STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505386	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Care Center	1821 Grove Street Marysville, WA 98270

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47047 Based on observation, interview, and record review, the facility failed to maintain a system to ensure resident grievances were identified, logged, and resolved timely for 2 of 3 residents (Residents 1 and 2) reviewed for grievances. Facility failure to ensure missing personal items were found or replaced and resident representative comfort concerns were addressed placed residents at risk for missing property, discomfort and a decreased quality of life. Findings included . Review of the facility policy titled, Grievance Program (Comment and Concern reviewed date of 09/26/2024 showed: -Comment and concern program was utilized to address concerns of residents, family members, visitors and guests. -Any associate (staff) could assist in the completion of the comment and concern form and resolved the concern if possible and report all concerns to the supervisor on duty who will then contact the Administrator and Director of Nursing. <RESIDENT 1> Resident 1 admitted to the facility with diagnoses that included lung cancer, malnutrition, and spinal stenosis (spaces inside the bones of the spine get too small). In an interview on 10/07/2024 at 12:47 PM, Collateral Contact 4 (CC4-Resident 1's representative) stated they had requested an air mattress for Resident 1's back pain and they were told their insurance would not cover the cost. In an interview on 10/10/2024 at 10:42 AM Staff C, Licensed Practical Nurse (LPN), stated Resident 1 was on hospice services and CC4 wanted the same mattress that the roommate had, and they had referred the request to hospice. Staff C stated hospice sent an air mattress overlay, but the resident slid off the air mattress overlay, and it was removed for their safety. Staff C stated hospice was supposed to find something better for Resident 1. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/10/2024 at 10:45 AM Staff I, Resident Care Manager (RCM)-LPN stated they had a care conference the day before with CC4 and Resident 1 and discussed the mattress concern. Staff I directed Staff C, LPN, to contact hospice to check on the status of a mattress for Resident 1. In an interview on 10/10/2024 at 1:22 PM Staff G, Social Services Director stated they did not know anything about a mattress and there was not a discussion about it at the care conference. Staff G stated when Resident 1 initially admitted CC4 wanted them to have an air mattress, but they did not have any skin issues to warrant placing an air mattress. Review of Resident 1's Significant Change Minimum Data Set (MDS-an assessment tool) dated 09/11/2024 showed Resident 1 was at risk for skin breakdown and/or pressure ulcer. Review of Resident 1's progress notes dated 07/30/2024 through 10/09/2024 showed no documentation regarding CC4's preference/request of an air mattress for Resident 1. In an interview on 10/10/2024 at 1:22 PM Staff B, Director of Nursing Services, stated they were not aware that there was an ongoing concern related to Resident 1's mattress. 42927 <RESIDENT 2> Resident 2 admitted to the facility 07/12/2018. During an interview and observation on 10/07/2024 at 12:29 PM, Resident 2 was noted to be wearing upper dentures, but no lower dentures were in place. Resident 2 reported they had not been wearing their lower dentures because they did not fit. During an interview and observation on 10/08/2024 at 4:53 PM, Resident 2 was wearing their upper dentures but was not wearing their lower dentures. Resident 2 stated their lower dentures did not fit and not using their lower dentures was causing them to have difficulty chewing food. Review of Resident 2's current care plan, print date 10/09/2024, showed the resident used upper and lower dentures. During an interview on 10/09/2024 at 8:26 AM, Staff R, Certified Nursing Assistant, observed Resident 2 not wearing their lower dentures. Staff R looked in Resident 2's room but was not able to find the lower dentures. During an interview and record review on 10/09/2024 at 8:32 AM, Staff N, [NAME] Clerk, showed surveyor a request to set up a dental appointment for Resident 2 as they had lost their lower denture. The form was dated 07/09/2024. Staff M reported they were having difficulty setting up a dentist to see Resident 2 because of funding issues. During an interview on 10/13/2024 at 11:02 AM, Staff G, stated they were not aware of the missing denture and there was no grievance for the denture missing. Staff G stated the facility practice was to reimburse family for the cost of missing items if they could not be located. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to WAC 388-97-0460 (2)

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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** 47047 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals who had a mental disorder or intellectual disabilities were offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and receive the services they need in those settings), was followed for 1 of 6 sampled residents (Resident 17). Failure to accurately complete a level one PASRR for Resident 17 and refer for a level two (an in-depth evaluation to determine whether the resident required specialized rehabilitation services) as indicated placed residents at risk for not receiving care and services in the most integrated setting appropriate to their needs. Findings included . Review of the facility policy titled Pre-admission Screening and Resident Review (PASRR) review date of 09/26/2024 showed any resident with newly evident or possible serious mental disorder, intellectual disability or a related condition must be referred, by the facility to the appropriate state-designated mental health or intellectual disability authority for review. Resident 17 admitted to the facility on [DATE] with diagnoses that included major depressive disorder and unspecified psychosis. Review of Resident 17's PASRR dated 06/17/2020 showed they exhibited signs and symptoms of a serious mental illness (SMI) and managed with psychotropic medication; a level two evaluation was not indicated. Review of Resident 17's Medication Administration Record for October 2024 showed they were not prescribed any psychotropic medications. Review of Resident 17's provider note dated 10/05/2024 showed they did not feel well and had hallucinations. Review of Resident 17's updated PASRR dated 10/08/2024 showed they had no indicators of SMI and did not require a level two evaluation. In an interview on 10/09/2024 at 2:40 PM Staff G, Social Services Director, stated if there was a change in a resident, they review the PASRR and complete a new level one if indicated and if a level two was needed they coordinate with the state designated mental health authority for review. Staff G described changes that would warrant a review of the PASRR to include behaviors, mood, hallucinations, and mental health status. Staff G stated they gathered information about changes in a resident through the nursing staff and provider notes. Staff G stated they were not aware of Resident 17's hallucinations. In an interview on 10/11/2024 at 9:04 AM Staff B, Director of Nursing Services, stated the facility was aware of PASRR concerns, mainly related to inaccurate PASRR sent from the hospital. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to WAC 388-97-1975 (1)

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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** 33954 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR - a federally required screening of all individuals who has both an Intellectual Disability (ID) or Related Condition (RC) and a serious mental illness (SMI) prior to admission to a Medicaid-certified nursing facility or a significant change of condition) form was completed prior to admission and according to the guidelines specified for 3 of 6 sampled residents (Residents 48, 59 and 60) reviewed. Incomplete or inaccurate PASRR's placed residents at risk for inappropriate placement and/or lack of access to specialized services for residents with identified mental health diagnoses or disability. Findings included . <RESIDENT 48> Resident 48 admitted to the facility on [DATE] with diagnoses to include dementia, anxiety and depression. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 08/20/2024, the resident had moderate cognitive impairment. Review of Resident 48's Level 1 PASRR, dated 08/16/2024, showed the PASRR was positive and an invalidation was to follow due to the diagnosis of dementia and comfort care measures. The PASRR indicated the resident had a severe, chronic disability, other than mental illness (an intellectual disability), that resulted in impairment of their general intellectual functioning or adaptive functioning, and it was expected to continue indefinitely, and it resulted in the resident having substantial functional limitations in three or more areas of major life activity. In a clinical record review on 10/08/2024, no documentation was found that Resident 48 had an intellectual disability, and no Level 2 Invalidation statement was found, and there was no documentation that a required PASRR level 2 evaluation had been completed prior to admission as required. In an interview on 10/09/2024 at 11:45 AM, Staff G, SSD, stated the facility did not yet have a Level 2 invalidation statement for the resident, and they had set up an appointment for 10/15/2024 with the Level 2 PASRR evaluator to triage their Level 2 referrals to see if they were going to invalidate the Level 2 or do a Level 2 PASRR evaluation. In a joint interview on 10/09/2024 at 2:41 PM, Staff B, Director of Nursing, and Staff H, Admissions Director, were unable to provide any information about Resident 48's Level I PASRR that indicated they had an intellectual disability. 47104 <RESIDENT 59> Resident 59 admitted to the facility on [DATE] with diagnoses to include depression and panic disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 59 admitted to the facility on anti-depressant and anti-anxiety medications. Review of a Level 1 PASRR dated 07/08/2024, located in the clinical records, showed mood disorder and anxiety were checked as a mental illness indicator category. Resident 59 was referred for Level II PASRR assessment. Review of Resident 59's current clinical record showed no evidence of Level 2 PASRR evaluation completed. In an interview on 10/09/2024 at 1:48 PM, Staff H, Admissions Director, stated a resident with a Level I PASRR that was referred for Level II PASRR assessment should not be admitted to the facility until the evaluation was completed. In an interview on 10/10/2024 at 1:21 PM, Staff G, Social Services Director (SSD), stated social services was responsible for reviewing PASRR's. Staff G stated Resident 59's PASRR showed a Level II evaluation was required. Staff G stated Resident 59 did not have a Level II evaluation or invalidation. Staff G stated they would follow up with the PASRR coordinator. 50725 <RESIDENT 60> Resident 60 admitted to the facility on [DATE] with admitting diagnoses to include bipolar affective disorder (mental health condition causes extreme mood swings that include emotional highs, called mania, and lows known as depression), anxiety, depression and dementia. In a record review on 10/09/2024 at 11:00 AM, the PASRR form, showed Resident 60 had an SMI Indicator, and no Level II evaluation indicated. This was signed by a provider dated 08/23/2024 and signed by Staff G, SSD, dated 08/21/2024 with a note stating PASRR updated to reflect current diagnosis. Patient stable with current treatment. In a joint interview on 10/09/2024 at 3:03 PM, Staff G, SSD and Staff A, Administrator, stated that [NAME] II evaluation was not indicated for Resident 60 because they think Resident 60 was stable despite them checking yes on the SMI Indicator for Mood Disorders -Depressive or Bipolar. Both Staff G and Staff A, confirmed that if a resident was stable with their medications and had no behaviors that they don't need to send a Level II evaluation even if they check yes on the SMI Indicators. In a joint telephone interview on 10/09/2024 at 3:35 PM with Collateral Contact 3 (CC3), State PASRR Evaluator, and Staff G, SSD, CC3 stated that if the yes box was marked for SMI Indicators, then the Level II evaluation referral required for SMI must be checked and sent to the PASRR evaluator for review. Staff G stated they would revise the PASRR and send it to the PASRR evaluator for review. Refer to WAC 388-97-1915 (2) and 388-97-1975(1)

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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** 50725 Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan for 1 of 9 sampled residents (Resident 60) reviewed for care planning. The care plan for respiratory care did not show monitoring for signs of hypoxia (low oxygen (O2) level) and administering O2, the skin care plan did not include the type of wound, wound care, or interventions to prevent the wound from worsening, and the Diabetes (a disease in which blood sugar levels are too high) care plan did not include interventions for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). This failure placed residents at risk for unidentified outcomes or goals, inconsistent or lack of interventions, and diminished quality of life. Findings included . Resident 60 admitted to the facility on [DATE] with diagnoses to include a Stage 2 pressure ulcer (a partial thickness skin loss that appears as a shallow open wound with a red or pink wound bed), diabetes, and respiratory failure. According to the Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], Resident 60 had moderate cognitive impairment, required moderate assistance with bed mobility and was receiving O2. <RESPIRATORY CARE> In an observation on 10/09/2024 at 9:41 AM, Resident 60 was lying in bed receiving O2 via nasal cannula (nc - a tube that delivers O2) and the O2 concentrator (a machine that delivers O2) was set at one liter per minute. Review of Resident 60's medical record on 10/11/2024 at 8:54 AM showed a physician order for O2 one to two liters per minute per nc as needed (PRN), dated 08/20/2024. Review of the Resident 60's medical record showed a provider progress note dated 10/09/2024, for Resident 60 to continue using O2 PRN. In a record review on 10/11/2024 at 8:54 AM, Resident 60's care plan did not include a focus, goal, or interventions for O2 therapy. <PRESSURE ULCER> In an observation on 10/08/2024 at 11:34 AM, Resident 60 was lying in bed on their back. In an interview on 10/08/2024 at 12:02 PM, Staff Q, Certified Nursing Assistant (CNA) stated that Resident 60 preferred to stay in bed and to lay on their back most of the time despite offering the resident to turn or get out of bed. In an observation and interview on 10/10/2024 at 11:55 AM, Resident 60 was laying on their back. Resident 60 stated they could turn on their side in bed on their own and that they turn when their back side started to hurt. (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 10/11/2024 at 9:32 AM, Staff R, CNA, stated that they read the Kardex (care directive for CNAs) to find out how to take care of a resident. Staff R stated that they did not know what kind of wound Resident 60 had but knew that there was a wound care nurse that came in and if the dressing to the wound was soiled to notify the nurse. Review of Resident 60's medical record on 10/11/2024 at 9:41 AM, showed a Provider order for wound care dressing to the wound on the resident's coccyx. Review of Resident 60's care plan focus for skin integrity, copy date 10/08/2024, did not specify the type of wound the resident had. The care plan did not include interventions to prevent worsening of the wound or who to notify. Review of Resident 60's Kardex on 10/11/2024, did not show or mention anything about their pressure ulcer or how to care or monitor the resident. <DIABETES > Review of Resident 60's care plan focus for diabetes, dated 10/08/2024 did not show interventions for hypoglycemia or hyperglycemia. In an interview on 10/09/2024 at 10:00 AM, Staff F, Registered Nurse (RN) stated that they did not update the care plan and that the Resident Care Manager (RCM) did it. In an interview on 10/11/2024 at 9:51 AM, Staff S, RN, stated that the care plan for Resident 60 needed more interventions added to help care for the resident better. Staff S stated the RCM was responsible for updating the care plan. In an interview on 10/10/2024 at 10:45 AM, Staff D, RN/RCM, stated that they updated the care plan if they identified changes regarding a resident and they reviewed it quarterly to ensure that the care plan was up to date. In a joint interview on 10/11/2024 at 11:10 AM, with Staff A, Administrator, and Staff B, RN/Director of Nursing, Staff B stated the initial care plan was done by the admission nurse based on their assessment, interview and history and physical. Staff B stated an initial care conference with the resident and/or family members was conducted based on information received and a resident-centered care plan was developed. Staff B stated the RCM was responsible for reviewing the care plan and creating a more comprehensive resident-centered care plan. Staff B was not sure what the time frame was for developing the comprehensive care plan. Staff A stated that they reviewed residents in their daily stand-up meetings and could update care plans at that time. Staff B stated that O2 should be care planned. Staff B stated that they would review Resident 60's care plan and ensure that interventions were in place for Resident 60's wound, diabetes and O2. Refer to WAC 388 97 1020(1)(2)(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42927 Based on observation, interview and record review, the facility failed to ensure care plans were reviewed and revised for 3 of 8 (Residents 13, 2 and 28) sampled residents reviewed for care plan revisions. Failure to revise care plans to accurately reflect resident conditions and needs placed residents at risk for unmet care needs. Findings included . <RESIDENT 13> Resident 13 initially admitted to the facility on [DATE], and recently readmitted from the hospital on 03/25/2024. During an observation and interview on 10/07/2024 at 9:05 AM, Resident 13 was lying in bed. Resident 13 stated they had had a decline in their ADL (activities of daily living) abilities over the past six months. Review of a nurse practitioner note, dated 05/21/2024, showed that Resident 13 likely had kidney failure. The note showed the provider spoke with Resident 13 and they did not want to go to the hospital and wanted to remain in the facility on comfort care. The note showed that Resident 13 was no longer feeding themselves or performing ADL's. Review of Resident 13's nursing assistant documentation for transfers, dated 09/11/2024 - 10/09/2024, showed they had not transferred the resident out of bed during that time except for on 09/26/2024 and 10/07/2024. Review of the facility matrix, dated 10/07/2024, showed Resident 13 did not have any pressure ulcers (bed sores.) Review of Resident 13's current care plan, print date 10/09/2024, showed three different problems for skin and wound condition: Risk for impairment to skin that showed actual impairments to left heel, blisters to left thigh and coccyx (tail bone). Actual impairment to skin integrity that showed wound on left buttock, right buttock, left gluteal (lower part of buttock) fold, left lower leg vascular wound, right anterior (front) thigh. Chronic ulcer (wound) to left lower leg. Further review of the care plan showed two different problems for mobility: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADL assistance and therapy services. The goals were Resident 13 would be able to transfer from bed to chair with partial moderate assistance and Resident 13 wished to attain prior level of function. The interventions showed Resident 13 used a standard wheelchair and FWW (front wheeled walker), therapy services, weight bearing as tolerated with orthotic shoe (specialized shoe for standing) and dependent on transfers with Hoyer lift (machine that moves person from one surface to another). Functional goal care plan, Resident had limited physical mobility. The interventions showed to refer resident to therapy, update physician with changes in mobility and that resident was weight bearing. Review of the care plan also showed a problem for at risk for rehospitalization , revised on 05/24/2024. The goal statement showed resident will not have an avoidable rehospitalization related to current medical diagnosis within the first 30 days. There was no update after the 30 days had passed. During an interview on 10/08/2024 at 11:13 AM, Staff X, Nursing Assistant Certified, stated Resident 13 was having therapy and getting out of bed a year ago, but now they refused to get out of bed. Staff X stated the resident was only getting out of bed to be weighed with the Hoyer lift and then setting them back on the bed. During an interview on 10/09/2024 at 10:08 AM, Staff AA, occupational therapist, stated Resident 13 was not tolerating much therapy when they were on caseload, and since being discharged from therapy, resident had declined further due to multiple medical conditions and the resident was no longer getting out of bed. During an interview and joint record review on 10/08/2024 at 11:24 AM, Staff I, Licensed Practical Nurse/Resident Care Manger, reported Resident 13 was on comfort care, no longer was getting out of bed, and had no wounds except for a vascular condition of their left lower leg. Staff I stated the residents care plan had not been updated with their changes and Resident 13's care plan had not been reviewed in its entirety to remove the duplications of problems last quarter. <RESIDENT 2> Resident 2 is a long term resident at the facility since 07/12/2018. During an interview and observation on 10/07/2024 at 12:29 PM, Resident 2 was noted to be wearing upper dentures but did not have lower dentures in place. Resident 2 reported they had not been wearing their lower dentures as they did not fit. During an interview and observation on 10/08/2024 at 4:53 PM, Resident 2 was wearing their upper dentures and not their lower dentures. Resident 2 stated they had not been wearing her lower dentures. Review of the current care plan, print date 10/09/2024, showed Resident 2 wore full upper and lower dentures. During an interview on 10/09/2024 at 11:02 AM, Staff G, Social Service Director, stated they had spoken with resident's family and Resident had not worn their lower dentures for a year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/2024 at 11:19 AM, Staff I reviewed the care plan. Staff I stated Resident 2's care plan did not get updated when they stopped wearing their lower dentures or when the lower denture was lost. 47047 <RESIDENT 28> Resident 28 admitted to the facility on [DATE] with diagnoses that included stroke affecting their left side with hemiplegia (paralysis or severe weakness) and hemiparesis (weakness on one side of the body). In a review of Resident 28's care plan, dated 08/29/2019 showed they had limited physical mobility related to left side hemiplegia and hemiparesis and would remain free of complications with no worsening in contracture. The care plan did not identify the location of Resident 28's contracture. Interventions included nursing rehabilitation/restorative program which included active range of motion (AROM-the range of movement a person can achieve by using their muscled to move a body part without assistance) to their bilateral upper and lower extremities in all planes to Resident 28's tolerance. On 10/11/2024 at 9:30 AM observed Resident 28 in the unit activity room with other residents participating in an exercise activity. Resident 28 received passive range of motion (PROM-the range of movement in a joint when an external force moves the joint) to their upper and lower extremities. On 10/11/2024 at 11:15 AM observed Resident 28 in their room in their wheelchair. Resident 28's left hand and fingers lying flat on the arm rest of the wheelchair. When asked if they could move their left arm, hand and fingers with their right hand, Resident 28 was able move them without resistance. Review of Resident 28's Range of Joint Motion Evaluation Chart dated 08/08/2024 showed the left upper extremity was within functional limits. Review of Resident 28's Occupational Therapy Evaluation dated 06/10/2024 showed they did not have any functional limitations present due to a contracture. In an interview on 10/11/2024 9:04 AM, Staff B, Director of Nursing Services (DNS) stated the expectation of updating the care plan was at least quarterly and with any change of condition. Staff B stated they have a meeting with the interdisciplinary team where they review residents care plans for their quarterly and annual assessment. Refer to 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on observation, interview and record review, the facility failed to provide dentures prior to meals for 1 of 5 sample residents (Resident 31) reviewed for Activities of Daily Living (ADL). This failure placed the resident at risk for poor nutrition, and diminished quality of life. Findings included . Review of the facility policy titled, Activities of Daily Living, revised date of 09/10/2024, showed that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident 31 admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (conditions that cause weakness or paralysis on one side of the body) following stroke, diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly), dysphagia (difficulty swallowing), aphasia following cerebral infarction (a language disorder affects a person's ability to understand or produce language after stroke). According to the quarterly Minimum Data Set (MDS-an assessment tool) assessment, dated 08/14/2024, Resident 31 had severe cognitive impairment and had functional limitation to one side of their upper and lower extremities (arms, hands, legs, and feet) and required set up or clean-up assistance (helper assists prior to or following the activity) with eating. In an observation on 10/09/2024 at 8:20 AM, Resident 31 was sitting up with their breakfast tray eating breakfast without dentures in place. Review of Resident 31's Medication Administration Record (MAR), copy date 10/09/2024 at 8:20 AM, showed an order for upper and lower dentures in denture cup with cleaning solution placed in med room overnight, and given to resident in the am. This had not be marked as given to the resident. In an observation on 10/09/2024 at 8:30 AM, observed Staff C, Licensed Practical Nurse (LPN) went to get the dentures from the medication room and asked the aide to put in for Resident 31. Review of the facility meal schedule showed breakfast trays started at 7:20 AM. In an interview on 10/09/2024 at 8:37 AM, Resident 31 stated they did not have dentures, and it was difficult for them to chew food. The resident stated they ate without dentures often, chewing with their gums and their dentures were locked in the room every day. In an interview on 10/09/2024 at 8:46 AM, Staff C, LPN stated Resident 31's lower dentures were broken since a week and a half ago and Resident 31 was only wearing the upper dentures. Staff C stated the lower dentures were broken when the resident was trying to put them in on their own. Staff C stated that ever since the lower dentures broke, they have been locking the upper dentures in the medication room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 10/10/2024 at 8:20AM, Resident 31 was noted to be eating breakfast with no dentures in their mouth. In an observation on 10/10/2024 at 8:31 AM, Resident 31 finished breakfast with no dentures in their mouth. In an interview on 10/10/2024 at 8:31 AM, Resident 31 stated they did not like the toast because it was too hard to chew. When asked if any nurse brought dentures and assisted them to put in, they stated that the nurse locked the dentures in the room every day. In a joint interview on 10/10/2024 at 8:40 AM, Staff C, LPN, and Staff I, LPN/Resident Care Manager (RCM), stated the dentures were in the medication room and the licensed nurse was supposed to get them from the medication room and the nursing assistant was supposed to assist to put on the resident before breakfast. Staff stated the nursing assistant who was taking care of the resident on that day was new and did not know the resident needed dentures for breakfast. In an interview on 10/10/2024 at 8:50 AM, Staff J, Certified Nurse Assistant (CNA), stated they were new to the hall. Staff J stated they receive report from the night shift, and no staff had told them Resident 31 needed dentures for breakfast. Staff J stated they use a Kardex (identifies residents care needs in the electronic health record) which had resident specific care information on it. Review of Resident 31's Kardex, dated 10/09/2024, showed the resident had upper/lower dentures and the licensed nurses were to verify after meals dentures were in mouth. At bedtime staff were to place the resident's dentures in a denture cup with cleaning solution in medication room overnight and to return them to the resident in the morning. Review of Resident 31 's care plan, dated 09/26/2024, showed the resident had upper/lower dentures and licensed nurse were to verify after meals dentures were in the resident's mouth. At bedtime staff were to place the resident's dentures in a denture cup with cleaning solution in medication room overnight and to return them to the resident in the morning. In a review on 10/10/2024 at 9:09 AM, Resident 31's Medication Administration Record (MAR) showed the nurse had not signed off the order of giving dentures in AM at 8AM. Refer to WAC 388-97-1060 (2)(c)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42927 Based on observation, interview and record review, the facility failed to accurately assess and provide care and treatment to improve a resident's communication deficit for 1 of 2 sampled residents (Resident 12) reviewed for hearing. Failure to accurately assess, provide interventions to mitigate hearing loss, and/or offer a referral to improve a hearing deficit placed residents at risk of a decreased quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1, dated October 2024, (a guide to accurately complete the Minimum Data Set (MDS) assessment). The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths. Care Area Assessment (CAA) is the further investigation of triggered areas to determine if the care area triggers require interventions and care planning. Relevant documentation for each triggered CAA describes causes and contributing factors, to include: The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly was the issue/problem for this resident and why was it a problem. Complications affecting or caused by the care area for this resident. Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning. Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident. The need for additional evaluation by the attending physician and other health professionals, as appropriate. Resident 12 admitted to the facility on [DATE]. Review of Resident 12's MDS, dated [DATE], showed a BIMS (test that evaluates cognitive function) score of 14 which indicated intact cognitive function. During an interview and observation on 10/07/2024 at 8:31 AM, Resident 12 stated they did not have any cognitive issues, they just could not hear. Resident 12 stated they wanted to get hearing aids and had reported that to the staff. Resident 12 reported the staff never mentioned they could assist him in obtaining hearing aids. Surveyor had to stand close to resident and increase volume of speech during conversation. Resident 12 asked surveyor to repeat information during conversation as they had not heard what surveyor had said. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 10/09/2024 at 9:35 AM, Resident 12 stated they would not be able to hear their daughter on the phone during the upcoming care conference due to their hearing deficit. Surveyor had to increase volume of speech during conversation for resident to hear adequately. Review of the admission assessment, dated 09/11/2024, showed the resident had moderately impaired hearing, which meant the speaker had to increase volume and speak distinctly. The assessment showed Resident 12's discharge plan was to remain in the facility for long-term care. Review of the activity assessment, dated 09/11/2024, showed Resident 12's hearing was adequate/good. Review of the occupational therapy evaluation, dated 09/12/2024, showed Resident 12's sensory function was impaired. Review of progress note, dated 09/16/2024, showed Resident 12 was hard of hearing and was trying to get hearing aids. Review of the MDS, dated [DATE], showed Resident 12 had minimal difficulty hearing and did not use hearing aids. Review of the communication CAA, dated 09/20/2024, showed communication investigation was triggered due to minimal difficulty hearing. The sections for resident input/goals and for any needed referrals was blank. The summary statement showed LN administer medication as ordered, provide treatment as ordered, anticipate and meet resident's needs. assist with word finding as needed. Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. NAC assist the task to be completed, assist communication as needed, anticipate and meet resident's needs. The summary did not show any documentation as it related to Resident 12's hearing. There was no documentation of the cause of hearing loss or what interventions should have been care planned such as assisting with obtaining hearing aids or staff to increase volume or speak distinctly. Review of the care plan showed a problem statement for communication deficit related to minimal difficulty hearing deficit, dated 09/20/2024. The interventions for problem area showed: - Anticipate needs - Observe and report any changes in communication - Observe for physical/nonverbal signs of discomfort - Observe for problems- deterioration of respiratory status, oral motor function, poor fitting/missing dental appliances, hearing impairment (ear discharge or wax accumulation). There was no intervention for staff to talk with increased volume, limit background noise, or assisting resident to obtain hearing aids. During an interview on 10/09/2024 at 11:16 AM, Staff I, Licensed Practical Nurse/Resident Care Manager, stated Resident 12 was hard of hearing and they had to talk loudly for them to hear. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/09/2024 at 11:38 AM, Staff V, Registered Nurse (RN)/ MDS coordinator, stated the CAA process should include what the resident goals were, what the risk factors for the area was, and how facility would fix the problem. Staff V stated they did not offer help with setting up an audiology appointment or obtaining hearing aids because resident was not a long-term care resident. During an interview on 10/09/2024 at 12:07 PM, Staff W, RN/ MDS coordinator, stated they reviewed progress notes and assessments in the medical record, interviewed the resident and interviewed staff to gather data to complete the MDS and CAA's. Staff W stated they did not offer resident an audiology appointment or assistance with hearing aids because they did not have difficulty communicating with the resident with the TV turned off and the door shut. Staff W stated they had completed the care plan after they had completed the communication CAA but did not put interventions on the care plan to limit background noise such as turning off TV or shutting room door. Staff W was asked about staff monitoring the dental appliances as an intervention for the communication problem and they stated they just clicked on prepopulated interventions and did not modify them to be resident specific. Refer to WAC 388-97-1060 (3)(a)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview and record review, the facility failed to develop a dementia care plan that addressed the significant mental and psychosocial needs of the resident, established personalized and achievable goals, and identified interventions to promote a person-centered environment for 1 of 3 residents (Resident 48) reviewed for dementia care. These failures placed residents at risk for unmet psychosocial needs, increased behaviors and decreased quality of life. Findings included . In an email interview on 10/11/2024 at 12:56 PM, Staff B, Director of Nursing, stated the only policy the facility had regarding dementia was a policy that specified education, for staff. Review of the facility policy titled Dementia Required Education, dated 09/22/2023, showed the facility had a policy that specified the facility would provide staff training and education. Resident 48 admitted to the facility on [DATE] with diagnoses to include dementia, anxiety and depression. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 08/20/2024, showed the resident had moderate cognitive impairment, no behavioral symptoms, and they had non-Alzheimer's dementia. Review of Resident 48's August 2024 Medication Administration Records (MARS) showed the facility had administered the antipsychotic medication Quetiapine for four separate orders to include Quetiapine for dementia, and Quetiapine for agitation (agitation - a state of anxiety or nervous excitement), these orders included two orders for as needed Quetiapine, and two orders that were scheduled doses of Quetiapine. Review of Resident 48's September 2024 MARS showed the facility administered the resident the Quetiapine for dementia by using five orders, and they also administered Risperidone (Risperidone - an antipsychotic medication) for dementia and Rivastigmine (Rivastigmine - a cognitive enhancer for dementia). The MARS showed behaviors exhibited included agitation and yelling out for both behaviors to include over 40 shifts with agitation and as many as 30 incidents per shift and documentation of multi representing multiple, and cont representing continuous. For yelling out, from 09/10/2024 - 09/30/2024 the resident had over 50 shifts where they were yelling out to include shifts where staff documented they called out 20, 25, 30 and 45 times during a shift. Review of Resident 48's October MARS from 10/01/2024 - 10/10/2024 showed the facility continued to administer Risperidone for dementia, mild, with agitation, and they continued to administer Rivastigmine from 10/01/2024 - 10/07/2024 for dementia, mild, with agitation. The behavior monitor showed 17 shifts with documented agitation, to include 10 shifts with continuous agitation documented. The behavior monitors also included 27 shifts with yelling out documented, to include eight shifts with continuous yelling out documented and many shifts with 15 instances of yelling out documented. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 10/07/2024 at 11:42, Collateral Contact 1, the representative of Resident 48's roommate, Resident 56, stated Resident 48 called out at all hours of the day and night and they had to make a formal complaint to the facility, and they were told the facility would be moving Resident 48 to a different room. Review of Resident 48's care plan, copy date 10/09/2024, showed no documentation the facility had care-planned interventions for how staff were to treat the resident's behaviors of calling out and agitation, except for administering psychotropic medications. In a review of Resident 48's clinical record on 10/09/2024, no documentation was found in the clinical record that the facility had assessed the resident's dementia, how long they'd had dementia, how the resident's dementia manifested in their behaviors, or what had been effective or ineffective in treating the resident's dementia and behaviors in the past. In an observation on 10/09/2024 at 10:56 AM, Resident 48 was observed calling out loudly from their room and they could be heard yelling from down the hall, they called out multiple times and did not use their call light. In an observation/interview on 10/10/2024 at 2:45 PM, Resident 48 was observed calling out loudly from down the hall, the resident's room door was closed, and their call light was not on. The resident was interviewed regarding their calling out, and their call light was observed to be right in front of them, the resident stated they were calling out because something fell on the floor. The resident stated they didn't use their call light because when they used it no one came. The resident stated they didn't like bellering ([NAME] - to shout in a loud voice), but they bellered because when they used their call light no one came, and if they don't like it, they (staff) should come when they called. Resident 48 stated it's not fun to have to yell, but that is what they have to do. In a joint interview/record review on 10/11/2024 at 10:22 AM, Staff S, Registered Nurse, stated Resident 48 had been calling out that morning, and they had addressed the resident's needs. Staff S stated the resident wanted to get up in a chair, so they got them up in a chair. Staff S stated that the resident called out again because they wanted to call their daughter, and they assisted them to call their daughter, but there was no answer on the phone, so the resident didn't stop calling out, they focused on calling their daughter, and the resident kept calling out until they got sleepy and requested to go back to bed. Staff S reviewed the resident's care plan, and stated they couldn't find anything specific in the care plan regarding their calling out. Staff S stated the only thing they could find in the care plan specific to the resident's calling out behavior was to administer Risperidone. Staff S stated the resident's care plan indicated the resident was supposed to have a psychiatric consult, but they did not know if that had happened. Refer to WAC 388-97-1060 (1)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview and record review, the facility failed to ensure 2 of 5 residents (Residents 60 and 48) reviewed for unnecessary medications were free from unnecessary psychotropic drugs (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure there were valid and accurate diagnoses for use of psychotropic medications, appropriate indications for treatment with antipsychotic medications, to monitor adverse side effects and monitor and document appropriate behaviors. These failures placed the residents at risk for receiving unnecessary psychotropic medications, for adverse medication-related side effects, and for diminished quality of life. Findings included According to the facility policy titled Psychotropic Medication Informed Consent Policy, reviewed on 09/16/2024: Other medications not classified as anti-psychotic, anti-depressant, anti-anxiety, or hypnotic medications can also affect brain activity and should not be used as a substitution for another psychotropic medication listed in 483.45(c)(3), unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice. Categories of medications which affect brain activity include central nervous system agents used to treat conditions such as seizures, mood disorders, pseudobulbar affect, and muscle spasms or stiffness. The requirements pertaining to psychotropic medications apply to these types of medications when their documented use appears to be a substitution for another psychotropic medication rather than for the original or approved indication. For example, if a resident is prescribed valproic acid and the medical record shows no history of seizures but there is documentation that the medication is being used to treat agitation or other expressions of distress, then the use of valproic acid should be consistent with the psychotropic medication requirements under 483.45(e). <RESIDENT 60> Resident 60 admitted to the facility on [DATE] with admitting diagnoses to include bipolar affective disorder (mental health condition that causes extreme mood swings that include emotional highs, called mania, and lows known as depression), anxiety, depression (constant feeling of sadness and loss of interest) and dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Review of Resident 60's clinical record on 10/08/2024 at 1:10 PM showed a provider's order for Divalproex Sodium oral tablet delayed release 500 milligram (mg) by mouth every evening shift for seizures (abnormal electrical activity in your brain that temporarily affects your consciousness, muscle control and behavior), dated 8/21/2024. Review of Resident 60's history and physical note dated 10/08/2024 at 1:10 PM showed bipolar disorder, current episode manic without psychotic features, unspecified. Stable and chronic. Continue Depakote (brand name for Divalproex Sodium). Reviewed Provider's progress notes and hospital records and did not find a seizure diagnosis documented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/09/2024 at 10:42 AM Resident 60's spouse stated the Divalproex Sodium was for the residents mood and it helped them sleep at night. Review of Resident 60's Medication Administration Records (MAR) for September and October 2024 showed the Divalproex Sodium indication for use was Seizures and was given daily. There was no monitoring for adverse side effects or behaviors related to this medication. In a joint interview/record review on 10/10/2024 at 9:04 AM, Staff E, Licensed Practical Nurse (LPN) stated they did not see a seizure disorder documented in Resident 60's clinical record. They did not know why they used seizure as the diagnosis for the Divalproex Sodium medication use. In an interview on 10/10/2024 at 9:18 AM Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) stated that the Divalproex Sodium was for Resident 60's mental disorder and not for seizures and they would update the order. 33954 <RESIDENT 48> Resident 48 admitted to the facility on [DATE] with diagnoses to include encephalopathy (encephalopathy - broad term for any brain disease that alters brain function or structure and can result in a declining ability to reason and concentrate), dementia, anxiety and depression. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 08/20/2024, showed the resident had moderate cognitive impairment, and no behavioral symptoms. Review of Resident 48's hospital discharge summary, dated 08/16/2024, showed the resident was given multiple diagnoses to include acute encephalopathy and dementia with behavioral disturbance as they had a one-week change in behavior, and waxing and waning mentation where their baseline was demanding and brusque, but was now polite and quiet, and the providers suspected their behavior change was due to hypoxemia (low oxygen in the blood). The discharge summary indicated the physical exam showed neurologically the resident was at their baseline with normal mood and affect and behavior. The discharge orders included the antipsychotic medication Quetiapine, which was to be taken nightly, as needed, for agitation. Review of the Resident 48's August 2024 MARS, showed the facility implemented the admission order for as needed Quetiapine, for agitation, and the resident was given as needed doses on 08/18/2024, 08/19/2024, 08/22/2024, and 08/24/2024. The MAR review also showed the facility implemented three additional orders for Quetiapine, including an order dated 08/24/2024 to now give the Quetiapine nightly for dementia, mild, with agitation. Then on 08/29/2024 the facility implemented another Quetiapine order, which indicated the medication was to be given twice daily, for dementia, mild, with agitation. Review of the behavior monitor included in the MARS showed the resident had 11 instances of agitation during August 2024. Review of Resident 48's progress notes for 08/18/2024, 08/19/2024, 08/22/2024, and 08/24/2024, showed no progress notes specifying the situations/indications for the four doses of as needed Quetiapine, except there was a note dated 08/19/2024 at 10:15 PM, that indicated the resident required one on one care, they did not like to be alone, they held the call light for most of the shift, and they refused to turn the call light off even after staff had assisted them. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 48's care management progress note, dated/timed 08/28/2024 at 11:25 AM, showed the facility had a care meeting with the facility Executive Director, Director of Rehab, Social Services Director, the Minimum Data Set coordinator, and the Resident Care Managers, there was no documentation at all regarding the resident's treatment with Quetiapine. Review of a provider progress note dated 08/29/2024, showed Encephalopathy, Quetiapine nightly. There was no documentation showing why the Quetiapine dosing was increased from as needed to nightly. Review of Resident 48's September 2024 MARS showed the facility administered Quetiapine during the month using five different orders, four were for dementia, mild, with agitation, and one order was for dementia, mild, with agitation and for anxiety disorder unspecified. Then on 09/18/2024, the facility started administering the resident Risperidone (an antipsychotic medication), for dementia, mild, with agitation. Additionally, the facility started administering Rivastigmine (a cognitive enhancer medication) for dementia, mild, with agitation, due to an order dated 09/03/2024, and a second order for Rivastigmine was implemented on 09/10/2024 increasing the dose, this was also administered for dementia, mild, with agitation. Review of the September 2024 behavior monitors in the MARS showed the resident had in excess of 350 instances of agitation during the month, not including many entries in the behavior monitor that indicated continuous or multiple instances of agitation. The behavior monitors also showed over 500 instances of the resident yelling out during the month. Review of a provider note, dated 09/03/2024, showed they were treating both the resident's encephalopathy and dementia with Gabapentin (medication for nerve pain), Trazadone (antidepressant medication), and Quetiapine. The note indicated they had added Quetiapine in the morning as well as their evening dose to assist with confusion, but it did not seem to help, so they started the Rivastigmine and tapered the Quetiapine. The note also indicated the resident needed a Behavioral Health Services evaluation. Review of provider notes dated 09/05/2024, 09/09/2024, 09/11/2024, 09/12/2024, 09/13/2024, 09/18/2024, 09/19/2024, 09/24/2024, 09/26/2024, showed the resident needed a Behavioral Health Services evaluation. Review of a provider note, dated 10/09/2024, showed Behavioral Health Services evaluation - spoke to DPOA (Resident 48's Durable Power of Attorney) regarding behavioral health evaluation, and they did not want this done at that time. Review of Resident 48's MARS from 10/01/2024 - 10/10/2024, showed the facility continued to administer Risperidone twice daily for dementia, mild, with agitation, and they administered the Rivastigmine for dementia from 10/01/2024 - 10/07/2024. The behavior monitors for the behavior of agitation showed numerous shifts with continuous agitation documented. The behavior monitors for yelling out showed numerous shifts with continuous calling out documented. Review of Resident 48's care plan, copy date 10/09/2024, showed no documentation the facility had care-planned interventions for how staff were to treat the resident's behaviors of calling out and agitation, except for administering psychotropic medications. The care plan indicated staff were to arrange referrals indicated by PASRR Level 2 findings (PASRR - Pre-Admission Screening and Resident Review for residents with indicators of mental illness or intellectual disability). The care plan also indicated the facility would obtain a psychiatric consult as indicated. (continued on next page)

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	505386	A. Building B. Wing	10/11/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 48's clinical record on 10/09/2024 showed no documentation of a PASRR Level 2 evaluation, no psychiatric consult evaluation, no behavioral health services evaluation, and no dementia evaluation/assessment. In an interview on 10/09/2024 at 11:45 AM, Staff G, Social Services Director, stated they never did obtain a PASRR Level 2 evaluation for Resident 48, they planned to coordinate that at an appointment the following week. In an observation/interview on 10/10/2024 at 2:45 PM, Resident 48 was observed calling out loudly from down the hall, the resident's room door was closed, and their call light was not on. The resident was interviewed regarding their calling out, and their call light was observed to be right in front of them, the resident stated they were calling out because something fell on the floor. The resident stated they didn't use their call light because when they used it no one came. The resident stated they didn't like bellering ([NAME] - to shout in a loud voice), but they bellered because when they used their call light no one came, and if they don't like it, they (staff) should come when they called. Resident 48 stated it's not fun to have to yell, but that is what they have to do. In an interview on 10/11/2024 at 10:22 AM, Staff S, Registered Nurse, stated Resident 48 had been calling out that morning, and what they did was they addressed the resident's needs, what they wanted was to get up in a chair, so they got them up in a chair, then they called out again because they wanted to call their daughter, and they assisted them to call their daughter, but there was no answer on the phone, so the resident didn't stop calling out, they focused on calling their daughter, and the resident kept calling out until they got sleepy and requested to go back to bed. Staff S reviewed the resident's care plan, and stated they couldn't find anything specific in the care plan regarding their calling out. Staff S stated the only thing they could find in the care plan specific to the resident's calling out behavior was to administer Risperidone. Staff S stated the resident's care plan indicated the resident was supposed to have a psychiatric consult, but they did not know if that had happened. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview on 10/11/2024 at 11:15 AM, Staff B, Director of Nursing, stated the indications for Resident 48's treatment with antipsychotic medication was the resident's dementia. Staff B stated the behavior being monitored for the antipsychotic medication treatment was agitation. Staff B was asked what agitation meant, they stated a state of anxiety or nervous excitement. Staff B was asked how the resident's agitation had manifested, they were unable to provide any information. Staff B stated they thought the resident's agitation had improved, and now they were seeing anxiety. Staff B was asked where documentation could be found the resident's behaviors had improved, they stated it was throughout the resident's chart, but they were unable to state a specific place this documentation could be found. Staff A, Administrator, stated the resident was being treated for yelling out. Staff A and B were asked if the facility interdisciplinary team had evaluated the resident's needs, goals, comorbid conditions and prognosis to determine factors that affected their signs/symptoms being treated with antipsychotic medications, they were unable to provide any information. Staff A and B were asked if there had been any referrals for the resident and their behaviors necessitating treatment with antipsychotic medications, they were unable to provide any information. Staff A and B were asked what behavioral interventions had been care planned to treat the resident's behaviors of agitation and calling out, they were unable to provide any information. Staff A and B were asked about the resident's behaviors that had been exhibited when the facility started administering them antipsychotic medication on 08/18/2024 and 08/19/2024, Staff B stated agitation. Staff A and B were asked what had been care planned regarding the resident's dementia with behaviors, no information provided. In a phone interview on 10/11/2024 at 12:14 PM, Collateral Contact 2 (CC2), Resident 48's daughter/durable power of attorney, stated the resident had been calling out at home prior to admission to the facility. CC2 stated for as long as they could remember the resident had been very demanding, they wanted what they want and they wanted it when they wanted it, and if their response was not met on demand, they could become rather belligerent and verbally abusive. CC1 stated the family dynamics changed since the resident's spouse passed away, as the spouse was able to put them into a mode where they would have to wait, and since their passing the resident had an increased need for constant attention and interaction. CC1 reviewed the resident's home medication bottles and did not find one for an antipsychotic medication, they stated they thought the nursing home may have started that due to the resident's anxiety. CC1 stated the facility never asked permission to get a mental health evaluation or a behavioral health evaluation. CC1 was asked about the provider note that stated a behavioral health services evaluation had been declined by them, they stated that was bullshit, they did not get a call and were not asked that question, that they would not deny that because that would just add more tools to their tool bag, and they wanted that. CC1 stated they knew the resident screamed like a banshee, as they had visited the resident in the nursing home, and the second they walked out the room door to go home, they screamed at the top of their lungs and would think nothing of it. CC1 stated they agreed there was some medical reasons for some of their behavior, but not all, as some was behavioral, for example the resident would call them 30 times, and their sister 28 times to come down and visit. CC1 stated the resident had gotten worse with their calling out, and that quite frankly, they had the skill to push any button. CC1 stated they sat there and watched the resident plead and bed, and start to cry, then get angry because they wanted to go home, that they went through every emotional button there was, then at the end, the resident stated don't forget, I can be even worse, I can be meaner. Refer to WAC 388-97-1060 (3)(k)(i)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to ensure dental services were coordinated for 1 of 2 residents (Resident 17) reviewed for dental services. Failure to follow up on dental referrals and ensure the coordination of dental services for residents who had missing and broken teeth placed the residents at increased risk for difficulty chewing, associated health complications, and diminished quality of life. Findings included . Resident 17 admitted to the facility on [DATE] with diagnoses that included weakness, diabetes mellitus type two (condition in which the body had trouble controlling blood sugar), and arthropathic psoriasis (a type of arthritis that affects people with the skin condition psoriasis). In an interview on 10/07/2024 at 9:17 AM, Resident 17 stated they needed a dentist to have their teeth replaced and fixed. Review of the dental hygienist consultation report dated 12/06/2023 showed Resident 17 requested to see a dentist to address missing teeth, broken teeth, and a failing filling on their upper left jaw. Review of the dental hygienist consultation report dated 06/26/2024 showed Resident 17 required a referral to a dentist, wanted to discuss replacement options for their missing teeth, get their upper molars fixed and complained of occasional sensitivity to their upper back teeth. Review of Resident 17's progress notes from 06/05/2023 through 10/07/2024 showed: -On 06/05/2023 they were noted to have been seen by the dental hygienist on this day and wanted to be seen by a dentist. -On 06/29/2023 they were seen by the provider and a referral for dental was completed and they were set to see a dentist in an upcoming appointment. -On 12/06/2023 they were seen by the orthodontist and tolerated care well. -On 03/22/2024 they were noted to have some missing teeth and one cavity to their right upper arch, denied pain to site. It was noted the ward clerk would make an appointment with a dentist. -On 06/05/2024 they were noted to have been seen by the dental hygienist on this day and wanted to be seen by a dentist. -On 06/28/2024 they were seen by the dental hygienist and wanted to see a dentist. A call was made to Resident 17's representative with no answer. -On 08/23/2024 they were seen by a dentist and were started on an antibiotic medication for a dental infection. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 17's Annual Minimum Data Set (MDS-an assessment tool) assessment, dated 06/20/2024, showed they had obvious or likely cavity or broken natural teeth. Review of Resident 17's care plan dated 08/04/2021 showed they had oral/health problems with poor oral hygiene and loose lower/upper teeth. Interventions included coordination of dental care and transportation as needed/ordered. In an interview on 10/08/2024 at 2:13 PM Staff P, Nursing Assistant Certified (NAC) stated they would report to the nurse if a resident wanted an appointment to the dentist. In an interview on 10/08/2024 at 2:13 PM Staff BB, Licensed Practical Nurse (LPN) stated the unit coordinator would coordinate and schedule any dental appointments for residents. In an interview on 10/09/2024 at 3:17 PM Staff G, Social Services Director, stated the unit coordinator worked on scheduling and coordinating requested dental appointments. In an interview on 10/10/2024 at 8:20 AM Staff I, LPN-Resident Care Manager (RCM), stated they review the notes from the dental hygienist, note them in a progress note, and if a dental appointment was necessary, the unit coordinator would be told verbally. Staff I stated Resident 17's representative scheduled all their appointments. In an interview on 10/10/2024 at 8:47 AM Staff N, Unit Coordinator, stated the RCM would provide information to them if an appointment needed to be scheduled. Staff N stated they would communicate with Resident 17's representative if a referral was made for them to see an outside provider. Staff N stated Resident 17's representative scheduled and communicated the appointments with them and the information was placed on a calendar. Staff N stated they did not have access to document appointments in any of the resident's clinical record or discussions with family/representatives. Staff N stated they could not recall a discussion with Resident 17's representative in December 2023 about a dentist referral. Staff N stated Resident 17 was seen by a dentist in 08/14/2024. In an interview on 10/11/2024 at 9:04 AM Staff B, Director of Nursing Services, stated there was difficulty in finding dentists that would accept residents with limited mobility and specialized wheelchairs. Staff B stated the unit coordinator should have access to the electronic medical record to add notes related to referrals and upcoming appointments. Refer to WAC 388-97-1060(1)(3)(j)(vii)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47104 Based on interview and record review, the facility failed to maintain records in accordance with accepted professional standards and practices for 2 of 4 sampled residents (Resident 50 and 64) reviewed for dialysis communication, 8 of 8 sampled residents (Residents 58,14,36,60,22,42,33 and 67) reviewed for Rehabilitation documentation, 2 of 2 sampled residents (Resident 10 and 60) reviewed for Oxygen (O2) orders, and 1 of 1 sampled residents (Resident 17) reviewed for provider consultation notes. The facility failed to ensure there was complete and accurate documentation in the clinical record. Failure to ensure the medical record was complete and accurately documented placed residents at risk for inconsistent care and treatment. Findings included . Review of the facility policy titled, Medical Record Organization dated 03/21/2024 showed all medical records must be complete, accurately documented, readily accessible and systematically organized. Additionally, the medical record would contain information to support diagnoses, treatments and document progress and continuity between health care providers. Review of the facility policy titled, Oxygen Administration, revised on 09/24/2024, showed that oxygen orders should be written for specific liter flow required by the resident. <RESIDENT 50> Resident 50 was admitted to the facility on [DATE] with diagnoses to include end stage kidney disease on dialysis. Review of Resident 50's medical record showed a document titled Pre/Post Dialysis Communication, dated 10/02/2024. Review of the document showed no documentation for the section to be completed by dialysis staff. There was no documentation of an attempt to obtain the missing information Review of Resident 50's medical record showed a document titled Pre/Post Dialysis Communication, dated 10/09/2024. Review of the document showed incomplete documentation. The pre-dialysis section to be completed by nursing home staff, and the section requiring completion by the dialysis staff were both incomplete. There was no documentation of an attempt to obtain the missing information In an interview on 10/09/2024 at 9:59 AM, Staff T, Licensed Practical Nurse (LPN), stated that the facility nurse was responsible for filling out the pre-dialysis section of the dialysis communication sheet, and for putting the sheet in the resident's dialysis binder which was sent with the resident to dialysis on dialysis days, The dialysis center would then complete their section of the form and send the form back to the facility with the resident after dialysis. The nurse assigned to the resident completed the post-dialysis section of the form and the form would go to medical records. Staff T stated if the dialysis center section of the form was incomplete upon the resident's return from the dialysis center, the nurse should call and attempt to obtain the missing information. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/2024 at 10:28 AM, Staff Y, Medical Records Director, provided a document titled Performance Improvement Project: Dialysis Documentation, initiated on 09/30/2024. Review of the Performance Improvement Project: Dialysis Documentation dated 09/30/2024 showed: -A 14-day look back of dialysis documentation would be completed and negative findings would be addressed, -Nurses re-educated on the dialysis policy to ensure dialysis documentation is follow up on per policy. -Dialysis binders updated. -Resident Care Managers (RCM) would complete weekly audits and follow-up with dialysis as necessary to ensure appropriate documentation was completed. In an interview on 10/10/2024 at 3:07 PM, Staff B, Registered Nurse (RN), Director of Nursing Services (DNS), stated that a Performance Improvement Plan (PIP) for dialysis documentation had been initiated. Staff B stated the PIP included staff education and auditing. Staff B stated that the process was to review the communication sheets for completion and follow up with the floor nurse and/or communication with the dialysis center for completion of their portion. In an interview on 10/11/2024 at 10:03 AM, Staff U, RN/Resident Care Manager (RCM), stated there was a performance improvement for completion of dialysis communication sheets but they did not know what the process was. In an interview on 10/11/2024 at 10:05 AM, Staff M, LPN, RCM, stated the PIP was initiated on 10/01/2024. The process was to audit the dialysis communication sheets and if there was missing documentation the RCMs would follow up with dialysis center or floor nurses to complete the missing information. Staff M stated attempts to contact the dialysis center would be documented on the dialysis communication form. In an interview on 10/11/2024 at 11:52 AM, Staff B, DNS, stated Resident 50's pre/post dialysis communication forms dated 10/02/2024, and 10/09/2024 were incomplete and there was no documentation that an attempt was made to collect the missing information. Staff B stated they would look for documentation and provide it if found. No further information was provided. <RESIDENT 64> Resident 64 admitted to the facility on [DATE] with diagnoses to include end stage renal disease on dialysis. Review of Resident 64's medical record showed documents titled Pre/Post Dialysis Communication, dated 10/02/2024, and 10/04/2024. Review of the documents showed no documentation for the section to be completed by dialysis staff. There was no documentation of an attempt to obtain the missing information (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/11/2024 at 11:52 AM, Staff B, DNS, stated Resident 64's pre/post dialysis communication forms dated 10/02/2024, and 10/09/2024 were incomplete and there was no documentation that an attempt was made to collect the missing information. Staff B stated they would look for documentation and provide it if found. No further information was provided. 47047 <RESIDENT 17> Resident 17 admitted to the facility on [DATE] with diagnoses that included weakness, diabetes mellitus type two (condition in which the body had trouble controlling blood sugar), and arthropathic psoriasis (a type of arthritis that affects people with the skin condition psoriasis). Review of Resident 17's progress note dated 08/23/2024 showed the resident had been seen by a dentist and were started on an antibiotic medication for a dental infection. Review of Resident 17's electronic and paper medical record showed no consultation report regarding their visit to the dentist on 08/23/2024. In an interview on 10/10/2024 at 8:47 AM Staff N, Unit Coordinator, stated they send out a blank consultation report with residents when they leave the facility for an appointment, and they rarely get returned. Staff N stated they were not aware of a process to follow up with the outside provider to obtain records related to a resident's appointment. In an interview on 10/11/2024 at 9:04 AM Staff B, DNS, stated Resident 17 had been started on antibiotics after their dental appointment on 08/23/2024 and was not aware of what happened to the records. Staff B stated they sent a staff member to obtain the records on 10/10/2024. 50725 <RESIDENT 60> Resident 60 admitted to the facility on [DATE] with diagnoses to include respiratory failure with hypoxia (low levels of oxygen in body tissues) and pleural effusion (a buildup of fluid between the tissues that line the lungs and chest). According to the Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], the resident has moderate cognitive impairment. In an observation on 10/07/2024 at 9:29 AM, Staff F, RN, was putting on oxygen on Resident 60 via nasal cannula (NC). According to Staff F, the resident had an order for oxygen as needed. In an observation on 10/09/2024 at 9:41 AM, Resident 60 was in their room lying on the bed with oxygen via NC, the concentrator was set at one liter of oxygen per minute (L/min). In a record review on 10/11/2024 at 8:54 AM, a provider's order for Resident 60 showed Oxygen at 1-2 liters/minute per nasal cannula as needed, the order was dated 08/20/2024. In an interview on 10/10/2024 at 9:04 AM, Staff E, LPN, stated the oxygen order was incomplete, and that it should have the reason or parameters on when to give the oxygen. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/10/2024 at 10:45 AM Staff D, RN/RCM, stated they would update the oxygen order to show the indication and the parameters on when to administer the oxygen. 51551 <RESIDENT 10> Resident 10 admitted to the facility on [DATE] with diagnoses to include chronic heart failure (progressive condition that the heart was unable to pump blood around the body properly), and pleural effusion. In an observation on 10/07/2024 at 8:40 AM, Resident 10 was sitting in the chair next to the bed with NC on and oxygen was set at one L/min. Review of a progress note, dated 10/07/2024 at 9:17 PM, showed Resident 10 was on oxygen at two L/min per NC with oxygen saturation above 90%. In an observation on 10/08/2024 at 10:54 AM, Resident 10 was observed sitting in the chair in their room. The oxygen NC was not on Resident 10, it was laying on the bed. The oxygen flow was set at one L/min. In an observation on 10/08/1024 at 11:10 AM, Resident 10 was observed in their room with oxygen on at one L/min. In an interview on 10/08/2024 at 11:41 AM, Staff M, LPN/RCM, stated there was no specific documentation to show how many liters of oxygen was given to Resident 10. Staff M stated the order showed give oxygen 1-2 L/min when their oxygen saturation was below 92%. Review of Resident 10's Medication Administration Record (MAR) dated 10/08/2024 at 11:56 AM, showed the oxygen ordered had been changed from continuous to one to two L/min per NC as needed to keep their oxygen saturation > 92%. There was no specific documentation to show how many liters of oxygen was given to Resident 10 when needed. In an observation on 10/08/2024 at 12:47 PM, Resident 10 was observed sitting in chair at their bedside with no oxygen on. Review of a progress note, dated 10/08/2024 at 9:57 PM, showed Resident 10 was on oxygen at two liters continuously and their oxygen saturation above 90%. In an observation on 10/09/2024 at 11:20 AM, Resident 10 was observed sitting in a wheelchair with nasal cannula oxygen at 1.5L/min. Review of a progress note dated 10/09/2024, showed there was no oxygen documentation. In an observation on 10/10/2024 at 8:17 AM, Resident 10 was observed eating breakfast in their room with NC on and oxygen set at one L/min. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note, dated 10/10/2024 at 4:55 PM, showed Resident 10 continued oxygen at 1.5 liter/minute via nasal cannula. Review of an oxygen Saturation flowsheet, dated 10/10/2024, showed no specific documentation of how many liters of oxygen was administered. In an interview on 10/11/2024 at 11:55 AM with Staff B, DNS, stated there was no specific documentation of how many liters of oxygen was given to Resident 10. They said the policy was just a policy and 1-2 liters was a specific oxygen range. They said they could not control what the provider wrote on the order. Staff B stated the policy did not require nurses to document specific flow of oxygen given to the resident. Refer to WAC 388-97-1720 (1)(a)(i)(ii)(iii)(b)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a Compliance and Ethics Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40998 Based on interview and record review the facility failed to properly implement the compliance and ethics program, prevent the submission of data/documentation known to be inaccurate and unethical practice for eight of ten residents (Residents 14, 22,33,36, 42, 58, 60 and 67) reviewed for therapy missed visit documentation. This failure placed residents at risk of not receiving appropriate physician ordered therapy services and potential decline in condition. Findings included . Review of the facility's policy titled Compliance and Ethics Program dated 06/01/2024, showed the facility and associates are committed to providing quality care and services necessary to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. The facility is also firmly committed to preventing fraud and abuse, complying with all applicable Federal and state laws and regulations and ethical behavior. The policy also showed Falsification of Documentation - Documentation of care or service that was not provided or provided in a different manner or time than documented. Falsification of documentation can be a criminal violation and may require certain reporting (e.g., to state licensing boards). In an interview on 09/30/2024 at 3:30 PM, Collateral Contact 5 (CC5), Licensed Physical Therapist Assistant (LPTA) stated they were notified by a previous co-worker at the facility that they saw a Missed Visit Note for Date of Service (DOS) 09/16/2024, reason for missed visit stated Unavailable. The note was electronically signed by Staff Z, Certified Occupational Therapy Assistant (COTA)/Director of Rehab (DOR) on 09/28/2024 at 10:03 AM on behalf of CC5. CC5 stated they were upset/concerned about Staff Z signing notes on their behalf and without their knowledge as they had not worked at the facility since 08/22/2024. CC5 stated they felt the reason missed visit notes were being completed by Staff Z was related to the therapy department being understaffed and accounted for missed visits at the close of the month. <RESIDENT 14> Resident 14 readmitted to the facility on [DATE] with diagnoses to include hemiplegia (paralysis to one side of the body) and hemiparesis (a condition that causes weakness or partial paralysis on one side of the body) following a stroke affecting the use of their right-side, right-hand contracture (tightening of muscle/tendons, preventing normal movement of a specific body part), muscle weakness, and dysphagia (difficulty swallowing). Review of therapy Missed Visit documentation showed: - Date of Service (DOS) 09/16/2024: Reason for missed visit - unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. - DOS 09/18/2024: Reason for missed visit - unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of Collateral Contact 7 (CC7), Physical Therapist (PT). (continued on next page)

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	505386	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marysville Care Center	1821 Grove Street Marysville, WA 98270

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- DOS 09/20/2024: Reason for missed visit - unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC7. <RESIDENT 22> Resident 22 admitted to the facility on [DATE] with diagnoses to include Parkinson' s disease, muscle weakness, difficulty in walking, low back pain, and dysphagia. Review of therapy Missed Visit documentation showed: - DOS 09/14/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. - DOS 09/16/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. <RESIDENT 33> Resident 33 admitted to the facility on [DATE] with diagnoses to include muscle weakness, history of stroke, gait and mobility abnormalities and falls. Review of therapy Missed Visit documentation showed: - DOS 09/17/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC7. <RESIDENT 36> Resident 36 admitted to the facility on [DATE] with diagnoses to include multiple sclerosis, muscle weakness, right leg below knee amputation, and spinal stenosis. Review of therapy Missed Visit documentation showed: - DOS 09/14/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. - DOS 09/16/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. - DOS 09/23/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z, COTA/Director of Rehab (DOR) on behalf of CC7. <RESIDENT 42> Resident 42 admitted to the facility on [DATE] with diagnoses to include right fibula fracture, muscle weakness and difficulty walking. Review of therapy Missed Visit documentation for Resident 42 showed: (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- DOS 09/16/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. <RESIDENT 58> Resident 58 admitted to the facility on [DATE] with diagnoses to include lumbar fracture, muscle weakness, malnutrition and difficulty walking. Review of therapy Missed Visit documentation for Resident 58 showed: - DOS 09/14/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. - DOS 09/16/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. - DOS 09/17/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC7. <RESIDENT 60> Resident 60 admitted to the facility on [DATE] with diagnoses to include muscle weakness, and dementia. Review of therapy Missed Visit documentation for Resident 60 showed: -DOS 09/23/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC7. <RESIDENT 67> Resident 67 admitted to the facility on [DATE] with diagnoses to include gait, mobility abnormalities, muscle weakness, and malnutrition. Review of therapy Missed Visit documentation for Resident 67 showed: - DOS 09/16/2024: Reason for missed visit- unavailable. Electronically signed on 09/26/2024 by Staff Z on behalf of CC5. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/08/2024 at 12:02 PM, Staff CC, COTA stated they had a daily schedule, provided by their supervisor, of residents they would see that day. Staff CC stated if they were unable to see all the residents on their schedule, they would notify Staff Z so they could try to reschedule that therapy session with the resident. Staff CC stated a missed visit note would be completed when they were unable to provide therapy to specific resident. Some of the reasons for not seeing a resident included resident illness, being out of the facility, a conflict of some kind or just unavailable. Staff CC stated they were familiar with CC7, PT, who completed evaluations only and never treated residents and therefore would have no reason to complete a missed visit note. Staff CC stated that if they did not see/treat a resident personally, they would never document anything for that resident, stating I would never document for another therapist. In an interview on 10/08/2024 at 4:27 PM, Collateral Contact 6 (CC6-LPTA), stated that they observed documentation that was signed by Staff Z on behalf of a co-worker that hadn't worked in the facility for over a month. CC6 stated they were confused how CC5 had missed visit notes when they had not worked any shifts during the time these notes were signed. CC6 stated that is not normal for anyone to sign documentation on behalf of other staff, stating I would not be ok with that, I had another DOR at another facility I was working at that called me for missed documentation and offered to put my time in and I said No I will be back to the facility and take care of it myself. In an interview on 10/10/2024 at 2:25 PM, CC7, PT, stated they were a previous PRN (as needed) employee of the facility that would come in strictly to complete evaluations on residents, they never actually treated residents. CC7 stated they were unaware of what a Missed visit note was, they had never completed one. CC7 stated they had not worked at the facility in close to two months they thought, stating that they had taken a full time DOR at another facility and just hadn't had any extra time. CC7 stated that Staff Z had never contacted/spoke with them about signing any documentation on their behalf and were unaware this had happened. CC7 stated that the only documentation they completed while in the facility was evaluations and if those did not get done there wasn't documentation that was completed in lieu of that. In a joint interview/record review on 10/10/2024 at 1:47 PM, Staff Z, DOR stated the purpose of missed visit documentation was if a resident was unable to be treated by therapy, for a variety of reasons, a missed visit note would need to be completed. Staff Z stated reasons for missed visit notes included if the resident was not feeling good, they may be out of the facility, medical hold, resident is unavailable, schedule conflict or even staffing concerns. Staff Z stated generally residents were seen by therapy five times a week and they would be out of compliance if they did not have a missed visit note in the clinical record when those residents weren't seen. Staff Z stated that they completed missed visit notes for CC5 and CC7 because they were scheduled to work those days and called out, listing the reason of the missed visit as Unavailable, and that was what they had been directed to do by corporate. Staff Z stated maybe unavailable wasn't the right thing to list because they were referring to the staff member being unavailable and agreed the options for the missed visits were resident specific. Staff Z stated they personally spoke to CC5 and CC7 on the phone about signing missed visit notes on their behalf but did not document that communication anywhere. Staff Z was unable to provide any further information about missed shifts or schedules for CC5 or CC7. (continued on next page)

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