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	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Wenatchee Rehabiliation & Nursing Center	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 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** 43280 Based on interview and record review, the facility failed to ensure grievances (resident and/or resident representative concerns that can be voiced or written) conveyed to staff underwent prompt resolution and appropriately updated residents on the grievance progress/conclusion for 1 of 2 residents (Resident 46) reviewed for grievances. This failure placed residents at risk for unresolved concerns and unmet care needs. Findings included . Review of the facility policy titled, Grievances Procedure, revised August 2023, showed the facility would ensure each residents' right to .voice grievances (such as those about treatment, care, management of funds, lost clothing, or violation of rights) . and that facility staff were responsible for making prompt efforts to resolve a grievance and to keep the resident appropriately apprised (updated on information) of progress towards the residents grievance resolution. The policy showed the facility would .have a process in place for identification, investigation and follow-up of resident/resident representative grievances in a timely manner, and that residents had a right to obtain a written decision regarding their grievance. Additionally, the policy showed the facility would ensure that grievance decisions included the date the grievance was received, a summary of the resident's grievance, the steps taken to investigate the grievance, and the finding or conclusions of the grievance and the date the written decision was issued. <Resident 46> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including pneumonia (an infection in the lungs, that can cause a build-up of fluid, making it difficult to breathe), insomnia (difficulty falling and/or staying asleep), sepsis with septic shock (a potentially life-threatening condition that comes when the body's response to an overwhelming infection causes injury to its own tissues and organs) and delirium (a serious change in metal ability that causes confused thinking and lack of awareness of surroundings and can be caused by infections). The 04/14/2025 comprehensive assessment showed that Resident 46 had a moderately impaired cognition with evidence of delirium but was able to make their needs known. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/28/2025 at 2:09 PM, when asked if they were missing any personal items, Resident 46 stated that right after their admission to the facility, 193 dollars in cash went missing, but the facility staff found 93 dollars of it. Resident 46 stated they had a conversation with Staff A, Administrator, about the missing money after the facility had found the 93 dollars, but they had not received any money back nor an update since Staff A had informed them that an investigation would be conducted into the missing money. During an interview on 04/30/2025 at 9:26 AM, Staff N, Laundry/Housekeeping Supervisor, stated the process when money was found in the laundry room was to fill out a grievance form and then give the money over to the Administrator to continue the grievance process. Staff N stated that a weekend laundry aid contacted Staff A and informed them that they had found 93 dollars in cash, which belonged to Resident 46. Staff A stated the money was found the day after the resident had been admitted to the facility and the weekend laundry aid put the money under the Administrator's locked door. During a follow-up interview on the same day at 10:43 AM, Staff N stated they were unaware of the additional 100 dollar amount of cash that Resident 46 stated was in their clothes and would have investigated further by interviewing the laundry aid/looking into where the money might have gone. Review of the facility's grievance log for April 2025, showed no documentation of grievance regarding missing money. During an interview on 04/30/2025 at 10:01 AM Staff A stated that if a resident was missing cash monies in the facility the grievance process would be started, and the facility would try to get them a locked drawer for the money. When asked about Resident 46's missing money, Staff A stated they intended to go through the grievance process, I probably missed that one, since a grievance form was not filled out and the resident informed Staff A that there was 100 more dollars that was in the resident's pants pocket, in addition to the 93 dollars found in the laundry. Staff A stated they did not have documentation of the steps taken to investigate and/or the resolution/conclusion of Resident 46's grievance. Reference: WAC 388-97-0460(2)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure nursing staff reported, witnessed verbal and physical abuse, to the State Agency, immediately, but no later than two hours after the abuse took place, for 1 of 3 residents (Residents 41), reviewed for abuse/neglect. This failure placed the residents at risk for unidentified abuse/neglect, and the potential continued exposure to abuse and/or neglect. Findings included . Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised October 2022, showed that all facility employees were mandated reporters that must immediately report when there was a reasonable cause to believe an incident of abuse occurred. The facility policy stated all alleged violations involving abuse were to be reported immediately, but not later than two hours after the event had taken place. <Resident 41> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including right below the knee amputation (BKA, removal of a body part) surgical aftercare, anxiety, long term pain, and peripheral vascular disease (PVD, a narrowing or blockage of blood vessels, leading to reduced blood flow, primarily to the legs and feet, with common symptoms including leg pain and non-healing wounds). The 04/26/2025 comprehensive assessment showed Resident 41 had moderate cognitive impairment but was able to make their needs known. Review of Resident 41's incident investigation, dated 04/24/2025 at 9:00 AM, showed that on 04/24/2025 at 3:40 AM Staff H, Nursing Assistant (NA), witnessed Staff I, Registered Nurse (RN), when providing care , grabbed Resident 41's left arm and shoved the resident while cursing at the resident, telling the resident to Stop (Resident 41's), f*****g s**t. During an interview on 04/29/2025 at 10:25 AM, Resident 41 stated they could not remember the exact date of the incident, but the incident happened in the early morning when the nurse and nursing assistants (NA) had come into the room to change the resident brief. Resident 41 stated Staff I got hostile (showing strong dislike and unfriendly) because the resident was not turning to their side fast enough during incontinent care. During an interview on 05/01/2025 at 5:01 PM, Staff H stated they had gone in/out of Resident 41's room early on the morning of 04/24/2025, and upon entering back into the resident room, after grabbing supplies, Staff H witnessed Staff I grabbing Resident's 41 arm, as the resident swung at Staff I, and Staff I proceeded to pushed the residents arm down while cussing at the resident to stop. Staff H stated they did not report the witnessed verbal and physical abuse to any other staff or State Agency until around 7:30 AM to 8:00 AM, when they texted Staff A, Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/2025 at 11:29 AM, Staff B, Director of Nursing Services, stated they were informed of the allegation of verbal and physical abuse towards Resident at 9:00 AM on 04/24/2025 by Staff H. Staff B stated that the report to the State Agency was made after Staff B became aware of the allegations. Staff B stated a report to the State Agency should have been made immediately after being witnessed by Staff H or within two hours. Staff B stated the correct process for reporting abuse allegations was not followed. Reference: WAC 388-97-0640(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to immediately implement effective measures in the protection of a resident from further abuse/neglect, nor conduct a thorough investigation into an allegation of abuse for 2 of 3 residents (Residents 41 and 11), reviewed for abuse and neglect. This failure placed the residents at risk for unidentified abuse, unmet care needs, and the potential for continued exposure to abuse and/or neglect. Findings included . Review of the facility's policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised October 2022, showed that it was the facility's policy to protect residents from abuse and .All alleged incidents of abuse, neglect, misappropriation of resident property and injuries of unknown source must be thoroughly investigated . The policy showed the investigator would collect as much data as needed to be able to reach a reasonable conclusion and that data collection could involve .Interview assigned caregiver, caregivers in the immediate area, caregivers from the shift prior to the incident's discovery, visitors, family, roommates and the alleged perpetrator .' Additionally, the policy showed .Protecting the resident from further harm means keeping the resident safe by .immediately suspend the alleged perpetrator .having a trusted person stay with the resident . <Resident 41> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including right below the knee amputation (BKA, removal of a body part) surgical aftercare, anxiety, long term pain, and peripheral vascular disease (PVD, a narrowing or blockage of blood vessels, leading to reduced blood flow, primarily to the legs and feet, with common symptoms including leg pain and non-healing wounds). The 04/26/2025 comprehensive assessment showed Resident 41 had moderate cognitive impairment but was able to make their needs known. Review of the alleged abuse investigation, dated 04/24/2025 at 9:00 AM, showed that Staff H, Nursing Assistant (NA), reported to the Administrator and Director of Nursing Services (DNS), that they had witnessed Staff I, Registered Nurse (RN), physically and verbally abuse Resident 41 when administering medications and providing care to the resident. Staff H stated that Resident 41 had requested a suppository medication (a type of drug, inserted through the rectum) to help them have a bowel movement. Staff H stated that Staff I's inserted the suppository medication incorrectly, and Resident 41 yelled at Staff I you're hurting me. Staff H stated that both Staff H and Staff I left the resident's room to gather supplies and upon Staff H's reentry to Resident 41's room they overheard the resident telling Staff I you're hurting me you b***h, and witnessed Resident 41 swinging her left arm at Staff I and Staff I grabbing the resident's left arm and proceeded to shove while cursing at the resident, telling the resident to Stop (Resident 41) f*****g s**t. The investigation showed Resident 41 stated that when the suppository was inserted incorrect the resident threw their arm up at Staff I to get the staff members attention and Staff I grabbed the resident's arm and pushed them, The nurse is rude and was rough with me. Resident 41 requested their emergency contact to be informed about the incident. Additionally, no interview with Resident 41's representative (RR) was documented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the 04/24/2025 alleged abuse investigation showed Staff H conveyed the witnessed abuse to the Director of Nursing Services (DNS) on 04/24/2025 at 9:00 AM and then Staff I, who had already completed their night shift, was suspended pending the investigation and safety of Resident 41 was ensured. The investigation showed that Staff H feared the nurse and so did not report the witnessed event until after their shift had ended. During an interview on 04/29/2025 at 10:25 AM, Resident 41 was unable to remember specifics about the incident at certain times, was not interested in talking more about the incident and did not remember the suppository medication that was administered by Staff I. Resident 41 then stated that during the incident Staff I was really mean and aggressive when providing cares, because the resident was not turning to their side fast enough and they did not feel safe with Staff I. During a follow-up interview on 04/30/2025 at 2:36 PM Resident 41 was forgetful/confused on specifics related to the incident but then stated feeling uncomfortable and helpless with the way Staff I provided care to them. During an interview on 05/01/2025 at 5:01 PM, Staff H stated that after witnessing the incident of abuse in Resident 41's room. Staff H stated they did not report the witnessed abuse to any other staff until around 7:30 AM to 8:00 AM, when they notified the Administrator. Staff H stated they did not report to the State Agency hotline number. Staff H stated they did not protect the resident from further harm and was afraid of the nurse, so after the incident went back to their regular duties. When asked if Staff I had gone back into Resident 41's room, Staff H stated that it was possible. During an interview on 05/02/2025 at 7:13 AM, Staff A, Administrator, stated that interviews with other staff, Resident 41's roommate and other residents were completed during the investigation and did not correlate with Staff H's witnessed statements of verbal/physical abuse by Staff I on Resident 41. Staff A stated that none of the interviews conducted corroborated (to support with evidence or make something more certain) with the allegations brought forth by Staff H. Staff A stated the investigation had been completed and education was performed on Staff I regarding the incorrect insertion of the suppository medications. During an interview on 05/02/2025 at 9:20 AM, Resident 41's Representative (RR), stated they had known the resident for [AGE] years now and were notified by the Administrator about the incident. The RR stated they came to talk with Resident 41 after they got off work. The RR stated Resident 41 stated that Staff I was hurting them, pushing them and the resident felt helpless in the situation. RR stated, (Resident 41) did feel abused and did not feel safe with Staff I and did not want that nurse working with them anymore. (Resident 41) was frightened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/2025 at 11:29 AM, Staff B, DNS, stated they had interviewed Resident 41, other residents, staff and the RR. When inquiring about the RR, Staff B stated that Resident 41 did not have family, and the resident had requested to talk with their RR after the incident/allegation of abuse took place. Staff B stated the RR came in to talk with Resident 41 on the 24th or 25th of April 2025 but was unsure of the exact date/time. Staff B stated that per Resident 41, Staff I was rude, rough and fast when providing care, but felt safe with the staff member. Staff B stated the resident's recollection of the events was not good and that it would change. Staff B stated that staff/resident interviews conducted could not corroborate the allegations brought forth by Staff H and the investigation was completed. When informed of RR interview, Staff B stated they were unaware of information conveyed to the RR by Resident 41 and thought Staff A had interviewed the RR and that the RR did not have any concerns. Staff B stated the correct process was not followed and the investigation was not thorough. Staff B stated the investigation would have to be reopened and follow-up with the RR. During an interview on 05/05/2025 at 5:11 PM, Staff C, Regional Clinical Director (RCD), stated that Staff H should have protected Resident 41 after witnessing the alleged abuse by Staff I. Staff C stated the protection of the resident from further harm was not implemented, Staff I still had access to Resident 41 after the witnessed abuse and the correct process was not followed. <Resident 11> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including dementia and degenerative joint disease (a type of arthritis characterized by the breakdown of [NAME] in the joints causing pain, stiffness and decreased movement) in both knees. Resident 11 ' s most recent comprehensive assessment dated [DATE] showed they had moderately impaired cognition and required minimum to moderate assistance of one to two caregivers for activities of daily living (ADL ' s) and could not ambulate. During an observation and interview with Resident 11 on 05/02/2025 at 11:13 AM, showed them sitting in their wheelchair in their room looking out the window. Resident 11 stated they had never had a fall in their room or bathroom and could walk independently without any assistance. Review of the facility reporting logbook showed Resident 11 had nine falls in the facility within the past five months. November 2024 through March 2025. Review of the facility incident reports for Resident 11 showed they had two observed falls on 11/14/2024 and 12/23/2024 and seven unobserved falls on 11/04/2024, 12/26/2024, 01/13/2025, 02/19/2025, 03/01/2025, 03/13/2025 and 03/31/2025. None of the unobserved falls had witness statements attached showing a thorough investigation was completed into the possible causes of the falls or that abuse, and neglect had thoroughly been ruled out as a cause of the falls. Review of Resident 11 ' s care plan initiated on 03/03/2021 and last revised on 04/07/2025, showed the resident was at risk for falls related to pain, weakness, deconditioning, degenerative joint disease in both knees, vertigo (dizziness), history of falls, cognitive impairment, profound hearing loss, epilepsy (a seizure disorder), impulsiveness, impaired vision, poor decision making, and overestimating abilities. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the care plan showed the problem of being at a high risk for falls and goals to be free of falls were updated on 01/13/2025, 03/18/2025 and 04/07/2025. Additional interventions to decrease the risk for falls were only initiated for the two of the nine falls dated 01/13/2025 and 02/19/2025. During an interview with Staff B, DON and Staff C, RCD, on 05/07/2025 at 12:48 PM, they both acknowledged that thorough investigations into the causes of the falls and to ensure abuse or neglect was not the cause of the falls was not completed. In addition, they both acknowledged that limited interventions were put into place after the falls to prevent future falls and keep Resident 11 as safe as possible. Reference: WAC 388-97-0640 (2)(a)(6)(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interviews and record reviews, the facility failed to follow up on written notices of bed holds (holding or reserving a resident's bed while the resident was absent from the facility) given at the time of hospital transfers, and/or failed to send a copy of the notice of transfers to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a person that advocates for residents in nursing homes) for four of four residents (Residents 35, 14, 51 and 49) reviewed for discharge process. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold while in the hospital and disallowed the resident and/or their representative an opportunity to fully understand the rationale/resident rights associated with the discharge. This failure also placed the residents at risk for diminished protection, lack of access to an advocate that could inform them of their options and rights, and to ensure the resident advocacy agency was aware of the facility practices and activities related to transfer or discharge. Finding included . Review of a facility policy titled Bed Hold/Notice of Transfer/Discharge last revised on 02/2025 and located in the transfer and discharge packets sent with residents on transfer or discharge from the facility, shows Statement #5 of the policy reading as If a resident is Medicaid, the resident may elect to privately pay for the bed hold at 90% of the current rate per day. <Resident 35> Review of the medical record showed Resident 35 was readmitted to the facility on [DATE] with diagnoses including a fractured pelvis and chronic pain. The resident's comprehensive assessment dated [DATE] showed they required moderate assistance of one staff member for activities of daily living (ADLs) and was cognitively intact. Further review of Resident 35's medical record showed the resident was transferred to the hospital on 03/19/2025 following a ground level fall in their bathroom. The resident was admitted to the hospital for a fractured pelvis and returned to the facility on [DATE]. The record showed no notice of a bed hold was given to either Resident 35 or their representative. During an interview on 04/29/2025 at 10:07 AM with Resident 35's representative, they stated they had not seen a notification of a bed hold policy sent to the hospital with Resident 35 on 03/19/2025 and no one from the facility had contacted them at anytime during the resident's hospital stay asking if they would like to hold the resident's bed. <Resident 14> Review of the medical record showed Resident 35 was readmitted to the facility on [DATE] with diagnoses including end stage renal disease with dialysis, and paralysis of the lower extremities. The resident's comprehensive assessment dated [DATE] showed they required maximum total assistance of one to two caregivers for ADLs and was cognitively intact. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 14's medical record showed they were transferred to the hospital on 01/23/2025 for abdominal pain and was admitted . The resident returned to the facility on [DATE] with diagnoses of a urinary tract infection and a fecal impaction. There was no record showing whether the resident or their representative were given a bed hold notification. During an interview on 04/29/2025 at 11:10 AM with Resident 14, they stated they did not recall ever being asked if they wanted to hold their bed when they were transferred out to the hospital and did not know it was a possibility, they might not have a bed to return to. 43280 <Resident 51> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including surgical aftercare of a left ankle infection/debridement (removal of dead, damaged or infected skin) with intravenous (medication through a vein in the body) antibiotic therapy. The 01/25/2025 comprehensive assessment showed Resident 41 was cognitively intact and was able to make their needs known. Resident 51 was discharged on [DATE]. An additional review of Resident 51's medical showed no documentation that the LTC Ombudsman was notified of the resident's discharge. <Resident 49> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including multiple heart/lung complications, depression and anxiety. The 02/10/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Review of Resident 49's hospital transfer evaluation showed the resident was transferred to the hospital on 02/22/2025 when they became confused and unable to stay awake. Resident 49 was discharged on [DATE]. An additional review of Resident 49's medical record showed no documentation that the LTC Ombudsman was notified of the resident's discharge. During an interview on 05/01/2025 at 4:17 PM with Staff A, Administrator, about the facility's processes for bed holds, and Ombudsman notifications of transfers and discharges, they stated bed holds go out with the resident's in a packet on transfer and are followed up if necessary after admission to the hospital with the resident and/or their representative by the facility's Business Office Manager (BOM). Staff A stated during the same interview they recently discovered the facility was not sending out notifications of transfers and discharges to the Ombudsman office as required. Staff A stated the medical records department previously sent out the Ombudsman notifications and would have more information on the facility's current process. During an interview on 05/05/2025 at 11:08 AM, Staff S, Medical Records, stated they had started their position in the facility in July of 2024 and had not sent any notifications of residents transferred and discharged out of the facility to the Ombudsman office since that time. Staff S stated that no one had informed them when they took the position that it was a requirement to do so. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/05/2025 at 11:16 AM, with Staff T, BOM, they stated they did not follow up on bed holds for residents if their payor source was Medicaid because Medicaid paid for 20 days of hospitalization automatically. Staff T stated the facility always held these residents beds for them and took them back regardless of how many days they had been gone as this was their home. The BOM stated during the same interview that all residents transferred to the hospital get a packet sent with them that had a bed hold policy in it regardless of pay source, so they thought the requirement was met by providing the information on all transfers and/or discharges. Reference: WAC 388-97-0120(3)(c)(5)(a)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 45117 Based on observation, interview, and record review, the facility failed to ensure a Preadmission Screening and Resident Review [(PASARR) a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment] accurately reflected residents' mental health conditions for 1 of 5 residents (Resident 39) reviewed for PASARR accuracy. This failure placed the residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings including . Review of a policy titled, Pre-Admission Screening and Resident Review, revised 06/2024, showed prior to admitting a resident, the admission coordinator or designee would request a PASARR Level I screening. The Level I screening must be completed prior to admission to identify individuals who have or may have a serious mental illness or related condition. A negative screen would permit admission and end the pre-screening process. Those individuals identified with any qualifying criteria, or a positive screen would require a PASARR Level II referral for evaluation and determination prior to admission to the facility. Social Services was responsible to review the PASARR to verify accuracy. <Resident 39> Review of the medical record showed Resident 39 was admitted to the facility with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), delirium (a sudden change in mental state characterized by confusion, disorientation), hallucinations (sensory perceptions that occur in the absence of a real external stimulus), anxiety, and depressive disorder. The 04/25/2025 comprehensive assessment showed Resident 39 required substantial/maximum assistance of one staff member for activities of daily living (ADLs) and had a severely impaired cognition. The assessment also showed Resident 39 was receiving hospice services. Record review of Resident 39's medical record showed a PASARR Level I form, dated 04/14/2025, showed Resident 39 had no serious mental illness indicators, no evidence of serious functional limitation during the past six month related to a serious mental illness, and had not had psychiatric treatment greater than outpatient care or experienced a significant disruption to the normal living situation. The PASARR Level I form showed no Level II evaluation was indicated for Resident 39, despite their mental health diagnoses of dementia, delirium, hallucinations, anxiety, and depressive disorder. During a concurrent observation and interview on 05/02/2025 at 11:41 AM, Staff K, Social Services Director, review Resident 39's PASARR Level I form. Staff K stated they were responsible to ensure the facility received the PASARR Level I form prior to admission and to review it for accuracy. Staff K stated Resident 39's PASARR form was filled out incorrectly and it should have been sent for a PASARR Level II evaluation prior to admission. Staff K stated they were unsure why they had not caught the error. They stated if they had realized the form was incorrect, they would have sent it to the admissions coordinator to reach out to the hospital case manager for accuracy. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/2025 at 11:52 AM, Staff A, Administrator, stated the admissions coordinator was responsible for the initial review of the PASARR Level I form to ensure it was accurate before admitting the resident. They stated a second check was completed by the Social Services Director. Staff A stated they were not sure how Resident 39's incorrect PASARR got by us. Reference: WAC 388-97-1915(1)(2)(a-c)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to develop a baseline care plan [(BCP) a document outlining initial care goals and necessary healthcare information for a resident], within 48 hours of admission, that included the minimum requirements of resident specific goals, physician orders, dietary orders, treatment plans, and social service needs for 6 of 10 residents (Residents 39, 13, 202, 33, 41, and 32) reviewed for new admissions (residents admitted to the facility in the last 30 days). Failure to develop a BCP placed the residents at risk of not receiving continuity of care and resident centered care needs. Findings included . Review of a policy titled, Baseline Care Plan, revised 11/08/2021, showed a BCP would be developed within 48 hours of admission that included the minimum healthcare information necessary to care for the resident, that also met regulatory requirements. <Resident 39> Review of the medical record showed Resident 39 was admitted to the facility on [DATE] with diagnoses including palliative care (specialized medical care for individuals with serious illnesses, focusing on relieving symptoms, managing stress, and improving quality of life), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), severe malnutrition (significant low body weight for height), and adult failure to thrive (a progressive loss of physical and functional abilities, often accompanied by weight loss, poor appetite, and reduced activity levels. The 04/25/2025 comprehensive assessment showed Resident 39 required substantial/maximum assistance of one staff member for activities of daily living (ADLs) and had a severely impaired cognition. The assessment also showed Resident 39 was receiving hospice services. Record review of Resident 39's BCP, dated 04/21/2025, showed no resident specific goals or interventions for Resident 39's dietary orders, social services, or hospice services. <Resident 13> Review of the medical record showed Resident 13 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening condition that arises when the body's response to an infection that damages its own tissues and organs), bacteremia (the presence of bacteria in the blood), and inflammation of the brain and spinal cord. The 03/29/2025 comprehensive assessment showed Resident 13 was dependent on one to two staff for ADLs and was cognitively intact. The assessment also showed Resident 13 was receiving antibiotics (medications that fight bacterial infections) through a peripherally inserted central catheter [PICC) a long, thin tube inserted into a vein in the upper arm and threaded to a larger vein in the chest, near the heart). Record review of Resident 13's BCP, dated 03/25/2025, showed no resident specific goals or interventions for Resident 13's dietary orders, physicians orders, social services, or care and treatment of their PICC line. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 202> Review of the medical record showed Resident 202 was admitted to the facility on [DATE] with diagnoses including a stroke (damage to the brain from interruption of its blood supply), pain, and difficulty swallowing. The 04/28/2025 comprehensive assessment showed Resident 202 required supervision for eating, and set-up assistance for personal cares. The assessment showed Resident 202 had an intact cognition. Record review of Resident 202's BCP, dated 04/24/2025, showed no specific goals or interventions for Resident 202's dietary orders and social service's needs. 43280 <Resident 33> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including left ankle surgical aftercare, with a long-term history of spin/back complications. The 03/29/2025 comprehensive assessment showed Resident 33 had functional impairments (weakened or damaged) to their range of motion on both upper and lower legs/arms. The resident had moderately impaired cognition but was able to make their needs known. Record review of Resident 33's medical record showed no documentation of a BCP had been completed. <Resident 41> Review of the medical record showed the resident was admitted to the facility on [DATE] and readmitted from the hospital on 04/22/2025 with diagnoses including right below the knee amputation (BKA, removal of a body part) surgical aftercare, anxiety, long term pain, and peripheral vascular disease (PVD, a narrowing or blockage of blood vessels, leading to reduced blood flow, primarily to the legs and feet, with common symptoms including leg pain and non-healing wounds) with a history of PVD angioplasty (a procedure to open the blocked or narrowed arteries in the legs). The 04/26/2025 comprehensive assessment showed Resident 41 had moderately impaired cognition but was able to make their needs known. Record review of Resident 41's medical record showed no documentation of a BCP had been completed. <Resident 32> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including bone infection and right-hand surgical aftercare. The 04/06/2025 comprehensive assessment showed the resident had a PICC line for antibiotic therapy, was cognitively intact and able to make their needs known. Record review of Resident 32's medical record showed no documentation of a BCP had been completed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/05/2025 at 3:22 PM, Staff D, Registered Nurse/Resident Case Manager, stated the facility's process would be to go over the residents BCP within 24 hours after their admission and it would include a summary of a resident's initial care goals and necessary healthcare information. Staff D stated that Resident 33, 41 and 32's BCP were not completed, just slipped by. Staff D stated they were working on a new process to make sure BCP were completed for the facility's residents. During an interview on 05/05/2025 at 2:11 PM, Staff C, Regional Clinical Nurse, stated there were recent changes in staffing that led to gaps in the completion of baseline care plans. During a follow up interview on 05/05/2025 at 4:34 PM, Staff C stated the facility was not following the correct procedure for BCP and they were no longer utilizing that process. Staff C stated they would make a new process that included the requirements and was according to the BCP regulation. Reference: WAC 388-97-1020(3)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice regarding, A) a residents Central Vascular Access Device (CVAD, also known as a central line, is a thin, soft tube that is inserted into a main vein in the arm, leg, or neck for long-term administration of antibiotics, medication, nutrition, and/or blood draws) dressing change and medication administration after nursing staff noted the central line migration (movement of the tubing from its original position) for 1 of 4 residents (Residents 32) reviewed for central lines, B) nursing staff failing to process, initiate, and follow physician orders with residents wound care for 1 of 4 residents (Resident 41) reviewed for wound care orders. This failed practice placed residents at risk for improper medication delivery, a delay in treatment, and adverse outcomes. Findings included . Review of the facility's guidance titled, Central Vascular Access Device Dressing Change, revised 01/15/2004, showed a Peripherally Inserted Central Catheter (PICC) was a specific type of central line, the dressing on all CVAD's should be dated, so a dressing change schedule could be started for every seven days and .upper arm circumference (a measurement around a residents arm, used as a baseline to detect possible swelling or blood clots) with PICC, and external catheter length measurement must still be completed as part of the initial assessment . The facility's guidance showed that the external catheter measurement was to be obtained upon admission, during dressing changes and that a securement/stabilization device (a small attachment that helps anchor the PICC line in place, to the skin, and prevent migration of the line) should be used and to not removed during a PICC line dressing change. Additionally, the facility's guidance showed that when changing the PICC line dressing, staff should not . disturb (to move or change something from its usual position) catheter . or remove the securement device. Review of Lippincott's nursing procedures manual, 8th edition, Peripherally Inserted Central Catheter Use, dated 2019, showed that a stabilization device should be used to decrease the risk of unintentional movement of the catheter or dislodgement which could lead to complications. Additionally, movement of the catheter should be avoided but if noted during a dressing change that the catheter has migrated more than two centimeters (cm, a unit of measure) a provider should be notified due to the need to confirm if the PICC is still in the correct position. <Resident 32> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including bone infection and right-hand surgical aftercare. The 04/06/2025 comprehensive assessment showed the resident had a PICC line for antibiotic therapy, was cognitively intact and able to make their needs known. Review of the resident admission assessment dated [DATE] showed the resident was receiving intravenous (IV, the administration of medications or fluids directly into a person's vein) therapy with antibiotics for their bone infection with an IV insertion date of 04/04/2025. The assessment did not show the external catheter length measurement or the upper arm circumference measurement. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/29/2025 at 9:10 AM, showed Resident 32 in their room. The resident's PICC line had a change date of 04/23/2025 handwritten on the top of the dressing and a small two inch (in, a unit of measure) long by 1/4 in wide amount of blood was noted under the PICC line dressing. The external catheter length and time of the last dressing change were not noted on the dressing. During an interview on 05/01/2025 at 12:54 PM, while in Resident 32's room observing the PICC line dressing, Staff O, Registered Nurse (RN), stated they did not know the external catheter length and the blood noted under the dressing was recent since the last dressing change. During a concurrent observation and interview on 05/01/2025 at 1:28 PM, Staff O was in Resident 32's room performing a PICC line dressing change. Staff O stated they remembered the external catheter length was six cm but was unsure if it was documented. Observations showed after removing the old dressing, Staff O picked up and moved the placement of the PICC line from a downward position, where the PICC line access ports were pointing toward the residents elbow, to an upward position, where the PICC line access ports were pointing toward the resident's armpit and then continued to flip/rotate the PICC line two more times (no securement device was in place). Staff O measured the external catheter length and noted that it had been pulled out from six cm to nine cm. Staff O did not measure Resident 32's upper arm circumference. During an interview on 05/01/2025 at 2:07 PM, Staff D, RN/Resident Case Manager (RCM), stated the process for admission/assessments of residents with PICC lines would include documenting the external catheter length. Staff D was unable to find documentation showing Resident 32's external PICC length or upper arm circumference. Staff D stated the external length of the PICC line was needed to assess if migration of the line took place. Staff D stated that when migration of the PICC line was noted, the line would no longer be used for infusion of medications and the provider would be notified. During an interview on 05/01/2025 at 2:19 PM, Staff B, Director of Nursing Services, and Staff C, Regional Clinical Director, stated that when a resident was admitted with a PICC line a group of orders were to bed and included the external catheter length. Staff B stated the process for central lines included assessing the PICC lines external catheter length and the upper arm circumference, so that migration of the catheter line or complications with swelling could be noted/acted upon. Staff B stated they were unable to find Resident 32's external catheter length or upper arm circumference and the correct process was not followed. Staff B and Staff C stated they were informed that Resident 32's PICC line catheter had migrated from six cm to nine cm, so Resident 32's IV medication infusions should be stopped and a notification to the provider would be completed before utilizing the residents PICC line. During a concurrent observation, upon the surveyor and Staff B entering Resident 32's room, and interview on 05/01/2025 at 2:45 PM showed IV medication infusing through the residents PICC line. Staff B stated the IV medication should not be infused through the PICC line since the line had migrated and Staff O did not follow the correct process. Staff B stated they were going to stop the infusion immediately. During an interview on 05/01/2025 at 3:21 PM, Staff B stated that during a CVAD/PICC dressing change the catheter should not be moved from its usual position and Staff O's moving the catheter placement and flipping/rotating catheter during a central line dressing change was not the correct process. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 41> Review of the medical record showed the resident was admitted to the facility on [DATE] and readmitted from the hospital on 04/22/2025 with diagnoses including right below the knee amputation (BKA, removal of a body part) surgical aftercare, anxiety, long term pain, and peripheral vascular disease (PVD, a narrowing or blockage of blood vessels, leading to reduced blood flow, primarily to the legs and feet, with common symptoms including leg pain and non-healing wounds) with a history of PVD angioplasty (a procedure to open the blocked or narrowed arteries in the legs). The 04/26/2025 comprehensive assessment showed Resident 41 had moderate cognitive impairment but was able to make their needs known. Review of the hospital physician's transfer orders dated 04/22/2025, showed Resident 41 right BKA was to have a dressing change every other day/as needed and to apply betadine (a solution that is used to disinfect skin and prevents further infections) over the incision site. The transfer orders stated the left fourth toe was necrotic (a term used to describe the death of living tissue due to a lack of blood supply) and .gauze to keep in between 4th/5th toe . Review of the admission assessment dated [DATE] at 11:36 AM, showed Staff P, RN/RCM, stated that Resident 41's fourth toe on their left foot was necrotic and was to be painted with betadine every other day. Review of Resident 41's provider orders dated 04/25/2025, showed that nursing staff input orders for necrotic 4th digit left toe: monitor daily. Notify MD (facility provider) of any change or if it falls off. every shift. No orders for a dressing change or gauze placement for the resident's necrotic toe were noted. During a concurrent observation and interview on 04/29/2025 at 11:36 AM, Resident 41 was noted lying in bed with their left foot open to the air. The resident's fourth toe on the left foot was necrotic and no dressing was in place. Resident 41 was unsure if a dressing was in place between their toes on their left foot, but did not have their pressure relieving boot in place under their left foot so they could let it air out. During a concurrent observation and interview on 05/01/2025 at 11:52 AM, Resident 41 was noted in their room with Staff Q, RN and Staff R, Medical Provider, performing a dressing change on the resident's right BKA. No dressing or gauze noted in between the resident's left [NAME] necrotic 4th toe. After the resident's right BKA dressing was completed Staff R inquired about the resident left fourth necrotic toe and Staff Q stated that they were not performing a dressing change for the residents necrotic fourth toe and were to be monitoring the toe daily. During an interview on 05/01/2025 at 12:38 PM, Staff Q stated that no dressing had been in place for Resident 41's left foot necrotic toe since the resident's readmission on 04/22/2025. Staff Q stated they looked at the orders in a resident chart and it was not their process to look at the wound care transfer orders from the hospital. During an interview on 05/01/2025 at 12:51 PM, after reviewing Resident 41's wound care transfer orders, Staff R stated that nursing staff should have been completing a dressing change for the resident's necrotic 4th toe. Staff R stated the necrotic toe's dead tissue should have been separated from the living tissue of the resident's other toes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/05/2025 at 3:30 PM, Staff P stated they completed the admission assessment for Resident 41. Staff P stated they had missed the orders to have the gauze in-between the resident necrotic fourth/fifth toe, and they did not read through the whole order. During an interview on 05/05/2025 at 4:34 PM, Staff C, Regional Clinical Director, stated that Resident 41's physician's orders transfer orders from the hospital were not processed or initiated correctly and nursing staff were not following the orders regarding the resident's wound care. Reference: WAC 388-97-1620(2)(b)(ii)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview, and record review, the facility failed to identify the risks and initiate interventions to prevent further accidents for 2 of 3 residents (Residents 35 and 11) reviewed for accidents. Resident 35 experienced harm when hot soup was served on the overbed table and when the resident went to pull the tray closer to them to be within reach, the soup spilt onto their lap causing a third-degree burn to the left thigh. In addition, the facility failed to provide consistent supervision, thoroughly investigate the cause of falls, and ensure interventions were put into place to prevent further falls for Resident 11. These failures placed the residents at risk for injury and/or medical complications and a decreased quality of life. Findings included . Review of an article written by the American Burn Association titled Scald Injury Prevention dated 04/25/2017, showed the time and temperatures it would take for a hot liquid to cause a third-degree burn as, 155 degrees Fahrenheit (F), one second, 148 degrees F, two seconds, 140 degrees F, five seconds, 133 degrees F, 15 seconds, 127 degrees F, one minute, 124 degrees F, three minutes, 120 degrees F, five minutes and 100 degrees F as a safe temperature. <Resident 35> Review of the medical record showed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including a fractured pelvis, heart disease, and chronic pain. Resident 35 ' s most recent comprehensive assessment dated [DATE] showed they were cognitively intact and required moderate to maximum assistance of one to two caregivers for activities of daily living (ADLs). During an interview on 04/29/2025 at 10:07 AM with Resident 35 ' s Representative, they stated the resident received a third-degree burn on the top of their left thigh on 03/27/2025 from hot soup spilling on their lap. The Representative stated they had concerns that the soup was so hot that it caused such a serious burn and that it was taking so long to heal. They stated they felt Resident 35 ' s health status had declined in both their ability to care for themselves and cognitively since they returned from the hospital on 03/22/2025 after falling and fracturing their pelvis and had shared this concern with the facility ' s administrative staff. During an interview on 04/30/2025 at 9:32 AM, Resident 35 stated they remembered well what had happened the day the soup spilled on their lap but could not recall the date. They stated they were eating in their room because the dining room was closed that day, and their dinner was brought to them and set on the overbed table. Resident 35 stated they went to pull the tray closer to them and the tray with the soup bowl fell off onto their lap and they felt it burn through their pants right away. Resident 35 stated they called for help and a nurse came in and helped them clean up and later told them the area was starting to blister and would call their physician. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During the same interview Resident 35 stated their physician examined the burn about a week ago (prior the interview) and said it was a stage three burn and looked infected, which caused them a lot of concern. They stated they had been taking antibiotics for the burn which was still painful and itched constantly. Review of a provider note dated 04/17/2025 stated, left thigh 2/3- (second to third) degree burn observed and noted green eschar (a thick, dry, crusty layer of dead tissue that forms on the surface of a wound or burn) in the center of the wound and would be starting the resident on antibiotics. Review of the facility ' s incident report regarding the burn dated 04/01/2025 showed the resident received a burn to the top of the left thigh on 03/27/2025 from hot soup spilling in their lap. The resident ' s skin was checked at the time and a light pink area measuring 8.0 centimeters (cm) (a unit of measure) in width by 4.0 cm in length was noted to the left medial (middle) thigh. The skin was checked later that evening and the skin on the thigh was loose and a blister had formed measuring 6.5 cm in width by 2.0 cm in length. The area was cleansed and covered with a dressing and the resident ' s physician was notified. The incident report further showed that the soup was being held at a temperature of 187 degrees Fahrenheit (F) on the tray line in the kitchen, an appropriate temperature to allow for cooling during service. Per the Registered Dietician statement, the soup likely would have cooled as much as 20 degrees F or more at the time of delivery to the resident. Review of Resident 35 ' s care plan last revised on 11/29/2024 showed they were independent with eating and set up. An updated intervention on the care plan dated 04/04/2025 showed when the resident ate in their room, staff would provide frequent checks to ensure the resident did not require any assistance during the meal and all items were within reach and easily accessible before leaving the room. Review of the facility ' s kitchen temperature logbook showed staff were to take the temperature of the food prior to the tray line service and again halfway through the tray line service. Review of the temperatures of the food for dinner on 03/27/2025 showed the holding temperature for soup was 187 degrees F both prior to serve out and mid serve out. Review of soup temperatures from 03/27/2025 through 04/17/2025 for dinner showed the lowest holding temperature as 175 degrees F and the highest holding temperature as 196 degrees F with varying degrees in between the high and low temperatures noted. During an interview with the Staff L, Dietician, on 04/30/2025 at 12:35 PM, they stated the facility kitchen staff followed the regulations that required certain foods to be cooked to a specific degree for food safety and all hot foods needed to be held at a temperature of 135 degrees F or higher to prevent food borne illness and then to a temperature that was palatable (pleasant to taste) for the residents. Staff L stated the facility did not hold food or drink to the degrees to prevent possible burns if spilled on a resident as different foods and drinks have different palatable tastes, but if there is a concern that a resident was not physically or cognitively able to safely handle hot liquids, then an individual assessment of the resident ' s competence to do so should be completed. (continued on next page)

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	505382	A. Building B. Wing	05/06/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Staff M, Dietary Manager (DM) on 05/01/2025 at 12:44 PM, they stated they kept soup in the holding cabinet warmer in soup bowls prior to serve out or the kitchen staff microwaved the soup and sent it out if the soup was cold. Staff M stated when residents asked for soup and had not preordered it for the meal, the staff would microwave the soup for them. The DM stated they did not take the temperature of the soup after it came out of the microwave and had no process or direction in place on how long to microwave the soup or any food, but usually did it for two or three minutes, or until it seemed hot. In addition, Staff M did not know how long it took for staff to deliver the food to the residents after it was microwaved or if Resident 35 ' s soup was kept in the holding cabinet or microwaved prior to serving them on 03/27/2025. Observation of the wound on 05/02/2025 at 9:47AM, while being toileted by a nursing assistant, showed a 4. 0 cm width by 2.0 cm length wound to the left medial thigh with black eschar in the center of the wound with surrounding redness. The resident stated the wound hurt all the time but hurt the worst when the dressings were changed on it. During an interview with Staff A, Administrator, on 05/01/2025 at 4:17 PM, they stated the facility did not do any follow up assessments on Resident 35 to see if they were capable of handling hot liquids at a high temperature after they obtained the burn on 03/27/2025 to possibly prevent burns in the future. During an interview with Staff B, Director of Nursing and Staff C, Regional Clinical Director on 05/06/2025 at 12:25 PM, they stated no further follow up was completed for Resident 35 after the burn happened to see if they could competently handle hot liquids while eating or drinking to mitigate the risk for repeated burns from occurring. <Resident 11> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including dementia and degenerative joint disease (a type of arthritis characterized by the breakdown of [NAME] in the joints causing pain, stiffness and decreased movement) in both knees. Resident 11's most recent comprehensive assessment dated [DATE] showed they had moderately impaired cognition and required minimum to moderate assistance of one to two caregivers for activities of daily living (ADL's) and could not ambulate. During an observation and interview with Resident 11 on 05/02/2025 at 11:13 AM, showed them sitting in their wheelchair in their room looking out the window. Resident 11 stated they had never had a fall in their room or bathroom and could walk independently without any assistance. Review of the facility reporting logbook showed Resident 11 had nine falls in the facility within the past five months. November 2024 through March 2025. Review of the facility incident reports for Resident 11 showed they had two observed falls on 11/14/2024 and 12/23/2024 and seven unobserved falls on 11/04/2024, 12/26/2024, 01/13/2025, 02/19/2025, 03/01/2025, 03/13/2025 and 03/31/2025. None of the unobserved falls had witness statements attached showing a thorough investigation was completed into the possible causes of the falls or that abuse, and neglect had thoroughly been ruled out as a cause of the falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 11's care plan initiated on 03/03/2021 and last revised on 04/07/2025, showed the resident was at risk for falls r/t pain, weakness, deconditioning, degenerative joint disease in both knees, vertigo (dizziness), history of falls, cognitive impairment, profound hearing loss, epilepsy (a seizure disorder), impulsiveness, impaired vision, poor decision making, and overestimating abilities. Further review of the care plan showed the problem of being at a high risk for falls and goals to be free of falls were updated on 01/13/2025, 03/18/2025 and 04/07/2025, additional interventions to decrease the risk for falls were only initiated for the two of the nine falls dated 01/13/2025 and 02/19/2025. During an interview with Staff B, DON and Staff C, RCD on 05/07/2025 at 12:48 PM, they both acknowledged that thorough investigations into the causes of the falls and to ensure abuse or neglect was not the cause of the falls was not completed. In addition, they both acknowledged that limited interventions were put into place after the falls to prevent future falls and keep Resident 11 as safe as possible. Reference: WAC 388-97-1060(3)(g)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45117 Based on observation, interview, and record review, the facility failed to follow the Centers for Disease Control [(CDC) a public agency that protects the public's health and well-being] guidance for temperature monitoring of vaccines in 1 of 1 medication storage refrigerators (Refrigerator 1) reviewed for medication storage. This failure placed the residents at risk of receiving compromised or ineffective vaccines and negative outcomes. Findings included . Review of the CDC guidance titled, Vaccine Storage and Handling, dated 04/03/2024, showed to ensure safety of vaccines, the refrigerator must have a reliable temperature monitoring device with the recommended use of a recording device called a digital date logger (DDL-a device that records temperatures at least every 30 minutes). The guidance further showed when a DDL was not used, the facility should monitor and record the vaccine refrigerator temperature at a minimum of twice daily. Review of a policy titled Storage and Expiration Dating of Medications and Biologicals, revised 08/01/2024, showed the facility would ensure medication and biologicals were stored at their appropriate temperatures according to the guidelines for temperature ranges and manufacturer guidance. Facility staff should monitor cold storage containing vaccines two times daily per CDC guidelines. An observation on 05/06/2025 at 8:39 AM, accompanied by Staff C, Regional Clinical Director, showed a temperature log posted to the front of Refrigerator 1. The temperature log showed once a day temperature monitoring for the months of March 2025, April 2025, and May 2025. Refrigerator 1 contained influenza (a contagious respiratory virus caused by the influenza virus) and pneumococcal (an invasive bacterial infection) vaccines. During an interview on 05/06/2025 at 9:34 AM, Staff C stated the vaccines stored in Refrigerator 1 required twice daily monitoring. Staff C stated the facility had posted the wrong temperature log for staff to complete. Reference: WAC 388-97-1300(2)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 45117 Based on interview and record review, the facility failed to identify a designated interdisciplinary [(IDT) a group of healthcare professionals from different disciplines to help people receive the care they need] team member, appointed as the responsible party for coordinating care and communication with hospice, and implement the written agreement that ensured effective communication, collaboration, and coordination of care between the facility and the hospice (a specialized type of care focused on providing comfort and support to individuals nearing the end of life) provider for 2 of 2 residents (Resident 39 and 45) reviewed for hospice services. This failure placed the residents at risk of not receiving necessary care and services at end-of-life. Findings included . Review of a policy titled, Palliative/End of Life Care, revised 11/2015, showed the facility and hospice would identify specific services that would be provided by each entity, and that information would be communicated in the care plan. Record review of a document titled, Hospice Services Agreement, dated 09/10/2020, showed the facility would coordinate with hospice in developing a plan of care for the resident. The facility would designate a member of the IDT that was responsible for working with hospice representatives to coordinate care of the resident. The facility was responsible for obtaining the hospice care plan, medications, orders, hospice election form, and physician certification of illness from hospice. <Resident 39> Review of the medical record showed Resident 39 was admitted to the facility with diagnoses including Alzheimer ' s disease (a progressive disease that destroys memory and other important mental functions), severe malnutrition (significantly low body weight for height), and weakness. The 04/25/2025 comprehensive assessment showed Resident 39 required substantial/maximum assistance of one staff member for activities of daily living (ADLs) and had a severely impaired cognition. The assessment also showed Resident 39 was receiving hospice services. Record review of Resident 39's medical record showed there was no documentation of a designated facility employee responsible for coordinating the resident ' s care. There was no hospice election form (a document that a patient or their authorized representative signs to formally choose to receive hospice care under Medicare), physician certification of Resident 39's terminal illness, or their most recent hospice care plan/coordinated care plan. Record review of Resident 39's facility care plan dated 04/24/2025 showed interventions related to palliative as hospice to provide the following services with no documentation of what those services were and refer to hospice care plan for coordination of services with no documentation of a hospice care plan. <Resident 45> (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 45 was admitted to the facility with diagnoses including palliative care (specialized medical care for individuals with serious illnesses that focuses on relieving symptoms, managing stress, and improving the resident's quality of life), cancer of the digestive system, and severe malnutrition. The 04/11/2025 comprehensive assessment showed Resident 45 was independent/required set-up assistance with ADLs. The assessment also showed Resident 45 was cognitively intact and was receiving hospice services. Record review of Resident 45's medical record showed no documentation of a designated facility employee responsible for coordinating the resident's care, no hospice election form, or physician certification of Resident 45's terminal illness. During an interview on 05/02/2025 at 9:37 AM, Staff D, Resident Care Manager, stated the process for enrolling a resident into hospice services included receiving the hospice care plan and coordinating it with the resident's current facility care plan. There should be a terminal illness (a medical prognosis that includes life expectancy of six months or less if the illness ran its normal course). that would come from the hospice physician. Staff D, Resident Care Manager (RCM), stated they were not aware of a hospice care plan for Resident 39. They stated they did not receive a physician order for a terminal illness, a hospice care plan, or daily communication. Staff D stated the hospice process was a broken system. During an interview on 05/02/2025 at 11:24 AM, Collateral Contact 1 (CC1), hospice Registered Nurse, stated the process for admitting a resident to hospice services included the resident's primary care provider putting in an order for hospice services. Hospice would complete an on-site evaluation of the resident and create an individualized care plan. That care plan was sent to the facility for collaboration of care. Hospice communication occurred through both verbal and written communication that was sent to the facility by fax after each visit. The CC1 stated they updated the resident's care plan as needed in the hospice charting system but was unsure if the facility received any copies of that updated care plan. During an interview on 05/05/2025 at 2:35 PM, Staff C, Regional Clinical Director, stated the facility did not follow the process for new admissions. They stated the facility did not have a designated member of the IDT to coordinate the hospice program that would have ensured the process was followed. During an interview on 05/06/2025 at 11:24 AM, Staff A, Administrator, stated the facility did not have a designated employee appointed for coordinating and collaborating care with hospice services. They stated the RCMs were primarily the contact and that was split over three hallways, so it could be anyone. Staff A stated they were not aware of the regulatory requirement of designating (in writing) an appointed staff member for the coordination of services. Staff A stated they expected staff to follow the facility's policy for hospice care and services. Reference: WAC 388-97-0020

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure residents were offered the pneumococcal immunizations (a vaccine that protects against pneumococcal infections that can lead to serious lung infections) nor documentation of the resident refusal or acceptance of the vaccine along with education on the risk/benefits of the vaccine for 1 of 5 residents (Resident 29) residents reviewed for pneumococcal immunizations. This failure placed the resident at an increased risk for a contagious disease without the opportunity to make an informed decision in the refusal or acceptance of the pneumococcal vaccine. Findings included . Review of the facility policy titled, Resident Immunizations, revised 2022, showed the facility would offer the pneumococcal vaccine to residents with the facility, and have a consent completed, education and the pneumococcal vaccine administered unless medically contraindicated (something that is not advised as the course of treatment). Additionally, the policy showed that PneumoRecs VaxAdvisor (a tool used to help determine which pneumococcal vaccine a resident might need), would be used to easily determine which pneumococcal vaccine was required. <Resident 29> Review of the resident's medical record showed they were admitted to the facility on [DATE], with diagnosis including heart failure, bladder infection and pneumonia (an infection in the lungs, that can cause a build-up of fluid, making it difficult to breathe). Review of the 03/03/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Review of Resident 29's immunization records showed the facility completed an assessment on 03/11/2025 and is up to date on all pneumococcal vaccines, was not offered a pneumococcal vaccine and no consent was obtained. Additionally, the records showed the resident had a history of receiving one of the pneumococcal vaccines on 05/03/2023. Review of Resident 29's PneumoRecs VaxAdvisor showed that for the resident to be up-to-date regarding the pneumococcal vaccine they would require another pneumococcal vaccine one year after their last dose in 05/03/2023 (so the resident was not up-to-date and needed to be offered a pneumococcal vaccine). During an interview on 05/02/2025 at 10:52 AM, Resident 29 stated they had not been offered or educated on the pneumococcal vaccine and was not aware of the risk/versus benefits. During an interview on 05/02/2025 at 11:04 AM, Staff B, Director of Nursing Services, stated that Resident 29 had not been offered the pneumococcal vaccine. After reviewing Resident 29's immunization records, Staff B stated the resident needed an additional dose of the pneumococcal vaccine and the correct process was not followed for offering the pneumococcal vaccine to the resident. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/05/2025 at 4:47 PM, Staff C, Regional Clinical Director, stated the correct process was not followed for offering or educating Resident 29 on the risk/benefits of the pneumococcal vaccine. Reference: WAC 388-97-1340(2)