obtained timely as recommended by the pharmacist. In an interview on 01/15/2025 at 1:48 PM, with Staff B, Director of Nursing, and Staff C, Assistant Director of Nursing, they explained the pharmacist monthly medication review process. Both Staff B and C expected the provider to respond to a pharmacy recommendation within two-four weeks and expected pharmacy recommendations to be completed by the end of the month. Staff C acknowledged Resident 24 had an outside primary care physician. Both staff B and C reviewed Resident 24's medical record. Staff C acknowledged Resident 24 had blood work obtained 10/17/2024 but a lipid panel was not obtained until 11/25/2024. In an interview on 01/15/2025 at 3:26 PM, Staff A, Administrator, reviewed Resident 24's medical record. Staff A acknowledged Resident 24's order to obtain fasting lipid blood work was entered into the medical record on 11/22/2024 with the blood work obtained on 11/25/2024, 95 days after it was originally ordered by Resident 24's provider. Staff A stated they expected staff to follow the facility monthly medication review process. Reference WAC 388-97-1300 (4)(c)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46033 Based on record review and interview, the facility failed to ensure significant medication errors were prevented when medications ordered by the provider were not supplied and as administered for 1 of 5 sampled residents (Resident 156) reviewed for unneccesary medications. This failure put the resident at risk for a possible decline in their physical and mental well-being and decreased quality of life. Findings included . A review of the 01/01/2025 admission assessment documented Resident 156 had diagnoses including bone infection of the hip, ankylosing spondylosis (causes swelling, joint pain and fatigue), and depression. Resident 156 was cognitively intact, and took antidepressant, antianxiety, and opioid pain medications daily. The resident had a depression screening score of 6 (on a scale of 0 to 27, six indicating mild depression) related to poor appetite, feeling tired, feeling down and depressed, and little interest in doing things. The 12/26/2024 care plan documented Resident 156 used antidepressant medication. Staff were instructed to administer medications as ordered, educate the resident regarding the risks and benefits of the medication and possible side effects, monitor for effectiveness and report any side effects. The provider had given orders for Resident 156 to receive the following medications: -12/26/2024 amitriptyline 150 milligrams (mg) at bedtime for depression and -12/29/2024 Enbrel 50 mg/milliliter (ml), inject 1 ml weekly every Sunday for osteoarthritis (when flexible tissue at the end of bones wore down, caused pain, swelling and stiffness in the joints). A review of the medication administration records (MAR) for December 2024 and January 2025 showed Resident 156 did not receive Enbrel on 12/29/2024, 01/05/2025, and 01/12/2025. A code OO was entered on the MAR. The Resident also did not receive amitriptyline on 01/11/2025, 01/12/2025, and 01/15/2025 and the same code OO was entered on the MAR. The key on the MAR documented code OO indicated the medication was on order from the pharmacy. When reviewed, there were no progress notes related to the missed doses of the Enbrel and amitriptyline. During an interview on 01/17/2025 at 12:32 PM, Staff Y, Resident Care Manager, stated if a medication is not in the cart, staff were to look in the the overflow drawer on the cart and if not there, they were to see if it was available in the Cubex (a large medication storage unit that housed various medications staff were able to use until the regular ordered medications were received from the pharmacy.) If not in the Cubex, staff were to notify the pharmacy so the medication could be special delivered. Staff were also to notify the provider. Staff Y reviewed the Cubex Inventory report the facility provided to the surveyor, and neither the Enbrel nor amitriptyline were in the Cubex. Staff Y stated they would need to contact the pharmacy and would follow up. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 01/17/2025 at 3:56 PM, Staff Y stated the pharmacy had previously sent a fax requesting authorization for the Enbrel. A signature was required before it was to be dispensed because of the cost. Staff Y stated the amitriptyline would be delivered that afternoon. Staff Y stated it was possible the wrong administration code was entered on the MAR, and they would check with Staff Z, Licensed Practical Nurse, the nurse that administered the medications. During an interview on 01/17/2025 at 3:59 PM, Staff Z stated it had been passed on in their shift report that the amitriptyline had been ordered from the pharmacy. Staff Z stated it was difficult getting the medication from the pharmacy. They stated it might have been an insurance issue, but they had not entered the wrong code, they had not given the medication; it had not come from the pharmacy yet. During an interview on 01/17/2025 at 5:24 PM, Staff B, Director of Nursing, stated they had signed the authorization that day, 01/17/2025, for Resident 156's Enbrel. It was a policy that an authorization had to be signed for medications that cost over a certain amount. Staff B stated they usually received an email when an authroization was needed but did not remember getting one for the Enbrel. Staff D expected staff to call the pharmacy and notify the provider so medication doses were not missed. This is a repeat citation from the previous recertification survey conducted on 10/04/2023 and on 03/07/2024. Reference: WAC 388-97-1060(3)(k)(iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 40297 Based on observation, interview, and record review, the facility failed to ensure the staff dated multi-dose vials of medications when first accessed or opened, monitored refrigerator temperatures to ensure vaccinations were adequately stored in 2 of 2 medication storage rooms, cleaned 1 of 2 medication carts reviewed for cleanliness, and ensured medications were secured in a resident's room. This failure placed residents at risk for receiving compromised or ineffective medication management. Findings included . <Expired Medications> An observation on 01/08/2025 at 2:08 PM with Staff PP, Licensed Practial Nurse (LPN), in the Oak Hall Medication Room identified an undated vial of Tuberculosis screening solution. The plastic cap on the vial's rubber stopper was removed and the vial had been accessed. The box where the vial was stored showed an instruction to the staff to discard the medication after 30 days from being opened.Staff PP stated the medication vial should have been dated when opend and needed to be discarded. This continued medication room observation on 01/08/2025 identified two bottles of mineral oil with an expiration date of 01/04/2025. Staff PP acknowledged the mineral oil was expired and should be discarded. An observation in the Transitional Care Unit (TCU) Hall Medication Room on 01/09/2025 at 10:35 AM showed two bottles of expired mineral oil dated 11/19/2024 and 01/04/2025. Staff QQ, Agency LPN, acknowledged they were expired and should be discarded. <Unmonitored Refrigerator Temperatures> Review of Temperature Log for Vaccines in the Oak Hall Medication Room with Staff PP on 01/08/2025 at 2:08 PM showed an instruction to the staff to check the temperature in both the freezer and the refrigerator compartments at least twice a day, each working day. The form also instructed the staff what to do in the case they identified unacceptable temperate ranges for the storage of the vaccines. Observation showed a vaccine inside the refrigerator for Resident 12 for respiratory syncytial virus (RSV, a contagious respiratory virus that infects the nose, throat, and lungs). The vaccine showed the pharmacy dispensed the vaccine on 11/2024. Review of the Oak Hall October, November, and December 2024 and January 2025 Temperature Log for Vaccines showed the staff only documented temperatures once a day for the refrigerator and did not document freezer temperatures. Additionally, the staff failed to document any temperatures on 12/23/2024, 12/27/2024, 12/30/2024, and 12/31/2024, and from 01/03/2025 to 01/07/025, or five consecutive days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the TCU Medication Room refrigerator with Staff QQ on 01/09/2025 at 2:08 PM identified a box with two influenza vaccines and another box that contained six influenza vaccines. Also present in the refrigerator were pneumonia and RSV vaccines for Residents 70 and 88. Review of the TCU October 2024 through January 2025 Temperature Log for Vaccines showed the staff only documented temperatures once a day for the refrigerator and did not document freezer temperatures. Additionally, the staff failed to document any temperatures on 01/01/2025, 01/04/2025, and 01/05/2025. The above findings were shared with Staff J, LPN and acting Infection Preventionist, on 01/09/2025 at 12:07 PM. Staff J acknowledged the omissions in temperature recordings. <Unsanitary Medication Cart> An observation of the Oak Hall Medication Cart 1 on 01/09/2025 at 10:08 AM showed extensive dry stains inside the medication cart drawers, to include the plastic storage bins in the top drawer that held eye drops and other medications. Staff RR, LPN, identified the stains as medication residue. Some of the stains ranged in color from opaque white to darker grey steaks.The medication cart was observed with run off stains to the outside, to include the attached garbage can. Staff RR stated the night shift was supposed to clean the medication carts weekly and acknowledged the medication cart required cleaning. <Drug Storage> An observation with Staff QQ on 01/09/2025 at 8:48 AM identified a tube of Triamcinolone acetonide cream on the Resident 70's bed and a bottle of ammonium lactate 12% lotion on their bedside table. Resident 70 stated that they applied it to their right foot at night and in the morning. Record review with Staff QQ on 01/09/2025 at 9:05 AM showed no orders for the medications found in the resident's room. Staff QQ stated that there should be an order for the application of the medications, and both an evaluation and an order to safely store at bedside. Reference: WAC 388-97-1300(2) Refer to F554 and WAC 1080 for additional information.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview and record review, the facility failed to ensure dietary staff had the required training for 4 of 17 sampled dietary staff (Staff M, N, O and P) reviewed for credentialing. This failed practice had the potential risk for unsafe food handling practices and placed all residents at risk for developing foodborne illness. Findings included . A review of the dietary cards showed Staff P had no Washington State Food Workers card. Staff P had an expired certificate that was not provided. Staff M, N, and O had a certificate from Food Handler Solutions for completing the food handler's course. Review of Food Handler Solutions website, foodhandlersolutions.com/[NAME]-food-handler-card/ showed, the Food Handler Solutions Program was not currently an approved credentialing program in the State of [NAME]. This program was only intended to be used for personal development and preparation for the State provided training. During an interview on [DATE] at 2:24 PM, Staff Q, Dietary Manager, stated they were unaware the program did not meet credentialing requirements. Reference: WAC [DATE]

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46115 Based on observation, interview and record review, the facility failed to prepare palatable (acceptable/appetizing) meals for 7 of 10 residents (Residents 10, 28, 31, 35, 40, 50 and 77), reviewed for food palatability.This failure placed the residents at risk for a diminished dining experience, dissatisfaction with food served and a potential for less than adequate nutritional intake leading to weight loss. Findings included . <Resident 77> According to the 11/09/2024 annual assessment, Resident 77 was cognitively intact and able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 77 filed the following grievances: -09/03/2024 the clam chowder smelled and tasted bad with a 09/04/2024 resolution that the facility switched out soup for a replacement item. Review of a 09/24/2024 provider progress note showed Resident 77 was concerned about their weight loss. The note further showed Resident 77 had a 15-pound (lbs) weight loss in the last six months, moderate protein-calorie malnutrition with muscle wasting in their abdomen, thighs, and face. Resident 77 stated the food is horrible. Review of a 12/04/2024 provider note showed Resident 77 was seen for follow-up on their protein calorie malnutrition. Resident 77 was on nutritional supplements and their weight had stabilized between 157-158 lbs for the last three months. Resident 77 attributed their weight loss to disliking the facility food. In an interview on 01/07/2025 at 2:53 PM, Resident 77 stated the facility food was terrible, if I didn't have to eat, I would not eat here. Resident 77 explained the food consisted of tough pork, turkey, chicken, and beef so tough it was like rubber and they were unable to chew. Resident 77 further stated they had lost 30 lbs, from 180 lbs down to 160 lbs, and it bothered them. In a follow-up interview on 01/07/2025 at 3:24 PM, Resident 77 stated they had chicken for lunch that day. Resident 77 explained the chicken was so dry they were unable to cut or chew it and had to place it on their fork and try to gnaw at it. <Resident 28> According to the 12/16/2024 quarterly assessment, Resident 28 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/07/2025 at 11:27 AM, Resident 28 stated the hot food was typically lukewarm, they had cold eggs for breakfast and a cold hamburger for lunch that day. Resident 28 further stated they could not tolerate when their food was cold. In a follow-up interview on 01/09/2025 at 12:14 PM, Resident 28 stated they had a big lump of turkey for lunch that day, it was dry and hard and they could not cut or chew it. Resident 28 stated they refused to eat their food and were not offered an alternative meal or nutritional supplement. <Resident 40> According to the 11/02/2024 quarterly assessment, Resident 40 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 40 filed the following grievance: -08/06/2024 the beef tips tasted like sawdust. In an interview on 01/08/2025 at 11:31 AM, Resident 40 stated the soup was gross, flavorless, it tasted like flour and water. <Resident 31> According to the 11/19/2024 quarterly assessment, Resident 31 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 31 filed the following grievance: -09/03/2024 the clam chowder smelled and tasted bad. In an interview on 01/08/2025 at 11:31 AM, Resident 31 agreed with Resident 40 and stated the soup was gross, flavorless, it tasted like flour and water. <Resident 10> According to the 10/19/2024 annual assessment, Resident 10 was cognitively intact, understood others, made themselves understood, and was able to clearly verbalize their needs. Review of July 2024 through December 2024 grievance log showed Resident 10 filed the following grievance: -09/03/2024 Teriyaki beef was too tough. In an interview on 01/08/2025 at 10:55 AM, Resident 10 stated they rarely ate the facility meat because they could not chew it. <Additional Food Concerns> (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/07/2025 at 2:35 PM, Resident 50 stated the food was overcooked and was not good. Resident 50 stated they picked and chose what they were going to eat. In an interview on 01/07/2025 at 3:15 PM, Resident 35 stated for the most part the food was bad and had no flavor. On 01/14/2025 at 12:44 PM, a test tray was received which contained crab pasta, carrots, peach crisp, milk and water. The crab pasta did not taste like crab, the sauce was bland, tasted like flour and had no appetizing flavor. The peach crisp tasted like plain unsweetened oatmeal topped with chocolate syrup. During an interview on 01/14/2025 at 1:56 PM, Staff Q, Dietary Manager, stated the food was under seasoned and they had received complaints about the food. Staff Q explained some residents were not allowed to have salt and recently they had a resident allergic to black pepper. Staff Q added, the residents were tired of the food because the menu had not been changed in years. 47328 Reference WAC 388-97-1100 (1), (2) Refer to F585 and F692 for additional information.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Specifically, expired foods were not discarded for 1 of 2 refrigerators, 1 of 1 dry storage areas, and food items in the refrigerator and freezer were not dated when opened. The facility further failed to maintain a clean cooking environment. These failures placed residents at risk for food-borne illnesses. Findings included . <Expired/undated food> During an initial tour of the kitchen on [DATE] at 8:47 AM, the dry storage area revealed a container of French salad dressing and two containers of Caesar salad dressing with no received or expiration date, six cartons of thickened cranberry cocktail that expired [DATE], a bag of coconut that expired [DATE], and twelve containers of a vanilla nutritional drink that expired on [DATE]. The refrigerator in the main kitchen contained a bag of brown, wilted salad, two bags of brown wilted lettuce and a bag of spinach that was brown that had no received or expiration dates. The freezer contained a bag of ham with a use by date of [DATE], a bag of tortillas with a use by date of [DATE], a bag of zucchini with a use by date of [DATE], two pecan pies with a use by date of [DATE], three bags of meatballs that expired on [DATE], a bag of opened egg rolls and chicken breasts with no open or expiration date, and an opened bag of beef fritters and uncovered wheat rolls that were freezer burned. During an interview on [DATE] at 9:34 AM, Staff S, Registered Dietician, stated there needed to be a date on all food items and it was important for quality, safety and to prevent food borne illnesses. <Food Temperatures> During observation of a lunch tray line on [DATE] at 11:19 AM, Staff Q, Dietary Manager, had checked the temperatures of the cold items.The salad was 52.1 degrees Fahrenheit (F), cottage cheese was 44 degrees F, and the Jello was 64.6 degrees F., all above the recommended food temperature of 41 degrees. Staff Q placed the cottage cheese, salads, and sandwiches on an ice bath. At 11:39 AM, Staff Q served the items from the ice bath, no further temperatures of the food were obtained. At 11:58 AM, Staff Q served a chicken breast from a warmer and no temperature was obtained. At 12:02 PM, Staff Q served a sandwich from the refrigerator and no temperature was obtained. At 12:19 PM, Staff Q served another chicken breast and no temperature was obtained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 12:21 PM, Staff Q stated they were not sure if the items from the ice bath were at an appropriate temperature because they had not rechecked them. Staff Q stated it was important to check the temperatures of the food to prevent food borne illnesses. <Sanitary Environment> During an observation on [DATE] at 10:03 AM, the oven was unclean with food debris on the outside of the oven and thick burned food debris covered the bottom of the inside of the oven. The food warmer was unclean with food debris. Staff Q initially stated it was from spilled food and the outside of the oven was cleaned once a month and the inside every three months. Staff S stated the oven warmer, and oven needed to be cleaned, and Staff Q stated the outside of them gets cleaned every evening. Staff S stated the oven and oven warmer needed to be kept clean to ensure safety. During a second observation of the kitchen seven days later on [DATE] at 1:25 PM, the thick layer of burned food debris remained on the bottom of the oven and the outside of the warmer and oven were unclean. Reference: WAC [DATE] (3), 2980

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to ensure resident records were complete, accurate, readily accessible and resident records were safeguarded against loss, destruction, or unauthorized use for 1 of 4 sampled residents (Resident 98), reviewed for accidents. This failure placed residents at risk of having an incomplete medical record, unauthorized access to confidential health information, and diminished quality of life. Findings included . Review of the facility employee handbook related to use of business equipment showed company telephones, computers, tablets, handheld computers, copiers, supplies, and other equipment were to be used for business use. Employees were not allowed to use cell phones or smart phones in resident care areas. Direct care staff were prohibited from using or having their cell phones turned on while on duty and were only to use these items during their meal or break times in non-resident care areas. The handbook further showed all employees were expected to follow applicable state or federal law or regulations regarding the use of cell phones or smart phones at all times. According to the [DATE] admission assessment, Resident 98 admitted to the facility on [DATE] with diagnoses including muscle weakness, reduced mobility, lack of coordination, and chronic pain. Resident 98 required touch assistance to transfer onto the toilet and moderate staff assistance to perform toileting hygiene. Resident 98 had severe cognitive impairment. Review of the admission agreement, consent for medical treatment, showed the resident group authorizes the center to take photographs of the resident which are necessary for identification, medical purposes, or both, at any time during the resident's stay and the section on personal health information disclosure showed the center will not disclose the resident's personal health information, including the resident's medical record, without express written authorization except as permitted by law. The admission agreement further showed it was electronically signed by the severely cognitively impaired Resident 98, not their legal representative, on [DATE]. Review of a [DATE] facility incident report showed Resident 98 experienced an unanticipated death. Resident 98 was found slumped over on the toilet with a laceration above their left eyebrow. Review of [DATE] nursing progress notes showed Resident 98 required moderate assistance for toileting. On [DATE], Resident 98 was found sitting on the toilet unresponsive, staff called emergency medical services and initiated cardiopulmonary resuscitation (CPR) per Resident 98's wishes. Resident 98 expired and the medical examiner (ME) was notified of the laceration to the left upper eyebrow. The progress notes further showed the ME was sent pictures of Resident 98's facial laceration and Resident 98 would need to be picked up for further testing. Further review of Resident 98's medical record showed no pictures of Resident 98's facial laceration were found. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pictures of Resident 98's facial laceration sent to the ME on [DATE] were requested from Staff B, Director of Nursing, on [DATE] at 2:31 PM, and again on [DATE] at 1:41 PM, from Staff A, Administrator. In an interview on [DATE] at 2:16 PM, Staff KK, Corporate Licensed Nurse, stated the nurse who took the pictures of Resident 98 deleted the picture from their phone after they were sent to the ME. Staff KK acknowledged the pictures sent to the ME were not in Resident 98's medical record. In an interview on [DATE] at 9:35 AM, the ME stated they requested pictures of Resident 98's head injury to determine the severity of the head injury. The ME acknowledged they received two photographs of Resident 98's head injury via text messaging to the ME's work phone. In an interview on [DATE] at 11:05 AM, Staff GG, Nursing Assistant, stated staff were not allowed to photograph residents, especially by using a staff's personal electronic device. Staff GG explained the health unit coordinators (HUC) would photograph residents for an electronic medical record profile picture. In an interview on [DATE] at 11:21 AM, Staff LL, Licensed Practical Nurse, stated if a resident photograph was taken for medical purposes, then it should be in their medical record. Staff LL acknowledged staff should not use personal phones to take photographs of residents because it would violate HIPAA (Health Insurance Portability and Accountability Act, established standards that protect sensitive health information from disclosure without a patient's consent and protected one's privacy). In an interview on [DATE] at 11:57 AM, Staff Y, Resident Care Manager, stated they were unsure on the facility process for photographing residents. In an interview on [DATE] at 3:10 PM, Staff B, Director of Nursing, stated HUCs used the facility mobile device to obtain resident's profile pictures. Staff B acknowledged staff should not take resident pictures using their own personal cell phones because of HIPAA concerns. In an interview on [DATE] at 12:45 PM, Staff NN, HUC, stated they used the facility mobile tablet to take a resident's picture for their electronic medical record profile. Staff NN explained pictures taken with the facility's mobile tablet were automatically uploaded to the facility computer. Staff NN further sated they had not had to transmit resident photographs and was unsure of the process. Staff NN acknowledged staff were not to use any other devices besides the facility equipment to photograph residents. In an interview on [DATE] at 4:15 PM, Staff A, Administrator, acknowledged Resident 98's picture was taken using a staff's personal cell phone and transmitted to the ME via normal text messaging to a phone number provided by the ME. Review of additional information provided by the facility on [DATE] showed a handwritten statement dated [DATE] and signed by Staff MM, Licensed Practical Nurse. The statement acknowledged Staff MM used their personal mobile phone to take a picture of Resident 98, transmitted the photo to the ME as requested, and immediately deleted the picture from my phone. Reference WAC [DATE] (1)(b), (5)(a)(b)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on interview and record review, the facility failed to ensure arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) agreement in a form, manner, and/or language understood by the resident and/or their legal representative for 2 of 3 sampled residents (Residents 13 and 88) reviewed for arbitration. Failure to ensure residents had the cognitive ability to understand and enter into an arbitration agreement with the facility, and failure to ensure staff responsible for explaining the arbitration process and offering the arbitration agreement had adequate training, placed the residents at risk of being uninformed of their rights, losing legal protection, the right to pursue legal action, and a diminishd quality of life. Findings included . The facility policy, [NAME] Arbitration Agreement, last updated September 2022, stated the parties understood that any legal dispute, controversy, demand or claim that arose out of or related to the Resident Admission Agreement, or any service or care provided by the Center to the Resident would be resolved exclusively by binding arbitration, and not by a lawsuit or court process. The policy further stated that the parties understood and agreed that by entering the arbitration agreement, they waived their constitutional right to have any claim decided in a court of law before a judge or jury, and that by signing the agreement, they fully understand the terms contained in the agreement. <Resident 13> The 12/26/2024 admission assessment documented Resident 13 admitted to the facility on [DATE], was severely cognitively impaired and had diagnoses which included non-Alzheimer's dementia. Review of Resident 13's record showed the facility's voluntary arbitration agreement was signed on 12/23/2024 by Resident 13 and not their legal representative. Review of the progress notes from 12/20/2024 through 01/15/2025 showed Resident 13 was cognitively impaired, had dementia, and was alert to self only, but able to make needs known. In an interview on 01/15/2025 at 12:20 PM, Staff GG, Nursing Assistant, stated Resident 13 was confused, was able to make needs known to staff, but decisions regarding their care was made by the resident's daughter. On 01/15/2025 at 12:28 PM, Resident 13 was observed sitting in the dayroom, being assisted with eating lunch. The resident smiled and stated yes when asked if they were doing well but was unable to state the date or where they were when asked. <Resident 88> The 12/24/2024 admission assessment documented Resident 88 admitted to the facility on [DATE] and had severe cognitive impairment. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 88's record showed the facility's voluntary arbitration agreement was signed on 12/19/2024 by the Resident 88 and not their legal representative. An admission progress note on 12/18/2024 at 4:15 PM documented Resident 88 was confused and oriented to self only, and on 12/19/2024 at 11:49 AM, the day Resident 88 signed the arbitration agreement, Staff HH, Physician, documented Resident 88 was still confused. In an interview on 01/15/2025 at 12:23 PM, Staff GG stated Resident 88 was very confused, and decisions regarding their care were made by the resident's spouse. On 01/15/2025 at 12:33 PM, Resident 88 was observed in their room, lying in bed, visiting with their spouse. When Resident 88 and their spouse were asked if the facility's arbitration process had been explained to them, and if they had signed the arbitration agreement, the resident stated they knew nothing about that, and the spouse stated they were not aware of any arbitration process or agreement. When the spouse was asked if they were aware the resident had signed the arbitration agreement, they stated no. Resident 88 then asked for clarification about what they had signed when they were in high school. After the arbitration process was explained, Resident 88 stated, That is over my head, I know nothing. Do you have a business card? You can bring me a report when you finish. In an interview on 01/15/2025 at 12:05 PM, Staff K, Admission Coordinator, provided a copy of the facility's arbitration agreement and stated the agreement was offered and explained to residents and/or family, representatives when the resident was admitted to the facility. In an interview with Staff K, Admission Coordinator, and Staff II, Admission Director, on 01/15/2025 at 2:51 PM, they were asked the facility had a process or assessment to determine if the resident was cognitively able and had the mental capacity to enter into and sign an arbitration agreement. Staff II stated Staff JJ, Nursing Assistant/Transportation driver, assisted with completing the arbitration agreements, and they would not be able to assess the resident. Staff II stated if a resident was cognitively impaired or unable to sign the agreement, it was offered to the resident's guardian, power of attorney, or next of kin. When informed both Residents 13 and 88 had severe cognitive impairment, and had signed the arbitration agreement, Staff II stated they would need to follow up with Staff JJ to find out if the resident's representative/family had been offered the agreement. When informed that no documentation had been found that showed either Resident 13 or 88's family and/or representative had been offered the agreement, and asked if the residents should have signed the arbitration agreement, Staff II stated they did not believe they should have. In an interview on 01/16/2025 from 11:04 to 11:20 AM, Staff JJ stated their main responsibility was as the transportation driver, but they assisted with completion of the admission paperwork and the arbitration agreements. Staff JJ stated they had received training on arbitration from the previous transportation driver and the agreements were offered when residents admitted to the facility. Staff JJ was unable to explain the arbitration process and when asked if the resident and/or representative gave up the right to go to court if they entered into an agreement, Staff JJ stated they did not believe they gave up the right. When the arbitration process and agreement was explained to Staff JJ, they stated they did not know the right to sue the facility was lost when the agreement was signed. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 01/16/2025 at 3:54 PM with Staff H and Staff JJ, Staff JJ stated they understood the arbitration process and stated any issues/conflicts were resolved by a third party instead of going to court. When Staff H and Staff JJ were asked if the resident and/or family gave up the right to sue or take the facility to court if they entered into an arbitration agreement, Staff H stated, no, the resident and/or representative was still able to take the facility to court. No Associated WAC

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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** 47328 Based on observation, interview, and record review the facility failed to perform hand hygiene when indicated and follow transmission-based precautions (TBP) when implemented for 1 of 3 sampled residents (Resident 61), reviewed for infection control. This failure placed residents at risk of acquiring communicable diseases and diminished quality of life Findings included . TRANSMISSION BASED PRECAUTIONS Review of the facility policy titled, Transmission-Based Precautions (Isolation) revised March 2024, showed TBP were used whenever measures more stringent than standard precautions were needed to prevent or control the spread of infection. There were three types of TBP (airborne, contact, and droplet). Contact precautions were implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The policy listed infections, including Shingles (viral infection that caused a painful blistery rash), that would require contact precautions be implemented. The policy instructed persons entering a contact precaution room to wear gloves and a disposable gown upon entering the room, adequately clean and disinfect commonly used items between residents if unable to use or dedicate equipment to a resident on contact precautions. According to the Center for Disease Control website CDC.gov - with regard to TBP showed, Use contact precautions for patient with known or suspected infections that represent an increased risk for contact transmission. Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning [applying] PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. <Resident 61> According to the 01/08/2025 annual assessment, Resident 61 had moderate cognitive impairment and was able to clearly verbalize their needs. Review of the 01/02/2025 care plan showed Resident 61 had shingles and instructed staff to maintain contact precautions, administer antiviral medication per provider orders, and pregnant woman should not provide cares. Review of provider orders showed a 01/02/2025 order for Resident 61 to be on Contact precautions as recommended for residents known or suspected to be infected with infectious agents transmitted person to person via the direct/indirect contact route for shingles. Review of 01/09/2025 provider progress note showed Resident 61 had shingles and was on isolation precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 01/07/2025 at 8:59 AM, a contact precaution sign was posted on the wall outside of Resident 61's room. The sign instructed staff to perform hand hygiene and wear a gown and gloves prior to entering the room. The sign also instructed staff to clean and disinfect shared equipment. Similar observations were made on 01/07/2025 at 11:12 AM, on 01/08/2025 at 1:34 PM, on 01/09/2025 at 8:04 AM, and on 01/10/2025 at 8:14 AM. In an interview on 01/08/2025 at 10:38 AM, Resident 61's roommate stated staff did not clean the toilet after Resident 61 used it. Resident 61's roommate further stated the garbage in the room often overflowed with used and soiled gloves and they often emptied it because staff did not. During observation on 01/08/2025 at 1:34 PM, Staff R, Nursing Assistant, entered Resident 61's room without performing hand hygiene or putting on a gown or gloves. Staff R walked half way into the room, adjusted the privacy curtain, shut the call light off, and exited the room. During interview on 01/08/2025 at 1:35 PM, Resident 61's roommate stated staff only had to put a gown and gloves on when they worked with Resident 61 but not when they worked with them. Resident 61's roommate explained to Resident 61 staff had to wear the gown and gloves because of the rash on their leg. Resident 61 stated Oh yeah, that rash is driving me nuts, and lifted their blankets to show a blistery rash to their right groin/inner upper thigh. In an interview on 01/17/2025 at 9:20 AM, Staff EE, Housekeeper, stated housekeeping was responsible for emptying out the garbage, cleaned and disinfected transmission-based precaution rooms but typically waited to until the end of the day to clean TBP rooms. Staff EE explained housekeeping only worked on day shift, but housekeeping would round in the morning and empty out garbage in TBP rooms if it was full. Staff EE acknowledge garbage in TBP rooms got full from evening/night shifts and needed emptied in the morning. Staff EE further stated residents in TBP rooms should not empty out the garbage because it was a potential infection control issue. In an interview on 01/17/2025 at 9:33 AM, Staff G, Nursing Assistant (NA), was unable to state what contact precautions were. In an interview on 01/17/2025 at 9:37 AM, Staff FF, NA, explained everyone should put a gown and gloves on prior to entering a room with a contact precautions sign posted. Staff FF further stated staff should always clean/disinfect the bathroom between roommates. Staff FF stated residents should not empty out garbage in TBP rooms because it was not their job. Staff FF acknowledged TBP should always be followed when implemented to prevent the spread of germs. In an interview on 01/17/2025 at 9:45 AM, Staff E, Registered Nurse, stated staff were to disinfect the toilet between residents and empty garbage in TBP rooms, not the residents, because of potential infection control issues. Staff E further stated staff should follow TBP when implemented to prevent the spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/17/2025 at 10:47 AM, Staff J, acting Infection Preventionist, explained any staff who entered a room to provide care to a resident on contact precautions needed to put a gown and gloves on prior to crossing the threshold of the room. This was different than enhanced barrier precautions which allowed persons to cross the threshold of the room without putting PPE on unless they were going to assist with high contact care activities. Staff J further stated trash in TBP rooms should be emptied by staff, not residents. Staff J expected staff to follow TBP when implemented to prevent the spread of germs and infections. In an interview on 01/17/2025 at 11:28 AM, Staff B, Director of Nursing, explained a gown and gloves should be placed prior to crossing the threshold of a room on contact precautions. Staff B stated they expected staff to follow the posted TBP signage. In an interview on 01/17/2025 at 3:54 PM, Staff A, Administrator, stated they expected staff to follow TBP when implemented. Staff A further stated staff should empty the garbage in TBP rooms but they could not stop residents from doing it. HAND HYGIENE Review of the facility policy titled, Handwashing/Hand Hygiene updated March 2018, showed hand hygiene was the primary means to prevent the spread of infections. Hand hygiene could be performed by use of alcohol-based hand rub (ABHR) or washing hands with soap and water. The policy showed hand hygiene should be performed before and after direct contact with residents, after contact with a resident's intact skin, after contact with objects in the immediate vicinity of a resident and after glove removal, before and after entering an isolation precaution setting, and before and after assisting a resident with meals. According to the website CDC.gov - with regard to hand hygiene showed, hand hygiene protects both healthcare personnel and patients. Hand hygiene means handwashing with water and soap or antiseptic hand rub (alcohol-based foam or gel hand sanitizer). Recommendations for hand hygiene in healthcare settings are immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. During observation on 01/07/2025 at 12:00 PM, Staff R, NA, did not perform hand hygiene and delivered a lunch tray to room [ROOM NUMBER], set up the tray, and exited the room without performing hand hygiene. Staff R obtained another lunch tray, delivered it to room [ROOM NUMBER], and exited the room without performing hand hygiene. Staff R obtained another lunch tray, delivered it to room [ROOM NUMBER], and exited the room without performing hand hygiene. During observation on 01/07/2025 at 12:02 PM, Staff DD, NA, did not perform hand hygiene, delivered a lunch tray to room [ROOM NUMBER], and exited the room without performing hand hygiene. During observation on 01/15/2025 at 11:54 AM, Staff R, NA, did not perform hand hygiene, delivered a lunch tray to room [ROOM NUMBER], and exited room without performing hand hygiene. Staff R obtained another try, delivered it to room [ROOM NUMBER], and exited the room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/15/2025 at 12:15 PM, Staff R, stated hand hygiene was washing their hands but there was no way to do it when passing trays. In an interview on 01/15/2025 at 1:16 PM, Staff D, Resident Care Manager, explained hand hygiene included using ABHR or washing hands with soap and water. Staff D stated hand hygiene was to be performed when entering or exiting a resident room, before serving meals, between residents, before and after cares. Staff D further stated if hand hygiene was not performed when indicated it could spread germs and expected staff to perform hand hygiene when indicated. In an interview on 01/17/2025 at 10:40 AM, Staff J, acting Infection Preventionist, stated hand hygiene was using ABHR or washing hands with soap and water. Staff J explained if hand hygiene was not performed when indicated it could potentially spread germs. Staff J stated they expected staff to perform hand hygiene when indicated. In an interview on 01/17/2025 at 11:25 AM, Staff B, DNS, stated hand hygiene was using ABHR or washing hands with soap and water. Staff B stated they expected staff to perform hand hygiene when indicated, including during meal service when passing different resident meal trays. In an interview on 01/17/2025 at 3:53 PM, Staff A, Administrator, stated they expected staff to perform hand hygiene when indicated. Reference WAC 388-97-1320 (1)(c), (2)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Health & Rehabilitation Center	7411 North Nevada Spokane, WA 99208

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview and record review, the facility failed to ensure staff were offered the COVID-19 vaccine (COVID-19, a viral illness that caused fever, difficult breathing, and other viral symptoms that included possible hospitalization or even death), were provided education regarding the risks/benefits and potential side effects of the vaccine, and maintained documentation related to vaccine education, declination,or administration of the vaccine as required for 3 of 3 sampled staff (Staff G, H, and I) reviewed. This failure placed residents and staff at risk of illness or exposure to the COVID-19 virus and potential unintended health consequences. Findings included . The Centers for Disease Control and Prevention (CDC) Recommended Adult Immunization Schedule 2025 for ages [AGE] years or older retrieved from www.cdc.gov/acip-recs/hcp/vaccine-specific/ documented adults age 19-[AGE] years or adults age 65 or older who were unvaccinated for COVID-19 were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of COVID-19 vaccine unless contraindicated. Those previously vaccinated before 2024-2025 were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of 2024-2025 COVID-19 vaccine unless contraindicated. On 01/15/2025 at 12:58 PM, room [ROOM NUMBER] on Evergreen Unit was observed to have a new aerosol precaution sign (signage that notified staff of important measures to implement prior to entering a resident room such as donning personal protective equipment, PPE, or performing hand hygiene, for example) on their door and the door was closed. A bin of PPE was positioned at the doorway, and Staff F, Nursing Assistant, NA, was observed putting on a disposable gown, gloves and a respirator-type mask. When interviewed, Staff F stated the resident in room [ROOM NUMBER] had been at the facility for 6 days and had just tested positive for COVID-19 that morning when they developed symptoms of respiratory illness. During an interview on 01/17/2025 at 9:27 AM, Staff G, NA, stated they had been vaccinated for COVID-19 probably two years prior when the vaccine first came out and was unaware there were additional COVID-19 vaccines available. Staff G stated they had never received any education regarding the vaccine and had not been offered one recently. During an interview on 01/17/2025 at 10:33 AM, Staff H, NA, stated they did not remember being offered a COVID-19 vaccine recently unless it was offered as part of their initial employment onboarding paperwork. A review of staff COVID-19 vaccinations documented the following: -Staff G received two doses of the COVID-19 vaccine on 05/07/2021 and 06/08/2021 and signed a declination for an additional vaccine on 07/26/2023. -Staff H received two doses of the COVID-19 vaccine on 09/12/2021 and 10/11/2021. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A third staff, Staff I, NA, was added to the review and had received two doses of COVID-19 vaccine on 08/25/2021 and 09/16/2021. During an interview on 01/17/2025 at 1:13 PM, Staff J, Licensed Practical Nurse and temporary acting Infection Prevention Nurse, stated the facility did not offer COVID-19 vaccines to staff. They encouraged the staff to see their primary care provider or pharmacies that offered discounted vaccinations and bring in their proof of vaccination. Staff J was uncertain when the facility stopped offering COVID-19 vaccines. They stated if staff did not bring in evidence of their vaccine, the facility had no documentation. Staff J stated they did not keep track of staff education or who had received or declined the COVID-19 vaccine. Reference: WAC 388-97-1320