STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Arcadia Medical Resort of Parkside		STREET ADDRESS, CITY, STATE, ZIP CODE: 308 West Emma, Union Gap, WA 98903	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview and record review the facility failed to ensure 1 of 3 residents (Resident 17) reviewed for resident rights, was treated with respect and dignity. The facility developed the resident's care plan with inaccurate information which labeled the resident in a negative manner. The inaccurate information had the potential to create an environment that did not promote Resident 17's quality of life. Additionally, the facility did not identify appropriate interventions based on Resident 17's individualized care needs to ensure their right to a dignified existence. Findings included . <Resident 17> Review of Resident 17's medical record showed they were admitted to the facility with diagnoses which included, deafness (inability to hear), diabetes (a condition in which the body has trouble processing blood sugar), end stage renal disease (the kidneys no longer work) with dialysis (a procedure that removes excess fluid and waste from the body when the kidneys no longer work) and Post Traumatic Stress Disorder (PTSD, a mental disorder caused by extremely terrifying event/events). Review of the comprehensive assessment dated [DATE] showed Resident 17 was cognitively intact and had no identified negative behaviors during the assessment period. During an interview on 02/03/2025 at 11:46 AM, Resident 17 wrote on their small eraser board that they felt the facility management staff did not understand how to communicate with deaf people. Resident 17 further wrote they sometimes got frustrated and felt they were misunderstood. Resident 17 used their dry erase board to communicate during the interview and there were no concerns with their ability to make their needs known or actively participate in the interview. Record review of Resident 17's care plan dated 12/19/2024 showed the resident had identified behaviors which included, striking out, lack of energy, yelling, hallucinations, refusal of care and inappropriate sexual contact. Further review showed the resident had an intervention for cares in pairs (care provided with a witness). (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview on 02/04/2025 at 10:46 AM, Staff F, Social Services Director (SSD) stated Resident 17 was deaf and their communication was different than the hearing world and could be mistaken for aggression. Staff F felt the resident asking staff for hugs was not intended to be a sexual behavior but it had made several staff uncomfortable. Staff F stated some of Resident 17's communication was tactile (touch related) because they were deaf. I really don't think a request for a hug was intended to be sexual, but I do understand why it made some staff uncomfortable. Staff K, Resident Care Manager, (RCM), stated they felt Resident 17 was being manipulative with staff and could do more for themselves than they let on. In an interview on 02/05/2025 at 3:11 PM, Staff Z, Nursing Assistant, (NA) stated they routinely worked with Resident 17 and had not witnessed any sexually inappropriate behaviors or aggression. Staff Z stated they were not sure why the resident was 'labeled as sexually aggressive as the only thing they had experienced was when the resident had asked for a hug after they had helped them. Staff Z stated they told Resident 17 they were not allowed to hug residents, and that the resident was easily re-directed. Staff Z further stated Resident 17 was nice and respectful and was trying to say thank you when they asked for a hug and just needs a little time to communicate with us. During an interview on 02/05/2025 at 3:25 PM Staff DD, NA, stated Resident 17 had not exhibited aggression, hallucinations or sexually inappropriate behavior. Staff DD stated the only behavior that had concerned them was when they had seen Resident 17 sad and had reported it to the nurse. In an interview on 02/06/2025 at10:16 AM, Staff CC, Registered Nurse (RN), stated Resident 17 had asked them to give them a hug when the resident was in bed but I have never seen the resident be sexual or inappropriate. Staff CC stated they have been told Resident 17 yelled out, however they had never heard this and further stated It ' s all in the approach and if we could not hear or speak how else could we communicate if there was no one available to use the eraser board. During multiple observations on 02/04/2025 at 8:50 AM, 02/06/2025 at 12:49 PM, 02/06/2025 at 4:50 PM showed the resident pleasantly interacting with staff and other residents using a communication board to make their needs known. In a follow up interview on 02/06/2025 at 3:42 PM Staff K stated they had documented on Resident 17's behavior care plan when they first arrived so that staff could monitor if a behavior occurred. Staff K stated the care plan was generic and the reason Resident 17 was identified as having hallucinations and other behaviors was to establish a baseline. When asked about some of the inaccurate information on Resident 17's care plan, Staff K stated, there is only one of me and I have a lot of care plans to create,. therefore, they expected other disciplines to review the care plan and update and discontinue information that was not accurate. Reference WAC 388-97-0180(1-4)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 48368 Based on interview and record review the facility failed to fully inform the Resident Representative (RR) of benefits, options and treatment alternatives to receive hospice services (a program that gives special care to people who are near the end of life offering physical, emotional, social, and spiritual support for residents and their family) when a resident experienced a significant change in medical condition and placed on end-of life care (medical and supportive services provided for individuals nearing the end of their life due to a terminal illness or advanced age) for 1 of 6 residents (Resident 1) reviewed for resident rights. This failure prevented the resident and their representative from making an informed decision regarding their treatment alternatives. Findings included . Review of the policy titled, Providing End of Life Care, revised 10/23/2024, showed the facility would provide the needed care and services to end of life care residents in accordance with the resident ' s preferences, goals and professional standards of practice. In addition, the end-of-life care choices made by the resident and/or representative would be followed by the facility. Review of a progress note dated 12/04/2024, showed Staff K, Resident Case Manager, was asked about hospice care from the RR, Staff K stated they (the resident) could receive comfort measures in the facility without bringing in an outside hospice provider. During an interview on 02/07/2025 at 9:13 AM, the RR stated they asked about hospice services a few months ago and were not given an option, they (nursing staff) stated they could do everything that hospice did in the facility for comfort care. The RR stated they would have liked to have been given other options and educated on the services hospice would have provided to the resident and family. During an interview on 02/05/2025 at 12:17 PM, the contracted medical provider stated the process was for the nurses to educate the RR on end-of-life care provided by the facility and hospice services that allowed them to make an informed choice regarding their treatment. The contracted medical provider stated they can provide comfort care such as pain management and behavior management for end-of-life care and were unsure exactly what hospice offered. Reference (WAC) 388-97-0300(3)(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44922 Based on observation, interview, and record review the facility failed to ensure the physical environment accommodated the individualized needs of 2 of 2 residents (Residents 32 and 12) reviewed for accommodation of needs. The failure to make needed adjustments to the resident's living space, placed the residents at risk for frustration, lack of desired independence, and injury. Findings included . <Resident 32> Review of the resident's medical record showed they admitted with diagnoses including Parkinson's Disease (a movement disorder of the nervous system that worsens over time). The 11/08/2024 comprehensive assessment showed Resident 32's cognition was intact and was very important for them to choose what clothes to wear and to care for their personal belongings. The assessment also showed Resident 32 used a wheelchair (w/c) and a walker and required staff supervision for personal hygiene and mobility. An observation on 02/03/2025 at 9:48 AM, showed Resident 32 was independently self-propelling their w/c into their room. Resident 32's bed was the furthest away from the entry way of the door and their roommate's bed (Resident 12) was at the entrance of the room. Resident 32's w/c kept getting stuck in between the door and the bottom of the footboard of their roommate's bed as there was not enough room to maneuver through the space available. Resident 32's hands and forearms bumped and rubbed into the door, along the wall, and the footboard of Resident 12's bed as they self-propelled through their room. The entry way door would not remain open and would close on Resident 32's left hand when they entered the room. During an interview on 02/06/2025 at 10:50 AM, Resident 32 stated it was extremely difficult to get to their side of the room without scraping their hands on everything from the entry door to their bed. Resident 32 stated they could not independently propel themselves around their room as there was only a straight line from the door to their bed. Resident 32 stated there was not room for them to get to their closet to choose what clothes to wear as their roommates' personal belongings blocked the closet doors. Resident 32 stated I have to ask staff or my family when they are here to get me things out of the closet that I need . I would like to get those things for myself but there's no way my w/c would fit over there. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and concurrent interview on 02/07/2025 at 11:03 AM, showed Resident 32 sitting in their recliner chair positioned in front of the sink and mirror in their room. Resident 32 had a quarter sized black and blue area to their left hand below their index finger. Resident 32 stated they bruised their hands and arms all the time. while trying to propel themselves around their room. Resident 32 reached over the right side of their recliner, to the sink area, obtained their soiled dentures from the countertop of the sink, rinsed them in water, while they sat in their recliner. The recliner occupied all the space between the sink and the wall in front of the sink. Resident 32's w/c measured a total width of 32 inches (in, a unit of measurement). Additionally, Resident 32 stated their urinary catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) was removed the day prior (02/06/2025) and had difficulty maneuvering their w/c into the bathroom. Resident 32 was concerned they would have to use a portable urinal (a device used to collect urine outside of a traditional bathroom setting) instead of the bathroom toilet. <Resident 12> Review of the resident's medical record showed they admitted with diagnoses including chronic obstructive pulmonary disease (COPD- a long-term exposure to lung irritants that damage the lungs and airways) and malnutrition. The 12/02/2024 comprehensive assessment showed Resident 12's cognition was moderately impaired and was very important for the resident to choose what clothes they wanted to wear and to take care of their personal belongings. Further review showed Resident 12 required partial staff assistance with transfers and personal hygiene. An observation and concurrent interview on 02/02/2025 at 11:59 AM, showed Resident 12 lying in bed with both feet pushed up against the footboard. There was a walker to the left side of their bed, in front of two closet doors (the closet on the left belonged to Resident 32, the roommate, and the closet on the right, closest to the entry way door, belonged to Resident 12), an oxygen concentrator (a medical device that provides a concentrated supply of oxygen for breathing) in front of Resident 32's closet door, and a bedside table placed in front of the oxygen concentrator and the walker. To the right side of Resident 12 ' s bed was their folded-up w/c, the privacy curtain, and directly on the other side of the privacy curtain, was Resident 32's bed. There was no room for either Resident 12 or 32 to easily access their closets. An additional observation of the room showed Resident 32 had their recliner chair placed in front of the only sink and mirror in the room, and Resident 12 had no access to the sink. The shared bathroom (shared by a total of four residents) had a single sink with a mirror, with no place to keep personal hygiene belongings. Resident 12 stated they did not have anywhere for their shaving or teeth supplies and were stored in the top drawer of their bedside nightstand. An observation and concurrent interview on 02/05/2025 at 9:31 AM, showed Resident 12 had two visitors that entered while the surveyor was standing to the right side of the resident's bed. One visitor entered and sat at the bottom of Resident 12's bed as there was no room to place a chair for them to sit. When the Surveyor was leaving the room, the second visitor exited the room first as there was not enough room for the Surveyor to exit at the same time. The second visitor remained standing over the top of Resident 12 to visit. (continued on next page)

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	505401	A. Building B. Wing	02/07/2025

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and concurrent interview on 02/05/2025 at 3:13 PM, Staff H, Maintenance Director, stated they were newer to the facility and was not aware of the room requirements for useable space for residents. Staff H measured the space from Resident 12's side of the privacy curtain to the entry way. The measurement showed 78 sq. ft (a way of measuring how much space a flat surface takes up) of useable space for Resident 12 (less than the required useable space for a multi-bedroom of 80 sq. ft). The space between Resident 12's-foot board on the end of their bed to the wall showed 36 in. of space for a w/c or walker to get through to the opposite side of the room (Resident 32's w/c was 32 in wide). During an interview on 02/06/2025 at 10:46 AM, Resident 12 stated they had no room for visitors, and they would like to use their sink if I could get to it, I don't have room to move around. During an interview on 02/06/2025 at 4:15 PM, Staff B, Director of Nursing Services, stated they did not have other rooms that would accommodate the needs for Residents 12 and 32. Observation of the front hallway (100 hallway) showed 4 spacious, empty rooms. Staff B stated they could have taken Resident 12's bed and turned it to the side, up against the wall, and that would have opened more room for Residents 32 and 12 to access their closets. Staff B stated if they moved Resident 12 ' s bed it would not leave room for Resident 32's recliner, that was blocking access to the sink and mirror in the room. Staff B stated moving Resident 32's bed would have blocked the resident ' s access to the restroom. Reference WAC: 388-97-0860 (2)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 39652 Based on interview and record review the facility failed to ensure management staff only attended Resident Council meetings (a group at the facility comprised of and ran by residents) with a specific invitation to attend. This failure resulted in 2 of 4 residents (Resident's 11 and 35) expressed discomfort with voicing their concerns in the presence of management staff during their Resident Council meeting. This failure placed residents who attended Resident Council meetings at risk for discomfort and fear of reprisal (an act of retaliation) if bringing up issues that concerned them. Findings included . On 02/05/2025 at 9:30 AM a Resident Council meeting was held with surveyors per the long-term care survey process for nursing homes. Four facility residents participated in the meeting (Residents 20, 35, 23 and 11) and there were no staff present at the meeting. During a concurrent interview on 02/05/2025 at 9:36 AM, Resident 11 stated they felt uncomfortable speaking up in their usual Resident Council meetings because Staff A, Administrator, and Staff K, Resident Care Manager always attend. Resident 11 further stated I am afraid I may say something wrong, so I don't say anything. Resident 35 stated Staff A and Staff K attend all our meetings and they come in and sit in the back of the room. Resident 35 further stated that it was uncomfortable for them to say they did not want the management staff in their meetings. During an interview on 02/05/2025 at 11:25 AM Staff EE, Activities Director, stated generally Staff A and Staff K had attended Resident Council meetings as they had been invited in the past by the residents. Staff EE stated they asked permission at the beginning of the meetings if Staff A or Staff K could attend and were not aware some of the residents had felt uncomfortable with Staff A and Staff K attending but had not spoken up. Staff EE further stated they understood that Resident Council meetings were for the residents, and they should be able to invite whoever they wanted to the meeting. During an interview on 02/06/2025 at 4:15 PM, Staff A, stated they had attended Resident Council meetings as they thought the residents had wanted them there to hear concerns and were unaware that some of the current residents did not want them to attend. Reference WAC-388-97-0460(1)(2)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 48368 Based on observation, interview, and record review the facility failed to ensure pooled resident funds had separate accounting with separate statements maintained showing deposits and withdrawals for 3 of 5 resident ' s (Resident 12, 40 and 43) reviewed for personal funds. This failure placed residents at risk of not having an accurate accounting of their personal funds held in trust. Findings included . Review of the facility policy titled Resident Personal Funds, dated 12/11/2024, showed the facility deposits the resident's personal funds of more than $50 in an interest-bearing account (or accounts) separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be separate accounting for each resident's share.) <Resident 12> Review of the residents medical record showed they admitted with diagnoses of chronic obstructive pulmonary disease (a group of lung diseases that cause persistent airflow obstruction and breathing problems). The 12/02/2024 comprehensive assessment showed Resident 12 required the assistance of one staff member for activities of daily living (ADLs) and had a moderately impaired cognition. Review of Resident 12 's Resident Personal Fund Statement from 10/01/2024 to 12/31/2024, showed, Resident 12 's funds were deposited monthly into a secure interest-bearing account. Further review showed a monthly care fee (the fee the resident was responsible to pay to the facility) was deducted from the same trust account monthly with no sperate accounting or statement for the resident 's share. <Resident 40> Review of the residents medical record showed they admitted with diagnoses of dementia (a group of conditions that cause a gradual decline in thinking, memory, and reasoning skills). The 01/16/2025 comprehensive assessment showed Resident 40 required the assistance of two staff member for ADLs and had a severely impaired cognition. Review of Resident 40's Resident Personal Fund Statement from 10/01/2024 to 12/31/2024 showed, Resident 40's funds were deposited monthly into a secure interest-bearing account. Further review showed a monthly care fee was deducted from the Residents personal trust account with no sperate accounting or statement for the resident ' s share. <Resident 43> (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the residents medical record showed they admitted with diagnoses of end stage renal disease (when your kidneys have completely stopped working, so they can no longer filter waste from your blood). The 12/12/2024 comprehensive assessment showed Resident 43 required the assistance of two staff members for ADLs and had an intact cognition. Review of Resident 43's Resident Personal Fund Statement from 10/01/2024, to 12/31/2024 showed, Resident 43's funds were deposited monthly, into a secure interest-bearing account. Further review showed a monthly care fee was deducted from the resident's personal trust account with no sperate accounting or statement for the resident's share. During an interview on 02/04/2025 at 11:38 Am, Staff E, Business Office Manager, stated Resident 12, 40 and 43's trust funds were directly taken out of their personal bank accounts and were deposited into their resident trust account that the facility manages. Staff E stated the facility directly removed/charged their participation fee (the fee they owe the facility) each month from their personal trust accounts. Staff E stated they did not have a separate accounting or statements for residents personal funds and the charged amounts removed from the resident trust funds for their stay at the facility. It is all just one account. Reference WAC 388-97-0340(3)(a)(b)(c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review the facility failed to ensure a warm and comfortable, homelike environment for 6 of 12 residents (Residents 35, 42, 16, 13, 31, and 41) reviewed for heat and adaptive equipment maintenance. This failure placed residents at risk for unmet care needs, discomfort, and a non-homelike environment. Findings included . <Equipment> <Resident 35> Review of the resident 's medical records showed they admitted to the facility with diagnoses to include diabetes and chronic pain. The 11/22/2024 comprehensive assessment showed Resident 35 's cognition was intact and required staff supervision/touching assistance for personal hygiene. An observation on 02/02/2025 at 10:23 AM, showed Resident 35 sitting up in their wheelchair (w/c) at their bedside. Resident 35 ' s bed had padded mobility rails (used to prevent injury from unpredictable movements) to the sides of their bed. The outer pad material of the rails had missing areas that exposed the inner white mesh like material that was not a cleanable surface. <Resident 42> Review of the resident ' s medical records showed they admitted to the facility with diagnoses to include diabetes (elevated sugar in the blood) and had a history of falls. The 01/17/2025 comprehensive assessment showed Resident 42 ' s cognition was severely impaired and dependent upon staff for their transfers and staff supervision for w/c mobility. An observation and concurrent interview on 02/02/2025 at 10:31 AM, showed Resident 42 was lying in bed, there was a rectangular fall mat (a mat with non-skid backing and thick material to protect against fall related injuries) on the floor alongside the bed. The thin outer covering on the corners of the fall mat were peeling off and rolled back, and the edges along the length of the mat was peeled off exposing the inner material (foam) of the mat. Resident 42 ' s roommate, stated Resident 42 was mostly non-verbal and relayed Resident 42 had a fall a few days prior out of their w/c. <Resident 16> Review of the resident ' s medical records showed they admitted to the facility with diagnoses to include COPD and diabetes. The 11/18/2024 comprehensive assessment showed Resident 16 ' s cognition was intact. An observation on 02/05/2025 at 10:11 AM, showed Resident 16 used an alternating air overlay mattress. The machine to the mattress had two broken C-shaped clamps that were broken off the back, so the machine and the long tubing sat on the floor to the right side of the bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 13> Review of the resident ' s medical records showed they admitted to the facility with diagnoses to include multiple sclerosis (a disorder in which the immune system attacks the protective covering of the nerve cells in the brain, optic nerve and spinal cord) and diabetes. The 12/13/2024 comprehensive assessment showed Resident 13 ' s cognition was moderately impaired. An observation on 02/06/2025 at 3:05 PM, showed Resident 13 required the use of an alternating air overlay (a pump that cycles air between air cells, creating alternating high and low-pressure zones to distribute pressure to different parts of the body) mattress for skin care. The machine had long tubes that extended from the pump into the mattress and two C-shaped clamps on the back that would attach the machine to the bed, up off the floor. One of the C-clamps were broken off, so the machine sat on the floor at the end of the bed along with the long tubing. During an interview on 2/06/2025 at 11:26 AM, Staff J, Infection Control Preventionist, stated they did not reassess adaptive equipment for functional use and would have expected floor staff to report to them if something needed to be replaced. <Resident 31> Review of the resident ' s medical records showed they admitted to the facility with diagnoses to include diabetes and dementia (the loss of cognitive functioning that interferes with daily life and activities). The 01/09/2025 comprehensive assessment showed Resident 31 ' s cognition was severely impaired and had a history of falling. An observation on 02/07/2025 at 10:55 AM, showed Resident 31 used an alternating air overlay mattress. The mattress had two broken C-shaped clamps that were broken off the back of the machine, so the machine and the long tubing sat on the floor at the foot of the bed. Additionally, Resident 31 ' s footboard of their bed was broken and partially hanging off the frame of the bed on one side. <Resident 41> Review of the resident ' s medical records showed they admitted to the facility with diagnoses to include chronic obstructive pulmonary disease (COPD, long-term exposure to lung irritants that damage the lungs and airways) and a history of falling. The 01/17/2025 comprehensive assessment showed Resident 41 ' s cognition was intact. An observation on 02/07/2025 at 10:57 AM, showed Resident 41 used an alternating air overlay mattress. The machine to the mattress had two broken C-shaped clamps that were broken off the back, so the machine and the long tubing sat on the floor at the foot of the bed. <Temperatures> <Resident 35> (continued on next page)

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	505401	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Medical Resort of Parkside	308 West Emma Union Gap, WA 98903

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 02/02/2025 at 10:23 AM, Resident 35 stated they did not have any heat to their bathroom, and it was very chilled when they used it. Resident 35' s toilet was observed to have black rings around the inside of the toilet bowl. Resident 35 stated the housekeepers could not clean their toilet because they were allergic to the bleach chemicals they used for cleaning, and it would break their skin out in a rash. Resident 35 stated they had reported the heater issue to staff and maintenance. An observation and concurrent interview on 02/04/2025 at 8:19 AM, showed Resident 35 up in their w/c, ready for an outside appointment. Resident 35 stated no one had been in to look at their heater in their bathroom and it was still very cold. Observation of Resident 35 ' s bathroom showed no warm or hot air was coming out of the heater vent on the ceiling in the bathroom and the bathroom was cold. When standing outside of the bathroom door, with the door closed, the surveyor could feel the cold air coming out from underneath the door opening. During an interview on 02/05/2025 at 10:37 AM, Staff H, Maintenance Director, stated they did not assess the resident equipment for functional use. Staff H stated if a resident reported their room being cold, they would test it. Staff H stated there was a thermostat that controlled about six to ten rooms that was located inside of room [ROOM NUMBER]. Staff H stated they had a book outside their door that staff could report in if something was broken or needed replaced or the staff would verbally report issues to them. Staff H stated they checked the book daily. Review of the 11/01/2024 to 02/05/2025 maintenance repair book showed an entry on 10/25/2024 for room [ROOM NUMBER], that cold air was blowing through the vent and the room was very cold, with a result from Staff H that the heat turned on. Another entry on 11/08/2024, written in the book by Resident 35 themselves, that read Frozen .can you shut off the frozen air from the vents? I hurt from being cold, thank you for your help!, and Staff H documented fixed. The book also showed an entry on 11/19/2024 that the front and middle section (room [ROOM NUMBER] is in the middle section) residents complained about rooms being cold and Staff H documented waiting for AC [Air Conditioning] company to fix. <Resident 42> An observation and concurrent interview on 02/05/2025 at 9:27 AM showed Resident 42 (also in room [ROOM NUMBER]) lying in bed, blankets up under their chin, and stated they were doing horrible, it ' s freezing in here. An observation and concurrent interview on 02/05/2025 at 3:17 PM, Staff H stated Resident 35 reported to them their room and bathroom were cold, so Staff H stated they adjusted the thermostat, then got busy and did not recheck to see if the issue had been resolved. Staff H tested the air vent in Resident 35 ' s bathroom and the temperature showed 67 degrees Fahrenheit (F, a unit of measure) and in the vent in front of the sink in the main part of the room, the temperature was 72 to 73 degrees F. There was black tape observed around the vent in the main room and when asked what that was for, Staff H stated they would tape the vents closed if the room became too hot or too cold. Staff H then went to room [ROOM NUMBER] (where the thermostat was for that section of rooms) and showed the temperature at 75 degrees F. Staff H stated they had a heating and air conditioning company that was currently in the building working on something else and would have them look at the heating in room [ROOM NUMBER]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Medical Resort of Parkside	308 West Emma Union Gap, WA 98903

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 10:44 AM, Staff H stated the heating and air conditioning company were unable to look at room [ROOM NUMBER] ' s heater on 02/05/2025 and that another company was going to stop in that day to look at it. Staff H stated the motor was not blowing air into the vent in that bathroom and they did not know why. During an observation and concurrent interview on 02/07/2025 at 11:08 AM, Resident 35 and Resident 42 both stated their room was cold. Upon entering the bathroom, the bathroom was still cold and there was still no heat coming out of the vent. During an interview on 02/07/2025 at 1:37 PM, Staff A, Administrator, along with Staff B, Director of Nursing Services, stated they rented the alternating air overlay mattresses so if they were broken, they came to them broken. Staff A additionally stated they were aware of the heating issue in room [ROOM NUMBER], what more were we supposed to do, we had to wait on the motor for the heating unit to arrive. Reference WAC: 388-97-0880 (1)(2)(3) 46722

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NAME OF PROVIDER OR SUPPLIER Arcadia Medical Resort of Parkside		STREET ADDRESS, CITY, STATE, ZIP CODE 308 West Emma Union Gap, WA 98903	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 44922 48368 Based on observation, interview, and record review, the facility failed to accurately assess 2 of 5 residents (Residents 1 and 26), reviewed for Minimum Data Set (MDS, a standardized assessment tool used in long-term care facilities that assesses functional, medical, psychosocial, and cognitive status) accuracy. The failure to ensure accurate assessments regarding end-of-life care to guide the development of the comprehensive care plan placed the residents at risk for unmet care needs. Findings included . <Resident 1> Review of the resident's medical record showed they admitted with diagnoses of spastic quadriplegic cerebral palsy (a severe form of cerebral palsy where all four limbs (arms and legs) are effected by excessive muscle stiffness), dementia (a group of symptoms affecting memory, thinking and social abilities), major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), and post-traumatic stress disorder (PTSD - a mental health condition that can develop after experiencing or witnessing a traumatic event). The 12/15/2024 comprehensive assessment showed Resident 1 required the assistance of two staff members for activities of daily living (ADLs) and had a severely impaired cognition. The assessment also showed Resident 1 had a condition or chronic disease that may have resulted in a life expectancy of less than six months. Additionally, review of the 04/13/2024, 07/12/2024 and 10/11/2024 comprehensive assessments, showed Resident 1 had a life expectancy of less than six months. Record review of Resident 1's physicians orders for April 2024, July 2024 and October 2024 showed no physicians order were in place for the diagnosis of life expectancy less than six months. During an interview on 02/07/2025 at 9:13 AM, The Resident Representative (RR) stated that 02/05/2025, was the first time the facility had talked with them or mentioned Resident 1 had less than six months to live. The RR stated they were shocked and it took us by surprise. <Resident 26> Review of the resident's medical record showed they admitted to the facility with diagnoses to include diabetes (elevated sugar in the blood) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The 11/15/2024 comprehensive assessment showed Resident 26's cognition was severely impaired. The assessment showed Resident 26 had a condition or chronic disease that may have resulted in a life expectancy of less than six months. Review of the 02/17/2024, 05/17/2024, and 08/16/2024 comprehensive assessments, showed Resident 26 had a life expectancy of less than six months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and concurrent interview on 02/05/2025 at 9:41 AM showed Resident 26 lying in bed and eating breakfast. Resident 26 had a large, red, fluid filled lump to the right side of their forehead. Resident 26 stated they have had the lump for years and it would come and go and would need drained periodically. Resident 26 stated they would have liked the lump to be drained and was a little discomforting, but did not cause pain. Resident 26 stated they had a lady that helped them with their medical decisions that would come visit them often. During an interview on 02/06/2025 at 2:13 PM, Staff K, Resident Care Manager, RCM, stated Resident 26's RR had voiced concerns about the resident dying and it was discussed with nursing. Staff K stated they did not feel Resident 26 had less than 6 months to live. During an interview on 02/07/2025 at 8:32 AM, the RR stated they had not talked to anyone in the facility regarding Resident 26 dying or having less than six months to live. The RR stated they did not feel Resident 26 was imminent (about to happen) of death and did not know that was even a thing. The RR stated Resident 26 had health issues but none that were causing immediate danger or fear of death. During an interview on 02/07/2025 at 8:55 AM, Staff M, MDS Coordinator, stated they completed comprehensive assessments from home and the RCM completed the face to face assessments since they were not in the facility. Staff M stated they got the less than six-month life expectancy from the resident's diagnoses list in the medical record. Staff M stated they did not consistently look for documentation from the physician because the provider notes did not always get scanned in but if the diagnosis was in the list in the resident's medical record, then I am going to believe it. Staff M stated if they could not find the provider documentation they would clarify with the RCM if they questioned it, but not always. Review of the Resident Assessment Instrument (RAI- a detailed guide used by nursing homes to thoroughly assess each resident's physical, mental, and functional abilities) manual, dated October 2024, showed the physician must document the resident ' s condition or chronic disease that may result in a life expectancy of less than 6 months to live and that they have a terminal illness in the resident's medical record. The RAI manual further showed not to code the life expectancy of less than 6 months until there was documentation from the physician in the medical record. Reference: WAC 388-97-1000 (1)(b)

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NAME OF PROVIDER OR SUPPLIER: Arcadia Medical Resort of Parkside		STREET ADDRESS, CITY, STATE, ZIP CODE: 308 West Emma, Union Gap, WA 98903	

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 46722 48368 Based on interview and record review the facility failed to ensure residents ' Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] were not inappropriately placed in nursing homes for long term care) were accurately completed prior to admission and updated when new SMIs were identified and had the required Level II (a comprehensive evaluation by the appropriate state-designated authority) referral if residents had a positive Level I (a pre-screening evaluation for identifying SMI/ID/DD) PASARR for 4 of 9 residents (Residents 12, 42, 14 and 48) reviewed for PASARR. This failure placed the residents at risk of not receiving the mental health care and services appropriate for their needs. Findings Included . Review of the facility's undated policy titled Coordination with PASRR [newly titled PASARR] Program, showed all applicants to the facility would have a Level I PASAAR for SMI, ID/DD, and/or related conditions prior to admission to the Nursing Home (NH) and if an SMI/ID/DD should be diagnosed after admission. If the Level I showed the resident had an SMI/ID/DD, then a Level II evaluation would be completed prior to admission. The policy additionally showed any resident who was diagnosed with a SMI/ID/DD after admission would have been promptly referred for a Level II evaluation. The policy showed the Social Service Director (SSD) would be responsible for tracking resident's PASARR screening status and referrals to the appropriate authority. <Resident 12> Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include dementia (loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) with agitation (excessive talking or purposeless motions, feeling of unease or tension, and hostile behavior at times) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The 12/02/2024 comprehensive assessment showed Resident 12's cognition was moderately impaired and received anti-depressant and antipsychotic (used to manage symptoms such as delusions, hallucinations, paranoia, and disordered thoughts) medications. Review of the 06/10/2024 PASARR for resident 12 showed the resident had no SMI or dementia on admission to the facility. <Resident 42> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses including stroke (occurs when blood flow to a part of the brain is obstructed, typically by a blood clot, resulting in the death of brain cells) and depression. The 01/17/2025 comprehensive assessment showed Resident 42's cognition was severely impaired. The assessment additionally showed Resident 42 received an anti-depressant medication during the assessment period. Review of Resident 42's 03/27/2024 PASARR showed the resident had no SMIs on admission to the facility. Review of Resident 42's Diagnoses list, showed on 05/09/2024 there was a new diagnosis of depression and on 12/11/2024 a diagnoses was created for Post Traumatic Stress Disorder (PTSD, a mental health condition caused by an extreme stressful or terrifying event). Additional review of Resident 42 ' s medical record showed no new PASARR or Level II referral had been completed for the depression and PTSD. During an interview on 02/06/2025 at 1:54 PM, Staff F, Social Service Director, SSD, stated they reviewed PASARRs on admission and if they were not correct, they would then complete a new one. Staff F stated they were aware the PASARRs were required to be reviewed prior to admission to the facility and they had not been doing that. Staff F stated they had not updated resident's PASARRs if they had a new diagnosis of SMI. During an interview on 02/06/2025 at 2:53 PM, Staff B, Director of Nursing Services (DNS), stated the SSD was to review PASARRs prior to admission and ensure they were corrected before admitting. Staff B stated if a current resident had a new SMI diagnosis during their stay, then the SSD should have completed a new PASARR reflecting the new diagnosis and obtain an evaluation if indicated. <Resident 14> Review of the medical record showed Resident 14 was admitted to the facility on [DATE] with diagnoses including major depressive disorder [(MDD)- a mood disorder of persistent feelings of sadness, loss of interest, changes in sleep affecting how a person feels, thinks and behaves], PTSD, and anxiety. The 01/02/2025 comprehensive assessment showed Resident 14 required substantial/dependent assistance of one to two staff members for activities of daily living (ADLs) and had an intact cognition. Record review of Resident 14's PASARR, dated 08/01/2024, showed the resident had no serious mental illness indicators and no Level II evaluation was indicated. During a follow-up interview on 02/07/2025 at 2:54 PM, Staff F, SSD, stated Resident 14 and Resident 21's diagnoses were not included on their PASARR forms. Staff F stated they should have completed new PASARR's and sent for a Level II evaluation. <Resident 48> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they admitted with diagnoses of stroke (happens when blood flow to the brain is disrupted), chronic kidney disease (your kidneys are gradually damaged and can't filter waste from your blood properly, causing a buildup of toxins in your body over time), and PTSD. The 01/01/2025 comprehensive assessment showed Resident 48 required the assistance of two staff members for ADL's and had a moderately impaired cognition. Review of the 12/23/2024 PASARR for Resident 48 showed under section I, SMI/ID, all diagnoses were marked as no including PTSD and had not been updated. During an interview on 02/06/2025 at 3:28 PM, Staff B, DNS, stated the SSD was responsible for checking all PASARRs on admission to ensure they were correct with the correct diagnosis marked. Staff B stated the SSD was to update the PASARR with any change in condition or newly added diagnosis and they were to request a Level II evaluation. Staff B further stated they had not had the new PASARR training and were not aware of the new regulations. Staff B stated, the SSD had not received or had knowledge of the new PASARR regulations. Reference: WAC 388-97-1915 (1)(2)(a-c)

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	505401	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48368 Based on observation, interview, and record review, the facility failed to complete care conferences for 1 of 3 residents (Resident 1) reviewed for resident/resident representative participation in care conferences. The failure to complete care conferences and allow resident participation in planning their care placed residents at risk for unmet care needs. Findings included . Review of the facility policy titled Interdisciplinary Care Conference Policy, dated 05/2023, showed the Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goal of their residents) would hold a face-to-face care conference 72 hours after admission, 14 days after admission, quarterly (every three months), and with any significant changes in condition. <Resident 1> Review of the resident's medical record showed they admitted with diagnoses of spastic quadriplegic cerebral palsy (a severe form of cerebral palsy where all four limbs (arms and legs) are affected by excessive muscle stiffness) and dementia (a group of symptoms affecting memory, thinking and social abilities). The 12/15/2024 comprehensive assessment showed Resident 1 required the assistance of two staff members for activities of daily living and had a severely impaired cognition. Review of Resident 1's medical record showed no documentation that care conferences had been completed for Resident 1 from January 2024 to February 2025. During an interview on 02/02/2024 at 8:14 AM, Resident 1's Representative (RR) stated the facility had never scheduled a meeting with them to talk about Resident 1's care. The RR stated they only received phone calls from the facility when they were notified of any changes (like the flu). During an interview on 02/04/2025 at 2:15 PM, Staff F, Social Service Director, stated the process for care conferences was for all residents to have one on admission, quarterly, and as needed. Staff F stated the care conferences were to include the IDT, the residents, and the RRs. Staff F stated they had not scheduled or had any care conferences for Resident 1. During an interview on 02/06/2025 at 3:38 PM, Staff B, Director of Nursing Services, stated care conferences were to be completed on admission, quarterly, as needed, and for discharge planning. Staff B stated they would expect the care conferences to include the IDT team. Staff B stated they knew completing care conferences had been a problem and they were very aware of it. Staff B stated they had a problem with care conferences and the process needed work. Reference: WAC 388-97-1020 (2) (d-f) 39652

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on interviews and record review the facility failed to ensure staff followed accepted standards of clinical practice for 6 of 7 residents (Residents 16, 26, and 34) reviewed for end of life care(EOL, six months or less to live) and 3 of 6 residents (Resident's 12, 35 and 48) reviewed for Post Traumatic Stresss Disorder (PTSD, a mental health condition where someone continues to experience intense negative feelings and memories from a tramatic life event). All six residents were identified based on information provided on the Matrix (a form provided to the facility to be completed at the beginning of a Standard Re-Certification Survey to identify resident care categories) form. Residents 16, 26, and 34's medical records did not have supporting documentation to support the resident required EOL care nor were there diagnoses given by a physician. Additionally, Resident's 12 and 35 had no supporting documentation for the new diagnosis of PTSD and Resident 48 had no physician order or supporting documentaion for the diagnosis of PTSD. This failed practice placed residents and their RR at risk for unmet care needs as they did not have prior knowledge of their EOL or PTSD status, nor were they given the opportunity to discuss their EOL care wishes. Findings included . Record review of a manual from Lakehead Centre for Education and Research on Aging and Health (CERAH) titled Quality Palliative Performance Scale dated 9/2011, showed the PPS scale was a tool for identifying EOL expectancy based on the resident ' s functions including ambulation, activity level, self-care, oral intake, and level of consciousness. Drawbacks of the PPS showed as follows; * PPS was not created for Long-Term Care homes. * Performance standards may not be clear. * PPS is based on observation coding and there may be different opinions. *May be difficult to score at certain levels * Another task for staff to complete. <Resident 16> Review of Resident 16's record showed they admitted to the facility with diagnoses which included, chronic obstructive pulmonary disease (a chronic lung disease that damages the lungs and caused shortness of breath), diabetes (too much sugar in the blood) and congestive heart failure (the hear struggles to keep up with the demands of the body). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact and required substantial assistance for transfers, mobility, and dressing. The resident was able to complete grooming tasks and feed themselves after set-up assistance. The assessment further showed the resident did not have a prognosis of EOL care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 16's progress notes (PN) showed on 02/04/2025 at 4:59 PM, the physician had seen the resident and placed them on EOL care based on their PPS assessment (completed by Staff K) and other co-morbidities [are medical conditions that coexist with a primary diagnosis and affect your health and treatment]. Record review of a physician ' s order dated 02/04/2025 showed a new diagnosis was added for EOL care. Further review of Resident 16's PNs from 11/01/2024 to 02/05/2025 showed no discussion with the resident or their RR prior to the EOL diagnosis or significant changes in their health condition. Duirng a concurrent interview on 02/05/2025 at 12:22 PM, Staff K, Resident Care Manager (RCM), stated Staff B, Director of Nursing Services (DNS), instructed Staff K to amend [to make a change or correction to something, usally to improve it] the resident's record to match the Matrix form provided to the surveyors. Staff K stated they completed the Palliative Performance Scale (PPS, a scale used by the facility to assist in identifying if a resident had six months or less to live) used to determine a resident's EOL care. Staff K stated they had the physician review the PPS and add orders for the EOL care diagnosis to Residents 16, 26 and 34's medical records. Staff B or Staff K did not involve the residents or their RR's prior to obtaining new orders for EOL care which had the potential for major changes in condition to the residents physical and emotional health. Staff B stated the PPS scale had been brought into the facility in November 2024 by the Medical Director at that time (not the current Medical Director) and they had used it as a tool to predict if a resident was eligible for EOL care. Staff K stated they performed the PPS but did not use a specific form or documented the assessment in the residents records, I just do it and write the score in an order. Staff K stated they tried to keep the residents, and their RR informed of the process, but they had not involved Resident 16, their RR, or Social Services prior to their EOL diagnosis on 02/04/2025. Staff B and Staff K stated that the PPS score was the predictor scale they used to start the process for EOL care. Staff K stated I can look at the resident and see if they will die in six months and if they do not die in six months the provider can re-up [renew] their EOL diagnosis. Staff B stated if a resident was EOL care they would no longer obtain weights, they would eat for comfort, and would not be provided heavy duty wound care. During an interview on 02/07/2024 at 3:10 PM, Resident 16 stated they had a meeting with the facility staff (3 days after the EOL diagnosis had been added), and their son had discussed their care wishes to not be transported to the hospital but to have their needs met at the facility. The resident further stated they were unaware of their EOL diagnosis and relied on their son to help them make decisions. <Resident 26> Review of the Resident's medical records showed they admitted to the facility on [DATE] with diagnoses to include diabetes and heart disease, and on 09/08/2023 a diagnosis of Palliative Care [specialized medical care for people living with a serious illness]. The 11/15/2024 comprehensive assessment showed Resident 26's cognition was severely impaired. Review of Resident 26's February 2025 Physician orders showed an order on 02/02/2025 for End of Life care related to their PPS score of 40 percent or less. Also, on 02/04/2025 there was a 2nd order for End of Life, life expectancy less than 6 months related to a PPS score of 30 percent or less. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 26 ' s Physician PNs showed on 01/27/2025 the physician wrote the resident was seen for a routine visit. The PN showed Resident 26 was alert and oriented to self and place, had no complaints, was in no distress or pain, no significant weight change for the past six months, and vital signs were within normal range. The PN showed Resident 26 stated they had no issues with appetite, bowels, sleep, or their mood. The PN showed the Nursing staff reported no concerns. Additionally, a PN on 02/04/2025 (six days after the routine visit), showed Resident 26 continues with EOL care with six months or less of life expectancy. The PN showed skin breakdown, weight loss, and refusal of cares was expected and unavoidable. The note showed no physical assessment had been completed. During an interview on 02/06/2025 at 2:13 PM, Staff K stated they were directed to obtain those EOL orders by Staff B and stated [Resident 26] is not dying. During an interview on 02/07/2025 at 8:32 AM, the RR stated they had not discussed EOL care for Resident 26 with staff from the facility or the physician. The RR stated, I do not feel like we are at that point [life expectancy of six months or less]. <Resident 34> Review of the resident's medical records showed they admitted to the facility on [DATE] with diagnoses to include heart disease and diabetes. The 11/29/2024 comprehensive assessment showed Resident 34's cognition was intact. Review of Resident 34's February 2025 Physician orders showed an order on 02/04/2025 for End of Life, life expectancy less than 6 months related to a PPS score of 30 percent or less as well as natural progression of disease process and comorbidities. Then, on 02/05/2025 an order for comfort measures. Both the 02/04/2025 and 02/05/2025 orders showed skin breakdown and weight loss would be expected, discontinue obtaining weights, that Resident 34 may refuse showers, and their meals were for comfort and pleasure only. Review of Resident 34's Physician PNs showed on 01/16/2025 Resident 34 was seen for a routine visit. The PN showed the resident denied complaints of pain, shortness of breath, and difficulty urinating, appetite and sleep are good, bowels were regular, and vital signs and blood sugars (testing to monitor the amount of sugar in the blood) were within normal ranges. The PN showed for staff to ensure comfort measures and psychosocial and nutritional support. Additionally, a note on 02/04/2025 showed Resident 34 continues with EOL care with six months or less life expectancy and skin breakdown, weight loss, and refusal of care were expected and unavoidable. The PN showed no physical assessment had been completed. During an interview on 02/05/2025 at 1:40 PM, Staff B stated they understood that residents, the RRs, and Social Services should have been more involved with EOL diagnoses. Staff B stated some of the residents listed on the Matrix form for EOL care were not dying and should not have had those diagnoses added to their records. <Post Traumatic Stress Disorder> <Resident 12> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they admitted to the facility on [DATE] with diagnoses to include a fracture to their left hip and chronic pain. The record also showed a diagnosis for PTSD with a created date of 12/11/2024. The 12/02/2024 comprehensive assessment showed Resident 12's cognition was moderately impaired and was independent for bed mobility with staff set-up assistance for eating and oral hygiene. Review of the 01/02/2025 Contracted Mental Health Counselor's note, showed the resident had diagnosis to include depression and nothing was in the notes for PTSD. Review of the 06/11/2024 Trauma Informed Care assessment showed Resident 12 had some events that had happened in their life. The assessment showed that the other traumas in their life had not impacted their emotional well-being and does not consider [themselves] suffering from any related triggers. Review of a nursing progress note on 12/11/2024 showed a note written by Staff K that related to resident 12's positive trauma screen with known triggers (trauma assessment showed Resident 12 had no triggers), the provider gave orders to add the diagnosis of PTSD and to attach the order with the resident's admitted . Review of Physician notes from 12/01/2024 to 01/01/2025 showed no trauma screen or review of trauma screen had been completed by the physician. Then, a note on 02/04/2025 showed to add the diagnosis of PTSD related to Resident 12's positive trauma screen with triggers that bring back memories of trauma accompanied by emotional and physical reactions affecting quality of life with no accompanying assessment of the resident. <Resident 35> Review of the resident's medical record showed they admitted on [DATE] with diagnoses to include diabetes and low back pain. The record also showed a diagnosis of PTSD with a created date of 12/11/2024. The 11/22/2024 comprehensive assessment showed Resident 35's cognition was intact and required staff supervision/touching assistance with transfers, bed mobility, and hygiene. Review of the 07/17/2024 Trauma Informed Care assessment showed Resident 35 had experienced life events, with one of them being a sign painter. The assessment showed Resident 35 had developed an allergy to chemicals that forced them to have to change their career. There were no triggers identified in the assessment. Review of a nursing progress note on 12/11/2024 showed a note written by Staff K, related to resident 35's positive trauma screen with known triggers (trauma assessment showed Resident 35 had no triggers), the provider gave orders to add the diagnosis of PTSD and to attach the order with the resident's admitted . Review of Physician notes from 12/01/2024 to 01/01/2025 showed no trauma screen or review of trauma screen had been completed by the physician. Review of a note on 02/04/2025 showed to add the diagnosis of PTSD related to Resident 35's positive trauma screen with triggers that bring back memories of trauma accompanied by emotional and physical reactions affecting quality of life with no accompanying assessment of the resident. <Resident 48> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed they admitted with diagnoses of stroke (happens when blood flow to the brain is disrupted), chronic kidney disease (your kidneys are gradually damaged and can't filter waste from your blood properly, causing a buildup of toxins in your body over time) and PTSD, The 01/01/2025 comprehensive assessment showed Resident 48 requires the assistance of two staff members for ADL's and had a moderately impaired cognition. Review of the 12/30/2024 Stressfull Life Experiences Evaluation assesment showed Resident 48 had no stressfull life experiances. Duirng an interview on 02/06/2025 at 4:14 PM, The RR stated they did not know what PTSD was and Resident 48 had never had anything like that. The RR stated Resident 48 has never had trauma like that, not ever. During an interview on 02/06/2025 at 1:54 PM, Staff F, Social Services Director, stated the PTSD diagnoses did not come from the SSD, that's all nursing driven. Staff F stated they did not think the diagnoses were appropriate and did not agree with all of them. Staff F stated the residents did not require a mental health diagnosis to receive services from their contracted mental health counselor so did not know the reasons behind obtaining the diagnoses. During a follow-up interview on 02/06/2025 at 3:08 PM, Staff B stated I did not tell [Staff K] to go out and make the Matrix match with the residents record. I was shocked that [they] said that. Staff B stated Staff K took it upon themselves to get those orders. Staff B stated they handed Staff K the Matrix and asked them to see what was going on and now we have a huge mess to fix. Staff B stated they expected the MDSs to be accurate. Duirng an interview on 02/07/2024 at 9:26 AM, Staff L, RCM, stated they added the diagnosis of PTSD to Resident 48's diagnosis list because he had triggered a trauma care plan. Satff L stated to add a diagnisis to a resident's medical record they would need a physicians order. Staff L stated they did not get the diagnoisis of PTSD for Resident 48 from the physican they just added it themselves. Staff L stated they knew they could not diagnose and they should had not have added the PTSD diagnosis to Resident 48's medical record. During an interview on 02/05/2025 at 12:17 PM, the Attending Physician (AP) stated the nursing staff would complete the PPS assessments for residents that had terminal problems and were not likely to recover. The AP stated the key to EOL care would be when a resident decreased mentally or had kidney or cardiac (heart) issues. The AP stated some of the criteria they used to determine EOL was if a resident was bed bound, required total care, or if they had behaviors and required management. The AP stated the care for EOL residents should not have changed, everything stays the same the resident just would not be sent to the hospital or out to specialists for additional services if they required them. The AP stated it costed the medical system a lot of money to send, for example a dementia patient out to get tube feeding if they had dysphagia [difficulty with eating]. The AP stated if the family were available at the time they were giving the diagnosis of EOL care they would talk to them, but if not, they depended upon nursing staff to have those conversations and provide the resident or their RR the information regarding EOL care in the facility versus using a hospice service. The AP stated they received thier information for the PTSD diagnosis from the trauma assessment the nurses completed. The AP stated they gave all residents who have had a negative life experience the diagnosis of PTSD so they could get behavior health services. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1620(2)(b)(ii), (6)(b)(1) 44922 46722 48368

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44922 Based on observation, interview, and record review, the facility failed to ensure restorative therapy services (a personalized training program to help people maintain or regain their ability to do every day tasks, like walking, dressing, and eating) were consistently implemented to prevent avoidable reduction of range of motion (ROM, how far you can move a joint in any direction) for 1 of 4 residents (Resident 35), reviewed for restorative therapy and limited ROM. This failure placed the resident at risk for loss of ROM, deconditioning, and loss of independence. Findings included . <Resident 35> Review of the resident ' s medical record showed they admitted to the facility with diagnoses to include diabetes (elevated sugar in the blood) and low back pain. The 11/22/2024 comprehensive assessment showed Resident 35 had intact cognition, could eat independently, and required supervision/touching assistance of one staff member for bed mobility, transfers, and toileting. The assessment additionally showed the resident received no specialized therapy or restorative programs. During an interview on 02/02/2025 at 10:23 AM, Resident 35 stated they admitted to the facility almost two years ago. Resident 35 stated they had gone around eight months without any therapy, and they began to decline in what I was able to do [their baseline function] so they were put on Physical Therapy (PT, specialized therapy treatment that helps you improve how your body performs physical movements). Resident 35 stated they had a plan to go home but had not been strong enough to do what they needed to do, so that had been delayed. Resident 35 stated their PT stopped in January 2025 and they were placed on a restorative therapy program that they did not consistently receive. Resident 35 voiced concerns that they were feeling weaker in their upper arms, and this would decrease their chances of being able to discharge home. Review of the PT discharge notes on 01/02/2025 showed the Resident discharged from PT and was referred to a restorative therapy program. Review of the 01/01/2025 Therapy Referral Form, showed Resident 35 was to start a program, six times a week, for active ROM with the exercise bike for 15 minutes and an ambulation program with their front wheeled walker for up to 200 feet (a unit of measure), with cueing to stand tall. During an interview on 02/05/2025 at 9:47 AM, Staff W, Restorative Aide (RA), stated they were responsible for completing the restorative programs. Staff W stated they were not able to complete the programs for three of the five days they worked last week and this week so far, they were not able to complete any restorative programs. Staff W stated if they were short on staff or someone did not show up for their shift, they would have to take their place. Staff W stated they would get help from Staff Y, RA, but they would also get pulled to work the floor as a Nursing Assistant (NA) instead of the RA position. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/2025 at 2:46 PM, Staff Y stated they were also responsible for completing the restorative therapy programs. Staff Y stated they were not consistent with completing the programs because they would be pulled to the floor as a NA or to accompany a resident to an appointment. Staff Y stated they normally worked the evening shift and would be able to get some of the programs completed before dinner but also worked as a NA on the floor. Staff Y stated they were usually pulled to the floor at least three days a week to work as a NA instead. Staff Y stated they were able to complete the ROM program for Resident 35 on 2/04/2025. Staff Y stated they were unaware Resident 35 had a walking program, so it had not been completed. Review of the 01/23/2025 to 02/06/2025 (past 14 days) assignment sheets for Staff W showed Staff W worked as a NA and not as an RA on 10 of the 14 days scheduled for restorative therapy services. On two of those 14 days Staff W was scheduled to work as both a NA and an RA. The assignment sheet for 01/25/2025 showed no RA had been scheduled. Review of the 01/23/2025 to 02/06/2025 (past 14 days) assignment sheets showed Staff Y worked as a NA for five and a half days of the nine days scheduled for restorative therapy services. Staff Y was not listed as working on 1/25/2025, 01/26/2025, 1/31/2025, 02/01/2025, and 02/06/2025, and there was missing documentation for 02/02/2025. During an interview on 02/06/2025 at 11:14 AM, Staff J, Restorative Director, stated they just re-started the restorative therapy programs in January 2025. Staff J stated they were currently looking for another RA and they tried to have at least one RA scheduled daily. Staff J stated the RAs get pulled to work the floor as NAs when they were scheduled as an RA because daily care needs are a higher priority than the RA [restorative therapy] programs. During an interview on 02/06/2025 at 3:58 PM, Staff B, Director of Nursing Services, stated they had lost staff, and they had a choice to choose personal care needs versus restorative needs and personal care comes before them doing a few exercises a day. Staff B stated they had a staffing coordinator, but they had been out for the past three weeks, and did not know what happened with the scheduling of the RAs. Staff B stated they did not utilize agency staffing to assist with their staffing needs. WAC Reference: 388-97-1060(3)(d)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on interview and record review, the facility failed to ensure dialysis (the kidneys no longer function and require a mechanical process to remove waste and excess fluids from the blood stream) services met professional standards of care for 1 of 2 residents (Resident 17), reviewed for dialysis. The facility did not have an effective or coordinated process for communication between the facility and the offsite dialysis center for continuity of care. This failure placed residents receiving dialysis at risk for complications and unmet care needs. Findings included . Review of a policy titled Care Planning and Special Needs Dialysis dated April 2024 showed, The care plan will reflect coordination between the facility and the dialysis provider. Document, monitor pre/post dialysis weights and vital signs. Nursing staff will provide a report to the dialysis provider regarding the resident's condition each dialysis treatment. If no report is recieved upon return from dialysis, nursing staff will call provder to recieve a report. <Resident 17> Review of the resident's medical record showed they were readmitted to the facility with diagnoses including ESRD (the kidneys no longer work) with dialysis and diabetes (the body has too much sugar in the blood). Review of the comprehensive assessment dated [DATE] showed the resident was cognitively intact. Record review of the November 2024 physician orders showed the resident received dialysis three times weekly at an offsite dialysis center. Continued review of Resident 17's medical record showed no communication with the facility and the off-ste dialysis center before or after dialysis treatments. Further review showed no consistent vital signs documented or assessments of the residents condition upon return to the facility to monitor for complication s after the hemodialysis treatment had been completed. During an interview on 02/06/2025 at 11:20 AM, Staff B, Director of Nursing, stated the pre/post dialysis communication forms were no longer sent with the residents recieving dialysis off site. We tried to use them but could never get them back so we stopped using them. Staff B stated the facility Registered Dietician (RD) and the dialysis center RD communicate which they felt was adequate to monitor Resident 17's status. When asked about the nursing staff monitoring of the resident pre/post dialysis Staff B stated they should be [NAME] that and documenting it in the residents record. Reference: WAC 388-97-1900(1)(6)(a-c)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview and record review the facility failed to ensure 1 of 3 residents (Resident 17) received cultural, competent, trauma informed care in accordance with professional standards, reviewed for trauma care. The facility failed to implement identified care plan interventions related to Resident 17's Post Traumatic Stress Disorder (PTSD, a mental health condition that develops after an extremely traumatic event). This failure placed Resident 17 at risk for re-experiencing past trauma. Findings included . <Resident 17> Review of the resident's record showed they were admitted to the facility with diagnoses which included, deafness, PTSD, diabetes (elevate blood sugar levels) and end stage kidney disease (the kidneys are no longer functioning) with dialysis (a process in which removes waste and excess fluid from the blood). Review of the comprehensive assessment dated [DATE] showed the Resident 17 was cognitively intact. Further review showed the resident experienced feeling down and had trouble sleeping. Review of the care plan dated 12/09/2024 showed the resident had triggers for PTSD related to sexual assault (gang raped) by older boys when he resided in a school for the deaf. The assaults started when they were 8 years old and lasted until they were [AGE] years old. Interventions listed to minimize the residents PTSD triggers were identified as, leaving the door to their room open especially at night, being around people they know and trust, and not wanting to share a room with a stranger (roommate) as it scared them. During a concurrent interview on 02/04/2025 at 9:10 AM, Staff F, Social Services Director (SSD), stated Resident 17 had suffered years of serious abuse in a home for the deaf which had caused their PTSD. Staff D stated the resident did not like having a roommate which had brought on some triggered behaviors such as anger towards the roommate and wanting their own room. Staff F stated they had offered the resident a choice between several other rooms, but they all had roommates. Record review of a progress note dated 01/29/2025 at 12:51 AM, showed Resident 17 had exhibited triggered behaviors towards their roommate yelling out. The resident was difficult to re-direct however staff was able to resolve the situation. During a follow up interview on 02/07/2025 at 9:30 AM, Staff F stated having a roommate or someone they did not know in their room especially at night was absolutely a trigger for Resident 17's anger towards their roommate as well as anxiety and fear. Staff F stated the sexual abuse Resident 17 suffered for nine years when they were young was the PTSD trigger for not wanting some one, they did not know, in their room with them. Staff F further stated they had been told there was no option for Resident 17 to have a private room as they had been informed there were no private rooms available. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a care conference dated 02/03/2025 at 1:40 PM, showed Resident 17's discharge goals was to regain strength and function to return to the community. The resident was using their Medicare (a type of insurance) benefit to receive skilled therapy services and was making progress towards their discharge goals. There was no discussion about staying in the facility as a long-term resident. During an interview on 02/06/2025 at 1:30 PM, Staff B, Director of Nursing Services, stated they were aware that the resident had PTSD triggers and wanted a private room, however, they were unable to give them one as the only private rooms available were on the Medicare unit which were for short-term residents and I believe the resident is going to be a long-term resident. Staff B further stated, I understand they [Resident 17] want a private room, but they will have to have a roommate or wait for one to open up on the long-term care unit. Reference WAC 388-97-1060 (3)(e)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44922 Based on interview and record review, the facility failed to ensure residents were free of unnecessary psychotropic medications (medications capable of affecting the mind, emotions, and behavior) for 2 of 5 residents (Residents 12 and 42) reviewed for unnecessary medications. The facility failed to consistently develop, monitor, and document specific person-centered targeted behaviors, interventions, and adverse side effects of medication. Additionally, they failed to assess for abnormal involuntary movements with the Assessment Involuntary Movement Scale (AIMS, a scale that assesses the presence and severity of abnormal movements of the face, limbs, and body in patients with tardive dyskinesia [abnormal and uncontrollable movements caused by antipsychotic medications] prior to starting a psychotropic medication and periodically thereafter). The deficient practice placed residents at an increased risk for experiencing medication-related adverse side effects, receiving medications they no longer needed, and increased behaviors due to inadequate dosing of medication. Findings included . <Resident 12> Review of the resident ' s medical records showed they admitted with diagnoses including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (a group of symptoms affecting memory, thinking, and social abilities) with agitation (excessive talking or purposeless motions, feeling of unease or tension, and hostile behavior at times). The 12/02/2024 comprehensive assessment showed Resident 12 ' s cognition was moderately impaired and received psychotropic medications. An observation and concurrent interview on 02/04/2025 at 8:22 AM, showed Resident 12 lying in bed, wearing a nasal cannula (tubing with nose prongs that distribute air from an oxygen machine to the resident), and was difficult to arouse and keep active in a conversation. Resident 12 ' s oxygen machine power was not turned on. Staff U, Licensed Practical Nurse, entered the room, turned on the oxygen machine and stated Resident 12 had difficulty sleeping at night and at times would sleep a lot during the day. Staff U stated the resident would at times display behaviors such as exit seeking, talking about wanting to go home, and want to go out to smoke even though they quit smoking. Review of Resident 12 's February 2025 Medication Administration Record (MAR), showed Resident 12 received Remeron (a brand of antidepressant medication) for malnutrition (inadequate protein intake) and Seroquel (a brand of antipsychotic [used to manage symptoms such as delusions, hallucinations, paranoia, and disordered thoughts] medication). The MAR showed general behaviors and interventions that were not specific for Resident 12. There was no documented monitoring for adverse side effects of the medications. Review of Resident 12 's medical record showed no AIMS assessment had been completed for the use of the antipsychotic medication. <Resident 42> (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's medical records showed they admitted to the facility with diagnoses to include a stroke (a lack of blood and oxygen to the brain). The 01/17/2025 comprehensive assessment showed Resident 42' s cognition was severely impaired, they scored zero (no depression) on the depression scale and received antidepressant medication. During an observation on 02/04/2025 at 9:18 AM, Resident 42 was lying in bed, dressed, groomed, and pleasantly conversating with their roommate. Review of Resident 42 's April 2024 MAR, showed the resident was being monitored as of 04/11/2024 for generic (non-specific resident behaviors) behaviors for manipulation, false accusations, yelling, agitation, tearfulness, and refusal of cares. The MAR showed Resident 42 experienced no behaviors. Review of the May 2024 MAR showed no behaviors were experienced, and a new order on 05/10/2024 for Celexa (a brand of antidepressant medication) daily for depression. The MARs showed no documented adverse side effects were being monitored, and no changes were made to the resident 's behaviors. Review of the February 2025 MAR showed the resident continued to take Celexa. Review of Resident 42 's depression scale assessment on 04/02/2024, showed the resident had mild symptoms of depression. Review of Resident 42 's progress notes showed: 04/08/2024 - no new orders and no concerns for mood and behavior. 04/11/2024 - Resident 42 would be staying at facility long term, can be very stubborn, about cares at times, and would consult the provider for possible depression and start behavior monitoring. 05/01/2024 - written by Staff K,Resident Case manager, RCM, showed Resident 42 was disruptive, resistive to care, excessive crying, and anxious behaviors, with no other documented observations of these behaviors 05/09/2024 - Resident 42 could be very stubborn about cares at times but was compliant and participated in therapies 05/09/2024 - a call was placed to the medical provider regarding the depression scale assessment (mild depression) and received a new order for Celexa and a new diagnosis of depression. All other daily progress notes showed Resident 42 had no mood or behavior concerns documented before or after the medication was started. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 3:32 PM, Staff K, RCM,stated they placed general behavior monitoring on every resident when they admitted to the facility. Staff K stated when residents experienced behaviors, they could ask the provider to adjust or add medication as needed based off those behaviors. Staff K stated they had observed Resident 42 crying during their initial care conference and the Resident Representative (RR) expressed their concern about the resident possibly being depressed. Staff K stated they then asked the provider if they would like to start a mild antidepressant. Staff K stated they sometimes missed updating the behavior monitoring and interventions to be more resident specific and during their change of Electronic Health Records they lost some of that information and had to re-create it. Staff K stated monitoring of the adverse side effects of the psychotropic medications were only monitored for the first seven to 14 days of the new medication then was no longer monitored. Review of the 04/01/2024 and 04/05/2024 care conference progress notes showed no documented tearfulness of Resident 42 during the care conferences or that the RR verbalized concerns of depression. The notes showed the RR verbalized that the resident was not a social person so may not do well in group settings. The RR stated they felt concerned Resident 42 may have become satisfied with their sedentary habits. During an interview on 02/06/2025 at 3:53 PM, Staff B, Director of Nursing Services, stated they monitored resident specific behaviors, interventions, and adverse side effects but when the electronic health record system changed, we lost a lot of that stuff. Staff B stated they would have expected the consistency of documented behaviors that showed why a resident would need to be started on an antipsychotic medication. WAC Reference: 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview, and record review the facility failed to ensure medications and wound supplies were discarded when expired and labeled correctly for 1 of 1 medication storage rooms and 1 of 1 treatment storage rooms. This failure placed residents at risk for receiving expired medication and/or experiencing compromised or ineffective medications and treatments. Findings included . Review of the facility's ,d+[DATE] policy, titled Medication Storage showed, all medication rooms were routinely inspected for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels and would be destroyed. <Medication storage room> An observation on [DATE] at 3:55 Accompanied by Staff S, Registered Nurse, the medication room showed: Two - glucagon (an emergency medication used to treat severe low blood sugar) injection pens 1 milligram (mg-unit of measure) each that expired on ,d+[DATE]. One- 16 - ounce (oz-unit of measure) bottle of lactulose (a medication used to treat constipation) with the name of the resident tore off. 25 - albuterol sulfate (a medication used to treat wheezing, and shortness of breath caused by breathing problems) doses that expired on [DATE]. 25 - albuterol sulfate doses with no resident name on the box. 30 - ipratroprium bromide (a medication used to treat wheezing, and shortness of breath caused by breathing problems) doses that expired on [DATE]. 11- ipratroprium bromide doses that expired on ,d+[DATE]. 30 - ipratroprium bromide doses that expired on [DATE]. 25 - ipratroprium bromide doses with the resident name blacked out. One- two -gram vial of cefazolin (antibiotic) intravenous medication (into a vein) that expired on ,d+[DATE]. < Treatment room> An observation on [DATE] at 9:14 AM, of the treatment supply room showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two- four by five-inch calcium alginate gel (a gel that helps maintain a moist environment to promote wound healing) wound dressing that expired on [DATE]. Four- four by eight-inch calcium alginate wound dressing two that expired on ,d+[DATE] and two on [DATE]. Two- four by eight with calcium alginate that expired on ,d+[DATE] Four- four by four-inch hydrocellular foam wound dressing that expired on ,d+[DATE]. One- four by five-inch Xtrasorb super absorbent wound dressing that expired on ,d+[DATE]. Three- four by four-inch sheets of hydrogel (promotes tissue regeneration and healing) wound dressing that expired on [DATE], [DATE], [DATE]. Eight- four by four-inch hydrogel derma gauze that expired on [DATE]. Two- five by nine-inch foam gauze wound dressing that expired on ,d+[DATE]. One- 10.2 by 10.2 -inch hydro antibacterial wound dressing that expired [DATE] Three - packs of 2% chlorhexidine gluconate (an antiseptic liquid that kills bacteria and prevents infections) cloths that expired on ,d+[DATE]. Five - suction catheter kits (used to remove fluids from the respiratory tract, wounds or airways) that expired on [DATE]. During an interview on [DATE] at 3:35 PM, Staff B, Director of Nursing Services, stated it was the responsibility of the day charge nurse to check the treatment room and the medication room weekly for expired and unlabeled medications/wound supplies. Staff B stated they had to pull the day charge nurse to work on the floor due to low staffing. Staff B stated, it fell through the cracks. Reference WAC: [DATE](2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46722 Based on observation, interview and record review, the facility failed to ensure proper sanitization and food handling practices in accordance with standards of practice for 1 of 1 kitchen reviewed for food safety. The failure to maintain a clean/sanitary kitchen and complete Hand Hygiene (HH, washing or sanitizing hands) as required, placed residents at risk for foodborne illnesses. Findings included . Review of the policy titled, Food Safety Requirements, revised 01/2024, showed food safety practices would be followed throughout the entire food handling process. All equipment used for food handling would be cleaned, sanitized and handlined to prevent contamination. Clean dishes would be kept separate from dirty dishes. The policy also showed staff were to follow safe hygienic practices to prevent contamination of foods by washing hands and change gloves appropriately. Review of the policy titled, Handwashing Guidelines for Dietary Employees, revised 03/2023, showed employees were to perform handwashing to prevent the spread of bacteria that may cause foodborne illness. Dietary employees were to clean their hands in a handwashing sink and may not use a sink used for food preparation or washing kitchen ware. Additionally, the hand washing sink must have a supply of hand cleaning solutions and a means to dry the employees' hands. Staff were to perform hand washing often during the preparation of food, using clean equipment/utensils or after touching soiled surfaces or donning (put on) gloves, to prevent cross contamination when they changed tasks. <Kitchen Sanitation> An observation on 02/02/2025 at 9:36 AM, showed the following: Upon entrance to the kitchen department was a ceiling fan that had thick dark brown/gray substance inside and on the outside of the fan. The ceiling fan was above the area of a resident refrigerator, ice machine and an open cabinet that held resident clean drink cups and pitchers. The right side of the wall in front of the entrance doors had a stainless sink with sink handles and faucet covered in a thick yellow/white crusty substance. The sink drain was wet and covered in a reddish/brown substance and had pieces of food in the drain and sink. The cabinet below the sink contained a crockpot heating element, a large roll of paper towels and a 12 inch by eight inch open cut out missing cabinet base and ride side of the cabinet. The area of the missing cabinet base showed exposed concrete debris, two rodent traps and pipes covered in a white/brown substance. The cut out of the ride side of the cabinet showed exposed pipes, spray foam insulation and concrete. The bottom of the cabinet showed a large area of yellow film with a brown outline and multiple dark black/brown splatter spots. Upon entrance to the main kitchen area to the left was the dishwashing station. The dishwasher counter contained dirty trays, dishes, and watery food debris. (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Next to the dishwasher station to the right was an open wire rack that contained clean uncovered dishes, that included cups, mugs, bowels, plates, and pitchers.

In front of the wire rack, next to the cook top, was a large triple basin sink used for washing dirty cooking utensils, pots and pans. The sink had two large food covered silver tubs in the sink. The faucets were corroded with a brown and yellow crust on the handles, faucets, and sink basin.

Under the sink was a shelf that contained a basin with brushes with black/brown chunky debris.

The back of the large triple basin sink that was next to the cooktop had multiple areas of dried yellow/brown food debris splatters and dried white and blackish/brown crust on the pipes.

To the left of this sink was a room length stainless steel countertop. Above the countertop was an open window that had a plastic drink cup with red liquid and a straw on the window ledge.

To the right of the countertop was an electrical outlet that was covered in a thick brown substance and yellow particles.

There was a shelf below the countertop on the left that showed brown/white dried food debris on two pot lids, a white powder spilled on a plastic measuring container, two boxes of unopened cake mix, and a half-used jug of vegetable oil. The shelf also contained a large pot, a large colander, and a black hand mixer with many areas covered with brown/white hardened food debris and the power cord laying on the kitchen floor.

There was a hallway between the main kitchen and the food storage area. This area also contained a door to the outside, a hand-washing sink, a mop sink, a closet next to the mop sink that had a mop bucket and wet mop stored in the bucket and an employee restroom.

The hand washing sink showed the faucet had a thick brownish thick crust surrounding the entire faucet base. The sink had a separation from the wall that showed a gap with brown/yellow debris along the sink and wall.

The hand soap dispenser above the sink was open and displayed a crushed plastic bag of hand soap.

The paper towel dispenser was empty and there was no trash receptacle in this area.

The mop sink had stained brown/black basin and around the rim of the sink, the faucet, and the spout were covered with green/white thick substance.

<Food Preparation and Staff Hygiene>

During an observation and interview on 02/06/2025 at 10:33 AM, Staff P, Dietary Cook, stated the large triple basin sink was where they washed the large cooking dishes, pots and pans prior to placing them into the dishwasher. Staff P proceeded to wash their hands in this sink that contained dirty dishes. Staff P used the jug of dish soap for hand soap and after washing their hands proceeded to the hand washing sink and obtained a paper towel, dried their hands, and put the used paper towel into the kitchen trash.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 02/06/2025 at 10:36 AM, showed Staff Q, Dietary Aide (DA), preparing desserts on the prep counter, when Staff Q removed one glove from their right hand, walked across the kitchen, opened a drawer and removed a food scoop. Staff Q returned to the prep counter, scooped up food and placed it into a resident dessert cup, then put a new glove on their right hand. Staff Q did not perform any hand hygiene. An observation on 02/06/2025 at 11:08 AM, showed Staff O, Registered Dietician, stirring a large basin of food on the cook top next to the large triple bay sink. Staff P was washing dishes and soapy water was splashing around and onto the cook top. Staff P washed their hands in the triple basin sink after washing the dishes, then obtained paper towel from the hand washing sink area and dried hands. Staff P removed a cup from the dishwasher ' s gray wash bin, rinsed it with water from the large triple basin sink, and then placed onto the wire rack wet. An observation on 02/06/2025 at 11:15 AM, showed Staff Q, washed their hands in the hand washing sink. Staff Q used their hands to squeeze the soap from the soap bag, as the dispenser was open and not working. An observation on 02/06/2025 at 11:16 AM, showed an opened white, Red Bull drink can on top of the food delivery cart. A second opened Red Bull drink can was on the ledge above the food prep counter. The food delivery cart had four shelves, each shelf had multiple areas of splattered dried food debris and drips. During an observation on 02/06/2025 at 11:17 AM, Staff P put on clean gloves, without performing HH, and removed a cooking utensil from the clean dishwasher tray and placed it onto the back counter. They returned to the dishwasher area and placed their gloved hands onto the dishwasher sink edge for 10 seconds. Staff P opened the dishwasher from the entry (dirty) side during the dishwashing cycle, removed a gray dish tray bin and another cooking utensil and placed them onto the back counter. Staff P, still wearing the soiled gloves, obtained potholders and removed biscuits from the oven and placed them onto the food prep counter. Staff P proceeded to use the cooking utensil from the back counter and placed cooked vegetables into a blender. Staff P, wearing the same soiled gloves, performed a temperature check for the biscuits with a thermometer. They removed the biscuits from the baking sheet with a scraper and placed the biscuits into a large silver metal container. During the same observation, Staff P then removed their soiled gloves and did not perform HH. Staff P obtained foil, covered the container of biscuits and placed them on top of the food delivery cart with the opened can of Red Bull. Staff P then donned new gloves, without performing HH, and blended the cooked vegetables in the blender. Staff P opened a thickening powder container wearing the same gloves, used their finger to poke a hole into the paper cover and tore the cover off. They proceeded to open a drawer and retrieved a measuring spoon. While wearing the same gloves, they added the thickening powder to the blended vegetables and re-blended. Staff P placed the vegetable mixture into a small silver container, rinsed the blender in the large dish sink, and placed it into the dishwasher. Staff P returned to the food prep counter, obtained additional dirty dishes and put them into the dishwasher, started the cycle and, while wearing the same gloves, covered the blended vegetables with foil. An observation at 11:30 AM, showed Staff P remove their soiled gloves, obtained food scoops and utensils from a drawer, placed them into a silver bin and set the bin onto the food delivery cart uncovered, without performing HH. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 02/06/2025 at 11:55 AM, showed Staff R, DA, removed clean wet cups from the dishwasher tray and stacked them into the cabinet that contained resident drink cups without the cups being dry. During an interview on 02/06/2025 at 12:05 PM, Staff O stated dishes placed into the dishwasher were to run the entire wash cycle and once the cycle was completed, staff were to remove the cleaned dishes from the dishwasher from the opposite side, which was the clean side. Staff O stated dishes removed from the dishwasher were to air dry and needed to be completely dry prior to putting clean dishes away. Staff O stated kitchen staff should always be moving from an area of clean to dirty and remove their gloves and perform HH. Staff O stated kitchen staff were to use the designated hand washing sink and not any of the other sinks in the kitchen as they were for washing dirty dishes only. An observation and interview on 02/06/2025 at 12:08 PM, showed there was no trash bin by the designated hand washing sink. Staff O pointed to a large white plastic bin with a lid on the floor and stated that was the trash bin. Staff O proceeded to remove the lid which showed the bin contained dirty rags and used wet paper towels. Staff O reached into the bin and removed the wet paper towels, walked them into the kitchen and disposed of them in the kitchen trash can. Staff O returned to the hand washing sink area and did not perform any hand hygiene. During an observation and interview on 02/06/2025 at 12:10 PM, showed the shelf below the food prep countertop on the left-hand side, had white powder spilled on a plastic measuring container, a jug of vegetable oil that was 1/4 full, and an uncapped can of non-stick cooking spray. The shelf also contained a black hand mixer with many areas covered with brown/white hardened food debris. Staff O stated they were unsure why these items were on this shelf and were uncleaned. During an interview on 02/07/2025 at 11:34 AM, Staff P stated they used the large dish sink to wash their hand as it was located near their work area. Staff P stated it was not the designated hand washing sink. Staff P stated they did not perform hand hygiene as they should have during the meal preparation. During a concurrent interview on 02/07/2025 at 12:04 PM, Staff A, Administrator, stated their expectations were for kitchen staff not to have any personal drinks in the food/kitchen areas. Staff B, Director of Nursing Services, stated they understood the identified areas of concern in the kitchen were an infection control issue. Staff A stated they expected the kitchen staff to pay attention to detail and follow proper hand hygiene practices. Reference WAC: 388-97-1100(3), 388-97-2980 (3)(5)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 39652 Based on interview and record review the facility failed to ensure that direct care staffing information was electronically submitted to the Centers for Medicare and Medicaid Services (CMS) for 1 of 3 quartersof 2024 reviewed for Payroll Based Journal (PBJ a mandatory report for staffing based on payroll data submission). This failure caused CMS to have inaccuraterelated to Nursing home staffing levels and the potential impact on care and services provided by direct care staff. Findings included . Record review of the Certification and Survey Provider Enhanced Report (CASPER) showed the facility had failed to report PBJ data for the 4th Quarter July 1, 2024 to September 30, 2024. During an interview on 02/07/2025 at 3:50 PM, Staff A, Administrator, stated they were unaware that the PBJ data had not been submitted as required and would look into it. Reference WAC 388-97-109(1)(2)(3) 44922 46722

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program.

44922

Based on observation, interview, and record review, the facility failed to implement components of their infection prevention and control precautions for hand hygiene and glove change for 2 of 3 residents (Residents 14 and 48) reviewed during wound care treatment, and utilizing appropriate Personal Protective Equipment (PPE, clothing and equipment that is worn and used to provide protection against hazardous substances or environments) and the sanitation of blood glucose testing (a blood test that measures the level of sugar in your blood) equipment for 2 of 2 Licensed Nurses (Staff BB and Staff CC) reviewed for medication administration. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases.

Findings included .

<Medication Administration>

An observation of a medication pass on 02/06/2025 at 2:46 PM, showed Staff BB, Licensed Practical Nurse (LPN), administered blood glucose testing to Resident 46. Staff BB placed their supplies on a clean barrier, applied gloves, cleansed Resident 46's finger with an alcohol swab, poked their finger with the lancet (a small plastic cylinder that contain a sterile steel needle held within a lancing device [glucometer]), and obtained blood onto the test strip. Staff BB then read the result to the resident, exited the room, and placed the glucometer onto a tray on the medication cart while they prepared testing for the next resident. Staff BB then removed their gloves, sanitized their hands and did not sanitize the glucometer.

An observation and concurrent interview of a medication pass on 02/06/2025 at 2:53 PM, showed Staff BB entered Resident 42's room, placed a barrier, applied gloves, cleansed the resident's finger with an alcohol swab, poked their finger with a lancet, and obtained blood onto the test strip. Staff BB then read the results to the resident and exited the room, placing a white tray holding the glucometer onto the top of their medication cart. Staff BB removed their gloves, sanitized their hands and did not sanitize the glucometer. Staff BB stated they did not know they needed to sanitize the glucometer and allow for drying time in between each resident use.

An observation and concurrent interview of a medication pass on 02/07/2025 at 11:52 AM, showed Staff CC, LPN, entered Resident 1's room, a transmission-based precaution (requires additional PPE to prevent transmission of an infectious disease) room. The sign posted on the outside of the door showed a gown, gloves, mask, and eye protection must be worn prior to entering the room. Staff CC applied a gown, gloves, a surgical mask, and was wearing their own personal eyeglasses. Staff CC then entered the room, administered Resident 1 their medication, sanitized their hands, removed their gown, gloves, exited the room, then removed their surgical mask and sanitized their hands again. When Staff CC was asked why they did not wear eye protection, Staff CC stated, I did, I was wearing my glasses and that was my eye protection. Staff CC stated they had always worn their own eyeglasses as their eye protection.

<Hand Hygiene>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Medical Resort of Parkside	308 West Emma Union Gap, WA 98903

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 14> Review of the medical record showed Resident 14 was admitted with diagnoses including kidney disease, malnutrition and weakness. The 01/02/2025 comprehensive assessment showed Resident 14 required substantial/dependent assistance of one to two staff members for activities of daily living (ADLs) and had an intact cognition. Review of the facility provider note dated 02/04/2025, showed Resident 14 had excess fluid in their lower legs that resulted in skin tears. The skin tears were managed and followed by the wound nurse. During an observation and interview on 02/05/2025 at 10:34 AM, showed Staff I, Treatment Nurse, begin prepping for Resident 14's wound care without performing hand hygiene. Staff I stated their process was to prepare the wound dressings on top of their wound cart and bring into the Resident's room. Staff I stated Resident 14's wound dressings consisted of three sets of non-adherent dressings they taped together to cover their legs. Staff I also stated they put A&D ointment (skin protectant) onto the dressings to keep the wounds from sticking to the dressings. Staff I proceeded to open the drawers of the wound cart, removed two Kerlix (absorbent, flexible gauze) dressings and a roll of tape. Staff I hung strips of tape from the wound cart edge and put the date and their initials on the tape with black marker. Staff I gather the prepped wound care supplies and entered Resident 14's room and place the items onto the Residents bedside tray table. The bedside tray table had an open box of tissues, the residents water cup and eyeglasses. Staff I did not remove the items, clean the bedside table nor place a barrier on top of the bedside table before placing the wound care dressings on top of the table. Staff I then exited Resident 14's room, obtained and donned a yellow gown from the PPE bin, without hand hygiene. Staff I proceeded to the linen cabinet down the hall and obtained a white bath blanket, returned to the wound cart, removed the wound cart keys from their pocket and obtained a bottle of saline. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation, Staff I then entered Resident 14's room, no hand hygiene, no gloves and opened the bottle of saline. Staff I then donned gloves and placed the bath blanket under Resident 14's legs. Staff I poured some saline onto Resident 14's old dressings to loosen the tape on the gauze. Staff I then used scissors to cut away the old dressings from Resident 14's legs. After the old dressings were removed, Staff I placed the dressings and gauze from the bedside table onto Resident 14's leg and secured with the tape. Staff I stated they did not make enough wound dressings for both legs, removed their yellow gown and gloves placed into the resident's trash and exited the room, then used alcohol-based sanitizer (ABHS) from their wound cart. Staff I then removed the keys from their pocket, opened the wound cart, and prepared the wound dressings as before on top of their cart. Staff I donned a yellow gown from the PPE bin, obtained the dressings from the top of the wound cart and entered Resident 14's room. Staff I placed the dressings onto the resident's bedside tray table and donned gloves, without performing hand hygiene. Staff I placed the dressings onto Resident 14's leg and secured with tape. Staff I then placed foam foot protectors onto Resident 14's feet, removed the wet and soiled bath blanket from under the resident's legs, placed the resident's blankets over their body and put the used dressings into the trash. Staff I obtained a white garbage bag from the trash bin, placed the soiled bath blanket into the bag, used the resident's bed remote and lowered the bed, pushed the bedside tray table back across the Resident 14's lap area and told the resident their water, tissues and eyeglasses were still on the bedside table for their use. Staff I then removed their gown and gloves, put them into the trash bin, obtained the trash bag and exited the room. Staff I used ABHS for one hand when they exited and place the used linen in a bin in the hallway, picked up trash from the floor and put into trash bin. <Resident 48> Review of the resident's medical record showed they admitted with diagnoses of stroke (happens when blood flow to the brain is disrupted), chronic kidney disease (your kidneys are gradually damaged and can't filter waste from your blood properly, causing a buildup of toxins in your body over time). The 01/01/2025 comprehensive assessment showed Resident 1 requires the assistance of two staff members for ADLs and had a moderately impaired cognition. Further review showed Resident 48 had a Stage 3 pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and concurrent interview on 02/05/2025 at 2:37 PM, showed Staff I, treatment nurse, placed gloves on outside of Resident 48's room. Staff I grabbed the wound supplies from the top of the treatment cart, placed wound supplies and an open sterile boarded gauze dressings with medi honey (a substance that helps wounds heal) on the bedside table with no barrier between the wound supplies and the bedside table surface. Staff I with the same gloves on unfastened Resident 48's soiled brief and pulled it down. Staff I removed the dressing from Resident 48's left buttock the dressing was saturated with a large amount of pinkish-red drainage. Staff I placed the soiled dressing beside the resident on the sheet with no barrier. Staff I grabbed a small tube of saline (a mixture of salt and water used to clean wounds) and clean gauze off the bedside table with the same soiled gloves on and cleaned Resident 48's wound. Staff I placed the dirty gauze next to the dirty dressing on the sheet. Staff I grabbed the clean dressing off the bedside table with the same soiled gloves on and applied it to resident 48's left buttock wound. Staff I grabbed all the soiled dressings and supplies from the bed placed them on the bedside table next to the clean wound supplies with no barrier. Staff I removed their gloves and placed new gloves without performing hand hygiene and pulled up resident's soiled brief. Staff I with the same spoiled gloves grabbed a clean foam dressing from the bedside table and placed it on Resident 48's left side wound. Staff I with the same soiled gloves rolled resident over, fixed the sheets and pillows and covered resident with blankets. Staff I removed their gloves did not perform hand hygiene and grabbed the dirty dressings off the bedside table with ungloved hand and placed them in the trash. Staff I opened the door with soiled hands, went to the treatment cart and used hand sanitizer. Staff I stated the process was to place a barrier on the bedside table before placing the wound supplies, change their gloves going from dirty to clean, perform hand hygiene before placing new gloves and before exiting the room and they did not do that this time. During an interview on 02/06/2025 at 3:34 PM, Staff B, Director of Nursing Services, stated the process for hand hygiene for all staff was to follow the CDC guidelines. Staff B stated during wound care, a barrier should be placed between the clean supplies and the dirty surface, gloves should be changed between dirty and clean tasks, and hand hygiene should be completed when entering and exiting the rooms. WAC Reference: 388-97-1320 (1)(a)(c), (5)(c-e) 46722 48368

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 44922 Based on interview and record review, the facility failed to implement key components of their immunization program regarding the pneumococcal vaccine (a vaccine that protects against pneumococcal infections that can lead pneumonia and blood infections) by not ensuring residents were thoroughly screened for the pneumococcal vaccination status on admission and were administered the pneumococcal vaccines as required per current Center for Disease Control and Prevention (CDC) and Advisory Committee on Immunization practices guidance for 2 of 5 residents (Residents 2 and 21) reviewed for immunizations. This failure placed residents at risk of exposure to contagious diseases and an increased the risk for respiratory complications. Findings included . Review of the 05/01/2017 policy, titled Influenza and Pneumococcal Immunizations, showed upon admission residents would be given information regarding the immunizations risks and benefits, obtain history of previous immunizations, and obtain consent from the resident or the Resident Representative if an immunization needed to be given. <Resident 2> Review of the resident's medical records showed the resident admitted with diagnoses to include diabetes (elevated sugar in the blood). The 12/20/2024 comprehensive assessment showed Resident 2 had intact cognition and received their pneumococcal vaccine outside of the facility. Review of Resident 2's immunization records showed Resident 2 had signed a declination for the Pneumococcal vaccine on 03/15/2024 because they had previously received the vaccine. The record showed no verification of vaccination status, which vaccine resident had previously received if not the whole series, when they received it, or if they still required the vaccine. <Resident 21> Review of the resident's medical record showed they admitted to the facility with diagnoses to include dementia (a group of symptoms affecting memory, thinking and social abilities). The 01/17/2025 comprehensive assessment showed Resident 21's cognition was severely impaired, and their pneumococcal vaccine was up to date. Review of Resident 21's immunization records showed the resident was offered the pneumococcal vaccine and it was declined on 10/23/2024. The record showed no risks and benefits had been given to Resident 21 or a declination to receive or refuse the vaccine had been signed. The record additionally showed the resident had previously received the pneumococcal vaccine outside of the facility but there were no records to show when, where, or what the status was of the vaccine previously given. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 11:26 AM, Staff J, Infection Preventionist/Restorative Director, stated they did not make attempts to access previous immunizations given when a resident informed them, they had obtained a vaccination outside of the facility, other than looking in their discharge records. Staff J stated they just took their word for it. Staff J stated their normal process was to offer and if they refused or had the vaccine previously, they would have them decline and sign the declination. Staff J stated they must have missed that for Resident 21. WAC Reference: 388-97-1340 (2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48368 Based on observation and interview, the facility failed to provide a safe and sanitary environment for 2 of 2 storage rooms reviewed for environment. This failure placed residents at risk of injury and potential illness from unsanitary equipment storage. Findings included . Review of the facility policy titled, Resident Environmental Quality, revised 05/2023, showed the facility would maintain and provide a safe and sanitary environment by utilizing preventive maintenance schedules for the building and equipment to maintain a safe environment. <Storage Room> An observation on 02/02/2025 at 10:48 AM, showed the labeled storage room door ajar and unlocked. Inside the storage room was a wall to the left with an electrical panel, multiple electrical wires exposed. The floor had three-foot-tall computer network equipment system with an open computer laptop on top of the system. On the floor was two large spools of wire, a white board leaned up against the wall, and an easel. The back wall directly behind the computer network system had painted open wood shelving. The shelving had overflowing activity supplies, decorations and boxes. Observations on 02/03/2025 at 9:11 AM, 02/04/2025 at 8:21 AM, and on 02/05/2025 at 9:34 AM, showed the storage room door propped open 12 inches (unit of measure) with two stacked orange cones. <Hoyer (mechanical lift used to transfer residents from one surface to another) Storage Room> An observation on 02/06/2025 at 2:54 PM, showed the Hoyer storage room with two lift devices stored in the room and the flooring had a four foot (unit of measure) by three-foot section of linoleum flooring missing. One of the Hoyer lifts was parked on this area. The area of missing linoleum flooring was peeling up and chips of the linoleum were on the bare concrete. The exposed concrete had areas of green, white and brown coloring and a 10-inch circular drain with a white cover. The other linoleum floor area had an eight inch (unit of measure) circular area with exposed concrete and with two three-inch-high uncapped plumbing pipes. The linoleum flooring had additional areas of brown, black and gray scrape marks. Additionally, the entire Hoyer room had tile walls that had missing and/or broken tiles. During an interview on 02/07/2025 at 11:25 AM, Staff H, Maintenance Director, stated there were unaware of the condition of the Hoyer storage room. Staff H stated staff were to log needed repairs in a binder outside their office when needed. Staff H stated the Hoyer storage room had not been logged as an area for repair. Staff H stated the flooring would need to be torn out and replaced. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview on 02/07/2025 at 12:04 PM, Staff A, Administrator, stated the storage room contained the satellite television equipment and the activities department supplies. Staff A stated the facility kept the door open as the storage room would overheat when the door was closed. Staff B, Director of Nursing Services, stated the storage room door being closed, could be a fire and safety hazard. Staff B stated the Hoyer room could be an infection control concern as the flooring and walls were broken and had exposed concrete. Reference WAC: 388-97-3220(1)