STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505382	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Wenatchee Rehabiliation & Nursing Center	1326 Red Apple Rd Wenatchee, WA 98801

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure a clinically appropriate self-administration of medications assessment was completed by the interdisciplinary team [(IDT) a group of healthcare providers from different fields who work together for the best outcome for residents] for 1 of 1 resident (Resident 14) reviewed for safe self-administration of medications. Failure to complete a self-administration assessment placed the resident at risk for inaccurate and unsafe medication administration, adverse side effects, and medical complications. Findings included . <Resident 14> Review of the medical record showed Resident 14 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interferes with daily functioning). The 03/19/2024 comprehensive assessment, showed Resident 14 was dependent on one to two staff members for activities of daily living (activities related to personal care). The assessment also showed the resident had a moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). An observation on 03/26/2024 at 9:41 AM, showed Resident 14 lying in bed in their gown, leaning towards their right side, with their right hand on their bedside table. There was a medicine cup, filled two thirds from the top, with pieces of broken, white pills (aspirin, two diabetic medications, vitamins, a blood pressure medication, and potassium supplement). There was a water cup on the bedside table, and four puddles of water with a piece of white pill in each puddle. The pill pieces were melted in the center of each puddle. During a concurrent observation and interview on 03/27/2024 at 8:27 AM, Resident 14 was lying in bed, with a medication capsule (an antidepressant), one whole white pill, one white pill broken into two pieces, and one small round pill spread across the bedside tabletop. Resident 14 stated the nurses left their medications in the room and left. They stated when their medications get wet, the nurses throw my pills away and I don't get my medications. During an interview on 03/27/2024 at 8:38 AM, Staff Q, Nursing Assistant, stated they frequently found medications unattended at Resident 14's bedside. Staff Q stated when Resident 14 did not want to take their medications, they would pour water on them. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2024 at 1:55 PM, Staff O, Licensed Practical Nurse, stated they sometimes left Resident 14's medications in their room unattended. Staff O stated sometimes Resident 14 would take their medications and other times they would chop them up. Staff O stated they knew Resident 14's medications so they would throw out the ones (Resident 14) didn't take and get new ones. During an interview on 03/27/2024 at 2:34 PM, Staff R, Registered Nurse, stated they left medications unattended at the bedside for Resident 14, to take at their own pace. Staff R stated, I know the pills, usually I go back and destroy what wasn't taken. During an interview on 03/28/2024 at 11:24 AM, Staff J, Resident Care Manager, stated they were aware that medications were left in Resident 14's room unattended, and that practice had been happening for a long time. Staff J stated the process for allowing unattended medications at the bedside included completing an assessment to determine if the resident was capable of managing self-administration. They would then obtain a physician order, and care plan the resident appropriately. Staff J stated Resident 14 did not have an assessment completed and they would not be able to manage their own medications. Review of the medical record showed there was no documentation that a self-administration of medications assessment had been completed until 03/28/2024 at 2:50 PM, after the surveyor brought it to the facility's attention. The assessment showed Resident 14 was deemed unsafe to self-administer medications. During an interview on 03/28/2024 at 11:47 AM, Staff B, Regional Director of Nursing Services, stated an assessment for appropriateness, including safety, was part of the process for self-administration of medications, and Resident 14 would not be someone that could take their own medications. Staff B stated staff should offer Resident 14 their medications, if they refused, try a second attempt at a later time, and if they refused again, staff should document the medications as refused to ensure accurate records, and notify the provider. Staff B stated staff should not be leaving medications unattended in Resident 14's room. Reference: WAC 388-97-0440 44922

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NAME OF PROVIDER OR SUPPLIER Regency Wenatchee Rehabiliation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1326 Red Apple Rd Wenatchee, WA 98801	

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to provide a comfortable, appropriate length bed for 1 of 1 resident (Resident 33) reviewed for accommodations. This failed practice placed the resident at risk for discomfort and skin issues. Findings included . <Resident 33> Review of the resident's medical record showed Resident 33 admitted to the facility on [DATE] with diagnoses to include degeneration (decline or deterioration) of their lower spine, and left foot drop (difficulty lifting the top part of the foot). The comprehensive assessment, dated 03/02/2024, showed the resident's cognition was intact, required one staff member supervision for transferring, and was independent with bed mobility. An observation on 03/26/2024 at 9:22 AM, showed Resident 33 lying in bed, both feet pushed up against the foot board of the bed. Resident 33's area on the bottom of their left foot, underneath their toes, was red, and appeared soft and wrinkly. Resident 33 lowered the head of the bed and pulled themselves up, but as soon as they raised the head of the bed back up, the resident would slide down and their feet would push up against the foot board. An observation on 03/26/2024 at 11:34 AM, showed Resident 33 lying in bed and both feet were pushed up against the foot board of the bed. A concurrent observation and interview on 03/26/2024 at 3:25 PM, showed Resident 33 lying in bed, both feet pushed up against the foot board of the bed. Resident 33 stated it did no good to pull themselves up in the bed because they would go right back to the same place. An observation on 04/01/2024 at 12:06 PM, showed Resident 33 lying in bed, both feet pushed up against the foot board of the bed. Resident 33's area on the bottom of their left foot, underneath the toes, was red, soft, and wrinkled. A concurrent observation and interview on 04/02/2024 at 9:53 AM, showed Resident 33 lying in bed, both feet pushed up against the foot board of the bed. Resident 33 stated their height was 70 inches [(5 feet and 10 inches) a unit of measurement] in length and I do not feel the bed fits me properly. During an interview on 04/02/2024 at 4:04 PM, Staff A, Administrator, stated the beds were 80 inches long and Resident 33 should have had no problem fitting on the bed. Staff A further stated the resident could elevate the bottom of the bed so their feet would not touch the foot board of the bed. Staff A further stated Resident 33's roommate had currently been using the only foot board bed extender the facility had and they would figure it out. Reference: WAC 388-97-0860(2)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to address required documentation for Advanced Directives [(ADs) a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity] including incorporating ADs into the care planning process for 3 of 5 residents (Residents 6, 15, and 16) reviewed for ADs. These failures placed the residents at risk of losing their right to have their preferences and/or decisions followed regarding their end-of-life care. Findings included . Review of the policy titled, Advanced Directives/POLST (a portable physician order form that describes the residents care direction regarding end of life treatment), revised date 05/2019, showed the Social Services Director (SSD), would offer assistance in developing an AD if the resident wanted to formulate one and the ADs would be reviewed periodically. <Resident 6> Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include heart failure and Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement). The comprehensive assessment dated [DATE], showed the resident had an intact cognition and impairment to their right arm and leg. Review of Resident 6's medical record showed a document titled, Durable Power of Attorney for Healthcare (DPOA), dated 01/24/2011, showed no preferences for end-of-life care. Review of Resident 6's care plan dated 01/03/2024, showed no focus area care planned for ADs. Review of an admission assessment titled Psychosocial History and Discharge, dated 03/30/2022, showed Resident 6 was asked if they had an AD and the yes box was checked, with comments that showed the resident had a DPOA and a Physician Orders Life Sustaining Treatment. <Resident 15> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include dementia (a group of symptoms that affects memory, thinking and interferes with daily life). The comprehensive assessment, dated 02/27/2024, showed Resident 15's cognition was severely impaired and required one to two staff assistance for all activities of daily living (ADLs). Further review of the record showed the resident did not have an AD in place. Review of the care plan, with a revision date of 03/12/2024, showed a focus for comfort care (a specialized medical care aimed at easing suffering and improving the quality of life of people with severe medical conditions) for Resident 15 due to their disease process. The care plan showed an intervention to review the resident's AD and ensure it was followed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/25/2024 at 2:30 PM, the Resident's Representative (RR) stated the facility had not talked to them about formulating an AD or about any end-of-life preferences for Resident 15. <Resident 16> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include a stroke (when blood flow to the brain is interrupted) that caused deficits to the right side of the body and absence of speech. The comprehensive assessment dated [DATE], showed the resident's cognition was moderately impaired and required one to two staff assistance for bed mobility and transfers. Review of a document titled, Psychosocial History and Discharge Plan, dated 10/11/2023, showed Resident 16 did not have an AD. Review of an admission packet document titled Advanced Directive, dated 2013, showed no information about the facility offering assistance to formulate an AD or how to formulate an AD. Review of the care plan dated 01/01/2024, showed no care plan regarding Resident 16's wishes for end-of-life care or their refusal to formulate an AD. During an interview on 03/27/2024 at 10:34 AM, Staff E, SSD, stated it was the responsibility of the SSD to address ADs on admission. Staff E stated their process was to ask the resident or RR if there was an AD. If they did not have one and wanted one, they would assist the resident or the RR in obtaining/formulating one. Staff E stated they did not have a process for following up with the resident and/or RR, if an AD was refused on admission. Staff E further stated they did not know what transpired with Residents 6, 15, and 16's ADs because they were not employed at the time they were completed. During an interview on 03/28/2024 at 11:34 AM, Staff A, Administrator, stated they would expect for ADs to be asked about on admission and then followed up during quarterly care conferences. Staff A stated they expected the former and current SSD to have completed ADs in the same manner and the ADs should have been documented and care planned. Reference: WAC 388-97-0280 (3)(c)(i-ii), -0300(1)(b)(3)(a-b)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to provide a Skilled Nursing Facility (SNF) Advance Beneficiary Notice [(ABN) a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare; beneficiaries may choose to continue services but may be financially liable] as required for 1 of 5 residents (Resident 149) reviewed for beneficiary notification. Resident 149 was not issued the required ABN when they remained in the facility after their Medicare Part A skilled nursing and rehabilitation services (nursing services such as intravenous fluids or medications or therapy services) ended. This failure placed the resident at risk for the inability to make informed financial and care decisions related to their continued stay. Findings included . <Resident 149> Review of the medical record showed Resident 149 was admitted to the facility on [DATE] with diagnoses including an infection of the left lower leg and venous insufficiency (improper functioning of the vein valves in the leg that does not allow blood flow back to the heart). The 08/18/2023 comprehensive assessment showed Resident 149 required limited assistance of one staff member for activities of daily living. The assessment also showed Resident 149 had an intact cognition. Review of the medical record showed Resident 149 was not discharged to home as planned on 08/07/2023 and had remained in the facility until 08/18/2023. During an interview on 03/26/2024 at 4:17 PM, Staff G, Business Office Manager, stated Resident 149's last covered day for Medicare Part A was 08/07/2023. Staff G stated on 08/08/2023, Resident 149 decided they were not ready to leave the facility and had extended their stay until discharge on [DATE]. Staff G stated Resident 149 should have received an ABN when they came off of Medicare Part A. During an interview on 04/01/2024 at 12:23 PM, Staff A, Administrator, stated the Social Services Director was responsible for issuing the ABN when a resident was no longer using Medicare Part A benefits. Staff B stated Resident 149 should have received an ABN. During an interview on 04/02/2024 at 11:38 AM, Staff B, Regional Director of Nursing Services, stated the facility had identified issues with the process of issuance of beneficiary notices at that time. Staff B stated Resident 149 should have been issued the ABN. Reference: WAC 388-97-0300(1)(e)(5)

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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** 44922 Based on observation, interview, and record review, the facility failed to ensure a quiet, comfortable, and homelike environment for 4 of 10 resident rooms (Rooms 7, 5, 4, and 3) and 2 of 2 residents (Residents 25 and 33) reviewed for homelike environment. Observations showed resident rooms needed physical repairs, storage of nutritional supplies in cardboard boxes, and noisy beds. This failure placed residents at risk for unmet care needs, discomfort, and a non-homelike environment. Findings included . <Physical Repairs> <room [ROOM NUMBER]> An observation on 03/25/2024 at 8:56 AM, showed the wall to the left side of the sink had an area greater than 24 inches by four inches with scraped paint and missing pieces of drywall (a wall panel made of calcium). Additionally, the entrance to the room showed an area greater than 36 inches by four inches of scraped and missing paint and drywall. <room [ROOM NUMBER]> An observation on 03/25/2024 at 10:08 AM, showed an area on the wall, to the right of the sink that was greater than 48 inches by 18 inches of scraped and missing paint and drywall. <room [ROOM NUMBER]> An observation on 03/25/2024 at 10:31 AM, showed an area to the bottom of the wall to the left side of the bathroom, with an area of missing drywall the size of a softball. To the right side of the bathroom door, there was an area that was greater than six inches by six inches of scraped and missing drywall. Additionally, the wall at the head of Bed B, closest to the window, was an area greater than 18 inches by 18 inches of white, unpainted plaster (a building material used for the protective coating of walls). To the right of the closet, there was an area 36 inches by 18 inches of grayish/black scratch marks with missing paint and drywall. <Nutritional Supplies> <room [ROOM NUMBER]> During a concurrent observation and interview on 03/27/2024 at 8:33 AM, showed two cardboard boxes, the size of a shoe box, to the left side of the bed, in the middle of the floor. One box was half full of individual 60 milliliter (a type of measurement) syringes used for administering fluids and medications, and one box, half full of tubing in individualized packages used for enteral feeding (supplies used to provide nutrition through a tube inserted into the stomach). <Noisy beds> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 25 > Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a right hip fracture and insomnia (a sleep disorder). The comprehensive assessment dated [DATE], showed Resident 25's cognition was intact, required one to two person staff assistance for bed mobility, toileting, and transfers, and received medication to assist with sleep. During a concurrent observation and interview on 03/26/2024 at 9:36 AM, Resident 25 stated their bed was too noisy and would wake their roommate up at night when staff provided them care. The resident demonstrated the noise by raising the head of the bed. The bed made loud, high-pitched sounds, as if metal were rubbing against metal. Resident 25 stated the facility was aware of their concern. <Resident 33> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include degeneration (decline or deterioration) of their lower spine and insomnia. The comprehensive assessment dated [DATE], showed Resident 33's cognition was intact, independent for bed mobility, and received a medication to assist with sleep. During a concurrent observation and interview on 03/25/2024 at 8:35 AM, Resident 33 stated their bed was very squeaky (making a very high-pitched sound) and said they reported it to staff. Resident 33 stated the director (maintenance) told them there was nothing they could do about the noise of the bed because they (beds) were all that way. Resident 33 raised the head of the bed, and the bed made loud, high-pitched sounds, the same as Resident 25's bed. Resident 33 stated their roommate's bed was just as loud and made it hard for them to sleep at night, so they were sure their bed was keeping the roommate awake as well. Residents 33 and 25 were roommates. An observation on 03/27/2024 at 10:20 AM, showed, while standing in the hallway outside of rooms two and four, the Surveyor could clearly hear the same high-pitched sounds coming from Residents 25 and 33's room. During an interview on 03/27/2024 at 12:12 PM, Staff D, Maintenance Director, stated Residents 25 and 33's beds had a scissor frame and when the bed was being raised, the seal on the bar of the lifting mechanism rubbed together when the bars would slide back and forth. Staff D stated they had no other beds for the residents to use. During a concurrent observation and interview with Staff A, Administrator, on 04/01/2024 at 4:04 PM, Resident 25 could be heard adjusting their bed from the hallway outside their room. Staff A acknowledged the bed was loud and stated the beds would be looked at. Staff A stated they did not have a plan for the repairs on the rooms; Staff D would need to get more creative with moving long term residents out of their room when a vacant room became available, so repairs could be completed. Staff A stated feeding supplies should not be kept on the floor in a resident's room. Reference: WAC 388-97-0880(1)(2)(4)(b)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on interview and record review, the facility failed to ensure that prompt efforts were made to resolve a grievance involving a missing hearing aide for 1 of 1 resident (Resident 23) reviewed for grievances. The failure to promptly attempt to resolve a grievance disallowed the resident their right to a timely grievance resolution and placed the resident at risk for hearing difficulties and financial concerns. Findings included . Record review of a policy titled, Grievance Procedure, dated 08/2023, showed: Grievances are resolved immediately, when possible, by the individual receiving the grievance; The individual receiving the grievance will fill out a grievance form. <Resident 23> Review of the medical record showed the resident was admitted to the facility on [DATE] with a diagnosis of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). The comprehensive assessment dated [DATE], showed the resident had a severely impaired cognition and required extensive assistance of two staff members for activities of daily living. Review of the Grievance Log, dated 02/2024, showed no documentation that a grievance had been logged for Resident 23. During an interview on 03/25/2024 at 2:47 PM, Resident 23's Resident Representative (RR) stated that the resident's left hearing aid was lost two to three weeks ago, and they had not heard back from the facility on the status of the replacement. The RR further stated they reported the hearing aid missing to Staff S, Activities Director (AD). During an interview on 03/26/2024 at 3:37 PM, Staff S stated the normal process was to fill out a grievance form for any missing/lost item and turn it into the Administrator. Staff S further stated they did not fill out a grievance form at the time the RR reported the missing hearing aid on 02/20/2024; they assumed someone else had already done that. During an interview on 03/26/2024 at 3:45 PM, Staff A, Administrator, stated the normal process for missing items was for a staff member to fill out a grievance form and turn it in to Staff A. Staff A stated they were made aware of the lost hearing aid from Staff S and failed to fill out a grievance form. Since there was no grievance form filled out there was no way of tracking the lost item. Staff A further stated they did not follow the correct grievance procedure process . Reference: WAC 388-97-0180(1)(4)(ii)(5)

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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** 44922 Based on interview and record review, the facility failed to implement two components of their abuse policy when they did not verify licensure for 1 of 2 staff (Staff AA) for screening and did not provide abuse training for 5 of 8 staff (Staff O, T, U, V, and R) reviewed for abuse and neglect. This failure placed the residents at risk for unrecognized abuse, and unmet care needs. Findings included . Review of the policy titled, Abuse/Neglect/Misappropriation/Exploitation, dated ,d+[DATE], showed the facility would; screen employees by verifying their licensure, and train employees at orientation, annually, and as needed. <Licensure> Review of employee files showed Staff AA, Nursing Assistant Registered (NAR), was hired on [DATE] as a student in a Nursing Assistant (NA) training class at a nearby training center. Staff AA graduated the training class and worked as a NAR for the facility starting on ,d+[DATE]. Staff AA obtained NAR licensure on [DATE], which expired on [DATE] (on their annual birthdate) and failed to renew their license. Staff AA continued to work with an expired licensed, unsupervised, providing care to vulnerable adults on [DATE], [DATE], [DATE], and [DATE]. Staff AA was then removed from the schedule when their expired license was brought to the facility's attention. During an interview on [DATE] at 12:08 PM, Staff A, Administrator, stated they were not aware Staff AA had been working with an expired license. Staff A stated Staff M, Housekeeping Supervisor/Scheduler, was responsible for ensuring Staff AA had an active license . During an interview on [DATE] at 11:00 AM, Staff M stated they were not aware Staff AA's NAR license had expired. Staff M stated Staff AA had taken their Nursing Assistant Certification (NAC) test prior to their NAR license expiring but did not pass the NAC test and did not communicate that to the facility. Staff M stated they should have had better communication and did not have a process for following up or ensuring licenses were up to date and/or renewed. <Annual Training> Review of staff personnel files showed the following staff had no documented annual training for abuse and neglect: Staff O, Licensed Practical Nurse, was hired on [DATE]. Staff T, Registered Nurse, was hired on [DATE]. Staff U, Nursing Assistant (NA), was hired on [DATE]. Staff R, Registered Nurse, was hired on [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Regency Wenatchee Rehabiliation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1326 Red Apple Rd Wenatchee, WA 98801	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, Staff V, NA, was hired on [DATE]. The facility could not provide documentation that Staff V had received initial training on abuse and neglect. During an interview on [DATE] at 11:15 AM, Staff H, Infection Preventionist/Staff Development, stated they offered the required annual abuse and neglect training and had not reviewed which staff had received the training and which did not. Staff H stated when they had staff that worked on an as-needed (part-time) basis, they would put the education in their assigned mailbox so they could complete it. Staff H stated they did not have a process for following up to ensure the as-needed staff completed the trainings. Staff H could not verify which as-needed staff had abuse and neglect training. Review of a document provided by Staff A on [DATE], showed a list of employees who had and had not received the required annual abuse and neglect training. The list showed Staff O, T, U, R, and V had not received their annual abuse and neglect training. During an interview on [DATE] at 11:03 AM, Staff B, Regional Director of Nursing Services, stated they were unaware the abuse and neglect training had not been tracked more efficiently and needed a better process. Reference WAC: [DATE](2)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on interview and record review, the facility failed to provide a written notice to the resident and/or resident's representative (RR) of the facility policy for bed hold at the time of transfer to the hospital for 1 of 2 residents (Resident 9) reviewed for hospitalization . This failure placed the resident and/or resident's representative at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Record review of a policy titled, Bed Hold/Notice of Transfer/Discharge, dated 10/2018, showed: The facility would offer the option of a bed hold to residents and/or RRs that were out of the facility at the hospital or on social leave, and provide them information on the appeal process if denied readmission to the facility; Residents and/or RRs would be provided the bed hold notice at the time of transfer. <Resident 9> Review of the medical record showed the resident was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). The 02/04/2024 comprehensive assessment showed the resident had an intact cognition and required extensive assistance of one staff member for activities of daily living. Record review showed the resident was transferred and discharged to the hospital on 01/30/2024. There was no documentation to show that a Bed Hold/Notice of Transfer/Discharge was given to the resident at the time of transfer to the hospital. During an interview on 04/01/2024 at 10:55 AM, Staff G, Business Office Manager, stated they did not give a bed hold notice to resident's at the time of their transfer. Social Services or Administration would contact the resident at the hospital after a day or two and offer a bed hold. During an interview on 04/01/2024 at 11:03 AM, Staff A, Administrator, stated their expectation was for staff to follow the Bed Hold/Notice of Transfer/Discharge policy. Staff A further stated the correct process was not being followed. Reference: WAC 388-97-0120(4)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to ensure Pre-Admissions Screening and Resident Review [(PASARR) a federal required assessment to help ensure that individuals are not inappropriately placed in nursing homes for long term care. Assesses for serious mental illness and intellectual disability, ensures most appropriate setting for their needs, and receive services they need in those settings) assessment was accurately completed upon or prior to admission to the facility for 1 of 6 residents (Resident 33) reviewed for PASARR. This failure placed the resident at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health and/or developmentally disability care needs. Findings included . Review of a policy titled, Pre-Admission Screening and Resident Review (PASARR), dated 11/2016, showed the facility would request a PASARR prior to admission and it was the Social Service department's responsibility to review the document and ensure it was correct. <Resident 33> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and insomnia (a sleep disorder that can make it hard to fall asleep or stay asleep). The comprehensive assessment dated [DATE], showed Resident 33 had an intact cognition and received an anti-depressant medication. Review of Resident 33's February 2024 Medication Administration Record showed an order on 02/27/2024 for Zolpidem (a brand of sedative/hypnotic medication that assists with sleep) to be given as needed for insomnia. Review of Resident 33's PASARR dated 02/09/2024, showed no depression or insomnia had been identified. During an interview on 03/27/2024 at 10:56 AM, Staff E, Social Services Director (SSD), stated they were responsible for reviewing the PASARRs on admission and needed to correct them if they were inaccurate. During an interview on 04/01/2024 at 4:34 PM, Staff A, Administrator, stated the SSD would have been responsible for reviewing and correcting the PASAARs, if needed, on admission. Staff A stated in the absence of an SSD, they would have expected the nursing department to review PASAARs and correct them, if needed, on admission. Reference: WAC 388-97-1915(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to ensure interdisciplinary team [(IDT) a group of healthcare providers from different fields who work together for the best outcome for residents] care conferences were completed for 2 of 2 residents (Residents 18 and 6) reviewed for comprehensive care planning. Additionally, the facility failed to ensure the IDT care conference meetings included the required team members for 2 of 2 residents (Residents 14 and 25) reviewed for comprehensive care planning. These failures disallowed the resident and/or their representative the involvement in planning resident care and placed the residents at risk for unmet care needs. Findings included . <Care Conferences> <Resident 18> Review of the medical record showed Resident 18 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), kidney disease, and depression. The 02/03/2024 comprehensive assessment showed Resident 18 required substantial to dependent assistance of one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 18 had a severely impaired cognition. During an interview on 03/25/2024 at 1:04 PM, Resident 18's Representative, stated that when Resident 18 was initially admitted to the facility for short term care, they had frequent care conferences, and they would attend those conferences virtually (using computer technology to attend from another location). Resident 18's Representative stated that they had not been invited to or had a formal meeting with the facility for at least the last year. Review of the medical record showed the last IDT care conference was held on 03/29/2022 and the RR was present. There was no additional documentation of care conferences in the record. <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility 03/25/2022 with diagnoses including Parkinson's disease, heart failure, and contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the right side. The 01/02/2024 comprehensive assessment showed Resident 6 was dependent on one to two staff members for ADLs. The comprehensive assessment showed the resident had an intact cognition. During an interview on 03/25/2024 at 1:25 PM, Resident 6's Representative stated they had not been invited to a care conference in a long time. Resident 6's Representative further stated, it would be nice to have one (care conference) so we could discuss issues at that time rather than every time I have an issue. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's medical record showed the last IDT care conference was held on 04/14/2022. The record showed the RR attended. During an interview on 03/27/2024 at 10:34 AM, Staff E, Social Services Director (SSD), stated they completed IDT care conferences on admission to the facility, one week prior to discharge from the facility, quarterly, and annually. During an interview on 03/28/2024 at 11:34 AM, Staff A, Administrator, stated care conferences should be completed within the first two to three weeks of admission, quarterly, and as needed. <IDT Attendance> <Resident 14> Review of the medical record showed Resident 14 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia (a group of thinking and social symptoms that interferes with daily functioning). The 03/19/2024 comprehensive assessment showed Resident 14 was dependent on one to two staff members for ADLs. The assessment also showed the resident had a moderately impaired cognition. Review of Resident 14's medical record showed a quarterly IDT care conference had been completed on 03/15/2024, attended by Resident 14 and Staff E. There were no other IDT members represented at the IDT care conference. <Resident 25> Review of the medical record showed Resident 25 was admitted to the facility on [DATE] with diagnoses including a right hip fracture (a complete or partial break in a bone), right clavicle (collar bone) fracture, and atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow). The 03/10/2024 comprehensive assessment showed Resident 25 was dependent on one to two staff members for ADLs. The assessment also showed Resident 25 had an intact cognition. Review of Resident 25's medical record showed an IDT care conference was held on 03/15/2024 in the resident's room, with the resident, their representative, and Staff E present. There was no documentation that other required IDT members were present at the IDT care conference. During an interview on 04/01/2024 at 11:26 AM, Staff E stated their process for notification of upcoming IDT care conferences was to notify the family of the date and time of the IDT care conference by phone. They stated they gathered information from nursing, therapy, and social services and documented that information on the IDT care conference form. Staff E stated they were the only staff member that attended the IDT care conference meeting. Staff E understood that it was okay to document the information from each department and they did not need to attend the meetings. During an interview on 04/01/2024 at 12:53 PM, Staff A stated IDT care conferences were held for new admissions and quarterly. They stated Staff E called the family if the resident declined or were not able to attend the IDT care conference. Staff A stated that not all IDT members attended the IDT care conferences; they have focused on therapy, nursing, and social services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/2024 at 11:59 AM, Staff B, Regional Director of Nursing Services, stated the process was to reach out to the resident families to allow them to accept or decline attendance at the IDT care conferences. Staff B stated all required IDT staff members should be attending the IDT care conferences. Reference: WAC 388-97-1020(c)(i)(ii)(e)(f)(5)(b) 45117

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure a resident was provided assistance with meals for 1 of 1 resident (Resident 6) reviewed for dining. This failure placed the resident at risk for weight loss and an undignified dining experience. Findings included . <Resident 6> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include contractures (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement) to their right hand, arm, shoulder, and leg and Parkinson's disease (a chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement). The comprehensive assessment dated [DATE], showed the resident's cognition was intact and required one staff assistance with set-up or cleanup with meals. During an interview on 03/25/2024 at 1:25 PM, the Resident's Representative (RR) stated they had requested Resident 6 receive staff assistance with their meals but were told if the resident needed assistance to eat, they needed to go to the dining room. The RR stated Resident 6 did not want to eat in the dining room and was more comfortable eating in their room where everyone wasn't watching them. The RR further stated the resident preferred finger foods so they could use their hands to eat because it was difficult using utensils due to the tremors in their left hand and they did not have much use of their right hand from the contractures. During an interview on 03/26/2024 at 3:38 PM, Resident 6 stated they needed help with their meals, but they were not willing to go to the dining room for help. Resident 6 stated, at times, the staff would help them, but their RR came every evening to assist them with their dinner. An observation on 03/26/2024 at 5:29 PM, showed Resident 6 was sitting in their recliner eating dinner. The meal was a casserole the size of a deck of playing cards. Resident 6 struggled to cut the casserole into bite sized pieces. While taking a bite their left-hand shook causing the food to fall off of the spoon. Resident 6 then picked up another bite of food, set the spoon down on their plate, and used their shaky hand to pick up the food and put it into their mouth. An observation on 03/27/2024 at 8:23 AM, showed Resident 6 was sitting in their recliner eating breakfast. Resident 6 was observed eating their banana with their left, shaky hand, when it dropped onto their lap. Resident 6's diet slip read bite sized pieces and the resident preferred finger foods. During an interview on 03/27/2024 at 11:18 AM, Staff DD, Nursing Assistant (NA), stated they had a few residents on the unit that required assistance with their meals, but they ate in the dining room. Staff DD further stated if a resident required assistance with their meals, they would need to go to the dining room for help so staff would not be pulled off the floor to assist residents who preferred to eat in their rooms. Staff DD further stated Resident 6 was independent with eating and did not require assistance. (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 03/28/2024 at 8:31 AM, Resident 6 was eating breakfast, when they picked up their scrambled eggs using a weighted fork with a foam handle with their shaky left hand, the eggs dropped onto their lap and into the cracks of the recliner chair. The resident took deep breaths, sighed, and shook their head each time the eggs dropped. A concurrent observation and interview on 04/01/2024 at 12:28 PM, showed Resident 6 sitting in their recliner eating lunch. On the plate were large pieces of roast beef, larger than the size of an eye glass lens and a cauliflower floret with three to four stems on it. The food was not cut into bite sized pieces. Resident 6 stated they would just pick the chunks up with their fork and bite off pieces. During an interview on 04/01/2024 at 12:36 PM, Staff Q, NA, stated if a resident required help with eating, they would need to go to the dining room for assistance because we have more help in there rather than going room to room. Staff Q further stated the kitchen would be responsible for ensuring the food was cut into bite sized pieces. Staff Q further stated that if they had noticed the food was not cut into bite sized pieces, they would assist the resident with cutting it up. Staff Q stated they did not recognize Resident 6's food was not cut up and felt Resident 6 would benefit from having assistance with their meals hopefully [Resident 6] will decide to go to the lunchroom to get assistance. During an interview on 04/01/2024 at 12:53 PM, Staff EE, Dietary Manager, stated the family preferred to have Resident 6's food in sizes they could pick up with their fingers because the resident had a hard time getting their food from their plate to their mouth. Staff EE further stated Resident 6 was kind of embarrassed so preferred to eat in their room, but that might be hard for them (NAs) to get to them (Resident 6) right away. During an interview on 04/01/2024 at 4:04 PM, Staff A, Administrator, stated residents who required assistance with eating would be encouraged to eat in the dining room because it would result in different wait times for one-on-one assistance in their room. We do not have enough staff for assisting them in their room one-on-one. Staff A stated the residents could eat in their room with one-on-one assistance depending on staff availability. I think that would be a hardship on facilities if the facility had to assist residents one-on-one in their rooms. During a concurrent observation and interview on 04/02/2024 at 11:26 AM, Resident 6 was observed attempting to open a miniature candy bar, but their left hand was shaking and could not grip the package to open. Resident 6 stated they felt they needed assistance with eating but because they needed to use their hands to eat at times, was too embarrassed to go to the dining room. I feel like I am bothering them if I ask for help and don't want to cause any problems. Resident 6 further stated they would not go to the dining room for help. During an interview on 04/02/2024 at 10:58 AM, Staff B, Regional Director of Nursing Services, stated residents who required assistance with their meals and did not want to go to the dining room, should be allowed to eat in their rooms with one-on-one assistance. Reference: WAC 388-97-1060(2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to follow physician orders for bowel and pain management for 1 of 2 residents (Resident 25) reviewed for constipation and pain. This failure placed the resident at risk for unmet care needs and negative health outcomes. Findings included . <Resident 25> Review of the resident's medical health record showed the resident admitted to the facility on [DATE] with diagnoses to include constipation, a right hip fracture (a partial or complete break in the continuity of any bone in the body), and a right displaced collar bone fracture. The comprehensive assessment, dated 03/10/2024, showed Resident 25's cognition was intact and was dependent on two staff assistance for bed mobility, transfers, and toileting. The assessment further showed the resident received an opioid (a class of pain medication) and had constipation. During an interview on 03/26/2024 at 11:50 AM, Resident 25 stated they had issues with constipation and was not sure what they received for that. The resident stated they thought they received Mylanta (a brand of medication used for constipation) in my drinks. Resident 25 further stated they believed the pain pills they received were causing their constipation. Review of Resident 25's March 2024 Medication Administration Record (MAR), showed constipation orders as followed: 03/06/2024- Monitor for Opioid side effects including constipation. The documentation showed no constipation was present. 03/06/2024- Senna 8.6 milligrams (mg, a type of measurement), two tablets every 12 hours as needed for constipation. (Documentation showed no doses were given). 03/06/2024- Senna 8.6 mg, two tablets for bowel program #1, to be given on the 4th day (10th shift) if no bowel movement (BM) for 3 days. (Documentation showed one dose was given on 03/10/2024). 03/06/2024- Milk of Magnesia, 30 milliliters (ml, a type of measurement) for bowel program #2 if no BM by the 4th day pm shift. (Documentation showed no doses were given). 03/06/2024- Bisacodyl, 10mg suppository rectally for bowel program #3 if no BM by 5th day AM shift. Can give tablets or suppository. (Documentation showed one dose given on 03/11/2024 and effectiveness was unknown). 03/06/2024- Bisacodyl 5mg, two tablets for bowel program #3 if no BM by 5th day AM shift. Can give tablets or suppository. (Documentation showed doses given on 03/11/2024 at 11:29 PM and effectiveness was unknown, on 03/15/2024 and was ineffective, and again on 03/18/2024 and effectiveness was unknown); (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 03/06/2024- Fleet Enema rectally for bowel program #4 if no BM by 5th day PM shift. Call MD if no BM by the 6th day. (Documentation showed no doses were given); on 03/15/2024- Miralax 17 grams (gm, a type of measurement) to be given every morning. During an interview on 03/28/2024 at 9:00 AM, Staff FF, Nursing Assistant (NA), stated they charted BMs in the medical record under tasks and they documented whether the resident was incontinent/continent. Staff FF stated there would be an alert in the medical record if the resident had not had a BM in so many days. Staff FF stated if they received an alert, the resident would need to be monitored or the licensed nurse (LN) would let them know. Staff FF stated they would let the LN know during their shift or at the end of their shift if the resident had a BM or not. Review of Resident 25's March 2024 BM task records (NA documentation), showed the following: from 03/06/2024 to 03/11/2024, evening shift, the resident went 13 shifts without a BM. Documentation showed bowel program #1 was given on 03/10/2024 and was ineffective, bowel program #2 was not given, and bowel program #3 was given twice on the same day, via two different routes, on 03/10/2024 at 3:10 AM and again at 11:29 PM, both had unknown effectiveness. Bowel program #4 was not given. from 03/12/2024 to 03/15/2024, evening shift, the resident went 11 shifts without a BM. Documentation showed bowel program #1 and #2 were not given, and program #3 was given on 03/15/2024 at 5:59 AM and was ineffective. Documentation showed Resident 25 had a BM on the night shift of 03/15/2024. from 03/16/2024 to 03/22/2024, day shift, the resident went 18 shifts without a BM. Documentation showed bowel program #1 and #2 were not given, and program #3 was given on 03/18/2024 and effectiveness was unknown. No other bowel programs were initiated. During an interview on 03/28/2024 at 3:46 PM, Staff BB, Registered Nurse, stated during end of shift/beginning of shift report they would be informed of who was on alert for BMs and there was also an alert that showed in the medical record. The medical record displayed a red alert after a resident went three days without a BM to notify the LNs to start the bowel program. Staff BB stated they documented what they administered and if it was effective. If it was not effective, they would pass it on to the next shift and the next nurse on shift would follow the next step in the bowel program. Staff BB stated if unknown was documented it was because the previous shift didn't document or report the outcome of that medication given. During an interview on 03/29/2024 at 11:34 AM, Staff A, Administrator, stated the facility did not have a policy for bowel protocols/program, they would expect the LNs to follow the physician orders and document what was given and the effectiveness. During an interview on 04/02/2024, Staff B, Regional Director of Nursing Services, stated the NAs documented and reported BMs every shift which produced alerts for the LNs. The LNs then checked the alerts to determine what medications per the program/protocol to give and administered and documented what was given. Staff B stated if there were no results, the LN would pass that on to the next shift LN and they would administer what was next on the list until the resident produced a BM. <Pain> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 03/29/2024 at 1:10 PM, Resident 25 stated they had been up in their wheelchair for an hour and a half and their pain to their right leg was higher than normal. Resident 25 was moaning as they were rubbing their leg and stated their pain medication had been decreased from two tablets to one tablet and they did not know why. Resident 25 stated no one had spoken to them about decreasing their pain medication. Review of Resident 25's March 2024 MAR, showed physician orders for pain medications as followed: 03/06/2024- Oxycodone 5mg, give one tablet every four hours as needed for a pain level of three to six. Documentation showed out of 12 doses administered, five of those doses were administered for pain levels greater than six; 03/06/2024- Oxycodone 5mg, give two tablets every four hours as needed for a pain level of seven to 10. Documentation showed out of 55 doses administered, 32 of those doses were administered for pain levels less than seven. During an interview on 04/02/2024 at 9:41 AM, Staff N, Licensed Practical Nurse, stated they gave the resident whatever dose the resident asked for regardless of their pain level. They are alert and oriented and can self-direct their own care. Staff N stated the resident probably did not have a pain level high enough to receive two tablets so the nurse only gave them one, but other nurses may not be doing that. During an interview on 04/02/2024 at 10:42 AM, Staff B stated they would have expected the LNs to be following physician orders and if the resident required more medications to manage their pain, the provider needed to be called for new orders. Staff B stated they would expect the resident to advocate for their pain but the LNs needed to follow the process. Reference: WAC 388-97-1060(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure restorative therapy services including the consistent use of braces/splints were implemented for 4 of 4 residents (Resident 6, 16, 17, and 23), reviewed for restorative therapy and limited range of motion [(ROM) the extent the joint can move within the expected (normal) range of values]. This failure placed the residents at risk for loss of ROM, deconditioning, and contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Findings included . Review of a document titled, Restorative Program, dated 04/2018, showed: The goal of the Restorative Program was to promote and maintain functioning. Identify residents need for a restorative program at the time of admission/readmission/identified concerns. Restorative program to include but not limited to ROM, applying, and removing splint or braces, and walking with/without assisted devices. Daily documentation <Resident 6> Review of the resident's medical record showed Resident 6 admitted on [DATE] with diagnoses to include Parkinson's disease (a chronic and progressive movement disorder that initially causes tremor in one hand, stiffness or slowing of movement) and contractures to their right hand, arm, and shoulder. The comprehensive assessment dated [DATE] showed the resident's cognition was intact and had impairment to one side of their upper and lower extremities. Resident 6 was assessed to require partial/moderate assistance with their oral hygiene and dependent on staff assistance for toileting hygiene, upper/lower body dressing, bed mobility, and wheelchair (w/c) use. Additionally, the 01/02/2024 comprehensive assessment showed a decline in all areas when compared to the 04/01/2023 comprehensive assessment (nine months prior). A concurrent observation and interview on 03/25/2024 at 1:07 PM, showed Resident 6 sitting in their recliner reading, with a bedside table in front of them. Their legs were over the top of the leg of the bedside table, the right foot was dangling with no support, and the left foot was turned inward and resting on the leg of the bedside table. Resident 6 stated they used to have exercises to their upper right side with the previous Restorative Aide (RA), but the new one only does them every now and then. Resident 6 stated they had never received exercises to their upper left side or their legs and could not recall the last time they had exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/25/2024 at 3:27 PM, the Resident's Representative (RR) stated Resident 6 did not consistently receive exercises that they were aware of. The RR further stated Resident 6 wanted to be able to self-propel their w/c so they could go out of their room whenever they wanted to and not have to depend on staff. The RR stated the w/c was not the correct one for the resident due to their right-side contractures. Resident 6 was assessed and ordered a new w/c, one they could propel with their feet. The w/c arrived 2-3 months ago and required adjustments and no one has ever come back. During a concurrent observation and interview on 03/28/2024 at 8:34 AM, Resident 6 was sitting in their recliner, bedside table placed to the front of them, eating their breakfast. Their left knee was turned in towards the right knee, and left heel resting on the leg of the bedside table with their toes pointed to the floor. Resident 6 could lift their leg no more than an inch above the leg of the table. Resident 6 stated they could not lift their right leg or foot. Resident 6's right arm remained close to the right side of their body and their left arm and hand were used to eat with. Their left hand was shaky when taking bites of food. Resident 6 complained of discomfort to both of their knees. A concurrent observation and interview on 03/28/2024 at 4:17 PM, showed Resident 6 being assisted back to their room from an activity. The resident's feet, without footrests attached, dangled greater than 4 inches from the floor. Resident 6 stated the w/c was comfortable to sit in, but they could not move the w/c without staff assistance, I am absolutely immobile, and I have claustrophobia (fear of confined spaces) and wanted to get out of their room more often. Review of a document titled, Restorative Evaluation and Summary (a quarterly program review), dated 03/05/2024, showed Resident 6 received a ROM restorative program to both upper extremities. The evaluation showed if the resident did not participate, they would have decreased upper extremity ROM, independence, and a decreased quality of life. The evaluation further showed the program had been modified to reflect the resident's current status. The evaluation did not show a program for lower extremities. This was the only restorative evaluation completed after the initial program was initiated by Occupational Therapy [(OT) teaches a patient the skills they need to live independently or perform everyday tasks more easily and free of pain] in 05/2022 and the exercises had not been modified. During an interview on 03/29/2024 at 10:57 AM, Staff CC, RA, stated residents were referred to a restorative program when OT or Physical Therapy [(PT) treatment of disease, injury, or deformity by methods such as massage, heat, and exercise] assessed them to need more help. Staff CC stated they completed programs at least four days a week because they worked four days on and two days off and they were the only RA. Staff CC stated they completed stretching and stretching band exercises to Resident 6's right upper extremity. Staff CC stated the resident did not have a program for their left upper extremity or their legs. Review of Nursing Assistant (NA) task documentation, showed Resident 6 had a ROM program for their left upper extremity using a stretching band up to five times a week and to their right upper extremity with prolonged stretches up to five times a week and had been completed as follows: December 2023 had 10 of 31 days of exercises and two days showed not applicable. January 2024 had seven of 31 days of exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 2024 had three of 29 days of exercises. During an interview on 03/29/2024 at 11:34 AM, Staff I, Resident Care Manager (RCM), stated on admission, residents would be assessed by PT and OT and a restorative program would be started if they were assessed to need one. Staff I stated they were made aware of a decline in a resident by staff, family, or during quarterly assessments. Staff I stated Resident 6 had a program for both of their upper extremities and had been assessed by PT in September 2022, and was not sure what the outcome of that assessment was. Staff I further stated they were not aware Resident 6's w/c had been delivered and was not sure what had been done with it since it arrived. Review of a PT note dated 10/26/2022, showed Resident 6 had completed PT and a restorative program had been established for their bilateral lower extremities. Review of the record showed no program had ever been started. Further review of a PT note dated 09/15/2023, showed the resident had been referred to PT due to a decline in functional mobility that limited Resident 6's independence and participation in their ADL's. Further review of a PT discharge note dated 11/28/2023, showed Resident 6 had been fitted for a new w/c that would allow the resident to self-propel the w/c using their left upper and lower extremity and was awaiting delivery. The note further showed the resident would be reevaluated for w/c training when the new w/c arrived, and no restorative/functional maintenance program had been indicated. During an interview on 03/29/2024 at 12:26 PM, Staff F, Therapy Director, (TD), stated Resident 6 had a PT assessment in September 2023 related to their increased weakness and their inability to perform ADLs independently. Staff F stated they fitted and ordered a new w/c for the resident and were pending the delivery of the w/c. Staff F further stated Resident 6 should have been referred to a restorative program to maintain what they had gained while working with PT until their new w/c arrived and did not know why that had not been done. Staff F further stated, anyone that is long term should be set up on a restorative program. Staff F was unaware Resident 6 had the new w/c delivered and upon checking to see when it had been delivered, Staff F discovered the w/c had been delivered on 12/15/2023. Staff F stated the w/c would have been delivered to the resident by one of the therapy staff and did not know why the resident had not been put back on the therapy schedule. Staff F was unaware who delivered the w/c to the resident's room or assessed Resident 6 for use of the w/c. Staff F could not find any notes on an assessment and stated if there were not any notes, then it had not been done. <Resident 16> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include a stroke that resulted in weakness to the right side of the body, a contracture to their right hand, and absence of speech. Review of the comprehensive assessment, dated 12/31/2023, showed the resident's cognition was moderately impaired, used a cane and w/c for mobility, and required substantial/maximal staff assistance with rolling side to side in bed, w/c mobility at 50 and 100 feet ([ft) a type of measurement], dependent on staff assistance for toileting hygiene, and not applicable for walking 50 and 150 ft. Additionally, the 12/31/2023 comprehensive assessment showed a decline in all areas in comparison to the comprehensive assessment dated [DATE], three months prior. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 16's care plan dated 01/01/2024, showed no restorative program for the right upper extremity contracture or decline in the assessment areas identified on the 12/31/2023 assessment. Furthermore, the care plan showed no documentation that the resident used a hand brace/splint. Review of March 2024 physician orders showed no orders or a wearing schedule for Resident 16's hand brace/splint. A concurrent observation and interview on 03/25/2024 at 10:06 AM, showed Resident 16 sitting in their recliner and could only use hand gestures and yes/no head nodding for communication. On the nightstand, across the room from the resident to the left side of the sink, showed a blue/black hand brace/splint sitting on the top. The resident pointed to their right hand that was folded into a fist and sitting in their lap, when asked if the brace belonged to them. Resident 16 shrugged their shoulders and scrunched their forehead when asked if they wore the brace, as if they didn't understand what the Surveyor had asked. Observations on 03/26/2024 at 10:10 AM, 03/26/2024 at 3:30 PM, 03/27/2024 at 8:27 AM, and 04/01/2024 at 11:47 AM, showed the hand brace/splint was sitting on the nightstand next to the sink as previously observed on 03/25/2024. An observation on 03/29/2024 at 1:40 PM, Resident 16 was sitting in their recliner supporting their right arm and closed hand with their left hand. The hand brace/splint was sitting at the head of the bed, beside the resident. During an interview on 03/27/2024 at 8:27 AM, Staff N, Licensed Practical Nurse (LPN), stated they thought the hand brace/splint was worn at night and removed in the morning because it was not a task that was scheduled on their shift. During an interview on 03/28/2024 at 4:08 PM, Staff GG, NA, stated Resident 16 wore the hand brace/splint on their right hand because if not, their hand would be scrunched up like a fist. Staff GG was not sure what the wearing schedule was because it was not something they placed on the resident during their shift. During an interview on 03/29/2024 at 10:57 AM, Staff CC stated they were responsible for applying hand brace/splints and there was one resident that required one and that was not Resident 16. Staff CC stated they did not have a program for a hand splint/brace to be applied and removed for Resident 16. During an interview on 03/29/2024 at 1:03 PM, Staff K, Minimum Data Set Coordinator [(MDS) a standardized comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status], stated once a comprehensive assessment was completed, the facility had a program that alerted them if a resident had a decline in their functional abilities. Staff K further stated the reports were from one comprehensive assessment to the next (which were quarterly) and would not produce an alert if there was a decline over a period greater than quarterly. There had been no decline alert for Resident 16. Staff K further stated the RCMs were responsible for the MDS assessments as of 10/2023, but if the RCMs did not complete the assessments timely, Staff K was not able to use the information because they were completed outside of the timeline. Additionally, Staff K stated if there was a not applicable documented on the comprehensive assessment, it was because the resident was no longer able to do that task, or they did not have documentation that the task was completed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48368 <Resident 23> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent it interferes with a person's daily life and activities) and muscle weakness. The 01/30/2024 comprehensive assessment showed the resident had a moderately impaired cognition and required extensive assistance of one staff member for ADLs. Record review of Resident 23's medical record, showed no assessment had been completed by therapy and no restorative programs had been implemented since their admitted [DATE]. During an interview on 03/25/2024 at 2:55 PM, the RR stated Resident 23 had not had any therapy or exercise programs since they were admitted to the facility. The RR further stated they had requested therapy services about four to five months ago so Resident 23 could get stronger and out of their wheelchair more often The RR stated they did not hear back from the facility. During an interview on 03/29/2024 at 9:17 AM, Resident 23 stated they did not receive any exercises at the facility, and they were interested in it. During an interview on 03/29/2024 at 12:39 PM, Staff F stated long term care residents should be on a restorative program. Staff F stated they were new to the position, and they did not have an answer as to why Resident 23 was not on a restorative program or had an assessment completed. <Resident 17> Review of the medical record showed the resident was admitted to the facility on [DATE] with a diagnoses of acute kidney injury (when your kidneys suddenly stop working properly), history of a stroke (a loss of blood flow to part of the brain, which damages brain tissue), and congestive heart failure (when the heart does not pump blood as efficiently as it should). The 01/19/2024 comprehensive assessment showed the resident had an intact cognition and had impairment to both lower extremities requiring extensive assistance of one staff member for ADL's. Review of physician's orders dated 11/22/2023, showed Resident 17 was to have their ankle-foot brace to their left foot daily; do not wear to dialysis. During observations on 03/26/2024 at 10:00 AM, 03/28/2024 at 1:15 PM, 03/29/2024 at 9:02 AM, and 04/02/2024 at 9:15 AM, Resident 17's ankle-foot brace was located on the floor under their chair next to the television. During an interview on 03/26/2024 at 11:53 AM, Resident 17 stated the staff forget to put their ankle-foot brace on, I forget, they forget, so it never gets put on, I should remind staff. During an interview on 04/02/2024 at 11:07 AM, Staff L, Physical Therapy Assistant, stated Resident 17 should have had their left ankle-foot brace on when they were not at dialysis and the physician's order should be followed. Staff L further stated the correct process was not being followed for Resident 17. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/2024 at 10:27 AM, Staff B, Regional Director of Nursing Services, stated they would have expected restorative programs had been started for any resident who had contractures. Staff B stated they were unaware that Resident 6 had a new w/c and would have expected them to continue a ROM program until their w/c was delivered to maintain what they had already gained. Staff B stated they would expect residents who used braces/splints have an order, a wearing schedule, and be monitored by the Licensed Nurses. Staff B stated they would expect all residents to be evaluated by therapy for a Restorative program and did not know where the disconnect was. Reference: WAC 388-97-1060(1)(2(a)(i-ii)(b)(3)(d)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure appropriate administration and documentation of enteral feedings (delivery of nutrition directly to your stomach or small intestine through a tube) and fluid intake via gastrostomy tube [(g-tube) a device inserted into the stomach through the abdomen that provides nutrition when you are unable to eat on your own] feedings for 1 of 2 residents (Resident 16) reviewed for enteral feeding. This failed practice put Resident 16 at risk for dehydration, fluid overload, and weight loss/gain. Findings included . <Resident 16> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include difficulty swallowing which resulted in nutritional support provided via a g-tube, malnutrition (lack of sufficient nutrients in the body) and absent of speech. The comprehensive assessment, dated 12/31/2023, showed Resident 16's cognition was moderately impaired and received greater than 51 percent of their nutritional needs via the g-tube and received 501 milliliters [(ml) a measurement of volume] or more of fluids per day. The assessment further showed the resident required one staff assistance with eating. A concurrent observation and interview on 03/27/2024 at 8:27 AM, showed Staff N, Licensed Practical Nurse (LPN), administered fluids and medication to Resident 16 via their g-tube. Staff N stated Resident 16 received 210 ml of free water per their shift. Staff N then flushed the resident's g-tube with 120 ml of water prior to administering medications and 90 ml of water after medications were administered to equal the 210 ml prescribed. Staff N stated the resident received bolus (a given dose delivered within a specific time frame) feedings with formula that were started on the night shift and completed on the day shift. Staff N further stated the LNs worked 12 hour shifts, resulting in two shifts for a 24-hour period. Staff N did not check residuals (the amount of liquid that remains in the stomach after administering through a g-tube) prior to flushing or ask the resident if they experienced any symptoms. Review of the March 2024 physician orders, showed the following: 09/26/2023 Document the amount of (nutritional) formula administered in ml each shift. Clear the volume administered on the pump each shift. 09/26/2023 free water flush: 210 ml each shift, document total ml administered each shift, including water administered with medications. 09/27/2023 Jevity (a brand of nutritional formula) 1000 ml to be administered over 13 hours at 77 ml per hour (flow) once daily. Start at 8:00 PM and remove at 9:00 AM. 09/26/2023 Check residual as ordered. Hold if residual is greater than half the rate of the flow or half the amount of the bolus. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/26/2023 Administer 30 ml of water before and after medication administration every shift. 09/26/2023 If the resident is alert and oriented and able to report symptoms, gastric aspiration (checking residual) is not indicated. Review of a Registered Dietician (RD) Nutrition assessment dated [DATE], showed Resident 16's daily fluid needs were 1310 ml to 1510 ml per day. The resident received 807 ml of fluid from the Jevity, 210 ml every shift for a total of 630 ml per day, of free water (note that there are only two 12-hour shifts a day, this total would be for three shifts), 30 ml of flushes before and after medication administration and 5 ml between each medication for a total of 280 ml per day from the med pass. Total fluid calculated per day was 1717 ml. The assessment further showed the resident received two to four medications per day but listed eight medications, with one to be given twice daily, for a total of 9 medications. Review of Resident 16's March 2024 MAR, showed the following: document actual amount of formula administered in ml each shift (total of both shifts should equal 1000 to 1001 ml). The MAR showed out of 31 days, 27 days showed Resident 16 received greater than one and a half times the amount of formula ordered. document total free water administered every shift, including water administered with medications, plus 30 ml before and after medication administration (total should equal 910 ml for both shifts). The MAR showed 31 out of 31 days showed a total of 540 ml of free fluid had been given, which was 370 ml less than what the resident's fluid needs were. During an interview on 04/01/2024 at 11:42 AM, Staff N stated per the physician orders, if the resident was able to self-report their symptoms, residuals would not need to be checked. Staff N stated their normal process would be to ask Resident 16 if they had symptoms but must have forgotten on 03/27/2024. Staff N was unaware they were to clear the pump after each shift documented the amount of formula administered. During an interview on 04/01/2024 at 12:55 PM, Staff C, RD, stated when a resident admitted to the facility with a g-tube, the Resident Care Managers or the Admission's nurse would enter the orders into the medical record and Staff C would review them for appropriateness. Staff C stated if the resident admitted from home, then they would communicate with the home infusion RD, calculate any fluids that they received to make sure they met their fluid needs and adjust as needed. During an interview on 04/02/2024 at 10:49 AM, Staff B, Regional Director of Nursing Services, stated they would expect the orders to be entered as they received them on admission and would expect documentation to be accurate and the orders to be followed as written. Staff B stated they were not aware of the inaccuracy of the g-tube orders and documentation. Reference: WAC 388-97-1060(3)(f)

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NAME OF PROVIDER OR SUPPLIER Regency Wenatchee Rehabiliation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1326 Red Apple Rd Wenatchee, WA 98801	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview, and record review, the facility failed to ensure that pre/post dialysis (a process that uses a machine to filter waste and fluids from the blood when the kidneys no longer function) communication forms and vital signs (reflect essential body functions, including your heart beat, breathing rate, temperature, and blood pressure) were completed for 1 of 1 resident (Resident 17) reviewed for dialysis services. This failure placed the residents at risk for unidentified complications. Findings included . Record review of a policy titled Dialysis, dated 11/2015, showed: Send the dialysis communication form to the dialysis center on treatment days; Licensed nurse to complete the pre & post dialysis assessments with each dialysis visit, to include vital signs; Licensed Nurse will review dialysis communication form post dialysis; Completed dialysis communication forms will be scanned into the resident's medical record; The licensed nurse will contact the dialysis center if no dialysis communication form was returned. Review of the medical record showed the resident was admitted to the facility on [DATE] with a diagnosis of acute kidney injury (when your kidneys suddenly stop working properly) and was diagnosed with end stage renal disease (a disease in which the kidneys no longer function) requiring dialysis during their hospital stay on 02/09/2023. Record review of Resident 17's care plan dated 01/26/2024, showed resident 17 was scheduled for dialysis on Mondays, Wednesdays, and Fridays. The Licensed Nurse was required to initiate a dialysis communication form which included documentation of Resident 17's vital signs before and after dialysis treatments. Record review of Resident 17's March 2024 MAR, showed vital signs were taken every Monday morning. Further review of Resident 17's medical record showed inconsistent documentation of pre/post dialysis vital signs. The record also showed a lack of dialysis communication forms available in the resident's record for facility staff to review and monitor the residents post dialysis condition. Record review of Resident 17's dialysis communication forms showed: There were 14 opportunities to complete the communication form In January 2024; seven opportunities were missed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were 12 opportunities to complete the communication form in February 2024; eight opportunities were missed. There were 10 opportunities to complete the communication form in March 2024; 10 opportunities were missed. During an interview on 03/26/2024 at 10:54 AM, Resident 17 stated they get their vital signs checked sometimes, after they come back from dialysis, but not usually. During an interview on 03/29/2024 at 11:57 AM, Staff I, Resident Care Manager (RCM), stated vital signs should be monitored before and after dialysis. Staff I further stated that resident 17's vital signs were only being monitored before dialysis, not on return, and they could not find the communication forms; they must not be getting done. During an interview on 03/29/2024 at 12:18 PM, Staff B, Regional Director of Nursing Services, stated it was their expectation that the RCMs were checking to ensure the vital signs were completed before and after Resident 17 went to dialysis and the communication forms were sent back and completed. Staff B further stated they did not have a good system in place for the building and the correct process was not being followed for Resident 17. Reference: WAC 388-97-1900(1)(6)(a-c)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to ensure culturally competent, trauma-informed care, related to assessing for trauma and identifying triggers for residents with a history of the loss of a loved one for 1 of 2 residents (Resident 33) reviewed for mood and behavior. This failed practice put residents at risk for re-traumatization, unidentified triggers, and a decline in their psychosocial well-being. Findings included . Review of a policy titled, Trauma Informed Care, dated 10/2022, showed residents would be screened on admission, triggers and trauma history would be identified, a care plan would be developed, and services provided if needed. The policy further showed the care plan would be routinely reviewed. <Resident 33> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and insomnia (trouble sleeping). Review of the comprehensive assessment dated [DATE], showed the resident had intact cognition, was independent for bed mobility, and required one to two person staff assistance with transfers and wheelchair use. The assessment further showed Resident 33 received an anti-depressant medication. During an interview on 03/26/2024 at 9:38 AM, Resident 33 stated they had experienced past trauma due to their prior occupation as a Firefighter for [AGE] years. Resident 33 stated they experienced nightmares and became tearful as they talked about their experiences. Resident 33 stated they had trouble sleeping and took medication to help them sleep. Resident 33 stated they did not become violent or anything like that and used to have a therapist but no longer needed one. Resident 33 stated that talking about their trauma helps them deal with it when they are experiencing flashbacks. Review of a document titled, Psychosocial History and Discharge Plan, dated 03/01/2024, showed the resident had been asked about past traumatic events and Resident 33 stated yes their [significant other] had passed. There was no further documentation to show if Resident 33 experienced triggers that would cause them re-traumatization. The document further showed Resident 33 should have a care plan focus for the traumatic event with goals and interventions to prevent a decline in their psychosocial well-being. Review of Resident 33's care plan dated 02/27/2024, showed no care plan focus, goals, or interventions had been implemented for trauma informed care. During an interview on 03/27/2024 at 10:34 AM, Staff E, Social Services Director (SSD), stated they assessed residents on admission for trauma and would develop a care plan if they had triggers. Staff E stated they had worked at the facility for three weeks and did not assess Resident 33 for trauma; that assessment was completed by the other SSD that was no longer at the facility. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/01/2024 at 4:34 PM, Staff A, Administrator, stated Staff E had been training and was still learning their position. Staff A further stated Staff E knew to assess for trauma on admission, but they had not been the SSD at the time the resident admitted . Staff A could not speak to why the former SSD did not care plan Resident 33's trauma. Reference: WAC 388-97-1060(3)(e)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Eight medication errors were identified for 3 of 11 residents (Residents 9, 5 and 13) observed during 28 medication administration opportunities, that resulted in an error rate of 28.57%. Errors in medication administration placed the residents at risk for side effects and/or reduced or increased medication effectiveness due to improper administration. Findings included . Review of the Instructions for use of an insulin pen, by the U.S. Food and Drug Administration, (USFDA), dated 10/2022, showed the instructions for use stated to prime (to remove air from the needle and cartridge that may collect during administration) the insulin pen before each injection. This step was important to ensure the insulin pen worked correctly and the proper dose of medication was administered. Review of a document titled, Medication Administration Schedule, showed the following: AM- Meds to be administered between 6AM and 10AM; Midday-Meds to be administered between 10AM and 2PM; PM-Meds to be administered between 4PM and 8PM; HS (bedtime)-Meds to be administered between 8PM and 10PM. <Resident 9> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnosis of diabetes [your body can not make enough insulin (a hormone that lowers the level of sugar in the blood) or can't use it as well as it should]. The 02/04/2024 comprehensive assessment showed the resident had an intact cognition and required extensive assistance of one staff member for activities of daily living (ADLs). Review of Resident 9's physician orders, dated 03/04/2024, showed an insulin sliding scale (used as reference for insulin to be administered) to be given before meals based on the resident's blood sugar test results. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 03/07/2024 at 11:29 AM, Staff N, Licensed Practical Nurse (LPN), stated Resident 9's blood sugar level was 221 milligrams/deciliter(a unit of measure) and they would need to administer three units of insulin based on the sliding scale. Staff N prepared the insulin pen (a pre-filled disposable device containing insulin) by cleaning the pen tip with an alcohol swab and attached a needle to the pen. Staff N administered the insulin to Resident 9 with the insulin pen into the resident's left arm, pressed the button to dispense the medication, and removed the needle from their skin. Staff N did not prime the needle of the insulin pen prior to administration. Staff N stated that they did not prime the needle of the insulin pen this time, but they usually do. <Resident 5> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnosis of diabetes. The 01/07/2024 comprehensive assessment showed the resident had an intact cognition and required extensive assistance of one staff member for ADLs. Review of Resident 5's physician orders, dated 02/01/2024, showed the resident was to have 10 units of insulin administered subcutaneously (under the skin), with meals. Further review showed a sliding scale was to be administered in addition to the 10 units based on the resident's blood sugar test. During an observation and concurrent interview on 03/27/2024 at 12:14 PM, Staff O, LPN, stated Resident 5's blood sugar level was 169 milligrams/deciliter and they needed to administer 13 units of insulin based on the physician orders and sliding scale. Staff O prepared the insulin pen by attaching a needle. Staff O administered the insulin to the resident with the insulin pen into the resident's left arm, pressed the button to dispense the medication, and removed the needle from their skin. Staff O did not prime the needle of the insulin pen prior to administration. Staff O stated they were unaware that they needed to prime the needle of the insulin pen; it is not my normal process. <Resident 13> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include a right femur (thigh bone) fracture and hypertension (high blood pressure). The 02/04/2024 comprehensive assessment showed the resident had an intact cognition and required extensive assistance of one staff member for ADLs. During an observation and concurrent interview on 03/28/2024 at 1:00 PM, showed Staff I, Resident Care Manager, administered the following medications: Amlodipine (treatment of high blood pressure), Vitamin D, Vitamin B12, Miralax (used to relieve constipation), Mybetriq (treatment for overactive bladder), and Tums (stomach acid reducer). The physician's orders showed the above medications were to be administered in the morning (between 6:00 AM and 10:00 AM). Staff I stated they knew they were late giving the morning medications (three hours past the scheduled time), it is just so busy. During an interview on 03/29/2024 at 10:40 AM, Staff B, Regional Director of Nursing Services, stated they expected the nurses to know how to administer insulin correctly. Staff B further stated they would expect the nurses to follow the med pass times and physician orders and they would be giving education to all nurses on following the correct processes. Reference: WAC 388-97-1060(3)(k)(ii)(iii)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to serve a nourishing snack at bedtime for 3 of 4 residents (Residents 1, 4, and 17) reviewed for bedtime snacks. This failure placed the residents at risk for hunger, weight loss, and unmet nutritional needs. Findings included . <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including liver and kidney disease. The 03/07/2024 comprehensive assessment showed Resident 1 required moderate to maximum assistance of one staff member for activities of daily living (ADLs) and set up assistance of one staff member for eating. The assessment also showed the resident had a moderately impaired cognition. <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including cerebral palsy (a group of conditions that affect movement and posture) and type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). The 01/27/2024 comprehensive assessment showed Resident 4 required substantial to dependent assistance of one to two staff members for ADLs; setup assistance for eating. The assessment also showed the resident had an intact cognition. <Resident 17> Review of the medical record showed Resident 17 was admitted to the facility on [DATE] with diagnoses including type II diabetes mellitus, kidney disease, and heart disease. The 03/24/2024 comprehensive assessment showed Resident 17 required maximum to dependent assistance of one to two staff members for ADLs; independent for eating. The assessment also showed the resident had an intact cognition. During an interview on 03/26/2024 at 11:51 AM, Staff C, Registered Dietician, stated snacks were not routinely offered to residents. They stated residents with a diagnosis of diabetes had diabetic friendly snacks that were served to them in the evening. Staff C stated if a resident wanted a snack, they were available, but the resident would have to ask for the snack. During a Resident Council (an organized group of residents that meet regularly to discuss and address concerns about their rights, quality of care, and quality of life) meeting, conducted by the survey team on 03/26/2024 at 1:35 PM, Residents 1, 4, and 17 stated they were not served a snack at bedtime. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/01/2024 at 10:33 AM, Staff B, Regional Director of Nursing Services (RDNS), stated snacks were available to the residents, but were unsure if they were being served in the evening. Staff B stated there was a task for the staff to ensure residents with diabetes were receiving their evening snack but was not sure about the other residents. During an interview on 04/01/2024 at 10:41 AM, Resident 4 stated I would love a snack before going to sleep. They stated the staff don't always come around to give me a snack. During an interview on 04/01/2024 at 10:43 AM, Resident 1 stated they had to ask for a snack if they wanted one, but it depended on which staff was working. Resident 1 stated some of the staff brought them a snack at bedtime without asking for it. During an interview on 04/02/2024 at 9:40 AM, Resident 17 stated they had not received a snack at bedtime all the time. Resident 17 stated that it would be nice to be offered a bedtime snack, but they often had to ask for one. Review of Resident 4's March 2024 Diabetic Administration Record (DAR), showed offer snack at bedtime . document percentage eaten, at bedtime for DM (diabetes mellitus). The DAR showed Resident 4 was offered a snack at bedtime 25 out of 31 days. The record showed the resident consumed 100% of the snack on the 25 days they received their snack. Review of Resident 17's March 2024 DAR showed offer snack at bedtime .document percentage eaten, at bedtime for DM (diabetes mellitus). The DAR showed Resident 17 was offered a snack at bedtime 24 out of 31 days. The record showed the resident consumed 100% of the snack on the 24 days they received their snack. During an interview on 04/01/2024 at 12:43 PM, Staff A, Administrator, stated there was a snack refrigerator for residents that the dietary department kept stocked. Staff A stated they were aware that snacks were available for residents, but the staff were not serving the snacks to the residents at bedtime; they would have to ask for one. During a follow up interview on 04/02/2024 at 11:51 AM, Staff B, RDNS, stated the meal service times were changed and no one noticed the increased length of time between meals (greater than 14 hours between evening meal and breakfast meal). Reference: WAC 388-97-1120(1)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45117 Based on observation and interview, the facility failed to ensure the proper disposal of trash for 1 of 1 dumpster reviewed for outdoor refuse storage. Failure to ensure the dumpster was covered placed the facility at risk of attracting bugs, rodents, and an unsanitary environment. An observation on 03/26/2024 at 11:17 AM, showed the dumpster located in a walled off area of the parking lot, with two gates enclosing the front side of the wall and one opened gate on the side. There was one dumpster located inside the enclosure that had both lids open; visible trash included trash bags that were not secured to keep trash contained, and a mattress. An observation on 03/27/2024 at 8:15 AM, showed the dumpster in the same area, with additional bags of trash added from the previous observation, and both dumpster lids open. An observation on 03/28/2024 at 11:32 AM, showed the dumpster with one lid open. During an interview on 03/28/2024 at 11:45 AM, Staff D, Maintenance Director, stated they were responsible for the dumpster and surrounding area. Staff D stated they did not know the lids needed to be closed. During an interview on 04/01/2024 at 12:47 PM, Staff A, Administrator, stated they were not aware that the dumpster lids needed to be closed. During an interview on 04/02/2024 at 11:57 AM, Staff B, Regional Director of Nursing Services, stated they were aware of the regulations for the dumpster but were not aware that the dumpster lids were left open. Staff B stated the lids should have been closed. Reference: WAC 388-97-1320(4)