| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505387 | A. Building<br>B. Wing | 06/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woodard Creek Health & Rehabilitation | 3333 Ensign Road Northeast<br>Olympia, WA 98506 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview, and record review, the facility failed to provide care and services in a dignified manner for 2 of 3 residents (Residents 9 & 90) reviewed for dignity. Failure to ensure staff to residents interaction occured in a respectful and dignified manner, residents clothing was changed daily and residents were assisted out of their day clothes prior to bed, placed residents at risk for diminished self-worth and decreased quality of life.<br><br>Findings included .<br><br>1) Resident 90 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/10/2025, showed the resident was cognitively intact and demonstrated verbal and physical behaviors directed toward others.<br><br>On 06/23/2025 at 1:39 PM, Resident 90 was in the dining room and repeatedly called out Help me, please take me to my room. Staff Q, Certified Nursing Assistant (CNA), said, give me ten minutes. Resident 90 stated, That is too long. I am going to be on the floor; my body is killing me. Staff Q, CNA, while exiting the dining room said, Ok, when you are on the floor I will come get you. Resident 90 again said that ten minutes was too long. Staff Q, CNA, returned to the door of the dining room and said, 20 minutes. Resident 90 said no that's too long. Staff Q then said, 30 minutes. Resident 90 again began yelling that it was too long. Staff Q asked the resident to stop yelling. Resident 90 replied, Well I have asked you 20 times. Staff Q then requested assistance from another staff member and assisted Resident 90 to their room.<br><br>On 06/23/2025 at 2:03 PM, Staff A, Administrator, was informed of the interaction between Staff Q and Resident 90. Staff A confirmed Staff Q had not spoken to Resident 90 in a dignified manner. Staff Q was suspended at that time pending investigation.<br><br>Review of the facility's 06/23/2025 investigation showed Staff Q was educated on professionalism and standards of conduct prior to returning to work.<br><br>2) Resident 9 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident the resident was cognitively impaired and dependent on staff for their activities of daily living.<br><br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/17/2025 at 10:06 AM, Resident 9's wife explained they visited every morning around 9:00 AM. They reported recently staff had not been changing Resident 9's clothing daily. The wife indicated Resident 9 was in the same clothes from 06/14/2025- 06/16/2025, until they intervened and informed the nurse, who reportedly sent an aide who changed Resident 9's clothing.<br><br>On 06/23/2025 at 9:53 AM, Resident 9's wife reported staff were not changing Resident 9 into night clothes before putting him to bed. They then pulled back Resident 9's bedding and stated, See, he is still in his day clothes. That's not dignified. He is wearing his sweatshirt in bed. They reported Resident 9 preferred to sleep in a hospital gown. Resident 9 was observed resting in bed with eyes closed, wearing a grey sweatshirt.<br><br>During an interview on 06/24/2025 at 10:57 AM, Staff B, Director of Nursing, said it was the expectation that resident clothing be changed each day and that they are put to bed in their preferred clothing.<br><br>Reference WAC 388-97-0180(1-4)<br><br>. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure they informed and provided written information to residents on their right to formulate an advance directive (written instruction for the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney (POA) for health care) for 2 of 3 residents (Residents 91 & 94) reviewed for advance directives. This failure placed residents at risk for not having their choice of who to care for them when incapacitated, not having their health care wishes honored, and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 91 was admitted to the facility on [DATE]. The Medicare 5 Day Miminum Data Set (MDS, an assessment tool), dated [DATE], showed they were severely cognitively impaired.<br><br>Review of Resident 91's electronic health record (EHR) showed no documentation of an advance directive or that the facility had offered the opportunity to formulate an advance directive.<br><br>During a joint interview on [DATE] at 8:23 AM, with Staff K, Social Services, and Staff J, Social Services, when asked when an advance directive was offered to residents, Staff K said during the care conference. Staff J said if the care conference was delayed, then social services would do an assessment where they documented the presence of an advance directive and if one was offered. When asked for documentation of an advance directive or that one was offered to be formulated for Resident 91, Staff K looked in the EHR and said they could not find a POA and this information was not done in their social work evaluation for this resident. Staff J also reviewed the EHR and said they could not find this information for Resident 91.<br><br>During an interview on [DATE] at 11:42 AM, Staff B, Director of Nursing Services (DNS), said their expectation for advance directives being offered and for documentation, was that they should be offered to the patient or family, tailored to preference, documented, and uploaded into the system. Staff B requested to follow up on Resident 91's advance directive.<br><br>On [DATE] at 2:58 PM, Staff B said they could not find an advance directive for Resident 91 and this did not meet expectations.<br><br>2) Resident 94 was admitted to the facility on [DATE]. The admission Medicare 5 Day MDS, dated [DATE], showed Resident 94 was cognitively intact.<br><br>Review of Resident 94's EHR showed no documentation of an advance directive or that the facility had offered the opportunity to formulate an advance directive.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a joint interview on [DATE] at 8:23 AM, with Staff K, Social Services, and Staff J, Social Services, when asked for documentation of an advance directive or that one was offered to be formulated for Resident 94, Staff K reviewed the EHR and said Resident 94 did not have a POA and the social work note had only documented CPR (a Portable Orders for Life Sustaining Treatment, POLST) under advance directive. Staff J, when asked what counted as an advance directive, said a living will, a POA, guardian paperwork, or decision making paperwork, but a POLST did not count as an advance directive.<br><br>During an interview on [DATE] at 2:58 PM, Staff B, DNS, said they could not find an advance directive for Resident 94 and this did not meet expectations.<br><br>Reference WAC 388-97-0300 (1)(b), (3)(a-c)<br><br>. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>.<br><br>Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for 1 of 3 sampled residents (Resident 22) reviewed for Beneficiary Notices. This failure placed residents and/or their representatives at risk for not having adequate information to make financial decisions related to the residents' stay in the facility.<br><br>Findings included .<br><br>The Notice of Medicare Non-Coverage, dated 03/28/2025, documented Resident 22 was not provided with a SNF ABN.<br><br>On 06/20/2025 at 1:32 PM, Staff A, Administrator, said Resident 22 had not been provided with the SNF ABN and should have been.<br><br>Reference (WAC) 388-97-0300 (4)(a-c) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on record review and interview, the facility failed to ensure psychotropic medications (any drug that affects the brain activities associated with mental processes and behavior) were regularly monitored, documented on, had associated non-pharmacological interventions (non-medication interventions), that as needed psychotropic medications had end dates and limited to 14 days, and/or monthly pharmacist recommendations were acted upon timely, for 5 of 7 residents (Residents 9, 354, 91, 88 & 66) reviewed for unnecessary medication or hospice. This failure placed residents at risk of unnecessary medication usage, increase in side effects without intervention, and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 9 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/04/2025, showed the resident was cognitively impaired, had diagnoses of bipolar and depressive disorders and received antipsychotic medication (drugs that work by affecting brain chemistry, helping to reduce hallucinations, delusions, and disordered thinking) during the assessment period.<br><br>Resident 9 had the following psychotropic medication orders:<br><br>1. A 06/03/2025 order for lorazepam (an antianxiety) every six hours as needed for 14 days for anxiety.<br><br>2. A 05/03/2025 order for Zyprexa (an antipsychotic) for major depressive disorder.<br><br>An at risk for alterations in mood related to diagnoses of depression and anxiety care plan, revised 06/09/2025, directed staff to set up mental health services as ordered, discuss feelings of sadness, observe for worsening indicators of depressive symptoms, and evaluate effectiveness and side effects of medications for possible decrease/elimination of antipsychotic medication. The care plan did not indicate whether mental health services were ordered or what the resident's depressive symptoms were.<br><br>An antipsychotic use care plan, initiated 04/10/2025, had an identified goal Resident 9 would not experience adverse side effects (ASEs). A goal for the use of the antipsychotic medication, the diagnosis/justification for use, and the target behaviors (TBs) the medication was implemented to treat were not identified<br><br>Resident 9's comprehensive care plan did not address their bipolar disorder diagnosis or identify the use of antianxiety medication or the TBs the antianxiety medication was implemented to treat.<br><br>During an interview on 06/24/2025 at 10:05 AM, Staff B, Director of Nursing Services (DNS), said Resident 9's diagnosis of bipolar disorder, use of antianxiety medication, and the TBs the antianxiety and antipsychotic medications were implemented to treat should have been addressed in their comprehensive care plan.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 9's order history showed they had an order for lorazepam every six hours as needed for anxiety from 05/02/2025 - 06/03/2025, greater than 14 days. On 06/03/2025 the order was discontinued and then reinstated the same day as lorazepam every six hours as needed for 14 days for anxiety.<br><br>Review of the electronic health record (EHR) showed no resident specific clinical rationale was documented by the provider to indicate why Resident 9 required their lorazepam to be extended beyond 14 days.<br><br>During an interview on 06/24/2025 at 10:05 AM, when asked if the provider documented a clinical rationale for extending Resident 9's lorazepam beyond 14 days Staff B, DNS, said not that they saw in the EHR, but indicated they would check the resident's paper chart. No further documentation was provided.<br><br>Review of the June 2025 Medication Administration Records (MAR) showed the TBs for the use of lorazepam were identified as restlessness, agitation and uncontrollable worry. The TBs for the use of Zyprexa were identified as hallucinations, delusions and disorganized thinking and speech. Eight non-pharmacological interventions (NPIs) were identified for each medication with instruction for nurses to document the NPIs they attempted and their effectiveness.<br><br>On 06/24/2025 at 9:37 AM, Resident 9's Power of Attorney (POA) said the resident had not had hallucinations or delusions before. The POA said Resident 9 was started on Zyprexa for being combative with staff during care.<br><br>During an interview on 06/24/2025 at 10:05 AM, when asked what Resident 9's hallucinations and delusions were and what effect, if any, they had on the resident Staff B, DNS, indicated they were unsure and would check the paper record. No further documentation was provided.<br><br>Review of the May 2025 MAR showed Resident 9 was administered as needed lorazepam on:<br><br>1. 05/16/2025 at 4:34 PM.<br><br>2. 05/19/2025 at 2:28 AM.<br><br>3. 05/27/2025 at 2:30 AM.<br><br>The May 2025 MAR showed on 05/16/2025 and 05/19/2025 nurses documented Resident 9 demonstrated no TBs for the use of lorazepam and nurses attempted no NPIs prior to administering the lorazepam. On 05/27/2025 the facility nurse documented + for TBs demonstrated, a + for NPIs attempted, and a + for effectiveness, but did not identify what TBs were demonstrated, what NPIs were attempted, and it was unclear if a + documented under effectiveness, meant the NPIs were effective, if so, the medication should not have been administered.<br><br>During an interview on 06/24/2025 at 10:05 AM, when asked if there was documentation to show Resident 9 demonstrated an identified TB for the use of lorazepam, if NPIs were attempted, if so which ones, prior to the administration of lorazepam on the above referenced occasions Staff B, DNS, stated, No.5) Resident 66 was admitted to the facility on [DATE]. The significant change MDS dated [DATE] documented Resident 66 was cognitively intact and was on Hospice Care.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 66's EHR showed an order dated 04/30/2025 without an end date for lorazepam to be given every hour as needed for terminal agitation/anxiety.<br><br>A review of the EHR showed Resident 66 had not been given a dose of Lorazepam since it was ordered.<br><br>On 06/23/2025 at 9:18 AM, Staff D, Registered Nurse/Unit Manager said an as needed, psychotropic medication should be ordered for 14 days only with a stop date and then be re-evaluated. This order for lorazepam does not have a stop date and does not look like it was re-evaluated.<br><br>On 06/23/2025 at 11:30 AM Staff B, DNS said this lorazepam was ordered on 04/30/3035 and does not have a stop date. Staff B said there needed to be a stop date or documentation with an explanation of the rationale. Staff B said she did not see documentation to support the order for over 14 days.<br><br>Reference WAC 388-97-1060 (3)(k)(i), 0620 (1)(a)<br><br>2) Resident 354 was admitted to the facility on [DATE] with diagnoses that included Unspecified Dementia, Unspecified Severity, with mood disturbances (a diagnosis of dementia when the specific type and severity are not specified, but the patient is also experiencing mood disturbances like depression, apathy, or anhedonia) and Unspecified Dementia, Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (specific type of dementia is unknown, no significant behavioral disturbances, such as aggression, agitation, or wandering, no psychotic symptoms, such as hallucinations or delusions, and no mood disturbances, such as depression or anxiety). The Entry MDS, dated [DATE], had not yet been completed, cognition level unknown at the time.<br><br>Resident 354 was prescribed Buspirone (an antianxiety) for anxiety, Quetiapine (an antipsychotic) for mood disorder and Sertraline (an antidepressant) for depression. The EHR documented no diagnoses of anxiety or depression.<br><br>Resident 354's Psychoactive Medication care plan documented no diagnoses or anxiety or depression and no justification for the use of psychotropic medication.<br><br>On 06/20/2025 at 11:31 PM, Staff B, DNS, read through Resident 354's medical diagnoses list and confirmed Resident 354 had no diagnoses of anxiety or depression and was not sure what mood disorder indicated. Staff said the two unspecified dementia diagnoses contradicted each other and needed to be corrected. When reviewing Resident 354's medication list, Staff B said they did not know why Resident 354 was receiving an antianxiety, an antidepressant and an antipsychotic without the proper diagnoses. 3) Resident 91 admitted to the facility on [DATE]. According to the admission MDS, dated [DATE], Resident 91 was severely cognitively impaired. Resident 91 had diagnoses that included depression and anxiety disorder.<br><br>Resident 91's orders were reviewed, and four psychotropic medications were found.<br><br>1.<br><br>Antidepressant: Bupropion, two times a day for mood management<br><br>2.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Antidepressant: Venlafaxine, one time a day for mood management<br><br>3.<br><br>Anxiolytic (anti-anxiety medication): Buspirone, two times a day for mood stabilizer<br><br>4.<br><br>Antipsychotic: Olanzapine, one time a day for agitation related to Cognitive Communication Deficit.<br><br>Review of the EHR showed no active diagnosis for psychosis for Resident 91.<br><br>Review of Resident 91's 05/2025 and 06/2025 MAR and Treatment Administration Records (TAR) showed there was no monitoring ordered for TBs or ASEs for any of the 4 psychotropic medications that were ordered.<br><br>On 06/23/2025 at 10:17 AM, Staff B, DNS, when asked how staff would know if psychotropic medications were effective or not, Staff B said there would be monitoring in place in the MAR and TAR, and increased TBs. When asked if TBs, behaviors and ASEs should be ordered for anxiety, antidepressants and antipsychotic medications, Staff B said, yes, correct to all. Staff B said, there was an order set that was used for psychotropic medications that included monitoring for side effects and behavior monitoring. Regarding Resident 91's two antidepressants, antianxiety, and antipsychotic medications, Staff B acknowledged that there were no orders in place for TBs, behavior monitoring, and monitoring for ASEs, and said they should be there. Regarding the orders for the antidepressants Venlafaxine and Bupropion being written for mood management (not a medical or psychiatric diagnosis), Staff B said it did not meet expectations, Resident 91 had a diagnosis of depression which would be the correct diagnosis, mood management was not an acceptable diagnosis, and it needed to be fixed. Regarding the order for the antipsychotic medication Olanzapine being written for agitation related to cognitive communication deficit, Staff B acknowledged that cognitive communication deficit was not an appropriate diagnosis to be treated with an antipsychotic. Regarding the order for the antianxiety medication Buspirone being written as a mood stabilizer, Staff B said, again, we need the correct diagnosis. When asked how the facility would know if Resident 91's psychotropic medications were necessary if the facility was not monitoring behaviors and TBs, Staff B said the facility should have caught these issues and put documentation in.<br><br>4) Resident 88 was admitted to the facility on [DATE] with a diagnosis of encounter for palliative care (medical care focused on relief from symptoms). The admission MDS, dated [DATE], showed Resident 88 understood and understands, and was on hospice services (end of life care).<br><br>Resident 88 had two as needed psychotropic medications without end dates listed:<br><br>1. Lorazepam an antianxiety medication, ordered on 05/01/2025<br><br>2. Haloperidol an antipsychotic medication, ordered on 05/01/2025<br><br>Review of the EHR from 05/01/2025 to 06/16/2025, showed Resident 88 had not received any doses of haloperidol and only once received lorazepam, on 05/29/2025.<br><br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 88's pharmacist recommendation from 05/08/2025, showed the following recommendations:<br><br>1. For haloperidol, a provider must have directly examined the patient before writing a new 14 day script. If this as needed antipsychotic was to continue, the patient would have needed a new prescription for a 14 day supply.<br><br>2. For lorazepam, because the psychotropic medication was not an antipsychotic, the prescriber could have extended the prescription to an additional 180 days with a documented rational for extension and a specific duration in days for the extension.<br><br>During an interview on 06/18/2025 at 11:42 AM, Staff B, DNS, said pharmacist recommendations should have been implemented as soon as possible, and this did not happen for Resident 88's pharmacist recommendation on 05/08/2025. Staff B confirmed both as needed psychotropic medications had been ordered for greater than 14 days, and lorazepam had been given once on 05/29/2025 without any documented non-pharmacological interventions provided. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the State Agency within 24 hours for 1 of 2 sampled residents (Resident 39) reviewed for abuse. This failure placed residents at risk of incidents not being reported and at risk of abuse and neglect.<br><br>Findings included .<br><br>Resident 39 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (an assessment tool), dated 04/28/2025, documented Resident 39 was cognitively intact and required substantial/maximal assistance with toileting hygiene.<br><br>On 06/16/2025 at 2:26 PM, Resident 39 said on 05/04/2025 there was a bad episode, staff didn't change their brief and they didn't come back. Resident 39 said it had been reported to the state and that Staff V, had said he would report it. Resident 39 did not want to discuss this further at this time.<br><br>Review of the Incident Log (an incident tracking system) from 01/02/2025 through 06/13/2025 showed no entries for Resident 39.<br><br>Review of the Grievance log for 04/2025 through 05/2025 showed now entries for Resident 39.<br><br>On 06/18/2025 at 9:08 AM, Resident 39 said regarding the incident on 05/04/2025 a nurse had come in and said they were going to get a brief, the nurse undid Resident 39's brief and left, then another staff had come in and left Resident 39 uncovered, unchanged and wet. Resident 39 said it took forever for staff to return, approximately 2 hours later. Resident 39 said they had told everything to Staff V and Staff V had said it was important enough to call the State Agency to report it. Resident 39 said, I am not a tattle tale, but it was important. Resident 39 said the incident had made them feel neglected, frustrated and unheard.<br><br>On 06/18/2025 at 9:15 AM, Staff V, Occupational Therapy Assistant, said he was familiar with Resident 39. When asked if he recalled an incident in May reported by Resident 39, Staff V said, yes, they had told him. Staff V said, it was resident care stuff, I believe it was, I don't remember exactly. Staff V said Resident 39 had made complaints about the care that day and to previous nurses. When asked if he had reported Resident 39's complaints, Staff V said he did report it to the charge nurse but could not remember who that was. Staff V said he had given Resident 39 a grievance form and offered to help them fill it out, but Resident 39 had declined to fill it out. When told Resident 39 had said Staff V had reported the care concerns to the State Agency, Staff V said he had encouraged Resident 39 to report it themself and had given them the number to the Ombudsman (advocate for residents).<br><br>(continued on next page) |

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|---|---|---|---|
| | 505387 | A. Building<br>B. Wing | 06/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woodard Creek Health & Rehabilitation | 3333 Ensign Road Northeast<br>Olympia, WA 98506 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/18/2025 at 9:40 AM, Staff A, Administrator, was informed of Resident 39's allegations. At 9:47 AM, Staff B, Director of Nursing Services joined the conversation and said the incident was not ringing a bell with her, she knew who Staff V was, but did not recall the situation. Staff A said, they would investigate the situation, and they would have launched an investigation immediately if they had been informed. When asked if Staff V should have reported the allegation made by Resident 39, both staff A and Staff B said, yes.<br><br>Reference WAC 388-97-0640(5)(a)<br><br>. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to complete a thorough investigation to rule out abuse or neglect for 1 of 3 residents (Resident 91) reviewed for falls. Failure to conduct a thorough investigation placed the residents at risk for unidentified abuse or neglect, poor clinical outcomes and a decreased quality of life.<br><br>Findings included .<br><br>Review of the electronic health record (EHR) showed Resident 91 admitted to the facility on [DATE] with diagnoses of diabetes and chronic obstructive pulmonary disease. The resident was able to make needs known.<br><br>During an interview on 06/16/2025 at 12:55 PM, Resident 91 said they had a fall in their bathroom and had some small bruises on their arms.<br><br>Review of the EHR showed a note from 06/01/2025 which stated the resident had a fall at 10:15 AM when the resident was found to have no footwear on and had attempted to transfer into the wheelchair from bed.<br><br>Review of the facility provided incident log showed the resident had a fall on 05/21/2025, 05/22/2025 and 06/01/2025.<br><br>Review of the facility incident investigations showed no statements from care staff, no root cause was identified and no new interventions or care plan updates were completed. All 3 investigations showed a completion date of 06/03/2025, 13 days after the first fall.<br><br>During an interview on 06/20/2025 at 12:20 PM, Staff B, Director of Nursing Services said Resident 91's fall investigations did not include appropriate witness statements, did not identify the root cause of the falls to rule out abuse or neglect and did not identify or implement new interventions to decrease risk further falls and should have. Staff B said the investigations should have been completed within 5 days of the incidents but were not and this did not meet expectations.<br><br>Reference WAC 388-97--0640 (6)(a)(b)<br><br>. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to transmit required Minimum Data Set (MDS, an assessment tool) data to the Center for Medicare and Medicaid Services (CMS) within 14 days of completion as required for 8 of 9 residents (Residents 75, 36, 7, 31, 6, 62, 74 & 19) reviewed for resident assessment. The failure to ensure MDS assessment and tracking records were completed and transmitted timely as required, placed the resident at risk for unmet care needs and diminished quality of life.<br><br>Findings included .<br><br>Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, revised October 2023, showed Admission, Significant Change, Quarterly, and Annual MDS assessments must be completed no later than 14 days after the Assessment Reference Date (ARD), and must be submitted/transmitted to the CMS database, within 14 days of the MDS completion date.<br><br>Review of the electronic health record (EHR) for the above identified residents, showed no MDS data was present for MDS assessents with ARDs in March 2025. There was no indication if ther MDSs had been been scheduled, completed, or transmitted.<br><br>In an interview on 06/19/2025 at 2:23 PM, Staff A, Administrator, explained the facility recently changed ownership and EHR programs. This resulted in an inability to access the data for MDS assessments completed in March 2025. Staff A, Administrator, said they would continue to find a way to access and provide the requested information.<br><br>On 06/24/2025 at 1:35 PM, in an email, Staff A, Administrator, provided a copy of the facility's March 2025 MDS Final Validation Report [FVR] obtained from CMS. Review of the document showed the following:<br><br>1) Resident 75 was triggered for resident assessment secondary to a MDS record over 120 days old.<br><br>Review Resident 75's EHR showed the last MDS that was completed was a 01/21/2025 Quarterly MDS.<br><br>Review of the March 2025 FVR report from CMS showed Resident 75 had an admission MDS, dated [DATE], completed, that was submitted more than 14 days after the completion date.<br><br>2) Resident 36 triggered for resident assessment secondary to a MDS record over 120 days old.<br><br>Review Resident 36's EHR showed the last MDS completed was a 12/29/2024 Quarterly MDS.<br><br>Review of the March 2025 FVR report showed Resident 36 had a 03/31/2025, Annual MDS completed that was submitted more than 14 days after the completion date.<br><br>3) Resident 7 triggered for resident assessment secondary to a MDS record over 120 days old.<br><br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review Resident 7's EHR showed the last MDS completed was a 02/10/2025 Quarterly MDS.<br><br>Review of the March 2025 FVR report showed Resident 7 had a 03/18/2025 Quarterlyl MDS completed, that was submitted more than 14 days after the completion date.<br><br>4) Resident 31 triggered for resident assessment secondary to MDS record over 120 days old.<br><br>Review Resident 31s EHR showed the last MDS completed was a 12/23/2024 Quarterly MDS.<br><br>Review of the March 2025 FVR report showed Resident 31 had a 03/23/2025 Quarterlyl MDS completed, that was submitted more than 14 days after the completion date.<br><br>5) Resident 6 triggered for resident assessment secondary to MDS record over 120 days old.<br><br>Review Resident 6s EHR showed the last MDS completed was a 12/29/2024 Quarterly MDS.<br><br>Review of the March 2025 FVR report showed Resident 6 had a 03/28/2025 Annual MDS completed, that was submitted more than 14 days after the completion date.<br><br>6) Resident 62 triggered for resident assessment secondary to MDS record over 120 days old.<br><br>Review Resident 62's EHR showed the last MDS completed was a 12/19/2024 Quarterlyl MDS.<br><br>Review of the March 2025 FVR report showed Resident 62 had a 03/19/2025 Quarterlyl MDS completed, that was submitted more than 14 days after the completion date.<br><br>7) Resident 74 triggered for resident assessment secondary to MDS record over 120 days old.<br><br>Review Resident742's EHR showed the last MDS completed was a 12/23/2024 Quarterlyl MDS.<br><br>Review of the March 2025 FVR report showed Resident 74 had a 03/23/2025 Quarterlyl MDS completed, that was submitted more than 14 days after the completion date.<br><br>8) Resident 19 triggered for resident assessment secondary to a MDS record over 120 days old.<br><br>Review Resident 19's EHR showed the last MDS completed was a 12/28/2024 Quarterly MDS.<br><br>Review of the March 2025 FVR report showed Resident 19 had a 03/28/2025 Quarterlyl MDS completed, that was submitted more than 14 days after the completion date.<br><br>Reference WAC 388-97-1000(4)(b), (5)(b)<br><br>. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview, and record review the facility failed to develop, implement and/or ensure residents' comprehensive care plans accurately reflected care needs for 12 of 24 (Residents 9, 29, 33, 37, 90, 66, 57, 30, 79, 94, 91, & 88) residents reviewed. These failures placed residents at risk for unidentified and/or unmet care needs, medical complications and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 9 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/04/2025, showed the resident had severe cognitive impairment, diagnoses of heart failure, and malnutrition, and received diuretic medication (increases urine production and helps the body eliminate excess fluid and salt) during the assessment period.<br><br>Resident 9 had a 05/07/2025 order to apply ace wraps to the lower extremities in the morning and remove at bedtime.<br><br>Review of the comprehensive care plan showed no nutrition care plan addressing the resident's malnutrition had been developed or implemented.<br><br>During an interview on 06/24/2025 at 11:49 AM, Staff B, Director of Nursing Services (DNS), said a nutrition care plan should have been developed/implemented.<br><br>Review of the diuretic use, heart failure and kidney disease care plans, initiated 04/10/2025, showed staff were directed to monitor for fluid retention and edema. Resident 9's need for daily ace/compression wraps to both lower extremities was not identified/addressed.<br><br>During an interview on 06/24/2025 at 11:49 AM, Staff B, DNS, said the resident's ace/compression wraps should have been care planned.<br><br>2) Resident 29 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of obstructive uropathy and heart failure, required use of an indwelling urinary catheter, and received diuretic medication during the assessment period.<br><br>Review of Resident 29's electorinc health record (EHR) showed 05/04/2025 orders for:<br><br>a) A 16 French suprapubic urinary catheter, with a 10 cubic centimeter balloon.<br><br>b) Apply ace wraps to lower extremities in the morning and remove them at bedtime.<br><br>Review of a catheter care plan, initiated 04/10/2025, documented Resident 29 required a urinary catheter. The care plan did not indicate the type of urinary catheter (e.g. suprapubic) or provide a justification for use (e.g. obstructive uropathy.)<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 06/24/2025 at 11:49 AM, Staff B, DNS, said Resident 29's type of urinary catheter and justification for use should have been care planned.<br><br>Review of the diuretic and heart failure care plans, initiated 04/10/2025, showed staff were directed to monitor Resident 29's edema. The care plans did not address the order for daily weights or the associated weight variance parameters that would require physician notification.<br><br>During an interview on 06/24/2025 at 11:49 AM, Staff B, DNS, said Resident 29's daily weights and parameters requiring physician notification should have been care planned.<br><br>3) Resident 33 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident was cognitively intact, had diagnoses of atrial fibrillation (a common heart rhythm disorder), heart failure and kidney disease and required diuretic therapy.<br><br>Resident 33 had a 05/07/2025 order for daily weights with instruction to notify the provider if there was a weight variance of three pounds or greater in 24 hours, or five pounds or greater in a week.<br><br>Review of the comprehensive care plan showed Resident 33's need for daily weights and associated physician notification parameters were not addressed<br><br>During an interview on 06/24/2025 at 11:49 AM, Staff B, DNS, said Resident 33's daily weights and the associated parameters for physician notification should have been addressed on the care plan.<br><br>4) Resident 37 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively impaired, had diagnoses of heart failure, malnutrition, and failure to thrive, and received greater than 51% of total calories via tube feeding.<br><br>Review of the EHR showed a 06/02/2025 order for NPO (nothing by mouth.)<br><br>Review of the comprehensive care plan showed Resident 37 NPO status was not addressed.<br><br>During an interview on 06/24/2025 at 11:49 AM, when asked if Resident 37's NPO status should have been addressed on the comprehensive care plan Staff B, DNS, said, Yes.<br><br>Resident 37 had a 06/02/2025 order for weekly weights, with instructions to notify the physician and write a progress note if there was a weight variance of five pounds or greater in one week.<br><br>Review of the comprehensive care plan showed the residents need for weekly weights and associated physician notification parameters were not addressed.<br><br>During an interview on 06/24/2025 at 11:49 AM, Staff B, DNS, said Resident 37's need for weekly weights and the associated parameters for physician notification should have been addressed on the care plan.<br><br>5) Resident 90 was admitted to the facility on [DATE]. Review of the Restorative Nursing records showed Resident 90 was receiving a passive range of motion (ROM) program to bilateral (both) upper and lower extremities, two sets of 10-15 repetitions, three to four days a week.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A functional maintenance care plan, initiated 05/12/2025, showed Resident 90 was to receive a restorative nursing bed mobility program, not a passive ROM program to bilateral upper and lower extremities.<br><br>During an interview on 06/24/2025 at 11:49 AM, Staff B, DNS, indicated the care plan needed to be updated.<br>6) Resident 66 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 66 was cognitively intact and was on Hospice Care.<br><br>Review of the comprehensive care plan showed the hospice care plan did not address the residents' advanced directives preferences, goals of care, or name the hospice provider.<br><br>On 06/23/2025 at 9:18 AM, Staff D, Registered Nurse/Unit Manager, said they would add the name of the Hospice provider and Resident 66's goals of care to the hospice care plan to make it more personalized.<br><br>On 06/23/2025 at 11:30 AM, Staff B, DNS, said Resident 66 hospice care plan was not personalized and they would specify their advanced directives in the care plan.7) Resident 57 was admitted to the facility on [DATE] with diagnoses that included Major Depressive Disorder, Anxiety Disorder, and Post-Traumatic Stress Disorder (PTSD). The Quarterly MDS, dated [DATE], documented Resident 57 was moderately cognitively impaired.<br><br>On 06/17/2025 at 10:36 AM, Resident 57 said they were unaware if they were taking any psychotropic (mind altering) medication.<br><br>The EHR documented Resident 57 was prescribed two antidepressant medications, bupropion and fluoxetine for depression and primidone for PTSD.<br><br>Resident 57's Depression/Psychoactive Medication care plan documented indictors of depression and risk for complications for the antidepressant medication. There was no care plan regarding anxiety or PTSD diagnoses or medication use.<br><br>On 06/20/2025 at 11:31 PM, Staff B, DNS, said care plans were completed on admission by the MDS nurse and the nursing team management and reviewed quarterly. Staff B reviewed Resident 57's medical diagnoses, confirming Resident 57's mental health diagnoses. Staff B was shown Resident 57's Psychoactive Medication care plan and it only documented the diagnoses of depression. When asked about Resident 57's diagnoses of anxiety and PTSD, Staff B said the anxiety and PTSD diagnoses should have been on that care plan.<br><br>8) Resident 30 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], documented Resident 30 was frequently incontinent with bowels.<br><br>On 06/17/2025 at 12:03 PM, Resident 30 said regarding their bowel habits, that sometimes they made it to the restroom and sometimes not.<br><br>Review of Resident 30's June 2025 bowel continence record showed the following documentation:<br><br>06/06/2025- incontinent<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 06/07/2025- no bowel movement<br><br>06/08/2025- no bowel movement<br><br>06/09/2025- continent<br><br>06/10/2025- incontinent<br><br>06/11/2025- continent<br><br>06/12/202- incontinent<br><br>06/13/2025- no bowel movement<br><br>06/14/2025- continent<br><br>06/15/2025- continent<br><br>06/16/2025- continent<br><br>06/17/2025- no bowel movement<br><br>06/18/2025- no bowel movement<br><br>A 06/18/2025 nursing progress note, documented Resident 30 was noted to be continent of bowel. Review of Resident 30's continence care plan documented Resident 30 was incontinent with bladder and bowel.<br><br>On 06/20/2025 at 1:05 PM, Staff B, DNS, confirmed the care plan documented Resident 30 was incontinent with bladder and bowel. Staff B was informed that the resident reported being frequently continent of bowel and the bowel record documented this as well. When asked if the care plan was accurate and person centered to promote Resident 30's continence, Staff B said, it should have been updated.<br><br>9) Resident 79 admitted to the facility 05/07/2025. The admission MDS, dated [DATE], documented Resident 79 was cognitively intact and required substantial/maximal assistance with showering/bathing themselves.<br><br>On 06/17/2025 at 8:45 AM, Resident 79 said they could not shower because of their foot, and had not been given a bed bath since arriving.<br><br>Review of Resident 79's EHR showed a physician's order dated 05/07/2025, for non-weight bearing to right lower extremity other than to transfer due to right heel wound.<br><br>Review of Resident 30's care plan showed no plan had been developed for Resident 30's bathing hygiene with her non weight bearing status.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 06/20/2025 at 12:59 PM, Staff B, DNS, said they were unable to locate anything on the care plan regarding bathing. When asked if bathing should have been care planned due to resident 30's non weight bearing status, Staff B said yes, it should have been care planned.<br><br>10) Resident 94 was admitted to the facility on [DATE]. The admission Medicare 5 Day MDS, dated [DATE], showed Resident 94 was cognitively intact.<br><br>During an interview on 06/16/2025 at 11:13 AM, Resident 94 said they smoked cigarettes off the premises.<br><br>Review of Resident 94's tobacco use care plan on 06/18/2025, did not specify what Resident 94 smoked. It listed the resident prefers to smoke (cigarettes, cigar, pipes, electronic delivery systems (electronic cigarettes/e-cigs, vape pen, etc). It included to educate the resident on the facility's smoking policy and location to smoke off campus and times, but did not give details on where Resident 94 went to smoke. The care plan also did not have the location of where Resident 94 kept their cigarettes for safety.<br><br>During an interview on 06/18/2025 at 11:42 AM, Staff B, DNS, said a care plan for a resident that smokes should have included the location the resident smoked, hazards, assessments, and been tailored to the resident. When asked if Resident 94's care plan should have included what product the resident smoked, where they smoked outside, the location of where cigarettes were kept, Staff B looked at the care plan and said yes. Staff B acknowledged Resident 94's tobacco use care plan was not resident specific.<br><br>11) Resident 88 was admitted to the facility on [DATE] with a diagnosis of encounter for palliative care (medical care focused on relief from symptoms). The admission MDS, dated [DATE], showed Resident 88 understood and understands, and was on hospice services (end of life care).<br><br>Review of Resident 88's care plans on 06/17/2025, showed their antianxiety medication was not care planned and non-pharmacological interventions (non-medication interventions) were not listed for psychotropic medication usage. There also was no advance directive (written instruction for the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney (POA) for health care) care plan.<br><br>During an interview on 06/18/2025 at 11:42 AM, Staff B, DNS, said for a hospice care plan, they would expect information on the company providing care, interventions to comply with, and medications if needed. Staff B reviewed Resident 88's care plans and acknowledged there was no non-pharmacological interventions listed for psychotropic medication usage, there was no antianxiety care plan, the care plans did not say who to contact for hospice/who hospice was through, and did not include information on their advance directive.<br><br>12) Resident 91 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, lung and airway disease that restricts breathing) and respiratory failure. The Medicare 5 Day MDS, dated [DATE], showed they were severely cognitively impaired and required continuous oxygen use.<br><br>During an observation on 06/16/2025 at 12:59 PM, Resident 91's bed was seen against the wall.<br><br>(continued on next page) |

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| | 505387 | A. Building<br>B. Wing | 06/24/2025 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 91's care plans on 06/17/2025, showed their bed against the wall was not care planned. Resident 91's respiratory care plan said, the resident is at risk for respiratory complications secondary to with no diagnoses listed. There was no information on what to keep Resident 91's oxygen saturation levels at.<br><br>During an interview on 06/23/2025 at 10:45 AM, Staff B, DNS, said for residents with a bed against the wall, the facility needed to care plan this. After looking at Resident 91's care plans, Staff B said they did not see a care plan for Resident 91's bed against the wall.<br><br>On 06/23/2025 at 1:13 PM, Staff B said they would expect a respiratory care plan to include if the oxygen was continuous or as needed, if it was given by nasal cannula, the liters per minute and if it was a set amount or range, if a resident regularly takes off their oxygen, and diagnoses. Staff B reviewed Resident 91's respiratory care plan, said Resident 91 had diagnoses of COPD and chronic respiratory failure and those should have been listed, and acknowledge the care plan should have been more personalized.<br><br>Reference WAC 388-97-1020(1),(2)(a)(b)<br><br>. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Resident 37 was admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], showed the resident was cognitively impaired and received greater than 51% of their calories via tube feeding.<br><br>Review if the electronic health record (EHR) showed a 06/02/2025 order for nurses to change, date and initial Resident 37's tubefeeding syringe daily.<br><br>Observation on 06/17/2025 at 9:34 AM, 06/23/2025 at 1:53 PM, and 06/24/2025 at 10:49 AM, showed Resident 37 had an undated /initialed 60 cubic centimeter (cc) syringe at bedside.<br><br>Review of the June 2025 MAR showed the night shift nurse signed that the task was completed daily from 06/02/2025 - 06/23/2025.<br><br>During an interview on 06/24/2025 at 10:57 AM, Staff B, DNS, observed Resident 37's 60 cc syrnge at bedside and confirmed it was undated/initialed. Staff B said it was the expectation that nurses only sign for tasks they completed.<br><br>3) Resident 9 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively impaired, was dependent on staff for activities of daily living, and had a diagnosis of diabetes.<br><br>On 06/17/2025 at 9:58 AM, Resident 9's representative said facility staff were supposed to trim their fingernails every Monday, but they were not doing it. The representative held up Resident 9's left hand and stated, See, look they are too long. Resident 9's fingernails were observed to be clean, long and untrimmed on both hands.<br><br>Review of the June 2025 Treatment Administration Record (TAR) showed nurses were directed to trim and file the residents fingernails every Monday on day shift. Review of the documentation showed facility nurses signed that the task was completed on 06/02/2025, 06/09/2025 and 06/16/2025 (the day before Resident 9's fingernails were observed to be long and untrimmed).<br><br>During an interview on 06/24/2025 at 10:57 AM, Staff B, DNS, said it was the expectation that nurses only sign for tasks they completed.<br><br>Review of the EHR showed Resident 9 had a 05/13/2025 order for daily foot checks per podiatry.<br><br>Review of the May and June 2025 Nursing Task Administration Record (NTAR), showed from 05/13/2025 - 06/23/2025 (42 consecutive days) facility nurses failed to perform the daily foot checks on Resident 9 as directed.<br><br>During an interview on 06/24/2025 at 10:57 AM, Staff B, DNS, said assigned tasks were not optional, and nurses were expected to complete them as ordered. Staff B explained that nurses may not be able to see the orders that were input into the NTAR, and indicated they would look into it. No further information was provided.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4) Resident 33 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of heart failure and recived diuretic medication (medication that increases urine production and helps the body eliminate excess fluid and salt) during the assessment period.<br><br>Resident 33 had a 05/07/2025 order for daily weights, with instruction to notify the physician if there was a weight variance of greater than or equal to three pounds in 24 hours or five pounds in a week.<br><br>Review of the May and June 2025 NTAR showed from 05/07/2025 - 06/24/2025 (49 consecutive days), facility nurses failed to record Resident 33's weight onthe NTAR.<br><br>During an interview on 06/24/2025 at 10:26 AM, when asked if there was documentation to show Resident 33 was weighed daily as ordered Staff B, DNS, stated, No. Staff B said assigned tasks were not optional and nurses were expected to complete them as ordered. Staff B reiterated that there seeemed to be a problem with the order input into the NTAR, which prevented facility nurses from seeing the tasks. No further information was provided.<br><br>Review of Resident 33's weight record showed eleven weights were obtained/recorded during the 49 days from 05/07/2025 - 06/24/2025. Review of the weights showed on the following occasions the resident had a weight variance of greater than or equal to three pounds in 24 hours or five pounds in a week:<br><br>1. 05/29/2025 weight = 310 pounds; 06/06/2025 weight = 304 pounds (- 6 pounds in 7 days).<br><br>2. 06/12/2025 weight = 302 pounds; 06/15/2025 weight = 308 pounds (+ 6 pounds in 3 days).<br><br>On 06/24/2025 at 1:49 PM, when asked if there was documentation to show the provider was notified of the 06/06/2025 six pound weight loss in a week or the 06/15/2025 six pound weight gain in three days, as ordered, Staff B, DNS, stated, Not that I can see.<br><br>5) Resident 29 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of heart failure, and received diuretic medication<br><br>Resident 29 had a 05/05/2025 order for weights every Monday, Wednesday and Friday. Review of the May and June 2025 TARs showed from 05/05/2025 - 06/24/2025 facility nurses failed to record the resident's weight 22 consecutive times.<br><br>Review of Resident 29's weight record showed a weight was not recorded until 06/25/2025.<br><br>During an interview on 06/24/2025 at 10:26 AM, when asked if there was documentation to show Resident 29's weight was obtained every Monday, Wednesday and Friday as ordered, Staff B, DNS, stated, No. Staff B indicated there may have been a problem with the order input, which prevented facility nurses from seeing the daily weight order<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards for 6 of 26 residents (Resident 66, 37, 9, 33, 29 and 77) when reviewed for quality of care. The facility staff failed to document, follow, or transcribe physician orders when indicated, and only sign for tasks completed. The facility staff also failed to close a computer screen to protect resident information. These failures placed residents at risk for unmet care needs, medical complications, and a diminished quality of life.<br><br>Findings included .<br><br><Blanks on the Medication Administration Records (MARs)><br><br>Resident 66 was admitted to the facility on [DATE]. The significant change Minimum Data Set (MDS, an assessment tool) dated 05/05/2025, documented Resident 66 was cognitively intact.<br><br>A review of Resident 66's June 2025 MAR showed the listed orders below had blank boxes (no documentation) on 06/10/2025 on the night shift:<br><br>- Monitor side effects of antianxiety medication every shift and if side effect observed, enter a progress note.<br><br>- Monitor for side effects of antipsychotic medication every shift and if side effects observed, enter a progress note.<br><br>- Monitor for side effects of antidepressant medication every shift and if side effects observed, enter a progress note.<br><br>- Behavior monitoring every shift for antipsychotic and document number of episodes per shift of target behavior<br><br>- Behavior monitoring every shift for antidepressant and document number of episodes per shift of target behavior<br><br>- Behavior monitoring every shift of anitanxiety and document behavior and non-pharmacological intervention and outcome<br><br>On 06/23/2025 at 9:18 AM, Staff D, Registered Nurse/Unit Manager, said the blanks on the MAR mean they were not charted on, and the expectation was that every order would be completed and charted on in the MAR.<br><br>On 06/23/2025 at 11:30 AM, Staff B, Director of Nursing Services, said the blanks on the MAR indicate the orders were not completed. Staff B said the expectation was for all orders to be documented in the MAR and if they were not done, a reason would be documented in the resident's chart.<Lack of dressing change, documentation, and measurements><br><br>Resident 77 was admitted to the facility on [DATE]. Review of physician's orders showed Resident 77 had a peripherally inserted central catheter (PICC, a tube inserted into a vein in the arm and threaded to a large vein near the heart).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 77 had the following physician order, change PICC line dressing and cap once weekly and as needed. Document CMs (centimeters) of PICC line exposed weekly, to be done every evening on Wednesday.<br><br>On 06/17/2025 at 10:03 AM, Staff B, DNS, with Staff L, Licensed Practical Nurse/Infection Prevention Nurse present, was asked to look up the PICC dressing change order for Resident 77. Staff L looked up the order and said, PICC dressing changes were weekly every Wednesday evening.<br><br>On 06/17/2025 at 10:07 AM, Staff B went to Resident 77's room, when asked what the 06/06 date (a Friday, 11 days previous) on the PICC dressing represented, Staff B said, it was when it was last changed, and staff would take care of it right now.<br><br>Review of the Resident 77's June 2025 TAR documented the PICC dressing was changed on 06/04/2025 and again on 06/11/2025, there was no documentation of the centimeters of exposed line being recorded.<br><br>On 06/20/2025 at 1:10 PM, Staff B, DNS said with regards to the documentation reflecting the PICC dressing was changed on 06/11/2025 when it was changed on 06/06/2025, said it did not meet expectations for the dressing change and TAR to not match. Regarding the eleven days in between dressing changes, Staff B said this did not meet facility standards. When asked if the centimeters of exposed PICC line were being measured, Staff B said the order was wrong and there was supplementary documentation missing, it was not being documented and should have been.<br><br><Failure to protect resident information><br><br>On 06/23/2025 at 5:00 AM, observation of A wing medication cart showed a computer screen open with resident information visible, no staff was in sight.<br><br>On 06/23/2025 at 5:05 AM, Staff M, Registered Nurse, returned to the medication cart. When asked about the Resident's information being visible on the computer screen while they were away from the cart, Staff M said somebody came and gave me medication, and it distracted me, and I went to see the other nurse.<br><br>On 06/23/2025 at 9:55 AM, Staff B, DNS, said the expectation was for the computer to be locked when staff step away from the computer or if any non-staff were near. When told of the observation of Resident information being on the screen with the nurse not present, Staff B said it did not meet expectations.<br><br>Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)<br><br>. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to ensure residents were assisted with activities of daily living (ADLs) for 4 of 6 sampled residents (Residents 9, 33, 54 & 79) reviewed for ADLs and choices. Failure to provide assistance with nail care and/or bathing to residents who were dependent on staff for provision of such care, placed the residents at risk for poor hygiene, embarrassment, diminished self-image, and a decreased quality of life.<br><br>Findings included .<br><br>1) Resident 9 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 05/04/2025, showed the resident was cognitively impaired, was dependent on staff for ADLs, and decisions related to bathing were Very Important.<br><br>On 06/17/2025 at 9:58 AM, Resident 9's representative said facility staff were supposed to trim their fingernails every Monday, but they were not doing it. Resident 9's representative held up their left hand and stated, See, look they are too long. Resident 9's fingernails were observed to be clean, long and untrimmed on both hands.<br><br>Review of the June 2025 Treatment Administration Record (TAR) showed directions to nurses to trim and file nails every Monday on day shift. Review of the documentation showed facility nurses signed that the task was completed on 06/02/2025, 06/09/2025 and 06/16/2025 (the day before Resident 9's fingernails were observed.<br><br>On 06/24/2025 at 10:37 AM, Staff B, Director of Nursing Services (DNS), said it was the expectation that nurses complete all assigned tasks as ordered.<br><br>On 06/17/2025 at 10:08 AM, Resident 9's representative expressed concern about the frequency of bathing. They indicated the resident was supposed to be bathed twice a week, but often that did not occur.<br><br>Review of the electronic health record (EHR) showed Resident 9 was scheduled to be showered twice a week on Tueday and Friday evening shift.<br><br>Review of Resident 9's shower record showed they went the following periods without being offered/provided bathing:<br><br>1. 05/20/2025 - 05/30/2025 (10 days).<br><br>2. 06/01/2025 - 06/10/2025 (10 days).<br><br>During an interview on 06/24/2025 at 9:26 AM, Staff B, DNS, said it was the expectation that residents be showered/ bathed per their established shower schedule. When asked if that consistently occurred for Resident 9, Staff B said no.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2) Resident 33 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident was cognitively intact, required moderate to maximal assitance with most ADLs including showering.<br><br>On 06/17/2025 at 11:48 AM, Resident 33 complained that bathing was not consistently provided.<br><br>Review of the EHR showed Resident 33 was scheduled to be showered twice a week on Monday and Thursday evening shift.<br><br>Review of Resident 33's shower record showed they went from 05/29/2025 - 06/09/2025 (11 days), without being offered/provided bathing:<br><br>During an interview on 06/24/2025 at 9:26 AM, Staff B, DNS, said it was the expectation that residents be showered/ bathed per their established shower schedule. When asked if Resident 33 was consistently offered/provided bathing every Monday and Thursday as scheduled Staff B sais no, but indicated they would look through the facility's paper documentation. No further documents were provided.<br><br>2) Review of the EHR showed Resident 54 admitted to the facility on [DATE] with a diagnosis of right side hemiplegia (inability to move the right side of the body). The resident was able to make needs known.<br><br>During an observation and interview on 06/17/2025 at 9:37 AM, Resident 54 said the staff did not offer to assist them with brushing their teeth and they needed help because they could not hold the toothbrush anymore. The residents' teeth were visibly covered in a thick white substance. Toothbrushes and an empty tube of toothpaste were noted on the overbed table in a dish.<br><br>Review of the plan of care dated 04/08/2025 showed the resident required set up of supplies and required assistance with performing oral care.<br><br>During an observation and interview on 06/18/2025 at 9:15 AM, Resident 54 was noted to have thick white substance covering their teeth, the toothbrushes and an empty tube of toothpaste was unmoved on the overbed table in a dish. Resident 54 said the staff had not offered to assist them with oral care.<br><br>During an interview on 06/18/2025 at 9:25 AM, Staff R, Certified Nursing Assistant (CNA), said they should offer oral care every morning and as needed. Staff R said Resident 54 required help, but they had not offered the resident oral care today.<br><br>During an interview and observation on 06/20/2025 at 9:33 AM, Resident 54 said staff had not offered to assist them with oral care. The resident had a thick white substance covering their teeth.<br><br>During an interview on 06/20/2025 at 9:42 AM, Staff S, CNA stated, the nurse does the oral care.<br><br>During an interview on 06/24/2025 at 11:24 AM, Staff B, DNS said it was their expectation that the assigned staff offer and provide assistance with oral care every morning and evening and Resident 54 should have been offered assistance with oral care daily.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) Resident 79 admitted to the facility 05/07/2025. The admission MDS, dated [DATE], documented Resident 79 was cognitively intact and required substantial/maximal assistance with showering/bathing themselves.<br><br>On 06/17/2025 at 8:45 AM, Resident 79 said they could not shower because of their foot and had not been given a bed bath since arriving at the facility.<br><br>Review of Resident 79's Bathing task completed records showed no entries for bathing/showering since admission on [DATE].<br><br>On 6/20/2025 at 12:59 PM, regarding Resident 79's shower documentation, Staff B, DNS, said they saw Resident 79's last shower was on 06/15/2025. When shown the document bathing task completed was blank, Staff B said, according to the record she did not see that bathing/showering was done, but she would have to comb through it and would let me know.<br><br>On 6/20/2025 at 1:40 PM, Staff N, Registered Nurse/Regional Director of Operations accompanied by Staff A, Administrator, said the CNA's were charting showers/bed baths in three different areas in the EHR, and they were working on making a change in the EHR so the type of bathing and when bathing occurred would be documented. Staff N said they were working on the changes and had not gotten to Resident 79's chart yet, but they could see that Resident 79 had a shower or bath on 06/15/2025 with supervision and assistance.<br><br>On 06/20/2025 at 2:35 PM, Staff N provided documentation of Resident 79's showers and bed baths, totaling 15 showers or bed baths since admission. The documentation provided showed Resident 79 had no shower or bed bath from 05/07/2025 through 05/14/2025 (7 days).<br><br>On 06/24/2025 at 10:51 AM, Staff N said going for a week without a shower after admission was not acceptable and they would look at the May 2025 paper documentation to verify if it was not done. No additional documentation was provided.<br><br>Reference WAC 388-97-1060(2)(c)<br><br>. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with professional standards of practice and their person-centered plan of care for 4 of 9 residents (Resident 90, 29, 33, and 88) reviewed for bowel management, and 1 of 2 residents (Resident 29) reviewed for fluid volume status. The failure to obtain and evaluate daily weights and ensure the provision of bowel care in accordance with physicians' orders and/or the facility bowel protocol, placed residents at risk for fluid volume overload, delays in treatment, unmet care needs and a decreased quality of life.<br><br>Findings included .<br><br>1) Resident 90 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 04/10/2025, showed the resident was cognitively intact.<br><br>On 06/17/2025 at 11:34 AM, Resident 90 said constipation was occasionally a problem.<br><br>Review of Resident 90's bowel record showed they had no bowel movement (BM) from 05/02/2025 - 05/07/2025 (6 days).<br><br>Review of the electronic health record (EHR) showed a 04/29/2025 order for Miralax as needed (PRN) for constipation.<br><br>Review of May 2025 Medication Administration Record (MAR) showed no PRN bowel medications were administered.<br><br>During an interview on 06/24/2025 at 9:20 AM, Staff B, Director of Nursing Services (DNS), confirmed the nurse failed to administer PRN Miralax on 05/05/2025 as directed by the facility's bowel protocol.<br><br>2) Resident 29 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of heart failure, and received diuretic medication (medication that increases urine production and helps the body eliminate excess fluid and salt.)<br><br>On 06/17/2025 at 10:43 AM, Resident 29 said constipation was an ongoing battle for them.<br><br>Review of Resident 29's's bowel record showed they went the following periods without a BM:<br><br>05/13/2025 - 05/18/2025 (6 days)<br><br>05/20/2025 - 05/26/2025 (7 days)<br><br>Review of May 2025 MAR showed Resident 29 had no orders for PRN bowel medication.<br><br>(continued on next page) |

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| | 505387 | A. Building<br>B. Wing | 06/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Woodard Creek Health & Rehabilitation | 3333 Ensign Road Northeast<br>Olympia, WA 98506 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/24/2025 at 9:20 AM, Staff B, DNS, said Resident 29 should have been administered PRN bowel medication on 05/16/2025 and 05/23/2025 as directed by the facility's bowel protocol. Staff B indicated the PRN bowel medications were likely missed when the facility recently transitioned to a new EHR.<br><br>Resident 29 had a 05/05/2025 order for weights every Monday, Wednesday and Friday. Review of the May and June 2025 Treatment Administration Records (TARs) showed from 05/05/2025 -06/24/2025 facility nurses failed to record the resident's weight twenty two consecutive times.<br><br>Review of Resident 29's weight record showed a weight was not recorded until 06/25/2025.<br><br>During an interview on 06/24/2025 at 10:26 AM, when asked if there was documentation to show Resident 29's weight was obtained every Monday, Wednesday and Friday as ordered, Staff B, DNS, stated, No. Staff B indicated there may have been a problem with the order input, which prevented facility nurses from seeing the daily weight order.<br><br>3) Resident 33 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident was cognitively intact.<br><br>Review of Resident 33's bowel record showed they had no BM from 5/12/2025 - 5/16/2025 (5days).<br><br>Review of May 2025 MAR showed Resident 33 had no PRN bowel care orders.<br><br>During an interview on 06/24/2025 at 9:20 AM, Staff B, DNS, said Resident 33 should have been administered PRN bowel medication on 05/15/2025 as directed by the facility's bowel protocol, and indicated the PRN bowel medications were likely missed during the transmission to a new EHR.<br><br>Resident 33 had a 05/07/2025 order for daily weights, with instruction to notify the physician if there was a weight variance of greater than or equal to three pounds in 24 hours or five pounds in a week.<br><br>Review of the May and June 2025 Nursing Task Administration Record (NTAR) showed from 05/07/2025 - 06/24/2025 (49 consecutive days), facility nurses failed to record Resident 33's weight on the NTAR in the space provided.<br><br>Review of Resident 33's weight record showed 11 weights were recorded during the 49 days from 05/07/2025 - 06/24/2025.<br><br>During an interview on 06/24/2025 at 10:26 AM, when asked if there was documentation to show resident 33 was weighed daily as ordered Staff B, DNS, stated, No. Staff B indicated there may have been a problem with the order input, which prevented facility nurses from seeing the daily weight order.4) Resident 88 was admitted to the facility on [DATE] with a diagnosis of encounter for palliative care (medical care focused on relief from symptoms). The admission MDS, dated [DATE], showed Resident 88 understood and understands, and was on hospice services (end of life care).<br><br>Review of Resident 88's orders showed they had an order for twice a day scheduled Senna, a bowel stimulant, for constipation.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 88's bowel medications showed they had two as needed bowel stimulation orders:<br><br>1. MiraLax for constipation daily<br><br>2. Bisacody suppository for constipation every 24 hours<br><br>Review of bowel records from 05/19/2025 to 06/17/2025, showed Resident 88 did not have a bowel movement from 05/29/2025 to 06/01/2025 (4 days).<br><br>During an interview on 06/18/2025 at 11:42 AM, Staff B, DNS, looked in the EHR and confirmed Resident 88 went 4 days without a bowel movement, and no as needed bowel medications were given but should have been.<br><br>Reference WAC 388-97-1060(1)<br><br>. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to ensure ongoing assessment, monitoring, and documentation of identified pressure injuries (PIs/ injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time) for 1 of 2 residents (Resident 9) reviewed for pressure injuries. The failure to routinely assess and monitor PI wound characteristics with measurements, wound bed tissue type, details of drainage, wound edges, peri-wound (area of skin surrounding the wound) and response to treatment, impaired staffs' ability to determine if the wound was responding to treatment and determine if it was improving or declining. This failure placed residents at risk for unidentified wound decline, delays in treatment, prolonged wound healing, and diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Pressure Injury Prevention and Management, dated 10/01/2021, showed staff should promptly report any change in a resident's skin integrity. Observation of a new pressure injury should be reported to the physician for further evaluation and treatment, and referred to the designated wound nurse. Evaluation/Assessment of PIs would be completed. Weekly documentation may have included location, date identified, description of the PI with staging of wound if indicated, measurements, presence or absence of tunneling or undermining, tissue type, presence, character of drainage, presence of pain, description of surrounding, and current treatment and interventions in place to promote wound healing. Residents' care plans should be updated to reflect PI risks and interventions.<br><br>Resident 9 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (an assessment tool), dated 05/04/2025, showed the resident was cognitively impaired, was dependent or required substantial to maximal assistance with activities of daily living, and did not have any PIs but was at risk for them.<br><br>A 06/13/2025 nurse's note, documented Resident 9 was observed with a open area to the coccyx (tailbone). The note did not document if Resident 9's representative and provider were notified.<br><br>Review of the Skin Observation Weekly note, dated 06/13/2025, showed Resident 9 had an open wound to the coccyx area that was not new. The skin observation did not include measurements of the wound, type of wound (e.g. pressure), tissue type, amount and character of drainage, description of peri-wound, or documentation the provider and the resident's representative were notified.<br><br>An at risk for PIs care plan, initiated 04/08/2025, directed staff to: assess resident for risk of skin breakdown; keep skin clean and dry as possible; encourage to turn and reposition often; and implement an alternating low air-loss mattress for pressure redistribution. The care plan did not identify the presence of an active PI.<br><br>Review of the June 2025 Treatment Administration Record, showed a 05/02/2025 order to topically apply lanolin cream to Resident 9's buttocks and coccyx every shift. No new orders were obtained upon the identification of the open area.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the electronic health record, showed no documentation was present that showed Resident 9's open area to the coccyx, was previously identified, that the provider and resident representative were notified, or that any changes were made to resident's plan of care. Additionally, no initial or subsequent wound assessments, that included type of wound, size (measurements), and characteristics (tissue type, type, amount, character of drainage etc.) were found.<br><br>On 06/24/2025 at 9:38 AM, when asked if there was documentation to show an initial wound assessment was conducted upon identification of the open area to Resident 9's coccyx and whether any subsequent weekly assessments had been performed/documented, Staff B, Director of Nursing Services, said they were unable to locate any. When asked if there was documentation to show Resident 9's provider and representative were notified, Staff B said no. Staff B indicated some documentation may be in the resident's paper chart and they would provide it if found. No further documentation was provided.<br><br>Reference WAC 388-97-0520 (1), (2)<br><br>. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to provide the necessary care and services to maintain range of motion for 2 of 4 residents (Resident 18 and 54) reviewed for positioning and mobility. These failures placed the residents at risk for decreased mobility, pain, discomfort and a decreased quality of life.<br><br><Resident 18><br><br>Review of the electronic health record (EHR) showed Resident 18 admitted to the facility on [DATE] with diagnoses of stroke (when a portion of the brain is without blood flow for a period), hemiplegia (paralysis of one side of the body) and contracture of the right hand. The resident was able to make needs known.<br><br>During an observation on 06/16/2025 at 2:45 PM, Resident 18 was laying in bed, the resident was unable to move their right arm/hand and had a washcloth positioned in their right palm.<br><br>Review of the EHR showed a nursing task for NURSING REHAB/RESTORATIVE: Hand/Splint Care. Assist/Instruct the resident to wash their hands thoroughly with soap and warm water. Dry thoroughly. Place clean wash cloth (dry roll) in Right hand for a total of at least 15 minutes 7 days a week.<br><br>Review of the task documentation showed the restorative staff had provided the assigned care every other day, not 7 days a week.<br><br>Review of the EHR on 06/18/2025 showed no orders or care plan was in place to provide daily restorative services for the resident's hand contractures.<br><br><Resident 54><br><br>Review of the EHR showed Resident 54 admitted to the facility on [DATE] with a diagnosis of right-side hemiplegia (inability to move the right side of the body). The resident was able to make needs known.<br><br>During an interview and observation on 06/17/2025 at 9:05 AM, Resident 54 was lying in bed with a soft splint on their right hand. Resident 54 stated, staff did not wash their right hand or take off the splint anymore and it stinks. A musty odor was noted to the resident's right hand.<br><br>Review of the EHR on 06/18/2025 showed no care plan or orders for the right-hand splint and a nursing task was noted for NURSING REHAB/RESTORATIVE: Splint Care. (Palm protector with finger separator) Assist resident to [put on] splint. Allow resident to participate as able - Encourage Resident to wear for up to 16 hours a day 7 days a week.<br><br>Review of the task documentation on 06/18/2025 showed the last documented care provided to Resident 54's right hand was on 06/14/2025.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 06/18/2025 at 12:43 PM, Staff T, Restorative Nursing Assistant, said it was their understanding that the assigned Certified Nursing Assistant (CNA) on the floor should have provided care for the resident's hand contractures every other day.<br><br>During an interview on 06/18/2025 at 12:58 PM, Staff R, CNA, said the assigned floor staff did not do anything with the splints/palm protectors for their assigned residents. Only the restorative aides did.<br><br>During an interview on 06/18/2025 at 10:50 AM, Staff B, Director of Nursing Services, stated it was their expectation that residents 18 and 54 had a care plan and orders in place for the daily care of splints/palm protectors and the care be provided daily as planned but this did not happen.<br><br>Reference WAC 388-97-1060 (3)(d), (j)(ix)<br><br>. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview, and record review, the facility failed to maintain an environment free of accidents or hazards by creating a plan of care and implementing preventative measures and/or assessments for 3 of 4 residents (Residents 18, 91 & 94) reviewed for accident hazards. This failure placed residents at risk for falls, injuries, medical complications and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 18 was admitted to the facility on [DATE], with diagnoses of stroke (when a portion of the brain is without blood flow for a period of time) and hemiplegia (paralysis of one side of the body). The resident was able to make needs known.<br><br>Review of Resident 18's electronic health record (EHR), showed the resident had a fall on 06/16/2025 at 7:30 PM, during a shower and was assisted to the floor. An x-ray was completed on 06/17/2025 which showed a fracture on the right hip. Resident 18 was sent to the emergency room for evaluation on 06/17/2025 and returned to the facility on [DATE] with a referral for hospice.<br><br>Review of the EHR showed no fall care plan was in place.<br><br>During an interview on 06/20/2025 at 12:08 PM, Staff B, Director of Nursing Services, said their expectation was residents were assessed for fall risks and a care plan would be put in place to decrease risk for falls. Staff B said the resident was normally showered in the middle stall, but this day was showered in the end stall and the grab bars were on the residents weaker side. Staff B said Resident 18 should have had a fall care plan in place but did not.<br><br>2) Resident 91 admitted to the facility on [DATE], with diagnoses of diabetes and chronic obstructive pulmonary disease. The resident was able to make needs known.<br><br>During an interview on 06/16/2025 at 12:55 PM, Resident 91 said they had a fall in their bathroom and had some small bruises on their arms.<br><br>Review of the EHR showed a note from 06/01/2025 which documented the resident had a fall at 10:15 AM, when the resident was found to have no footwear on and had attempted to transfer into the wheelchair from bed.<br><br>Review of the incident log showed Resident 91 had falls on 05/21/2025, 05/22/2025 and 06/01/2025.<br><br>Resident 91 had a care plan for falls, initiated on 05/07/2025, with interventions for:<br><br>1. bed in lowest position<br><br>2. non-skid socks while out of bed<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. remind the resident to use their call light to ask for assistance with ADLs<br><br>Resident 91's fall care plan was updated, on 06/03/2025, with interventions for:<br><br>1. place bed in lowest position while resident is in bed<br><br>2. footwear to prevent slipping<br><br>3. provide reeducation and reorientation to the call light and request assistance with ADLs<br><br>Review of Resident 91's fall care plans showed no further/new interventions were added to prevent further falls.<br><br>During an observation on 06/21/2025 at 12:45 PM, Resident 91 sat in their wheelchair in their room, had no socks on, and one slipper was noted to be next to the bed, not on the resident's foot.<br><br>During an interview on 06/20/2025 at 12:08 PM, Staff B, DNS, said it was their expectation that residents who were at risk for falls had interventions in place to decrease that risk and Resident 91 should have had new interventions added after the falls on 5/21/2025, 05/22/2025 and 06/01/2025, not the same ones.<br><br>During an observation on 06/16/2025 at 12:59 PM, Resident 91 was observed with one side of their bed against the wall.<br><br>Review of Resident 91's EHR showed the bed against the wall was not care planned, had no order, had no consent, and had no assessment for safety or assessment that the bed against the wall was not a restraint.<br><br>During an interview on 06/23/2025 at 10:45 AM, Staff B, DNS, said that for a bed against the wall to be ruled out as a potential restraint, the facility needed to have completed an assessment, consent, care plan, and an order. Staff B confirmed in the EHR that none of these were found for Resident 91's bed against the wall.<br><br>3) Resident 94 was admitted to the facility on [DATE]. The admission Medicare 5 Day Minimum Datat Set Assessment, dated 05/20/2025, showed Resident 94 was cognitively intact.<br><br>Review of Resident 94's care plans showed the resident was permitted to smoke unsupervised.<br><br>Review of Resident 94's Smoking- Resident Safety Evaluation-V1 forms from 05/28/2025, showed tobacco utilization information was filled out, but there was no information in the smoking safety evaluation section.<br><br>During an interview on 06/18/2025 at 11:42 AM, Staff B, DNS, after looking at the smoking policy, said the facility was responsible for completing the smoking evaluation. When asked what the process for evaluating the resident for safety to independently smoke, Staff B said the unit manager was to launch an assessment and therapy was also responsible to asses they were safe. Staff B confirmed the smoking evaluations for Resident 94 did not have a safety evaluation and offered to follow up with therapy to confirm if they had a documented assessment.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a follow up interview on 06/18/2025 at 2:58 PM, Staff B said therapy could not find an assessment and there should have been one.<br><br>Reference WAC 388-97-1060(3)(g)<br><br>. |

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure significant weight loss was identified, the physician was notified, and nutritional interventions were evaluated for effectiveness for 1 of 1 sampled resident (Residents 28) reviewed for nutrition. These failures placed the resident at risk for continued weight loss, malnutrition, and a decreased quality of life.<br><br>Findings included .<br><br>Resident 28 was admitted to the facility on [DATE], with diagnoses of diabetes and kidney disease. The Quarterly Minimum Data Set (an assessment tool), dated 04/28/2025, documented Resident 28 was moderately cognitively impaired and had a recent weight of 107 pounds in the last 30 days. It documented a weight loss of 5% or more in the previous month or a loss of 10% or more in the previous 6 months, and Resident 28 was not on a physician prescribed weight loss regimen.<br><br>Resident 28 weighed 116.2 pounds (lbs) on 01/03/2025 and 100.2 lbs on 06/22/2025, which was a -13.77 %. This was a 16 lb loss in just over 5 months.<br><br>Resident 28 weighed 117.0 lbs on 03/03/2025 and 100.2 lbs on 06/22/2025, which was a -14.36 %. This was a 16.8 lb loss in just over 3 months.<br><br>Review of Resident 28's orders, dated 05/06/2025, showed staff were to:<br><br>1. Weigh the resident weekly. To reweigh and notify the provider if the weight difference was 3 lb in 1 day or 5 lb in 1 week.<br><br>2. Administer Nova Source Renal supplement, 237 milliliters (ml), in the evening and chart amount consumed.<br><br>A review of Resident 28's electronic health record (EHR), showed no documentation Resident 28 had any weights redone or that the provider was notified of Resident 28's weight loss, after meeting criteria for both reweigh and provider notification.<br><br>Resident 28's Medication Administration Record (MAR), for May 2025, documented mls consumed of Nova Source were as follows:<br><br>- 0 (none) on 13, 14, 15, 20, 21, 27, 28, 29 (8 days)<br><br>- X (not documented) on 19 (1 day)<br><br>- 100 (137 mls less than ordered) on 16, 17, 18, 22, 23, 24, 25, 26, 30 (9 days)<br><br>- 120 (117 mls less than ordered) on 31 (1 day)<br><br>Resident 28's MAR, for June 2025, documented mls consumed of Nova Source were as follows:<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 0 on 3, 4, 5, 6, 7, 8, 10, 11, 13, 14 (10 days)<br><br>- X (not documented) on 9, 12, 16, 17 (4 days)<br><br>- 25 (212 mls less than ordered) on 15 (1 day)<br><br>Review of the May and June 2025 MARs, showed Resident 28 only received the full amount of Nova Source, 237 ml, on 06/01/2025 and 06/02/2025 (two times).<br><br>Review of Resident 28's Nutrition at Risk Assessment, signed by Staff C, Dietician, dated 05/05/2025, documented a weight of 117.0 lbs on 03/03/2025 and a weight of 106.6 lbs on 03/27/2025, with a significant change of 9% and 10 lbs weight loss in less than 1 month.<br><br>Review of Resident 28's comprehensive care plan, showed there was not a nutrition or weight loss care plan.<br><br>On 06/20/2025 at 9:35 AM, Staff D, Registered Nurse/Unit Manager, said the documentation indicated Resident 28 had lost 16 lbs since March 2025, and she could not find documentation of a reweigh or the physician being notified. Staff D said while looking at Resident 28's MAR, it was hit or miss for Resident 28 drinking the Nova Source supplement and did not see where new interventions had been attempted. Staff D also said she did not see a nutrition care plan and her expectation was for there to have been one, especially given Resident 28's weight loss.<br><br>On 06/20/2025 at 10:06 AM, Staff E, Certified Medication Assistant, said Resident 28 did not like the Nova Source Supplement and they did not drink it.<br><br>On 06/20/2025 at 1:22 PM, Staff B, Director of Nursing Services, said she did not see a nutritional care plan for Resident 28, and they should have a care plan regarding nutrition and interventions to prevent weight loss. Staff B said they would have liked to have seen a reweight, the physician should have been notified, a supplement change should have been done by finding a better preference, and the interdisciplinary team should have discussed the weight loss.<br><br>Reference WAC 388-97-1060 (3)(h)<br><br>. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to ensure respiratory care and services were provided in accordance with Physician's orders and accepted professional standards of practice for 3 of 3 residents (Resident 29, 10, & 91) reviewed. The facility failed to ensure continuous positive airway (CPAP, a form of non-invasive ventilation therapy used to facilitate breathing) orders were complete and in place, to include the prescribed pressure settings, checking, refilling and cleaning of the humidifier reservoir, and identifying what solution was to be used in the humidifier. Additionally, staff failed to ensure oxygen (O2) was administered in accordance with physicians' orders, and portable oxygen tanks were refilled and periodically checked to ensure they were not empty. These failures placed residents at risk for ineffective assisted ventilation, shortness of breath, decreased oxygen saturation and other respiratory complications.<br><br>Findings included .<br><br>Review of the facility's undated CPAP/BiPAP [bilevel positive airway pressure machine is a mechanical breathing device with a mask that is used to treat sleep apnea and other health conditions] policy showed facility nurses would review physicians' orders to determine oxygen concentration and flow, and the Positive End-Expiratory Pressure (PEEP) for a BiPAP or the pressure setting for a CPAP. Nurses would then set the CPAP/BiPAP machine as prescribed. Machines with a humidifier chamber would be filled with distilled water only, cleaned weekly and air dried. To disinfect a humidifier chamber, it would be filled with a vinegar-water solution (1:3 ratio) and left to soak for 30 minutes, then would be rinsed thoroughly.<br><br>1) Resident 29 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/10/2025, showed the resident was cognitively intact, had diagnosis of obstructive sleep apnea (a condition that causes abnormal breathing during sleep and it is caused by the throat muscles relaxing and narrowing the airway, which can reduce oxygen levels in the blood) and required the use of a non-invasive mechanical ventilator.<br><br>On 06/17/2025 at 9:25 AM, and 06/24/2025 at 9:13 AM, an Aircurve-10 CPAP machine, with an empty humidifier reservoir, was observed sitting on the three-drawer chest to the left of Resident 29's bed.<br><br>Review of the electronic health record (EHR) showed Resident 29 had the following 05/04/2025 CPAP orders:<br><br>a) Apply CPAP machine at bedtime.<br><br>b) Change CPAP tubing every Sunday.<br><br>c) Clean CPAP mask daily.<br><br>The orders did not:<br><br>a) Identify what the ordered pressure setting was.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b) Direct staff to check and/or refill the humidifier reservoir.<br><br>c) Identify what solution the humidifier reservoir should be filled with (e.g. distilled water).<br><br>d) Direct staff to clean and air dry the humidifier reservoir weekly and air dry, as directed in the facility policy.<br><br>On 06/24/2025 at 10:36 AM, Staff B, Director of Nursing Services (DNS), observed Resident 29's CPAP machine and confirmed the humidifier reservoir remained empty.<br><br>On 06/24/2025 at 10:45 AM, when asked if Resident 29's CPAP orders were complete, Staff B, DNS, said no, and confirmed the orders should have included the ordered pressure setting(s), direction to check and refill the humidifier reservoir with distilled water and to clean it weekly and let air dry.2) Resident 10 was admitted to the facility on [DATE] and had a diagnosis of Obstructive Sleep Apnea. The Annual MDS, dated [DATE], documented Resident 10 was cognitively intact.<br><br>On 06/20/2025 at 9:33 AM, observations were made of the CPAP and nebulizer (a machine that works by converting liquid medicine into a fine mist that can be in-haled, delivering the medication directly to the lungs) machines at the bedside of Resident 10. No date and label were observed on the tubing and mask of the nebulizer.<br><br>An order, dated 05/07/2025, said to change nebulizer mask and tubing. Label with name and date every week on Sunday during the night shift. Resident 10's Medication Administration Order (MAR) for June 2025 showed blanks on the 1st, 8th, 15th and 22nd for this order.<br><br>A review of Resident 10's EHR did not show where Resident 10's CPAP settings were documented.<br><br>On 06/23/2025 at 8:56 AM, Staff D, Registered Nurse/Unit Manager, said while looking at Resident 10's EHR, they did not see the setting in the orders, that would likely be the easiest place to have it. When asked what the staff would do if they needed the CPAP setting, Staff D said unfortunately they would have to call the pulmonologist (a medical doctor who specializes in the diagnosis, treatment, and management of respiratory diseases and conditions that affect the lungs and airways) to get them. Staff D said they would call and have the settings faxed. Staff D said the blanks in the MAR meant they were not charted on, and it should have been completed.<br><br>On 06/23/2025 at 11:20 AM, Staff B, DNS, said the expectation was for the CPAP settings to be in Resident 10's orders or care plan. Staff B said the blanks on the June MAR meant it was not signed, and Staff B's expectation was that it would be signed out on the MAR, the order discontinued if not pertinent, or a progress note placed with a reason it was not completed.3) Resident 91 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (lung and airway disease that restricts breathing) and respiratory failure. The Medicare 5 Day MDS, dated [DATE], showed they were severely cognitively impaired and required continuous oxygen use.<br><br>Review of Resident 91's oxygen orders showed it was to be ran at 2 liters (L) via nasal cannula (NC).<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 06/16/2025 at 12:33 PM, Resident 91 was seen without their NC in their nostrils. Staff entered the room and said they were going to get new tubing since the old tubing had touched the ground. At 1:02 PM, Resident 91 was seen connected to the tank on their wheelchair at 2 L, with the tank reading empty.<br><br>During an observation on 06/18/2025 at 11:17 AM, Resident 91's oxygen was seen running at 5 L. Resident 91 was connected to long oxygen tubing and was observed to run over their tubing with their wheelchair.<br><br>On 06/18/2025 at 1:14 PM, Resident 91 was seen without any oxygen in their wheelchair moving throughout the facility. Resident 91 was observed to interact with a housekeeper, a nurse, and a certified nursing assistant.<br><br>During an interview on 06/23/2025 at 12:53 PM, Staff F, LPN, went into Resident 91's room and said their oxygen was at 2.9 L. Staff F said Resident 91 did not do well without oxygen and could drop to an oxygen saturation of 80% without oxygen administration. Staff F said staff should put Resident 91's oxygen back on if off.<br><br>During an interview on 06/23/2025 at 1:13 PM, Staff B, DNS, when told of the observation of Resident 91 moving around the facility without their NC and without staff assisting them with putting their oxygen back on, said their expectation was for staff to replace the NC or assess if Resident 91 did not need oxygen and update their information. When told of the observation of Resident 91 being connected to an empty oxygen canister, said no it did not meet expectations. When asked about the oxygen order for 2 L, and observations of other values being administered, said their expectations was for Resident 91 to stay at 2 L oxygen or that staff modify the order for resident need.<br><br>Reference WAC 388-97-1060 (3)(j)(vi)<br><br>. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>.<br><br>Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff were available to provide care in a timely manner and complete activities of daily living (ADLs) as evidenced by information provided during resident interview for 16 of 38 residents (Residents 28, 55, 30, 79, 16, 87, 10, 66, 1, 39, 56, 254, 154, 33, 62, & 28) and 2 of 7 staff (Staff R & U) interviewed for sufficient staffing or resident council, for 3 of 3 resident council monthly meeting notes (March 2025, April 2025, & May 2025) reviewed, and review of 1 of 3 grievance logs (May 2025). These failures placed residents at risk for unmet care needs, negative outcomes and a diminished quality of life.<br><br>Findings included .<br><br><Resident Interviews><br><br>1) On 06/16/2025 at 2:26 PM, Resident 39 said they could wait an hour with their light on, it happened quite often, and they kept track on the clock.<br><br>2) On 06/16/2025 at 11:41 AM, Resident 28 said it took 20 to 30 minutes for staff to respond, and at night they were short staffed.<br><br>3) On 06/17/2025 at 11:15 AM, Resident 55 said it usually took 25 minutes for staff to answer the call light.<br><br>4) On 06/16/2025 at 12:02 PM, Resident 30 said a lot of times staff did not come when they were called, they usually had to wait 30 minutes, and it caused them aggravation. Resident 30 said when needing to have a bowel movement they hit their call bell, but they had to poop my pants because it was too long of a wait.<br><br>5) On 06/17/2025 at 8:28 AM, Resident 79 said the nursing assistants are understaffed, it could take two hours for a call light to be answered, and they remembered waiting two hours on morning shift. Resident 79 said they kept track of the two hour waits by using the clock, and they had to sat in bowel movement and urine at shift change.<br><br>6) On 06/16/2025 at 10:17 AM, Resident 16 said night shift had been an hour long wait at times when they used their call light.<br><br>7) On 06/16/2025 at 02:05 PM, Resident 87 said they had waited an hour for staff to respond, they would push their call button at night, and would look at the clock on the wall to measure time.<br><br>8) On 06/16/2025 at 12:08 PM, Resident 10 said they had waited an hour and a half during the shift change in the afternoon.<br><br>9) On 06/16/2025 at 02:34 PM, Resident 66 said sometimes staff came, but it took a while. Resident 66 stated, I had pooped my pants due to staff not coming in time.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10) On 06/16/2025 at 01:26 PM, Resident 1 said it took forever, mostly at night, for assistance. Resident 1 said they waited a long time for a bed pan and there were not enough people to help.<br><br>11)On 06/16/2025 at 11:29 AM, Resident 56 said they thought staff did not do showers because there were not enough staff.<br><br>12) On 06/16/2025 at 12:30 PM, Resident 254 said staff had missed their pain medications the day before and they had almost pooped myself.<br><br><Resident Council Interview><br><br>On 06/20/2025 at 10:57 AM, residents that were members of the resident council were group interviewed and voiced concerns as follows:<br><br>13) Resident 154 said the call light could be on for an hour and a half, staff could leave you on the toilet, and they waited a long time to be changed at night.<br><br>14) Resident 33 said staff would turn off their call light, staff said they needed to help someone else, and would not come back. Resident 33 said they would ring their call light to be put in bed, no one would come, and staff were standing around the nurses desk gabbing. They would look down the hall and would see 4-5 lights on, staff were not answering the call lights. They went 2-3 weeks without a shower, had to remind staff, and staff said they were too busy.<br><br>15) Resident 62 said they had waited for staff for over an hour.<br><br>16) Resident 28 said staff would say they needed to hurry so they could help someone else.<br><br><Resident Council Meeting Notes><br><br>March 2025 meeting notes documented the following concerns:<br><br>- The afternoon staffing needed to do more frequent rounding.<br><br>April 2025 meeting notes documented the following concerns:<br><br>- Night shift: 4 hours to give resident medications.<br><br>- Night shift: Catheter bags were not getting emptied.<br><br>- Showers were supposed to be earlier in the day, but staff came in the evening when residents were too tired.<br><br>May 2025 meeting notes documented the following concerns:<br><br>- Catheters were not changed during night shift.<br><br>- Short staffed due to agency staff not showing up or they did not answer their phone(s).<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Medications should have been reordered when there were 5 doses remaining instead of waiting until 1 or none<br><br>- Agency aids were not doing their jobs, were very disrespectful, and opened drawers<br><br>- Too much time spent playing and shooting their bull<br><br><Grievances><br><br>Review of the May 2025 Grievance log, showed the following concerns with call bell responses:<br><br>1. Grievance, dated 05/07/2025, for Resident 35 regarding care-call bell response. The concern was the Certified Nursing Assistant (CNA) response time.<br><br>2. Grievance, dated 05/07/2025, for Resident 23 regarding care-call bell response. The concern was the call light response time.<br><br>3. Grievance, dated 05/16/2025, for Resident 23 regarding care-call bell response. The concern was the call light response time.<br><br>4. Grievance, dated 05/20/2025, for Resident 35 regarding care- call bell response. The concern was regarding check and change.<br><br>5. Grievance, dated 05/22/2025, for Resident 154 regarding care-call bell response. The concern was the call light response time.<br><br><ADLs><br><br>On 06/18/2025 at 11:02 AM, Staff U, CNA, when asked if they had enough time to complete required assignments each day, said no. Staff U said staff did not have time for tooth care, nail care, cleanliness/organizing rooms and extra cosmetic stuff like makeup and/or hair, which she said were not requirements but things that make people feel engaged and whole. When asked about being able to complete assignments on the weekends, Staff U said most of the time staff were squeaking by on things that were mandatory, but extras were harder. Staff U said today she was assigned three showers in addition to her other responsibilities, it was tough to complete, and three showers were pretty much impossible for staff to do during the day. When asked which assignments they were not able to complete, Staff U said hair care, tooth care, and nail care. Staff U said after not being at work for a week, they had come back to find residents with hair in knots, and she had observed residents with dentures still in their mouth upon awakening. Staff U said 50% of the time when they came to work, they saw things such as dentures still in resident's mouths. Staff U said she often would stay late to complete showers and most staff did not get breaks due to getting things done for residents.When asked if they had concerns with the agency staff that the facility employed, Staff U said yes, she had observed residents in dirty briefs all day because agency staff said the resident refused the care. Staff U said agency staff did not assist residents who required assistance with meals and did not do showers.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 06/20/2025 at 10:35 AM, Staff R, CNA, when asked if he had enough time on his shift to provide oral care to residents, said it depended on the day. Staff R said on some days staff were very busy and did not have enough time to do it. Staff R said, we fall behind in some stuff.<br><br>On 06/23/2025 at 09:55 AM, Staff B, Director of Nursing Services, said her expectation for call bell response time was that it would not be greater than 15 minutes, and that staff usually tried to respond in 5-7 minutes. When told staff reported not having enough time to complete ADLs such as oral care, hair care, and nail care, Staff B said her expectation was that oral care, hair care, and nail care be performed as staff care for residents or during showers. Regarding staff reporting observations of resident's hair being in knots or arriving to find residents with dentures still in their mouth, Staff B said that did not meet her expectations. Regarding staff concerns with agency staff not changing residents' briefs, assisting with meals, or doing showers, Staff B said she was not aware of the concerns, and she would expect this to be reported to nursing management or the administrator.<br><br>Reference Federal Tags F677, F609, F550, F759<br><br>Reference WAC 388-97-1080(1)<br><br>. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on interview and record review, the facility failed to ensure freedom from unnecessary medications for 2 of 5 sampled residents (Residents 62 & 91) when reviewed for unnecessary medications. The facility failed to ensure residents were provided non-pharmacological interventions (NPIs, treatments or strategies used to prevent, reduce, or manage symptoms without the use of medications) prior to the use of as needed pain medications. These failures placed residents at risk of taking unnecessary medications, avoidable medication side effects, and a diminished quality of life.<br><br>Findings included .<br><br>1) Resident 62 was re-admitted to the facility on [DATE], with diagnoses including history of falling, humerus fracture (upper arm bone) and chronic pain. The resident was able to make needs known.<br><br>During an interview on 06/16/2025 at 10:21 AM, Resident 62 said they had frequent pain and took as needed medication, which helped.<br><br>Review of the electronic health record (EHR), showed a provider order, dated 05/01/2025, for oxycodone (a narcotic pain medication) every six hours as needed for pain. Resident 62 was administered oxycodone two to three times a day from 06/01/2025 to 06/21/2025, with no documented NPIs given prior to pain medication administration.<br><br>During an interview on 06/18/2025 at 10:23 AM, Staff G, Registered Nurse, said it was their expectation that NPI be attempted prior to as needed pain medication and documented in the medication administration record (MAR), but Resident 62 did not have any orders for NPI.<br><br>During an interview on 06/18/2025 at 10:50 AM, Staff B, Director of Nursing Services (DNS), said it was their expectation NPIs were attempted prior to pain medications and should be attached to the order, but was not for Resident 62 and this did not meet expectations.<br><br>2) Resident 91 admitted to the facility on [DATE]. According to the admission Minimum Data Set (an assessment tool), dated 05/13/2025, Resident 91 was severely cognitively impaired.<br><br>Resident 91's orders were reviewed and two orders for oxycodone were found.<br><br>1. Oxycodone-Acetaminophen, give 1 tablet by mouth two times a day.<br><br>2. Oxycodone-Acetaminophen, give ½ tablet as needed for moderate pain.<br><br>Review of Resident 91's May 2025 and June 2025 MARs, showed there were no NPIs ordered and no adverse (negative) side effect (ASE) monitoring for oxycodone. Further review of the MAR from 06/01/2025 through 06/17/2025, documented 23 administrations of the scheduled oxycodone with a pain score of zero (1-10 pain scale, zero indicating no pain).<br><br>(continued on next page) |

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| | 505387 | A. Building<br>B. Wing | 06/24/2025 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/23/2025 at 10:17 AM, Staff B, DNS, when asked her expectations for NPIs being implemented for pain, said staff should intervene and provide change of positions, attempt to do some type of NPI, and NPIs should be attempted prior to administering as needed pain medication. When asked if NPIs were being done and documented for the ordered oxycodone for Resident 91, Staff B said she did not see documentation in the EHR and this did not meet her expectations. When asked if ASE monitoring should be in place for ordered pain medications, Staff B said yes. Regarding the 23 administrations of oxycodone with documented zero pain for Resident 91, Staff B said, if staff consistently saw this, they should have contacted the provider to see if there needed to be any changes. Staff B looked in the EHR and said she did not see any documentation that the provider was contacted, but communication could have been sent by fax and she would provide it if found. No further documentation was provided.<br><br>Reference WAC 388-97-1060(3)(k)(i)<br><br>. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, record review, and interview, the facility failed to ensure a medication error rate less than 5%, by having an error rate of 15.38%, with 4 errors of 26 medication administration opportunities observed. This failure placed residents at risk of medication complications and a diminished quality of life.<br><br>Findings included .<br><br>On 06/17/2025 at 9:22 AM, Resident 20 was observed to be given 3 insulin medications late:<br><br>1. Insulin Deglu[DATE] units one time a day, due at 8:00 AM<br><br>2. Insulin Lispro 13 units two times a day, with instructions to give with breakfast and dinner, due at 8:00 AM<br><br>3. Insulin Lispro, on a sliding scale (dependent on what the blood glucose level was), 2 units, with instructions to give with each meal, due at 8:00 AM<br><br>On 06/17/2025 at 9:23 AM, Resident 20 reported they already had breakfast. Resident 20's breakfast tray had already been removed from the room.<br><br>On 06/18/2025 at 1:25 PM, Resident 46 was observed to be given 1 oral medication late:<br><br>1. Baclofen for muscle spasms four times a day, due at 12:00 PM<br><br>During an interview on 06/18/2025 at 2:58 PM, Staff B, Director of Nursing Services, said staff have one hour before and one hour after a medication was due, to give the medication. When told of Resident 20's late insulin administrations, Staff B said their expectation was for them to have been given closer to the time frame, closer to 8:00 AM. For Resident 46's late medication, Staff B said it should have been given one hour prior or after it was due.<br><br>Reference WAC 388-97-1060 (3)(k)(ii)<br><br>. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>.<br><br>Based on observation, record review, and staff interviews, the facility failed to ensure medication carts were locked/secured in the absence of a nurse for 1 of 5 carts observed (A wing medication cart), and proper labeling and storing of medications and expired medications/equipment were discarded timely for 3 of 3 carts reviewed (carts #2, #3, #5). These failures placed residents at risk for receiving compromised or inaccurate medications, medication diversion and potential harm.<br><br>Findings included .<br><br><Expired Medications/Equipment and Storage ><br><br>On 06/18/2025 at 11:11 AM, an observation of Emerald Cart #3 with Staff G Registered Nurse (RN), showed:<br><br>- an open resident medication cup containing white pills labeled with a marker APAP 500mg and no expiration date labeled on the cup<br><br>- a bottle of Ibuprofen 200mg tablets that expired in May 2025<br><br>- 4 bottles of anti-itch lotion for Residents 41, 19, 31 and 13 that expired May 2025<br><br>And Staff G said we cannot give this medication, and I will get them out of the cart.<br><br>On 06/18/2025 at 11:29 AM, an observation of C Wing Cart #5 with Staff H, Licensed Practical Nurse (LPN) showed:<br><br>-2 bottles of anti-itch lotion which expired May 2025. The first bottle was labeled with a resident name that was illegible, and the second bottle had a first name but not a last name on the label.<br><br>-control drops for an accu chek machine (checks blood sugar levels with a drop of blood) expired on 09/11/2024<br><br>And Staff H acknowledged the bottles of anti-itch lotion were expired and said I am an agency nurse, I don't know the last name of this resident. Staff H said she would have to get another bottle of the control drops because that one was expired.<br><br>On 06/18/2025 at 11:50 AM, an observation of Cart #2 with Staff I, LPN showed:<br><br>- a bottle of Zinc 50mg with an expiration of January 2025<br><br>And Staff I said I have not given this in a long time. I will get rid of it and get a new bottle.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/18/2025 at 12:17 PM, Staff B, Director of Nursing Services (DNS), said they just had two pharmacy consultants look at everything and this was disappointing. Staff B said the expired medications should have been removed and destroyed. Staff B said the open cup of APAP 500mg should not be in the cart and should all be in a bottle. She also said the control drops for the accu check machine should have been tossed and replaced with a new one. If the loose dollar bill belongs to a staff, it should be kept with their belongings.<Medication cart not locked><br><br>On 06/23/2025 at 5:00 AM, an observation showed a medication cart that was unlocked, and no staff in sight.<br><br>On 06/03/2025 at 5:05 AM, Staff M, when asked about the unlocked medication cart, opened a drawer and said, she had never noticed and that it normally locks.<br><br>On 06/23/2025 at 9:55 AM, Staff B, DNS, asked when medication carts should be locked said, when staff are stepping away from the cart. When told of observation of the medication cart not being locked and no staff in sight, Staff B said it did not meet her expectations.<br><br>Reference WAC 388-97-1300 (2), -2340<br><br>. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .<br><br>Based on observation, interview and record review, the facility failed to prepare food in a manner that conserved nutritive value and palatability for 4 of 4 residents (Resident 9, 71, 156 and 157) with pureed diet textures, to honor residents' preferences for 3 of 5 residents (Residents 158, 356, and 46) observed with identified preferences, and to ensure meals/beverages were appetizing and served at appropriate temperatures as evidenced by 7 resident interviews and test tray results. These failures placed resident at risk of dissatisfaction with meals, decreased intake, weight loss, and decreased quality of life.<br><br>Findings included .<br><br><Resident Interviews><br><br>On 06/17/2025 at 9:04 AM, Resident 44 said they wanted their meals hot, but by the time the meals reached the table they were cold.<br><br>On 06/17/2025 at 8:44 AM, Resident 355 complained that facility food was often dried out or tasteless.<br><br>On 06/16/2025 at 12:48 PM, Resident 15 said the food was horrible and it was not hot when received.<br><br>On 06/16/2025 at 2:38 PM, Resident 82 said since the new ownership took over the food was delivered cold.<br><br>On 06/16/2025 at 12:49 PM, Resident 91 said the food could be better and showed a piece of hard dry bread.<br><br>On 06/17/2025 at 11:49 AM, Resident 30 complained about being served cold oatmeal and soup.<br><br>On 06/17/2025 at 8:42 AM, Resident 79 said that more than 50% of the time, food served is cold.<br><br><Meal Preparation><br><br>On 06/20/2025 at 9:47 AM, observation of Staff P, Cook, preparing pureed peas showed the following:<br><br>Staff P poured an unmeasured amount of peas from a plastic container into the blender then proceeded to the sink and added an unmeasured amount of water directly from the spigot. The mixture was blended for 30 seconds then removed. Staff P then poured in a quarter cup of thickener and stirred the mixture. After looking at the texture, Staff P added a little more (unmeasured) thickener to the mixture, mixed it together and said the pureed peas were ready and placed them on the steam table. When asked how they knew how much water and thickener to add to the peas Staff P said they looked at the texture of the peas and added more water to see if it was too thick or more thickener if the mixture was too thin. Staff O indicated the mixture should be pudding like.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/20/2025 at 9:56 AM, when asked if they had a recipe for pureed peas for staff to follow Staff O, Food Service Supervisor, stated, Yes. A copy was requested but Staff O was unable to immediately locate it. Staff O acknowledged the recipe provided measurements (e.g. how much fluid and thickener to add to a set amount of peas) and directed staff to use broth instead of water to improve flavor. When asked (for clarification) if using measured ingredients and broth instead of water was to ensure consistency, nutritional value, palatability Staff O said yes, and confirmed Staff P should have followed a recipe.<br><br><Tray Line><br><br>Observation of tray line on 06/20/2025 from 11:59 AM - 1:04 PM showed the following:<br><br>On 06/20/2025 at 1:03 PM, Staff O, Food Service Supervisor, explained the following:<br><br>a) large portions= one and a half scoops of the main and side dishes.<br><br>b) small portions= one half scoops.<br><br>c) double portions= two scoops.<br><br>d) large protein= one and a half scoops of meat.<br><br>Observation of the steam table showed each food bin had one scoop present and the size matched the serving size identified on the therapeutic menu.<br><br>Review of Resident 158's tray card showed they were to receive large portions per resident preference, Staff P, Cook, was observed to provide one scoop of the main and side dishes when preparing the residents meal.<br><br>Review of Resident 356's tray card showed they had an order for Large protein. When preparing Resident 356's meal, Staff P, Cook, provided one scoop of chicken, rather than one and a half as directed.<br><br>Review of Resident 46's tray card showed the resident was to receive Small Portions. When preparing Resident 46's meal, Staff P, Cook, provided one scoop of the main and side dishes.<br><br>During an interview on 06/20/2025 at 1:03 PM, Staff O, Food Service Supervisor, said the cook was expected to provide the portion size that was indicated on residents' tray cards. Additionally, Staff O confirmed Staff P only had one scoop available in each bin and explained that there should have been two to ensure provision of the appropriate portion size (e.g. if the portion size of the main dish was four ounces, a resident on large portions should receive six ounces. Thus, the cook should have a four-ounce and two-ounce scoop present.)<br><br><Test Tray><br><br>A test ray was delivered on 06/23/2025 at 12:36 PM. The temperature of the cranberry juice was 52 degrees, and the butterscotch pudding was 71 degrees.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The pureed ham was not palatable. The predominant flavor was cinnamon, not ham and it tasted diluted.<br><br>On 06/23/2025 at 2:03 PM, Staff O, Food Service Supervisor, said cold food/beverages should be served at or below 41 degrees. <Resident Food Preferences><br><br>Resident 87 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 87 was cognitively intact.<br><br>On 06/16/2025 at 12:17 PM, Resident 87 was sitting in their wheelchair (WC) with bedside table sitting in front of the WC. On the bedside table was Resident 87's breakfast meal. On the plate was two half slices of white bread. Resident 87 stated, the food is garbage. Resident 87 said they had repeatedly told the facility they did not like white bread but they continued to get it with every meal. Resident 87 said they were often told there were no snacks available in the refrigerator and they needed a snack due to being diabetic. Resident 87 said it was always the same three proteins; chicken, fish of canned ham and the food was always cold.<br><br>On 06/16/2025 at 1:11 PM, Staff member delivered Resident 87's lunch meal tray and placed it on the bedside table in front of Resident 87. Resident 87 lifted the plastic cover off the meal tray and observed two half slices of white bread toast sitting on the plate.<br><br>A Nutritional At Risk Assessment, dated 04/28/2025, documented Resident 87's dislikes were white bread, tea, coffee, ham and bacon.<br><br>On 06/20/2025 at 11:31 AM, in a joint interview with Staff A, Administration, and Staff B, Director of Nursing Services, Staff B said when a resident was admitted , the Registered Dietitian (RD), would develop a care plan regarding the resident's food preferences. Staff B said if there was a change in preference, nursing staff would contact the RD to provide an update. Staff A and Staff B were asked to review Resident 87's Nutritional At Risk Assessment, dated 04/28/2025. When asked what Resident 87's dislikes were, Staff A said white bread, tea, coffee, ham and bacon. After observations of two meal tray observed with white bread on them and asked if that was acceptable, both Staff A and Staff B said no.<br><br>Reference WAC 388-97 -1100 (1), (2)<br><br>. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>.<br><br>Based on observation, interview and record review, the facility failed to ensure food was stored or covered to prevent cross-contamination, that outdated or unlabled food was discarded, and/or refridgerator temperature logs were filled out and monitored for 1 of 1 kitchen reviewed and from resident accessible refrigerators for 2 of 4 dining rooms (Country Kitchen & Bistro) reviewed. These failures placed residents at risk of eating expired/outdated food and/or food borne illnesses.<br><br>Findings included .<br><br>During an observation of the dietary service department on 06/16/2025 from 9:49 AM to 10:22 AM, the following was observed:<br><br><Kitchen's Walk-in Refrigerator><br><br>Observations of the walk-in refrigerator showed the following:<br><br>1. A large, uncovered metal bin of white rice.<br><br>2. A large, uncovered metal bin of brown gravy.<br><br>On 06/16/2025 at 10:34 AM, Staff O, Food Service Supervisor, said the uncovered bins of rice and brown gravy had just been prepared and were in the refrigerator, unlidded, to cool down.<br><br><Kitchen's Refrigerator 3><br><br>Observation of Refrigerator 3 showed a container of peaches and pineapple, with a prepared by date of 06/10/2025 and a use by date of 06/15/2025.<br><br>On 06/16/2025 at 10:38 AM, Staff O said the container of peaches and pineapple were past the use by date and needed to be discarded.<br><br><Kitchen's Walk-in Freezer><br><br>Observation of the walk-in freezer showed a tray of chicken and a couple bags of pepperoni were stored over a tray of sugar cookies covered by a sheet of wax paper.<br><br>On 06/16/2025 at 10:02 AM, when asked if it was ok to store meat products above a tray of sugar cookie dough covered with wax paper, Staff O stated, No, we will have to correct that.<br><br><Country Kitchen Dining Room><br><br>On 06/16/2025 at 12:48 PM, review of the refrigerator temperature log, showed staff were directed to check and record the temperature twice daily. Review of the documentation showed the refrigerator's temperature had not been checked or recorded since 06/09/2025 (7 days).<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 06/20/2025 at 1:43 PM, Staff O said it was the expectation the refrigerator temperatures be checked twice daily and acknowledged it had not occurred. Staff O explained the refrigerator was recently moved into the Country Kitchen Dining Room and nursing staff likely were unaware that it was there.<br><br><Bistro Dining Room><br><br>On 06/16/2025 at 1:02 PM, observation of the Bistro Dining Room's refrigerator showed the following:<br><br>1. A plastic container labeled Eggs and Pancakes; Todays date: 06/10/2025.<br><br>2. A plastic container of strawberries and cantaloupe labeled Todays date as 06/03/2025 and read May store for 3 days.<br><br>3. A plastic container of pineapple labeled Todays date as 06/03/2025 and read May store for 3 days.<br><br>4. An unlabeled and undated Ziplock bag containing tortillas filled with beans and meat product(s) wrapped in tinfoil.<br><br>On 06/17/2025 at 1:12 PM, Staff O confirmed the above listed food products were outdated/expired and explained prepared food should be discarded three days after the prepared date.<br><br>Reference WAC 388-97-1100 (3), -2980<br><br>. |