| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505400 | A. Building<br>B. Wing | 06/13/2025 |

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation, interview, and record review the facility failed to provide care in a manner that promoted dignity for 2 (Resident 13 & 18) of 17 sample residents reviewed. The facility failed to provide privacy during medication pass for Resident 13 and have washcloths available for staff and residents to use for personal care for Resident 18. These failures placed residents at risk for feelings of diminished self-worth and embarrassment.<br><br>Findings included .<br><br><Resident 13><br><br>Observations during medication pass on 06/12/2025 at 9:45 AM showed Staff Q (Licensed Practical Nurse) prepare medications for Resident 13. Another staff member from the activities department went into Resident 13's room and brought the resident out in a wheelchair to join an activity. Staff Q stopped the staff member and let them know they needed to administer Resident 13's medications first, and stated, you can leave [them] here. Staff Q put on gloves, administered the medications, and handed the resident an inhaler to use. Staff Q then administered eye drops while Resident 13 remained in the hallway and other residents were walking by.<br><br>In an interview on 06/12/2025 at 10:42 AM, Staff B (Director of Nursing) stated it was their expectation staff not administer medications in the hallway and that staff should offer the medication administration to be conducted in private to promote dignity for a resident.<br><br><Resident 18><br><br>In an interview on 06/08/2025 at 1:43 PM, Resident 18 stated they were frustrated the facility was often out of washcloths and reported they had to be, cleaned with a pillowcase. Resident 18 stated they were embarrassed that a pillowcase had to be used for their toileting hygiene care.<br><br>Observations on 06/10/2025 at 8:47 AM showed the linen closet on the 100 and 500 units had no washcloths available.<br><br>In an interview on 06/10/2025 at 1:35 PM, Resident 18 stated there were still no washcloths available the night before.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observations on 06/11/2025 at 5:00 AM revealed no washcloths were available in the laundry department. In an interview at this time, Staff Y (Housekeeping Supervisor) stated they did not have any washcloths currently available and stated, they are gone. Staff Y stated they put out 300 washcloths originally, but the linen closets were empty when they go to restock them. Staff Y stated they would be ordering linen this month but with the budget, they were not able to order as often. Staff Y stated the washcloths started slowly disappearing and have had a minimal amount for a few weeks. Staff Y stated they kept a log with outgoing linen counts which showed only 44-49 washcloths were going out to be used by the whole facility. Staff Y stated they had no washcloths to put out for the day, but would be washing some loads to have some back out on the floor within a couple hours.<br><br>Observations on 06/11/2025 at 5:20 AM showed no washcloths for residents or staff were available in the 500-unit linen closet.<br><br>In an interview on 06/11/2025 at 5:23 AM, Staff Z (Certified Nursing Assistant - CNA) stated they do not usually have washcloths available and stated, we have a tiny stack for the whole building. When asked how long they have been out of washcloths, Staff Z stated, at least a couple weeks.<br><br>Observations on 06/11/2025 at 5:49 AM showed no washcloths were available for residents or staff in the 100-unit linen closet. Staff Y was observed restocking the 100-unit linen closet but had no washcloths. In an interview at this time, Staff Y stated, the director is going to buy them today to tide us over.<br><br>In an interview on 06/11/2025 at 10:55 AM, Resident 18 stated there were no washcloths available, so staff had to use a towel for their toileting hygiene care and stated, at least it wasn't a pillowcase this time.<br><br>In an interview on 06/11/2025 at 11:01 AM, Staff AA (CNA) stated they were frustrated with the lack of washcloths and stated, I don't know where they are going. Staff AA stated they only had five washcloths to start the day providing showers to residents and stated the supply was low, off and on for a while.<br><br>In an interview on 06/12/2025 at 10:36 AM, Staff BB (CNA) stated the facility had finally ordered some washcloths but stated, we had zero for at least the past three weeks. Staff BB stated there were a couple of residents that expressed concerns regarding not having washcloths available for use.<br><br>In an interview on 06/12/2025 at 3:28 PM, Staff CC (CNA) stated they struggled not having washcloths and it was hard explaining to residents when they asked why there are none. Staff CC stated they would often have to use towels, and at times, pillowcases, if they did not have the supplies they needed for resident care.<br><br>In an interview on 06/13/2025 at 11:34 AM, Staff B stated it was their expectation towels and washcloths be readily available for use by staff and residents. Staff B stated not having the supplies needed for care was a dignity issue and stated this was the resident's home, they should be treated the way we would want to be treated.<br><br>REFERENCE: WAC 388-97-0180(1-4).<br><br>. |

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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure funds were reimbursed to the state Office of Financial Recovery (OFR), within 30 days of resident discharge or death, for 2 (Residents 73 & 74) of 3 discharged residents reviewed. This failure caused a delay in reconciling residents' accounts within 30 days as required.<br><br>Findings included .<br><br><Facility Policy><br><br>According to a revised facility [DATE] Resident Trust Fund policy, the facility would maintain resident trust fund accounts in accordance with state and federal regulations. This policy showed when a resident discharged or expired, the balance of the resident's personal funds would be returned to the resident, responsible party, or as directed by state regulation.<br><br><Resident 73><br><br>Record review showed Resident 73 discharged from the facility on [DATE]. Review of the facility's trust records showed the resident had a balance of $229.61 which was not transferred to the OFR until [DATE], over three months after Resident 73's discharge from the facility.<br><br><Resident 74><br><br>Record review showed Resident 74 discharged from the facility on [DATE]. Review of the facility's trust records showed the resident had a balance of $55.84 which was not transferred to the OFR until [DATE], four days after the 30 day timeframe.<br><br>In an interview on [DATE] at 2:32 PM, Staff E (Business Office Manager) reviewed the accounts and confirmed the trust balances were not transferred within the 30 day timeframe from the residents' discharges, as required.<br><br>REFERENCE: WAC 388-97-0340(4)(5).<br><br>. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Carpet><br><br>Observations on 06/08/2025 at 8:52 AM, 06/11/2025 at 5:54 AM, and 06/13/2025 at 11:29 AM showed a large carpet stain in the hallway across from room [ROOM NUMBER].<br><br>In an observation and interview on 06/13/2025 at 11:29 AM, Staff K stated it was their expectation housekeeping staff would address carpet stains promptly.<br><br><Blinds><br><br>Observations on 06/08/2025 at 8:52 AM, 06/11/2025 at 5:54 AM, and 06/13/2025 at 11:29 AM showed there were missing and broken window blinds to the windows at the end of the 100-hall and the 200-hall.<br><br>An observation of the 200-hall window with Staff K on 06/13/2025 at 11:29 AM showed Staff K pick up a broken blind lying on the floor under the window. In an interview at this time, Staff K stated the broken blinds needed to be fixed and the missing blinds replaced. Staff K stated it was important for the facility to be clean and in good repair, so it felt like home for the residents and to keep everything functional.<br><br>REFERENCE: WAC 388-97-0880.<br><br>Based on observation, interview, and record review, the facility failed to provide necessary maintenance and housekeeping for 3 of 3 units and the main dining room. The facility failed to ensure residents' living environment was free from broken and/or missing window blinds, stained carpets, and air vents with debris accumulation. The failure to maintain window blinds, carpets, and ceiling vents in good repair and sanitary condition placed the residents at risk for diminished quality of life.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of the facility's Notice Of Resident Rights Under Federal Law, updated 11/2016, showed the facility would provide residents with a safe, clean, comfortable, and homelike environment.<br><br>Review of the facility's admission Agreement and Resident Handbook, updated December 2023, showed the facility would provide daily housekeeping services and the maintenance department would regularly review the facility to identify and perform needed improvements.<br><br><Air Vents><br><br>Observation on 06/08/2025 at 12:25 PM, 06/10/2025 at 10:32 AM, and 06/13/2025 at 1:50 PM showed a buildup of debris on two ceiling air vents in the main dining room.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observations on 06/13/2025 at 1:49 PM showed a buildup of debris on the bathroom ceiling air vents in rooms 102, 309, 501, and 502. The air vent for the wall-mounted heater in the 100 unit hallway showed a buildup of debris.<br><br>In an interview on 06/13/2025 at 1:53 PM, Staff K (Maintenance Supervisor) stated the air vents in the facility needed to be cleaned and would be taken care of the following weekend. Staff K stated a clean and homelike environment was important for residents to be able to feel comfortable, as the facility was their home. Staff K was unaware of the availability of records documenting regular facility reviews. The facility was unable to provide further documention. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 3><br><br>According to a 04/25/2025 Quarterly MDS, Resident 3 had multiple medically complex diagnoses including a history of falling, required substantial assistance with transfers, and was dependent on staff for toileting hygiene.<br><br>In an interview on 06/09/2025 at 10:18 AM, Resident 3's family stated they were concerned about the resident having recent falls.<br><br>Observations on 06/09/2025 at 12:38 PM, showed Resident 3 lying in bed with their call light in reach.<br><br>Review of a revised 08/16/2024 risk for falls CP showed Resident 3 had a history of frequent falls and gave directions to staff to anticipate resident needs, ensure the resident's call light was within reach, and keep the room free of clutter due to poor eyesight.<br><br>Review of a revised 05/18/2024 actual fall CP showed an intervention to assist Resident 3 with the bathroom upon awakening, before/after meals, and at bedtime.<br><br>Review of a 01/05/2025 12:00 PM facility incident report showed Resident 3 was found in their room, lying on the floor face down, with their wheelchair nearby. The investigation was blank under the Predisposing Environmental Factors assessment section showing staff did not indicate if Resident 3's room was cluttered, if wheelchair locks were working, or if the resident had what they needed within reach. There was no information included in the report to show if Resident 3 needed assistance with toileting or other care needs and/or when the last time any assistance was provided to the resident prior to the fall.<br><br>Review of a 01/20/2025 6:30 PM facility incident report showed Resident 3 was found on the floor by their bed with their wheelchair behind them. The investigation was blank under the Predisposing Environmental Factors assessment section of the incident report showing staff did not indicate if Resident 3's room was cluttered, if wheelchair locks were working, or if the resident had what they needed within reach. There was no information included in the report to show if Resident 3 needed assistance with toileting or other care needs and/or when the last time any assistance was provided to the resident prior to the fall.<br><br><Resident 26><br><br>According to an 04/16/2025 Significant Change MDS, Resident 26 had multiple medically complex diagnoses including diabetes (a disease that affects how your body regulates blood sugar) and a history of repeated falls. This MDS showed Resident 26 had a fall with injury since the previous assessment and required substantial assistance with transfers and toileting hygiene.<br><br>Review of a revised 05/24/2024 fall CP showed Resident 26 had low blood sugars, confusion, poor balance, impulsive behavior, and received high-risk medications.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observations on 06/08/2025 at 12:21 PM showed Resident 26 sitting on their bed with their walker nearby. In an interview at this time, Resident 26 stated they had recent falls.<br><br>Review of a 01/11/2025 4:04 AM facility incident report showed Resident 26 was found standing staring at the wall, and began lowering themselves to the floor. The staff in the room assisted Resident 26 to their knees. There was no information included in the report to show if staff assessed Resident 26's blood sugar, needed assistance with toileting or other care needs, and/or when the last time any assistance was provided to the resident prior to the fall.<br><br>Review of a 03/24/2025 12:08 AM facility incident report showed Resident 26 was found on the floor in the hallway with injuries to their face. The investigation records showed Resident 26's call light was on at the time of the fall. There was no information included in the report to indicate how long the resident's light was on or how long it was since they received toileting assistance from staff, prior to the fall. There was no information to show if staff assessed Resident 26's blood sugar after the fall.<br><br>Review of a 05/01/2025 10:00 PM facility incident report showed Resident 26 was found on the floor by their bed with a broken walker next to them and injuries to their finger. The investigation records showed Resident 26's call light was on at the time of the fall. There was no information included in the report to indicate how long the resident's light was on at the time of the fall or if staff assessed Resident 26's blood sugar after the fall.<br><br>In a joint interview on 06/13/2025 at 11:34 AM with Staff B and Staff G (Regional Director of Clinical Operations), Staff G stated it was important to try and figure out the root cause of a fall so staff would know how to formulate the interventions to prevent further falls and decrease the risk for injuries. Staff B stated the incident reports for Residents 3 and 26 were not thorough and should have, but did not include more information and assessments.<br><br>Refer to F689 - Free of Accidents Hazards.<br><br>REFERENCE: WAC 388-97-0640(6)(a)(b).<br><br>Based on observation, interview, and record review, the facility failed to ensure thorough and complete investigations for 4 of 7 residents (Resident 28, 42, 3, & 26) reviewed for falls. Failure to conduct a thorough investigation placed residents at risk for further injuries, potential abuse/neglect, and other negative health outcomes.<br><br>Findings included .<br><br><Policy><br><br>According to a facility policy titled, Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation, dated March 2025, an example of neglect was failure to implement and monitor care planned interventions. The policy showed the facility would conduct a thorough investigation of potential neglect/abuse in accordance with state and federal regulations.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to a facility policy titled, Abuse Investigation, dated October 2022, the facility would determine if abuse/neglect had occurred and determine the extent and cause. The policy showed the facility would maintain complete and thorough documentation of the investigation.<br><br>According to a facility policy titled, Resident Falls Management. Dated November 2016, the facility would assess and decrease clutter in the room, assess footwear and guarantee the resident's footwear fit appropriately, and evaluate lighting in the room and adjust as needed.<br><br><Resident 28><br><br>According to a 05/28/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 28 admitted to the facility on [DATE] with no memory impairment. The MDS showed Resident 28 had a history of falls.<br><br>In an observation and interview on 06/09/2025 at 9:28 AM, Resident 28 was lying in bed with a bandage to their left knee and elbow. Resident 28 stated they had a fall the other day causing an abrasion to their left knee and elbow.<br><br>Review of a 05/24/2025 investigation for a fall, showed the nurse answered Resident 28's call light and found the resident sitting on their bed and reported they fell, with skin injuries to their left knee and elbow. The incident report showed a Neurological Assessment (an assessment of the resident's level of consciousness, vital signs, mental status, motor response, and strength initiated and conducted over a minimum of 24 hours after a resident had the possibility of hitting their head or actually hit their head) was initiated with no documentation of the assessment being done. The investigation was blank under the Predisposing Environmental Factors assessment section of the incident report showing the environment was not assessed for causative factors such as clutter, wet floor, or appropriate footwear for Resident 28's fall on 05/24/2025. The investigation did not include a skin assessment of the left knee skin injury documenting the appearance, measurements of the injury, or any noted drainage.<br><br><Resident 42><br><br>According to an 11/18/2024 admission MDS, Resident 42 was dependent on staff for bed to chair transfers. The MDS showed Resident 42 had a diagnosis of, but not limited to, paralysis of the lower half of the body.<br><br>Review of Resident 42's 12/26/2024 High Risk for Falls related to Paralysis Care Plan (CP), staff would anticipate and meet the needs of the resident. Resident 42's .had an actual fall with no injury CP showed neurological checks would be completed for the 05/22/2025 fall.<br><br>In an observation and interview on 06/09/2025 at 10:23 AM Resident 42 was lying in bed with bilateral above the knee amputations. Res 42 stated they fell after staff placed them in their wheelchair crooked and they attempted to reposition themselves. Resident 42 stated the wheelchair tipped over backward and they hit their head so hard on the corner of the wall.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the investigation documents showed the incident report for Resident 42 identified they hit their head during a fall on 05/22/2025. The report showed Resident 42 was transferred by two staff with a mechanical lift to their wheelchair and Resident 42 attempted to self-adjust after the staff placed them in their wheelchair causing the wheelchair to tip over backwards with staff still present in the room. The report showed Resident 42 hit their head on the corner of the wall when their wheelchair tipped over backward. The investigation of Resident 42's fall showed neurological assessment initiated. Review of the 05/22/2025 investigation and Resident 42's records showed no neurological assessment was done. Resident 42's incident report showed there was no predisposing situation factors for the fall including whether the resident was uncomfortable in their wheelchair after the transfer. The investigation did not include statements from the two staff members that transferred Resident 42 investigating if they ensured the residents comfort after placing them in their wheelchair.<br><br>In an interview on 06/13/2025 at 1:32 PM Staff B (Director of Nursing) stated they did not have documentation of a completed neurological assessment as part of the investigation file or in Resident 28 or 42's health records but should. Staff B stated a skin assessment documenting measurements and appearance of Resident 28's skin tear should have be done but was not. Staff B stated it was important to complete these assessments as part of the investigation to ensure the residents did not have further injuries or other negative health outcomes. Staff B stated they expected staff to complete all sections of the incident report as part of the investigation to include assessment of the environmental factors and predisposing situation factors, but staff did not for Resident 28 and 42's falls. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 24><br><br>Review of Resident 24's 07/15/2024 and 10/15/2024 Discharge MDS showed the resident was transferred to an acute care hospital on [DATE] and 10/15/2024, with their return anticipated.<br><br><Report to Receiving Facility><br><br>Review of Resident 24's records showed staff did not document the hospital was given report of the resident's condition at the time of transfer and no e-interact form was completed by staff for the resident's 10/15/2024 transfer.<br><br><Written Notice><br><br>Record review showed no documentation staff provided written notification to Resident 24 and/or the resident's representative regarding their discharge on [DATE] or 10/15/2024 as required.<br><br><LTCO Notification><br><br>Record review showed no documentation indicating the LTCO was notified of Resident 24's 07/15/2024 or 10/15/2024 transfer as required.<br><br><Resident 46><br><br>Review of Resident 46's 05/12/2025 Discharge MDS showed the resident was transferred to an acute care hospital on [DATE], with their return anticipated.<br><br><Report to Receiving Facility><br><br>Review of Resident 46's records showed staff did not document the hospital was given report of the resident's condition at the time of transfer and no e-interact form was completed by staff for the resident's 05/12/2025 transfer.<br><br><Written Notice><br><br>Record review showed no documentation staff provided written notification to Resident 46 and/or the resident's representative regarding their discharge on [DATE] as required.<br><br><LTCO Notification><br><br>Record review showed no documentation indicating the LTCO was notified of Resident 46's 05/12/2025 transfer as required.<br><br>In an interview on 06/13/2025 at 9:26 AM, Staff C stated the nursing department was responsible for notifying the LTCO of hospital transfers.<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In a joint interview with Staff R and Staff J (RCM) on 06/13/2025 at 1:03 PM, Staff R stated the nursing department does not notify LTCO with hospital transfers and indicated the social services department was supposed to do that. Staff R stated it was their expectation staff call and provide a report to the hospital with all transfers and stated they would expect documentation of that in the resident's records. Staff J reviewed Resident 24's records and was unable to locate staff gave report to the hospital for the 10/15/2024 transfer, or provided written notice of discharge to the resident and/or representative for the 07/15/2024 or 10/15/2024 transfers as required.<br><br>In an interview on 06/13/2025 at 2:54 PM, Staff R stated it was their expectation the notification to LTCO, hospital report from facility, and discharge notice be documented in Resident 46's records, no documentation was found.Based on interview and record review, the facility failed to offer bed holds upon transfer to the hospital for 1 of 5 residents (Resident 6), call report to the hospital regarding the resident's status for 4 of 5 residents (Residents 6, 24, 46, & 42), provide a written transfer notice to 4 of 5 residents (Residents 6, 24, 46, & 42), and notify the Office of the State Long Term Care Ombudsman (LTCO) for 4 of 5 residents (Resident 6, 24, 46, & 42) who were reviewed for hospitalization and notify the Office of the LTCO for 1 of 3 residents (Resident 71) reviewed for discharge process. Failure to offer bed holds placed residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized . Failure to call report to the receiving hospital placed residents at risk of a break in communication and continuity of care. Failure to notify the LTCO and ensure written notification was provided to the resident/resident representative, in a language and manner they understood, placed residents at risk for not having an opportunity to make informed decisions about their transfer/discharge rights.<br><br>Findings included .<br><br><Facility Policy><br><br>According to the facility's Transfer and Discharge policy, updated 04/2025, when a resident was transferred outside of the facility, the facility would document the transfer in the resident's record and communicate with the receiving institution. The policy showed staff would provide a written notice to the resident/representative that included contact information for the LTCO. This policy showed a copy of the notice would be sent to the LTCO.<br><br>According to the facility's Bed Hold policy, updated 05/2025, the facility would offer the resident/representative the option to hold the resident's bed upon transfer from the facility.<br><br><Resident 6><br><br><Bed Hold><br><br>Review of the 08/31/2024 Discharge Minimum Data Set (MDS - an assessment tool) showed Resident 6 was transferred to a short-term hospital on [DATE] with their return anticipated.<br><br>Review of Resident 6's records on 06/11/2025 showed no documentation a bed hold was offered to Resident 6.<br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/11/2025 at 10:34 AM, Staff S (Director of Admissions) stated bed holds were offered to residents/representatives within 24 hours of the resident's transfer. Staff S stated the document was done electronically and kept in the resident's record. At that time, Staff S was unable to provide documentation showing Resident 6 was offered a bed hold as required.<br><br><Report to Receiving Facility><br><br>Review of Resident 6's records on 06/11/2025 showed staff did not that the short-term general hospital was given report of the resident's condition. Resident 6's record did not include an e-interact form (document completed by staff that includes documentation showing staff gave report to receiving facility) completed by the staff for the resident's 08/31/2024 hospital transfer.<br><br>In an interview on 06/13/2025 at 11:01 AM, Staff R (Resident Care Manager - RCM) stated it was their expectation staff called and gave report to the receiving hospital when a resident was transferred out. Staff R confirmed there was no documentation in Resident 6's record showing staff gave report to the hospital.<br><br><Written Notice><br><br>Review of Resident 6's record on 06/11/2025 did not show a written notice was completed and provided to the resident.<br><br>In an interview on 06/12/2025 at 1:45 PM, Staff B (Director of Nursing) stated they expected staff to fill out the written notice, provide one copy to the resident and one copy for the residents' record. Staff B was unable to provide documentation that a written notice was completed for Resident 6's 08/31/2024 hospital transfer.<br><br><LTCO Notification><br><br>In an interview on 06/11/2025 at 9:21 AM, Staff C (Social Services Director) stated they did not notify the LTCO when residents were transferred to the hospital. Staff C stated the nursing staff was supposed to fax a copy of the written notice to the LTCO when they completed the form.<br><br>In an interview on 06/12/2025 at 1:45 PM, Staff B stated it was their expectation social services department notified the LTCO of resident transfers to the hospital.<br><br><Resident 71><br><br><LTCO Notification><br><br>Review of the 03/10/2025 Comprehensive MDS showed Resident 71 discharged from the facility on 03/10/2025 to home/community with their return not anticipated.<br><br>In an interview on 06/13/2025 at 1:33 PM, Staff C reviewed their records and stated they did not notify the LTCO of Resident 71's discharge. Staff C stated if they did not receive a discharge packet from nursing staff, then they did not notify the LTCO. <Resident 42><br><br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to a 12/18/2024 Discharge Return Anticipated MDS Resident 42 was transferred to an acute care hospital on [DATE]. The MDS showed Resident 42 presented with an acute change in mental status from their baseline.<br><br><Report to Receiving Facility><br><br>Review of Resident 42's records showed staff did not document the hospital was given report of the resident's condition at the time of transfer and no e-interact form was completed by staff for the resident's 12/18/2024 transfer.<br><br><Written Notice><br><br>Record review showed no documentation staff provided written notification to Resident 42 and/or the resident's representative regarding their discharge on [DATE] as required.<br><br><LTCO Notification><br><br>Record review showed no documentation indicating the LTCO was notified of Resident 42's 12/18/2024 transfer as required.<br><br>In an interview on 06/13/2025 at 11:08 AM Staff B, Staff G (Regional Director of Clinical Operations), and Staff A (Administrator) reviewed Resident 42's records and stated a report was not called to the receiving hospital, notification of the LTCO was not done, and a written transfer notification was not provided to the resident or their representative for the 12/18/2024 transfer, but should have been. Staff B stated it was important to call report to the receiving hospital for continuity of care.<br><br>REFERENCE: WAC 388-97-0120(2)(a-d)(3)(a)(4), -0140(1)(a)(b)(c)(i-iii).<br><br>. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 24><br><br>According to a 02/10/2025 Annual MDS, Resident 24 had no areas of concern for their dental status.<br><br>In an interview on 06/08/2025 at 12:06 PM, Resident 24 stated they had some broken teeth that needed to be fixed for a while.<br><br>Review of Resident 24's revised 02/29/2024 dental health CP showed tooth decay was found on an oral assessment and gave instructions to staff to coordinate arrangements for dental care, transportation as needed.<br><br>Record review showed Resident 24 was seen by dental on 05/05/2025 with documentation showing the resident had several decayed and broken teeth and required a referral for evaluation and extractions.<br><br>In an interview on 06/13/2025 at 10:31 AM, Staff D stated it was important to have an accurate MDS to provide a proper picture of the resident and to CP appropriately. Staff D reviewed Resident 24's 02/10/2025 Annual MDS and stated the dental status section was coded inaccurately and needed to be modified.<br><br><Resident 26><br><br>According to a 04/16/2025 Significant Change MDS, Resident 26 had multiple medically complex diagnoses including heart failure and a psychotic disorder (a severe mental illness that causes abnormal thinking) and required the use of an antipsychotic medication during the assessment period. This MDS showed staff did not mark Resident 26 was receiving a diuretic (water pill) medication and in a different section, staff marked No antipsychotics were received.<br><br>Review of the April 2025 medication administration record showed Resident 26 was receiving diuretic medication daily and an antipsychotic medication twice daily.<br><br>In an interview on 06/13/2025 at 10:31 AM, Staff D reviewed Resident 26's 04/16/2025 Significant Change MDS and stated the resident was receiving a diuretic and an antipsychotic medication during the assessment period and the MDS was coded inaccurately.<br><br><Resident 46><br><br>According to a 05/22/2025 Significant Change MDS, Resident 46 had multiple medically complex diagnoses including anxiety, depression, a mental illness characterized by extreme mood swings, and a mental health condition that developed after experiencing or witnessing a traumatic event. This MDS showed Resident 46 required the use of antipsychotic and antianxiety medications during the assessment period. This MDS showed staff indicated Resident 46 was not currently considered to have a serious mental illness.<br><br>Review of a 04/16/2025 behavioral health notice of determination form showed Resident 46 had an evaluation and was determined to have a mental health diagnosis and may benefit from specialized behavioral health services.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/13/2025 at 10:31 AM, Staff D reviewed the 05/22/2025 Significant Change MDS and stated Resident 46 was identified with a serious mental illness and the MDS was coded inaccurately.<br><br>REFERENCE: WAC 388-97-1000 (1)(b).<br><br>Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) accurately reflected the status for 5 (Resident 6, 70, 24, 26, & 46) of 17 sample residents reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br><Facility Policy><br><br>According to the facility's Resident Assessment Instrument (RAI) policy, revised 03/2019, showed the facility would complete MDS assessments per the RAI manual.<br><br><Resident 6><br><br>Review of Resident 6's 01/08/2024 alteration in gastrointestinal (bodily system involved in digestion and absorption of food) status . Care Plan (CP) showed the resident had a colostomy (surgical procedure creating an opening in the abdomen that collects bowel movements into an external pouch). The CP directed staff to care for the colostomy each shift and instructed nursing aides to empty the pouch every shift.<br><br>Review of Resident 6's 03/26/2025 Quarterly MDS showed staff coded the resident as being occasionally incontinent of bowel instead of Not Rated, resident had an ostomy .<br><br>In an interview on 06/12/2025 at 10:16 AM, Staff D (MDS Coordinator) reviewed Resident 6's record and confirmed the MDS was coded inaccurately. Staff D stated the 03/26/2025 MDS required modification.<br><br><Resident 70><br><br>According to Resident 70's 04/14/2025 Comprehensive MDS, the resident discharged from the facility with their return not anticipated. The MDS showed Resident 70 discharged to a short-term hospital on [DATE].<br><br>Review of Resident 70's nursing progress notes showed a 04/14/2025 progress note stating the resident discharged from the facility against medical advice. Staff explained the risks of leaving against medical advice. The resident left the facility at 4:45 PM that day.<br><br>In an interview on 06/25/2025 at 10:15 AM, Staff D reviewed Resident 70's records and confirmed the 04/14/2025 MDS was coded incorrectly and required modification. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>Based on interview and record review, the facility failed to ensure the recommendation of a Level II Preadmission Screen and Resident Review (PASRR) evaluation was incorporated into the Care Plan (CP) upon receiving recommendations for 2 (Resident 46 & 32) of 5 sampled residents reviewed for coordination of PASRR and assessments. This failure placed residents at risk for unmet mental health care needs and a diminished quality of life.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of a revised 01/01/2025 PASRR Process Policy and Procedures, showed once the Level II evaluation was complete, the Social Services Director (SSD) would give the evaluation to medical records to be placed in the resident's records. This policy showed the SSD would additionally expand the CP to include recommended approaches noted on the Level II PASRR evaluation.<br><br><Resident 46><br><br>According to a Quarterly 05/22/2025 Minimum Data Set (MDS - an assessment tool), Resident 46 had multiple medically complex diagnoses including anxiety, depression, a mental illness characterized by extreme mood swings, and a mental health condition that developed after experiencing or witnessing a traumatic event. This MDS showed Resident 46 required the use of antipsychotic and antianxiety medications during the assessment period.<br><br>Review of Resident 46's records showed facility staff completed a 10/21/2024 Level 1 PASRR indicating the resident had Serious Mental Health Indicators (SMI) and required a Level II evaluation referral. On 04/16/2025 a PASRR Notice of Determination (NOD) was completed and provided to the facility. This NOD showed Resident 46's screening identified the need for a Level II PASRR evaluation due to an existing/suspected behavioral health diagnosis and the resident could benefit from specialized behavioral health services. No Level II evaluation was found in Resident 46's records.<br><br>In an interview on 06/13/2025 at 9:26 AM, Staff C (SSD) stated the PASRR process was important to make sure residents had proper placement and their mental health needs were met. Staff C stated it was their expectation a Level II PASRR was integrated into the resident's CP once completed and obtained. Staff C reviewed Resident 46's records and was unable to locate the Level II PASRR, only the NOD. Staff C reviewed their computer emails from the PASRR evaluator and found an email from 05/01/2025, over a month previously, with Resident 46's Level II PASRR recommendations. Staff C stated these recommendations should have, but were not implemented into the Resident 46's CP and records.<br><br><Resident 32><br><br>According to a 05/20/2025 Significant Change MDS, Resident 32 had multiple medically complex diagnoses including dementia (loss of memory or other thinking abilities) and depression. This MDS showed Resident 32 required the use of an antipsychotic, antianxiety, and an antidepressant during the assessment period.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a 05/29/2024 Level 1 PASRR showed facility staff identified Resident 32 had an SMI and required a Level II evaluation referral. Record review showed no Level II PASRR evaluation was found for Resident 32.<br><br>In an interview on 06/13/2025 at 9:26 AM, Staff C stated if a resident was determined to have an SMI, they would expect an evaluation to be obtained and be included in the resident's records.<br><br>REFERENCE: WAC 388-97-1915(4).<br><br>. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 24><br><br>According to a 05/09/2025 Quarterly MDS, Resident 24 had clear speech, understands, and was understood by others.<br><br>In an interview on 06/08/2025 at 12:09 PM, Resident 24 stated they felt staff did not include them in their plan of care and did not have any recent care conference meetings with the different departments to discuss their care.<br><br>Review of Resident 24's records showed a 04/04/2025 care conference was held with the only IDT members in attendance listed were Staff R (RCM) and Staff DD (Social Services Assistant - SSA). Staff documented, none for the other categories of: MDS, Executive Director, CNA (Certified Nursing Assistant) responsible; DNS (Director of Nursing), Therapy, FANS (Dietary department); and activities. Similar observations were noted of only the RCM and SSA attending care conferences with Resident 24 on 01/09/2025 and 09/11/2024.<br><br>In an interview on 06/13/2025 at 9:26 AM, Staff DD stated they were involved in the care conference scheduling and sent out notice to the IDT members. Staff DD stated the only staff that attended with them was the RCM.<br><br>In an interview on 06/13/2025 at 1:03 PM, Staff R stated the IDT members do not attend care conferences with the resident, only themselves and the SSA.<br><br>REFERENCE: WAC 388-97-1020(2)(d-e), (4)(c)(i-ii).<br><br><Resident 53><br><br>According to the 05/12/2025 admission MDS, Resident 53 admitted to the facility on [DATE]. The MDS showed Resident 53 had minimal difficulty with hearing, was sometimes understood, and could sometimes understand others. Resident 53 had diagnoses including a brain bleed and limited mobility to one side of their body. The MDS showed Resident 53 received 51 percent or more of their nutrition via tube feeding (artificial nutrition delivered directly to the digestive system via a surgically placed tube).<br><br>Review of Resident 53's 05/12/2025 Care Conference Evaluation form showed the only IDT members in attendance were Staff C and Staff J. The form showed Staff C completed the discharge planning section on 05/16/2025 and Staff J completed the care conference details, nursing, nutrition, social services, and activities sections on 05/21/2025. The care conference evaluation was not completed together by the IDT or within 72 hours of the resident's admission as required.<br><br>In an interview on 06/13/2025 at 10:43 AM, Staff C confirmed the care conference only consisted of Staff J and Staff C and that the care conference was not done with the IDT.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Based on interview and record review, the facility failed to conduct care conferences for residents with their resident representative and the applicable Interdisciplinary Team (IDT) members for 4 of 6 residents (Residents 28, 222, 53, & 24) and offer timely care conferences for 2 of 6 residents (Resident 28 & 53) reviewed for care planning. This failure placed residents at risk for unmet care needs, unnecessary care, frustration, and other negative health outcomes.<br><br>Findings included .<br><br><admission Agreement><br><br>According to the facility's admission agreement, the resident and /or resident representative would be included in their plan of care during their care conference with their team. The admission agreement showed the facility would encourage the residents and representatives to attend the care conference for discussion with the resident care team about their plan of care.<br><br><Resident 28><br><br>According to the 05/28/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 28 admitted to the facility on [DATE]. The MDS showed Resident 28 could make themselves understood and understood others. Resident 28 had diagnoses of, but not limited to, a long-term degenerative neurological disorder and a life-threatening response to an infection. The MDS showed Resident 28 was receiving physical and occupational therapy services at the facility. The MDS showed it was very important to have their family or close friends involved in discussions about their care.<br><br>Review of Resident 28's 05/27/2025 Care Conference Evaluation form showed the only IDT members in attendance were Staff C (Social Services Director) and Staff J (Resident Care Manager -RCM). The form showed Staff C completed the social services section on 05/27/2025, the discharge planning section on 05/29/2025, and the nutrition section on 05/30/2025. The Care Conference Evaluation form showed Staff EE (Activity Assistant) completed the activities section on 05/28/2025 but were not in attendance at the 05/27/2025 care conference. The Care Conference Evaluation form showed Staff J completed the care conference details and nursing sections on 05/28/2025. The care conference was not completed together with Resident 28's vital IDT members, the resident representative was not invited to the care conference, and it was not completed within 72 hours of the resident's admission as required.<br><br>In an observation and interview on 06/09/2025 at 8:50 AM Resident 28 stated they had not had a care conference that included nursing, therapy, social services, dietary, and activities department. Resident 28 stated they were not included in their plan of care, had not received a copy of their care plan, and were visibly frustrated. Resident 28 stated they had an assigned power of attorney that should be involved in their care.<br><br>Record review of Resident 28's health records showed demographic information obtained on admission with three resident representatives listed.<br><br><Resident 222><br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to the 06/10/2025 admission MDS Resident 222 admitted to the facility on [DATE]. The MDS showed Resident 222 could make themselves understood and understood others. Resident 222 had diagnoses of, but not limited to, a stroke and a restrictive lung disease. The MDS showed Resident 222 was receiving physical and occupational therapy services at the facility. The MDS showed it was somewhat important to attend group activities. The MDS showed it was very important to have their family or close friends involved in discussions about their care.<br><br>Review of Resident 222's 06/04/2025 Care Conference Evaluation form showed the only IDT members in attendance were Staff C and Staff J. The form showed Staff C completed the social services and discharge planning section on 06/09/2025. The Care Conference Evaluation form showed Staff U (Activities Director) completed the activities section on 06/05/2025 but were not in attendance at the 06/04/2025 care conference. The Care Conference Evaluation form showed Staff J completed the care conference details, nursing, and nutrition sections on 06/10/2025. The care conference was not completed together with Resident 222's vital IDT members and the resident representative was not invited to the care conference as required.<br><br>In an observation and interview on 06/08/2025 at 12:23 PM Resident 222 stated they had not had a care conference that included nursing, therapy, social services, dietary, and activities department. Resident 222 stated they were not included in their plan of care, had not received a copy of their care plan, and were visibly frustrated. Resident 222 stated they had a representative that should be involved in their care.<br><br>Record review of Resident 222's health records showed demographic information obtained on admission included a resident representative with their contact information listed.<br><br>In an interview on 06/13/2025 at 12:42 PM, Staff C confirmed Resident 28 and 222's care conferences only consisted of Staff J and Staff C and that the care conferences were not done with the vital IDT members for the residents. Staff C stated all departments received invitations to the residents care conferences but did not attend the meetings with the residents. Staff C confirmed therapy, nutrition, and activities were a vital part of Resident 28 and 222's IDT but were not in attendance at their care conferences. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><Medications Given Outside of Parameters><br><br><Resident 45><br><br>According to a 05/27/2025 Significant Change Minimum Data Set (MDS- an assessment tool), Resident 45 had multiple medically complex diagnoses including high Blood Pressure (BP).<br><br>Review of Resident 45's May 2025 Medication Administration Records (MAR) showed the resident was receiving two different medications for high BP with directions to staff to hold doses if the Systolic BP (SBP - a measure of the pressure in your arteries when your heart beats) was less than 110. This MAR showed staff gave the medications outside of these parameters on three occasions. Review of Resident 45's June 2025 MAR showed staff administered these medications outside of parameters on two occasions.<br><br><Resident 26><br><br>According to a 04/16/2025 Significant Change MDS, Resident 26 had multiple medically complex diagnoses including high BP.<br><br>Review of Resident 26's April 2025 MAR showed the resident was receiving three different medications for high BP with directions to hold doses if the heart rate was less than 60 and/or SBP was less than 110. This MAR showed staff gave the medications outside of these parameters on four occasions. Review of Resident 26's May 2025 MAR showed staff administered these medications outside of parameters on six occasions.<br><br>In an interview on 06/13/2025 at 11:34 AM, Staff B (Director of Nursing) stated it was their expectation staff administer medications to residents as directed and hold doses outside of parameters as directed.<br><br><Medication Pass Observation><br><br>During medication pass observations on 06/12/2025 at 9:41 AM, Staff Q was observed preparing medications for a resident. Staff Q went to a resident's room with the medications, called out their first name, and asked them to sit up to take their medications. Staff Q did not ask the resident their name to confirm or follow the facility's policy for checking resident identifiers, prior to administering the resident's medications.<br><br>In an interview on 06/12/2025 at 9:50 AM, Staff Q stated they were agency staff, and it was their first time working in the facility.<br><br>In an interview on 06/12/2025 at 10:42 AM, Staff B stated it was the facility policy and expectation for nurses to verify the right resident prior to administering any medications. Staff B stated those safety checks were important to verify staff were giving the right medication to the right residents.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During observations of medication pass on 06/12/2025 at 10:18 AM, Staff Q opened the top drawer of the medication cart and picked up one of two unlabeled medication cups filled with different pills. Staff Q then took the cup of pills and delivered them to a resident in room [ROOM NUMBER].<br><br>In an interview on 06/12/2025 at 10:20 AM, Staff Q stated the resident was busy earlier so they placed the medication cup of pills in the top drawer for later use. When asked what medications were in the other unlabeled cup in the top drawer, Staff Q stated they were unsure as the cup of pills was there since their shift started.<br><br>In an interview on 06/13/2025 at 11:34 AM, Staff B stated it was their expectation a medication cup would be labeled if it had to be placed in the drawer and stated having medications pre-poured and unlabeled increased the risk for medication errors.<br><br>REFERENCE: WAC 388-97-1620(2)(b)(i)(ii), (6)(b)(i).<br><br>Based on observation, interview, and record review the facility failed to ensure: physician's orders were followed and/or clarified for 2 (Resident 31 & 9) of 6 sample residents, medications were not administered outside of ordered parameters for 2 (Resident 45 & 26) of 6 sample residents, and ensure 1 (Staff Q - Licensed Practical Nurse) of 4 staff reviewed, followed professional standards of practice during medication pass. These failures left residents at risk for unmet care needs, unnecessary treatments, and other negative health outcomes.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of a 01/2023 facility Medication Administration General Guidelines policy showed the following: medications would be administered in accordance with written orders of the prescriber; medications were to be administered at the time they were prepared; privacy would be provided as appropriate; residents were to be identified before medication was administered using at least two resident identifiers, and noting the resident's room number or physical location was not used as an identifier.<br><br><Following/Clarifying Physician Orders><br><br><Resident 31><br><br>Review of Resident 31's physician orders showed a 09/13/2024 order directing staff to obtain the resident's weight every 4 weeks.<br><br>Review of Resident 31's weight report showed no weights were obtained for the month of February 2025 or March 2025. Resident 31's February 2025 Treatment Administration Record (TAR) directed staff to obtain the resident's weight on 02/03/2025. Staff documented other/see progress notes but did not document a weight. Review of progress notes showed no documentation indicating why staff did not obtain the weight as ordered. Review of Resident 31's March 2025 TAR directed staff to obtain the resident's weight on 03/03/2025. Staff documented the weight was not obtained because the resident was sleeping. Resident 31's record showed staff did not attempt to obtain the weight later, when the resident was awake.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/12/2025 at 11:13 AM, Staff R (Resident Care Manager) stated it was their expectation staff followed physician orders and obtained residents weights as ordered.<br><br><Resident 9><br><br>Review of Resident 9's physician orders showed a 04/01/2025 order directing staff to administer an over-the-counter pain-relieving medication to the resident every six hours as needed for a pain level of 1 - 2/10. The physician orders showed a 04/03/2025 order directing staff to administer a narcotic pain relieving medication every 12 hours as needed for a pain level of 1 - 2/10. These orders did not specify which medication should be administered first since both medications were for the same level of pain.<br><br>Review of Resident 9's bowel protocol orders showed a 01/26/2024 physician order directing staff to administer a suppository to the resident if they did not have a bowel movement after receiving a liquid laxative. Further review of the resident's physician's orders showed their was no order for a liquid laxative to be administered. Resident 9's bowel protocol orders showed a 02/22/2024 for a powder laxative to be administered to the resident every 24 hours as needed for constipation. Resident 9 had a 02/22/2024 order for a tablet laxative to be administered every 24 hours as needed for constipation. There were no instructions directing staff on which stool softener should be administered before the other.<br><br>In an interview on 06/13/2025 at 11:34 AM, Staff R confirmed the as needed pain medication ordered required clarification. Staff R reviewed Resident 6's bowel protocol orders and confirmed the orders should be clarified so staff knew which medications to administer. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 24><br><br>According to a 05/09/2025 Quarterly MDS, Resident 24 had clear speech, was able to understand, and be understood by others. This MDS showed Resident 24 was dependent on staff for bathing, required substantial assistance from staff for personal hygiene, and had no rejection of care.<br><br>Review of a revised 02/29/2024 functional abilities Care Plan (CP) showed directions to staff for Resident 24 to have a shower twice weekly and the resident required assistance from staff for personal hygiene.<br><br>Observations on 06/08/2025 at 12:03 PM showed Resident 24 with facial hair on their chin and fingernails that extended past their fingertips with debris underneath. In an interview at this time, Resident 24 stated they preferred to be clean shaven and stated it was a couple of weeks since staff assisted them with shaving. Resident 24 stated they preferred their fingernails to be a lot shorter and stated, I have asked for help and I don't get it. Resident 24 stated they were only getting a bed bath once a week and preferred bathing more often. Similar observations of being unshaven with long dirty nails was noted on 06/10/2025 at 1:31 PM and 06/11/2025 at 10:44 AM.<br><br>Review of Resident 24's May 2025 ADL documentation showed staff documented the resident only received three out of the eight opportunities scheduled for bathing. Review of Resident 24's June 2025 ADL documentation showed staff documented the resident only received one out of the three opportunities scheduled for bathing.<br><br>In an observation with Staff H (Infection Preventionist) on 06/13/2025 at 11:01 AM, Staff H confirmed Resident 24 had untrimmed facial hair and fingernails. In an interview at this time, Staff H stated they expected staff to assist resident's as needed.<br><br>In an interview on 06/13/2025 at 1:03 PM, Staff R (Resident Care Manager) stated it was their expectation staff provide assistance with shaving, nail care, and bathing as needed and/or document if a resident refuses. <Resident 9><br><br>According to the 04/18/2025 Quarterly MDS, Resident 9 had severe cognitive impairment with a diagnosis of a progressive memory loss disorder. The MDS showed Resident 9 required substantial/maximal assistance from staff with personal hygiene including shaving.<br><br>Review of Resident 9's 03/07/2024 revised .Baseline Plan of Care CP directed staff to assist the resident with showers three times per week. The CP showed Resident 9 required substantial/maximal assistance with showering.<br><br>Observation on 06/09/2025 at 11:09 AM showed Resident 9 self-propelling in their wheelchair around the nurse's station. Resident 9 had several long, black chin hairs. Similar observations were made on 06/10/2025 at 1:56 PM, 06/11/2025 at 8:35 AM, 06/12/2025 at 9:41 AM, and on 06/13/2025 at 10:57 AM.<br><br>Review of Resident 9's June 2025 shower documentation showed the resident was only offered showers once per week and received a shower on 06/06/2025 and 06/13/2025.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/13/2025 at 11:27 AM, Staff R stated they expected staff to offer shaving to residents during their showers and as needed. Staff R stated they expected staff to document any refusals.<br><br><Resident 53><br><br>According to the 05/12/2025 admission MDS, Resident 53 had mild cognitive impairment and diagnoses including a brain bleed and weakness to one side of their body. The MDS showed Resident 53 required substantial/maximal assistance from staff for personal hygiene and that the resident did not receive showering/bathing assistance during the look back period.<br><br>Review of Resident 59's .Baseline Plan of Care CP showed two staff were to assist the resident with bathing once per week, on Wednesdays.<br><br>Observation on 06/09/2025 at 8:27 AM showed Resident 59 lying in bed. Their fingernails and toenails on their left side had dark debris underneath the nails.<br><br>In an observation and interview on 06/11/2025 at 10:48 AM, Resident 59 had dark debris under their finger and toenails on the left side. In an interview at that time, Staff P (Registered Nurse) confirmed the nails were dirty and needed to be cleaned.<br><br>Review of Resident 59's May 2025 bathing documentation showed the resident received two showers for the month of May, one on 05/10/2025 and the other on 05/20/2025.<br><br>Review of Resident 59's June 2025 bathing documentation on 06/12/2025 showed staff documented the resident received one shower on 06/04/2025, 15 days after their last shower on 05/20/2025.<br><br>In an interview on 06/13/2025 at 11:05 AM, Staff R stated it was their expectation staff follow the resident's CP and provide showers/bathing as care planned. Staff R stated they expected refusals to be documented if a resident refused the bathing assistance.<br><br><Resident 31><br><br>According to the 05/14/2025 Quarterly MDS, Resident 31 did not have cognitive impairment and had diagnoses including brain damage. The MDS showed Resident 31 had impairment to both arms and legs and was totally dependent on staff for bathing and personal hygiene.<br><br>Review of Resident 31's 04/26/2024 Functional Mobility Plan of Care CP showed staff were to assist the resident with showers twice weekly in the evening time.<br><br>In an interview on 06/09/2025 at 9:08 AM, Resident 31 stated they would love two or three showers per week, I get one if I am lucky.<br><br>Review of Resident 31's March 2025 bathing documentation showed staff were to provide the resident with showers on Monday and Friday evenings. Staff documented Not Applicable on seven of nine opportunities. Two of nine opportunities were left blank and staff did not document. Resident 31's March 2025 Bathing As needed order showed staff provided Resident 31 one shower for the month of March.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 31's April 2025 bathing documentation showed staff were to provide the resident showers on Monday and Friday evenings. On five of eight opportunities, staff documented Not Applicable. On one of eight opportunities, staff documented Resident 31 refused to have a shower. Staff documented Resident 31 received one shower for the month of April.<br><br>Review of Resident 31's May 2025 bathing documentation showed staff were to provide showers to the resident on Monday and Friday evenings. Staff documented Not Applicable on four of nine opportunities. Staff documented Resident 31 refused showers on two of nine opportunities, staff left two of nine shower opportunities blank and did not document. On one of nine opportunities, staff documented Resident 31 received a bed bath.<br><br>In an interview on 06/13/2025 at 11:05 AM, Staff R stated when staff documented Not Applicable it indicated staff did not offer the resident a shower and did not follow the plan of care for the resident. Staff R stated when a resident refused a shower, staff were supposed to approach the resident three times, if the resident continued to refuse, a refusal form was filled out and staff were supposed to report the refusal to management.<br><br><Resident 42><br><br>According to a 05/16/2025 Modified Quarterly MDS Resident 42 admitted to the facility on [DATE]. The MDS showed it was very important for Resident 42 to be able to choose between tub bath, bed bath, or showers. The MDS showed the functional ability and goals section dashed (-) on the assistance required for bathing assessment. The MDS showed Resident 42 required moderate assistance with hygiene.<br><br>Review of Resident 42's 11/12/2024 Baseline Plan of Care CP showed the resident preferred showers or bed baths one time a week on Sundays. The CP showed Resident 42 required moderate assistance with bathing.<br><br>Review of Resident 42's May and June 2025 bathing records showed no documentation of bathing offered.<br><br>In an interview on 06/08/2025 at 9:38 AM Resident 42 stated they did not receive a shower since admission to the facility. Resident 42 stated they requested several times for weekend showers and even spoke to the administrator, and they agreed to accommodate Sunday showers, but they were still not offered or received a shower.<br><br><Resident 222><br><br>According to a 06/10/2025 admission MDS, Resident 222 admitted to the facility on [DATE]. The MDS showed it was very important for Resident 222 to be able to choose between tub bath, bed bath, or showers. The MDS showed Resident 222 required moderate assistance with hygiene.<br><br>Review of Resident 222's 06/04/2025 Baseline CP showed they required staff assistance for bathing.<br><br>Review of Resident 222's June 2025 bathing records showed no documentation of bathing offered since admission.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/08/2025 at 12:28 PM Resident 222 stated they were not offered a shower since admission. Resident 222 stated staff gave them baby wipes and informed them they could clean themselves up with them.<br><br>In an interview on 06/13/2025 at 11:00 AM Staff B (Director of Nursing) stated they expected staff to offer bathing per the CP or residents request and document in the resident's records if they accepted, what type of bathing, or if the resident refused. Staff B stated residents records should not be left blank or documented NA. Staff B stated they expected staff to offer and assist residents per the CP with bathing. Staff B stated it was important to offer residents bathing for hygiene, skin breakdown, and infection prevention.<br><br>REFERENCE: WAC 388-97-1060(2)(c).<br><br>Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) related to bathing, shaving, nail care, and grooming for 7 of 7 dependent residents (Residents 64, 24, 9, 31, 53, 42, & 222) reviewed for ADLs. Failure to provide assistance with bathing, shaving, nail care, and grooming to residents who were dependent on staff for the provision of such care, placed residents at risk for unmet care needs, poor hygiene, decreased quality of care, and a diminished quality of life.<br><br>Findings included .<br><br><Personal Hygiene><br><br><Resident 64><br><br>According to the 05/06/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 64 was cognitively intact with clear speech, had no rejection of care behaviors and was dependent on staff for personal care including combing hair.<br><br>In an interview on 06/09/2025 at 2:05 PM, Resident 64 complained they did not have their hair combed since their admission to the facility.<br><br>Observations on 06/10/2025 at 10:23 AM showed Resident 64 had uncombed, greasy hair twisted into a bun on the top of their head. Resident 64's hair was matted in the back where their head touched the pillow.<br><br>Observations on 06/13/2025 at 11:12 AM showed Resident 64's hair was unbrushed. In an interview at this time, Resident 64 stated staff only brushed their hair on dialysis days, and they would not brush it thoroughly to remove mats from their hair.<br><br>Review of Resident 64's May and June 2025 ADL documentation showed no refusals of care for personal hygiene. Review of nursing assistant morning documentation for 05/02/2025, 05/04/2025, 05/09/2025, 05/13/2025, 05/15/2025, 05/19/2025, 05/23/2025, 05/24/2025, 05/26/2025, and 06/01/2025 showed staff did not provide assistance with personal hygiene to Resident 64. Review of nursing assistant evening documentation for 05/04/2025, 05/06/2025, 05/11/2025, 05/23/2025, 05/25/2025, and 06/01/2025 showed staff did not provide assistance with personal hygiene to Resident 64.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/13/2025 at 11:23 AM, Staff M (Licensed Practical Nurse) confirmed Resident 64's hair remained uncombed. Staff M stated they expected staff to assist dependent residents with ADLs daily upon waking in the morning and prior to residents' bedtime. Staff M stated residents had a right to care.<br><br>In an interview on 06/13/2025 at 12:52 AM, Staff J (Resident Care Manager) stated their expectation was that nursing assistants should receive report in the morning to better understand residents care needs for ADLs and then providing the care. Staff J stated Resident 64 had rejection of care behaviors. Staff J stated rejection of care behaviors should be reported to the nurse for further intervention and documented in the residents' record. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>Based on observation, record review, and interview, the facility failed to ensure treatments were done as ordered and documented by staff for 2 of 2 residents (Residents 52 & 28) reviewed for antibiotic use and 1 supplemental resident (Resident 47). Failure to change Intravenous (IV) dressings as ordered by the physician and as documented placed residents at risk for infection, skin impairment, and other negative health outcomes.<br><br>Findings included .<br><br><Facility Policy><br><br>According to a facility policy titled, Dressing Change for Vascular Access Devices, dated 08/2021, central venous access device dressings would be changed every seven days and as needed.<br><br><Resident 52><br><br>According to a 05/20/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 52 had a central IV access and was receiving IV antibiotic therapy. The MDS showed Resident 52 had a diagnosis of, but not limited to, an infection in their bone.<br><br>Review of Resident 52's health records showed a 05/18/2025 physician order to change IV dressing every seven days and as needed.<br><br>Review of Resident 52's Treatment Administration Records (TAR) showed the IV site dressing was signed as done on 06/01/2025 and 06/08/2025.<br><br>Observation on 06/09/2025 at 9:36 AM showed Resident 52's IV dressing with a last changed date of 05/31/2025.<br><br><Resident 28><br><br>According to a 05/28/2025 admission MDS Resident 28 had a central IV access and was receiving IV antibiotic therapy. The MDS showed Resident 28 had a diagnosis of, but not limited to, Sepsis (a life-threatening condition that arises when the body's response to an infection causes injury to its own tissues and organs).<br><br>Review of Resident 28's health records showed a 05/22/2025 physician order to change IV dressing every seven days and as needed.<br><br>Review of Resident 28's TAR showed the IV site dressing was signed as done on 06/01/2025 and 06/08/2025.<br><br>Observation on 06/09/2025 at 9:36 AM showed Resident 28's IV dressing with a last changed date of 05/31/2025.<br><br><Resident 47><br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | According to a 05/28/2025 admission MDS Resident 47 had a central IV access and was receiving IV antibiotic therapy. The MDS showed Resident 47 had a diagnosis of, but not limited to, infection of the heart chambers and valves. The MDS showed Resident 47 had a central IV line which was inserted directly into the heart valve for treatment of the heart infection.<br><br>Review of Resident 47's health records showed a 04/21/2025 physician order to change IV dressing every seven days and as needed.<br><br>Review of Resident 47's TAR showed the IV site dressing was signed as done on 06/01/2025.<br><br>Observation on 06/09/2025 at 9:36 AM showed Resident 47's IV dressing with a last changed date of 05/31/2025.<br><br>In an interview on 06/09/2025 at 10:01 AM Staff G (Regional Director of Clinical Operations) observed the IV dressings for Residents 52, 28, & 47 and confirmed the last changed date of 05/31/2025. Staff G stated they expected staff to change central IV dressings weekly and as needed. Staff G stated it was important to change central IV dressings weekly and when staff signed the residents TAR that they had changed the dressing to decrease the risk of skin complications, infections, and ensure residents were receiving appropriate care.<br><br>Reference: WAC 388-97-1060 (1).<br><br>. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>Based on observation, interview, and record review the facility failed to ensure residents received proper assistive devices to maintain vision and hearing abilities for 1 (Resident 46) of 2 residents reviewed for hearing services. Failure to ensure Resident 46 received assistance in obtaining hearing devices placed this resident at risk for a decline in hearing abilities and frustration.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of an updated July 2015 Clinical and Support Services policy showed the social services department would assist residents in obtaining needed clinical and support services. This policy showed social services would coordinate services with the nursing department and maintain a list of individuals requiring hearing services.<br><br><Resident 46><br><br>According to a 07/05/2024 admission Minimum Data Set (an assessment tool) Resident 46 had adequate hearing with the use of a hearing aid.<br><br>Review of a 05/30/2024 baseline care plan showed instructions to staff that Resident 46 was hard of hearing in both ears and had hearing aids for both ears.<br><br>In an interview on 06/09/2025 at 9:54 AM, Resident 46 stated they used to wear hearing aids in both ears but indicated their right one broke after it fell out and they accidentally stepped on it. Resident 46 stated it happened last year and staff were going to set them up for an appointment to get it fixed. Resident 46 stated, I never heard another word about it.<br><br>Observation on 06/12/2025 at 9:28 AM showed Resident 46 wearing a hearing aid in their left ear only.<br><br>Review of a 07/17/2024 social services progress note showed staff documented Resident 46 reported they found their right hearing aid on the floor near their bed broken in two pieces. Staff documented the resident care manager and director of nursing were advised.<br><br>Record review showed no further information regarding setting up an appointment or assisting Resident 46 with obtaining a replacement for their broken hearing aid.<br><br>In an interview on 06/13/2025 at 9:26 AM, Staff C (Social Services Director) stated they were unaware of any residents that had broken hearing aids and required a referral. Staff C stated they did not believe Resident 46 wore hearing aids.<br><br>In an interview on 06/13/2025 at 2:54 PM, Staff R (Resident Care Manager) stated they thought Resident 46 had hearing aids but would not wear them. Staff R stated they were unaware of any referrals for Resident 46's hearing aids.<br><br>(continued on next page) |

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| | 505400 | A. Building<br>B. Wing | 06/13/2025 |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/13/2025 at 11:34 AM, Staff G (Regional Director of Clinical Operations) stated it was their expectation appointment referrals be followed up on by staff.<br><br>REFERENCE: WAC 388-97-1060(3)(a).<br><br>. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 3><br><br>According to an 04/25/2025 Quarterly MDS, Resident 3 had multiple medically complex diagnoses, was dependent on staff for wheelchair mobility, and had a history of falling.<br><br>In an interview on 06/09/2025 at 10:18 AM, Resident 3's family stated they were concerned about the resident having recent falls.<br><br>Observations on 06/09/2025 at 12:38 PM, showed Resident 3 lying in bed with their call light in reach.<br><br>Review of a 01/05/2025 12:00 PM facility incident report showed Resident 3 had a fall in their room. This report showed staff were educated not to leave Resident 3 in their room alone and an intervention was added to their CP to place the resident in a wheelchair near the nurse's station and to encourage them to participate in activities of choice. On 01/20/2025 at 6:30 PM, Resident 3 had another fall and was found on the floor in their room with their wheelchair behind them. This report showed staff were again educated that if Resident 3 was sitting in their wheelchair they, were to remain in the hallway or by the nurse's station, a new intervention was added to place the resident on assisted dining for assistance with meals.<br><br>In an interview on 06/13/2025 at 11:34 AM, Staff B stated it was their expectation staff follow fall interventions in order to decrease the risk for further falls and indicated the fall interventions for Resident 3 needed to be clarified and updated.<br><br><Resident 26><br><br>According to an 04/16/2025 Significant Change MDS, Resident 26 had a history of repeated falls, had a fall with injury since the previous assessment, and required substantial assistance with transfers.<br><br>Observations on 06/08/2025 at 12:21 PM, 06/10/2025 at 1:04 PM, and 06/12/2025 at 9:23 PM showed Resident 26's bed positioned away from the wall.<br><br>Review of Resident 26's functional abilities CP showed safety directions to staff for the resident's bed to be against the wall for safety and to maximize living space.<br><br>In an interview on 06/13/2025 at 11:34 AM, Staff B stated Resident 26's safety CP interventions needed to be updated and revised to reflect the current interventions.<br><br>Refer to F610 - Investigate/Prevent/Correct Alleged Violation.<br><br>REFERENCE: WAC 388-97-1060(3)(g).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview, and record review, the facility failed to initiate interventions to prevent continued falls for 4 of 7 residents (Resident 28, 42, 3, & 26) reviewed for falls. This failure placed residents at risk of continued falls, potential neglect, and other negative health outcomes.<br><br>Findings included .<br><br><Facility Policy><br><br>According to a facility policy titled, Resident Falls Management, when a resident had a fall the facility would develop an appropriate plan to minimize recurrence. The policy showed the facility would evaluate and modify plans to prevent the recurrence of falls.<br><br><Resident 28><br><br>According to a 05/28/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 28 admitted to the facility on [DATE] with no memory impairment. The MDS showed Resident 28 had a history of falls.<br><br>Review of a 05/21/2025 Resident is Moderate Risk for Falls related to Deconditioning Care Plan (CP) showed staff would ensure Resident 28 was wearing appropriate footwear. Review of a 05/29/2025 resident had an actual fall CP showed an intervention continue interventions on the at risk plan with no new added interventions related to this fall to prevent future falls.<br><br>In an observation and interview on 06/09/2025 at 9:28 AM Resident 28 had a dressing on their left knee. Resident 28 stated their feet got caught up when walking back from closing their window blinds and they fell. Resident 28 stated they did call for staff but nobody came so they got out of bed on their own to close the blinds.<br><br><Resident 42><br><br>According to an 11/18/2024 admission MDS Resident 42 was dependent on staff for bed to chair transfers. The MDS showed Resident 42 had a diagnosis of, but not limited to, paralysis of the lower half of the body.<br><br>Review of Resident 42's 12/26/2024 High Risk for Falls related to Paralysis CP, staff would anticipate and meet the needs of the resident. Review of Resident 42's 05/22/2025 .had an actual fall with no injury CP showed continue interventions on the at risk plan with no new interventions related to the 05/22/2025 fall added.<br><br>In an observation and interview on 06/09/2025 at 10:23 AM Resident 42 was lying in bed with bilateral above the knee amputations. Res 42 stated they fell after staff placed them in their wheelchair crooked and they attempted to reposition themselves. Resident 42 stated the wheelchair tipped over backward and they hit their head so hard on the corner of the wall.<br><br>In an interview on 06/13/2025 at 1:32 PM Staff B (Director of Nursing) stated no new interventions were documented for prevention of future falls for Residents 28 and 42 but should have been. Staff B stated it was important after a resident had a fall to evaluate and add new interventions to prevent similar future falls for resident safety. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and record review the facility failed to ensure Narcotic Ledgers were accurate for 2 of 2 Narcotic Ledgers (500 cart & 200/300 cart) reviewed for accuracy. Failure to ensure accurate account of resident narcotic medications placed residents at risk for uncontrolled pain, decreased quality of life, and possible diversion of controlled substances.<br><br>Findings included .<br><br><Facility Policy><br><br>According to the facility policy titled, Controlled Substances, dated 01/2023, the facility would establish a system of records to ensure accurate reconciliation to account for all controlled drugs. The policy showed at each shift change, a physical inventory of controlled medications would be conducted by two licensed staff and documented on the record. The policy showed any discrepancies in controlled substances would immediately be reported to Staff B (Director of Nursing). The policy showed controlled medications removed from a Narcotic Ledger would include the signatures of the nurse releasing the medication and the nurse or resident receiving the card of medication.<br><br><500 cart><br><br>Observation and record review on 06/11/2025 at 5:19 AM showed page 60 of the Narcotic Ledger for 500 cart with 21 tablets remaining but no card of the medication on the cart. In an interview at this time Staff O (Registered Nurse) stated they had not caught this missing card when they counted the controlled medications with the day shift. Staff O stated they are expected to go page by page throughout the Narcotic Ledger to ensure accuracy but only counted the physical cards in the lock box. Staff O stated it was important to account for every page in the Narcotic Ledger to ensure no cards of medication were missing.<br><br><200/300 cart><br><br>Observation and record review of 200/300 cart Narcotic Ledger on 06/12/2025 at 10:20 AM showed the following discrepancies:<br><br>Page 1 - 63 tablets with one nurse initials transferred to another unit, not the required releasing and receiving nurse.<br><br>Page 2 - 60 tablets with one nurse initials transferred to another unit, not the required releasing and receiving nurse.<br><br>Page 3 - 36 tablets with one nurse initials transferred to another unit, not the required releasing and receiving nurse.<br><br>Page 4 - 4 Milliliters (ml) with one nurse initials transferred to another unit, not the required releasing and receiving nurse.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Page 5 - 79 tablets with one nurse initials transferred to another unit, not the required releasing and receiving nurse.<br><br>Page 6 - 18 tablets with one nurse initials transferred to another unit, not the required releasing and receiving nurse.<br><br>Page 8 - no name of medication or Prescription (rx) #, 84 ml with one nurse initials transferred to another unit, not the required releasing and receiving nurse.<br><br>Page 9 - no name of medication or rx #, 240 ml with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 12 - no rx #, 30 tablets with a line crossed through the whole page, no nurse signature for medication card transfer.<br><br>Page 16 - 68 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 21 - 13 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 22 - 39 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 23 - no rx #, 14 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 24 - no rx #, 8 remaining (form unidentified) with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 26 - 26 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 27 - 12 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 31 - 60 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 32 - 30 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 33 - 60 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 34 - 30 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Page 35 - 10 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 36 - 8 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 40 - 20 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 41 - 20 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 43 - no rx #, 32 tablets with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 44 - no rx #, 10 bottles with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>Page 45 - no rx #, 23 remaining (form unidentified) with one nurse initials transferred to another unit not the required releasing and receiving nurse.<br><br>In an interview on 06/12/2025 at 10:20 AM Staff N (Licensed Practical Nurse) stated there was no cards for these pages. Staff N stated both the releasing and receiving nurse should have signed the Narcotic Ledger but they did not. Staff N they were expected to go page by page in the Narcotic Ledger to ensure all controlled medications were accounted for but did not. Staff N stated it was important to go page by page to catch any missing cards of medications.<br><br>In an interview on 06/13/2025 at 11:03 AM Staff B stated they expected staff to go page by page in the Narcotic Ledger when counting controlled substances to ensure no cards were missing. Staff B stated when a medication was transferred to another cart or sent home with a resident they expected both the releasing medication nurse and the receiving nurse or resident to sign the amount transferred in the Narcotic Ledger. Staff B stated this was important in prevention of Narcotic diversion and accounting for controlled medications.<br><br>Reference: WAC 300-97-1300(1)(b)(i-ii).<br><br>. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 Percent (%). Failure to properly administer 5 of 28 medications for 2 of 5 residents (Resident 43 & 13) observed during medication pass resulted in a medication error rate of 17.86%. This failure placed residents at risk for not receiving the correct dose or receiving less than the intended therapeutic effects of physician ordered medication.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of a 01/2023 facility Medication Administration General Guidelines policy showed the following: medications were to be administered in accordance with written orders of the prescriber; If necessary, the nurse contacts the prescriber for clarification. This policy showed prior to medication administration, the nurse would review and confirm medication orders for each individual resident on the Medication Administration Record (MAR) with the medication label, if different, the prescriber's orders would be checked for the correct dosage schedule and labeled.<br><br><Resident 43><br><br>Observation of medication pass on 06/11/2025 at 8:53 AM showed Staff P (Registered Nurse) prepare and administer multiple medications to Resident 43, including a pain medication patch to their left hip. At the time of administration, Resident 43 requested the patch to be applied to their left hip.<br><br>Review of a June 2025 MAR revealed directions to staff to administer the pain medication patch to Resident 43's right shoulder, rather than to the left hip as administered.<br><br>In an interview on 06/11/2025 at 9:05 AM, Staff P stated they should have clarified the physician's order prior to administering the patch to a location different than directed in the order.<br><br><Resident 13><br><br>Observation of medication pass on 06/12/2025 at 9:45 AM showed Staff Q (Licensed Practical Nurse) prepare and administer multiple medications to Resident 13, including a low dose chewable medication used to prevent heart attacks, 25 milligrams (mg) of a blood pressure medication, and 30 mg of an antidepressant. Staff Q did not apply a pain medication gel during the observation.<br><br>Review of a June 2025 MAR revealed directions to staff to administer an enteric (special coating to slow the release of a medication) coated low dose medication used to prevent heart attacks, rather than the chewable form that was administered by staff. The blood pressure medication showed directions to administer 75 mg, rather than the 25 mg that was administered. The antidepressant medication showed directions to administer 60 mg, rather than the 30 mg administered by staff. This MAR showed staff documented they administered a pain medication gel to Resident 13's shoulder, however no gel was administered during the med pass observations.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/12/2025 at 10:42 AM, Staff B (Director of Nursing) stated it was their expectation nursing staff complete the seven rights of medication administration, which included assuring the right medication, the right dose, and the right route were followed prior to administration. Staff B stated physician orders should be followed and administered as prescribed.<br><br>REFERENCE: WAC 388-97-1060(3)(k)(ii).<br><br>. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <100 Unit><br><br><Resident 44><br><br>Review of Resident 44's 06/09/2025 physician orders showed the resident did not have an order directing staff to keep medications at the resident's bedside.<br><br>Observation on 06/08/2025 at 8:33 AM showed a topical pain-relieving patch on Resident 44's nightstand.<br><br>Observation on 06/13/2025 at 10:32 AM showed the topical pain-relieving patch remained on Resident 44's nightstand. In an interview at that time, Staff P (Registered Nurse) stated the topical pain-relieving patch should not be left on the resident's nightstand. Staff P removed the unsecured patch from the resident's room.<br><br>Reference: WAC 388-97-1300(2), -2340.<br><br>Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 2 of 2 medication carts (Medication carts 200/300 & 500), 1 of 1 medication rooms (Medication room [ROOM NUMBER]), and 3 of 3 units (Units 500, 200/300, & 100), 3 of 3 residents (Resident 11, 32 & 44) observed for medication storage. This failure placed residents at risk for receiving expired medications, ineffective treatment, accidental ingestion of medication, and a diminished quality of life.<br><br>Findings included .<br><br><Facility Policy><br><br>According to a facility policy titled, Medication Storage, dated 01/2023, the facility would store medications properly, following manufacturer or provider pharmacy recommendations, to maintain their integrity and effectiveness. The policy showed staff would date insulin products and nasal sprays upon opening for initial use and discard medications with shortened dates. The policy showed medication and supplies would be stored in a locked medication cart or room only licensed nurses would have access to.<br><br>According to a facility policy titled, Enteral Feeding Tube, dated 05/2025, containers of tube feeding formula opened and not used in their entirety were to be labeled with the time and date, covered, and kept in the refrigerator when not in use.<br><br><200/300 Medication Cart><br><br>(continued on next page) |

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an observation, record review and interview on 06/12/2025 at 10:20 AM, medication cart 200/300 showed one nasal spray opened on 04/21/2025, three opened nasal sprays without documentation of the open date on them, and one insulin pen opened without documentation of the open date on it. Staff N (Licensed Practical Nurse) stated the 04/21/2025 nasal spray should be discarded after 30 days of opening, the three bottles of nasal spray opened and being used should have an open date documented on them to ensure not administering past the 30 day limit for nasal sprays, and the one insulin pen should also have an open date documented on it to ensure it was discarded after 28 days of opening. Staff N stated it was important to discard nasal sprays after 30 days of opening and insulin after 28 days of opening to ensure effective treatment for these types of medications.<br><br><500 Medication Cart><br><br>In an observation, record review, and interview on 06/11/2025 at 5:19 AM, 500 medication cart showed a card of 30 tablets of a medication used to treat high blood pressure with an expiration date of 06/01/2025, another card of 75 tablets for high blood pressure expired on 05/21/2025, and nine bottles of medicated creams that are to be applied to the skin stored next to medications that are to be inhaled into the lungs. Staff O (Registered Nurse) stated the expired medications should not be destroyed to ensure staff were not administering them. Staff O stated skin creams should be separated from inhaled medications and stored on the treatment cart for infection prevention.<br><br><500 Medication Room><br><br>In an observation, record review, and interview on 06/11/2025 at 5:09 AM, 500 medication room showed two bottles of vitamins expired on 05/20/25, 32 syringes expired on 04/06/2024, 23 needles expired on 03/09/2023, and an intravenous device stabilizer expired on 02/28/2024. Staff O stated these medications and supplies should be discarded by the expiration date and not stored in the medication room. Staff O stated it was important to discard expired medications and supplies to ensure that residents were not receiving expired medications or treatments.<br><br>In an interview on 06/13/2025 at 11:03 AM Staff B (Director of Nursing) and Staff G (Regional Director of Clinical Operations) stated their expectations of staff were to remove and destroy expired medications and supplies upon expiration. Staff B stated they expected staff to date nasal sprays upon opening and discard in 30 days of opening and date insulin upon opening and discard in 28 days after opening.<br><br><500 unit><br><br>In an observation, record review, and interview on 06/11/2025 at 10:22 AM, room [ROOM NUMBER] had multiple wound care supplies stored on their nightstand to include wound cleanser sprays and medicated skin protectant sprays.<br><br>In an interview on 06/13/2025 at 9:32 AM Staff H (Infection Preventionist) stated they stored the wound care supplies in the residents room to prevent infection and to ensure all staff had access to the supplies. Staff H stated the nurses that required access to the supplies did have access to the locked treatment supply cart and there wasn't a concern of contamination of the supplies in the treatment cart. Staff H stated it was important to store wound care supplies in the locked treatment cart to prevent infection and for the safety of other residents.<br><br>(continued on next page) |

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| | 505400 | A. Building<br>B. Wing | 06/13/2025 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 06/13/2025 at 11:06 AM Staff B stated they expected staff to store wound care supplies in the locked treatment cart and not in resident rooms. Staff B stated it was important to prevent contamination of the supplies and for resident safety.<br><br><Medications At Bedside><br><br><Resident 11><br><br>Observation on 06/11/2025 at 7:33 AM showed a container of topical anti-fungal cream and a container of anti-fungal powder on Resident 11's bedside cabinet. Resident 11's name was on the label.<br><br>Review of Resident 11's 06/10/2025 physician orders showed the resident did not have an order directing staff to keep medications at bedside.<br><br><Resident 32><br><br>Observations on 06/11/2025 at 7:35 AM showed a half-full container of tube feeding formula on Resident 32's bedside cabinet. The container was not labeled with Resident 32's name, date opened or timed.<br><br>Review of Resident 32's health records showed a 05/07/2025 physician order to administer 300 ml of tube feeding formula two times a day at 8:00 AM and 8:00 PM.<br><br>In an interview on 06/11/2025 at 7:35 AM, Staff I (Registered Nurse) stated that medications and opened containers of tube feeding formula should not be left in the residents' rooms. Staff I stated that topical medications should be dispensed into disposable cups prior to entering the resident's room and bottles should remain in the medication cart. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review the facility failed to store, prepare, and serve food under sanitary conditions. Failure to ensure food items in the dietary department were properly stored, labeled, and out-of-date foods were identified and discarded, staff used appropriate hand washing and sanitation, placed residents at risk for consuming expired/contaminated foods, and potential exposure to food-borne illness.<br><br>Findings included .<br><br><Facility Policy><br><br>According to the facility's updated October 2017 Food Storage policy, food storage areas would be kept clean at all times. The policy showed all food received by the facility would be dated with the month and year, except for perishable food with use-by dates of 30 days or less. The policy showed cold foods must be held at 41 degrees Fahrenheit (F) or less. The policy showed opened food packages must have a use-by date.<br><br>The facility's updated October 2017 Food Temperature policy showed dietary staff should measure and record the temperature of all potentially hazardous foods served and ensure hot foods remained above 140 F and cold foods remained at 41 F or less.<br><br><Initial Rounds><br><br>During initial observations of the kitchen on 06/08/2025 at 8:15 AM the following was observed in the facility's walk-in refrigerator:<br><br>-a bag of cut carrots with a use-by date of 05/18/2025, sixteen days prior.<br><br>-an unsealed storage bag with sliced cheese inside, dated to be used by 08/02/2025.<br><br>-an unsealed storage bag of cooked chicken, dated to be used by 06/20/2025.<br><br>-two opened packages of pork without a date indicating when they were opened or when they should be used by.<br><br>-an open package of a ham loaf without a date indicating when it was opened or when it should be used by.<br><br>-two opened packages of boiled eggs without a date indicating when they were opened or when they should be used by.<br><br>-two sealed packages of sliced roast beef with a received date of 4/25 without a use by date.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In an interview on 06/08/2025 at 8:15 AM, Staff FF (Dietary Cook) stated the bag of carrots needed to be removed and all the food should be sealed for storage. Staff FF stated they were unable to tell how long the unlabeled food packages were in the refrigerator and stated they should be dated when opened and include the use by date.<br><br>During initial observations of the kitchen on 06/08/2025 at 8:15 AM the following were observed stored on the same shelf next to each other: A bottle of sink and surface sanitizer with a label that said, keep out of reach of children sitting next to a bottle of powdered protein powder and a bottle of a lemon-flavored dietary supplement.<br><br>Observation on 06/08/2025 at 8:41 AM showed Staff JJ (Registered Nurse) walk into the kitchen, pass the yellow tape marked on the floor, went to a counter with a toaster to prepare food, and then over towards some dry food product storage bins. Staff JJ was not wearing a hair net.<br><br>Observations on 06/11/2025 at 9:20 AM with Staff GG (Dietary Manager) showed the same unsealed storage bag with sliced cheese previously observed on 06/08/2025 and a new unsealed bag of turkey breast. In an interview at this time, Staff GG stated it was their expectation food was sealed and labeled with the use by and open dates for food safety and so staff knew which items to use first.<br><br><Food Preparation><br><br>Observations at 06/11/2025 at 9:42 AM showed an open container filled with mushrooms soaking in water being set on a counter next to a bucket of sanitizer by Staff GG. Staff GG was observed washing their hands. While Staff GG dried their hands with a paper towel, their hands passed over and dripped above the open container of mushrooms when they went to throw the paper towels away in a garbage can. Staff GG then moved the container of mushrooms to another counter next to dirty containers of raw egg residue.<br><br>In an interview on 06/11/2025 at 10:15 AM, Staff GG stated their expectation was for dirty items to be kept on the left side of the sink bins and indicated food should not be stored with dirty items on the counter to the left side.<br><br>Observation on 06/11/2025 at 9:54 AM showed Staff II (Dietary Aide) scraping broccoli into a rinsing bin from a large produce box. Staff II removed their glasses, wiped their mouth with the back of their hand and returned the broccoli box to the walk-in refrigerator before washing their hands.<br><br>Observation on 06/11/2025 at 10:04 AM showed Staff HH (Dietary Cook) patting and molding raw ground meat on a sheet pan right next to an open cart of clean trays. Pieces of raw meat were observed splattering out on to the nearby surfaces. This was observed at the same time by Staff GG who told staff to rewash the entire cart of clean trays.<br><br>Observation on 06/11/2025 at 10:07 AM showed Staff HH place the sheet pan of raw meat on top of a lid and shelf of the steam table. Staff HH then placed the pan in the oven and did not sanitize the steam table counter after coming in contact with the sheet pan used for the raw meat. Staff HH removed their gloves, at the same level as the the food rinsing bin and counter area, raw meat was observed to splatter off of the gloves when staff removed them.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observation on 06/11/2025 at 10:08 AM showed Staff II wipe their nose with the back of their gloved hand before picking up a carton of milk to use in a can of cream of mushroom soup. Staff II lifted the lid of the pot of soup before adding the milk.<br><br><Food Service><br><br>Observation of lunch service on 06/11/2025 at 11:32 AM showed Staff HH measuring the temperature of the chilled drinks and dishes prepared for the lunch. Staff HH measured the temperature of the glasses of milk as 49 F, eight degrees F higher than the facility's policy stated was a safe holding temperature. The glasses of juice were at 45 F, and two desserts were at 44 F, all over 41 F. A plate of salad was measured at 55 F, 14 F higher than the policy showed was safe.<br><br>Observation on 06/12/2025 at 11:50 AM showed the green handle of a ladle, previously touched with soiled hands, submerged in the brussel sprout pan it was placed in. Kitchen staff did not replace the dish At this time Staff GG was observed to measure more temperatures. Desserts were measured at 43 F and a second at 45.5 F. After measuring a glass of milk at 42 F, Staff GG wiped the thermometer with a dry rag before measuring a glass of juice at 42 F. Staff GG then recorded the temperature of a dessert at 55 F and a juice at 45 F, without sanitizing the thermometer between use. The dietary staff then began placing the drinks and desserts on to trays to distribute to residents, and placing the trays in carts to send out to the units. The lunch cart doors were closed and was heading to the unit to be delivered when the surveyor stopped to request a temperature check of one of the loaded trays for a resident. Staff GG tested the cold dessert from the tray which measured at 45 F, four degrees F higher than the policy showed was safe. At this time Staff GG confirmed cold food should be held at 41 F or lower and started pulling all of the drinks, desserts, and salads and placed the items in the freezer to cool.<br><br>Observation on 06/12/2025 at 12:22 PM showed Staff GG re-enter the kitchen and head directly to the walk-in refrigerator. Staff GG did not wash their hands when they entered.<br><br>Observation on 06/12/2025 12:55 PM showed a member of the nursing staff enter the kitchen and take several steps past the yellow tape placed just inside the door before putting on a hairnet. The tape was placed on the floor to indicate the point beyond which staff entering the kitchen must wear a hairnet.<br><br>Observation on 06/12/2025 12:57 PM showed Staff GG preparing food on a counter with dirty trays placed on the same work surface.<br><br>Observation on 06/12/2025 at 1:34 PM of the tray service showed Staff HH resting their elbows on the steam table counter in between preparing food plates, then placed tongs being used for food service on the steam table, without sanitizing the counter.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In an interview on 06/13/2025 at 9:09 AM, Staff GG stated it was important for all staff who entered the kitchen beyond the yellow taped area by the door, to secure their hair in hair net, and that food was not left by dirty dishes to minimize the risk of food contamination. Staff GG stated dietary staff should wash their hands before preparing food and after any contact with potential food contaminants, including after touching their faces, using the bathroom, re-entering the kitchen, touching doors, and any other high contact surfaces in order to minimize the risk of food borne illness. Staff GG stated staff should not remove gloves contaminated with raw meat in the immediate proximity of food preparation areas such as the food rinsing bin and counter area, as raw meat was observed to splatter when staff removed their gloves. Staff GG stated the tray with raw meat should not be placed on the steam table counter without proper sanitation afterwards. Staff GG stated staff should not wipe their noses on the back of their gloved hands and then touch a milk container. Staff GG stated when serving food, staff should not touch residents' plates with their thumbs, place tongs on the soiled counter, or let scoops fall into the bins and come in contact with the food after being handled with bare, soiled hands. Staff GG stated cold foods must be held at a temperature of 41 F or lower. Staff GG stated when monitoring the temperature of food, staff should use an alcohol wipe to sanitize the thermometer between dishes, not a cloth or paper towel.<br><br>REFERENCE: WAC 388-97-1100 (3).<br><br>. |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or get specialized rehabilitative services as required for a resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure specialized rehabilitative services were provided as determined by the physician's orders for 1 (Resident 53) of 2 residents who were reviewed for position/mobility. This failure placed residents at risk for decline in physical and functional mobility, and a diminished quality of life.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of the facility's, Therapy Evaluation Time Line policy dated 06/2010, showed upon receiving the physician's order for a therapy evaluation, the resident would be seen and evaluated by the therapy department in a timely manner (within 48 hours .).<br><br><Resident 53><br><br>According to the 05/12/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 53 admitted to the facility from another long term care facility and had moderate cognitive impairment indicating some difficulties with thinking and processing. The MDS showed Resident 53 had a diagnosis of a brain bleed with severe weakness to the right side of their body. The MDS showed the resident did not receive restorative nursing services or any skilled therapy services including physical, occupational, or speech therapy during the assessment period.<br><br>In an observation and interview on 06/09/2025 at 8:22 AM, Resident 53 was lying in bed awake. Resident 53's right arm and leg were resting loosely on the bed. Resident 53 stated they were sitting there wasting away and their right arm and leg did not work. Resident 53 stated they were not doing therapy or an exercise program with staff. Resident 53 stated if they had ways of getting around, I would be much better. Similar observations were made on 06/11/2025 at 10:48 AM and on 06/12/2025 at 1:43 PM.<br><br>Review of Resident 53's 05/07/025 baseline care plan showed the resident required assistance from two staff members for activities of daily living including bathing, changing position from lying down to sitting up, rolling side to side, and with toileting assistance. The care plan directed staff to turn and reposition Resident 53 routinely.<br><br>Review of Resident 53's physician orders showed a 05/09/2025 order for physical therapy, occupational therapy, and speech therapy to evaluate and treat the resident as indicated.<br><br>Review of Resident 53's comprehensive record on 06/12/2025 showed no documentation indicating the resident was evaluated or treated by the therapy department as ordered.<br><br>In an interview on 06/12/2025 at 12:17 PM, Staff F (Therapy Director) stated the facility attempted to get pre-authorization from Resident 53's insurance company on admission in order to evaluate the resident, but Staff D believed the authorization did not go through and stated they needed to follow up.<br><br>(continued on next page) |

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| F 0825<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 06/12/2025 at 12:47 PM, Staff E (Business Office Manager) reviewed Resident 53's records and insurance information. Staff E stated Resident 53's insurance did not require a pre-authorization in order for the therapy department to evaluate the resident and stated the resident was eligible for evaluation by the therapy department since their admission to the facility on [DATE], more than a month prior. Staff E provided email documentation dated 05/10/2025 that was sent to Staff F, indicating Resident 53 was able to be evaluated by therapy.<br><br>In an interview on 06/12/2025 at 3:01 PM, Staff F stated it was their expectation resident's were seen by the therapy department within 24 - 48 hours of receiving a physician's order for evaluation. Staff F stated we missed that one regarding evaluating Resident 53 as ordered by the physician. Staff F stated it was important to be prompt with therapy evaluations so the resident did not experience a delay in cares or further deficit.<br><br>REFERENCE: WAC 388-97-1280 (1)(a-b), (3)(a-b).<br><br>. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br><Unit 500><br><br>Observation on 06/12/2025 at 9:50 AM showed a unit 500 nurse run sheet left unattended in view on the unit 500 medication cart. The unit 500 nurse run sheet included resident's names, room number, and diagnoses on it.<br><br>In an interview on 06/12/2025 at 9:52 AM Staff W (Licensed Practical Nurse) stated the nurse run sheet should be protected and not visible for all. Staff W stated it was important to protect PHI for resident rights.<br><br>In an interview on 06/13/2025 at 11:02 AM Staff A (Administrator), Staff B (Director of Nursing), and Staff G (Regional Director of Clinical Operations) stated they expected staff to protect residents PHI for residents rights to privacy.<br><br>Reference: WAC 388-97-1720(1)(c), -0360(1-3).<br><br>Based on observation, interview, and record review the facility failed to keep all Protected Health Information (PHI) out of view from unauthorized individuals for 2 of 3 units (Units 200/300 and 500). This failure placed residents at risk for a violation of their right to privacy.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of the facility's admission agreement, dated 09/2023, showed the facility would implement appropriate measures to protect and maintain confidentiality of all residents' PHI.<br><br><Unit 200/300><br><br>Observation on 06/10/2025 at 10:29 AM showed a printed document titled 200 & 300 & 501-506 Hall Nurse Run Sheet was left unattended on the medication cart with viewable PHI including full names, room numbers, and diagnoses of 15 residents from Units 200 and 300. Nursing staff were not observed near the medication cart or in the hallway.<br><br>In an interview on 06/10/2025 at 10:32 AM, Staff I (Registered Nurse) confirmed they left the unit roster unattended on the medication cart with PHI visible. Staff I stated PHI should not be visible to unauthorized individuals. Staff I stated all residents had a right to privacy and PHI protection. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Hand Hygiene><br><br><Dining><br><br>Observations of meal tray pass on 06/08/2025 at 12:53 PM, showed Staff V delivering a lunch tray to a resident in room [ROOM NUMBER]. While in the room, Staff V touched items on the bedside table and exited the room without performing HH. Staff V then wiped their face with their hand, picked up another tray, delivered the tray to a resident in room [ROOM NUMBER], and exited the room without performing HH. At that time, Staff V approached a resident in a wheelchair and pushed them to room [ROOM NUMBER]. At 12:59 PM, Staff V picked up another tray to deliver to a resident in a room with TBP. Staff V did not perform HH since observations started at 12:53 PM.<br><br>In an interview on 06/13/2025 at 10:42 AM, Staff H stated it was their expectation staff complete HH before entering resident rooms, after touching items in a resident's room, and after exiting rooms. Staff H stated HH was important in reducing the risk of spreading diseases.<br><br><Medication Pass><br><br>Continuous observations during a medication pass on 06/12/2025 between 9:41 AM and 10:31 AM showed Staff Q pull out a medication bingo card from the cart and pop one of the pills into their bare hands. Staff Q then put the pill into a cup, went into the resident's room and administered it to the resident. While in the room, Staff Q touched items and surface areas, then without performing HH, exited the room to return to the medication cart. Staff Q began preparing medications for another resident, including an inhaler, and eye drops. Staff Q put on a pair of gloves, approached the resident, handed them the inhaler to self-administer, administered the resident's eye drops, and removed their gloves without performing HH. Staff Q retrieved the inhaler from the resident, put it into their shirt pocket, and walked into another resident's room prior to returning to the medication cart. Staff Q took the inhaler out of their pocket, returned it to the cart, and did not perform HH. Staff Q began preparing another resident's medications by popping the pills from bingo cards into their soiled hands, which were not sanitized since the start of the medication pass observation. Staff Q went into a different resident's room, administered the medications, exited the room without performing HH, and returned to the cart. Staff Q was observed wiping their nose with a tissue, and without performing HH afterwards, applied a medication patch on a resident. Staff Q returned to the cart, used their cell phone, and did not perform HH before popping pills from medication bingo cards into their still soiled, bare hands.<br><br>In an interview on 06/12/2025 at 10:42 AM, Staff B stated there should be no direct handling of medications by staff and stated it was their expectation staff placed medications directly into a cup during preparations.<br><br>REFERENCE: WAC 388-97-1320(1)(c)(2)(b).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on observation, interview, and record review the facility failed to ensure staff followed Contact Precautions (a type of isolation used to prevent spread of infections) for 3 of 4 residents (Residents 52, 47, & 32) reviewed for Transmission Based Precautions (TBP), ensure proper Hand Hygiene (HH) was performed by 3 staff (Staff L - Certified Nursing Assistant - CNA, Staff Q - Licensend Practical Nurse & Staff V - CNA), ensure staff used appropriate Personal Protective Equipment (PPE) (Staff H - Infection Preventionist), and ensure staff used appropriate infection prevention measures during medication pass (Staff Q). These failures placed residents at risk for exposure to and development of facility-acquired or healthcare-associated infections and related complications.<br><br>Findings included .<br><br><Facility Policy><br><br>Review of the facility policy titled, Transmission Based Precautions (Isolation), dated March 2025, showed determination for the type of TBP used was based on how the infectious agent was transmitted. The policy showed communication of TBP was accomplished with pertinent signage and verbal report to personnel and visitors. The policy showed indirect transmission of infectious agents could occur through contact with resident care equipment, so personal care items would be dedicated for use only for the infected resident. The policy showed Contact Precautions were the most significant mode of transmission of infectious agents and could occur through direct contact with the residents or the residents' environment. The policy showed when entering a Contact Precautions room, personnel would wear gowns and gloves, remove the PPE prior to exiting the room, and perform HH.<br><br>According to a revised 2018 Handwashing/Hand Hygiene policy, the facility considered HH to be the primary means to prevent the spread of infections. This policy showed staff would follow the handwashing/HH procedures to help prevent the spread of infections to others, which included the following: before and after direct contact with residents; before preparing or handling medications; before putting on gloves, after contact with objects in the immediate area of the resident; after removing gloves; before and after entering isolation precaution settings; and after conducting their own personal hygiene.<br><br><TBP><br><br><Resident 52><br><br>According to a 05/20/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 52 admitted to the facility on TBP for an active infectious disease.<br><br>Review of Resident 52's 05/15/2025 Care Plan (CP) showed an intervention for family/visitors/caregivers to wear disposable gown and gloves during physical contact with the resident.<br><br><Resident 47><br><br>According to the 04/29/2025 Significant Change MDS, Resident 47 admitted to the facility on TBP for an active infectious disease.<br><br>Review of Resident 47's 04/17/2025 Baseline CP showed an intervention for isolation precautions for an infection.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505400 | A. Building<br>B. Wing | 06/13/2025 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an observation and interview on 06/09/2025 at 9:25 AM Staff T (CNA) and Staff U (Activities Director) entered room [ROOM NUMBER] occupied by Residents 52 & 47. Observation showed a TBP sign for Contact Precautions posted on the outside of the room instructing all who entered room [ROOM NUMBER] were to put on a disposable gown and gloves provided in a cart outside of the room. Staff T and Staff U entered room [ROOM NUMBER] without putting on the appropriate PPE. Staff T stated they were instructed they only needed to wear PPE when providing direct care to the residents. Staff T and Staff U reviewed the sign instructions and stated they saw all who entered were to wear a gown and gloves prior to entering the room.<br><br>In an interview on 06/10/2025 at 10:06 AM Staff H and Staff B (Director of Nursing) stated they expected staff to read and follow TBP signs posted outside of the rooms. Staff H stated it was important for prevention of spreading infections to other residents.<Resident 32><br><br>Observations on 06/08/2025 at 12:59 PM showed Staff V putting on PPE prior to entering Resident 32's room with a posted sign at the door stating: Special Droplet/Contact Precautions. The sign directed staff to wear a gown, eye protection, mask, and gloves prior to entering the room. Staff were to perform HH when entering and exiting the room. Staff V did not put on eye protection prior to entering the resident's room.<br><br>Observations on 06/12/2025 at 9:01 AM showed Staff L and Staff X (CNA) standing outside Resident 32's room. Staff L and Staff X were observed putting on gowns, face masks, goggles, and gloves. Staff L did not perform HH prior to putting on gloves. After entering the room, Staff X and Staff L performed incontinence care and linen changes for Resident 32's roommate. During incontinence care for the roommate, Staff L was observed to be wearing a damaged glove exposing one of their fingers. Staff L continued to provide resident care, linen change, and the disposal of soiled linen and garbage wearing the damaged glove. Staff L placed bags of soiled linen and garbage near the door, removed their gloves, and put on new gloves without performing HH.<br><br>Observations on 06/12/2025 at 9:22 AM showed Staff L assisting Staff X in providing incontinence care and linen changes for Resident 32. Staff L removed their PPE in the room, did not perform HH, and exited the room to dispose of soiled linen and garbage.<br><br>In an interview on 06/12/2025 at 9:34 AM, Staff L stated they were not aware of their lack of HH practices and confirmed they received HH training during their recent hire to the facility. Staff L acknowledged their lack of HH demonstrated cross contamination and placed residents at risk for infection.<br><br>In an interview on 06/13/2025 at 10:42 AM, Staff H stated their expectation was for staff to follow the directions posted on the signs at the door and for staff to wear the appropriate PPE based on the precautions a resident was on. Staff H stated for Resident 32, staff were expected to wear a face shield or goggles prior to entering the room. |