STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505383	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Park Care Center	14820 East Fourth Spokane, WA 99216

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure appropriate consents were obtained prior to the administration of psychoactive (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior and are typically used to treat mental health conditions) medications for 3 of 5 sampled residents (Residents 91, 102 and 411) reviewed for unnecessary medications. This failure precluded the residents or their representatives to participate in decisions regarding their care and treatment. Findings included . <Resident 411> A 10/2022 facility policy titled Psychoactive Medications showed, the staff obtained informed consent from the resident or their representative prior to the administration of any psychoactive medication. Informed consent included a review of the risks and benefits of the psychoactive medication. Review of a 02/21/2025 Social History Assessment showed Resident 411 admitted to the facility on [DATE] and the staff assessed the resident was, alert and oriented to time/date, able to make needs known. The assessment showed the resident was on several psychoactive medications, to include buspirone for anxiety, doxepin and duloxetine for depression, and aripiprazole for borderline personality disorder. Review of the February 2025 Medication Administration Record (MAR) on 02/27/2025, showed the staff administered the psychoactive medications since 02/20/2025. Review of the medical record showed no documentation the facility reviewed with Resident 411 the use the psychoactive agents, to include the risks and benefits. The above information was shared with Staff G, Resident Care Manager, on 03/04/2025 at 11:01 AM. Staff G stated that when a resident wass prescribed a psychoactive drug, the staff completed a consent evaluation before the first dose was given. Staff G acknowledged the medical record showed no consent evaluations and stated, I'm not seeing them in there. That should have been done on admission. 46033 <Resident 102> (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 01/20/2025 five-day assessment documented Resident 102 had diagnoses that included delusional disorders (beliefs in things that could not possibly be true) and major depression. The resident was cognitively intact and took antipsychotic and antidepressant medications (collectively referred to psychotropic medications, used to treat delusions, hallucinations and depression) daily. On 01/14/2025, consents were obtained for Resident 102 to take citalopram daily for their depression, and risperidone twice daily for psychosis with behavioral disturbances, both ordered as part of the resident's transfer orders from the local hospital. The 02/23/2025 behavioral health provider progress note documented Resident 102 was seen for their initial evaluation. The resident appeared anxious and depressed and reported people in the facility were trying to poison them and had become increasingly depressed and suicidal related to their current situation. The provider recommended increasing the dose of the risperidone and stopping the citalopram. They also recommended starting escitalopram and increasing the dose after two days. The recommended changes were ordered on 02/25/2025. Further review of Resident 102's medical record failed to identify that consents had been obtained for the changes in the resident's psychotropic medications as required. During an interview with Staff F, Resident Care Manager (RCM) and Staff G, RCM on 03/05/2025 at 10:41 AM, Staff F stated the admission nurse was to obtain consents for antipsychotic medications on admission, and if medications changed, another consent was needed. Staff G stated new orders were discussed in the morning huddle and Resident 102 should have been discussed in their morning meetings but they could not remember doing so. Staff F and Staff G both stated when the escitalopram was ordered a new consent should have been obtained. 50027 <Resident 91> Per the 02/27/2025 comprehensive quarterly assessment, Resident 91 had diagnoses which included stroke, aphasia and dementia. The resident was severely cognitively impaired and unable to make decisions regarding their care. In addition, the assessment documented the resident had received psychotropic medications. Review of the Order Summary Report from September 2024 through February 2025 documented the resident was prescribed had been prescribed the following medications to treat their psychosis and insomnia: Trazodone on 09/25/2024, Seroquel on 9/20/2024 and Zyprexa on 11/25/2024 Review of Resident 91's record found an informed consent that explained the risks and benefits of taking psychotropic medications to treat psychosis and insomnia signed on 09/25/2024. However, this form was signed by Resident 91, whom had severe cognitive impairment. In an interview on 03/05/2025 at 3:30 PM, Staff B, Director of Nursing, acknowledged that the acknowledged the resident should not have signed the form. Reference WAC 388-97--0300(3)(a), -0260, -1020(4)(a-b).

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 42802 Based on observation, interview and record review the facility failed to ensure a resident was evaluated to self-administer their medications for 1 of 5 sampled residents (Resident 20), observed during medication administration. This failure placed residents at risk for missed medication doses or unintended health consequences. According to a 01/10/2025 comprehensive assessment, Resident 20 had diagnoses that included diabetes, heart failure and aphasia (a partial or total loss of the ability to articulate or comprehend language). Per the assessment, they could usually understand and made their needs known. Their Brief Interview for Mental Status (BIMS, a cognitive test) score was 00 (out of a maximum of 15), and all responses were either: no answer, missed, incorrect or could not recall. A review of Resident 20's care plan, initiated on 01/06/2022 and revised on 01/13/2025, showed a focus that the resident had episodes of refusing cares, and the goal was the resident would accept cares and have fewer episodes of refusals. An Interdisciplinary Team Conference Note, dated 01/10/2025, under Medication/Treatment compliance No was checked, and that the risk of refusal of medication/treatments/plan of care was explained to the resident and/or responsible party. No provider order or evaluation of the resident's ability to self-administer their medication was found in their medical record. On 02/25/2025 at 8:15 AM, Staff M, Registered Nurse, prepared medications for Resident 20, and placed them in a med cup. These included diabetic, blood pressure, heart failure, and blood thinner medications. Resident 20 was seated in a wheelchair in their room. Staff M told Resident 20 they had brought their morning medications and left the medication cup of pills on the table in front of the resident. Staff M had not asked the resident to take the pills at the time and left the room and passed medications to the next resident. On 02/25/2025 at 8:58 AM, observed that Resident 20's pills were no longer on their bedside table. The resident stated they had taken the medications. During an interview on 02/25/2025 at 1:13 PM, Staff M stated that Resident 20 was alert and took their medications without problems. They further stated that some residents were not responsible and nurses needed to make sure they took their pills. When asked if it was written anywhere if a resident could take their medication without supervision, Staff M looked in Resident 20's medical record and acknowledged they should have watched the resident take the pills, as there was nothing in their record that indicated the resident could take them independently. During an interview on 02/26/2025 at 1:55 PM, Staff B, Director of Nursing, stated that the expectation was for nurses to observe the residents take their medication, unless there was an evaluation/authorization that the medication could be left at the bedside. Staff B acknowleged that Resident 20 did not have the specific documentation that documented they could take their medication independently and should have been observed taking their pills. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-0440

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47328 Based on observation, interview, and record review the facility failed to make reasonable efforts to accommodate a resident's visual impairment needs for 1 of 4 sampled resident (Resident 46), reviewed for personal property. This failure placed residents at risk of eye strain, potentially avoidable accidents, and diminished quality of life. Findings included . According to the 02/17/2025 quarterly assessment, Resident 46 had diagnoses including cataracts (the natural clear eye lens becomes cloudy making it difficult to see). The assessment further showed Resident 46 had impaired vision and had no corrective lenses. Resident 46 was cognitively intact and able to clearly verbalize their needs. Review of the 10/19/2021 vision care plan showed Resident 46's vision was within normal limits with use of their glasses and instructed staff to arrange eye appointments as needed, monitor for signs and/or symptoms of eye problems and to ensure Resident 46's glasses were clean, in good repair, and easily available for use. Review of a 01/22/2025 vison exam progress notes showed Resident 46 was seen related to complaints of blurred vision and difficulty with their near vision. The note further showed Resident 46 was happy with the cataract surgery they had last summer but did not get new glasses at that time related to not liking any of the frames the eye clinic offered. Resident 46's vision was within normal limits with use of glasses, a new glasses prescription was written at that time but again did not like any of the frames offered. Review of the January 2024 through March 2024 nursing progress notes showed no documentation Resident 46 had blurred vision, wore glasses, or what follow-up was done related to their new 01/22/2025 prescription for glasses. In an interview on 02/24/2025 at 2:19 PM, Resident 46 stated their glasses went missing and they were given a replacement pair that did not fit them. In observation and follow-up interview on 02/25/2025 at 9:21 AM, Resident 46 showed their glasses and stated they could not see out of them. In an interview on 03/04/2025 at 7:53 AM, Staff JJ, Nursing Assistant, stated a resident's care plan would indicate if they wore glasses or not. Staff JJ further stated they had not seen Resident 46 wear glasses and was unsure if they had difficulty seeing. In an interview on 03/04/2025 at 9:06 AM, Staff M, Registered Nurse, stated Resident 46 sometimes wore glasses but did not most of the time. Staff M was unsure if Resident 46 had vision issues. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/2025 at 9:19 AM, Staff E, Resident Care Manager (RCM), stated the facility did not typically label or have a process to track glasses. Staff E stated a resident's care plan should indicate if they wore glasses or not. Staff E further stated they typically did not see Resident 46 wearing glasses. Staff E reviewed Resident 46's medical record. Staff E acknowledged Resident 46 was care planned to wear glasses, they were seen by the eye doctor on 01/22/2025, had normal vision with glasses, and received a new prescription for glasses at that time. Staff E was unsure of the progress made for obtaining new glasses for Resident 46. In an interview on 03/06/2025 at 12:44 PM, Staff B, Director of Nursing, stated nurses and/or the RCM should review progress notes from appointments and/or specialist, implementing orders and following up as needed. Staff B acknowledged it was important for Resident 46 to have glasses that worked for them. In an interview on 03/06/2025 at 12:56 PM, Staff A, Administrator, stated they were unsure of the facility process when a new prescription for glasses was received. Staff A stated they expected staff to follow-up as needed when residents were seen by providers. Reference WAC 388-97-0860 (2)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46033 Based on interview and record review the facility failed to ensure advanced directive documents were completed accurately and the correct information was entered into the medical record for 3 of 3 sampled residents (Residents 102, 91 and 63), reviewed for advanced directives. Specifically, Resident 102 had conflicting information regarding what interventions staff were to take during a code situation (an emergency where one would die if cardio-pulmonary rescusitation, CPR, was not started) and Resident 91 had severe cognitive impairement and signed their own advanced directive documents. These failures created potential for confusion during medical emergencies and for resident decision makers to be uninformed of a resident's care. Findings included Review of the facility policy titled, Advanced Directives reviewed [DATE], defined advanced directives as written instruction, such as a living will or durable power of attorney (POA) for healthcare, recognized under law, related to the provision of healthcare when the individual was incapacitated. An advanced directive was not a medical order for care but should be taken into account when orders for care were given. The policy further showed during the admission process, staff was to identify if a resident had an advanced directive or physican orders related to life sustaining treatment (POLST, form documented if a resident desired life-saving measures in a code situation, of if a resident preferred to be allowed to die of natural causes if their heart or breathing stopped. This decision was usually determined much in advance of a resident's decline) and request a copy to be kept in a resident's medical record. The policy instructed staff to provide assistance in filling out a POLST if a resident desired to have one. If a resident was incapacitated, advanced directive information would be given to the representative. A person must be capable of understanding and signing an advanced directive for it to be effective. Staff were to identify a resident's primary decision maker or appropriate legal representative and invoke this person at any time the resident was assessed as unable to make relevant health care decisions. <Resident 102> A review of the [DATE] five-day assessment documented Resident 102 had diagnoses that included stroke with paralysis on one side of their body and malnutrition. Resident 102 was able to make decisions regarding their care and required staff assistance for activities of daily living. The [DATE] hospital discharge summary documented Resident 102 had been found on the ground at their home and had been down for an unknown length of time. Resident 102 had suffered a stroke and had a rapid irregular heartbeat. While at the hospital, the palliative (care that focused on quality of care) care provider was consulted to help with treatment decision making. Resident 102 determined they did not want to be intubated (a tube inserted in the airway to assist breathing when one was unable to breathe effectively), have chest compressions (pushing on the chest to create a heartbeat and keep blood flowing to vital organs), and if they further declined the resident wished for comfort measures. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] care plan documented Resident 102 had an advanced directive for full code status (to administer life saving CPR if breathing or the heart stopped). Interventions included that the advanced directives and medical orders for treatment would be in the medical record at all times, code status was to be reviewed with the resident and the provider notified of desire for changes to the advanced directives as indicated, and staff were to notify ambulance/hospital providers of the resident's code status. A review of Resident 102's electronic medical record (EMR) dashboard section, a section that had quick access to resident specific information such as their most recent weight, vital signs, and allergies, for example, documented Resident 102's code status was CPR, full treatment. A [DATE] POLST form scanned into the EMR documented Resident 102 desired full CPR to be performed in a code situation. A [DATE] POLST scanned into the EMR documented Resident 102 preferred Do Not Resuscitate (DNR) status, to allow natural death if their heart or breathing stopped. A provider order dated [DATE] documented Resident 102 was to receive CPR, full treatment, in the event their heart or breathing stopped. During an interview on [DATE] at 11:57 AM, Staff O, Licensed Practical Nurse (LPN), stated if a resident was not well, they were able to quickly locate the resident's code status on the dashboard screen in the EMR. Staff O stated the original POLST forms were kept in a binder at the nurse's station. When observed, the POLST in the binder was dated [DATE], and documented Resident 102 requested DNR status. Staff O stated they were unaware the resident's EMR dashboard information did not match the original POLST paper document. During an interview on [DATE] at 2:21 PM, Staff P, LPN, stated if staff needed to know a resident's code status, the POLST documents were in the binder at the nurse's station. Staff P stated the information was also in the EMR, but Staff P stated they looked in both places because the information did not always match. During an interview with Staff F, Resident Care Manager (RCM), and Staff G, RCM, on [DATE] at 10:41 AM, Staff F stated many residents came to the facility with advanced directive documents already in place. If not, the admission nurse went over the POLST form with the resident or had the resident's decision maker sign the document. The form was then placed in the binder for the provider to sign. After reviewing Resident 102's POLST documents and their dashboard, Staff F stated staff were instructed to go to the binder when they needed to know a resident's code status. Staff F stated it was important that all areas of the resident's medical record matched and contained the correct code status information so staff could provide the correct care for the resident. <Resident 63> According to the [DATE] quarterly assessment, Resident 63 admitted to the facility on [DATE] with diagnoses including progressive neurological conditions (disease that caused gradual decline in brain function, spinal cord, or nerves), severe dementia with behavioral disturbances, and delirium (sudden change in mental state that caused confusion and disorientation). The assessment further showed Resident 63 had severe cognitive impairment with inattention and disorganized thinking. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medical record face sheet (like an identification card containing key information at a glance including contact details) showed a Resident 63 had a POA. Review of the [DATE] advanced directive care plan showed Resident 63 had advanced directives and instructed staff review advanced directives with the resident and/or their responsible party, and honor Resident 63's wishes. Further review of Resident 63's medical record showed no documentation of POA paperwork found on file. In an interview on [DATE] at 11:06 AM, Resident 63's identified POA stated they were not involved in Resident 63's care and referred the surveyor to Resident 63's child. In an interview on [DATE] at 1:27 PM, Staff Q, Social Service Director, explained they reviewed a resident's POLST and/or discussed formulating advanced directives quarterly during care conferences. Staff Q reviewed Resident 63's medical record. Staff Q acknowledged Resident 63's face sheet identified a POA, but they were unable to locate POA paperwork. Staff Q further stated social services should reach out to an identified POA for appropriate paperwork because it was important for the facility to have the correct resident representative information in the medical record. In a follow-up interview on [DATE] at 12:01 PM, Resident 63's identified POA stated they did not have any official POA paperwork for Resident 63. In an interview on [DATE] at 12:30 PM, Resident 63's child stated there was no official POA paperwork for their parent. In an interview on [DATE] at 12:49 PM, Staff B, Director of Nursing, explained a resident's face sheet was developed based on information found in a referral packet prior to admission, and social services was to review the correct contact information was on file when they held the first care conference 72 hours after an admission. Staff B stated they expected a resident's emergency contact information to be accurate. In an interview on [DATE] at 12:59 PM, Staff A, Administrator, stated it was important to have the correct resident representative listed in a resident's medical record and expected staff to ensure the information was accurate. 50027 <Resident 91> Per the [DATE] comprehensive quarterly assessment, Resident 91 had diagnoses which included stroke, aphasia and dementia. The resident was severely cognitively impaired and unable to make decisions regarding their care. Review of Resident 91's record found an Admission Agreement, which included the right to formulate the advanced directives, was esigned by the severely cognitively impaired resident on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition, record review showed the POLST was also signed by the severely impaired cognitive resident on [DATE]. In an interview on [DATE] at 3:30 PM, Staff B, Director of Nursing, acknowledged that the acknowledged the resident should not have signed the form. Reference (WAC): [DATE] (3)(c)(i-ii), 0300 (1)(b)(3)(a-c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview, and record review the facility failed to maintain a clean, comfortable, safe and homelike environment for 1 of 2 sampled residents (Resident 20), reviewed for environment. Specifically, Resident 20's walls in their room were in disrepair and chemicals were not properly secured in a storage room. These failures placed all residents at risk for potentially avoidable injuries and a diminished quality of life. Findings included . During an observation and interview on 02/24/2025 at 10:31 AM, Resident 20 was sitting in their wheelchair in their room. Resident 20's room had multiple patches of drywall on the wall next to their bed and the wall at the foot of their bed. The wall to the right as you entered the room had black scrapes and gauges out of the wall. The wall to the left as you entered the room had a hole near the floor. The bathroom was painted a tan color, a paper towel dispenser in the room had been raised and the area was blue from the previous paint job. The resident stated they did not feel like it was a homelike environment. Subsequent observations of the walls in disrepair were made on 02/27/2025 at 08:40 AM and 12:47 PM, 02/28/2025 at 08:19 AM and 03/03/2025 at 8:42 AM. In an interview on 02/28/2025 at 10:13 AM, Staff L, Maintenance Director, stated the staff notified them when repairs were needed. Staff L stated they tried to repair as much as they could with the time they had. When Staff L was asked if the above was homelike, they stated no, and it was important for the resident to have a homelike environment because they wanted them to feel like this was their home. During an interview on 02/28/2025 at 10:19 AM, Staff A, Administrator, stated they would get to the resident's room as soon as possible and it was not an ideal homelike environment. 47328 <Soiled Utility room [ROOM NUMBER] Hall> During observation on 02/24/2025 at 9:42 AM, the soiled utility room on 600 hall ajar, off set, not lached closed, and a large cleansing spray bottle was inside. No residents were observed wandering near the area. Similar observations were made at 10:48 AM and 11:36 AM. During observation and interview on 11:38 AM, Staff WW, Maintenance, the 600-hall soiled utility room was ajar and not latched with a large cleansing spray bottle inside. Staff WW stated the fire door had been ajar for at least a month, but the fire door repair company had been called. At 11:39 AM, Staff K, Nursing Assistant, approached the soiled utility room. Staff K stated the spray bottle contained floor cleansing chemicals that needed to be secured, and the soiled utility room door needed to be kept closed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/24/2025 at 11:40, an unidentified staff placed soiled bagged items in the soiled utility room but did not ensure the door shut or latched closed. There was no signage posted near or on the door to notify staff the door needed to be pulled shut in order to latch closed. During observation and interview on 02/24/2025 at 11:42 AM, Staff L, Maintenance Director, the 600-hall soiled utility room door was observed. Staff L acknowledged the door had been ajar for some time and was working with two different fire door companies to repair the door. Staff L was asked how they ensured resident safety on a unit with confused wandering residents and unsecured chemicals. Staff L nodded their head and stated, I see what you are saying. Staff L was asked how staff were notified the door needed to be pulled to shut and latch completely if there was no signage posted near the area. Staff L did not provide an answer. Staff L was asked if they attempted to store the chemicals in an alternate secured location until the door could be fixed. Staff L stated they were unsure what chemicals were stored inside the soiled utility room. Documentation on the progress of fire door repair was requested at that time. During a follow up interview and record review on 02/24/2025 at 12:15 PM, Staff L, stated they typed up a word document with the timeline of events for fixing the identified door. Review of paperwork provided included a 12/17/2024 e-mail correspondence with a quote from one company to make needed repairs to the identified door. Review of the word document showed a second fire door repair company assessed the fire door for needed repairs on 01/14/2025 (28 days after the first company's repair quote) and requested the facility call them with the total number of fire door that needed servicing. The second fire door company was not called back until 02/11/2025, 28 days after their request for additional information and 56 days after the first fire door company's quote. In an interview on 03/03/2025 at 10:08 AM, Staff J, Nursing Assistant, stated the 600-hall soiled utility room door had been broken for a year. In an interview on 03/03/2025 at 10:53 AM, Staff A, Administrator, stated the fire door companies were not in a hurry to get the doors fixed. Staff A further stated they expected staff to secure chemicals to prevent unintended access. Reference WAC 388-97-0880

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Sullivan Park Care Center	14820 East Fourth Spokane, WA 99216

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview, and record review the facility failed to consistently supervise and/or monitor cognitively impaired residents' behaviors to prevent verbal and/or physical resident-to-resident altercations to the extent possible for 2 of 10 sampled residents (Resident 89 and 63), reviewed for abuse. This failure placed residents at risk of potential abuse, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021, documented the facility would develop and implement policies to prevent and identify abuse or mistreatment of residents; neglect of residents; and/or theft, exploitation or misappropriation of resident property. Staff would be provided orientation and training on abuse prevention, incident identification and reporting. The policy further showed all potential allegations of abuse, neglect, mistreatment, or misappropriation of resident property would be identified, reported within the required timeframes, investigated, and residents protected from potential harm during the investigation process. <Resident 89> The 01/30/2025 significant change assessment documented Resident 89 had moderate cognitive impairment with verbal behaviors that had worsened. Resident 89's behaviors significantly interfered with the resident's participation in activities or social interactions and disrupted care and the living environment. Wandering was not checked on the assessment. Review of 11/18/2024 elopement assessment documented Resident 89 was cognitively impaired, ambulated independently, expressed the desire to leave, looked for their spouse, and wandered in the past month. The summary stated Resident 89 wandered frequently, had exit seeking behaviors, experienced delusions and hallucinations. Review of the 10/22/2024 behavioral care plan documented Resident 89 experienced hallucinations, delusions and was verbally aggressive toward others. The care plan instructed staff to monitor the resident and document changes to behaviors, approach in a calm and non-threatening manner, remove the resident for safety of the resident and others, and notify the provider. The care plan instructed nursing to remain calm and offer a diversional activity, food/drink or conversation when the resident had hallucinations and delusions and if the resident experienced aggression, they needed to leave and notify nursing. The 08/29/2024 elopement risk care plan documented Resident 89 wandered related to altered cognition, exit seeking behaviors, history of elopement or attempts and wandered aimlessly. The care plan instructed staff to monitor the resident's whereabouts frequently, provide redirection as needed, check placement and function of the wandering bracelet/alarm system, if wandering or elopement was attempted follow the facility protocol, and to keep an updated photograph in the risk for elopement binder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the progress notes from September 2024 through February 2024 documented Resident 89 wandered into other resident rooms, was argumentative, yelled, hovered over and had aggression toward other residents. A 02/10/2025 nursing progress note stated they were taking resident off alert because they wandered into Resident 408's room on 02/05/2025. Staff were aware to keep them separated and the resident needed redirection when they wandered toward other resident's rooms. Resident forgetful with cognitive impairment related to dementia and did not recall that they wandered into room [ROOM NUMBER]. There was no progress note made on 02/05/2025 regarding the incident. Review of the August 2024 through February 2025 incident log documented no resident-to-resident altercations, although an altercation occurred on 02/05/2025. In an interview on 02/24/2025 at 10:46 AM, Resident 20 stated there was a resident on the same hall that entered their room and yelled at them. Resident 20 stated three staff members removed the resident from their room. Resident 20 stated the resident wandered into their room often. The incident for 02/05/2025 was written on a piece of paper that stated Staff A, Administrator, spoke to Resident 20 regarding their interaction with Resident 89 on 02/05/2025 at 5:00 PM. Resident 20 stated Resident 89 was trying to enter their room, and they blocked them from coming in with their wheelchair. Resident 20 stated Resident 89 placed their hand on their left arm to support themselves when they turned around. Staff A stated they had asked Resident 20 if Resident 89 had squeezed their arm, and they said no. Resident 20 stated they told Resident 89 to leave their room, and staff came and redirected the resident. Staff A stated Resident 20 reassured them several times that nothing happened, nor did Resident 89 hit them, and they were not afraid of them. In an interview on 02/28/2025 at 8:19 AM, Resident 20 stated Resident 89 had wheeled themselves into my room, they were angry and held my arm. Resident 20 stated they yelled at me, and this was the worst experience I had with them. Resident 20 stated you never knew how the resident was going to act. A statement obtained from Staff OO, Registered Nurse, stated Resident 89 was in Resident 20's room and they tried to remove them. Staff OO stated Resident 89 was yelling, cursing and swinging at them and refused to leave. Staff OO stated they pulled Resident 89 out of the room. Resident 20 reported they felt something on their right arm but could not feel much pain on that side related to a stroke. The residents were separated for safety and regular checks were made on Resident 89 for disruptive behaviors. During an interview on 02/26/2025 at 8:27 AM, Resident 18 stated Resident 89 wandered into their room. In an interview on 02/26/2025 at 9:12 AM, Staff S, Nursing Assistant, stated Resident 89 wandered on the hall. During an interview on 02/26/2025 at 9:40 AM, Staff M, Registered Nurse, stated Resident 89 wandered. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/2025 at 4:19 AM, Staff KK, Nursing Assistant, stated they had lots of wanderers at night with behaviors that tried to elope. During an interview on 03/04/2025 at 4:25 AM, Staff LL, Registered Nurse, stated they had a lot of residents with behaviors who wandered. In an observation on 03/04/2025 at 4:39 AM, Resident 89 was observed sitting in a chair near the nurse's station without a shirt. A nursing assistant was able to put a shirt on them and gave them a blanket. In an interview on 03/06/2025 at 11:18 AM, Staff B, Director of Nursing, stated Resident 89 had hallucinations, agitation and behaviors. Staff B stated Resident 89 wandered and hit the staff. When Staff B was asked how they ensured the safety of the other residents on the 400 hall they stated they were trying to find them a smaller setting to live in, their medications were assessed, stop signs were placed on some resident rooms, and tried to ensure staff were alternating their breaks so there was supervision on the hall. Staff B stated they felt Resident 89 needed increased supervision, a formalized schedule to have someone with them during waking hours. Staff B agreed there was a concern for the other residents safety. 47328 <Resident 63> According to the 02/03/2025 quarterly assessment, Resident 63 had severe cognitive impairment with inattention and disorganized thinking. Resident 63 had worsening wandering that significantly intruded on the privacy or activities of others and placed Resident 63 at significant risk of getting into potentially dangerous places. Review of 08/20/2024 elopement assessment showed Resident 63 was confused, disoriented, able to propel their wheelchair and did not exhibit unsafe wandering. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of August 2024 through November 2024 nursing progress notes documented Resident 63 spoke little English and had advanced cognitive impairment with hallucinations at times. Staff noted wandering in September 2024, and on 09/18/2024 Resident 63 was found in an opposite sex peer's bed, both sound asleep. On 10/01/2024 Resident 63 showed increased confusion and wandered. On 10/15/2024 Resident 63 moved to the 400 hall. On 10/29/2024 Resident 63 demonstrated increased aggression over the last two days, entering other resident rooms with difficulty in redirection. On 10/30/2024 Resident 63 was involved in a resident-to-resident altercation where they open handedly slapped a peer on the back of their head. On 10/31/2024 Resident 63 refused medications, chased staff and attempted to run them over, wandered through the lobby to the other side of the building, and a wanderguard (system consisting of a bracelet placed on an individual that will set off an alarm when exit doors were approached) was placed at that time. On 11/01/2024 Resident 63 wandered onto 400 hall and verbally harassed a peer while swinging a hairbrush. On 11/05/2024 Resident 63 wandered throughout the South side of the building (South side contained 400, 500, and 600 halls). On 11/06/2024 the resident had verbal and physical aggression towards staff, and bit a staff member's arm. On 11/09/2024 at 2:30 AM, Resident 63 was found in a 400-hall peer's room and had rummaged through the bedside dresser, was agitated when redirected and threatened to throw objects at peers. On 11/10/2024 at 5:30 AM, Resident 63 undressed in the 400-hall, became violent and combative by kicking, swinging arms and attempted to scratch staff with redirection. At 1:19 PM, Resident 63 yelled and cursed at peers, became aggressive with staff, and pulled a peer's hair on 400-hall. On 11/11/2024 at 6:30 AM, Resident 63 wandered into a peer's room on 500-hall and began hitting them in the head with a hairbrush. At 10:44 AM, medication changes were made, and staff were currently waiting to see if medication changes were effective. Review of the 11/01/2024 psychosocial behavioral care plan showed Resident 63 struck out, was combative, wandered, and exhibited verbal, physical and sexually inappropriate behaviors. The care plan instructed staff to administer medications as ordered, anticipate Resident 63's needs, provide supervision, offer distractions/activities as needed, provide simple, direct reminders, and observe whether behaviors endangered the resident and/or others and intervene if necessary. The 11/01/2024 elopement risk care plan documented Resident 63 wandered related to agitation and combative behaviors. The care plan instructed staff to administer medications as ordered, allow wandering in safe areas within the facility, check placement and function of the wandering bracelet/alarm system, address potential pain, encourage attendance and participation in activities. Review of the October 2024 through November 2024 incident log showed Resident 63 was involved in resident-to-resident altercations on 10/30/2024, 11/10/2024 and 11/11/2024. Review of the facility incident investigations showed the following: -10/30/2024 at 1:45 PM: Staff witnessed Resident 63 open handedly slapped a peer on the back of their head. Intervention was to increase psychotropic (medication that affect the mind, emotions, and behavior) medication dose and move Resident 63 to the 600 hall. -11/10/2024 at 11:45 AM: Resident 63 wandered onto 400 hall and exhibited aggressive behaviors. Staff witnessed when Resident 63 pulled a peer's hair. -11/11/2024 at 6:35 AM: Resident 63 wandered onto 500 hall and exhibited aggressive behaviors. Staff found Resident 63 in a peer's room and they had hit them on the back of the head with a hairbrush. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 11/10/2024 elopement assessment documented Resident 63 was cognitively impaired, had a history of wandering that significantly intruded on the privacy or activities of others and placed the resident at significant risk of getting to an unsafe place. The assessment identified Resident 63 was at risk to wander and/or elopement, a wanderguard was placed on the resident to enable maximal independence with mobility in facility while allowing safety. The assessment showed it was signed as completed on 02/19/2025. During observation on 02/24/2025 at 11:08 AM, Resident 63 was observed dressed, in their wheelchair, self-propelling, and wandering the South unit without staff supervision. Similar observations were made on 02/24/2025 at 4:00 PM, on 02/26/2025 at 8:31 AM, 9:34 AM, and 1:04 PM, on 02/27/2025 at 2:38 PM, on 03/03/2025 at 9:29 AM, on 03/05/2025 at 11:21 AM, 11:54 AM, and 12:03 PM. In an interview on 02/25/2025 at 11:22 AM, Resident 63's family member acknowledged Resident 63 wandered often. In an interview on 02/26/2025 at 10:01 AM, Staff N, Nursing Assistant, stated sometimes wandering interventions were in a resident's care plan. Staff N acknowledged Resident 63 wandered including entering into other resident's rooms. Staff N was asked what interventions Resident 63 had for wandering besides the use of a wanderguard. Staff N stated Resident 63 had a peer they were to avoid because of a previous resident-to-resident altercation, I guess, we just try to pay attention where [Resident 63] is at and staff on the units attempted to redirect residents who wandered. In a follow-up interview on 02/26/2025 at 12:56 PM, Resident 63's family member was observed pushing Resident 63 down the hall in their wheelchair. Resident 63's family member had stopped to speak with the surveyor as Resident 63 stopped briefly but then continued to self-propel/wander down the hall. Resident 63's family member stated it was hard to visit with their parent because they wandered around all the time. In an interview on 03/06/2025 at 12:26 PM, Staff H, Registered Nurse, acknowledged Resident 63 wandered all over. Staff H stated Resident 63 was involved in a resident-to-resident altercation with a non-English speaking peer and was moved to the 600 hall. Staff H further stated Resident 63 wandered onto the other units but was now buddies with a peer they experienced an altercation with, and they now roamed around hand in hand without issues. In an interview on 03/06/2025 at 12:52 PM, Staff B, Director of Nursing, acknowledged Resident 63 wandered and experienced behaviors when their psychotropic medications were decreased when the facility attempted to determine if the medications were necessary or not. In an interview on 03/06/2025 at 1:02 PM, Staff A, Administrator, acknowledged Resident 63 wandered onto the other units. Staff A was asked how the facility ensured resident safety while psychotropic medications took effect. Staff A stated they expected staff to follow the care plan. Reference WAC 388-97-0640 (1) Refer to F607, F725 and F726 for additional information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 46115 Based on interview and record review the facility failed to implement the facility's abuse prevention policy including identification of potential allegations, timely reporting allegations to the State Survey Agency as required, thoroughly investigating allegations, and monitoring residents for potential psychosocial harm after allegations were made for 6 of 10 sampled residents (Resident 42, 62, 63, 35, 311, and 20), reviewed for abuse. This failure placed residents at risk of potential abuse, neglect and/or misappropriation or their property and diminished quality of life. Findings included . Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021, documented the facility would develop and implement policies to prevent and identify abuse or mistreatment of residents; neglect of residents; and/or theft, exploitation or misappropriation of resident property. Staff would be provided orientation and training on abuse prevention, incident identification and reporting. The policy further showed all potential allegations of abuse, neglect, mistreatment, or misappropriation of resident property would be identified, reported within the required timeframes, investigated, and residents protected from potential harm during the investigation process. <Resident 20> The 01/10/2025 quarterly assessment documented Resident 20 was cognitively intact and made their needs known. In an interview on 02/24/2025 at 10:46 AM, Resident 20 stated there was a resident on the same hall that entered their room and yelled at them and wandered into their room often. Resident 20 stated three staff members removed the resident from their room. The incident for 02/05/2025 was written on a single piece of paper that stated Staff A, Administrator, spoke to Resident 20 regarding their interaction with Resident 89 on 02/05/2025 at 5:00 PM. Resident 20 stated Resident 89 was trying to enter their room, and Resident 20 blocked them from coming in with their wheelchair. Resident 20 stated Resident 89 placed their hand on their left arm to support themselves when they turned around. Staff A stated they had asked Resident 20 if Resident 89 had squeezed their arm, and Resident 20 said no. Resident 20 stated they told Resident 89 to leave their room, staff came and redirected the resident. Staff A stated Resident 20 reassured them several times that nothing happened, Resident 89 did not hit them, and they were not afraid of them. Review of the February 2025 incident log had no documentation that Resident 20 was involved in a resident-to-resident altercation and the State Survey Agency was not notified as required. In a follow-up interview on 02/28/2025 at 8:19 AM, Resident 20 stated Resident 89 had wheeled themselves into my room, they were angry and held my arm. Resident 20 stated they yelled at me, and this was the worst experience I had with them. Resident 20 stated you never knew how Resident 89 was going to act. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility investigation did not include staff or other resident interviews. There was no progress note written on 02/05/2025 regarding the resident-to-resident altercation. A progress note on 02/06/2025 stated there was no evidence of latent injury to Resident 20's right arm and no psychosocial issues were noted. The investigation was reopened after concerns were shared with Staff A, Administrator. The investigation documented a stop sign was placed across Resident 20's door to their room, a behavioral health visit was requested for Resident 89, an activity referral was made, the interdisciplinary team discussed a memory care unit for the resident, and resident and staff interviews were completed. Staff A was provided re-education by the Regional Director of Clinical Services on Washington State reporting guidelines to prevent future similar incidents from going unreported. In an interview on 03/06/2025 at 11:18 AM, Staff B, Director of Nursing, stated it was important to do thorough investigations to prevent harm or re-occurrence and to identify triggers to prevent future occurrences. Staff B stated staff, and resident interviews should have been completed. 47328 <Resident 42> According to the 12/12/2024 annual assessment, Resident 42 had diagnoses including muscle weakness and pain. Resident 42 was cognitively intact and able to clearly verbalize their needs. In an interview on 02/24/2025 at 10:26 AM, Resident 42 stated the night prior (02/23/2025), they waited for an hour and 15 minutes for their call light to be answered. Resident 42 explained they had a clock in their room, turned their call light on at 9:45 PM to be changed after an incontinence episode but staff did not enter their room until 11:00 PM. Resident 42 further stated this had also occurred 4 other times. In an interview on 02/24/2025 at 2:02 PM, Staff A, Administrator, was notified of the allegation Resident 42 made earlier that morning. Staff A stated they were not aware of the allegation. Review of the 02/24/2025 facility incident investigation documented residents and staff were interviewed related to the allegation of delay in response to call lights the weekend on February 22 and 23, 2025. A 02/27/2025 statement by Staff I, Nursing Assistant (NA), documented Resident 42 was glad Staff I answered their call light because Resident 42 had waited for an hour to be changed. Staff I reported Resident 42's allegation of delayed call light response time to the nurse. The investigation further documented the allegation of abuse and/or neglect was not reported to the State Survey Agency until 02/24/2025 at 3:40 PM, after the allegation was brought up to administration by the surveyor. <Resident 62> According to the 01/14/2025 quarterly assessment, Resident 62 had diagnoses including anxiety and depression. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/24/2025 at 2:56 PM, Resident 62 stated approximately three months ago, a night shift staff knocked me on the head with a bottle of roll-on pain relief lotion that was on the bedside table. Resident 62 explained they had concerns with being hit in the head. Review of the facility 08/23/2024 facility incident investigation documented Resident 62 alleged they were hit in the head by the nurse around midnight when they had requested pain medications. The investigation further documented the allegation of abuse was not reported to the State Survey Agency until 08/23/2024 at 5:44 PM, over 24 hours after the allegation was made. Review of August 2024 nursing progress notes showed a 08/23/2024 note no behaviors noted. No further documentation was found until 08/27/2024, 4 days later, to monitor Resident 62 for potential psychosocial harm related to the allegation of abuse. <Resident 35> According to the 02/26/2025 annual assessment, Resident 35 was cognitively intact and able to clearly verbalize their needs. Review of the 10/31/2024 grievance form documented Resident 35 was missing $50 that was replaced by the facility when they were unable to locate the money. Review of the October 2024 through November 2024 incident log showed no entries for Resident 35's missing $50. <Resident 311> According to the 10/03/2024 discharge assessment, Resident 311 admitted to the facility on [DATE] and discharged on [DATE]. Resident 311 was cognitively intact. Review of the 10/02/2024 grievance form showed Resident 311 was missing $40 that was replaced by the facility when they were unable to locate the money. Review of the October 2024 incident log showed no entries for Resident 311's missing $40. <Resident 63> According to the 02/03/2025 quarterly assessment, Resident 63 had severe cognitive impairment with inattention and disorganized thinking. Resident 63 had worsening wandering that significantly intruded on the privacy or activities of others and placed Resident 63 at significant risk of getting into potentially dangerous places. Review of the September 2024 through November 2024 incident log showed Resident 63 was involved in resident-to-resident altercations on 10/30/2024, 11/10/2024 and 11/11/2024. Review of the facility incident investigations showed the following: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/30/2024 at 1:45 PM: Staff witnessed Resident 63 open handedly slapped a peer on the back of their head. The incident was not reported to the State Survey Agency until 10/31/2024 at 1:00 PM, 23 hours after the physical aggression incident was witnessed by staff. -11/10/2024 at 11:45 AM: Resident 63 wandered onto 400 hall and had exhibited aggressive behaviors. Staff witnessed when Resident 63 pulled a peer's hair. The incident was not reported to the State Survey Agency until 11/11/2024 at 11:55 AM, 24 hours after the physical aggression incident was witnessed by staff and another resident-to-resident altercation occurred the following day. -11/11/2024 at 6:35 AM: Resident 63 wandered onto 500 hall and had exhibited aggressive behaviors. Staff found Resident 63 in a peer's room and they had hit them on the back of the head with a hairbrush. The incident was not reported to the State Survey Agency until 11/11/2024 at 11:40 AM. In an interview on 03/04/2025 at 5:15 AM, Staff K, NA, stated allegations of abuse needed to be reported to the State Survey Agency within two hours, the nurse should have been notified so the resident could have been monitored for potential psychosocial harm, and management notified so an investigation was completed. Staff K explained everyone was a mandated reporter and acknowledged allegations of waiting over an hour to have a call light answered, missing money, and resident-to resident verbal/physical aggression were all potential allegations of abuse and/or neglect that needed to be reported and thoroughly investigated. In an interview on 03/04/2025 at 9:42 AM, Staff H, Registered Nurse, stated when an allegation of abuse/neglect was made against a staff member, they needed to be immediately removed from providing direct resident care pending the results of the investigation. Staff H stated residents were placed on alert charting to monitor for potential psychosocial harm after an allegation was made. Staff H was unsure how abuse and/or neglect was ruled out. Staff H acknowledged allegations of waiting over an hour to have a call light answered, missing money, and resident-to resident verbal/physical aggression were all potential allegations of abuse and/or neglect that needed to be reported and thoroughly investigated. In an interview on 03/05/2025 at 12:03 PM, Staff E, Resident Care Manager, stated when an allegation of abuse was made resident safety was the first priority. Staff E explained if an allegation identified an individual staff, the staff needed to be immediately removed from direct resident care pending the results of the investigation. Staff E further stated all allegations needed to be reported to the State Survey Agency per the required timelines and thoroughly investigated by conducting resident and staff interviews. Staff E acknowledged allegations of waiting over an hour to have a call light answered, missing money, and resident-to resident verbal/physical aggression were all potential allegations of abuse and/or neglect that needed to be reported and thoroughly investigated. Staff E explained the facility would not wait until they suspected theft prior to reporting missing money because the facility might not suspect theft until instances of missing money were investigated. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/05/2025 at 3:44 PM, Staff B, Director of Nursing, stated allegations of abuse needed to be reported to the State Survey Agency within two hours, residents placed on alert to monitor for potential psychosocial harm after an allegation was made, abuse and/or neglect was ruled out through resident and staff interviews. Staff B was informed Staff I was informed of Resident 42's allegation of delayed call light response times when the incident occurred but it was not identified as a potential allegation or reported until the allegation was brought to administration by the surveyor. Staff B explained if an allegation identified an individual staff, ideally the staff was immediately removed from direct resident care pending the results of the investigation. Staff B was informed Resident 62's allegation of abuse occurred on night shift when only one nurse was working the South unit, but the identified nurse was not removed from direct resident care at that time and Resident 62 was not monitored for potential psychosocial harm following the allegation. Staff B further stated allegations of missing money was individualized depending on the amount of money missing and if it was found within 24 hours or not. Staff B was informed Resident 35 and 311's grievances of missing money were not identified as potential allegations, reported or investigated as such. In an interview on 03/06/2025 at 10:55 AM, Staff A, Administrator, stated allegations of abuse and/or neglect were reported to the State Survey Agency within two hours, thoroughly investigated, and residents monitored after allegations were made. Staff A explained if an allegation identified a staff, they would be removed from direct resident care as soon as the facility became aware of the allegation. Staff A stated they expected staff to report allegations within two hours. Staff A further stated instances of missing money were reported to the State Survey Agency on a case-by-case basis, if it was over $100 or if theft was suspected. Reference WAC 388-97-0640 (2) Refer to F725, F726, F600 and F689 for additional information.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure the completion of a required Pre-Admission Screening and Resident Review (PASRR) Level 2 evaluation (a person-centered evaluation that is completed for anyone identified as having or suspected of having a serious mental illness, intellectual disability, developmental disability, or related condition) prior to admission for 2 of 5 sampled residents (Resident 6 and 102), reviewed for PASRR. Additionally, the facility failed to ensure Resident 52's PASRR Level 2 recommendations were implemented. These failures placed the residents at risk for unmet mental health care needs. Findings included . Review of the facility policy titled PASRR Process dated March 2019, showed that if a Level 2 PASRR was indicated the facility Social Worker would ensure the resident was evaluated within a timely period. <Resident 6> Review of a 02/17/2025 assessment showed Resident 6 admitted to the facility on [DATE] with medically complex conditions and assessed as cognitively intact. The assessment showed diagnoses of depression, anxiety disorder, and post-traumatic stress disorder. Review of a 12/06/2024 PASRR Level 1 completed by the hospital showed, Resident 6 was identified with indicators of Serious Mental Illness (SMI). This evaluation showed a PASRR Level 2 was required for the SMI and a referral was sent to PASRR coordinator on 12/06/24. Review of Resident 6's medical record showed no documentation the facility ensured completion of the PASRR Level 2 prior to the resident's admission to the facility. The above information was shared with Staff Q, Social Services Director, on 03/04/2025 at 8:40 AM. Staff Q acknowledged the lack of the required PASRR Level 2 prior to admission and afterwards and stated, PASRRs from the hospitals are a mixed bag. No further information was provided. <Resident 102> A review of the 01/20/2025 admission assessment documented Resident 102 had diagnoses that included delusional disorder (unshakeable false beliefs) and major depressive disorder. The resident took antipsychotic and antidepressant medications (also referred to psychotropic medications that affect the mind, emotions and behavior) daily. A PASRR-level I screen dated 01/02/2025 documented Resident 102 required a level II evaluation related to their history of delusions and psychotic disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 01/14/2025 hospital discharge summary documented Resident 102 exhibited paranoid delusions while hospitalized , particularly with regards to his neighbors, and had some hallucinations. The summary stated Resident 102 was started on citalopram and risperidone, both psychotropic medications, and required outpatient mental health follow-up when discharged . A copy of the PASRR level II evaluation was requested. In an email dated 03/04/2025 at 7:48 AM, Staff A, Administrator, wrote that the facility did not have a level II evaluation for Resident 102 yet, the evaluator was behind. <Resident 52> The 12/26/2024 admission assessment documented Resident 52 had diagnoses that included borderline personality disorder and depression. Resident 52 was cognitively intact and took antipsychotic and antidepressant medications daily. The 12/18/2024 PASRR level II notice of determination documented Resident 52 had an existing behavioral health diagnosis and required specialized behavioral health services, met the requirement for nursing home level of care and required specialized behavioral health services. The 02/04/2025 Physician Assistant progress note documented Resident 52 was seen for suicidal ideation, had always reached out for help in the past and had never harmed themselves. Resident 52 was agreeable to a behavioral health consultation while at the facility. An order was entered for the behavioral health referral. On 03/03/2025 12:22 PM, any behavioral health provider progress notes for Resident 52 were requested and none were provided. During an interview on 03/03/2025 at 2:23 PM, Resident 52 stated someone had recently asked them about seeing a behavioral health provider about it. During an interview on 03/05/2025 at 1:14 PM, Staff Q, Social Work Director, stated Resident 52 had a level II evaluation completed prior to their admission to the facility. Staff Q stated they were not aware the resident had not been seen by a behavioral health provider yet and acknowledged this was not timely. Staff Q stated they were not aware that if a level II evaluation was recommended that it was required to be completed prior to admission to the facility. Staff Q further stated the admission nurses reviewed documentation prior to admission to ensure everything was complete. Staff Q stated they were not involved with the PASRR process until after residents had already arrived at the facility. In an interview on 03/05/2025 at 1:01 PM, Staff A, Administrator, stated they expected staff to follow the appropriate PASRR process. 46033 50027 <Resident 91> (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the 02/24/2025 comprehensive quarterly assessment, Resident 91 had diagnoses which included stroke, aphasia and dementia. The resident was severely cognitively impaired. A review of Resident 91's record documented a Level I PASARR was completed on 02/27/2025, 155 days after the resident admitted to the facility. On 11/01/2024, the resident had a physician's order to start an antidepressant medication following a new diagnosis of depression. No new Level I PASARR or a Level II PASARR was found. In an interview on 03/05/2025 at 12:18 PM, Staff Q, Social Services Director, stated they did not have an earlier Level 1 PASARR for Resident 91. They stated there was a different process in place last year to ensure PASARRs were completed. They stated that social services should have been notified regarding Resident 91's new diagnosis to implement a new Level I PASARR with a Level II referral. Staff Q stated this important so that residents were appropriately evaluated for state programs. Reference: WAC 388-97-1915(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** 40297 Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review Level I (PASRR, determines if an individual had or was suspected of having a serious mental illness [SMI], intellectual or developmental disability or related condition) were accurately completed for 3 of 5 sampled residents (Residents 6, 411, and 63) reviewed for PASRR. This failure placed the residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . Review of the facility policy titled, PASRR Process dated March 2019, showed the facility ensured that upon a resident's admission to the facility, a PASRR Level I was included in the admission paperwork. If there was no PASRR Level I, the Medical Records Director or designee contacted the hospital to obtain it. Review of the Washington State Department of Social and Health Services Level I PASRR form showed the facility was responsible for ensuring the form was complete and accurate before a resident's admission to the facility. In the event the resident experienced a significant change in condition, or if an inaccuracy in the current Level I was discovered, the facility was instructed to complete a new PASRR Level I and make referrals to the appropriate entities if a SMI and/or intellectual disability or related condition was identified or suspected. <Resident 6> Review of a 02/17/2025 admission assessment showed Resident 6 admitted to the facility on [DATE] with medically complex conditions. This assessment showed the diagnoses of anxiety disorder, depression, and post-traumatic stress disorder (PTSD). Review of a 12/06/2024 PASRR Level I showed the diagnosis of PTSD but no identification of the anxiety disorder or depression. <Resident 411> Review of the medical record showed Resident 411 admitted to the facility on [DATE]. The diagnoses list included depression, anxiety, borderline personality disorder, and PTSD. Review of a 02/11/2025 PASRR Level 1 showed no mention of the PTSD, and that Resident 411 showed indicators within the last two years of Schizophrenia, for which there was no diagnosis for in the medical record. The above information was shared with Staff Q, Social Services Director, on 03/04/2025 at 8:53 AM. Staff Q acknowledged the inaccurate PASRR Level I's for Residents 6 and 411. Staff Q stated, That would be good to double check on these on admission. We would do a new PASRR that is more accurate. <Resident 63> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 02/03/2025 quarterly assessment, Resident 63 admitted to the facility on [DATE] with diagnoses including depression. The assessment further showed Resident 63 took antipsychotic (a drug or other substance that affected how the brain worked and caused changes in mood, awareness, thoughts, feelings, or behavior and were typically used to treat mental health conditions) and antidepressant medications. Review of the 08/15/2024 PASRR showed Resident 63 had no mood or psychotic disorders and identified a level II evaluation was not indicated. Review of Resident 63's diagnoses showed a 08/20/2024 depression diagnosis. In an interview on 03/05/2025 at 1:03 PM, Staff Q, explained PASRRs were completed by hospitals prior to admission, reviewed by the facility's central admission intake nurse prior to admission and social services reviewed them once the resident admitted to the facility. Staff Q reviewed Resident 63's medical record. Staff Q stated Resident 63 had a diagnoses of depression upon admission and went through several psychotropic medication changes since admission. Staff Q acknowledged Resident 63's PASRR was inaccurate, should have been reviewed for accuracy and corrected as needed. Staff Q further stated social services should review PASRRs prior to admission for accuracy. In an interview on 03/05/2025 at 1:01 PM, Staff A, Administrator, stated they expected social services to review PASRRs for accuracy, make corrections as needed, and follow the appropriate PASRR process. Refer to WAC 388-97-1915 (1)(2)(a-c) Refer to F644 and F699 for additional information.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40297 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission that documented resident specific goals and treatment plans for 2 of 3 residents (Resident 6 and 411), reviewed for new admissions. This failure placed residents at risk for unmet care needs, possible medical complications, and diminished quality of life. Findings included . <Resident 6> Review of an admission assessment showed Resident 6 admitted to the facility on [DATE]. The medical record showed the resident was treated with medications for heart failure, high blood pressure, and atrial fibrillation (an irregular and often very rapid heart rhythm). Additionally, the resident was diagnosed as legally blind. Review of the resident's baseline care plan showed no goals or interventions to address the provider orders for the management of the cardiovascular diagnoses or the vision impairment. <Resident 411> Review of the medical record showed Resident 411 admitted to the facility on [DATE]. The medical record showed the resident was treated with medications for chronic obstructive pulmonary disease (lung diseases that lead to breathing difficulties) and asthma. Review of the resident's baseline care plan showed no goals or interventions to address the provider orders for the management of the lung diseases. The above information was shared with Staff G, Resident Care Manager, on 03/04/2025 at 10:43 AM. Staff G acknowledged Resident 6's and 411's baseline care plans did not identify the residents' nursing needs, interventions, or goals related to the active or treated diagnoses, and should have been included. Reference WAC 388-97-1020 (3).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review the facility failed to develop the care plans and implement interventions for 3 of 24 sampled residents (Resident 78, 62, and 41), reviewed for care planning. This failure placed the residents at risk for inadequate care, unmet care needs, and a diminished quality of life. Findings included . Review of the facility policy titled Quarterly MDS [Minimum Data Set, an assessment]/Care Plan Review dated June 2017 showed, the facility reviewed a resident's care plan, no less frequently than quarterly to ensure the care plan reflected the resident's current needs. <Resident 78> Review of a 12/16/2024 admission assessment showed Resident 78 admitted to the facility on [DATE] with medically complex conditions. The assessment further showed Resident 78 had difficulty hearing and used a hearing aid or other hearing appliance. During an observation on 02/24/2025 at 9:50 AM, Resident 78 was in bed with a hearing aid (HA) to the right ear. An observation on 02/25/2025 at 10:19 AM showed Resident 78 in bed. The HA was observed on the over the bed table to the left side of the resident's bed. Resident 78 took the HA, and this time placed it in the left ear, upside down. Resident 78 gestured they could not hear from it. Communication with Resident 78 occurred in a handwritten interview. Resident 78 stated their family took care of the HA when they came in the evening hours and that they communicated with the staff through feeling. Resident 78 stated that HA was old and chose to wear it and keep their brand-new HAs at home for safe keeping. Resident 78 stated that the staff use a little bit of both writing or use of pictures to communicate with them. On 02/27/2025 at 10:08 AM, Resident 78 was observed in bed, the HA was on the over-the-bed table. Resident 78 placed the HA in the left ear. Staff T, Licensed Practical Nurse (LPN), stepped by the doorway and stated to the Surveyor, Just so you know, [Resident 78] is very hard or hearing, even with a hearing aid. In a written interview, Resident 78 stated they only had one hearing in use at the facility. An interview with a Resident Representative (RR) on 02/27/2025 at 5:02 PM showed Resident 78 was, very hard of hearing, almost 100% deaf, and used HAs, reads lips, and if anybody knows how to sign [language], [Resident 78] signs. The RR stated, It's difficult to have conversations with Resident 78. The RR explained Resident 78 managed the care of their HAs and the one HA went in their left ear. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/04/2025 at 8:02 AM, Staff BB, Nursing Assistant stated they communicated with Resident 78, Most of the time [Resident 78] read my lips, then I will put [their] hearing aid in, and just watching your face. Staff BB stated that when reading lips was not effective for Resident 78, they would then use written communication. Review of a 12/19/2024 Communication care plan showed Resident 78 had mild hearing loss with HA and moderate loss without. A 12/19/2024 intervention showed Resident 78 had hearing aids to both ears, contrary to observations and interviews. All other interventions were dated 12/19/2024 and did not include other ways the resident and staff could communicate with each other, like sign language, reading lips, or written form. The above information was shared with Staff F, Resident Care Manager, on 03/04/2025 at 6:47 AM. Staff F stated that they communicated with Resident 78 verbally by using a louder tone and, Not to my knowledge does [Resident 78] wear any hearing aids. Staff F acknowledged Resident 78's care plan was not developed to showed resident-centered alternative communication techniques, like sign language, lip reading, or written communication, nor show the use of only one HA. 47328 <Resident 62> According to the 01/14/2025 quarterly assessment, Resident 62 had diagnoses including anxiety and depression. In an interview on 02/24/2025 at 2:56 PM, Resident 62 stated approximately three months ago, a night shift staff knocked me on the head with a bottle of roll-on pain relief lotion that was on the bedside table. Review of the facility 08/23/2024 facility incident investigation showed Resident 62 alleged being hit in the head by the nurse around midnight when they requested pain medications. Resident 62's care plan was updated to included two staff for all interactions including medication administration and conversations. Review of general information care plan showed Resident 62's care plan was updated on 09/04/2024 requiring two staff for all interactions. During observation on 03/03/2025 at 1:14 PM, Staff J, Nursing Assistant, entered Resident 62's room alone to answer their call light. At 1:15 PM, Staff J informed the surveyor Resident 62 wanted to speak with them and the surveyor entered the room. Resident 62 stated they do not send two staff in here all the time. During observation on 03/04/2025 at 10:59 AM, Staff J, again entered Resident 62's room alone to answer their call light. Staff J exited Resident 62's room at 11:01 AM. At 11:03 AM, Staff J returned to Resident 62's room with crackers as requested. At 11:06 AM, Staff J exited the room and informed Staff H, Registered Nurse (RN), Resident 62 was ready to take their pills. At 11:07 AM, Staff H entered Resident 62's room, alone, to administer medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/2025 at 11:16 AM, Staff J, stated Resident 62 had behaviors, yelled, cursed and was mean to staff. Staff J further stated Resident 62 was two person assist when care was provided but did not require two staff to answer the call light. Staff J reviewed Resident 62's record. Staff J acknowledged Resident 62 required two staff for all interactions and stated that would be hard to do. In an interview on 03/04/2025 at 11:21 AM, Staff H, RN, stated Resident 62 was verbally abusive to staff. Staff H reviewed Resident 62's medical record. Staff H acknowledged Resident 62 required two staff for all interactions. Staff H explained that having a conversation with a person was an interaction so technically Resident 62 required two staff to talk with them. In an interview on 03/05/2025 at 12:17 PM, Staff E, RCM, reviewed Resident 62's medical record. Staff E acknowledged Resident 62 required two staff for all interactions and expected staff to follow the care plan. In an interview on 03/06/2025 at 11:11 AM, Staff A, Administrator, stated they expected staff to follow care planned interventions. 50027 <Resident 41> Per the 02/21/2025 quarterly assessment, Resident 41 had diagnoses which included stroke and heart failure. The resident was moderately cognitively impaired, had adequate vision with glasses and reading books, newspapers and magazines was important to them. Per review of the 11/20/2024 care plan, there was no documentation related to Resident 41's vision. Review of the November 2024 to February 2025 nursing and provider progress notes documented no changes or interventions regarding Resident's 41's eyes or vision. A nursing note on 02/25/2025 documented the resident was scheduled for an eye appointment for cataracts (clouding of the eye lens which was typically clear) in March 2025. In an observation and interview on 02/25/25 at 09:07 AM, Resident 41 was in their room near their computer desk holding a typed letter. They stated they were in the process of improving their eyesight and should be wearing their glasses. The resident began to read the letter out loud. They struggled to read the first sentence and then placed the letter down on their desk. No glasses were found in their room. Subsequent observations of Resident 41 not wearing their glasses were made on: 02/26/2025 at 11:40 AM and 1:38 PM. In an observation on 02/27/25 at 08:34 AM, Resident 41 was in their room sitting at the desk with their computer on. They were not wearing their glasses. There were various pieces of unopened mail scattered across their desk. In an observation on 02/28/2025 at 08:26 AM, Resident 41 not wearing their glasses. At 09:04 they had letters, unopened mail and snacks spread across their desk in their room. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/2025 at 08:49 AM, Resident 41 was in the unit quad area and was observed for the first time wearing their glasses. In an observation on 03/04/2025 at 11:14 AM, Resident 41 was sitting at the table in the unit quad area. They had an insurance letter on the table in front of them and was not wearing their glasses. They stated they needed their glasses to read the letter and reminders to wear them daily. In an observation on 03/05/2025 at 11:09 AM, Resident 41 was wearing their glasses and the right lens was missing. In an interview on 03/06/25 at 12:25 PM, Staff FF, Registered Nurse, stated Resident 41 wore glasses daily. They stated the resident occasionally misplaced their glasses, in which staff would have to find them. In an interview on 03/06/2025 at 1:00 PM, Staff E, Resident Care Manager, acknowledged Resident 41 required glasses for their activities of daily living (ADLs) and should have been documented in their care plan. They stated this was important for the resident's safety during ADLs and performance for activities of interests. Reference WAC 388-97-1020 (1), (2)(a)(b) Refer to F607 and F686 for additional information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 46033 Based on observation, interview and record review, the facility failed to revise the care plans in response to changing goals, needs of the residents or in response to current interventions for 2 of 33 sampled residents (Residents 44 and 35) reviewed. Specifically, Resident 44 fell and broke their hip, and had continued falls and the care plan was not updated. Additionally, Resident 35 was newly diagnosed with Addison's disease (when the adrenal glands are damaged and do not produce enough hormones to regulate blood pressure, water and salt balance, and respond to stress), and disease related interventions were not added to the residents care plan. These failures put the residents at risk for unmet care needs and unintended health consequences. Findings included . <Resident 44> A review of the 12/18/2024 significant change assessment documented Resident 44 had diagnoses that included dementia with behavioral disturbances and right femur (upper thigh bone) fracture. Resident 44 was severely cognitively impaired, behaviors had worsened since their last assessment, and they had fallen and sustained a major injury since their admission. The 08/05/2024 admission Basic Care Plan documented Resident 44 was at risk for falls. Staff were instructed to keep the call light and personal items in the resident's reach, remind to use the call light for assistance, and use non-skid footwear when transferring the resident. The resident was high risk for falls. A review of nursing progress notes documented on 08/10/2024, Resident 44's roommate came to the door and stated the resident was on the floor. Resident 44 stated they tried to transfer from the wheelchair to their bed. They reported pain, especially in their right hip. After x-ray results were obtained that showed the right femur was broken, the resident was transferred to the hospital. The 09/19/2024 progress note documented Resident 44 was assisted to the bathroom and was advised to use the call light when done. The resident yelled out that they were done and by the time the nurse entered the bathroom, the resident was walking out of the bathroom with their walker and stated they had fallen. The nurse wrote that they had never left the resident's room, the resident's story kept changing but the nurse assessed the resident and there were no injuries. The 11/17/2024 progress note documented Resident 44 was in the common area and slid out of the recliner. The resident had been exhibiting more aggressive behaviors and required frequent bathroom trips every 10 minutes. The resident had been started on an antibiotic for urinary tract infection symptoms. A review of the facility incident logs showed the resident had the following additional falls: -11/21/2024 at 6:00 PM, the resident fell in their room with no injury. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/04/2024 at 9:01 PM, the resident fell in their room, sustained skin tears. -12/27/2024 at 9:21 PM, the resident fell in their room with no injury. -01/13/2025 at 1:30 AM, the resident fell in their room with no injury. After Resident 44 fell and fractured their femur on 08/10/2024, their care plan related to their fall risk was not updated until 11/18/2024. A review of the comprehensive care plan showed on 11/18/2024, a fall care plan was initiated for Resident 44, that documented the resident had an unwitnessed fall and was at risk for injury, pain and recurring falls. Staff were instructed to anticipate the resident's need, keep the call light in reach, explain procedures and provide reassurance during mobility tasks to alleviate fear of falling, keep personal items within reach, provide proper footwear, remind/cue the resident to ask for assistance, monitor for complications from falls and notify the provider if observed. On 01/09/2025, the care plan was updated to include remind the resident to use the call light and wait for assistance prior to attempting to transfer. On 02/04/2025, the care plan was updated to include remind the resident to call for assistance. On 02/24/2025 at 11:05 AM, Resident 44 was observed resting in their bed. The bed was in low position and there was a fall mat on the floor. Resident 44 stated they did not feel well. When asked if they had ever fallen, they stated they had fallen but was unable to remember when. Resident 44 stated nothing got broken when they fell , but it never felt good. During an interview on 03/04/25 at 8:56 AM, Staff B, Director of Nursing, stated if a resident fell and broke their leg, they would expect to see changes to the resident's plan of care. Staff B stated the incident occurred during a time of transition of facility ownership and there was a period that documentation was completed on paper. Staff B stated they would attempt to see if they could locate additional documentation regarding Resident 44's care plan. During an interview on 03/04/2025 at 9:30 AM, Staff Y, Nursing Assistant, stated they remembered when Resident 44 fell and broke their leg. Staff Y stated the resident used to be and was still impulsive and tried to sit on the edge of the bed and holler. Staff Y stated they tell Resident 44 to wait until they get there, and if they do not get there timely the resident tried to get up. Staff Y stated Resident 44 probably did not know what their call bell was for most of the time. During an interview with Staff F, Resident Care Manager (RCM), and Staff G, RCM, on 03/05/2025 at 10:14 AM, Staff G stated a fall with major injury was reviewed in the morning meetings with the interdisciplinary team. Staff G stated the MDS (Minimum Data Set) coordinators initiated the resident care plans. The RCMs might add a few interventions, or they emailed the MDS coordinator when an incident occurred so the MDS coordinator could update the care plan. 50027 <Resident 35> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the 02/26/2025 comprehensive assessment, Resident 35 had diagnoses which included chronic respiratory failure (a condition in which the lungs were unable to adequately exchange oxygen and carbon dioxide over an extended period), dry eye syndrome (a condition where both upper eyelid glands failed to produce enough tears) and diabetes. The resident was cognitively intact to make decisions regarding their care. In an observation and interview on 02/24/2025 at 03:34 PM, Resident 35 was lying in their bed. They stated they were concerned about their medical care related to their diagnosis, Addison's disease (when the adrenal glands are damaged and do not produce enough hormones to regulate blood pressure, water and salt balance, and respond to stress) during an adrenal crisis (a flare-up). They stated they were administered an injection when they had an adrenal crisis. They stated they had an adrenal crisis at the facility which did not subside until 48 hours later after two injections. The resident stated they felt the nursing staff were not educated on how to address it. Review of the December 2024 through February 2025 MARS documented Resident 35 had two physician orders for primary adrenocortical insufficiency (Addison's Disease): Hydrocortisone oral tablet, 20 mg, three times daily ordered on 07/12/2024 and Hydrocortisone injection, 100 mg as needed every 24 hours for an adrenal crisis ordered on 10/02/2024. Review of the December 2024 MARS and nursing progress notes documented Resident 35 was administered the injection on 12/03/2024 at 9:58 PM, 12/28/2024 at 8:04 AM, and 12/31/2024 at 10:19 AM. Further review documented the only words the resident was able to state was that they needed their injection on 12/31/2024. The progress note documented the resident had spastic movements and their eyes tracked to the right. There was no further documentation found related to interventions. Review of the January 2025 MARS and nursing progress notes documented Resident 35 was administered the injection on 01/05/2025 at 6:00 PM and 1/10/2025 at 12:21 AM. There was no further documentation found related to interventions. Review of the February 2025 MARS and nursing progress notes documented Resident 35 had muscle spasms and was administered the injection on 02/02/2025 at 3:21 PM. The resident initially had no response to the injection. The nurse called the provider at 4:10 PM. While on the phone, the resident showed improvement in their condition at 4:30 PM and was placed on alert charting. There was no further documentation found related to interventions. Review of the 12/05/2024 care plan showed no documentation related to Resident 41's Addison's Disease diagnosis. In an observation and interview on 03/03/2025 at 08:44 AM, Resident 41 was lying in their bed. They stated they received an injection after convincing the new nurse on duty that they needed one. They stated they were in pain and I know my body. They stated their symptoms began at 4:00 AM. They stated they delayed informing the new nurse of their symptoms because it was too difficult to explain their disease since it is a rare condition. Review of the March 2025 nursing progress notes documented Resident 35 was administered the injection on 03/03/2025 at 8:01 AM. There was no further documentation found related to interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/2025 at 1:38 PM, Staff Y, Registered Nurse, reviewed the resident's physician orders for their disease and stated if the resident continued to show symptoms after an injection then the nurse should know to contact the provider. They stated when a resident has a change in their health, the nurse should put them in the alert charting system, but they primarily were verbally informed during a staff shift change. In an interview on 03/05/2025 at 03:22 PM, Staff E, Resident Care Manager, stated they had previously met with Resident 35 regarding their concerns about making sure that staff was aware of the interventions for their disease. They stated the disease should have been added to the resident's care plan with special instructions/interventions. Staff E further stated this was important because it would ensure staff provided the appropriate care for Resident 35 and management of their condition. Reference: WAC 388-97-1020(5)(b)

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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. 46033 Based on observation, interview and record review, the facility failed to ensure that residents requiring assistance with their activities of daily living (ADLs), were provided timely assistance according to their needs and preference for 2 of XXX sampled residents (Residents 52 and 41) reviewed for ADLs. Specifically, Resident 52 was not provided showers per their preference and Resident 41 was not shaved when indicated. This failure put residents at risk for decreased quality of life. Findings included . <Resident 52> The 12/26/2024 admission assessment documented Resident 52 had diagnoses that included empyema (pockets of infection that build up in the space between the lung and the chest wall) and fractured ribs. The resident was cognitively intact and required substantial assistance of 1 to 2 staff for showering. The 12/28/24 care plan revised on 01/30/2025 documented Resident 52 was at risk for skin breakdown related to incontinence. Staff were instructed to keep the skin clean and dry, and minimize exposure to moisture from incontinence, wounds, and perspiration. Nursing Assistance shower task documentation reviewed on 03/04/2025 documented the resident received showers on 02/06/2025, 02/08/20258, then not again until 02/15/2025; then again 02/19/2025, 02/22/2025, 02/26/2025 and 02/28/2025. There were no showers documented after 02/28/2025. During an interview on 02/24/2025 at 10:18 AM, Resident 52 stated that ever since their admission they had not received their showers twice weekly as scheduled and preferred. They stated many times, the shower aide was removed from shower duties and given assignments on a different unit. Resident 52 stated their showers were scheduled on the evening shift when there was less staff and they were often told there was no one to give them their shower. On 02/26/2025 at 1:25 PM, Resident 52 stated they had not been given their shower the previous evening. They stated they asked for one and was told there was not enough staff. At this time, Resident 52 notified the nurse and was told they would work it in for the resident. On 02/27/2025 at 8:31 AM, Staff P, Licensed Practical Nurse stated Resident 52 was provided their shower on 02/26/2025 as they had requested. During an interview on 03/04/2025 at 9:40 AM, Staff Y, Nursing Assistant, stated there were two shower aides for the 100, 200 and 300 units that worked on the day shift. Staff Y stated the shower aides were frequently pulled from shower duties to cover staff that had called in. Staff Y stated the shower aides were also pulled to accompany residents on appointments if an escort was needed. Staff Y stated residents that had showers scheduled on evening shifts usually did not get them. Staff Y stated if there was no shower aide scheduled, they worked with the other aide on their unit to try to get them done but that took them away from other care. (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 interview on 03/05/2025 at 11:07 AM, Staff F, Resident Care Manager, stated if Resident 52 did not receive a shower on their scheduled day, the shower aides worked to make it up the next day. Staff F stated they wondered if it was a matter of the showers not being documented. Staff F stated if the shower aide was pulled to work on the unit, the Nursing Assistant on the unit was expected to provide the shower. Staff F thought the shower aide was pulled to the unit maybe once a week but was unsure. Staff F reviewed the shower documentation and agreed Resident 52 had not gotten a shower since 02/28/2025. <Resident 41> Per the 02/21/2025 quarterly assessment, Resident 41 had diagnoses which included stroke and heart failure. The assessment further documented the resident had moderate cognitive impairment, required partial to moderate assistance with personal hygiene and substantial to maximal assistance with showering. Review of the 11/20/2024 nursing care plan, revised on 02/24/2025, documented staff were instructed to provide Resident 41 partial assistance with personal hygiene and substantial assistance with showering. In an observation and interview on 02/25/2025 at 9:15 AM, Resident 41 was unshaved and had a stubbled, scruffy, wispy beard. They stated they could not recall the last time they were shaved. Resident 41 stated they felt refreshed when they were shaved. Per review of the personal hygiene record from 01/31/2025 to 02/25/2025, Resident 41 received personal hygiene tasks daily and required mostly partial to dependent assistance. Per review of the shower record from 01/31/2025 to 02/25/2025, Resident 41 received showers two days a week, on Tuesdays and Fridays. One refusal was documented on 01/31/2025. In an observation on 02/26/2025 at 9:07 AM, Resident 41 had a clean-shaven face. In an observation and interview on 02/27/2025 at 08:34 AM, Resident 41 had noticeable stubbled facial hair. The resident stated they had a shower 2-3 days ago. In an observation on 03/03/2025 at 8:49 AM, Resident 41 had a 5 o'clock shadow beard. In an observation and interview on 03/06/2025 at 11:10 AM, Staff XX, Nursing Assistant, stated residents were groomed daily. They stated residents were shaved on their shower days and during the week as needed. They stated Resident 41 required assistance with shaving, and it was the staff's responsibility to initiate it. In an observation and interview on 03/06/2025 at 11:25 AM, Resident 41 wheeled through the dining area in their wheelchair. They had a scruffy beard with wispy whiskers. Staff XX viewed the resident as they passed by and acknowledged they should have been shaved. In an interview on 03/06/25 at 12:13 PM, Staff FF, Registered Nurse, confirmed Resident 41 had a shower on 03/04/2025 and acknowledged Resident 41 should have been shaved. They stated this was important because they needed to be treated with dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1060(2)(a)(ii). 50027

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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 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. 46115 Based on observation, interview and record review the facility failed to implement the bowel management protocol when indicated for 2 of 3 sampled residents (Resident 18 and 71), reviewed for constipation. In addition, the facility failed to identify changes in a resident's skin condition timely for 1 of 2 sampled residents, (Resident 15), reviewed for skin conditions. These failures placed residents at risk for complications, worsening conditions, and diminished quality of life. Findings included . Review of the facility policy titled, Bowel Protocol, revised Febuary 2019, documented nursing staff was to review a resident's bowel monitor every shift. The policy instructed nursing staff to implement the bowel program if a resident did not have a bowel movement (BM) for three days. The policy documented nursing staff was to administer Milk of Magnesia (MOM) on day three and a laxative suppository was to be administered the next shift if there were no results from MOM. If the resident exceeded four days without a BM, the Licensed Nurse performed an abdominal assessment and notified the provider. CONSTIPATION <Resident 18> The 12/26/2024 quarterly assessment documented Resident 18 was able to make decisions regarding cares and needed substantial to maximal assistance from staff for activities of daily living, such as toileting. Review of the 05/09/2022 constipation care plan documented interventions for Resident 18 to have the bowel protocol placed upon admission and the licensed nurse was to initiate the protocol as ordered. The care plan instructed staff to monitor bowel movements and for signs and/or symptoms of constipation. Review of the Order Summary Report documented on 05/09/2022, the physician ordered Resident 18 to be administered a laxative (Milk of Magnesia) to be given on day three of no BM as needed, and a suppository to be given the next shift if no results from the MOM. Review of the bowel records from 01/31/2025 through 02/28/2025, documented Resident 18 had no BMs for the following dates: 01/31/2025 through 02/04/2025 (five days) 02/06/2025 through 02/09/2025 (four days) 02/11/2025 through 02/13/2025 (three days) 02/15/2025 through 02/18/2025 (four days) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/21/2025 through 02/23/2025 (three days) 02/25/2025 through 02/28/2025 (four days) Additional review of the Medication Administration Records (MARs) for January 2025 and February 2025, documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 18's record that stated the reason for the omissions. <Resident 71> The 01/10/2025 quarterly assessment documented Resident 71 was able to make decisions regarding cares and needed substantial to maximal assistance from staff for activities of daily living, such as toileting. Review of the 07/19/2023 constipation care plan documented interventions for Resident 71 to have the bowel protocol placed upon admission and the licensed nurse was to initiate the protocol as ordered. The care plan instructed staff to monitor bowel movements and for signs and/or symptoms of constipation. Review of the Order Summary Report documented on 07/19/2023, the physician had ordered a laxative (Milk of Magnesia) to be given on day three of no BM as needed, and a suppository was to be given the next shift if no results from the MOM. Review of the bowel records from 01/28/2025 through 02/28/2025, documented Resident 71 had no BMs for the following dates: 01/28/2025 through 01/30/2025 (three days) 02/05/2025 through 02/07/2025 (three days) Additional review of the MARs for January and February 2025, documented Resident 71 had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 71's record that stated the reason for the omissions. In an interview on 03/04/2025 at 9:37 AM, Staff M, Registered Nurse, stated MOM was administered on day three of no BM, if that was not effective a suppository was given on the next shift, if that was not effective an enema (liquid laxative inserted rectally) was given, and the provider was notified. During an interview on 03/04/2025 at 9:48 AM, Staff E, Resident Care Manager, stated the bowel medications should have been administered for the above dates. In an interview on 03/05/2025 at 2:05 PM, Staff B, Director of Nursing, stated the bowel medications should have been given as ordered, an abdominal assessment completed and documented, and the provider notified. Staff B stated it was important for the bowel protocol to be followed to prevent bowel obstruction. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50027 SKIN <Resident 15> Per the 02/25/2025 quarterly assessment, Resident 15 had diagnoses which included Alzheimer's Disease, heart failure, and depression. Resident 15 did not have any skin conditions and was not cognitively intact to make decisions regarding their care. Resident 15 required substantial to maximal assistance to complete personal hygiene and bathing tasks. During an observation on 02/24/2025 at 11:35 AM, Resident 15 was in their room, sitting in their wheelchair watching TV. Their head was shaved in a low buzz cut. The right side of their head showed a visible patch of red, irritated scalp the size of an average avocado, with striations of blood and hard flakes scattered throughout their scalp, transcending down towards their right ear. Resident 15 had heavy flakes of skin in and around their right ear, in which they were significantly rubbing, picking, and flicking flakes onto the floor. Resident 15 had a noticeable amount of dry skin flakes on their shirt and pants. In an observation on 02/26/2025 at 8:52 AM, Resident 15 was sitting in their room watching television. Their scalp had reddish indentations on the right side with hard crud flakes. Their ears, face and neck were dry, showing flakes of skin that had fallen on their upper and lower shirt. Their skin was pinkish red within the goatee area on their face. Resident 15 was digging in and scratching their right ear and rubbing their eyes lids. In an observation on 02/27/2025 at 8:47 AM, Resident 15 was asleep sitting in their wheelchair in the dining area. They were wearing a baseball cap and had noticeable flakes of skin on their black shirt. In an interview on 02/25/2025 at 02:04 PM, a family member stated Resident 15 had a medical history of psoriasis (a condition in which the skin cells build up and formed scales and itchy dry patches). They stated Resident 15's ears were not cleaned during showers. They stated Resident 15's head was bleeding and itching during their visit on the previous day. The family member stated they cleaned Resident 15's ears and applied their personal psoriasis moisturizing cream to their scalp, face, and neck while they were visiting. Per record review of the 11/20/2024 nursing care plan, staff were instructed to use lotion on Resident 15's dry skin skin as needed and inform the nurse of any new skin issues. No documentation was found to show Resident 15 required interventions specifically for their scalp. Review of the September 2024 through February 2025 nursing and provider progress notes showed no changes in Resident 15's skin condition. Review of the provider orders as of 02/26/2025 showed Resident 15 had no orders to treat their skin conditions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per review of the shower record from 01/29/2025 to 02/27/2025, Resident 15 received showers on Saturdays and Wednesdays. Per review of the personal hygiene record from 01/29/2025 to 02/27/2025, Resident 15 received personal hygiene cares two to three times daily. There was no documentation found for new skin changes. In an observation on 02/28/2025 at 8:28 AM, Resident 15 was sitting in their wheelchair in the dining area. They had speckles of reddish scabs on the right side of their scalp. In an observation on 03/04/2025 at 11:16 AM, the right side of Resident 15's scalp had residual reddish indentations with a few hard scabbed flakes, in and around their right ear, with noticeable flakes that had fallen onto their upper shirt. In an observation and interview on 03/05/2025 at 10:56 AM, Resident 15 was in their room with a family member. Their scalp was slightly reddish with flakes in the same area and in and around both of their ears. The family member stated that Resident 15 did not have a prescription at the facility for their skin and/or scalp. They stated staff was aware they needed to apply their personal psoriasis moisturizing cream. In an interview on 03/06/2025 at 9:51 AM, Staff FF, Registered Nurse, stated they assessed residents' skin every shower day and as needed when there were skin issues. Staff FF stated staff had informed nurse of residents' skin issues. Staff FF stated they were not aware Resident 15 had new skin issues and/or concerns nor that they used a personal psoriasis moisturizing cream. In an interview on 03/06/2025 at 12:54 PM, Staff E, RCM, acknowledged staff should have informed the nurse regarding Resident 15's skin issues. Staff E stated this was important to ensure a resident's skin was healthy and interventions were in place to prevent infection. Reference WAC 388-97-1060 (1).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review the facility failed to ensure residents who admitted without pressure injuries did not develop pressure injuries and residents with pressure injuries did not worsen. Specifically, the facility failed to communicate interventions to the staff including settings of specialty mattresses, the correct use of positioning devices, and to address the identification of refusals of care for 3 of 5 residents (Residents 101, 1, and 105), reviewed for pressure injury. These failures placed residents at risk for pressure injury development, wound infections and/or complications, and diminished quality of life. Findings included . Review of the facility policy titled, Skin at Risk/Skin Breakdown revised September 2020, showed residents who entered the facility without pressure injuries would not develop pressure injuries unless the clinical condition demonstrated it was unavoidable and a resident with pressure injuries would receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Residents would be evaluated for risk for pressure injury development upon admission, weekly for the initial three weeks following admission, significant changes of condition, and annually. The licensed nurse was to complete full body skin evaluations weekly, indicating if new skin impairment was observed or not. If new skin impairment was noted after admission staff was to initiate alert charting, review current skin risk and interventions for effectiveness, and implement new interventions as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The national institute of health website nih.gov with regard to the revised National Pressure Ulcer Advisory Panel pressure injury staging system showed a pressure injury is localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion [flow of fluid or blood to cells and tissues], comorbid condition [medical conditions that coexist and affect health and treatment], and condition of the soft tissue. Stage 1 pressure injury: intact skin with a localized area of non-blanching erythema [redness that does not disappear when pressure is applied to the area]. Stage 2 pressure injury: partial thickness [involving epidermis and/or dermis] loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Stage 3 pressure injury: full thickness [wound that extends below the epidermis and dermis into the subcutaneous tissue or deeper] skin loss, in which adipose (fat) or granulation [new connective tissue] tissue is visible in the ulcer. Stage 4 pressure injury: full thickness skin and tissue loss with exposed or directly palpable fascia [connective tissue], muscle, tendon [strong cords of tissue that connect muscle to bones], ligament [bands that connect bones and joints], cartilage [tough, flexible connective tissue that protects bones and joints, and provides structure to the nose and ears], or bone in the ulcer. Unstageable pressure injury: full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough [dead skin or tissue that can appear in a wound] or eschar [dead tissue that forms over healthy skin and eventually falls off]. Deep Tissue Pressure Injury [DTPI]: intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation reveling a dark wound bed or blood-filled blister. It is essential that the intended staging or classification system be used for each type of injury to ensure appropriate treatment. <Use of Positioning Devices> <Resident 101> Review of an admission assessment showed Resident 101 admitted to the facility on [DATE] with medically complex conditions. This assessment showed the staff assessed the resident had severe cognitive impairment, was dependent on the staff for bed mobility and transfers, and did not reject care. The assessment showed Resident 101 admitted to the facility with no pressure ulcers but was at risk of developing pressure ulcers. Review of a 01/17/2025 worksheet associated with the assessment showed the staff assessed Resident 101, Needs special mattress or seat cushion to reduce or relieve pressure. An observation on 02/25/2025 at 9:38 AM showed Resident 101 in bed. Observed at the foot of the bed was a pump connected to the mattress, set at a 230 pound setting, a 10 minute cycle time, and on alternate mode. Observed under the mattress were two blue colored foam wedges placed under the resident's mid torso and legs areas. In an interview on 02/25/2025 at 9:38 AM, Staff T, Licensed Practical Nurse (LPN), stated that the staff placed the wedges under the mattress, I believe to get pressure off the bottom like turning the resident to the side. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/25 at 6:21 AM, Staff U, Bath Aide, stated that the wedges in Resident 101's room go under the sheet to keep the resident turned. Staff U stated that the wedges were used like every two hours in when [the resident was] in bed. Staff U stated Resident 101 rarely refused cares provided by the staff, to include turning and repositioning. Review of the February 2025 physician orders and the care plan showed no instruction to the staff on the use of the wedges or the pump settings for the specialty mattress. The above findings were shared with Staff G, LPN Supervisor, on 03/04/2025 at 10:14 AM. Staff G stated that the wedges should be placed under the bed sheet and not under the mattress. Staff G acknowledged Resident 101's care plan and orders showed no instructions for the pump settings associated with the specialty mattress and that, it should be care planned and have an order with the settings. Staff G stated the use and purpose of the wedge, should be in the care plan. <Management of Refusals> Review of Resident 101's 01/10/2025 Admission Evaluation showed, No other skin concerns are noted. Resident refused and resisted turning in bed to check [their] buttocks, coccyx [tailbone], sacrum, and back. The evaluation showed that an aide stated the resident, is also resisting/refusing turning and pericare [hygiene] for them. Review of a Skin at Risk care plan, initiated and revised on 01/13/2025 showed, Pressure reduction cushion to chair and Pressure reduction mattress as ordered if indicated, Staff to reposition resident frequently during every shift to offload high pressure areas, and Use lift pads to minimize friction and shear. Review of a 01/20/2025 progress note showed the staff, Noted new pressure ulcer spanning the sacrum [the lower back, above the tail bone] and Resident doesn't tolerate much time up in w/c [wheel chair] and spends most of [their] day in bed. The note showed the staff revised the care plan, for an air mattress to reduce pressure. Air mattress placed. Review of the medical record showed no documentation what the staff did differently to prevent pressure ulcer development prior to 01/20/2025, even though they had knowledge Resident 101 was intolerant to much time up in w/c, or spent most of [their] day in bed. Review of a 01/20/2025 Wound Consultant note showed, Consultation was requested for sacral wound. The note showed the staff identified Resident 101, refused, turning and repositioning upon arrival to facility and for several days after admission. The note showed the staff identified an open wound to sacrum when up for their shower and a LAL [low air loss, a specialty mattress] was obtained today after discovery of the wound. The wound consultant assessed the wound as a DT or deep tissue injury (DTI). Review of progress notes from 01/10/2025 to 01/17/2025 showed no documentation what the staff did to address the refusals mentioned by the Wound Consultant in the 01/17/2025 notes, to include identifying the reason why Resident 101 refused to turn or reposition. Review of a Skin care plan initiated on 01/21/2025 and revised on 02/25/2025 showed no documentation the staff considered refusals as a contributor to the development of Resident 101's pressure ulcer or put interventions in place to address rejection of turning and repositioning, as stated by the Wound Consultant's note of 01/17/2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/25 at 10:23 AM, Staff G, Resident Care Manager, stated they expected, the aide to alert their nurse, who then could have alerted me to get an order to track the refusals, and alerted the wound nurse so they could assess and order something different. Find out why the resident is refusing. Interview the resident. Look at the care plan and see what needs to be changed. Staff G acknowledged the medical record did not show the staff acted upon their identification of Resident 101's refusals to turn or reposition prior to the development of a DTI. 47328 <Resident 1> According to the 02/14/2025 quarterly assessment, Resident 1 had diagnoses including malnutrition and multiple sclerosis (disorder where nerve cells deteriorate). The assessment further showed Resident 1 required substantial up to dependent staff assistance for bed mobility, lower body dressing, and transfers. Resident 1 did not refuse cares, was at risk for pressure injury development and had one Stage 4 pressure injury, not present on admission. Resident 1 was cognitively intact and able to clearly verbalize their needs. Review of the skin care plan revised 08/14/2024 showed Resident 1 had chronic moisture associated skin damage (MASD) that deteriorated into a Stage 3 pressure injury. The care plan showed Resident 1 refused to adhere to skin integrity interventions and instructed staff to review risk versus benefits of refusals to adhere to skin integrity interventions with Resident 1, quarterly. The care plan showed Resident 1 used an air mattres but no documentation of resident specific settings for the use of the air mattress was found. Review of January 2024 through August 2024 nursing progress notes showed no documentation Resident 1 refused to adhere to skin integrity interventions or risk versus benefits of refusals were discussed with Resident 1 quarterly, as care planned. On 07/01/2025 Resident 1 was seen by the wound specialist for deteriorating bilateral buttock skin breakdown with use of an air mattress and compliance with turning. On 07/08/2024 Resident 1's MASD deteriorated and presented as a Stage 3 pressure injury. Review of provider orders as of 02/25/2025 showed a 12/04/2023 order for staff to monitor Resident 1's Roho (a cushion with individual flexible air-filled cells) cushion for proper inflation twice daily. No documentation was found to show Resident 1 to have or use an air mattress or what the settings were to be set to. In an interview on 03/03/2025 at 1:28 PM, Staff J, Nursing Assistant, stated resident skin was monitored during routine cares and new skin issues identified would be reported to the nurse for follow-up. Staff J further stated skin interventions were in a resident's care plan and staff were to implement them because skin and/or wounds could worsen if not implemented. Staff J stated Resident 1 did not refuse cares but had a wound on their buttock for awhile because they used to like to stay up in their WC. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 03/05/2025 at 9:27 AM, Staff H, RN, stated residents' skin was monitored via weekly skin assessments. Staff H stated skin interventions implemented would be in a resident's care plan and staff were expected to implement interventions. Staff H further stated if a resident used an air mattress for skin integrity, then a provider order was required as well as care planning. Staff H demonstrated two different air mattresses/pumps on the unit and explained air mattresses were set up based on the resident's weight. One of the air mattress/pump observed did not show a weight range for the settings and had a comfort zone instead. Staff H was asked how the appropriate comfort zone setting was determined. Staff H explained if the comfort zone setting was determined based on the resident's comfort level and was adjusted as needed. Staff H acknowledged Resident 1 developed a pressure injury from resisting to lay down and staying up in their WC all day. In an interview on 03/05/2025 at 9:11 AM, Staff E, Resident Care Manager (RCM), stated NAs monitored skin during routine care and nurses completed weekly skin assessments. Staff E further stated if a skin issue was identified current interventions were reviewed and new interventions added as needed. Staff were expected to implement care planned interventions and notify the RCM if/when a resident refused so appropriate education could be done. Staff E explained when an air mattress was used for skin integrity it was typically just care planned, and no provider order or consent was obtained. Staff H stated air mattresses were set up by restorative nursing staff or maintenance staff and settings determined based on the resident's comfort level. Staff H reviewed Resident 1's medical record. Staff H stated Resident 1 had MASD to their buttock that deteriorated into a pressure injury last year because of refusal to reposition. Documentation of quarterly risk versus benefit education was requested at that time. In an interview on 03/05/2025 at 9:42 AM, Staff CC, Restorative Nursing Assistant, stated restorative nursing had nothing to do with setting up air mattresses. Staff CC stated maintenance set up air mattresses. In an interview on 03/05/2025 at 9:46 AM, Staff L, Maintenance Director, stated maintenance only assisted nursing by setting up new air mattresses, by unpackaging them when purchased, all other times air mattresses were set up by nursing staff. Staff E explained the facility used two different brands of air mattresses and the setting could be very easily adjusted by nursing staff. <Resident 105> According to the 02/02/2025 admission assessment, Resident 105 admitted to the facility on [DATE] with diagnoses including malnutrition, muscle weakness, difficulty walking, and repeat falls. The assessment further showed Resident 105 required substantial up to dependent staff assistance for bed mobility, lower body dressing, and transfers. Resident 105 was assessed and identified to be at risk for pressure injury development and admitted to the facility without any pressure injuries. Resident 105 was cognitively intact and able to clearly verbalize their needs. Review of the 01/27/2025 hospital discharge summary showed Resident 105 had worsening progressive generalized weakness and was referred to a neurologist (doctor that specializes in disorders of the nervous system) for evaluation of a possible neurodegenerative (condition where nerve cells deteriorate and lead to progressive loss of function) condition. Review of the 01/27/2025 BRADEN (simple tool used to check how likely someone was to a develop pressure injury) showed Resident 105 was at risk for pressure injury development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 01/27/2025 admission assessment showed Resident 105 admitted to the facility with a Stage 1 pressure injury to their right buttock. Review of the 01/28/2025 baseline care plan showed Resident 105 required maximal assistance from staff for bed mobility, had a current pressure injury and required wound care. No description or documentation of interventions implemented was found. Review of the 02/04/2025 skin evaluation showed Resident 105 now had a DTI to their coccyx. The evaluation included notes that showed the wound began as a Stage 1 that developed into a DTI, an air mattress was requested at that time. Review of the skin care plan implemented on 02/05/2025 showed Resident 105 had a DTI to their buttock and DTI to bilateral heels were identified on 02/20/2025. The care plan instructed staff to administer medications as ordered, use a pressure reduction cushion in the wheelchair (WC), educate the resident on pressure injury risk factors, use an air mattress and use of padded boots when in bed/WC. The care plan showed no resident specific settings for the use of the air mattress and the padded boots were implemented on 02/22/2025, after the bilateral heel DTIs developed. Review of the 02/10/2025 wound assessment report showed Resident 105's coccyx DTI developed in the facility on 02/04/2025. Review of provider orders as of 02/24/2025 showed no provider order for Resident 105 to have or use an air mattress. Review of the 02/24/2025 wound assessment report showed Resident 105's acquired the bilateral heel blisters in the facility on 02/21/2025. In an interview on 02/24/2025 at 9:19 AM, Resident 105's spouse stated Resident 105 had a wound to their buttock that worsened at the facility. During observation on 02/24/2025 at 10:21 AM, Resident 105's wounds were observed. Resident 105 had an unstageable wound to their coccyx covered with black eschar in the center surrounded by thick attached yellow slough, left heel had a large fluid filled blister, and the right heel had a smaller intact blister. During interview and record review on 03/04/2025 at 5:18 AM, Staff K, Nursing Assistant, stated Resident 105 did not refuse cares, had a wound on their buttocks and blisters on both heels. Staff K further stated skin interventions were in a resident's care plan and pulled up Resident 105's medical record to show they were care planned to use bilateral heel boots, an air mattress, and a Roho WC cushion. Staff K explained it was very important to ensure the Roho cushion was filled up properly or else it would not be effective. During observation on 03/04/2025 at 9:34 AM, Staff H, RN, Resident 105's air mattress pump was observed to be set at 5/8 firmness. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 03/04/2025 at 10:47 AM, Resident 105 stated their bed was too hard and uncomfortable. Resident 105 further stated they were unable to assist with bed mobility and typically just laid in bed once in bed. The air mattress pump hanging off the footboard showed the air mattress was set at 5/8 on firmness. In an interview on 03/05/2025 at 9:26 AM, Staff E, RCM, reviewed Resident 105's medical record. Staff E acknowledged Resident 105 admitted with a Stage 1 pressure injury to their coccyx that developed into a DTI and also acquired bilateral heel blisters since admission. Staff E was unsure how air mattress setting were determined when the pump had a comfort zone versus a weight range. In an interview on 03/05/2025 at 3:27 PM, Staff C, Assistant Director of Nursing, stated air mattresses were placed by maintenance and setting based on resident comfort. Staff C was asked how staff were to monitor air mattresses for proper settings when no provider order was implemented with resident specific settings. Staff C stated air mattresses were adjusted based on resident comfort. Staff C was informed different individuals could have different comfort levels, some individuals could prefer the firmest setting. Staff C acknowledged adjusting air mattress settings based on resident comfort was not the best practice. In an interview on 03/06/2025 at 10:47 AM, Staff A, Administrator, acknowledged Resident 105 had a coccyx wound that worsened and developed bilateral heel blisters, since their admission. Staff A stated they expected staff to follow care planned interventions. Reference WAC 388-97-1060 (3)(b) Refer to F656 for additional information.

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F 0689 Level of Harm - Minimal harm or potential for 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** 40297 Based on observation, interview and record review the facility failed to ensure smoking materials were secured as care planned for 1 of 3 sampled residents (Resident 18), reviewed for smoking. In Addition, the facility failed to assessed and monitored for the safe use of an electrical heating appliance for 1 of 5 sampled residents (Resident 78), reviewed for accident hazards. These failures placed residents at risk for potentially avoidable accident and placed the facility at risk of fire. Findings included . <Electrical Appliances> Review of a 12/16/2024 admission assessment showed Resident 78 admitted to the facility on [DATE] with medically complex conditions. The assessment further showed Resident 78's cognition as intact and had both vision and hearing impairment. Resident 78 required assistance from the staff to complete Activities of Daily Living. An observation on 02/25/2025 at 10:19 AM showed Resident 78 in bed, head slightly up, and a heating pad to their right side. When asked about its use, Resident 78 stated, I just put it on there. Resident 78 stated their family brought the heating pad in and they used it when they get cold at night. An observation on 02/27/2025 at 10:08 AM showed Resident 78 in bed with the heating pad observed to the left side of the head of the bed. Resident 78 stated they used the heating pad, This morning. When touched, the heating pad was warm to touch and set at 100 degrees for 45 minutes. Review of Resident 78's physician orders showed no instructions for the use of a heating pad. Review of Resident 78's care plan showed no documentation of the heating pad, its purpose or interventions for its safe use. An observation on 02/28/2025 at 8:32 AM, showed Resident 78 in bed on their left side with a heating pad on edge of the bed next to them. On 02/28/2025 at 8:35 AM, Staff T, Licensed Practical Nurse (LPN), identified the appliance as a hot pad. Staff T stated, I think [Resident 78's] family brought it in. [Resident 78] is using it for just relaxing. Staff T then asked Resident 78 why they used the hot pad, and Resident 78 stated, When I get pain to the side and pointed to the left stomach area. Staff T then asked the Surveyor, Do we need to get rid of that [the hot pad]? Staff T stated they knew of no other residents that used a hot pad and confirmed they were aware Resident 78 used the hot pad prior to 02/28/2025. Staff T stated, I thought it was just for comfort to be honest. Staff T stated that some of the risks of using heating pads without monitoring included, They get too hot if they turn it up too high. Burns from not checking it often. Staff T stated they, Usually make sure the aides are aware of [the hot pad] and check on it a lot make sure it's not too hot. Find out if [Resident 78] is physically able to manage it. Staff T again asked the Surveyor, Should I get rid of it? I'll double check with my boss. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/28/2025 at 8:41 AM, Staff BB, Nursing Assistant (NA), familiar with Resident 78's care, was asked if they were aware of any residents that used electrical heating appliances or a heating pad. Staff BB stated, I have not seen any of those on my hallway. Staff BB stated the risks involved with the use of electrical heating pads included, The cords can be frail and catch on fire if it's plugged improperly, and just getting too hot for the patient and causing burns. Staff BB stated that if they observed a resident with a heating pad they would, Ask them if they made sure it was okay to have in their room and double check with nurse and ask if it's okay with them and if they feel it's not safe then take it out and [the resident] can use it when in public view. The above findings were shared with Staff A, Administrator, on 02/28/2025 at 8:46 AM. Staff A stated that they were unaware of any resident that used an electric heating pad. Staff A stated the use of an electric heating pad could cause a burn or thermal injury if it got too warm. Staff A stated they expected staff to, Notify management and unplug [the appliance], if staff saw residents using these appliances. No further information was provided. 46115 <Smoking> Per the 12/26/2024 quarterly assessment, Resident 18 had diagnoses which included a stroke, hemiplegia (paralysis that affected only one side of your body), diabetes and was able to make decisions regarding their care. During an observation and interview on 02/24/2025 at 9:29 AM, Resident 18 stated they smoked and always kept their cigarettes and lighter with them. Resident 18 had a cup that was attached to their wheelchair and there was a pack of cigarettes and a lighter in it. The 05/19/2022 smoking care plan documented Resident 18's smoking materials were to be kept locked in the medication cart. In an observation on 02/24/2025 at 4:00 PM, a cognitively impaire resident from another hall (Resident 63) wandered down to the 400 hall (the hall Resident 18 lived on) in their wheelchair. Resident 63 picked up another resident's drink and wheeled off while they drank from it. At 4:02 PM, Staff R, Licensed Practical Nurse, came out of a room and took the cup away from Resident 63 and escorted them back to their own hall. In an observation on 02/26/2025 at 9:11 AM, Resident 63 again wandered onto the 400 hall and was tampering with the lift that assisted residents to stand. In an interview on 02/26/2025 at 9:36 AM, Resident 70, another resident that smoked and lived on 400 hall, stated a month or two ago they had cigarettes that went missing. At 10:19 AM Resident 70 stated they kept their cigarettes and lighter in a basket that was attached to their wheelchair. During an interview on 02/26/2025 at 10:26 AM, Resident 18 stated there were two residents on the 400 hall that wandered into rooms. Resident 18 stated the one resident wandered in their room about twice a week. Resident 18 stated they had taken some candy out of their room and if the resident saw something they liked they would take that too. Resident 18 stated staff had attempted to put a stop sign on their door but that did not keep the wandering residents out of their room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent observations of Resident 18 with their cigarettes and lighter in their wheelchair cup were made on 02/25/2025 at 2:22 PM, 02/27/2025 at 11:43 AM and 2:57 PM. In an interview on 02/26/2025 at 9:12 AM, Staff S, NA, stated there were two residents that wandered on 400 hall and three residents wandered from the other two halls on the secured unit that wandered onto 400 hall. Staff S stated Resident 63 went into the other resident's rooms, took items, and held them in their lap. During an interview on 02/26/2025 at 9:40 AM, Staff M, Registered Nurse, stated there were three residents on the 400 hall that wandered and two residents from other halls on the secured unit wandered onto 400 hall. Staff M stated there was one resident on 400 hall that would take things out of resident rooms. Staff M stated they told Resident 18 today they had onto hold their lighter. In an interview on 02/26/2025 at 1:26 AM, Staff B, Director of Nursing, stated they had residents that wandered into other resident's rooms and took things. When Staff B was asked if they felt it was safe for Resident 18 to have their smoking supplies on them when they had a roommate on oxygen. Staff B stated Resident 18's supplies needed to be kept in the nurse's cart as care planned. Staff B added it was important that smoking supplies were kept in the nurse's cart for safety reasons. Staff B acknowledged the concern about the residents who wandered and the unsecured smoking supplies and agreed this was unsafe. Reference: WAC 388-97-1060(3)(g) 50027

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 46033 Based on observation, interview and record review, the facility failed to ensure a resident's peripherally inserted central catheter (PICC, also known as a central line, a catheter placed in a large vein in the arm that extended to a large vein in the heart, used if long term antibiotic therapy was required or if antiobiotics were damaging to smaller veins) was maintained according to standards for 1 of 1 sampled residents (Resident 52) reviewed. This failure placed the resident at risk for complications related to their PICC including blood stream infections, blood clots, or inflammation of the vein. Findings included . The 2011 Centers for Disease Control and Prevention Guidelines for the Prevention of Intravascular Catheter-Related Infections, updated October 2017, retrieved at https://www.cdc.gov/infection-control/hcp/intravascular-catheter-related-infection/index.html documented the following recommendations: replace transparent dressings used on central venous catheters at least every 7 days or if it becomes loosened, damp, or visibly soiled, and promptly remove any intravascular (inside a vein) catheter that is no longer essential. The 2015 Association for Professionals in Infection Control and Epidemiology Guide to Preventing Central Line-Associated Bloodstream Infections recommended the transparent dressing be changed every 7 days, and that a daily assessment of the necessity of the catheter be performed and the catheter be removed promptly if no longer essential. <Resident 52> The 02/04/2025 re-admission assessment documented Resident 52 had diagnoses that included fractured ribs and empyema (pockets of infection between the lung and the chest wall). Resident 52 was cognitively intact, made decisions regarding their care and received antibiotics through a peripherally inserted central venous catheter (PICC line). A review of the 01/30/2025 care plan revealed there were no goals or interventions developed related to the management of Resident 52's PICC line. Resident 52 had the following provider orders: -01/30/2025 flush PICC with 20 milliliters (m)l of saline after each blood draw -01/30/2025 flush PICC with 10 ml saline prior to and after each dose of antibiotic -01//30/2025 flush PICC with 10ml saline every 8 hours and prn (as needed) -01/30/2025 Change PICC transparent dressing every 7 days on Sunday evenings and prn -01/30/2025 Measure upper arm circumference weekly with dressing change (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-01/30/2025 Measure external length of the PICC from the insertion site to the end where the intravenous (IV) tubing connects, document the length in centimeters every Sunday -01/30/2025 Monitor for phlebitis (redness, pain, tenderness, drainage) daily, document + if present, - if not present. -03/02/2025 Cathflo activase (an enzyme that breaks up clots) once for occluded PICC. A review of the February 2025 and March 2025 medication and treatment administration records (MAR/TAR) documented the resident received the last dose of their antibiotic on 02/20/2025 at 6:00 AM. The PICC dressing changes were omitted on 2/16/2025 and on 03/02/2025. The saline flushes ordered every 8 hours and as needed were omitted from 02/25/2025 until 03/01/2025 at 6:00 AM. The Cathflo Activase ordered on 03/02/2025 was omitted. A corresponding progress note documented the Cathflo Activase was not available. There were no progress notes that documented attempts to restore the patency of the PICC after it became occluded, notes regarding the continued need for the PICC line or orders for its discontinuation. On 02/25/2025 at 9:33 AM, Resident 52 was dressed and seated in their wheelchair in the common area of the unit. A PICC line was observed on the inner upper portion of the resident's right arm. A transparent dressing covered the insertion site and was dated 02/16/2025 (9 days previous). The edges of the dressing were peeling off. Resident 52 stated they were finished with their antibiotics but had not heard what the plan was for the removal of the PICC line. On 02/26/2025 at 7:50 AM, Resident 52 was seated in the entry area waiting for a ride to an appointment. Their PICC was observed; the dressing was dated as changed on 02/25/2025. On 03/03/2025 at 9:24 AM, Resident 52 was in the common are of the unit. Their PICC line was still present, the dressing was still dated 02/25/2025. On 03/04/2025 at 10:06 AM, Resident 52's PICC line was observed. It was dated 02/25/2025. Resident 52 stated on Sunday, 03/02/2025, the PICC would no longer flush. They stated the nurse on Monday evening tried again to flush it and it still would not so the nurse reported to the resident that they would have Staff D, Infection Prevention, just remove it. Resident 52 had not heard anything further about getting it out since it no longer functioned. On 03/05/2025 at 10:06 AM, Resident 52 stated the PICC line was removed the prior evening by Staff D, and it came out without any difficulty. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/2025 at 11:20 AM, Staff F, Resident Care Manager, stated a PICC dressing change was considered a procedure that required sterile technique and if Licensed Practical Nurses were not comfortable changing them, there were other nurses that were able. Staff F stated PICC lines were removed when the antibiotics therapy had been completed, or as soon as it was determined that the infection was cured. Staff F stated they expected PICC dressing changes to be completed every 7 days as ordered. This was important because residents that had PICC lines were already being treated for infections so were already at risk for other infections. Staff F stated they assumed there could be a risk to a resident if an occluded PICC line was not removed promptly, but they were unaware what those complications were. Staff F knew there had been Cathflo ordered but had not been aware that it was not given. Staff F stated they were unaware if nurses had completed competencies for the management and care of a resident with a PICC line but they did not think so. Staff F stated, We do not do competencies that I am aware of. That would be a good one. On 03/06/2025 at 10:32 AM, Staff D, Infection Prevention stated best practice was for PICC dressings to be changed weekly. They had changed the dressing for Resident 52 on 02/25/2025 and had also removed the resident' s PICC. Staff D stated the PICC was not removed sooner as there had been speculation that maybe Resident 52 was going to need more antibiotics. Staff D stated they had been told on Monday, 03/03/2025 that the PICC was occluded, but did not think leaving it in after it became occluded was a risk for the resident. They expected there would be a progress note regarding the Cathflo, and whether it was effective in re-opening the PICC or not. Staff D stated they were not part of providing competencies for the nursing staff. Reference: WAC 388-97-1060(3)(j)(ii)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46115 Based on observation, interview, and record review, the facility failed to ensure oxygen delivery equipment was maintained in a clean manner for 2 of 4 sampled residents (Residents 35, 74) reviewed for respiratory care. These failures placed the residents at risk for respiratory complications and infection. Findings included . Review of the facility policy titled, Respiratory Treatment, dated 06/22/2022, documented the external filter of an oxygen concentrator provided no protection to the resident from respiratory illness, per manufacturers. The filter kept debris from the concentrator compressor only and provided no respiratory protection to the resident. Oxygen cannulas/mask and tubing were to be changed as needed if soiled or damaged and the concentrator filters were to be cleaned weekly. <Resident 74> Per the 12/18/2024 quarterly assessment, Resident 74 had diagnoses which included chronic obstructive lung disease (COPD, a group of lung diseases that make it difficult to breathe), respiratory failure and needed oxygen due to those conditions. Review of the physician orders documented on 08/30/2024, the resident had been prescribed oxygen to be used continuously at 3 liters per minute (lpm), due to COPD. The 06/21/2024 respiratory care plan showed no direction for cleaning oxygen filters on the oxygen concentrator, a machine that delivers oxygen to the resident. On 02/24/2025 at 9:53 AM, Resident 74 was observed wearing oxygen at 4 lpm (not 3 lpm as ordered) while sitting in their wheelchair. An inspection of the oxygen concentrator in the resident's room showed the concentrator was unclean with thick dust debris. Subsequent observations of the oxygen concentrator filter being unclean were made on 02/25/2025 at 2:18 PM, 02/26/2025 at 8:38 AM and 12:22 PM. Subsequent observations were made of Resident 74 wearing their oxygen at 4 lpm on 02/25/2025 at 2:18 PM, 02/26/2025 at 8:38 AM and 12:22 PM, 02/27/2025 at 8:29 AM and 11:46 AM, 02/28/2025 at 8:18 AM. In an observation and interview on 02/27/2025 at 8:29 AM, Resident 74's oxygen concentrator filter was clean. The resident stated they had cleaned their filter yesterday. In an observation on 03/03/2025 at 8:41 AM, Res was observed lying in bed wearing oxygen at 2 lpm. In an interview on 02/28/2025 at 8:50 AM, Staff M, Registered Nurse, stated Resident 74 received oxygen at 3 lpm. Staff M accompanied the surveyor to the resident's room and adjusted the oxygen from 4 lpm to 3 lpm. Staff M had asked the resident if they had adjusted the oxygen, and the resident said no. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/28/2025 at 8:57 PM, Staff C, Assistant Director of Nursing, stated maintenance cleaned the oxygen concentrators weekly. Staff C stated Resident 74 should have had oxygen administered as ordered unless they had an acute change. Staff C stated it was important to follow the provider orders to avoid carbon dioxide retention and it was important to maintain clean oxygen concentrator filters to ensure the efficacy of the machine. In an interview on 03/05/2025 at 1:17 PM, a collateral contact from the oxygen supplier, stated when the oxygen filter was unclean it could clog the airway for the flow of air into the concentrator and would impact the flow of oxygen. 50027 <Resident 35> Per the 12/04/2024 quarterly assessment, Resident 35 had diagnoses which included chronic respiratory failure and needed oxygen. Review of the physician orders documented on 07/12/2024, the resident had been prescribed oxygen to be used continuously at 1 lpm, and 2 lpm as needed for oxygen levels below 90 percent due to chronic respiratory failure. The 05/11/2022 care plan documented the resident required oxygen as needed and instructed maintenance staff to clean the concentrator filter weekly. Nursing staff was instructed to change the oxygen tubing as needed when soiled or damaged. In an interview and observation on 02/24/2025 at 3:07 PM, Resident 35 stated they had asked for a new nasal cannula two days ago because it was dirty with blood on it. The resident stated their tubing was supposed to be changed weekly but had to request that it be done. The resident was observed with dried blood on their oxygen tubing, and it was unclean. In an observation on 02/24/2025 at 3:20 PM, Resident 35 wore oxygen tubing that was dated 08/02/2024. The oxygen filter on the concentrator was unclean with dust debris in the vents. The resident's oxygen was set at 2 lpm. Subsequent observations of the filter being unclean were made on 02/25/2025 at 11:02 AM, 02/26/2025 at 9:29 AM, 02/27/2025 at 1:14 PM, 03/03/2025 at 8:35 AM and 12:28 PM. In an interview on 03/05/2025 at 3:45 PM, Staff E, Resident Care Manager, verified there was no documentation in the chart that showed the oxygen tubing and cannula had been changed. Staff E added it was important to change the oxygen tubing for infection control. Reference: WAC 388-97-1060 (3)(j)(vi)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to ensure 6 of 6 sampled residents (Resident 6, 23, 411, 416, 417, and 62) reviewed for trauma informed care, received culturally competent, trauma-informed care in accordance with professional standards of practice. The failure of the facility to adequately screen, assess, identify potential triggers (a psychological stimulus that prompts recall of a previous traumatic event), and develop and implement a Trauma Informed Care Plan to help limit the residents' exposure to potential trauma triggers, placed the residents at risk for re-traumatization and a diminished quality of life. Findings included . Review of the [DATE] facility policy titled, Trauma-Informed Care showed, the facility screened residents for indications of trauma for newly admitted residents and as part of the comprehensive care plan process, and developed appropriate interventions based upon the screening responses and resident observations. The facility interviewed the resident and/or their representative as part of the screening process and care plan development. <Resident 6> Review of a [DATE] admission assessment showed Resident 6 admitted to the facility on [DATE] with the diagnosis of Post Traumatic Stress Disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event). The staff assessed Resident 6 as cognitively intact. Review of a [DATE] hospital History and Physical document showed Resident 6 experienced sudden losses of relatives or spouse at a young age. Resident 6 also experienced gunshot wounds to the chest which left the resident unable to perform their job any longer. Review of a [DATE] facility Social History Assessment showed a questionnaire for Significant Life Events. The questionnaire asked about a number of difficult or stressful things that sometimes happen to people. All the events, to include, Assault with a weapon and Sudden, unexpected death of someone close to you were marked as Not sure. Review of the medical record showed four emergency contacts and relatives of Resident 6 listed. Progress notes review showed no indication the facility made additional efforts to collaborate with family members to determine the type of PTSD Resident 6 experienced and its possible triggers. Additionally, no care plan development for Trauma Informed Care was noted to help direct the staff on preventing re-traumatization of Resident 6. On [DATE] at 9:04 AM, Staff PP, Nursing Assistant (NA), stated that they were familiar with Resident 6, a resident on the 300 Hall. Staff PP stated that they knew if a resident was a trauma survivor by, I would hope that the nurses would articulate that to the aides to let us know because we do not have access to their personal record. Sometimes the admission person would let us know. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:24 AM, Staff QQ, Licensed Practical Nurse (LPN), stated that they were familiar with Resident 6 as they were a primary nurse assigned to the 300 Hall. Staff QQ stated that they did not know of any residents on the 300 Hall with the diagnosis of PTSD or were trauma-survivors. Staff QQ stated that they knew a resident was a trauma-survivor by, sometimes when they are admitted I will look at admission documents from hospital. Staff QQ stated that they knew what triggers to avoid to prevent re-trauma by asking the resident, reviewing the progress notes and, some of it is common sense thing. The above information was shared with Staff Q, Social Services Director, on [DATE] at 8:19 AM. Staff Q stated he was unaware of Resident 6's history of PTSD as stated in the hospital records of [DATE], It should be in the care plan but to be honest I don't think it got seen in those documents when [the resident] got here but that warrants a follow up. We would start with reaching out to a POA [Power of Attorney], always be our first step, spouse or child, any direct contacts. <Resident 23 and 417> Review of a Diagnosis Report showed Residents 23 and 417 resided on the 300 Hall and both carried the diagnosis of PTSD from admission. Record review showed Resident 23 admitted to the facility on [DATE] and Resident 417 on [DATE]. Neither resident's medical record showed the development of a Trauma Informed Care Plan to help direct the staff on recognizing triggers and preventing re-traumatization of the residents. Review of Resident 417's [DATE] and Resident 23's [DATE] Social History Assessments showed the answer of Not sure to all the Significant Life Events questionnaire. <Resident 411> Review of the medical record showed Resident 411 admitted to the facility on [DATE] with a diagnosis of PTSD. Review of an undated hospital admission referral showed, Pt [patient] requesting [their] door be left open and reports [their] father passed away while hospitalized . Review of a [DATE] Social History Assessment showed the answer of Not sure to all the Significant Life Events questionnaire. Resident 411 resided in the 200 Hall. <Resident 416> Review of the medical record showed Resident 416 admitted to the facility on [DATE] with a diagnosis of PTSD. Review of a [DATE] Social History Assessment showed the answer of Not sure to all the Significant Life Events questionnaire. Resident 416 resided in the 200 Hall. Neither Resident 411 or 416's medical record showed the development of a Trauma Informed Care Plan to help direct the staff on recognizing triggers and preventing re-traumatization of the residents. On [DATE] at 9:02 AM, Staff BB, Nursing Assistant stated that they were a primary aide on the 200 Hall. Staff BB stated that they became aware a resident was a trauma survivor by, It should come with their admission paperwork so we get that information in report. I don't remember if I've ever taken care of a resident with PTSD before. Staff BB stated that it was difficult for them to know what triggers to avoid for a resident with a history of trauma unless they know the type of trauma. Staff BB mentioned there might be a resident on the 200 Hall with PTSD because the resident, was telling me [they] had trauma. It just came in conversation. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:52 AM, Staff T, LPN, stated they were a 200 Hall primary nurse. Staff T stated that they knew a resident was a trauma survivor and what triggers to avoid through, report when they get here. Like in their History and Physical [from the hospital]. Find out from the family. Staff T was unaware of any residents on the 200 Hall with the diagnosis of PTSD. The above findings were shared with Staff Q on [DATE] at 9:01 AM. Staff Q stated that since nothing triggered secondary to the Not Sure answers throughout the Significant Life Events questionnaire, it did not trigger a Trauma informed Care Plan for the residents. 47328 <Resident 62> According to the [DATE] quarterly assessment, Resident 62 had diagnoses including anxiety and depression. The assessment further showed Resident 62 was able to clearly verbalize their needs. Review of the [DATE] behavior care plan showed Resident 62 rejected care, became mute, and made accusations. The care plan instructed staff to re-approach, create a calming environment, and inform social services of any new accusations. No documentation was found to show Resident 62 experienced trauma or any identified trauma triggers for staff to avoid. Review of the [DATE] trauma screen showed no documentation Resident 62 was asked if they had experienced any traumatic events. Review of the facility [DATE] facility incident investigation showed Resident 62 alleged being hit in the head by the nurse around midnight when they requested pain medications. In an interview on [DATE] at 2:56 PM, Resident 62 stated approximately three months ago, a night shift staff knocked me on the head with a bottle of roll-on pain relief lotion that was on the bedside table. Resident 62 explained they had concerns with being hit in the head because they previously lived in California, where the culture was different, and they were beat with a baseball bat. Resident 62 stated they were aware of the potential risk of death secondary to a head injury and explained they knew someone who died from a ruptured aneurysm (bulge or ballooning of a blood vessel) after they sustained a head injury. In an interview on [DATE] at 11:15 AM, Staff J, NA, was unsure if Resident 62 had experienced any traumatic events. In an interview on [DATE] at 12:19 PM, Staff E, Resident Care Manager, was unsure if Resident 62 had experienced any traumatic events. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 1:42 PM, Staff Q, Social Service Director, stated residents were screened for trauma upon admission but if they were not willing to talk about trauma experienced or if they state they did not experience trauma then the conversation stopped. Staff Q reviewed Resident 62's trauma screen. Staff Q acknowledged the trauma screen did not ask the resident if they had experienced any traumatic events, the screen only asked the resident if they wanted to talk about trauma experienced. Staff Q further acknowledged it would be better practice to ask the resident if they experienced trauma prior to asking them if they would like to talk about trauma because that way the facility could identify/be aware the resident experienced trauma so staff could be on the lookout for potential unidentified trauma triggers to avoid and/or verbalizations of trauma details. In an interview on [DATE] at 11:07 AM, Staff A, Administrator, stated they expected staff to appropriately screen residents for trauma to identify potential triggers to avoid. No associated WAC Refer to F607 for additional information.

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Sullivan Park Care Center	14820 East Fourth Spokane, WA 99216

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to ensure the facility had enough staff to provide care according to facility acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations, and conditions) and/or care plans for 5 of 10 sampled resident's, (Resident 63, 62, 91, 89, and 42), reviewed for sufficient staffing. This failure placed all residents at risk for potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment reviewed January 2025, documented the facility's average daily census was 120. The facility admitted more acutely ill residents with multiple co-morbidities and provided care for an increased number of residents with drug abuse, cognitive impairment, behaviors and used a wander guard system (system consisting of a bracelet that would alarm when an exit door was approached) on the south side of the building (400, 500, and 600 halls) with secured doors leading onto the unit, for residents that wandered. The assessment further documented the interdisciplinary team met daily Monday through Friday to review resident acuity and staffing needs making staffing levels adjustments as needed. The facility utilized a staffing coordinator and staffed the facility based on [NAME] State's 'Per Patient Day' minimum staffing levels. Agency staff was used as needed to ensure proper staffing patters if in-house staff was not sufficient to meet resident needs. <Resident 63> According to the 02/03/2025 quarterly assessment, Resident 63 had severe cognitive impairment with inattention and disorganized thinking. Resident 63 had worsening wandering that significantly intruded on the privacy or activities of others and placed Resident 63 at significant risk of getting into potentially dangerous places. Review of the 11/01/2024 psychosocial behavioral care plan documented Resident 63 struck out, was combative, wandered, and exhibited verbal, physical and sexually inappropriate behaviors. The care plan instructed staff to administer medications as ordered, anticipate Resident 63's needs, provide supervision, offer distractions/activities as needed, provide simple, direct reminders, and observe whether behaviors endangered the resident and/or others and intervene if necessary. The 11/01/2024 elopement risk care plan documented Resident 63 wandered related to agitation and combative behaviors. The care plan instructed staff to administer medications as ordered, allow wandering in safe areas within the facility, check placement and function of the wandering bracelet/alarm system, address potential pain, encourage attendance and participation in activities. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of August 2024 through November 2024 nursing progress notes documented Resident 63 spoke little English and had advanced cognitive impairment with hallucinations at times. Staff noted wandering in September 2024, and on 09/18/2024 Resident 63 was found in an opposite sex peer's bed, both sound asleep. On 10/01/2024 Resident 63 had increased confusion and wandered. On 10/15/2024 Resident 63 moved to the 400 hall. On 10/29/2024 Resident 63 demonstrated increased aggression over the last two days, entered other resident rooms with difficulty in redirection. On 10/30/2024 Resident 63 was involved in a resident-to-resident altercation where they open handedly slapped a peer on the back of their head. On 10/31/2024 Resident 63 refused medications, chased staff attempting to run them over, wandered through the lobby to the other side of the building, and a wanderguard was placed at that time. On 11/01/2024 Resident 63 wandered onto 400 hall and verbally harassed a peer while they swung a hairbrush. On 11/05/2024 Resident 63 wandered throughout the South side of the building. On 11/06/2024 verbal and physical aggression towards staff and they bit a staff member's arm. On 11/09/2024 at 2:30 AM, Resident 63 was found in a 400-hall peer's room and had rummaged through the bedside dresser, became agitated when redirected and threatened to throw objects at peers. On 11/10/2024 at 5:30 AM, Resident 63 undressed in the 400-hall, became violent and was combative by kicking, swinging arms and attempting to scratch staff with redirection. At 1:19 PM, Resident 63 yelled and cursed at peers, became aggressive with staff, and pulled a peer's hair on 400-hall. On 11/11/2024 at 6:30 AM, Resident 63 wandered into a peer's room on 500-hall and hit them in the head with a hairbrush. At 10:44 AM, medication changes were made, and staff were currently waiting to see if medication changes were effective. Review of the October 2024 through November 2024 incident log showed Resident 63 was involved in resident-to-resident altercations on 10/30/2024, 11/10/2024 and 11/11/2024. Review of the 11/10/2024 elopement assessment showed Resident 63 was cognitively impaired, wandered and significantly intruded on the privacy or activities of others and placed the resident at significant risk of getting to an unsafe place. The assessment identified Resident 63 as at risk to wander and/or elopement, a wanderguard was placed on the resident to enable maximal independence with mobility in facility while allowing safety. During observation on 02/24/2025 at 4:00 PM, Resident 63 was observed dressed, in their wheelchair, self-propelled and wandered down the South unit halls without staff supervision, picked up a peer's tumbler, and wheeled off with it as they drank the unknown contents. Similar unsupervised wandering observations were made on 02/26/2025 at 8:31 AM, 9:34 AM, and 1:04 PM, on 02/27/2025 at 2:38 PM, on 03/03/2025 at 9:29 AM, on 03/05/2025 at 11:21 AM, 11:54 AM, and 12:03 PM. In an interview on 02/25/2025 at 11:22 AM, Resident 63's family member acknowledged Resident 63 wandered often. In an interview on 02/26/2025 at 10:01 AM, Staff N, Nursing Assistant (NA), stated sometimes wandering interventions were in a resident's care plan. Staff N acknowledged Resident 63 wandered including entering into other resident's rooms. Staff N was asked what interventions Resident 63 had for wandering besides the use of a wanderguard. Staff N stated Resident 63 had a peer they were to avoid because of a previous resident-to-resident altercation, I guess, we just try to pay attention where [Resident 63] is at and staff on the South units halls attempted to redirect wandering residents. <Resident 62> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/14/2025 quarterly assessment, Resident 62 had diagnoses including anxiety and depression. Review of the facility 08/23/2024 facility incident investigation documented Resident 62 alleged being hit in the head by the nurse around midnight when they requested pain medications. Resident 62's care plan was updated to included two staff for all interactions including medication administration and conversations. Review of general information care plan documented Resident 62's care plan was updated on 09/04/2024 requiring two staff for all interactions. During an observation on 03/03/2025 at 1:14 PM, Staff J, Nursing Assistant, entered Resident 62's room alone to answer their call light. At 1:15 PM, Staff J informed the surveyor Resident 62 wanted to speak with them and the surveyor entered the room. Resident 62 stated they do not send two staff in here all the time. During an observation on 03/04/2025 at 10:59 AM, Staff J, again entered Resident 62's room alone to answer their call light. Staff J exited Resident 62's room at 11:01 AM. At 11:03 AM, Staff J returned to Resident 62's room with crackers as requested. At 11:06 AM, Staff J exited the room and informed Staff H, Registered Nurse (RN), Resident 62 was ready to take their pills. At 11:07 AM, Staff H entered Resident 62's room, alone, to administer medications. In an interview on 03/04/2025 at 11:16 AM, Staff J, stated Resident 62 had behaviors, yelled, cursed and was mean to staff. Staff J further stated Resident 62 was two person assist when care was provided but did not require two staff to answer the call light. Staff J reviewed Resident 62's record. Staff J acknowledged Resident 62 required two staff for all interactions and stated that would be hard to do. <Resident 89> According to the 01/30/2025 significant change in status assessment, Resident 89 had severe cognitive impairment. The assessment further documented Resident 89 had exhibited worsening wandering that significantly interfered with participation in activities and disrupted the living environment. Resident 89 was able to ambulate independently with staff supervision and exhibited verbal behaviors directed towards others. Review of the 08/14/2024 cognitive impairment care plan instructed staff to administer medications as ordered, cue, orient, and supervise as needed. Review of the 08/26/2024 behavior care plan showed Resident 89 wandered the halls, entered peer's rooms, and believed they were an employee. Behavioral interventions instructed staff to remind Resident 89 where they were, ensure their care needs were met, reduce stimulation in the environment, and redirect as needed. The 09/04/2024 elopement care plan showed Resident 89 exhibited exit seeking behaviors and wandered aimlessly with interventions to administer medications as ordered, allow for wandering in safe areas within the facility, approach in a calm manner, provide redirection as needed, check placement and function of the wanderguard system. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the August 2024 through January 2025 facility incident log documented Resident 89 eloped from the facility on 08/29/2024 and sustained falls on 10/15/2024, 10/24/2024, 12/09/2024, 12/28/2024, 01/11/2024, 01/26/2024, and 01/28/2024. During observation on 03/04/2025 at 4:08 AM, the secured South unit was entered, the double doors leading onto the South unit (400, 500, and 600 halls) were closed. Upon opening the doors, a strong pungent urine odor was smelled, and Resident 89 was observed sitting in the common area, shirtless. <Resident 91> According to the 02/24/2025 quarterly assessment, Resident 91 had severe cognitive impairment. The assessment further documented Resident 91 exhibited wandering that significantly interfered with their care, participation in activities, intruded on the privacy of others, and disrupted the living environment. Resident 91 was able to ambulate independently with staff supervision and exhibited verbal behaviors directed towards others. Review of the 09/24/2024 mobility care plan showed Resident 91 required distant supervision for transfers and used both a walker and wheelchair for mobility. The 10/08/2024 behavioral care plan showed Resident 91 often ambulated independently without an assistive device, followed staff as they performed their duties, entered peer's rooms, disrobed in public and wandered down other halls on the unit. Behavioral interventions instructed staff to distract Resident 91 with conversation of their favorite movies, remind resident sitting is safer, make family phone calls, offer television, and avoid overstimulation. The 12/16/2024 elopement care plan documented Resident 91 wandered related to cognitive impairment and instructed staff to allow for wandering in safe areas within the facility, approach in a calm manner, provide redirection as needed, check placement and function of the wanderguard system. Review of September 2024 through January 2025 facility incident log showed Resident 91 sustained falls on 9/25/2024, 9/27/2024, 10/13/2024, 10/29/2024, 12/06/2024, 12/24/2025, 12/25/2024, and 01/02/2025. Review of October 2024 through February 2025 nursing progress notes documented Resident 91 often ambulated independently on the unit, wandered into peer's rooms, rummaged through peer's belongings, was verbally and physically aggressive towards staff, took and wore peer's items and clothes. During observation on 03/04/2025 at 4:32 AM, Resident 91 stood in the doorway to their room, wandered down the hall, looked inside the ice chest, and stumbled to the common area on the South unit between 400, 500, and 600 halls. At 4:36 AM, Resident 91 wandered toward the nursing station and placed their hand in a bag with unknown contents. <Resident 42> According to the 12/12/2024 annual assessment, Resident 42 had diagnoses including muscle weakness and pain. Resident 42 was cognitively intact and able to clearly verbalize their needs. Review of a 10/15/2024 grievance form documented multiple residents had concerns about excessively long call light wait times and/or not having a call light within reach. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/24/2025 at 10:26 AM, Resident 42 stated the night prior (02/23/2025), they waited for an hour and 15 minutes for their call light to be answered. Resident 42 explained they had a clock in their room, turned their call light on at 9:45 PM to be changed after an incontinence episode but staff did not enter their room until 11:00 PM. Resident 42 further stated this had also occurred four other times. During observation on 02/27/2025 at 9:25 AM, the bathroom call light for room [ROOM NUMBER] came on. Staff answered the bathroom call light at 9:46 AM, 21 minutes later. During observation on 02/27/2025 at 9:28 AM, the call light for room [ROOM NUMBER] came on. Staff answered the call light at 9:54 AM, 26 minutes later. During observation on 02/27/2025 at 2:42 PM, the call light for room [ROOM NUMBER] came on while staff were observed at the nurse's station. At 2:47 PM, the resident in room [ROOM NUMBER] yelled out for assistance to get staff's attention. Staff then approached and the resident stated they needed oxygen. In an interview on 03/04/2025 at 4:19 AM, Staff KK, Nursing Assistant (NA), stated the facility did not have enough staff on night shift. Staff KK explained the South unit of the facility had a lot of residents that wandered, tried to elope, and exhibited behaviors. Staff KK further stated staff were unable to take lunch breaks most nights and had a hard time completing extra duties such as cleaning wheelchairs because they were too busy trying to manage resident care. Staff KK stated staffing an extra person on night shift would be very beneficial. In an interview on 03/04/2025 at 4:25 AM, Staff LL, Registered Nurse, stated the facility did not have enough staff. Staff LL explained the South unit had lots of behaviors, residents that wandered, and it was hard for the aides to keep up and get everything done. Staff LL further stated the South unit used to staff two nurses on night shift and it was rough with only one nurse. In a confidential interview on 03/04/2025 at 4:31 AM, Confidential Staff 1, stated the facility did not staff sufficient staff. Confidential Staff 1 explained the South unit had quite a few behaviors including residents that did not sleep, wandered, were aggressive, and high fall risks. Confidential Staff 1 further stated they were unable to check and change residents timely because of managing residents with behaviors and having an extra staff member would be helpful. In an interview on 03/04/2025 at 4:46 AM, Staff NN, Staffing Coordinator, stated they did not work night shift that night but was called in around 4:00 AM (the survey team entered the facility at 4:00 AM) to provide support. Staff NN stated the night shift on the South unit was typically staffed with only one nurse and one nursing assistant per each hall (400, 500, and 600). Staff NN further stated the South unit had gotten into a good routine and did not require more staff. Review of the 02/25/2025 secured South unit resident census showed the 400-hall had 22 residents, 500-hall had 18 residents, and 600-hall had 21 residents. 61 residents:1 night shift nurse and approximately 20 residents:1 NA. The secured South unit housed majority of the facility's cognitively impaired and behavioral residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/04/2025 at 4:59 AM, Staff K, Nursing Assistant, stated they worked day shift, which started at 6:00 AM, but often came in early at 5:00 AM to help clean, organize the unit, and prepare for the day. During a follow-up interview and record review on 03/06/2025 at 9:12 AM, Staff NN, stated the North unit was the more acute (intense) unit because that was where most of the new admissions were, and the South unit was more long-term care. Staff NN explained they used a spread sheet to determine staffing levels for day and evening shift. Night shift was always staffed with six nursing assistants, one per hall, two nurses on the North unit but only one nurse on the South unit. Review of the spread sheet provided documented three columns 1) resident census, 2) total day shift NAs, and 3) total evening shift NAs. Staff NN stated depending on the number of residents the next column showed how many NAs were needed. Staff NN further stated they had not heard night shift needed more staff to help manage residents that wandering and/or had behaviors. Staff NN stated Staff L, Maintenance Director, was responsible for staffing the laundry department, Staff NN only staffed laundry with nursing staff if they had a person with light duty restrictions. LAUNDRY STAFFING During an interview on 02/24/2025 at 3:03 PM, Resident 50 stated they had not sent their personal clothing to the laundry anymore, because it was not getting done. They further reported some laundry staff had quit and the facility was using maintenance staff now in that department. During an interview on 03/03/2025 at 12:56 PM, Resident 68 stated they requested to talk to the surveyor because some of their clothing (pants, shirts, underwear and socks) had not been returned from the laundry for about three weeks. During an interview on 03/03/2025 at 12: 59 PM, Staff W, NA, stated that resident laundry had been an issue for about three weeks and management was in the process of addressing it. Staff W further stated the priority was getting the linens and towels washed. Resident laundry was only delivered on Sunday or Monday and had not arrived yet. Additionally, if a resident was out of clothing, the aides had to go and dig through the bins, which were so high it was time-consuming to sort through them. The interview with Staff W was interrupted when Resident 33 was observed in their doorway, wearing only their footwear. Another staff went to the laundry to get some clothes for Resident 33, as they didn't have any in their room. During a tour of the laundry area on 03/05/2025 at 12:31 PM with Staff X, Laundry Aide/NA, a large rectangular rolling bin was observed in the soiled laundry area. This bin was approximately four feet wide, three feet deep and waist high. The bin was overflowing with resident clothing. During a concurrent interview, Staff X stated that they usually had 3 staff daily and just got approval to hire a fourth person for the laundry. Washing facility linens was currently prioritized over resident laundry, and nursing assistants brought the dirty linen from the resident care areas to the laundry, rather than having the laundry staff pick it up. Staff X further stated that if they had a sick call or not enough staff, a nursing assistant was pulled from resident care to help. Per Staff X, when fully staffed and resident clothing came into the laundry, it took 24 hours until it was returned to the resident. When asked how long it was currently taking to get resident clothing back to them, Staff X stated, honestly, about a week. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/2025 at 10:21 AM, Staff B, Director of Nursing, stated Staff A, Administrator, and Staff NN determined staffing levels based on census. Staff B explained night shift was staffed with two nurses on the North unit, one nurse on the South unit with one NA per each of the six halls. Staff B stated they had not heard residents and/or staff voice staffing concerns. In an interview on 03/06/2025 at 10:34 AM, Staff A, stated they expected sufficient staff to provide care to the facility residents and staffed the facility above the Washington State minimum requirements. Reference WAC 388-97-1080 (1), 1090 (1) Refer to F600, F656, F726, and WAC 388-97-1080 for additional information.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 47328 Based on interview and record review, the facility failed to develop and implement a system to evaluate staff competencies in skills and techniques to ensure staff provided necessary care and respond to each resident's individualized needs for 10 of 12 sampled staff (Staff I, S, N, BB, HH, JJ, LL, RR, SS, and UU), reviewed for nursing services. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment reviewed January 2025, showed the facility's average daily census was 120. The facility admitted more acutely ill residents with multiple co-morbidities (two or more medical conditions) and was able to provide care for residents who required total parental nutrition (TPN, liquid nutrition provided into the bloodstream), respiratory care, intravenous (IV) medications, and wound care. Staff completed routine competency checks to ensure staff could provide care to the facility population to include infection prevention and control practices. The facility cared for an increased number of residents with drug abuse, cognitive impairment, behaviors and used a wander guard system (system consisting of a bracelet that will alarm when an exit door was approached) on the south side of the building with secured doors leading onto the unit, for wandering residents. The facility utilized a staffing coordinator and staffed the facility based on Washington State's 'Per Patient Day' minimum staffing levels. Agency staff was used as needed to ensure proper staffing patterns if in-house staff was not sufficient to meet resident needs. FACILITY STAFF <Staff N> Review of Staff N's, Nursing Assistant (NA), personnel file showed they were originally hired on 09/06/2016. Review of Staff N's training records showed no training or competency documentation on infection control and prevention. <Staff UU> Review of Staff UU's, NA, personnel file showed they were originally hired on 02/21/2018. Review of Staff UU's training records showed no training or competency documentation on infection control and prevention. <Staff I> Review of Staff I's, NA, personnel file showed they were originally hired on 01/14/2022. Review of Staff I's training records showed no training or competency documentation for infection control and prevention. <Staff BB> (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Staff BB's, NA, personnel file showed they were originally hired on 03/14/2022. Review of Staff BB's training records showed no training or competency documentation on infection control and prevention. <Staff RR> Review of Staff RR's, Licensed Practical Nurse, personnel file showed they were originally hired on 07/31/2023. Review of Staff RR's training records showed no training or competency documentation for administering TPN, IV care and/or management, or infection control and prevention. <Staff LL > Review of Staff LL's, Registered Nurse, personnel file showed they were originally hired on 01/10/2024. Review of Staff LL's training records showed no training or competency documentation for caring for cognitively impaired residents, administering TPN or IV care and/or management. <Staff S> Review of Staff S's, NA, personnel file showed they were hired on 01/17/2025. Review of Staff S's training records showed no training documentation for dementia care or infection control and prevention. AGENCY STAFF <Staff SS> Review of Staff SS's, NA, personnel file showed they were an agency staff. Review of the minimal training records provided showed Staff SS received dementia care training on 06/18/2024, and no other training or competency documentation was provided. <Staff JJ> Review of Staff JJ's, NA, personnel file showed they were an agency staff. Review of the minimal training records provided showed Staff JJ received dementia care training 12/09/2022, not yearly as required. Staff JJ reviewed and signed an infection control policy on 07/30/2024 that included information on transmission-based precautions (TBP) and hand hygiene, but no documentation of skills competency was included. <Staff HH> Review of Staff HH's, NA, personnel file showed they were an agency staff. Review of the minimal training records provided showed Staff HH had no dementia care training on file. Staff HH reviewed and signed an infection control policy on 07/04/2024 that included information on TBP and hand hygiene, but no documentation of skills competency was included. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/05/2025 at 2:42 PM, Staff AA, Human Resources, acknowledged the facility had no process in place to train or orient agency staff. Staff AA further stated the facility was working on developing a process to train all staff. Staff AA acknowledged Staff SS only had dementia care training in their file. In a follow-up interview on 03/06/2025 at 8:52 AM, Staff AA acknowledged Staff S did not have dementia care or infection prevention and control training in their file. During an interview and record review on 03/06/2025 at 9:12 AM, Staff NN, Staffing Coordinator, stated the facility used both agency nurses and nursing assistants as needed. Staff NN explained they had a paper packet that agency nurses reviewed, signed, and returned the cover page prior to working but there was no packet for agency nursing assistants to review, sign, or return. Review of the packet provided showed it contained information on how to access the electronic medical record, fall documentation, what to do when medication was unavailable, steps for transferring and/or discharging a resident, mealtimes, emergency processes, and tips on resident rights, behavior management, and reporting allegations of abuse and/or neglect. Staff NN further stated the facility had no process in place to verify agency staff skills and/or competencies. In an interview on 03/06/2025 at 10:00 AM, Staff C, Staff Development, stated they took over the staff development role October 2024 and was still in the process of developing a process to verify staff skills and/or competencies. In an interview on 03/06/2025 at 10:21 AM, Staff B, Director of Nursing, stated the facility ensured staff had the skills and/or competencies through Staff C. In an interview on 03/06/2025 at 10:34 AM, Staff A, Administrator, stated they expected staff to have the appropriate skills and/or competencies to provide care to the facility residents. Refer to WAC 388-97-1080 (1), 1090 (1) Refer to F600, F607, F694, F695, and F880 for additional information.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47328 Based on interview and record review, the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 4 of 6 sampled staff (Staff I, BB, N, and UU), reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, and diminished quality of life. Findings included . <Staff N> Review of Staff N's, Nursing Assistant (NA), personnel file showed they were originally hired on 09/06/2016. No documentation of a performance evaluation was found. <Staff UU> Review of Staff UU's, NA, personnel file showed they were originally hired on 02/21/2018. No documentation of a performance evaluation was found. <Staff I> Review of Staff I's, NA, personnel file showed they were originally hired on 01/14/2022. No documentation of a performance evaluation was found. <Staff BB> Review of Staff BB's, NA, personnel file showed they were originally hired on 03/14/2022. No documentation of a performance evaluation was found. In an interview on 03/05/2025 at 2:42 PM, Staff AA, Human Resources, acknowledged Staff I, N, BB, and UU did not have a yearly performance evaluation on file, as required. In an interview on 03/06/2025 at 10:21 AM, Staff B, Director of Nursing, stated evaluations were completed yearly but when the recent facility change of ownership occurred, there was a gap in paperwork. Staff B acknowledged some staff did not have yearly performance evaluations on file, as required. In an interview on 03/06/2025 at 10:34 AM, Staff A, Administrator, stated they expected performance evaluations to be completed yearly, as required. Reference WAC 388-97-1680 (1), (2)(a-c) Refer to F600, F607, and F726 for additional information.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42802 Based on observations, interview and record review, the facility failed to ensure that controlled medications were tracked, and controlled medications for discharged residents were discarded, in 1 of 2 medication rooms (North Hall) inspected. This failure placed the facility at risk for drug diversion. Findings included . On [DATE] at 8:40 AM, the North Hall medication room was inspected with Staff F, Licensed Practical Nurse/ Resident Care Manager (LPN/RCM.) In the locked narcotic box in the refrigerator, the following medications were found for two residents: Resident 999 1) an unopened, full sealed bottle of liquid Morphine (a narcotic pain medication) that was filled on [DATE]. 2) an unopened, full sealed bottle of liquid Lorazepam (a controlled anti-anxiety medication) that was filled on [DATE]. 3) a medication card contained 10 Dronabinol 5 milligram (mg) capsules (used to treat nausea and stimulate appetite) was filled on [DATE] and had expired on [DATE]. Resident 998 4) an unopened, full sealed bottle of liquid Lorazepam that was filled on [DATE]. During a concurrent interview, Staff F stated that all medications that were locked in the narcotic box, had a page number (written on the medication) that corresponded to the page number in the narcotic book and was counted every shift. The bottles of Lorazepam and Morphine did not have a page numbers on them, and the Dronabinol had page number 140 on the card. Additionally, Staff F stated all 4 of the medications definitely should have been counted every shift. Per Staff F, the bottles of Morphine and Lorazepam likely were not entered into the narcotic book, and they thought that Resident 999 and 998 were discharged a while back. A review of Resident 999's medical record showed that the resident had discharged on [DATE] (almost five months ago) and had been on the 300 Hall. A review of Resident 998's medical record showed the resident had discharged on [DATE] (over seven months ago) and had been on the 100 Hall. During an interview on [DATE] at 11:29 AM, Staff P, LPN stated there were currently no narcotics on the 100 Hall that were in the refrigerator. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the 100 Hall Narcotic books (#3 and #4,) dated back to [DATE], showed no entry for the liquid Lorazepam bottle for Resident 998. A review of the 300 Hall Narcotic book #29, dated back to [DATE], showed no entries for the liquid Lorazepam bottle, liquid Morphine bottle or the Dronabinol 5mg capsules for Resident 999. Page 140 was blank (page number on the Dronabinol capsules) The prior 300 Hall Narcotic books were not found on the 300 Hall. During an interview on [DATE] at 9:41 AM, Staff H, Registered Nurse (RN) stated that the facility nurse that received the medication from the pharmacy was responsible for putting it in the refrigerator and entering the medication into the appropriate hall narcotic book. During an interview on [DATE] at 10:15 AM, Staff QQ, LPN stated that the facility nurse was supposed to put the narcotics in the log book when delivered, and if for some reason a refrigerated narcotic was not in the log book, the mistake probably wouldn't be caught. During an interview on [DATE] at 2:46 PM, Staff B, Director of Nursing verified that the facility staff who received the medication from the pharmacy would put the medication in the locked box in the refrigerator, with the page number of the narcotic book written on the medication. Staff B was informed of the medications found in the North Hall narcotic box for Resident 999 and 998. When asked what was done with medications once a resident was discharged , Staff B stated that they would go through the resident's medications and waste or send them back to the pharmacy. Staff B admitted that they had not been checking the narcotic box in the medication refrigerator for discharged resident medications, especially if they weren't in the medication book. Staff B acknowledged that if they were not tracked in the narcotic books, there was a risk of drug diversion and the facility staff would not even know it. Reference: WAC [DATE](1)(b)(ii), (2)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46033 Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the provider's order for 2 of 7 sampled residents (Residents 95 and 102) reviewed for medication administration. Specifically, multiple doses of a medication that treated Resident 95's lupus (the body's immune system attacks it's own healthy tissues causing pain and swelling) were omitted. Additionally, medication to control Resident 102's heart rate was not held when hold parameters were met. This failure placed the residents at risk for unintended health consequences from omitted doses, and medication side effects when medications were not held as ordered. Findings included . <Resident 95> A review of the 02/14/2025 quarterly assessment documented Resident 95 had diagnoses that included lupus and drug-induced suppression of the immune system. Resident 95 was cognitively intact and frequently had pain that interfered with therapy and day-to-day activities. The 11/19/2024 care plan documented Resident 95 was at risk for pain and discomfort. Staff were instructed to administer medications as ordered, monitor for medication side effect and notify the provider if observed, position for comfort, and assess for the presence of pain every shift. A review of the January 2025 and February 2025 medication administration records (MARs) documented Resident 95 was to receive Cellcept, (a medication to treat lupus that reduced overactive immune system activity) daily at bedtime. Further review of the MARs documented Resident 95 did not receive Cellcept on 01/31/2025, 02/01/2025, 02/02/2025, 02/08/2025, 02/09/2025, 02/10/2025, 02/16/2025, 02/17/2025, and 02/18/2025 . A code 9 was entered on the MAR on those dates. The key on the MAR defined the code 9 as Other/see Nurses Notes. Corresponding progress notes documented the medication was not available, was ordered from the pharmacy, had not been delivered and was unavailable in the Cubex (a medication storage unit that held extra doses of commonly ordered medications). On 02/25/2025 at 2:06 PM, Resident 95 was seated in their wheelchair at the dining table in the common area of the nursing unit. Resident 95 stated they had pain and took medication for lupus. Resident 95 stated that several times during their stay, the facility had run out of the medication and it caused them to have more pain. They stated the longest they went without it was four days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/2025 at 11:33 AM, Staff F, Resident Care Manager, stated for specialty medications like Resident 95's Cellcept, they received an order from the provider and the order is sent to the pharmacy. Staff F stated after review, the medication might need a prior authorization before the pharmacy will dispense it. A form is filled and sent back to the pharmacy and, if all is complete, the medication is sent to the facility. Staff F reviewed the February 2025 MARs and progress notes and agreed there had been omissions of the medication. They stated they expected to see more documentation that the nurses contacted the pharmacy or notified the provider if the medication was unavailable so adjustments to the medication could be made, or other arrangements to obtain the medication could be made. Staff F stated if Resident 95 missed doses of Cellcept, it could cause a flare-up of their lupus and that could cause the resident increased pain, inflammation, fatigue, or many other concerns. <Resident 102> A review of the 01/20/2025 admission assessment documented Resident 102 had diagnoses that included rapid atrial fibrillation (AFIB, a rapid irregular heartbeat) and stroke. Resident 102 was able to make decisions regarding their care and required substantial assistance of staff for activities of daily living. A review of the 01/14/2025 hospital discharge summary documented Resident 102 was found down at their home for an undetermined amount of time and was taken to the hospital. The resident was diagnosed with a stroke and AFIB. The AFIB was initially treated with medication named Cardizem to control the fast heartbeat and was eventually switched to amiodarone. The amiodarone provided good rate control. Eventually the resident was discharged to the facility. On 01/15/2025, an order was received to give Resident 102 amiodarone once a day. The order instructed staff to take the resident's pulse and blood pressure before administration. The medication was to be held if the heart rate was less than 60 beats per minute, or if the systolic blood pressure (SBP, the top number of a blood pressure reading) was less than 110, and the provider was to be notified. A review of the February 2025 MAR showed Resident 102's SBP reading was below 110 but the amiodarone was still given on 02/17/2025, 02/18/2025, 02/20/2025, 02/21/2025, 02/24/2025 and 02/25/2025. During an interview on 03/05/2025 at 9:25 AM, Staff P, Licensed Practical Nurse, reviewed the MAR and stated they had just begun their employment at the facility on the dates mentioned and did not realize the amiodarone was to be held if the SBP was below 110. Staff P stated they had not discussed the low readings with the provider and if a resident had low blood pressure, they would want to make sure the resident was not having any symptoms. Staff P stated they should have held the amiodarone. They stated there were frequent interruptions that prevented them from concentrating when giving medications. During an interview on 03/05/2025 at 10:41 AM, Staff F stated when there are parameters ordered for a medication, the medication needed to be held, and the provider was to be notified. This allowed the provider to change the dose if necessary. If the medication was given, staff needed to monitor the resident to make sure their blood pressure or heart rate did not get even lower. Reference: WAC 388-97-1060(3)(k)(iii).

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 50027 Based on observation, interview, and record review, the facility failed to ensure dietary staff had the required qualifications (current Washington State Food Worker Cards) for 1 of 14 dietary staff (Staff Z), whose records were reviewed. This failed practice had the potential risk for unsafe food handling practices and placed residents at risk for developing foodborne illness. Findings included . On 02/28/2025, a copy of dietary staff's current Washington State Food Worker cards were requested. Review of dietary cards on 02/28/2025 at 3:25 PM showed no documentation Staff Z, Dietary Manager/Registered Dietician, had a Food Workers Card, as required. Staff Z acknowledged they did not have a Washington State Food Worker card. In a follow-up interview on 03/06/2025 at 10:53 AM, Staff Z confirmed they were required to obtain the Washington State Food Worker card. Staff Z further stated it was important because it showed proof of competency and knowledge of dietary operations. Reference WAC 388-97-1160. .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027 Based on observation, interview, and record review, the facility failed to provide appetizing and palatable food for 5 of 14 sampled residents (Residents 35, 46, 211, 20, and 17) reviewed for food. This failure placed the residents at risk for decreased nutritional intake, potential weight loss, and a diminished quality of life. Findings included . In a Resident Council (group of facility residents that regularly met to discuss care at the facility) Meeting on [DATE] at 10:37 AM, the Council stated the food was only good maybe two days a week. The Council explained the vegetables were overcooked, the menu lacked variety, and the weekend food was the worst. <Resident 35> The [DATE] comprehensive assessment documented Resident 35 had diagnoses which included diabetes and depression. Resident 35 was cognitively intact to make decisions regarding their care. In an observation and interview on [DATE] at 3:16 PM, Resident 35 was lying in bed and watching television. Resident 35 stated the quality and taste of the food had diminished over the past year. Resident 35 explained the meat (i.e., chicken, hamburger patties) was extremely overcooked and so tough they could not chew it, the vegetables were mushy, and desserts were even worse because there was often cake without icing. In an observation on [DATE] at 1:02 PM, Resident 35 was sitting up in their bed with their lunch tray on the table in front of them. The meal served was beef stroganoff with noodles, peas, a roll, cake and 1 cup of milk. The beef stroganoff looked like chunky gravy with barely any meat, all the peas were welted like raisins, and the cake looked dry with a thin layer of icing. Resident 35 only ate the noodles, half of the roll, cake, and drank half of their milk. In an observation and interview on [DATE] at 10:15 AM, Resident 35 was lying in bed making jewelry. Resident 35 stated last night's dinner was the worst meal they had been served. Resident 35 explained the chicken was so dry they could not swallow it, the vegetables were cooked to oblivion, the rice was undercooked, and the dessert was a version of a smashed flat chocolate peanut butter candy bar. Resident 35 stated that the meal was inedible and instead ate their left-over vegetable tray ordered from the local grocery store. 46033 <Resident 211> The [DATE] significant change assessment documented Resident 211 had diagnoses that included protein calorie malnutrition. Resident 211 was cognitively intact and required set-up assistance from staff to eat. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:10 PM, Resident 211 stated food was tough, overcooked and the hot food was not hot. On [DATE] at 2:56 PM, Resident 211 stated their lunch that day was not good. They stated the cheese ravioli had been cooked for so long that the sauce soaked completely into the pasta. They stated they picked off the pasta and were going to eat only the cheese insides, but that was rubbery and had no taste. They stated the pumpkin pie had a dark layer on top, beneath that was mushy and the pie had an off-putting smell. 46115 <Resident 20> The [DATE] quarterly assessment documented Resident 20 had diagnoses which included heart failure and diabetes. Resident 20 was cognitively intact and was independent with eating. During an interview on [DATE] at 10:31 AM, Resident 20 stated the food was terrible, overcooked and was served cold. On [DATE] at 12:27 PM, Resident 20 stated the chicken that was served was not good and they did not like it. In an interview on [DATE] at 12:27 PM, Resident 20 stated they did not like the beef stroganoff that was served so they requested an egg salad sandwich and said it was better than nothing. <Resident 71> The [DATE] quarterly assessment documented Resident 71 had diagnoses which included heart failure and diabetes. Resident 71 was cognitively intact and needed set up assistance for eating. In an interview on [DATE] at 2:43 PM, Resident 71 stated the food was not good, was not always served hot, the biscuits were hard, the food was flavorless, and the meat was tough and dry. During an interview on [DATE] at 12:30 PM, Resident 71 stated they were served tamales for dinner last night and it looked awful, and the beans were terrible. Resident 71 stated they had ordered food and ate that for dinner. 47328 <Resident 46> According to the [DATE] quarterly assessment, Resident 46 had diagnoses including malnutrition. The assessment further showed Resident 46 received a therapeutic diet, was cognitively intact and able to clearly verbalize their needs. In an interview on [DATE] at 2:19 PM, Resident 46 stated the food was terrible. Resident 46 explained there was an alternate menu, but they did not like that food either. <Test Tray> (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:23 PM, a test tray of the lunch meal directly from the kitchen steam table was sampled by the survey team. The entree meal consisted of a lemon fish (cod) almondine, red bliss potatoes, candied carrots, and fruit parfait. The temperature of the food was lukewarm, and the appearance of the main entree was unappetizing with dull colors. The fish and potatoes tasted bland; the fish had no lemon or almond flavoring and the potatoes taste like plain salt free boiled potatoes, the textures were firm. The carrots were watery, mushy with minimal carrot flavor and not candied . An egg salad and bacon, lettuce, and tomato (BLT) sandwiches were also ordered from the alternate menu. The egg salad sandwich tasted like hard boiled eggs with no seasoning. The fruit parfait was diced soft peaches with cinnamon and tasted mediocre. The BLT sandwich was the only food item that was appetizing and tasted flavorful. In an interview on [DATE] at 3:31 PM, Staff Z, Dietary Manager, stated the cooks tasted the food during the cooking process. Staff Z further stated they themselves also tasted the food to check for proper seasonings to ensure the meal was palatable and tasty. Staff Z adjusted ingredients as needed and consumed each meal served while they were present. Staff Z stated sampling the food was important for resident satisfaction. In a follow-up interview on [DATE] at 10:52 AM, Staff Z stated they had also eaten the entree meal served for lunch on [DATE]. Staff Z acknowledged the lemon fish almondine had no lemon flavor and had to add seasoning to their meal. Reference WAC [DATE] (1), (2).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50027 Based on observation, interview, and record review the facility failed to store, discard and distribute food, monitored temperatures of foods being served, ensure accuracy of preparation of thickened liquids, and maintain a cleaning schedule in accordance with professional standards for food safety for 1 of 1 facility kitchens, reviewed. This failure placed residents at risk for food borne illness and diminished quality of life. Findings included . Review of the U.S. Food and Drug Administration (FDA) Food Code 2022 revised [DATE], showed that food must be labeled with the date the food was prepared, the package opened, and the date the food must be discarded as directed by the food manufacturer's use-by-date. During a kitchen observation and interview on [DATE] at 09:02 AM, the reach-in refrigerator contained an unlabeled tossed salad covered with plastic wrap. Staff Z, Dietary Manager, acknowledged the salad should have been labeled with a date and quickly disposed of it. Staff Z stated that it was important for food to be discarded at the appropriate time to reduce potential for bacterial growth. During a kitchen observation and interview on [DATE] at 09:15 AM in the dry storage room, there were four opened bags of cereal with expired dates: Cornflakes expired on [DATE], Cheerios expired on [DATE], Raisin Bran expired on [DATE], and [NAME] Krispies expired on [DATE]. Further observation showed there was a 22-quart container of rice measured at 5 liters labeled with a use-by-date of [DATE]. During a kitchen observation on [DATE] at 09:22 AM, the walk-in refrigerator contained the following items opened and unlabeled with a date: precooked sausage patties (120 count), packages of sliced turkey meat, half a jar of dill pickles (,d+[DATE] count) size, 1 gallon of lemon juice with heavy sediment, 1 gallon of mayonnaise, 1 gallon of creamy Cesar salad dressing, 1 gallon of salsa. During a kitchen observation on [DATE] at 10:22 AM, the walk-in freezer contained the following items unlabeled with a date: frozen bunch of bananas blackened in a carboard box, 1 cup of bacon bits wrapped in plastic, 14 lemon cookies in a plastic bag, and a medium sized box of scones wrapped in an opened plastic bag. In an observation and interview on [DATE] at 09:45 AM, the north nourishment refrigerator was greatly overcrowded with resident commercial food and drink items. The refrigerator had the following resident food items opened and unlabeled with a date: overripen cut-up fruit in container, 3-inch block of cheese and a beef summer sausage in a plastic baggie, half of an egg salad sandwich in a baggie, two seafood salads in a bowl, dried up sliced raw vegetables in a container, medium sized bottle of V8 juice. Staff Z stated items in the refrigerator are rarely managed and the kitchen staff often inquired about unlabeled food. Staff Z stated the perishable food items should have been labeled with a date when opened and should have been discarded within 7 days due to bacterial contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further inspection of the north nourishment refrigerator found 20 facility assembled cups of applesauce with lids unlabeled. Staff Z stated the facility used the FIFO method (first in and first out) to track when the applesauce was used. <Food Preparation and Service> Review of the facility policy titled, Food Temperatures, dated [DATE] (reviewed February 2019), showed the dietary department would check food temperatures on all items prepared by the dietary department, hot foods should be held at 135 degrees Fahrenheit (F), and potentially hazardous cold food kept at or below 41 degrees F. The policy instructed staff to measure and record food temperatures on a temperature log every meal. The Serving temperatures will be recorded by the cook or other designated personnel for all items served prior to serving on a temperature log. Review of the U.S. Food and Drug Administration (FDA) Food Code 2022 revised [DATE], showed that there is an increased risk of contamination when food is held, cooled and reheated at improper temperatures. Thus, temperatures of food must be taken and monitored. Records must be maintained to verify food temperatures are within the parameters required for food safety. During an observation of a tray line service held in the kitchen on [DATE] at 11:25 AM, the fruit cups being served for lunch were setting on resident trays stacked on the meal cart. At 11:48 AM, Staff ZZ, Dietary Cook, began to prep food items, such as chopped hamburger, fixings and place them in the steam table pans where the other entree items were already placed. At 11:53 AM, the dietary staff began coordinate and serve the lunch meal (lemon almondine fish, red bliss potatoes, steamed carrots, butter roll, fruit parfait, hamburger with fixings, BLT sandwich). Staff ZZ began to serve from the steam table. Staff ZZ placed the hamburger and fixings on a plate and began to add other food items to it. No staff checked the food temperatures of the food resting in the steam table. This surveyor prompted Staff ZZ to check the temperatures of all food items at the steam table. Staff ZZ stated they took the temperatures right before this surveyor entered the kitchen approximately 30 minutes ago. They replied with an undetermined explanation of their policy on checking food temperatures during tray line. At 11:56 AM, this surveyor informed Staff ZZ they needed to check the temperatures during the inspection visit and proceeded to check the temperatures. At 12:00 PM, the fruit parfait had a temperature of 46 F. Staff Z instructed the dietary staff to remove the fruit parfait from the meal cart and they placed them in the refrigerator. Staff Z stated the cold food temperature needed to be below 40 F due to prevention of bacterial growth. In an observation at 12:06 PM, staff ZZ still had not checked the temperature of the regular and chopped hamburger, and fixings (lettuce, tomato, cheese). In an observation and interview on [DATE] at 12:22 PM, Staff Z instructed the dietary staff to obtain the fruit parfait from the refridgerator. The staff began to add the fruit parfait to the meal trays. Staff ZZ stated the fruit parfait was below 70 F, but safe for consumption. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Park Care Center	14820 East Fourth Spokane, WA 99216

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 12:39 PM, Staff Z stated the kitchen staff documented temperatures on a log daily. They stated holding temperatures were referenced to food items being held on the steam table. They stated that it was important to check food temperatures for prevention of bacteria, foodborne illness and ensure food palatability. Review of the kitchen temperature logs from [DATE] through [DATE] had missing final cooking and holding temperatures for the following dates: [DATE] to [DATE] and [DATE]-[DATE]. The log did not include temperature checks before tray line or mid service. <Thickened Liquids> Review of the facility policy titled, Thickened Liquids, dated [DATE], showed thickened liquids that not pre-thickened are prepared by the dietary department and thickened according to the mixing chart and provided for the requested meal or to nursing for hydration or medication pass, including oral liquids supplements. In an observation and interview during kitchen tray line on [DATE] at 12:10 PM, Staff AAA , Dietary Aide, pumped 3 full strokes of liquid thickener from a dispenser (Simply Thick Thickener) into an 8 ounce (oz) cup of lemonade, swished the cup around, placed a lid on the cup and set it on a tray in the resident meal cart. They stated the correct consistency for thickened liquids were 3 pumps for honey thick and 2 pumps for nectar thick liquids. They stated that if the liquid is too thin, then they added more thickener to thicken the drink. Staff Z stated the kitchen used the International Dysphagia Diet Standardization Initiative (IDDSI) Flow Test to measure the thickness of liquids with a syringe. In an interview on [DATE] at 12:15 PM, Staff Z stated that an 8 oz. cup of liquid required 4 pumped full strokes for honey thick and 3 pumped full strokes for nectar thick. Staff Z was informed of this surveyor's observations of Staff AAA. Staff Z acknowledged the dietary staff needed more education/training. Staff Z stated that this was important to ensure the accuracy of thickened liquids to decrease the risk of aspiration. In an interview on [DATE] at 3:31 PM, Staff Z stated the kitchen did not complete an IDDSI Flow Test every time thickened liquids were prepared. Staff Z stated they did not conduct training for all dietary staff but intended to do so. <Cleaning Schedule> In a kitchen observation and interview on [DATE] at 10:30 AM, there was no sanitizer bucket in the kitchen. Staff Z stated that the kitchen had a red sanitizer bucket that should have been in the designated area. Staff Z instructed Staff AAA to locate the sanitizer bucket. At 10:39 AM, Staff AAA found the bucket, filled it with cleaning solution and performed an Ecolab strip test (tool used to measure the concentration of various sanitizing and disinfecting solutions) which showed the correct strength. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 10:43 AM, Staff Z stated that they did not have a documented cleaning schedule for staff to follow. They stated they verbally instructed staff to complete cleaning tasks and they themselves inspected the results afterwards. They acknowledged there should have been a cleaning schedule log. They stated this was important to ensure proper sanitization, decrease bacteria and eliminate cross contamination within the kitchen was documented. Review of the latest cleaning schedule, Food Service Task Sheet, showed 3 weeks in the month of [DATE] (, d+[DATE]-,d+[DATE], ,d+[DATE]-,d+[DATE], & ,d+[DATE]-,d+[DATE]). The schedules had tasks that were not completed for the majority of the days. Reference: WAC [DATE](3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46033 Based on observation, interview, and record review, the facility failed to ensure medical records were complete and accurately documented for 1 of 5 sampled residents (Resident 104) whose discharge records reviewed. Specifically, Resident 104 was sent to the local hospital for urgent treatment and the medical record did not include events leading to the resident's decline and need for transfer. This failure created a risk for incomplete sharing of vital information with care givers across levels of care and lack of evidence of care provided. Findings included . A review of the 01/30/2025 five-day assessment documented Resident 104 had diagnoses that included stroke and difficult swallowing. Resident 104 required substantial staff assistance for their activities of daily living and was able to make decisions regarding their care. On 03/03/2025 at 9:07 AM, it was observed that Resident 104 was not present in their room and the nursing unit. When asked, Staff Y, Nursing Assistant, stated they heard Resident 104 had been vomiting blood and was sent to the hospital, but they were unsure. During an interview on 03/03/2025 at 9:10 AM, Staff P, Licensed Practical Nurse, stated the report they received was that Resident 104 had vomited and there was blood in it, so they were sent to the hospital at around 4:30 AM that morning. A review of progress notes documented the resident was last seen by the facility Physician Assistant on 02/28/2025. A 02/28/2025 nursing progress note documented the resident's care plan was updated to show female care givers only. A 03/03/2025 at 11:29 AM progress note documented the hospital had called and notified that Resident 104 was being admitted . The 03/02/2025 eINTERACT facility to hospital transfer form documented Resident 104 was sent to the hospital at 4:50 PM that day. The Reason for Transfer area was blank. There were no entries in the record from 02/28/2025 to 03/03/2025 that described events of the resident's decline, who was notified, any interventions that had been attempted, any provider notification, any orders given to intercede on the resident's behalf and what information had been provided to the hospital regarding the resident's clinical situation. During an interview on 03/05/2025 at 10:54 AM, Staff F, Resident Care Manager, stated they believed Resident 104 left the facility early on 03/03/2025 before 6:00 AM. Staff F stated the resident had nausea and vomiting and there was some blood in it. Staff F reviewed the resident's record and stated they did not see any documentation regarding that. Staff F stated they expected staff to document the events that lead up to the resident's transfer to the hospital, any notifications to the providers, and any other relevant information. Staff F stated, It was important because people would come in and want to know what happened to the resident. Reference: WAC 388-97-1720(2)(a-m).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed during wound care to include removal of gloves and performing hand hygiene (HH) when indicated for 2 of 5 sampled residents (Residents 101 and 105), reviewed for pressure ulcers. Specifically, staff did not implement or follow Enhanced Barrier and Contact Precautions when indicated. Additionally, staff failed to notify the Infection Preventionist (IP) of a potential gastrointestinal (GI) outbreak in 1 of 4 units in the facility. These failures placed the residents at risk for the spread of infections, illnesses and unintended health consequences. Findings included . The Centers for disease Control (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of infectious Agents in Healthcare Settings updated September 2004 retrieved from https://www.cdc.gov/infection-control/hcp/isolation-precautions/index.html documented Standard Precautions were recommended the use of gloves, disposable gowns, masks, or protective eyewear in any setting where there would be exposure to any body fluid. Contact precautions were recommended when the presence of excessive wound drainage, incontinence of stool or other discharges from the body created an increased potential for extensive environmental contamination. Implementation of Contact Precautions included donning a gown and gloves for all patient interactions upon room entry and discarding before exiting the room to help contain pathogens (viruses or bacteria that are highly contagious and cause illness) especially those transmitted through environmental spread including noroviruses and other intestinal pathogens. The CDC Implementation of Personal Protective Equipment (PPE, gloves, disposable gowns, eye protection or masks, for example) Use in Nursing Homes to prevent Spread of Multidrug-resistant Organisms updated July 12, 2002, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html recommended use of Enhanced Barrier Precautions (EBP) as an infection control intervention that employed targeted gown and glove use during high contact resident care activities when Contact Precautions do not apply for residents with wounds or indwelling medical devices such as feeding tubes or catheters. EBP directs staff to don gowns and gloves when dressing, bathing/showering, transferring, changing linens, providing hygiene, wound care and assisting with toileting. <Hand Hygiene> <Resident 101> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of wound care on 02/27/2025 at 9:34 AM, Staff T, Licensed Practical Nurse (LPN), began a dressing change on Resident 101. Staff T donned gown and gloves before entering the resident's room. Resident 101 was assisted to their right side while in bed. Staff T removed two soiled dressings, one from each buttock. Staff T then removed their gloves, did not complete HH, donned new gloves, and cleansed the wounds to the buttocks. After cleansing the wounds, Staff T did not remove gloves and complete HH, proceeded to apply dressings to the wounds, and dated the dressings with a writing instrument taken out of their uniform pocket. Resident 101 then rolled to their back. With the same gloves on, Staff T reapplied the resident's incontinence brief. Staff T then proceeded to physically check Resident 101's gastrostomy tube (G-tube, a tube inserted through the belly that delivered nutrition directly to the stomach) site with the same gloves on, touched the dressing to the G-tube site, tossed the used wound supplies and wrappers, rubbed the resident's left shoulder, then removed the gloves and washed their hands. Staff T then donned a new pair of gloves, cleaned the G-tube site, then removed their gloves. Staff T completed no HH, then donned another pair of gloves, and applied a new dressing to the G-tube site. Staff T removed the glove to the right hand, obtained a piece of tape, put a glove back on the right hand, secured the G-tube site dressing with the piece of tape, and dated the dressing. Staff T completed HH. On 02/27/2025 at 9:58 AM, Staff T stated that HH during a dressing change should occur, before and upon glove switching. Staff T acknowledged the missed opportunities where hand hygiene should have occurred but did not. <No notice of potential outbreak and no implementation of contact precautions > <Resident 74> The 12/18/2024 quarterly assessment documented Resident 74 had diagnoses that included heart failure, high blood pressure, and anxiety. The resident was cognitively intact and made their needs known. During an interview on 03/03/2025 at 8:41 AM, Resident 74 stated they had the flu, in reference to having nausea, vomiting and diarrhea. On 03/03/2025 at 12:55 PM, there was no contact precaution sign on Resident 74's door. At 1:02 PM, Resident 74 was observed in bed and stated they did not feel good. <Resident 20> The 01/10/2025 quarterly assessment documented Resident 20 had diagnoses that included heart failure, high blood pressure and diabetes. The resident was cognitively intact and made their needs known. During an interview on 03/03/2025 at 8:42 AM, Resident 20 stated they were nauseated and had vomited. On 03/03/2025 at 12:56 PM, there was no contact precaution sign on Resident 20's door. In an interview on 03/03/2025 at 1:13 PM, Staff M, Registered Nurse, stated Resident 20 had vomiting and diarrhea on 03/02/2025 and Resident 74 had nausea and diarrhea that morning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/03/2025 at 1:37 PM, Staff M, stated the residents probably needed contact precautions for nausea, vomiting and diarrhea. Staff M stated this was important to prevent the spread of germs to the other residents and themselves. Staff M added they needed to inform the infection preventionist when nausea, vomiting and diarrhea occurred but had not done so. <Enhanced Barrier Precautions Not Followed> <Resident 102> A review of the 01/20/2025 five-day assessment documented Resident 102 had diagnoses that included stroke and paralysis on one side of their body. Resident 102 had a stage 3 (involved all layers of skin loss that extended into the fat layer of tissue) and required substantial assistance from staff for their activities of daily living. On 03/03/2025 at 8:47 AM, the doorway to Resident 102's room was observed to have signage hanging that indicated EBP was to be used when care was provided for Resident 102. Upon entry, staff W, Nursing Assistant (NA), and Staff VV, NA, were observed standing next to resident 102's bed. They were moving a mechanical lift away from the bedside. Resident 102 was observed in bed. When asked if the resident required EBP, Staff W stated if they came in contact whit the resident's legs where there were wounds, they used EBP. Staff W stated they did not use EBP when they transferred the resident to bed or when they toileted the resident because they did not get near the legs. On 03/03/2025 at 11:48 AM, Resident 102's skin condition in their periarea (the groin, buttocks and lower back region) was observed. Staff W and Staff VV donned disposable gowns and gloves prior to entering the resident's room. When asked about the use of gown and gloves during this resident interaction, Staff W stated they planned on dressing Resident 102 in their pants after their skin was observed, so because they would be touching the resident's legs, they had to use EBP. <Resident 105> According to the 02/02/2025 admission assessment, Resident 105 had diagnoses that included malnutrition and muscle weakness. The assessment further showed Resident 105 had an indwelling urinary catheter (flexible tube inserted into the bladder to help drain urine) and required substantial staff assistance for most of their ADLs. Review of the 02/03/2025 bladder care plan showed Resident 105 used an indwelling urinary catheter and instructed staff to provide catheter care routinely and monitor for potential signs and/or symptoms of a bladder infection. The skin care plan implemented on 02/05/2025 showed Resident 105 had a deep tissue injury (DTI, intact or nonintact skin with localized area of persistent unchanging deep red, maroon, purple discoloration) to their buttock and bilateral heels blisters. The care plan did not include instructions for staff to use EBP. During an observation on 02/24/2025 at 10:21 AM, Resident 105's wound care was observed with Staff D, Infection Preventionist and a wound specialist staff. There was no enhanced barrier precaution signage posted outside of Resident 105's room and staff performing wound care did not don a disposable gown prior to providing the wound care. Resident 105 had an indwelling catheter present and a moist wound to their coccyx (tailbone) that was covered with dead tissue and required a dressing to contain drainage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/04/2025 at 9:12 AM, Staff J, Nursing Assistant, explained enhanced barrier precautions was the use of gown and gloves during high contact care activities and were required when a resident had a catheter and/or a wound. Staff J stated staff should follow enhanced barrier precautions. In an interview on 03/05/2025 at 9:26 AM, Staff E, Resident Care Manager, explained enhanced barrier precautions included use of gloves and a gown during high contact care activities. Staff E further stated EBP should be implemented when a resident had a chronic wound such as a pressure injury to protect the resident. In an interview on 03/05/2025 at 11:48 AM, Staff D, Infection Preventionist, acknowledged they did not wear a gown on 02/24/2025 at 10:21 AM when completing Resident 105's wound care, and they should have. <Additional Observations> During an observation on 03/03/2025 at 1:23 PM, Staff GG, Nursing Assistant and Staff HH, Nursing Assistant, were in room [ROOM NUMBER] providing cares for a resident on EBP. Signage on the resident's doorway indicated EBP was to be used. Staff GG and HH were not wearing gowns as instructed. When interviewed at 1:31 PM, Staff HH stated they were not aware the resident was on EBP precautions because they did not see the sign. Staff HH stated they should have worn a gown, and this was important to protect the residents from the spread of germs. On 03/04/2025 at 10:01 AM, Staff II, housekeeper, was observed in Resident 74's room without a gown. At 10:02 AM, Staff II walked out of the room and was asked about contact precautions. Staff II looked at the contact precaution sign and stated they should have worn a gown. Staff II stated it was important to wear a gown to protect the residents and themselves from spreading germs. On 03/04/2025 at 7:51 AM, room [ROOM NUMBER] had a contact precaution sign posted outside the door that instructed staff to perform hand hygiene then put gloves and a gown on prior to entering. Staff JJ, Nursing Assistant (NA), entered room [ROOM NUMBER] without performing hand hygiene or putting gloves or a gown on. Staff JJ exited the room with a meal tray, placed it on the meal cart, then reentered the same room, again without performing hand hygiene, or putting on gloves and/or a gown. During observation and interview on 03/04/2025 at 9:27 AM, room [ROOM NUMBER] had a contact precaution sign posted outside the door that instructed staff to perform hand hygiene then put gloves and a gown on prior to entering. Staff H, Registered Nurse, entered room [ROOM NUMBER] without performing hand hygiene or putting gloves or a gown on. The sign was pointed out to Staff H. Staff H stated staff only had to put PPE on when they provided care, not when entering the room. On 03/04/2025 at 10:51 AM, Staff M was observed in room [ROOM NUMBER] applying a treatment to Resident 20's chest and did not wear a gown. At 10:53 AM, Staff M stated they should have worn a gown, and it was important to do so to prevent the spread of infections. On 03/04/2025 at 11:02 AM, Staff JJ, NA, brought a mechanical lift out of resident 71's room and wheeled it down the hall and parked it. Staff JJ did not clean the machine after using it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/03/2025 at 1:51 PM, Staff D, Infection Prevention, stated they were unaware there were residents on the 400 hall with gastrointestinal issues. Staff D stated it was important to have contact precautions in place to ensure an infectious disease was not spread between residents. During an interview on 03/04/2025 at 11:46 AM, Staff B, Director of Nursing, stated mechanical lifts needed to be cleaned after each use for infection prevention. In an observation on 03/05/2025 at 9:21 AM, Staff M had assisted a resident on EBP and removed their PPE in the doorway. Staff M brought the soiled PPE down the hall and disposed of it in the soiled utility room. During an interview on 03/05/2025 at 9:28 AM, Staff D stated the PPE should have been placed in a bag and then disposed of to prevent exposure of germs. During an interview on 03/05/2025 at 3:42 PM, Staff B, Director of Nursing, stated they expected staff to implement and follow EBP when indicated. Staff B acknowledged Staff D should have worn a gown when providing wound care. During an interview on 03/06/25 at 10:47 AM, Staff D, Infection Prevention, stated staff education regarding the use of EBP occurred when they hung signage on a resident's doorway. It consisted of letting the staff on the unit at the time know the resident required EBP. Staff D stated the signage indicated what PPE was needed to be worn and when. Staff D stated there was no formal monitoring of staff compliance with EBP use. They expected the nurse on the unit to monitor the staff. Staff D stated they were comfortable having the nurses on the units determine when to implement EBP or contact precautions and then notifying them. Staff D stated they had not been notified of any residents on the 400's unit having diarrhea or vomiting and Staff D stated they should have been notified. Staff D stated most of the time, staff asked them when it was ok to take a resident off of isolation precautions. During an interview on 03/06/2025 at 10:52 AM, Staff A, Administrator, stated they expected staff to implement and follow EBP, as required. Reference: WAC 388-97-1320(1)(c)(2)(b) 46033 46115 47328

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46033 Based on observation, interview, and record review, the facility failed to ensure staff were educated regarding the risks and benefits of and provided the COVID (a highly contagious viral illness that caused fever, breathing difficulty and potential hospitalization) vaccine if desired, and failed to ensure minimum documentation was maintained regarding staff COVID vaccination status for 1 of 1 sampled staff (Staff P) reviewed. This failure placed staff and residents at risk of exposure to and illness from COVID-19. Findings included . The Centers for Disease Control and Prevention (CDC) Recommended Adult Immunization Schedule 2025 for ages [AGE] years or older retrieved from www.cdc.gov/acip-recs/hcp/vaccine-specific/ documented adults age 19-[AGE] years, or adults age 65 or older who were unvaccinated for COVID-19, were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of COVID-19 vaccine unless contraindicated. Those previously vaccinated before 2024-2025 were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of 2024-2025 COVID-19 vaccine unless contraindicated. During an interview on 03/04/2025 at 5:45 AM, Staff P, Licensed Practical Nurse, stated they had been employed by the facility for about two weeks. They stated they had been offered a COVID vaccine during orientation, but had not received any education and had not signed any type of consent or declination to receive the vaccine. During an interview on 03/06/2025 at 11:14 AM, Staff D, Infection Prevention Registered Nurse, stated they had started to look back and create a log of the staffs previous COVID vaccinations, but it was not yet completed and they were not the one that offered COVID vaccination to new hires. Staff D stated Human Resources kept vaccination records in employee files. During an interview and observation on 03/06/2025 at 11:37 AM, Staff P's employment file was reviewed with Staff AA, Human Resources. The file contained only a record of Staff P's tuberculosis screening and the results of their respirator mask fit test. Staff AA stated they kept a separate health folder for each employee for any health related documents given to them by Staff D. Staff AA stated they kept a spreadsheet of any documents they were given, but it was not a comprehensive list of what was required to be kept for each staff member. Reference: WAC 388-97-1320(1).