STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enumclaw Health & Rehab Center	2323 Jensen Street Enumclaw, WA 98022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43642 Based on observation, interview, and record review the facility failed to provide care and services in a manner that maintained and promoted dignity while assisting with meals for 3 of 18 residents (Resident 29, 5, & 12) reviewed for dining observations. This failure placed the resident at risk for a diminished self-worth and over-all well-being. Findings included . <Resident 29> According to a 04/11/2024 Quarterly MDS, Resident 29 had multiple medically complex diagnoses including cancer, anxiety, depression, and weakness. This MDS showed staff assessed Resident 29 to require substantial assistance from staff for eating and to roll from side to side in bed. Observations during meal services on 05/10/2024 starting at 8:29 AM showed staff delivered a breakfast tray to Resident 29 and placed it on their overbed table, out of the resident's reach, on the left side of the bed. At 8:33 AM, staff sat down to assist Resident 29's roommate to eat their breakfast. At 8:35 AM, Resident 29 was lying in bed watching staff feed their roommate, it was not until 8:54 AM, 25 minutes later, when staff came to assist Resident 29 to eat their breakfast. Observations during meal services on 05/10/2024 at 12:25 PM showed staff entered Resident 29's room and sat down to assist the roommate with their lunch meal. Resident 29 watched staff feeding the roommate. It was not until 12:55 PM, 30 minutes later, that staff delivered Resident 29's lunch tray. Observations during meal services on 05/13/2024 at 1:31 PM showed staff delivered a lunch tray to Resident 29 and placed it on their overbed table, out of the resident's reach. At 1:37 PM, Resident 29 put their call light on to request assistance with lunch. Staff responded to the call light, turned it off, and stated, oh, you are waiting for someone to feed you? We are coming to help after we pass all the trays. At 1:41 PM Resident 29 placed their call light on to again request assistance with lunch. At 1:48 PM, 17 minutes after Resident 29 had their lunch tray delivered. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 12:23 PM, Staff G (Resident Care Manager) stated their expectation was for staff to assist residents with feeding at the time the tray was delivered. Staff G stated residents having to watch others eat did not promote dignity for the resident. Staff G stated a resident should receive assistance with meals within five to ten minutes at the most and indicated meal tray service needed to be adjusted. <Resident 5> According to a 02/14/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 5 had multiple medically complex diagnoses including the loss of ability to move their arms and legs. This MDS showed staff assessed Resident 5 to be dependent on staff for eating. Observations during meal services on 05/14/2024 at 7:54 AM showed Staff EE (Certified Nursing Assistant - CNA) in the dining room standing, wearing a protective gown and gloves, while they were feeding Resident 5 at a table. <Resident 12> According to a 04/02/2024 Significant Change MDS, Resident 12 had multiple medically complex diagnoses including cancer and was assessed to require setup help with eating. Observations during meal services on 05/08/2024 at 8:45 AM showed Staff Y (CNA) in Resident 12's room standing at their bedside while feeding the resident. In an interview on 05/16/2024 at 3:17 PM, Staff B (Director of Nursing) stated their expectation was for staff to be sitting next to a resident while assisting with feeding. REFERENCE: WAC 38-977-0180(1-4). 42203

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43642 Based on observation, interview, and record review the facility failed to provide a comfortable, appropriately sized bed for 1 of 1 resident (Resident 15) reviewed for accommodation of needs. This failed practice placed the resident at risk for discomfort and skin issues. Findings included . <Resident 15> According to a 05/03/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 15 had multiple medically complex diagnoses including a hip fracture and dementia. This MDS showed staff assessed Resident 15 to have a functional limitation in their range of motion to both their arms and legs, and required substantial assistance from staff to roll from side to side or sit up in bed. Observations on 05/08/2024 at 12:36 PM showed Resident 15 lying in bed, with both feet pushed up against the footboard of the bed. Similar observations were made on 05/09/2024 at 10:19 AM, 12:06 PM, and 2:49 PM. In an interview on 05/10/2024 at 8:20 AM, Resident 15 stated their knees were sore. In an observation at this time, Resident 15's feet were pressed against the footboard, and they were unable to straighten their legs out. Observations on 05/16/2024 at 8:09 AM showed staff providing care to Resident 15. Staff completed the care and assisted the resident to be repositioned higher in their bed. After being repositioned, both of Resident 15's feet were pressed firmly against the footboard with their knees bent, unable to straighten their legs. In an interview and observation on 05/16/2024 at 1:02 PM, Staff G (Resident Care Manager) confirmed Resident 15's bed was not long enough for the resident to straighten their legs and stated they would have maintenance change beds. REFERENCE: WAC 388-97-0860(2).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42203 Based on interview and record review, the facility failed to ensure a system by which residents received required written notices at the time of transfer/discharge for 2 (Residents 23 & 28) of 2 residents reviewed for hospitalization s. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge, in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> Review of the facility's policy titled Transfer and Discharge updated October 2022, showed when a resident transfer of discharge was initiated, the resident would receive a written notice that included the reason for the transfer/discharge, where the resident was moving to, contact information for the State Long-Term Care Ombudsman (LTCO), and explanations of the resident's right to appeal the transfer/discharge. <Resident 23> According to the 04/30/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 23 had severely impaired memory and exhibited signs of inattentiveness and disorganized thinking. The MDS showed Resident 23 was dependent on staff for bathing, hygiene, toileting, and transfers. The MDS showed Resident 23 had diagnoses including a fungal infection of the brain and a seizure disorder. The MDS showed Resident 23 had a history of falling in the facility. Record review showed Resident discharged to the hospital on three occasions since admission: on 09/24/2023 following a seizure, on 12/30/2023 following a seizure, and on 03/15/2024 for a urinary tract infection. Record review showed no indication Resident 23 was provided the required, written transfer notice for any of the three hospitalization s. In an interview on 05/14/2024 at 2:14 PM Staff B (Director of Nursing) stated they could not locate a transfer notice for any of Resident 23's three hospitalization s. Staff B stated the facility should have but did not provide Resident 23's transfer notices as required. 46479 <Resident 28> Review of Resident 28's census information showed Resident 28 was transferred to the hospital for low blood pressure and low blood-oxygen levels on 03/19/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 28's records showed staff did not provide Resident 28 or their representative with a written notification explaining the reason for their transfer, LTCO contact information, or an explanation of the resident's rights regarding the transfer. In an interview on 05/16/2024 at 11:52 AM, Staff B confirmed staff did not provide a written notice to Resident 28 and stated the facility did not have a process for providing written notices to residents at that time. REFERENCE: WAC 388-97-0120(2)(a-d).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 43642 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA), including Care Area Assessments (CAAs), was completed within 14 days for 1 of 1 resident (Resident 57) reviewed for a decline in nutritional intake and a change in skin integrity. Failure to identify Resident 57's change in status and complete a SCSA placed the resident at risk for unidentified and/or unmet care needs. Findings included . According to the October 2023 Resident Assessment Instrument Manual (a manual that directed staff on how to accurately assess the status of residents) a SCSA was a comprehensive assessment that must be completed when the interdisciplinary team determined that a resident met the significant change guidelines for either major improvement or decline. Review of the guidelines showed, a SCSA was appropriate if there was a significant change in a resident's condition from their baseline that occurred, and the resident's condition was not expected to return to baseline within two weeks. <Resident 57> According to a 02/14/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 57 had multiple medically complex diagnoses including cancer, heart failure, and kidney failure. This MDS identified Resident 57 had no weight loss of 5 Percent (%) or more in the last month, or 10 % or more in the last six months, and did not have any pressure ulcers/injuries. In an interview on 05/08/2024 at 11:55 AM, Resident 57 stated they experienced some recent weight loss and had a wound on their foot. Observation at this time showed Resident 57 wore a protective boot on their left foot. Review of the weight documentation showed on 02/24/2024, Resident 57 weighed 156 Pounds (Lbs). On 03/27/2024, staff documented Resident 57 weighed 145.5 Lbs, a loss of 6.79 %. Review of a 03/27/2024 weekly skin evaluation form showed staff identified Resident 57 had a new deep tissue injury on their left heel. According to a 03/29/2024 Nutrition Hydration Skin Committee (NHSC) review form, staff documented Resident 57 was reviewed by the NHSC related to a significant weight loss and a new pressure injury to their left heel. Review of a 04/01/2024 wound care consult progress note showed Resident 57 was evaluated and assessed to have a new, deteriorating pressure injury on their left heel. The evaluation determined wound healing potential was poor, Resident 57 was at high risk for complications, and future wounds may be unavoidable due to the resident's health condition. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 11:10 AM, Staff CC (MDS Coordinator) stated a SCSA was important to identify changes needed in a resident's care, make care plan revisions, and notify staff. Staff CC stated their expectation was for staff to complete a SCSA within 14 days of staff identifying a resident experienced a change in condition. Staff CC reviewed Resident 57's records and stated staff should have but did not complete a SCSA as required for Resident 57. REFERENCE: WAC 388-97-1000 (3)(b).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was obtained, accurate, and/or available in the resident's records to reflect the residents' mental health conditions for 2 of 6 (Resident 61 & 29) residents reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Resident 61> According to a 03/08/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 61 was admitted on [DATE] with multiple medically complex diagnoses and required the use of an antidepressant medication. Review of Resident 61's records showed no PASRR Level 1 was available in the resident's records. In an interview on 05/14/2024 at 11:51 AM, Staff M (Medical Records) confirmed there was no PASRR Level 1 in Resident 61's records or overflow papers to be scanned and stated staff should have obtained a PASSR on admission. On 05/15/2024 at 9:47 AM, Staff M stated they located a 04/10/2024 PASRR Level 1 and scanned it into the resident's records. This form was not completed by the facility until over a month after Resident 61's admission and not added to the resident's records until two months after admission. In an interview on 05/15/2024 at 12:26 PM, Staff O (Divisional Director of Social Services) stated their expectation was for a PASRR Level 1 to be obtained prior to admission to the facility. <Resident 29> According to a 04/11/2024 Quarterly MDS, Resident 29 had multiple medically complex diagnoses including psychosis, anxiety, and depression and required the use of antipsychotic, antianxiety, and antidepressant medications during the assessment period. Review of a 04/26/2024 provider progress note showed Resident 29 had a follow up visit due to advancing dementia and gradual decline. On 10/13/2023 a psychiatry progress note showed documentation Resident 29 had a history of advanced dementia. Review of a 03/04/2024 PASRR Level 1 showed staff identified Resident 29's only Serious Mental Illness (SMI) indicator was anxiety and depression. Staff did not identify Resident 29 had dementia or a psychotic disorder and required the use of medications. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2024 at 11:39 AM, Staff M located a 04/11/2024 PASRR Level 1 in their office and stated they received the form about a week ago. Review of the 04/11/2024 PASRR Level 1 showed staff added the SMI indicator of a psychotic disorder along with the anxiety and depression indicators previously identified on the 03/04/2024 form. Staff did not identify the diagnosis of dementia, as indicated by the providers in Resident 29's records, in Section C on the PASRR Level 1 form. In an interview on 05/16/2024 at 11:35 AM, Staff R (Social Services Director) stated PASRR Level 1 forms should be updated and accurate to reflect the resident's current condition and should be readily available in the resident's records. In an interview on 05/16/2024 at 2:28 PM, Staff R stated staff did not, but should have identified Resident 29's diagnosis of dementia on the PASRR Level 1 form and indicated the form needed to be updated. REFERENCE: WAC 388-97-1915 (1)(2)(a-c). 50511

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42203 Based on observation, interview, and record review the facility failed to develop comprehensive Care Plans (CP) for 3 (Residents 5, 34, & 8) of 18 sampled residents whose comprehensive CPs were reviewed. Failure to establish individualized CPs with identified goals that accurately reflected the resident's condition, placed residents at risk for unmet care needs. Findings included . <Facility Policy> The facility used Centers for Medicare & Medicaid Services' (CMS's) October 2012 Resident Assessment Instrument Manual's Chapter 4: Care Are Assessment (CAA) Process and Care Planning, Table 2: Clinical Problem Solving and Decision Making Process Steps and Objectives to guide the care planning process. This manual showed CPs should reflect the resident or their representative's input and goals for health care, include measurable goals. <Resident 5> According to the 02/14/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 5 had intact memory, diagnoses including a traumatic spinal cord injury, paralysis from the neck down, and was totally dependent on staff for all self-care and mobility needs. According to the revised 08/28/2020 Alterations in Smoking . CP Resident 5's goal was to smoke safely in the facility's designated smoking area at the scheduled times with no injuries (i.e. burns) from smoking. The CP included an intervention for staff to ensure a smoking safety evaluation was completed quarterly and as needed. Record review showed the last smoking safety evaluation for Resident 5 was completed on 10/18/2023. This evaluation showed Resident 5 required assistance to smoke. In an interview on 05/16/2024 at 11:00 AM Staff G (Resident Care Manager - RCM) stated they would find out if staff completed a more recent smoking safety evaluation for Resident 5. No further information was provided. In an interview on 05/16/2024 at 3:17 PM Staff B (Director of Nursing) stated it was important for CP interventions to be implemented. <Resident 34> According to the 03/10/2024 Quarterly MDS Resident 34 had diagnoses including anxiety and depression. The MDS showed Resident 34 exhibited physical behavior towards others during the assessment's seven-day lookback period, and their behavior worsened. The MDS showed Resident 34 used an antipsychotic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the May 2024 Medication Administration Record (MAR) Resident 34 had an 11/22/2023 order for an antipsychotic medication. The 05/10/2024 antipsychotic medications CP showed Resident 34's goal was to be free of negative side effects from the medication. The CP did not identify which medication Resident 34 received or what symptoms the medication was ordered to treat. The CP had interventions to administer anti-psychotic medications as ordered and monitor for effectiveness and side effects, and to educate the resident/family about the risks, benefits, and side effects of treatment. In an interview on 05/16/2024 12:23 PM Staff B stated Resident 34's antipsychotic medication CP did not include resident-specific goals as required, including the symptoms or behaviors it was prescribed to treat, or other potential benefits of the medication. Staff B acknowledged the CP was developed over five and a half months after the medication was first prescribed, rather than at the time of first administration. 43642 <Resident 8> According to the 02/26/2024 Admission MDS, Resident 8 was understood and could understand by others in conversation. This MDS showed Resident 8 had no memory impairment and participated in occupational and physical therapy. Review of a 03/17/2024 occupational therapy discharge summary showed Resident 8 was being discharged from occupational therapy and the therapist recommended a restorative nursing program for Resident 8. The program recommended range of motion exercises for staff to perform on Resident 8's shoulder, elbow, and wrist. Review of Resident 8's 02/20/2024 comprehensive CP showed staff did not develop a CP for Resident 8 regarding their restorative nursing program. The comprehensive CP showed staff did not identify Resident 8 required assistance from staff with range of motion exercises. REFERENCE: WAC 388-97-1020(1), (2)(a)(b). . 46479

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42203 Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were updated and/or revised as needed to reflect person-centered care for 4 (Residents 34, 53, 9, & 28) of 18 sample residents whose CPs were reviewed. This failure left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings included . <Facility Policy> The facility used Centers for Medicare & Medicaid Services' (CMS's) October 2012 Resident Assessment Instrument Manual's Chapter 4: Care Are Assessment (CAA) Process and Care Planning, Table 2: Clinical Problem Solving and Decision Making Process Steps and Objectives to guide the care planning process. This manual showed CPs should reflect the resident or their representative's input and goals for health care, include measurable goals. <Resident 34> According to the 03/10/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 34 had a severe memory impairment. The MDS showed Resident 34 had diagnoses including dementia. According to the revised 10/18/2022 . impaired thought processes [related to] dementia . CP nurses would administer medications as ordered to treat Resident 34's dementia. The CP showed nursing staff would monitor for the effectiveness of the medication and side effects. Review of the May 2024 Medication Administration Record showed no medications ordered to treat dementia, and no monitoring of dementia medications for efficacy or side effects. In an interview on 05/16/2024 at 12:22 PM, Staff B (Director of Nursing) stated Resident 34 no longer took a medication to treat their dementia. Staff B stated the CP needed to be revised. 46479 <Resident 53> Review of the 03/25/2024 Quarterly MDS, showed Resident 53 had no memory impairment and had diagnoses of a stroke with limited mobility to one side of their body. This assessment showed Resident 53 required staff assistance with set up and clean up of the resident's meal. Resident 53 did not require assistance from staff to feed themself. Review of Resident 53's 02/28/2024 revised Baseline CP, showed Resident 53 required moderate assistance and was dependent on staff to eat their meals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/09/2024 at 8:40 AM showed Resident 53 sitting up in bed feeding themself breakfast. Similar observations were made on 05/13/2024 at 1:45 PM and 05/14/2024 at 1:08 PM. In an interview on 05/16/2024 at 11:27 AM, Staff B stated Resident 53 was independent with eating and confirmed staff needed to updated Resident 53's CP but did not. <Resident 9> Review of the 02/09/2024 Quarterly MDS showed Resident 9 had moderate memory loss and did not participate in a restorative nursing program during the lookback period. Review of a 04/05/2024 nursing progress note showed staff discontinued Resident 9's restorative nursing program due to the resident pattern of refusing to participate in the program. Review of Resident 9's 11/18/2022 Impaired Mobility CP showed a goal that staff would assist Resident 9 to walk 300 feet three to four times per week. Interventions for this CP directed staff to provide and active range of motion to Resident 9's legs three to six times per week and provide assistance to use a exercise bike three times per week. Review of Resident 9's revised 02/21/2024 activities of daily living CP showed staff were to encourage Resident 9 to be in their wheelchair for meals. This CP instructed staff not to give Resident 9 meals in bed. Observation on 05/15/2024 at 8:35 AM showed Resident 9 sitting up in bed eating breakfast. In an interview on 05/15/2024 at 12:58 PM, Staff B reviewed Resident 9's CP and confirmed staff discontinued the resident's restorative program. Staff B confirmed Resident 9 was able to eat in bed and stated the CP was not updated but should be. Staff B stated it was important to keep residents' CPs updated so staff could provide care in accordance with a resident's specific plan of care. <Resident 28> Review of Resident 28's Baseline CP included a revised 04/12/2024 intervention directing staff to provide substantial/maximal assistance to Resident 28 with their meals. A 04/20/2024 nurse progress note showed staff documented Resident 28 was able to feed themselves. In an interview on 05/16/2024 at 11:15 AM Staff N (Certified Nursing Assistant) stated when Resident 28 came back from the hospital a few weeks ago, staff needed to help the resident eat. Staff N stated now Resident 28 was able to feed themselves and the staff would check on the resident throughout the meal. In an interview on 05/16/2024 at 11:27 AM, Staff B stated baseline CPs were created upon the resident's admission and staff modified the CP as they learned about the resident. Staff B stated it was important to keep the CP updated so staff were aware of the current plan of care for the residents. REFERENCE: WAC 388-97-1020(5)(b). (continued on next page)

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	505400	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50511 43642

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42203 Based on observation, interview, and record review the facility failed to ensure: Physician's Orders (POs) were followed and/or clarified for 4 (Residents 50, 19, 29, & 57) and nurses signed only for tasks completed for 2 (Residents 57 & 29) of 18 sample residents. These failures left residents at risk for unmet care needs, unnecessary treatment, and other negative health outcomes. Findings included . <Following and/or Clarifying POs> <Resident 50> According to the 04/05/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 50 had diagnoses including muscle spasms, an abdominal hernia, and back pain. The MDS showed Resident 50 received regularly scheduled and as-needed pain medications, including narcotic pain medications. The May 2024 Medication Administration Record (MAR) included a 02/20/2024 order for an as-needed narcotic pain medication, give 5 Milligrams (MG) as needed for severe back pain of seven or more on a scale of 1-10. The MAR showed on 05/03/2024 at 6:13 PM, and on 05/04/2024 at 6:58 AM Resident 50 was given the narcotic pain medication for a pain of six, outside of the ordered parameters. The April 2024 MAR showed on 04/03/2024 at 6:57 AM, on 04/05/2024 at 8:32 AM, on 05/14/2024 at 7:02 AM, on 05/15/2024 at 8:00 AM, on 04/20/2024 at 9:25 AM, and on 04/30/2024 at 6:38 PM Resident 50 was given the narcotic pain medication for a pain of six. The April 2024 MAR showed on 04/10/2024 at 7:36 AM, on 04/11/2024 at 7:52 AM, on 04/19/2024 at 10:25 AM, and on 04/20 at 8:03 AM Resident 50 was given the narcotic pain medication for a pain of five. The April 2024 MAR showed on 04/11/2024 at 7:17 PM, and on 04/24/2024 at 12:25 PM for a pain of zero. In an interview on 05/09/2024 at 8:43 AM Staff B (Director of Nursing) stated it was important to follow ordered parameters for medications, Staff B reviewed the April and May 2024 MARs and stated the medication was provided outside of the ordered parameters. <Resident 19> According to the 03/08/2024 Quarterly MDS, Resident 19 had no memory impairment, could understand others, and was understood in conversation. This assessment showed Resident 19 had end stage kidney failure. Review of Resident 19's Functional Abilities Care Plan (CP) showed an 11/16/2023 intervention directing staff to apply a specialty compression stocking to Resident 19's left lower leg in the AM and remove the stocking at bedtime. Review of the April 2024 Treatment Administration Record (TAR) showed staff documented on 28 occasions they assisted Resident 19 with donning and doffing their specialty compression stocking. On two occasions, staff documented Resident 19 refused to wear their compression stocking. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/09/2024 at 9:43 AM showed Resident 19 in their room sitting in their wheelchair. Resident 19 had an ace bandage wrap in place on their left lower leg. At that time, Resident 19 stated it was for their edema and staff applied the wrap to the resident's left leg as needed. In an interview on 05/15/2024 at 2:38 PM, Staff Q (Licensed Practical Nurse) stated they never saw Resident 19 with their compression stocking on. In an interview at 2:42 PM, Staff P (Registered Nurse) stated Resident 19 preferred to wear the ace wrap instead of the compression stocking and stated Resident 19 sometimes refused to wear the stocking. In an interview on 05/16/2024 at 11:42 AM, Staff B stated they expected staff to clarify the order for the compression stocking or get a new order from the provider if Resident 19 was only using the compression stocking as needed. 43642 <Resident 29> Review of Resident 29's May 2024 MAR showed the resident had a 10/24/2023 order for a cough relieving medication to be administered every four hours as needed for cough. A second order from 01/27/2024 gave directions for a different cough medication to be administered every four hours as needed for cough. There were no instructions directing staff which cough medication should be administered to Resident 29 for cough symptoms. Review of Resident 29's May 2024 MAR showed the resident had two separate 05/08/2024 POs for a non-narcotic pain suppository to be administered as needed every six hours for pain or fever. These orders did not specify what dose of the medication nursing staff should administer. In addition, Resident 29 had two other orders for the same non-narcotic pain medication to be administered by mouth every four hours as needed for pain or fever. There was no instruction to staff which medication should be administered. In an interview on 05/16/2024 at 12:23 PM, Staff G (Resident Care Manager) stated the medications should include a dose to be administered, instructions on what medication to administer, and duplicate orders clarified by staff. <Signing For Tasks Not Completed> <Resident 57> Review of Resident 57's POs showed a 04/02/2024 order for the resident to wear a moon boot to their right foot while in bed to prevent pressure to their foot. Observations on 05/08/2024 at 11:55 AM, 05/09/2024 at 9:09 AM, 05/10/2024 at 1:59 PM, and 05/14/2024 at 1:51 PM showed Resident 57 with no moon boot to their right foot while in bed as ordered. Review of Resident 57's May 2024 TAR showed staff documented Resident 57 was wearing a moon boot to their right foot on 05/08/2024, 05/09/2024, 05/10/2024, and on 05/14/2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 12:23 PM, Staff G stated their expectation was for staff to follow the POs and not sign for tasks not completed. <Resident 29> Review of Resident 29's PO's showed a 04/08/2024 order for staff to monitor skin under knee splint daily and to report if splint missing, worn out, or not fitting anymore. Observations on 05/08/2024 at 9:56 AM, 05/09/2024 at 10:26 AM, 05/10/2024 at 12:55 PM, and 05/16/2024 at 8:02 AM showed Resident 29 with no splint to their knee as ordered. Review of Resident 29's May 2024 TAR showed staff documented the skin under the knee splint was monitored and would be reported if the splint was missing, worn out, or not fitting anymore. No documentation by staff identified concerns with the knee splint. In an interview on 05/16/2024 at 8:02 AM, Resident 29 stated they did not wear the knee splint for, a long time. In an interview and observation on 05/16/2024 at 1:02 PM, Staff G confirmed Resident 29 was not wearing the knee splint and stated staff should not sign for tasks not completed. REFERENCE: WAC 388-97-1620(b)(i)(ii),(6)(b)(i). 46479

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50511 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) for 3 (Residents 25, 15, & 218) of 3 residents who were assessed to be dependent on staff for ADLs. The failure to provide ADL assistance as required left residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes. Findings included . <Resident 25> According to a 04/18/2024 Annual Minimum Data Set (MDS - an assessment tool), Resident 25 had multiple medically complex diagnoses including kidney failure, Alzheimer's disease, and required hospice services. This MDS showed Resident 25 was dependent on staff for personal hygiene. Review of a revised 04/25/2024 skin integrity Care Plan (CP) showed directions to staff to keep Resident 25's fingernails short. Review of Resident 25's Physician Orders (POs) showed staff were to perform fingernail care every week. Observations on 05/08/2024 at 10:13 AM and 05/13/2024 at 11:14 AM showed Resident 25 with long jagged nails that extended beyond the fingertips on both hands. In an interview and observation on 05/16/2024 at 12:23 PM, Staff G (Resident Care Manager) stated their expectation was for staff to provide weekly nailcare. Staff G confirmed Resident 25's fingernails were not trimmed as ordered. <Resident 15> According to a 05/03/2024 Quarterly MDS, Resident 15 had multiple medically complex diagnoses including a hip fracture and dementia and had a functional limitation in range of motion to both arms and legs. This MDS showed Resident 15 was assessed to require substantial assistance for personal hygiene, dressing, rolling from side to side in bed, and sitting up in bed. Review of Resident 15's 02/08/2024 revised baseline CP showed Resident 15 required assistance from one staff member to dress Resident 15. This CP showed Resident 15 required the assistance of one staff member to set up their meals. A revised 02/22/2024 skin integrity CP directed to staff to keep Resident 15's fingernails short. In an interview on 05/09/2024 at 10:43 AM, Resident 15's representative stated they wished Resident 15 would get out of bed more. <Dressing > (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 05/08/2024 at 12:00 PM showed Resident 15 lying in bed awake, wearing a hospital gown. Observations on 05/09/2024 at 10:19 AM showed Resident 15 lying in bed sleeping with a hospital gown on. On 05/09/2024 at 12:06 PM, Resident 15 was sleeping and wearing a hospital gown. On 05/10/2024 at 12:27 PM, Resident 15 was in bed wearing a hospital gown. In an interview on 05/16/2024 at 12:23 PM, Staff G stated staff should assist Resident 15 to get dressed every day and encourage the resident to eat meals in the dining room. In an interview and observation on 05/16/2024 at 1:02 PM, Staff G confirmed Resident 15 was in a hospital gown and stated staff should have assisted them to get dressed. Staff G looked in Resident 15's closet and dresser and only found clothes that belonged to another resident. Staff G stated staff should have located clothes for Resident 15. <Nailcare> Review of Resident 15's POs showed staff were to perform fingernail care every week. Observations on 05/08/2024 at 12:00 PM showed Resident 15's fingernails were jagged and long extending past the fingertips of both hands. On 05/13/2024 at 9:12 AM, Resident 15's fingernails remained untrimmed. In an interview and observation on 05/16/2024 at 1:02 PM, Staff G confirmed Resident 15's fingernails were not trimmed as ordered. <Meal Assistance> Observations on 05/10/2024 at 1:19 PM showed staff delivering Resident 15's lunch tray to the resident. Staff placed the tray on the overbed table positioned off to the left side of the bed. The table was not positioned in front of the resident. Resident 15 was observed with a fork in their right hand and tried to reach across to the left side of the bed to obtain food. Observations on 05/15/2024 at 8:55 AM showed Resident 15's breakfast tray sitting on the overbed table off to the left side of the bed. Resident 15 was trying to reach across with their fork in their right hand and struggled getting food on the fork to bring back to their mouth. In an interview on 05/16/2024 at 12:23 PM, Staff G stated their expectation was for staff to set up and position a resident's meal tray in front of them to encourage the resident's ability to eat. <Resident 218> According to the 04/29/2024 Admission MDS, Resident 218's memory was impaired and they had medical diagnoses including facial paralysis, heart failure, repeated falls, and a recent right knee fracture. The MDS showed Resident 218 was assessed to require substantial/maximum assistance from staff with dressing. Review of the 04/24/2024 functional mobility CP showed Resident 218 had weight bearing restrictions and directed staff to provide one-person staff assistance with their ADLs including dressing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2024 at 9:35 AM, Resident 218's representative stated the resident was not being provided dressing assistance by staff and indicated Resident 218 was wearing the same gown for the past two days. Resident 218's representative stated there was a time when they helped the resident change into a new shirt and then noticed Resident 218 was still wearing the same shirt the following day. Observation on 05/10/24 at 9:20 AM showed Resident 218 wearing a button-up shirt top and an incontinent brief. Resident 218 pointed to their incontinent brief and stated, I would like this [brief] changed, are they [nursing aide] going to change me? I don't feel dressed . At 1:12 PM, Resident 218's representative was observed telling the nursing staff Resident 218 did not change clothes since yesterday. Observation on 05/13/2024 at 12:47 PM showed Resident 218 wearing a blue and green colored gown with a soil stain in the front. Resident 218 was observed wearing the same gown on 05/14/2024 at 8:08 AM and on 05/15/2024 at 1:28 PM. In an interview on 05/16/2024 at 11:14 AM Staff B (Director of Nursing) stated the nursing staff were expected to assist Resident 218 with dressing because the resident had limited weight bearing and functional mobility. Refer to F842- Resident Records. REFERENCE: WAC 388-97-1060 (2)(c). 43642

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42203 Based on observation, interview, and record review the facility failed to ensure residents with Diabetes Mellitus (DM - a condition making the regulation of Blood Glucose [BG] more difficult) received the care and services needed to manage their blood sugar for 1 of 1 residents (Resident 50) reviewed for administration of a BG lowering medication. The failure to notify the physician when the resident's BG fell below 80 milligrams per deciliter (mg/dl) left the resident at risk for blurred vision, fatigue, confusion, delirium, loss of consciousness, and other negative health outcomes. Findings included . <Facility Policy> The facility's October 2017 BG Monitoring protocol showed BG levels should be monitored per the Physician's Orders (POs). The policy showed the physician should be notified if the resident's BG dropped below 80 mg/dl or rose above 350 mg/dl unless otherwise specified by the physician. The policy showed if a resident's BG was measured below 80 mg/dl insulin should be held (not administered). <Resident 50> According to the 04/05/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 50 had intact memory and diagnoses including heart failure, DM, high cholesterol, and a heart blockage. The MDS showed Resident 50 received daily insulin injections. Record review showed the following POs related to Resident 50's DM diagnosis: a 09/30/2023 PO to check Resident 50's BG before meals; a 04/16/2024 PO for fast-acting insulin 100 units/Milliliter (ML), inject 5 units with meals; a 04/16/2024 PO for long-lasting insulin 100 Unit/ML, inject 20 units two times day. The revised 11/29/2023 DM Care Plan (CP) included a goal for Resident 50 to experience no complications related to their DM diagnosis. This CP included directions to nurses to administer diabetes medications as ordered. Review of the May 2024 Medication Administration Record (MAR) showed on 05/10/2024 at 11 AM Resident 50's BG was documented to be 70 mg/dl. The MAR showed at 12 PM on 05/10/2024 Resident 50 was given their fast-acting insulin. The insulin was not her per the facility's protocol. Record review showed there was no indication nurses notified the physician of Resident 50's low blood sugar as required. A 05/10/2024 progress note showed Resident 50 took a leave of absence from the facility starting at 3 PM on 05/10/2024 with a scheduled return at 12 PM on 05/13/2024. This meant four hours after nurses documented Resident 50's BG was 70 mg/dl, and three hours after the administration of the fast-acting insulin, the facility was unable to monitor Resident 50 and intervene or provide necessary care for three days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2024 MAR showed on 05/07/2024 at 4 PM Resident's BG was documented to be 91 mg/dl. The May 2024 MAR showed Resident 50's fast-acting insulin was held on 05/08/2024 at 5 PM. In an interview on 05/16/2024 at 1:02 PM Staff B (Director of Nursing) reviewed Resident 50's records and stated nurses should have notified Resident 50's physician about the low BG of 70 on 05/10/2024 but did not. Staff B stated Resident 50's insulin should have been held but was not. Staff B stated Resident 50 was placed at risk during their leave of absence. In an interview on 05/16/2024 at 3:17PM Staff B stated it was important for parameters for medication administration to be followed. REFERENCE: WAC 388-97-1060 (1).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 50511 Based on observation, interview, and record review the facility failed to ensure residents with hearing deficits were provided the assistance they were assessed to require for 1 of 1 residents (Resident 218) reviewed for hearing needs. These failures placed Resident 218 and other residents at risk for ineffective communication, unmet care needs, and a decreased quality of life. Findings included . <Facility Policy> The facility's Resident's Right policy, updated July 2015, showed residents should receive reasonable accommodation of individual needs and preferences. The policy showed residents had rights to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the center. <Resident 218> According to the 04/29/2024 Minimum Data Set (MDS - an assessment tool), Resident 218 had a hearing impairment and used a hearing aid. Review of the 05/01/2024 Care Area Assessment (CAA) showed Resident 218 used the hearing aids for communication and staff should ensure the resident used them. The CAA showed Resident 218 had an impaired ability to understand others but was able to hear if the hearing aids were used. The 04/24/2024 communication problem Care Plan (CP) showed Resident 218 had visual and hearing impairments that could impact the resident's ability to process information. This CP did not identify Resident 218's need for hearing aids or direct staff to ensure the use of hearing aids. Observations on 05/13/2024 at 8:37AM, 12:29 PM, and 2:13 PM, and on 05/14/2024 at 10:26 AM showed Resident 218 did not have hearing aids in their ears. On 05/13/2024 at 12:33 PM, Staff U (Certified Nursing Assistant - CNA) was observed asking Resident 218, who was not wearing their hearing aids, a question. Resident 218 could not understand and stated, I don't know. Staff U continued to talk to Resident 218, but the resident did not respond any further. Observation on 5/15/2024 at 8:48 AM showed Resident 218 wore their hearing aids while communicating with Staff K (CNA). Resident 218 tapped their hearing aids and stated, I don't think these are working ., and asked Staff K if they were saying something. Staff K told Resident 218 they checked the hearing aids that morning and confirmed the hearing aids were not charged when they checked. Staff K looked around for Resident 218's hearing aid case and charger and eventually found them on the floor under Resident 218's bed. In an interview on 05/16/2024 at 1:14 PM, Staff B (Director of Nursing) stated care staff should assist the Resident 218 to use their hearing aids when providing assistance with dressing and grooming in the morning. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1060(3)(a).

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F 0688 Level of Harm - Minimal harm or potential for actual harm 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. 43642 Based on observation, interview, and record review the facility failed to ensure a restorative program was provided for 4 of 5 (1, 29, 22, & 8) sample residents identified by staff with mobility limitations and reviewed for Range of Motion (ROM). These failures placed residents at risk for declines in ROM, reduction in mobility, increased dependence on staff, and a decreased quality of life. Findings included . <Facility Policy> Review of the facility's revised March 2019 Restorative Program policy showed the facility provided restorative programs to promote the resident's ability to adapt and adjust to living as independently and safely as possible. This policy showed the restorative referral form would be filled out by the skilled therapist and should include the recommended frequency the restorative program should be provided to the resident. <Resident 1> According to 03/22/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 1 had multiple medically complex diagnoses including a progressive neurological condition and was assessed with a functional limitation in ROM to both legs. This MDS showed staff assessed Resident 1 to require substantial assistance from staff to roll from side to side in bed and was dependent on staff for bed-to-chair transfers. Review of Resident 1's revised 02/18/2024 impaired mobility Care Plan (CP) showed instructions to staff for the resident to complete lower extremity ROM exercises three days a week per the resident's preference. Review of the April 2024 restorative documentation showed Resident 1 was only provided their restorative program on 5 of 10 opportunities. There was no documentation indicating Resident 1 was offered their program and/or refused. In an interview on 05/16/2024 at 12:23 PM, Staff G (Resident Care Manager) stated their expectation was for staff to provide the restorative program as directed. <Resident 22> According to a 04/26/2024 Quarterly MDS, Resident 22 had multiple medically complex diagnoses including lymphedema, severe obesity, low back pain, and arthritis. This MDS showed Resident 22 had a functional limitation in ROM to both legs, had no Restorative Nursing Program (RNP) and was assessed to require moderate assistance to roll from side to side in bed and was dependent on staff for bed-to-chair transfers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/08/2024 at 2:44 PM, Resident 22 stated they had concerns regarding their RNP. Resident 22 stated they were assessed by therapy but did not start a program yet. Resident 22 stated the restorative aide had too many residents to manage and stated, they do not have enough of a crew yet. Resident 22 stated they requested therapy as they had goals to get back in the wheelchair and be mobile again. Review of Resident 22's Physician's Orders (PO) showed a 04/16/2024 order for a Physical Therapy (PT) and Occupational Therapy (OT) evaluation and treatment. A 04/17/2024 progress note by Staff B (Director of Nursing) showed Resident 22 reported being seen by therapy and agreed to participate with the restorative aide for strengthening. On 04/23/2024 Resident 22 was evaluated by PT and according to the encounter note, the resident was agreeable to an RNP and would like to be offered to get up into their chair daily for meals. Review of Resident 22's CP on 05/08/2024 showed no RNP interventions were established. Review of Resident 22's restorative records showed a handwritten restorative sheet for lower extremity active ROM starting on 05/03/2024, over two weeks after the RNP recommendations were made. In an interview on 05/15/2024 at 1:22 PM, Staff DD (Therapy Director) stated it was important to continue an RNP to maintain residents at the level of function they reached with therapy. Staff DD stated it was their expectation an RNP would be initiated within one to two weeks hopefully and stated they did not want to lose too much ground if possible. Staff DD stated their process is to provide a copy of the RNP to the Director of Nursing, restorative nurse, and the restorative aide within one to three days after the therapy evaluation was completed. In an interview on 05/16/2024 at 12:23 PM, Staff G stated a restorative program was important for residents' flexibility and strength. Staff G stated their expectation was for an RNP to be initiated within a couple days after therapy provided their recommendations. Staff G stated restorative programs should be completed as directed and documented in the resident's records. Staff G stated the restorative program should be identified on a resident's CP and refusals followed up with and evaluated by staff. 46479 <Resident 8> Review of the 02/26/2024 Admission MDS showed Resident 8 did not have any memory impairment, was understood, and could understand others in conversation. Review of a 03/18/2024 Restorative Program Referral form showed skilled therapy referred Resident 8 for a restorative therapy program. This form showed skilled therapy recommended staff assist Resident 8 with shoulder exercises five times per week. Review of Resident 8's April 2024 restorative documentation showed staff assisted Resident 8 with their RNP on 14 of 22 opportunities. There was no documentation indicating Resident 8 was offered their program or refused to participate on the dates when no RNP was provided. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 12:21 PM, Staff AA (Restorative Aide) stated they were the only staff currently providing restorative programs to residents. Staff AA stated if they were off shift, the restorative programs were not completed. Staff AA stated if a resident refused their restorative program, Staff AA documented the refusal and the reason in the restorative binder. Staff AA confirmed Resident 8's program was scheduled for five times weekly. Staff AA stated they were unable to complete the program five times per week because of how many resident programs Staff AA was responsible for. <Resident 29> According to a 04/11/2024 Quarterly MDS, Resident 29 had multiple medically complex diagnoses including weakness. This MDS showed staff assessed Resident 29 to require substantial assistance from staff for upper body dressing and to roll from side to side in bed. Review of Resident 29's POs showed an 03/06/2024 order for an OT evaluation. According to a 03/12/2024 OT evaluation and plan of treatment form, Resident 29 was assessed to gain benefit from an RNP for active ROM and strengthening to maintain their ability to self-feed and reposition themselves in bed to relieve pressure to decrease the risk of skin breakdown. Review of a 03/12/2024 restorative program referral form showed OT recommended the RNP for arms to be provided three to five times per week. Review of a Resident 29's revised 02/10/2023 impaired mobility CP showed instructions to staff to provide passive ROM to the resident's knees and apply knee splints afterwards for four hours a day as tolerated. There was no update to Resident 29's CP reflecting the new RNP recommended by OT on 03/12/2024, two months prior. Review of the May 2024 paper record for Resident 29's restorative program showed only a RNP program for the resident's lower legs and splints. No program was established for Resident 29's arm RNP program as recommended by therapy. In an interview on 05/16/2024 at 12:23 PM, Staff G stated staff should have initiated Resident 29's RNP per OT recommendations. Staff G stated their expectation was for staff to provide restorative services to residents to assist with maintaining their strength and function. REFERENCE: WAC 388-97-1060(3)(d), (j)(ix).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review the facility failed to ensure 2 of 6 residents (Residents 218 & 15) reviewed for nutrition and hydration, and one supplemental resident (Resident 57) maintained acceptable parameters of nutritional status. The failure to ensure residents were consistently provided required eating assistance, and ordered weights were obtained and analyzed to determine the need for new interventions as ordered placed residents at risk for unwanted weight loss, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 06/10/2021 Weights policy, residents should be weighed on the day of admission. The policy defined a significant weight loss as 5 % or more in 30 days, 7.5 % or more in 90 days, or 10 % or more in 180 days. The policy showed if a resident was identified with five pounds (lbs) or more weight loss since the last weight, the resident should be reweighed. <Resident 218> According to the 04/29/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 218 admitted to the facility on [DATE]. The MDS showed Resident 218 had severe memory impairment and no rejection of care. The MDS showed Resident 218 had diagnoses including heart failure, high cholesterol, a right knee fracture, Bell's palsy (a condition where the face is partially paralyzed) and a history of falls. The MDS showed Resident 218 required an altered-textured diet, had no natural teeth, and required verbal cues and/or touching/steadying while eating. The MDS showed Resident 218 had moderate vision impairment and minimal difficulty hearing. The 04/29/2024 Care Area Assessment (CAA - a care planning tool) showed Resident 218 was at risk for a nutritional deficit related to abnormal lab values, chewing difficulties, memory issues, functional decline, limited physical mobility, and other factors. Resident 218's Physician's Orders (PO) included a 05/07/2024 PO for a pureed texture meal. Resident 218's POs did not include any diuretic medications (medications to treat excess fluid caused by heart failure that can lead to rapid weight loss). The revised 05/01/2024 .at risk for Nutrition and Hydration deficit . Care Plan (CP), included goals for Resident 218 to experience no unplanned significant weight loss and to consume at least 75 % of their meals. The CP showed Resident 218 ate in their room and directed staff to encourage the resident to eat at least 50 % of their meal and offer a substitute if Resident 218 did not eat 50 % or more. Record review showed a nutritional evaluation was completed for Resident 218 on 05/07/2024, 14 days after admission. This evaluation showed Resident 218 required staff supervision to eat in their room. This evaluation noted Resident 218 had fluctuating dietary intake, and sometimes ate less than 25 % of their meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed Resident 218's weight on 04/24/2024, the day after admission, was 102.2 lbs. Resident 218 was weighed on 04/30/2024 for a weight of 101.6 Lbs. No weight was obtained on 05/07/2024. The next weight was obtained on 05/14/2024 when Resident 218 weighed 91.2 lbs, representing a 10.76% weight loss in 21 days. Resident 218 was reweighed on 05/16/2024 at 90.4 lbs, representing a weight loss of 11.74%, more than double the threshold for significant weight loss in a month. Review of Resident 218's meal monitor showed on 04/25/2024 there was no intake documented of a meal after lunch at 12 PM, and no intake documented of any meals on 04/26/2024. The next meal intake documented per the meal monitor was at 5:34 PM on 04/27/2024, over 48 hours later. The meal monitor did not have an entry for Resident 218's lunch on 04/29/2024, or dinner on 05/01/2024. There were no meal intakes documented on the monitor on 05/02/2024 or 05/06/2024. On 05/07/2024 the only meal intake documented was dinner at 5:00 PM, meaning there was no evidence Resident 218 was provided a meal being from 05/05/2024 at 5:00 PM through 5:00 PM on 05/07/2024. The meal monitor showed the only documented meal intake for Resident 218 on 05/08/2024 was dinner at 5:00 PM. There were no meals intakes documented per the meal monitor on 05/09/2024. On 05/12/2024 the only meal intake documented was dinner at 5:50 PM. There were no documented refusals of meals by Resident 218 between 04/25/2024 and 05/12/2024. Observations on 05/10/2024 at 12:53 PM Resident 218's lunch tray was observed to be covered and out of reach of the resident on a table away from the bed. The tray was not placed where Resident 218's could reach their food. The meal items were not set up to facilitate Resident 218's ability to feed themselves. Observations on 05/10/2024 at 1:12 PM showed Resident 218's lunch tray still remained out of the resident's reach, preventing the resident from eating. At this time a visitor arrived and set up the tray for Resident 218, who then fed themselves. Observations on 05/15/2024 at 8:45 AM, Staff K (Certified Nursing Assistant - CNA) was overheard in the hallway stating they did not know Resident 218 required mealtime assistance. Staff K asked the nurse what assistance Resident 218 required. In an interview on 05/15/2024 at 8:54 AM, Staff K stated Resident 218's CP showed the resident required set up assistance only. On 05/15/2024 at 9:21 AM Resident 218 was observed to eat only 25% of their breakfast meal. Resident 218's meal monitor showed staff documented on 5/15/2024 the resident ate 50% of their breakfast. On 05/15/2024 at 1:38 PM Resident 218 was observed to eat only 10% of their lunch. Review of Resident 218's meal monitor showed staff documented on 5/15/2024 Resident 218 ate 100% of their lunch. In an interview on 05/16/2024 at 10:34 AM Staff E (Registered Dietician) stated Resident 218 required supervision when eating. Staff E stated Resident 218 was added to the list of residents with nutritional concerns. Staff E stated Resident 218's intake was monitored. Staff E stated If the facility identified weight loss, the process was to collect weights weekly for four weeks and implement nutritional interventions. Staff E stated if staff identified weight loss, they should report the weight loss to nursing. Staff E confirmed Resident 218 had an unplanned, significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/16/2024 at 10:56 AM Staff B (Director of Nursing) stated weights should be checked weekly for 1 month, care staff should weigh residents and report concerns to the nurse. Staff B stated no weight was collected on 05/07/2024, the facility policy was not implemented, a reweight was not obtained, and notification of the weight loss to the nurse did not occur. Staff B stated there was no re-weight of resident after the 05/14/2024 weight check and staff should have notified the nurse of the weight loss but did not. Staff B confirmed Resident 218 had an unplanned, significant weight loss. 43642 <Resident 15> According to a 05/03/2024 Quarterly MDS, Resident 15 had multiple medically complex diagnoses including diabetes (difficulty controlling blood sugar), dementia, and malnutrition. This MDS identified Resident 15 was independent with eating, required substantial assistance with rolling from side to side in bed and moving from lying to sitting, and had no weight loss/gain of five % or more in the last month, or 10 % or more in the last six months. The 02/08/2024 nutritional status CAA showed staff identified Resident 15 was at risk for a nutritional deficit related to a history of abnormal labs, acute infection, a change in their ability to feed themselves, functional decline, a medical condition, pain, and weight loss. According to a revised 05/08/2024 nutrition at risk CP, staff documented Resident 15's goal was to have no unplanned significant weight loss or gain. This CP showed staff identified interventions to monitor meal intake, offer a substitute or supplement if intake 50 % or less, refer to the dietician as appropriate, and weigh the resident per facility protocol. Review of Resident 15's records showed the resident admitted to the facility on [DATE] and according to the resident's weight record was not weighed until 01/30/2024, four days after admission. The weight documented by staff on 01/30/2024 was 173.8 lbs with the most recent weight of 163.4 lbs on 05/07/2024, a 10-pound loss since admission. Observations on 05/10/2024 at 1:19 PM showed staff delivered Resident 15's lunch tray to their room and placed it on the overbed table off to the left side of the resident's bed. Staff did not position the tray in front of the resident to promote eating. On 05/10/2024 at 1:22 PM Resident 15 was observed reaching across the bed to try to access the food with their right hand. Resident 15 dropped food from their fork as they tried to bring the fork to their mouth. Observations on 05/14/2024 at 1:05 PM showed Resident 15 sleeping. At 1:53 PM, Resident 15's lunch tray was still untouched to the side of their bed and the resident was still sleeping. On 05/14/2024 at 2:12 PM, observations showed Staff J (CNA) picking up Resident 15's untouched lunch tray. Staff J stated Resident 15 slept through lunch. Observations on 05/15/2024 at 8:47 AM showed Resident 15's breakfast tray was on the overbed table, to the left of the bed. Resident 15 tried to reach over with their right hand to eat. Resident 15 made several attempts to pick up a whole waffle with their fork but was unable to get the food to their mouth. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 15's May 2024 meal monitor showed staff did not document any meal intake for the resident on 7 of 15 meal occasions. No meal documentation occurred after dinner on 05/04/2024 until dinner on 05/05/2024, missing two full meals in a row. No meal documentation by staff occurred after dinner on 05/11/2024 until dinner on 05/12/2024, missing two full meals in a row. <Resident 57> According to a 02/14/2024 Admission MDS, Resident 57 had multiple complex diagnoses including cancer, heart failure, and diabetes. This MDS identified Resident 57 required setup assistance for eating and moderate assistance to roll from side to side in bed and had no weight loss/gain of five % or more in the last month, or 10 % or more in the last six months. Review of a 02/19/2024 nutritional status CAA showed staff identified Resident 57 was at risk for a nutritional deficit related to their current health status and trending weight loss and would address needs, preferences, preventative measures on the resident's care plan. Review of Resident 57's nutrition at risk CP showed Resident 57's goal was to have no unplanned significant weight loss or gain. This CP showed staff identified interventions to monitor meal intake, offer a substitute or supplement if intake 50 % or less, refer to the dietician as appropriate, and weigh the resident per facility protocol. Review of a 04/25/2024 Nutrition/Hydration skin committee review form showed staff documented Resident 57's most recent weight was 141 lbs on 04/25/2024 and 150 lbs on 03/23/2004, a loss of 6.38 % in one month, and 159.2 lbs on 02/13/2024, a loss of 12.91 % since the 04/25/2024 weight was obtained. Review of Resident 57's weight records showed the last weight obtained by staff was on 04/27/2024 at which time the resident's weight was 138.8 lbs, a loss of an additional 2.2 lbs. Review of Resident 57's April 2024 meal intake records showed staff failed to document any meal intake for the resident on 25 of 90 occasions for meals provided. Review of May 2024 meal intake records showed staff failed to document any meal intake on 4 of 45 occasions for meals provided to Resident 57. Observations on 05/10/2024 at 1:26 PM showed Resident 57 with their untouched lunch tray out of reach in their room on the overbed table. In an interview at this time, Resident 57 stated, I'm not hungry. In an interview on 05/16/2024 at 12:23 PM, Staff G (Resident Care Manager) stated their expectation was for staff to obtain weekly weights if a resident was experiencing weight loss or gain. Staff G stated they expected staff to document a residents meal intake and weights and indicated it was needed in order to evaluate a resident's full nutritional status. Staff G confirmed staff should have but did not obtain weekly weights for Resident 57 since 04/27/2024 due to weight loss. REFERENCE: WAC 388-97-1060 (3)(h).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46479 Based on interview and record review the facility failed to ensure 2 (Residents 9 & 118) of 5 residents reviewed for unnecessary medications were free from unnecessary psychotropic drugs. Failure to document rationale and identify a failed Gradual Dose Reduction (GDR) for Resident 9 and ensure informed consent was obtained prior to administration (Resident 118) placed residents at risk to receive unnecessary medications and/or adverse side effects. Findings included . <Facility Policy> Review of the facility's October 2022 revised Psychotropic Drug policy showed a Gradual Dose Reduction (GDR) consisted of tapering a resident's dose of a psychotropic medication to determine if the resident's symptoms could be managed by a lower dose or determine if the dose could be eliminated altogether. This policy showed if the GDR had an adverse effect on the resident and the GDR attempt was discontinued, staff would document this decision and indications of the decision in the medical record. The policy showed the resident's physician would include justification in the medical record why the continued use of the psychotropic was clinically appropriate. <Resident 9> According to Resident 9's 02/09/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 9 had moderate cognitive impairment and diagnoses of anxiety and depression. Review of Resident 9's 05/09/2024 Physician's Orders (POs) showed Resident 9 received 15 milligrams (mg) of an antianxiety medication two times daily. Review of Resident 9's June 2023 Medication Administration Record (MAR) showed on 06/13/2023, Resident 9 received a GDR of the antianxiety medication. This MAR showed staff administered 10 mg of the antianxiety medication in the morning and 15 mg of the antianxiety medication in the evening. This MAR showed a 07/27/2021 PO directing staff to document anxious behaviors displayed by Resident 9. Staff documented Resident 9 did not have any anxious behaviors in June 2023. Review of Resident 9's Care Plan (CP) showed a 02/21/2024 Antianxiety CP directing staff to monitor Resident 9 for behaviors related to their anxiety diagnosis. This CP showed Resident 9 had behaviors of pacing/wandering, maladaptive behaviors, accusatory behavior, and attention seeking. Review of the July 2023 behavior monitoring showed staff documented Resident 9 did not have anxious behaviors for the month of July. Review of the August 2023 behavior monitoring showed staff documented Resident 9 did not have anxious behaviors for the month of August. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's September 2023 MAR showed the GDR was discontinued on 09/01/2023. On 09/01/2023 the MAR showed a new PO for staff to administer 15 mg of the antianxiety medication twice daily. Review of Resident 9's progress notes showed no documentation of the failed GDR. Staff did not document if Resident 9 had anxious behaviors related to the GDR of the antianxiety medication. There was no justification from the physician to increase the antianxiety medication back to the original dose or documentation indicating the rationale of the failed GDR. In an interview on 05/15/2024 at 2:56 PM, Staff O (Divisional Director of Social Services) confirmed there was no documentation indicating specifically that the GDR failed. Staff O stated they expected staff to document the behaviors the resident was experiencing to justify the failed GDR and the reason for increasing the medication back to the original dose. In an interview on 05/16/2024 at 11:41 AM, Staff B (Director of Nursing) stated it was their expectation staff document behaviors when residents were experiencing the behaviors. 42203 <Resident 118> According to the 04/30/2024 Admission Evaluation, Resident 118 admitted to the facility on that date. This evaluation showed Resident 118 was oriented to their person, place, time, and environment and had intact memory. Review of the POS showed a 05/03/2024 PO for an Antidepressant medication. The PO showed Resident 118 should receive 5 mg by mouth once a day for depression. Record review showed no evidence the risks and benefits of the medication were discussed with Resident 118 prior to the administration of the antidepressant. There was no documentation Resident 118 was provided informed consent prior to administration of the medication. Review of the May 2024 MAR showed no monitoring of target behaviors (behaviors the medication was ordered to treat) was in place at the time the antidepressant treatment began. In an interview on 05/15/2024 at 1:13 PM Staff B reviewed Resident 118's record and stated the facility failed to obtain informed consent prior to administration of Resident 118's antidepressant medication. Staff B stated the facility should have but did not obtain consent. Staff B stated the facility failed to establish target behavior monitoring for the AD medication. REFERENCE: WAC 388-97-1060 (3)(k)(i).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43642 Based on observation and interview, the facility failed to ensure expired medications were disposed of timely for 2 of 2 medication carts and 1 of 1 central supply room and medications were stored securely in accordance with professional standards for one supplementary treatment cart. This failure placed residents at risk for receiving expired medications and at risk for medication errors. Findings included . <Facility Policy> Review of a 01/2023 facility Medication Storage policy showed medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access. This policy stated outdated medications were to be immediately removed from stock and disposed of according to procedures for medication disposal. <Medication Carts> <100 Hall> Observations on 05/08/2024 at 1:50 PM showed the 100 Hall medication cart with one opened bottle of a non-narcotic pain medication with an expiration date of 04/2024. In an interview at this time, Staff S (Licensed Practical Nurse - LPN) stated the bottle expired the previous month and should be removed from the cart. <500 Hall> Observations on 05/13/2024 at 10:52 AM showed the 500 Hall medication cart with one bottle of liquid calcium that expired 11/2023, two bottles of Vitamin E that expired 04/2024, and two bottles of a non-narcotic pain medication which expired 04/2024. In an interview on 05/13/2024 at 10:52 AM, Staff T (LPN) stated the medications were expired and should be removed from the medication cart. <Central Supply> Observations on 05/13/2024 at 10:02 AM showed the following expired medications in the central supply room: five bottles of an iron medication that expired 02/2024; eight bottles of a non-narcotic pain medication that expired 02/2024; eight bottles of a non-steroidal anti-inflammatory medication that expired 03/2024; one bottle of Vitamin E that expired 04/2024; one bottle of a digestion enzyme supplement that expired 12/2023; three bottles of a liquid calcium that expired 11/2023; two bottles of calcium tablets that expired 04/2024; six bottles of fiber liquid that expired 04/10/2024; and 48 packets of a protein powder that expired 01/27/2023. In an interview on 05/13/2024 at 10:31 AM, Staff A (Executive Director) stated the expired medications should not be on the shelves in central supply. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 3:17 PM, Staff B (Director of Nursing) stated their expectation was to have no expired medications on the medication carts or in central supply and stated expired medications should be removed and disposed timely. 42203 <500 Hall Treatment Cart> Observation on 05/15/2024 at 8:47 AM showed the treatment cart on 500 hall was unlocked while the nurse prepared a medication at the medication cart across the hallway. The unlocked treatment cart's contents included dressings, hydrocortisone cream, a bottle of iodine, and an antiseptic solution. At 8:53 AM the nurse locked their medication cart and entered a resident room to provide a medication. The treatment cart remained unlocked. In an interview on 05/15/2024 at 8:53 AM Staff D (Staff Development Coordinator) stated the treatment cart should be but was not locked. Staff D stated nurses were responsible for ensuring treatment carts were secured. REFERENCE: WAC 388-97-1300 (1)(b)(ii),(2). 50511

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 43642 Based on observation, interview, and record review the facility failed to ensure prompt dental services were provided for 2 (Resident 45 & 35) of 6 sample residents reviewed for dental services. This failure placed the residents at risk for unmet dental needs and a diminished quality of life. Findings included . <Policy> According to the facility's October 2017 Dental Services - Dentures policy, the facility would assist residents as necessary upon notification of lost or damaged dentures. The facility would refer a resident within three days of being notified and confirming lost or damaged dentures for dental services. This referral would be documented in the medical record. This policy showed staff would assist residents with arranging transportation to and from dental service locations. <Resident 45> According to a 03/06/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 45 had no memory impairment, had clear speech, was understood, and able to understand others. In an interview on 05/08/2024 at 3:20 PM, Resident 45 stated they had their teeth cleaned today, but reported they had not seen a dentist in many years. Resident 45 stated they had broken rotting teeth to the top left and bottom right side of their mouth. On 05/09/2024 at 9:16 AM, Resident 45 stated they would have liked to have seen a dentist previously, and indicated they were not aware the facility had in-house dental consultations. Review of physician orders showed a 12/01/2022 order that Resident 45 may have a dental consult with treatment as indicated. Review of a 12/07/2022 Admission MDS showed staff assessed Resident 45 with obvious or likely cavities or broken natural teeth and mouth or facial pain, discomfort, or difficulty with chewing. According to a 12/14/2022 dental Care Area Assessment (CAA), staff documented Resident 45 had a history of bleeding gums and sometimes chewing difficulty. Resident 45 stated they wanted to go to the dentist but was unable to afford it. Staff identified Resident 45 was at risk for poor oral intake, weight loss, and difficulty with chewing and swallowing. Staff documented on the CAA a referral to another discipline was warranted. Staff documented they spoke with social services and Resident 45 was to schedule their own dental appointments. Review of a 12/08/2023 Annual MDS showed staff assessed Resident 45 with obvious or likely cavities or broken natural teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 12/21/2023 dental CAA, staff documented Resident 45 had oral/dental health problems related to a history of bleeding gums, cavities, and occasional difficulty with chewing. This CAA identified Resident 45 was at risk for poor intake, weight gain/loss, altered mood, anxiety, poor participation in therapies, and activities of interest. Staff documented the Care Plan (CP) would address cares, needs, preferences, and preventative measures. Review of a revised 03/07/2024 dental CP showed directions to staff to monitor/document/report, as needed, any signs or symptoms of oral/dental problems needing attention, which included: pain; teeth missing; loose, broken, eroded, or decayed teeth. Review of Resident 45's podiatry/dental/hearing/vision recommendations section on the care conference forms showed staff did not address Resident 45's dental needs during care conferences held on 12/02/2022, 01/10/2023, 03/22/2023, and 03/18/2024. Staff did not address Resident 45's concerns regarding dental and wanting to see a dentist until 05/08/2024, almost a year and a half after staff identified Resident 45 with obvious or likely cavities or broken natural teeth. Resident had a dental consult on 05/08/2024 which indicated Resident 45 had concerns regarding an occasional dull ache to a tooth and had visible decay and roots observed. On the consult was a handwritten note that Resident 45 had advanced decay and the resident's plan was for extractions and dentures. In an interview on 05/16/2024 at 12:23 PM, Staff G (Resident Care Manager) stated it was their expectation staff obtained a dental consultation for a resident within a week or two once a concern was identified by staff. Staff G stated staff add residents to a list to see the in-house dentist on admission, or at any time, when dental concerns were identified. Staff G reviewed Resident 45's records and was unable to locate documentation staff assisted the resident to be seen by dental services and stated Resident 45 should have, but was not seen by a dentist prior to 05/08/2024. 46479 <Resident 35> Review of Resident 35's 04/11/2024 Admission MDS showed Resident 35 had severe cognitive impairment, could understand others, and was understood in conversation. This MDS showed Resident 35 had no natural teeth. Review of a 04/12/2024 .oral health problem . CP showed Resident 35 had missing teeth and chose not to wear their dentures. This CP had a 04/12/2024 intervention showing Resident 35 had missing dentures. This CP showed Resident 35 was independent with their oral hygiene. In an observation and interview on 05/08/2024 at 12:51 PM, Resident 35 was observed without teeth. Resident 35 stated they were waiting to get dentures. In an interview on 05/10/2024 at 11:29 AM, Staff P (Registered Nurse) stated they thought Resident 35 had dentures in the past but could not recall what happened to them. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an outside dental provider document showed Resident 35 received upper and lower dentures on 09/01/2022. Review of a 09/06/2023 in house dental provider report showed Resident 35 was evaluated by the dentist. The report showed Resident 35 was without their dentures. A handwritten note on the report showed Resident 35 reported they did not know where their dentures were. The note showed the dentures were made by another provider in 2022, one year earlier. Review of a 12/04/2023 in house dental provider report showed Resident 35 was evaluated by the dentist. The report showed Resident 35 was without their dentures. A handwritten note on the report showed staff searched Resident 35's room and were unable to locate the dentures. The note showed Resident 35 would like new dentures. Review of a 05/06/2024 in house dental provider report showed Resident 35 was evaluated by the dentist. A handwritten note on the report showed dentures lost. Review of Resident 35's progress notes from September 2022 to May 2024 showed staff did not document Resident 35's missing dentures for over 19 months. The progress notes showed staff did not follow up on the dental provider's recommendations for new dentures. In an interview on 05/14/2024 at 1:59 PM, Staff O (Divisional Director of Social Services) stated they expected staff to fill out a grievance form for Resident 35 when the dentures were first noted to be missing. Staff O stated they expected staff to follow up on dental recommendations within one week of receiving them. Staff O stated staff should document in the resident's record when dentures are received and add them to the resident's inventory list, but staff did not. In an interview on 05/15/2024 at 10:47 AM, Staff O and Staff R (Social Services Director) confirmed staff did not follow up or provide timely assistance to obtain new dentures for Resident 35. Staff O and Staff R stated staff did not complete a referral for Resident 35 to obtain new dentures within three days as required. REFERENCE: WAC 388-97-1060(1), (3)(j)(vii).

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46479 Based on observation, interview and record review, the facility failed to provide meals that accommodated resident food preferences for 2 (Resident 8 & 45) of 6 sample residents reviewed for preferences, and one supplementary resident (Resident 55). This failure placed residents at risk for weight loss, frustration, and a diminished quality of life. Findings included . <Facility Policy> According to the updated March 2016 Food Preference Record policy, the dietary manager should interview all residents regarding their food preferences (including likes and dislikes) and documents the resident's stated preferences, including cultural/religious food preferences, specialized diets, and foods frequently eaten/special requests. The dietary manager should then sign and date the form. The form should then be added to and remain in the resident's record. If a resident's food preferences changed significantly, a new form could be completed. <Resident 8> Review of the 02/26/2024 Admission Minimum Data Set (MDS - an assessment tool) showed Resident 8 admitted to the facility on [DATE]. Resident 8 had no memory impairment, was understood and could understand others in conversation. Review of a 03/05/2024 Food Preferences form obtained by Staff F (Dietary Manager) showed Resident 8 did not have any beverage preferences. The dislikes section of the form was blank indicating Resident 8 did not have any food dislikes. This form was completed with the resident 14 days after the resident was admitted to the facility. Review of a 04/17/2024 Grievance form filed by Resident 8 showed Resident 8 needed to speak with someone in the dietary department about their dietary needs. The form showed Resident 8 had bad teeth and could not chew all the foods. Resident 8 stated they did not like meat or seafood and could not chew potatoes with skin. In an in interview on 05/08/2024 at 10:41 AM, Resident 8 stated they could not eat the food at the facility. Resident 8 stated they needed softer food to chew. In an observation and interview on 05/08/2024 at 12:50 PM, Resident 8 was in their room with their lunch tray containing Chinese beef broccoli, fried rice, a mini egg roll, and strawberries. Resident 8 stated they were not a big eater. The resident stated they could eat some rice but [staff] smothered it with all the [broccoli]. The meal ticket on Resident 8's tray showed Resident 8 did not have any dislikes or preferences. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/15/2024 at 10:59 AM, Staff F stated resident preferences were obtained during the first three days of a resident's admission to the facility. Staff F stated they followed up with residents a week after the initial food preference was completed to check in with the resident and see how the resident's meals were going. Staff F reviewed Resident 8's 03/05/2024 Food Preference form and confirmed it was not filled out within the first three days of the resident's admission. Staff F stated they followed up with Resident 8 more frequently than usual but could not provide documentation to show the follow ups occurred. 43642 <Resident 45> According to a 03/06/2024 Quarterly MDS, Resident 45 had no memory loss, was understood, and able to understand others. In an interview on 05/08/2024 at 3:20 PM, Resident 45 stated they were unhappy with the food and staff did not follow their requests or preferences. Resident 45 stated each week they filled out a menu, gave it to staff, and kept a copy to make sure they got what they ordered. Observations on 05/10/2024 at 9:02 AM showed Staff F delivering a breakfast tray to Resident 45. Upon delivery, Resident 45 looked at their tray, became upset, and asked staff why they were given fried eggs instead of the scrambled eggs listed on the menu for Friday. Resident 45 asked, can't they read the menu? Staff F stated they would check with the kitchen staff. Review of the tray ticket showed Resident 45 should receive poached eggs on Fridays. In an interview at this time, Resident 45 stated they never told facility staff they wanted poached eggs. Review of Resident 45's 12/02/2022 and 05/15/2023 food preference forms showed staff did not document the resident had a preference for poached eggs on Fridays. In an interview and observation on 05/14/2024 at 1:43 PM, Resident 45 stated staff did not bring them what they requested for lunch. Resident 45 indicated they ordered cottage cheese only and stated, I got the main meal and no cottage cheese. Resident 45 stated they had to ask staff to bring the correct food to them. Review of Resident 45's copy of the ordered menu showed the resident crossed out the main meal choice and wrote cottage cheese underneath. In an interview on 05/14/2024 at 1:59 PM, Staff J (Certified Nursing Assistant - CNA) confirmed Resident 45 did not receive cottage cheese as requested and stated, I went to get it right away. In an interview on 05/16/2024 at 12:23 PM, Staff G (Resident Care Manager) stated it was their expectation a resident's food preferences be followed. <Resident 55> According to a 02/04/2024 Admission MDS, Resident 55 had no memory loss, and was understood, and able to understand others. Observations during kitchen rounds on 05/13/2024 at 12:07 PM showed Resident 55's lunch tray card with a dislike of zucchini identified. Staff prepared Resident 55's tray and placed zucchini on the plate. The tray was sent out of the kitchen in a tray cart for delivery. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of dining services on 05/13/2024 at 12:23 PM showed staff delivering hall trays to resident rooms. Staff BB (CNA) pulled a tray from the tray cart and handed it to another CNA entering Resident 55's room. On the tray was a tray ticket that identified Resident 55's dislikes were vegetables, beets, broccoli, cauliflower, carrots, and zucchini. The word zucchini was highlighted in yellow. In an interview at this time, Staff BB confirmed Resident 55's dislikes were being served to the resident and stated, I will send it back to the kitchen. In an interview on 05/15/2024 at 10:24 AM, Staff F stated their expectation was for dietary staff to follow the information on a resident's tray card. REFERENCE: WAC 388-97-1120 (2)(a).

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 46479 Based on observation, interview, and record review the facility failed to consistently serve meals within the posted timeframe's for 2 of 3 hallways (100/200 Hall Dining Cart) for meals served to residents who ate in their rooms. Failure to serve meals in a timely manner placed residents at risk of nutritional concerns, food temperatures served outside the of the desired temperature range, and a decreased quality of life. Findings included . Review of the facilities posted dining times showed the 100/200 Hall Dining cart served breakfast at 8:00 AM, lunch at 12:30 PM, and dinner was served at 6:00 PM. <200 Hall Dining Cart> Observation on 05/10/2024 at 8:53 AM showed the 200 hall cart containing breakfast trays waiting to be delivered to the residents. Observation on 05/10/2024 at 9:14 AM showed Resident 57 receiving their breakfast tray, 74 minutes after the posted meal service time. <100 Hall Dining Cart> Observation on 05/10/2024 at 12:56 PM showed the 100 hall cart arrived to the hall, 26 minutes after the posted service time. Observation on 05/13/2024 at 12:57 PM showed the 100 hall cart full of resident lunch trays that were not delivered. At that time, Staff A (Administrator) took the 100 hall cart, moved it away from the 100 hall and parked it by the kitchen. Observation on 05/13/2024 at 1:06 PM showed Resident 53 lying in bed. Resident 53 was asking where their lunch was. At that time, Resident 53 stated their lunch usually came between 12:00 and 12:30 PM. At that same time, Staff N (Certified Nursing Assistant - CNA) was observed walking down the hallway, talking to themselves stating no trays yet?. Observation on 05/13/2024 at 1:14 PM showed kitchen staff take the 100 hall cart and bring it back into the kitchen. In an observation and interview on 05/13/2024 at 1:22 PM, the 100 hall lunch cart was still not delivered to the residents. Staff Y (CNA) stated they did not have a process to follow when hall trays were late. Staff Y stated they did not inquire with the kitchen about where the resident's lunches were because Staff Y trusted the kitchen and knew they were working on getting the trays out to the residents. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/13/2024 at 1:27 PM, Staff Y stated they found out the 100 hall cart was delivered but someone moved the cart back to the kitchen. Staff Y stated the kitchen was now working on reheating all of the 100 hall meals. In an interview on 05/13/2024 at 1:28 PM, Resident 56 stated lunch usually arrived between 1:00 and 1:30 nothing out of the ordinary. In an interview on 05/13/2024 at 1:31 PM, Resident 13 stated they did not like lunch arriving this late. Resident 13 stated late lunch made for a late dinner and difficulty digesting food. Resident 13 stated dinner arrived close to 7:00 PM the other night . In an interview on 0/13/2024 at 1:33 PM, Resident 58 stated they were hungry waiting for lunch. Resident 58 stated the other night it was almost 7:00 PM before they got dinner. Observation on 05/13/2024 at 1:33 PM showed the 100 hall cart was delivered, 63 minutes after the posted service time. Observation on 05/15/2024 at 12:53 PM showed the 100 hall cart was delivered, 23 minutes after the posted service time. In an interview on 05/16/2024 at 1:13 PM, Staff F (Dietary Manager) stated it was their expectation meals were served at the same time as the posted meal service times. Staff F stated they expected staff to start passing out meal trays within five minutes of the meal carts arriving on the hall. Staff F stated it was important for trays to be delivered timely so the meal did not get cold and so residents did not get hungry. REFERENCE: WAC 388-97-1120(1).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation and interview, the facility failed to ensure resident meals were prepared or stored in accordance with professional standards of food safety for 1 of 1 facility kitchens, and 1 of 2 unit refrigerators. The failure to ensure staff hair was secured in food preparation areas, that all refrigerated food was dated and labeled as required, and food was covered when in the hall left residents at risk for food contamination, food borne illnesses, and spoiled food. Findings included . <Facility Policies> According to the facility's October 2017 Food Storage policy showed all food should be labeled with the month and year of receipt unless the item had an expiration date of 30 days or less. The policy showed all open containers should have a use by date. The facility's June 2021 Personal Hygiene Standards (for Dietary Staff) policy showed all dietary staff must secure their hair with provided hairnets. The policy showed if staff wore a hat to secure their hair, any remaining exposed hair must still be covered with a hairnet. <Initial Kitchen Observations> Observation on 05/08/2024 at 8:37 AM showed Staff F (Dietary Manager) and Staff I (Cook) working in the main kitchen area. Neither staff wore a hairnet. In an interview at this time, Staff F stated it was the facility's policy and a requirement that dietary staff wore hairnets in the kitchen. Staff F stated they and Staff I should have worn but did not wear hairnets in the kitchen. Observation of a kitchen freezer on 05/08/2024 at 8:47 AM showed five bowls of servings of white ice cream. These bowls were left in the freezer uncovered and there was no date indicating when they were placed there. Observation of a kitchen refrigerator at 05/08/2024 at 8:49 AM showed two opened jugs of whole milk. These jugs were not marked with a date to indicate when they were opened or by when they should be used. In an interview at this time Staff F stated dietary staff should have but did not date the milk jugs, and there was no no way to tell when they were opened or if the milk was still safe. Staff F stated the bowls of ice cream were stored incorrectly, not dated as required, and now needed to be discarded. <Unit Refrigerators> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/16/2024 at 11:34 AM showed the 500 Hall resident snack refrigerator had two thermometers, one in the main compartment, and one in the ice tray area in the top right-hand corner of the refrigerator. The refrigerator had multiple sticky stains of spilled liquid. On the door of the refrigerator was a temperature log where staff documented the temperature of both the main area and the ice tray area in two rows. The row with the main refrigerator temperature was last completed on 05/12/2024, meaning on 05/13/2024, 05/14/2024, and 05/15/2024 staff did not monitor the temperature. In an interview at this time Staff H (Resident Care Manager) stated the temperature was not but should be completed. Staff H declined to comment on the cleanliness of the refrigerator. On 05/16/2024 at 11:39 AM observations showed the 100 Hall resident snack refrigerator had stains on the shelves and the inside of the door. Inside the refrigerator was a container of food brought by a visitor for a resident. This container was not dated to indicate when it was brought in or when it should be used by. In an interview at this time, Staff F stated it was important to handle food brought by visitors appropriately. Staff F stated this container of food now needed to be disposed. Staff F stated it was important to monitor the snack refrigerator temperatures to ensure food was stored at a safe temperature and expressed frustration that the 500 Unit snack refrigerator log was not complete. 43642 <Uncovered Food> Observations of 200 Hall dining services on 05/10/2024 at 1:11 PM showed staff delivering lunch trays. The staff were carrying the trays with uncovered desserts through the hallways, past other residents, to deliver to resident rooms. Observations of the 100 Hall dining services on 05/13/2024 at 1:34 PM showed staff delivering the lunch trays to residents with uncovered desserts. The 100 hall lunch cart was parked outside room [ROOM NUMBER]. Staff were observed to carry lunch trays from the cart to the opposite end of the hall passing five resident rooms. In an interview on 05/13/2024 at 1:51 PM, Staff F stated staff should not be carrying the lunch trays past other resident rooms with uncovered food. Staff F stated it was their expectation staff moved the lunch cart down the hall close to the rooms that were receiving trays. Staff F stated it was important for staff to bring the meal cart down the hall as trays were delivered because it reduced the risk of the food becoming contaminated. REFERENCE: WAC 388-97-1100 (3).

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	505400	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enumclaw Health & Rehab Center	2323 Jensen Street Enumclaw, WA 98022

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42203 Based on interview and record review, the facility failed to ensure resident record were maintained comprehensively for 3 of 18 sample residents whose records were reviewed (Residents 50, 25, & 29). The failure to ensure health records were added to the chart timely left residents at risk for incomplete medical records, delays in treatment, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's updated October 2021 Electronic Health Record - Scanning Documents policy, facility staff would ensure documents were uploaded to residents' health records timely. The policy showed documentation should be left at collection bins where the Health Information Manager (HIM) would collect the documentation and add it to the appropriate resident record. <Resident 50> According to the 05/05/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 50 had diagnoses including heart failure, shortness of breath, and a rapid pulse. Review of Resident 50's record showed on 01/29/2024 recommendation to the physician from the facility's consultant pharmacist to consider a medication change as Resident 50 received two beta blockers (medications to treat a variety of heart conditions). On 02/09/2024 the physician annotated the pharmacy recommendation to indicate they agreed with the pharmacist. Review of the record showed this document was added to Resident 50's medical record on 05/02/2024, over three months after the pharmacist made the recommendation. 43642 <Resident 25> According to a 04/18/2024 Annual MDS, Resident 25 was assessed to require hospice services. Review of Resident 25's records showed hospice notes from February, March, and April 2024 were not scanned into the resident's records by staff until May 2024. Review of a hospice binder located at the nurse's station on 05/10/2024 at 12:18 PM showed no hospice notes for Resident 25 after 11/08/2023. In an interview on 05/14/2024 at 11:39 AM, Staff M (Medical Records) stated they had some hospice notes that needed to be scanned for Resident 25 that were, put in my box within the last week. Staff M stated they expected the hospice records to be readily available in the resident records and stated hospice leaves their notes with the resident care manager. <Resident 29> (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 04/11/2024 Quarterly MDS, Resident 29 had multiple medically complex diagnoses including psychosis, anxiety, and depression and required the use of antipsychotic, antianxiety, and antidepressant medications during the assessment period. Review of Resident 29's records revealed no pharmacy recommendation was found for February 2024. In an interview on 05/14/2024 at 11:39 AM, Staff M reviewed a stack of papers that needed to be uploaded into Resident 29's records. Resident 29's February 2024 pharmacy recommendation was found in the stack of papers. In an interview on 05/16/2024 at 3:17 PM, Staff B (Director of Nursing) stated their expectation was for resident records to be complete, accurate, updated, and readily available within 24 hours of receiving. REFERENCE: WAC 388-97 -1720 (1)(a)(i-iv)(b). 50511

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46479 Based on observation, interview, and record review the facility failed to maintain infection control practices that provided a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to ensure staff followed the instructions as written on signs posted on resident doors requiring staff to wear Personal Protective Equipment (PPE) for 1 (Residents 36) of 4 residents reviewed and 1 supplemental (Resident 16) resident reviewed, properly store resident urinals for 2 (Residents 46 & 57) of 3 residents reviewed, and maintain clean resident equipment for 1 (Resident 29). These failures placed residents at risk for the development and transmission of communicable disease and infections. Findings included . <Facility Policy> Review of the facility's May 2015 Transmission-Based Precautions (Isolation) policy showed Transmission-Based Precautions (TBP) were used for caring for residents who were documented or suspected to have communicable diseases or infections that could be transmitted to others. This policy showed contact precautions were implemented with residents who had known or suspected infections with microorganisms that could be transmitted by direct contact with the resident or indirect contact with the resident's environment. The policy showed gloves and a disposable gown were to be worn prior to entering a resident's room who was under contact precautions. <TBP> <Resident 36> According to the 03/05/2024 Functional Mobility Care Plan (CP), Resident 36 was on contact precautions for wounds to their right lower extremity that was infected with a type of bacteria that was resistant to several antibiotics and spread via skin-to-skin contact. The CP directed staff to follow the directions of the posted contact precautions sign. Observation on 05/08/2024 at 8:45 AM showed Resident 36 had a Contact Precautions sign posted on their door with a supply cart that contained gowns, gloves, face masks, and goggles. The sign on the door instructed the staff to don a gown, gloves, mask, and goggles, prior to entering Resident 36's room. Observation on 05/10/2024 at 8:28 AM showed staff passing breakfast trays on the 100 hall. Staff V (Housekeeping Supervisor) removed Resident 36's breakfast tray from the meal cart and took it inside Resident 36's room. Staff V did not don PPE as directed by the sign posted outside of Resident 36's room. In an interview on that same date at 8:39 AM, Staff V stated they should have donned PPE prior to entering Resident 36's room but stated they forgot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/10/2024 at 1:10 PM showed Staff W (Certified Nursing Assistant - CNA) deliver Resident 36's breakfast tray to their room without donning PPE. Staff W stated they did not gown up because they did not have any contact with the resident. Staff W stated they only donned PPE if/when they touched the resident. Observation on 05/10/2024 at 1:23 PM showed Staff X (CNA) knock on and open Resident 36's door. Staff X started to enter Resident 36's room when Staff G (Resident Care Manager) stopped Staff X and directed them to don PPE prior to entering the resident's room. Observation on 05/13/2024 at 1:39 PM showed Staff Y (CNA) remove Resident 36's lunch tray from the meal cart to deliver to Resident 36. Staff Y started to open Resident 36's door when another CNA (Staff Z) stopped Staff Y and directed them to don PPE prior to delivering Resident 36 their lunch meal. <Resident 16> According to the 04/17/2024 Baseline CP, Resident 16 was on contact precautions for a severe infection of their intestines. Observations on 05/09/2024 at 10:35 AM showed a provider in Resident 16's room. The provider was not wearing a gown or gloves while in Resident 16's room. In an interview on 05/15/2024 at 9:42 AM, Staff D (Infection Control Preventionist) stated it was their expectation staff donned PPE prior to entering any resident room with contact precautions. Staff D stated it was important for staff to don PPE for TBP rooms because it protected the residents and staff from transmitting infections to each other. Staff D stated education was consistently being provided to staff regarding TBP and PPE. Staff D stated there was a huddle before each shift during which Staff D discussed with staff working that shift, what TBP was and what PPE to don for each type of TBP. 43642 <Urinals> <Resident 46> Observations on 05/08/2024 at 10:18 AM, showed Resident 46 in bed with a urinal next to their breakfast tray on their overbed table while they were eating. <Resident 57> Observations on 05/10/2024 at 1:21 PM showed staff delivering a lunch tray to Resident 57. Staff placed the lunch tray on the overbed table next to a urinal with urine in it. At 1:59 PM, Resident 57 was observed sitting up eating the lunch with a bag of snacks sitting on the table next to the urinal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 05/13/2024 at 12:36 PM showed Staff G at Resident 57's bedside during wound rounds. Staff G was observed picking up Resident 57's urinal off the overbed table, emptied it, and placed it on a side table without objection from the resident. Observations on 05/14/2024 at 1:51 PM showed Resident 57 sitting up eating with their urinal next to the lunch tray on the overbed table. In an interview on 05/16/2024 at 12:23 PM, Staff G stated food should not be placed next to urinals as it was an infection control risk. <Resident Equipment> <Resident 29> Observations on 05/09/2024 at 10:26 AM showed Resident 29 with a floor mat next to their bed. The floor mat was cracked and peeling over the entire top layer of the floor mat material, exposing the underneath material. Similar observations were made on 05/10/2024 at 8:53 AM, and 05/15/2024 at 8:38 AM. In an interview on 05/16/2024 at 10:55 AM, Staff G stated the floor mats were not cleanable and should be replaced. REFERENCE: WAC 388-97-1320(1)(a)(c).