STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview, and record review the facility failed to ensure the resident was evaluated, assessed and a physician order was obtained for safe administration of medications for 1 of 1 resident (Resident 46) reviewed for clinically appropriate self-administration of medications. This failed practice placed the resident at risk for adverse medication interactions, complications, and a diminished quality of life. Findings included . Review of the facility policy titled Medication Administration Self-Administration by Resident: Self-Administration by Resident, dated 11/2017, showed: Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe, and the medications are appropriate and safe for self-administration. Resident 46 admitted on [DATE]. According to the Admission Minimum Data Set Assessment (an assessment tool) dated 05/05/2024, the resident had no cognitive impairment. In an observation and interview on 06/07/2024 at 1:03 PM, a bottle of Pedialyte (used to replace fluids and minerals) and a box of 10 NeuroBion B12 Forte (a vitamin B12 supplement) were observed on the bedside table. There were four of the 10 NeuroBion's left. Resident 46 stated they had been taking one dose of the NeuroBion a day. In an interview on 06/07/2024 at 1:34 PM, Staff P, Licensed Practical Nurse (LPN), stated they saw a container at bedside but were not aware that it was Pedialyte. Staff P did not see the Neurobion container. Staff P stated they did not know if Resident 46 was on a self-medication program. Reviewed of Resident 46's care plan, dated 06/06/2024, showed they were not care planned to be on a self-medication program. Review of a nursing progress note, dated 06/07/2024 at 8:03 PM, showed Resident 46's physician did not agree with them taking the NeuroBion medication because it could cause them problems and they were allowed to take a limited quantity of the Pedialyte each day. Refer to WAC 388-97-0440

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47104 Based on interview and record review, the facility failed to obtain, provide, and/or assist with completing Advance Directives for 4 of 5 sampled residents (Residents 22, 32, 62, and 65) reviewed for Advance Directives. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . <RESIDENT 32> Resident 32 was admitted to the facility on [DATE] with diagnoses including fall at home resulting in left tibia fracture, and infection at left tibia surgical site. Resident 32's profile information records showed they were self-responsible in making their own decisions. Review of Resident 32's current medical record on 06/05/2024 and 06/10/2024, showed no Advance Directives had been formulated. Review of the resident's medical record did not show documentation that the resident had been informed of their right to formulate an Advance Directive. In a joint interview on 06/07/2024 at 12:15 PM, with Staff A, Administrator, and Staff V, Unit Coordinator, Staff V stated Advance Directive documentation was included in the admission agreement and during the admission agreement process the Advance Directive document would be signed by the resident or resident representative for acknowledgement. Staff V stated if a resident had Advance Directives, it would be scanned into the resident's medical record and if a resident needed assistance formulating an Advance Directive the facility would assist them. Staff V stated a new administrative assistant had recently been hired and stated they are behind on completing admission agreements. Staff A stated the goal was for admission paperwork to be completed within 24 to 72 hours from admission. Staff A could not confirm whether Resident 32 had a signed Advance Directive document and stated they would provide the information. On 06/07/2024 at 2:40 PM Staff A provided a copy of Resident 32's Advance Directives that was dated 06/05/2024. No further information was provided. <RESIDENT 65> Resident 65 was admitted to the facility on [DATE] with diagnosis including fall at home resulting in multiple pelvic fractures, sacral (bottom of the spine) fracture, and left radial (wrist) fracture. Resident 65's profile information record showed they were self-responsible in making their own decisions. Review of Resident 65's current medical record on 06/05/2024 and 06/10/2024, showed no Advance Directives had been formulated. Review of the resident's medical record did not show documentation that the resident had been informed of their right to formulate an Advance Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/07/2024 at 12:15 PM, Staff A, could not confirm whether Resident 65 had Advance Directives and stated they would provide the information. On 06/07/2024 at 2:40 PM Staff A provided a copy of Resident 65's Advance Directives that was dated 06/07/2024. No further information was provided. 37890 <RESIDENT 22> Resident 22 admitted in 2022 and was a long term care resident. Review of Resident 22's medical record on 06/06/2024 showed no Advance Directives had been formulated. Review of the resident's medical record did not show documentation that the resident had been informed of their right to formulate an Advance Directive. In an interview on 06/05/2024 at 11:25 AM, Resident 22 stated they had not been asked about an Advance Directive that they were aware of and they did not have anything official set up if something happened to them. 44110 <RESIDENT 62> Resident 62 admitted to the facility on [DATE] with diagnoses including aftercare treatment for open heart surgery, and heart disease. The admission Minimum Data Set (MDS) assessment dated [DATE] showed the resident had intact cognition, and no legal authorized representative. Review of Resident 62's medical record on 06/05/2024 showed no advanced directive had been formulated. The medical record had no documentation that the resident had been informed of their right to formulate an advance directive. On 06/07/2024 at 2:46 PM, Staff A, Administrator provided Resident 62's admission paperwork, that included information that the resident was offered information on how to formulate an advance directive. The paperwork was signed by the resident on 06/05/2024, 23 days after the resident admitted to the facility. In an interview on 06/10/2024 at 10:27 AM, Staff F, Registered Nurse (RN)/Resident Care Manager stated social services was responsible for handling the advanced directives for residents. In an interview on 06/10/2024 at 10:43 AM, Staff E, Social Services Assistant stated the administrative assistant was responsible for reviewing that paperwork with the resident on admission. Staff E stated the facility just recently hired someone for that role and was aware they were behind with the admission agreements. Staff E stated they do not verify if the resident was offered the opportunity to formulate an advanced directive during the initial care conference. Refer to WAC 388-97-0280 (3)(a-c) (i-ii)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on observation, interview, and record review, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 1 of 2 floors (3rd floor). The failure to ensure resident's floors were clean and free of debris, and utility and housekeeping rooms were secured left residents at risk for a diminished quality of life, and a less than homelike environment. Findings included . <UNSECURED MAINTENANCE AND HOUSEKEEPING EQUIPMENT> In an observation on 06/05/2024 at 11:01 AM, the maintenance room door and the housekeeping room doors near room [ROOM NUMBER] were unlocked and unsecured. The maintenance room had paint, caulk, tools, various equipment, television (TV) screens and other clutter were stored all over the room and floor. The housekeeping room had chemicals to include Aromazyne drain and grease trap maintenance odor eliminator that was labeled to keep out of reach of children. In an interview on 06/05/2024 at 11:14 AM, Staff U, Maintenance Assistant, stated those rooms were supposed to be locked. In an interview on 06/05/2024 at 11:33 AM, Staff A, Administrator, stated those doors were supposed to be locked. In an observation on 06/07/2024 at 11:10 AM, the maintenance room door and the housekeeping room doors near room [ROOM NUMBER] were unlocked and unsecured. The room contained paint, caulk, tools, various equipment, TV screens and other clutter, and the housekeeping room had the Aromazyne drain and grease trap maintenance odor eliminator. In an interview on 06/07/2024 at 1:40 PM, Staff A was unable to provide any information why those maintenance room and housekeeping rooms were unlocked. <RESIDENT ROOMS> room [ROOM NUMBER]-B In an observation on 06/05/2024 at 2:09 PM, the wall close to the foot of the bed in room [ROOM NUMBER]-B had stains and patches of different colors, the picture on the wall was not centered and there was paint underneath and around it that was a different shade then the rest of the wall, and there were many unused picture hanging devices of various types. In an observation on 06/07/2024 at 11:09 AM, the wall facing the bed in room [ROOM NUMBER]-B had surfaces that were in poor repair, there was many patches of the wall of various sizes that had not been painted and there were several colors to the surface. There were many picture hanging devices of various types located in various places on the wall, and there was a large picture that was hanging crooked. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/10/2024 at 11:09 AM, Staff A stated they were going to be fixing the wall in room [ROOM NUMBER]-B. 47047 <room [ROOM NUMBER]-B> Observation on 06/06/2024 at 9:09 AM, a small round debris (the size of a pea), brown in color and dry on the floor next to the bedside table near a pair of shoes and an oxygen (O2) concentrator (a medical device that provides pure O2). The green O2 tubing was laying on the floor around and on touching the debris. The floor had not been swept. On 06/07/2024 at 9:47 AM, a small round debris, as above, was observed on the floor next to the bedside table and O2 concentrator. The green O2 tubing was laying on the floor around and touching the debris. The floor had not been swept. Observation on 06/10/2024 at 1:28 PM, as above, observed the same round debris from the prior week on the floor next to the bedside table near a pair of shoes and oxygen concentrator. The green oxygen tubing was laying on the floor around and touching the debris. The floor had not been swept. In an interview and observation on 06/10/2024 at 1:28 PM, Staff J, Licensed Practical Nurse (LPN), stated housekeeping came in daily and cleaned room [ROOM NUMBER]-B's floor. Staff J picked up their feet, one at a time from the floor, each time there was a noise that showed their feet were sticking to the floor. Staff J stated the flooring was not cleaned. When asked what the multiple pieces of debris were on the floor, Staff J stated they did not know. Staff J picked the green oxygen tubing off the floor and placed all the tubing in the bed side table drawer. Refer to WAC 388-97-0880(1)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review, the facility failed to complete accurate assessments for 1 of 3 sampled residents (Resident 58) reviewed for dental concerns, and 2 of 8 sampled residents (Resident 6 and 32), reviewed for Pre-Admission Screening and Resident Review (PASRR - a federally required screening of all individuals who has both an Intellectual Disability [ID] or Related Condition [RC] and a serious mental illness [SMI] prior to admission to a Medicaid-certified nursing facility or a significant change of condition). These failures placed residents at risk for unmet care needs. Findings included . <DENTAL> Resident 58 admitted to the facility on [DATE] with diagnoses that included kidney failure, urinary tract infection, and atrial fibrillation (an irregular heart rate). Review of Resident 58's Minimum Data Set (MDS-an assessment tool) assessment, dated 05/02/2024, showed they did not have any missing or broken teeth, abnormal mouth tissue, obvious or likely cavities, no teeth, inflamed or bleeding gums, mouth/facial pain or discomfort, and their teeth were able to be examined. Review of Resident 58's care plan, dated 04/26/2024, showed Resident 58 required maximum assistance for oral care and hygiene. Review of Resident 58's progress note, dated 04/29/2024, showed they had a computed Tomography (CAT scan-detailed imaging technique) done on 04/15/2024 which showed they had dental hardware. On 06/05/2024 at 1:48 PM, Resident 58 was observed with visibly missing teeth on their upper jaw. In an interview and observation on 06/07/2024 at 2:10 PM, Resident 58 stated they brush their own teeth and doesn't have any dental pain. Resident 58's teeth were observed to be a dark gray color at the gumline. In an interview on 06/10/2024 at 12:19 PM, Staff M, Licensed Practical Nurse (LPN), stated Resident 58 would not allow an examination of their mouth. Staff M stated they thought Resident 58 had a partial plate, did not know how it was cleaned, and believed Resident 58 completed their oral care independently. In an interview on 06/10/2024 at 1:21 PM, Staff N, Nursing Assistant Certified (NAC), stated Resident 58 had their own teeth and oral care was provided by their spouse. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/2024 at 9:05 AM, Staff O, Registered Nurse (RN)/MDS Nurse, stated the process for completing the MDS included a review of the medical records and an in-person interview with the resident being assessed. Staff O stated they assessed their oral cavity by asking questions and having the resident open their mouth. Staff O stated if a resident would not allow an assessment of the oral cavity the MDS would be coded as unable to examine. Staff O stated they were recently hired and did not complete Resident 58's MDS assessment. 47104 <PASRR> RESIDENT 6 Resident 6 admitted to the facility on [DATE] with diagnoses including depression and dementia. Review of Resident 6's current medical record showed the Level I (pre-screen to determine if a resident may have a SMI, ID, or related condition and is typically completed by the referring entity) PASRR completed on 05/15/2024, was positive requiring a Level II (an in-depth evaluation to determine if a resident has a SMI, ID, or related condition and is completed by a representative from the state intellectual disability authority or a representative from the state mental illness authority) PASRR. Review of the PASRR Level II section of the MDS assessment, dated 05/28/2024, showed Resident 6 had not been evaluated as having an SMI. In an interview on 06/11/2024 at 1:21 PM Staff E, Social Services Assistant, confirmed Resident 6 had a positive Level I PASRR requiring a Level II PASRR, and the MDS was not coded correctly. RESIDENT 32 Resident 32 admitted to the facility on [DATE] with diagnoses including depression and anxiety disorder. Review of Resident 32's current medical record showed the Level I PASSR completed on 05/10/2024, was positive, requiring a Level II PASRR. Review of the PASRR Level II section of the MDS assessment, dated 05/20/2024, showed the resident had not been evaluated as having a serious mental illness. In an interview on 06/10/2024 at 12:47 PM Staff E, Social Services Assistant, confirmed the resident had a positive Level I PASRR requiring a Level II PASRR, and the MDS was not coded correctly. Refer to WAC 388-97-1000 (1)(b)(2)(g)(k)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals who had a mental disorder or intellectual disabilities were offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and receive the services they need in those settings), was followed for 4 of 8 sampled residents (Resident 7, 42, 21 and 26). Failure to coordinate Resident 7, 42, 21, and 26 for Level II (an in-depth evaluation to determine whether the resident requires specialized rehabilitation services) services as indicated placed residents at risk for not receiving care and services in the most integrated setting appropriate to their needs. Findings included . <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses including anxiety, depression, and bi-polar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Review of Resident 7's PASRR, dated 04/12/2024, completed at the hospital, showed they had a serious mental illness (SMI) which was identified as a mood disorder and anxiety. Review of the service needs and assessor data showed the resident was determined that a Level II evaluation was indicated. Additional comments showed the resident had a positive PASRR and was awaiting validation or not. Review of Resident 7's medical record on 06/05/2024, showed no documentation the PASRR had been validated or invalidated. The medical record showed no documentation there was any communication with the PASRR validator. <RESIDENT 42> Resident 42 admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD - a psychiatric disorder that may occur in people who have experienced or witness a traumatic event), major depressive disorder (a mental health disorder where a person has a persistent depressed mood), panic disorder, and anxiety disorder. Review of Resident 42's hospital record, dated 05/02/2024, showed the resident had a history of anxiety, depression, panic disorder with agoraphobia (fear of leaving their known environment), personality disorder, PTSD, and schizotypal personality disorder (mental health condition marked by a consistent pattern of intense discomfort with relationships and social interactions). Review of Resident 42's PASRR, dated 05/14/2024, completed at the hospital, showed they had a SMI which was identified as a mood disorder and anxiety. There was no documentation for the resident's personality disorders or PTSD. Review of the service needs and assessor data showed the resident was determined that a Level II evaluation was indicated. Additional comments showed the resident had a positive PASRR and was awaiting validation or not. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 42's medical record on 06/05/2024, showed no documentation the PASRR had been validated or invalidated. The medical record showed no documentation there was any communication with the PASRR validator. In an interview on 06/10/2024 at 10:43 AM, Staff D, Social Services Director, stated at this time they did not have an audit system in place to follow up on PASRR's that need further assessments or validations. Staff D stated they were not aware Resident 7 and Resident 42 had a positive Level 1 PASRR's and needed Level II evaluations. 47047 <RESIDENT 21> Resident 21 admitted to the facility on [DATE] with diagnoses that included major depressive disorder, psychotic disorder (severe mental disorder that causes abnormal thinking and perceptions) with hallucinations (seeing, feeling, or hearing things that others do not), and Alzheimer's disease (progressive disease that destroys memory and other mental functions). Review of Resident 21's most recent PASRR, dated 8/31/2022, showed they had a SMI which was identified as a mood disorder, anxiety disorder, and had shown indicators within the last two years. Review of the service needs and assessor data it was determined a Level II evaluation was not indicated as the person did not show indicators of SMI. Review of Resident 21's provider progress note, dated 04/08/2024, showed they had a history of psychosis in the setting of their Alzheimer dementia and had paranoia and hallucinations in the past. Review of Resident 21's clinical physician orders showed they had antipsychotic medication prescribed since 10/27/2021. There was no other information found in Resident 21's clinical record related to them being referred for a Level II evaluation. In an interview on 06/11/2024 at 12:28 PM, Staff D stated they reviewed residents PASRR's quarterly, annually, and with any significant change. Staff D stated they were not aware Resident 21's PASRR was inaccurate. <RESIDENT 26> Resident 26 was admitted to the facility on [DATE] with diagnoses that included depression and cancer. Review of Resident 26's PASRR, dated 12/30/2023, completed in the hospital, showed they had a SMI, which was identified as a mood and anxiety disorders, and had shown indicators within the last two years. Review of the service needs and assessor data it was determined that a Level II evaluation was not indicated as the person did not show indicators of SMI. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 26's Care Area Assessment (CAA- a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned), dated 01/15/2024, showed they had depression symptoms secondary to impaired health and fading independence. Review of Resident 26's care plan, dated 01/03/2024, showed no focus on their depressive symptoms, goals or interventions identified on the CAA. There was no other information found in Resident 26's clinical record related to them being referred for a Level II evaluation. In an interview on 06/11/2024 at 12:28 PM, Staff D stated they were not aware Resident 26's PASRR was inaccurate. Refer to WAC 388-97-1975

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR - a federally required screening of all individuals identified with an Intellectual Disability [ID] or Related Condition [RC] or a serious mental illness [SMI] prior to admission to a Medicaid-certified nursing facility or a significant change of condition) form was completed according to the guidelines specified for 3 of 8 sampled residents (Residents 2, 6 and 32) reviewed for unnecessary medications. Incomplete or inaccurate PASRRs placed residents at risk for inappropriate placement and/or lack of access to specialized services for residents with identified serious mental health indicators or intellectual disability. Findings included . Review of Washington State's exempted hospital requirement (42 CFR 483.106(b)(2)(ii)), showed if an individual who entered a nursing facility as an exception (an exempted hospital discharge) was later found to require more than 30 days of nursing facility care, the State mental health or intellectual disability authority must conduct a Level II resident review within 40 calendar days of admission. <RESIDENT 2> Resident 2 admitted on [DATE] from an acute care hospital. Review of Resident 2's Level I PASSR (pre-screen to determine if a resident may have a SMI, ID, or related condition and is typically completed by the referring entity), dated 04/26/2024 showed Resident 2 was assessed as having indicators of Serious Mental Illness. The Level I PASSR further showed that a referral for level II (specialized services or specialized rehabilitative services that the PASRR Evaluator has determined are required to be provided by either the Nursing Facility or the designated state entity as appropriate) services was deferred, with a box selection stating the resident was exempted from a level 2 referral related to the expectation they would discharge from the facility within 30 days. Review of Resident 2's record on 06/10/2024 showed the resident had not discharged from the facility within 30 days and their stay had exceeded 40 calendar days with no Level II PASSR referral. In an interview on 06/10/2024 at 11:19 AM, Staff E, Social Services Assistant, referred to Resident 2's record from 05/21/2024 (approaching 30 days) that showed Resident 2 no longer met skilled Medicare criteria, which was discussed with the resident and family on that day. The notes discussed discharge planning and stated the resident would remain in the facility until they were able to determine an appropriate discharge plan. Staff E stated there were no notes that addressed a referral for PASSR Level II if the resident would not discharge within 30 days. Staff E stated there would have been a note stating they had made a referral if one had been done. 47104 <RESIDENT 6> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	06/12/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 6 admitted to the facility on [DATE] with diagnoses to include depression and dementia. Resident 6 admitted to the facility on an anti-depressant medication. Review of a Level I PASRR dated 05/15/2024, located in the clinical records, showed mood disorder and anxiety were checked as a mental illness indicator category. Resident 6 was referred for Level II PASRR assessment. Review of Resident 6's current clinical record showed no evidence of Level 2 PASRR evaluation was completed. In a joint interview on 06/11/2024 at 1:21 PM, Staff E and Staff D, Social Services Director, Staff D stated social services was responsible for reviewing PASRR's. Staff E stated Resident 6's PASRR showed a Level II evaluation was required. Staff E stated Resident 6 did not have a Level II evaluation or invalidation. Staff D stated they would follow up with the PASRR coordinator. <RESIDENT 32> Resident 32 admitted to the facility on [DATE] with diagnoses to include depression and anxiety disorder. A Level 1 PASRR, dated 05/15/2024, located in the clinical record, showed mood disorder and anxiety were checked as a mental illness indicator category. Resident 32 was referred for Level II PASRR assessment. Review of Resident 32's clinical record showed no evidence of Level II PASRR evaluation completed. In an interview on 06/10/2024 at 12:47 PM, Staff E, stated Resident 32's PASRR had a Level II evaluation referral required for SMI. Staff E stated they did not see a Level II evaluation or invalidation in Resident 32's clinical record. Staff E stated they would look for documentation of PASRR Level II assessment and provide the documentation if found. There was no further information provided. Refer to WAC 388-97-1915 (1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47104 Based on observation, interview and record review the facility failed to develop and implement comprehensive, person-centered care plans to meet the needs and preferences for 2 of 8 sample residents (Resident 32 and 6) reviewed for Level II PASRR (an in-depth evaluation to determine if a resident has a serious mental illness [SMI], Intellectual Disability [ID] or Related Condition [RC]and is completed by a representative from the state intellectual disability authority), 1 of 3 sampled residents (Resident 65) reviewed for discharge planning, 1 of 3 sampled residents (Resident 42) reviewed for emotion/behaviors, 1 of 3 sampled residents (Resident 26) reviewed for dental, and 1 of 3 sample residents (Resident 422) reviewed for accidents care plans. This failure placed residents at risk for not receiving needed and preferred care and services and a decreased quality of life. Findings include . <LEVEL II PASRR> RESIDENT 32 Resident 32 admitted to the facility on [DATE] with diagnoses to include depression and anxiety disorder. Review of Resident 32's current medical record showed a positive Level 1 PASRR, dated 05/10/2024. The Level I PASRR showed mood and anxiety disorders checked as a mental illness indicator category with a Level II PASRR. Review of Resident 32's current clinical record showed no care plan for a Level II PASRR. In an interview on 06/10/2024 at 2:40 PM, Staff E, Social Services Assistant (SSA), stated Resident 6 did not have a Level II PASRR care plan. Staff E stated they were not sure who was responsible for completing the Level II PASRR care plan. In an interview on 06/11/2024 at 1:21 PM, Staff D, Social Services Director (SSD), stated social services was responsible for the Level II PASRR care plan. RESIDENT 6 Resident 6 admitted to the facility on [DATE] with diagnoses to include depression and dementia. Resident 6 admitted to the facility on an anti-depressant medication. Review of Resident 6's current clinical record showed a positive Level 1 PASRR, dated 05/15/2024. The Level I PASRR showed mood and anxiety disorders checked as a mental illness indicator category with a Level II PASRR. Review of resident 6's current medical record showed no care plan for Level II PASRR. (continued on next page)

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	505404	A. Building B. Wing	06/12/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/11/2024 at 1:21 PM, Staff D stated social services is responsible for care planning PASRR recommendations. Staff D stated Resident 6 did not have a Level II PASRR care plan. <DISCHARGE PLANING> Resident 65 admitted to the facility on [DATE] with diagnoses to include pelvic fracture and left radial (wrist) fracture. In an interview on 06/05/2024 at 10:06 AM, Resident 65 stated they planned to discharge home with their spouse at the end of the week and was concerned about how to order a hospital bed for delivery prior to discharge from the facility. Resident 65 stated they would need a hospital bed on the main level of their house until they could safely go upstairs because of their wrist fracture. Resident 65 stated no one from the facility had talked to them about discharge planning or their upcoming discharge. In an interview on 06/06/2024 at 2:40 PM, Resident 65 stated nobody had talked with them about discharging home. Review of Resident 65's current clinical record showed no care plan for discharge from the facility. In a joint interview on 06/10/2024 at 12:46 PM, Staff E stated discharge planning started when a resident admitted to the facility and was ongoing throughout their stay. Staff D stated social services was responsible for initiating the discharge care plan. Staff D stated Resident 65 did not have a discharge care plan. 44110 <TRAMUA INFORMED CARE> Resident 42 admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder (PTSD - a psychiatric disorder that may occur in people who have experienced or witness a traumatic event), major depressive disorder (a mental health disorder where a person has a persistent depressed mood), panic disorder, and anxiety disorder. Review of Resident 42's Admission Minimum Date Set (MDS - an assessment tool) assessment, dated 05/20/2024, showed the resident had moderate depression, mental health diagnoses of anxiety, depression, PTSD, and was taking a psychotropic (medications that affect a person's mental health) medication. The MDS showed the resident was not receiving any mental health therapies. Review of Resident 42's hospital record, dated 05/02/2024, showed the resident had a history of anxiety, depression, panic disorder with agoraphobia (fear of leaving their known environment), personality disorder, PTSD, and schizotypal personality disorder (mental health condition marked by a consistent pattern of intense discomfort with relationships and social interactions). Review of Resident 42's care plan showed no plan of care to address the residents PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/10/2024 at 9:30 AM, Staff X, Nursing Assistant Certified (NAC), stated they use the care plan to determine if a resident had history or trauma, and it would direct how to provide care to that resident. Staff X was unaware Resident 42 had a diagnosis of PTSD. In an interview on 06/10/2024 at 9:36 AM, Staff Y, Registered Nurse (RN), stated if a resident had a history of trauma or PTSD that would be reflected in the care plan. Staff Y was unaware that Resident 42 had a diagnosis of PTSD. In an interview on 06/10/2024 at 10:27 AM, Staff F, RN/Resident Care Manager (RCM), stated if a resident had history or diagnosis of PTSD that should be part of the care plan. Staff F stated the social services department would be responsible for conducting the psycho-social assessment which would include their history of trauma. In an interview on 06/10/2024 at 10:43 AM, Staff E stated when the resident admitted to the facility they conducted a psycho-social assessment, and the results of that assessment were incorporated into the resident's care plan. Review of Resident 42's medical record on 06/10/2024, showed no psycho-social assessment had been completed for the resident. In an interview on 06/10/2024 at 12:39 PM, Staff E stated they never completed a psycho-social assessment for Resident 42, and that was why there was no plan of care for the residents PTSD diagnosis. 47047 <DENTAL> Resident 26 was admitted to the facility on [DATE] with diagnoses that included depression and cancer. Review of Resident 26's MDS assessment, dated 01/09/2024, showed they had likely cavities and broken teeth. Review of Resident 26's Care Area Assessment, (CAA- a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned), dated 01/15/2024, showed they had potential cavities and a few broken teeth. The CAA showed Resident 26's dental care would be addressed in the care plan with the goal of avoiding dental complications, maintaining their current level of function, and symptom relief. Review of Resident 26's care plan, dated 01/03/2024, showed no dental care plan focus, goals, or interventions. In an interview on 06/06/2024 at 3:05 PM, Resident 26 stated they have not seen a dentist in many years and does not have dental insurance. Resident 26 stated their teeth have been falling out a little at a time and they were able to brush their teeth. Resident 26 stated staff do not inquire about their teeth or their condition. (continued on next page)

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	505404	A. Building B. Wing	06/12/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/11/2024 at 1:17 PM, Staff L, NAC, stated they rely on the care plan and Kardex (a nursing worksheet that includes a summary of patient information and includes daily care schedules/patient specific care needs) to know how to care for a specific resident. 33954 <ACCIDENTS> Resident 422 admitted to the facility on [DATE]. According to the 5- day Medicare MDS assessment, dated 03/20/2024, the resident was rarely/never understood, and they had highly impaired vision. The resident was not interviewable. Review of Resident 422's care plan, dated 06/05/2024, showed an intervention to ensure the resident's call light was within reach and encourage them to use it for assistance as needed. In an observation on 06/07/2024 at 7:35 AM, Resident 422 was asleep in bed and their call light was clipped to the wall and not within their reach. In an observation on 06/10/2024 at 8:00 AM, Resident 422 was asleep in bed and the call light was behind the mattress at the head of the bed and not within their reach. In an interview on 06/10/2024 at 8:02 AM, Staff T, NAC, stated Resident 422 was not able to use their call light. Refer to WAC 388-97-1020 (1)(2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 4 of 18 sampled residents (Residents 8, 21, 26 and 58), reviewed for care plan revision. The failure to revise care plans for hospice services, resident caregiver preference, edema management, and use of psychotropic medication placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <RESIDENT 8> Resident 8 admitted to the facility on [DATE] with diagnoses that included stroke, anxiety disorder and high blood pressure. Review of Resident 8's electronic medical record showed they were admitted to hospice services on 03/14/2024. Observation on 06/06/2024 at 9:09 AM, an oxygen (O2) concentrator (a medical device that provides pure O2) was located next Resident 8's bedside table. There was green O2 tubing laying on the floor. Review of hospice binder, located at the nurse's station, on 06/11/2024 at 8:40 AM, showed a facility/hospice care coordination- delineation of responsibilities document. The document contained facility responsibilities to include: - Coordination with hospice aide. Hospice aide visits 2 times weekly. - Notification to Hospice of any changes in drugs or treatments or supply needs. - Notification to Hospice of any changes in resident's condition. - Therapies and activities unrelated to the resident's terminal illness. - Treatments contained in the plan. - Dates and times of Facility meetings for the resident's plan of care. - Help with all needed Activities of Daily Living. - Information to Hospice staff that supplies were low and what supplies were needed. - Weigh resident per Hospice request, as needed. - Facility to administer the resident's medication. (continued on next page)

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	505404	A. Building B. Wing	06/12/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of additional contents of the binder, showed Hospice team members, their contact information, and a plan of care update report, dated 03/26/2024. None of the documents located in the binder were found in Resident 8's electronic medical record. The hospice care plan update report, dated 03/26/2024, showed Resident 8 had a home health aide service for assistance with personal care and their medication list included O2 use. Review of Resident 8's care plan, dated 03/14/2024, showed they were on hospice care with an intervention to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. There were no specific interventions found in the care plan related to the use of a hospice aide, changes to Resident 8's medications, or use/supply of an O2 concentrator. In an interview on 06/10/2024 1:28 PM Staff J, Licensed Practical Nurse (LPN), stated they did not know why Resident 8 had a O2 concentrator in their room. Staff J stated Resident 8 must have used O2 in the past. When asked about coordination between hospice and the facility, Staff J stated they provided care and medications as they normally do. Staff J stated the same hospice nurse and bath aid comes to see Resident 8. When asked how the staff know to contact hospice, Staff J stated a hospice folder was located at the nurse's station for communication purposes. Staff J stated the facility does not keep a hospice care plan. In an interview on 06/11/2024 at 9:37 AM Staff M, LPN/Resident Care Manager (RCM), stated the hospice care plan was integrated with the facility's care plan. Staff M stated nursing staff rely on the care plan to care for Resident 8. <RESIDENT 21> Resident 21 admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mental health disorder where a person has a persistent depressed mood), psychotic disorder (severe mental disorder that causes abnormal thinking and perceptions) with hallucinations (seeing, feeling, or hearing things that others do not), Alzheimer's disease (progressive disease that destroys memory and other mental functions). Review of Resident 21's Medication Administration Record for June 2024, showed they were prescribed Seroquel (an antipsychotic medication) 75 milligrams (mg) at bedtime for psychotic disorder, lorazepam (an anti-anxiety medication) 1 mg every morning and bedtime for anxiety and Mirtazapine (an anti-depressant medication) 15 mg at bedtime for depression. Review of Resident 21's pharmacy review, dated 02/28/2024, showed Sertraline (an antidepressant) was discontinued. Review of Resident 21's electronic medical record, showed Fluoxetine was started 12/06/2019 and discontinued 01/08/2024 and started Sertraline 02/18/2024 and discontinued 02/26/2024. Review of Resident 21's progress note, dated 02/26/2024, showed the resident's representative refused to allow the resident to have the medication Sertraline due to increased lethargy (a lack of energy) and it was discontinued. Review of the progress note, dated 01/12/2024, showed Resident 21's use of Fluoxetine was discontinued after review by the pharmacist citing risk of falls and resident feeling tired and sleepy. (continued on next page)

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	505404	A. Building B. Wing	06/12/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 21's care plan, dated 12/04/2020, showed they used antidepressant medications mirtazapine and fluoxetine (an antidepressant medication) related to depression with a goal to be free from discomfort and adverse reactions with an intervention to monitor for side effects. The care plan did not reflect the changes in Resident 21's antidepressant use, potential impact it may have on Resident 21, or the resident or their representative input. In an interview on 06/11/2024 at 12:28 PM Staff D, Social Services Director (SSD), stated there had not been a routine meeting to discuss residents taking psychotropic medication. Staff D stated it was an interdisciplinary approach to updating care plans between nursing and social services. Staff D stated they were unaware of the discrepancies in Resident 21's care plan with regarding the use of antidepressant medication. <RESIDENT 26> Resident 26 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), depression, and cancer. In an observation and interview on 06/05/2024 at 10:28 AM, Resident 26 was observed with gauze wrapped around their left lower leg, was swollen and was larger in size as compared to their right. Resident 26 stated their left leg had been oozing fluid and the nurse wrapped their leg in gauze. In an observation and interview on 06/06/2024 at 3:05 PM, Resident 26 was observed wearing nonskid socks. When asked about their compression socks, Resident 26 stated they only had one pair and they should probably have worn them. In an interview on 06/10/2024 at 12:05 PM, Staff M stated there were multiple interventions in place for Resident 26's edema management which included use of medications, encouragement to elevate their legs, recliner chair in their room, a walking program, and application of a kerlix (a type of gauze bandage) when their legs are weeping (fluid that leaks directly from the skin). Staff M stated they did not know why the above interventions were not part of Resident 26's care plan. Review of Resident 26's progress notes, dated 04/08/2024 and 05/23/2024, showed Resident 26 had diuretic use and edema (swelling). Review of Resident 26's care plan, dated 01/03/2024, showed they had cellulitis (an infection) and actual impairment to their skin integrity) of their left lower leg. Interventions included applied lotion on dry skin, used caution during transfers and bed mobility, and encouraged good nutrition and hydration. There were no focus, goals, or interventions related to Resident 26's edema. <RESIDENT 58> Resident 58 admitted to the facility on [DATE] with diagnoses that included kidney failure, urinary tract infection, and atrial fibrillation (an irregular heart rate). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an incident report, dated 04/30/2024, showed Resident 58 had a fall in their room and they had stated they were trying to get to the bathroom. Resident 58's nursing assistant at the time of the fall was a male aide. Resident 58's care plan was changed to address toileting with the specific interventions of scheduled toileting. The incident report contained a note by therapy which showed Resident 58 requested female therapists only. The incident report did not contain any additional investigation, interventions, or review of Resident 58's preferences suggestive of female care only. In an interview on 06/10/2024 at 10:58 AM, Collateral Contact 2 (CC 2), Resident 58's family member, stated Resident 58 preferred female care only with peri care. In an interview on 06/10/2024 at 12:00 PM, Staff M stated Resident 58 moved from the sixth floor to the third floor to accommodate their preference of having female caregivers. In a review of Resident 58's care plan, dated 04/26/2024, showed there was no focus, goal, intervention to address their preference of having female only caregivers. Refer to WAC 388-97-1020(2)(a)(5)(b)

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	505404	A. Building B. Wing	06/12/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review the facility failed to ensure 1 of 2 sampled residents (Resident 30) reviewed for Pressure Ulcers (PU) were provided care planned interventions they required for the prevention or worsening of PU. This failure to implement pressure reducing devices in accordance with physician's orders placed residents at risk for PU development, worsening of PU, pain, and a diminished quality of life. Findings included . Resident 30 admitted to the facility on [DATE] with diagnoses that included stroke, high blood pressure, spinal stenosis (the spaces inside the backbones of the spine get too small), and right rotator cuff tear (injury to the group of muscles and tendons that hold the shoulder joint in place). In a review of Resident 30's Care Area Assessment (CAA- a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned), dated 11/10/2023, showed they were at risk for skin breakdown related incontinence and required assistance with bed mobility and positioning. Interventions included pressure redistributing wheelchair cushion and an air mattress. Review of Resident 30's care plan, dated 05/16/2024, showed they had a focus area of risk related to PU development as they had a history of PU's, were immobile, were incontinent, and preferred to spend their time in bed. The goal was Resident 30 would have intact skin, free from redness, blisters, or discoloration of their skin. Interventions included low air loss mattress and pressure reduction cushion for chair/wheelchair. In an additional care plan focus of Resident 30's skin integrity showed an intervention of using foam boots. In a review of Resident 30's skin assessment, dated 06/03/2024, showed Resident 30 had blanchable erythema (skin redness) to their coccyx and heels. In a review of Resident 30's skin assessment, dated 06/11/2024, showed Resident 30 had blanchable red areas on their coccyx and heels. Review of Resident 30's Kardex (a nursing worksheet that includes a summary of patient information and includes daily care schedules/patient specific care needs) directed nursing assistants to use foam boots for protection. On 06/10/2024 at 9:38 AM, Resident 30 was observed in their bed with no foam boots. In an observation and interview on 06/11/2024 at 8:55 AM, Resident 30 was observed in their bed with no foam boots. Resident 30 stated they had not worn any foam boots. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/2024 at 9:31 AM Staff M, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated the nurses on the care completed weekly skin checks and any concerns were reported to the RCM. Staff M stated the nursing aides report skin issues/concerns to the nurse and then the RCM was notified. Staff M stated once an issue/concern has been identified they would see the resident and complete an assessment. Staff M stated nursing assistants rely on the care plan and Kardex to know how to care for a resident. Staff M stated they were not aware of Resident 30's need for foam boots, there was no order for foam boots and did not think they wore them. Refer to WAC 388-97-1060(3)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	06/12/2024

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Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954 Based on interview and record review, the facility failed to ensure residents with limited range of motion (ROM) received the necessary services to maintain their level of functioning and/or prevent decline for 2 of 2 sample residents (Residents 14 and 26) reviewed for limited range of motion. This failure placed the residents at risk for decreased ROM and diminished quality of life. Findings included . Review of the facility policy titled, Restorative Nursing Programs, dated 05/01/2024, showed the interdisciplinary team would assure the ongoing review, evaluation, and decision-making regarding the services needed to maintain or improve the residents' abilities in accordance with their comprehensive assessment, goals and preferences. The policy also indicated the restorative nursing plan would include the frequency of the restorative activities. The policy indicated the restorative nurse would provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly. <RESIDENT 14> Resident 14 admitted to the facility 12/12/2013 with diagnoses to include a stroke affecting the right side of their body, and dementia. According to the Quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 05/19/2024, the resident had severe cognitive impairment and had limited ROM on one side of their upper and lower extremities. In an interview on 06/06/2024 at 8:40 AM, Resident 14 stated they did not receive any ROM services. Review of Resident 14's care plan, print date 06/06/2024, showed the resident was to receive active and passive restorative ROM services. The care plan did not indicate the frequency of the resident's ROM services. Review of Resident 14's electronic health record, showed the latest Restorative Evaluation was done 07/02/2021, it indicated the facility would review and adjust the resident's program through the quarter or as indicated. Review of a Restorative Program note, dated 12/02/2022, showed Resident 14 would benefit from continuing their restorative program because it enabled them to maintain their gains and highest level of physical function within their ability, and it may slow down further impairment. The note did not indicate the frequency Resident 14 was to receive their ROM services. Review of Resident 14's restorative participation documentation for their right upper extremity passive ROM program, dated 05/08/2024 - 06/06/2024, showed they had ROM services eight times, 10 refusals, and N/A (not applicable) was documented eight times. The documentation did not indicate how frequently the resident was to receive ROM services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 14's restorative participation documentation for their right lower extremity passive ROM program, dated 05/08/2024 - 06/06/2024, showed they had ROM services 15 times, and they had refused 10 times. The documentation did not indicate how frequently the resident was to receive ROM services. Review of Resident 14's restorative participation documentation for their left upper extremity active ROM program, dated 05/12/2024 - 06/10/2024, showed they had ROM services 14 times, they had refused eight times, and N/A was documented four times. The documentation did not indicate how frequently the resident received ROM services. Review of Resident 14's restorative participation documentation for their left lower extremity active ROM program, dated 05/12/2024 - 06/10/2024, showed they had ROM services eight times, eight refusals, and N/A was documented 10 times. The documentation did not indicate how frequently the resident received ROM services. Review of Resident 14's Quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 05/19/2024, showed for restorative nursing, there was no days documented that programs services were done. In an interview on 06/10/2024 at 2:20 PM, Staff A, Administrator, and Staff Z, Restorative Aide/Nursing Assistant Certified (NAC), were jointly interviewed. Staff A stated the last restorative evaluation was done in 2021 by a nurse that was no longer employed by the facility. Staff Z stated they documented Resident 14 refused even if they (Staff Z) weren't there and didn't offer restorative, as that was how they were trained. In an interview on 06/11/2024 at 12:07 PM, Staff O, Registered Nurse/MDS Nurse, stated they had not coded the MDS (dated 05/19/2024) that Resident 14 had participated in a restorative program, because there was no current restorative assessment, so the program didn't meet the requirements there actually was a restorative program. Staff O stated it was in the works to get a restorative assessment done by a nurse. 47047 <RESIDENT 26> Resident 26 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), depression, and cancer. Review of Resident 26's care plan, dated 01/03/2024, showed no care plan for a restorative program or any refusals of care and/or services. Review of Resident 26 MDS assessment, dated 04/23/2024, showed they were not on a restorative program and received 97 minutes of physical therapy three times in the prior seven days to the assessment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 26's physical therapy discharge summary, dated 02/13/2024, showed they were a fall risk, weight bearing as tolerated with less than 10 percent assistance of one person to walk and a plan for restorative follow up. Review of Resident 26's restorative program, dated 02/13/2024, showed they were to have the restorative program five to six times a week to improve/maintain their strength and flexibility in their both their legs. The program consisted of seated marches, seated quadriceps exercises, hip exercises, and ambulated (walk) to the gym using a walker with one person contact guard assistance and to follow the resident with their wheelchair. Review of Resident 26's restorative flow sheet, dated 02/13/2024 to 02/29/2024, showed they received their restorative program four times on 02/18/2024, 02/19/2024, 02/20/2024, and 02/26/2024. Review of Resident 26's March 2024 restorative flow sheets, showed Resident 26 received their restorative program 10 times, on 03/01/2024, 03/02/2024, 03/13/2024, 03/14/2024, 03/17/2024, 03/19/2024, 03/20/2024, 03/24/2024, 03/26/2024, and 03/27/2024. Review of Resident 26's April 2024 restorative flow sheet, showed they received their restorative program seven times (on04/03/2024, 04/04/2024, 04/05/2024, 04/06/2024, 04/08/2024, 04/09/2024 and 04/13/2024). Review of Resident 26's May 2024 restorative flow sheet, showed Resident 26 received a part of their restorative program five times (on05/20/2024, 05/21/2024, 05/23/2024, 05/24/2024 and 05/29/2024). Review of Resident 26's restorative flow sheet, dated 06/01/2024 through 06/07/2024, showed they had refused the restorative program. Review of Resident 26's progress notes, dated 01/02/2024 through 06/05/2024, showed no documentation of refusals of care/services. In an interview on 06/10/2024 at 10:28 AM, Resident 26 stated they sat in their chair all day and they don't think this was good for them. Resident 26 stated they were e losing their strength by not utilizing their muscles. Resident 26 stated they wanted more therapy. When asked about a restorative program, Resident 26 stated they did not have one, that they had seen staff helping other residents walk. In an interview on 06/07/2024 at 10:53 AM, Staff A stated Resident 26 had been refusing their restorative program. In an interview on 06/10/2024 at 12:05 PM, Staff M, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated they had recently been given information about Resident 26's restorative program and the goal was to provide them with more ambulation. Staff M stated Resident 26 had been doing the sitting exercises and physical therapy had recently added the walking component to their restorative program as of 06/01/2024. Staff M stated Resident 26 prefers one restorative aide over the other. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/10/2024 at 12:26 PM, Staff Z stated Resident 26 was unreliable with their ability to walk and they felt unsafe completing the walking portion of the program. Staff Z stated they code refusals on the restorative program flow sheets for instances in which the program could not be completed, if a resident refused, and when they did not administer the program in situations where the staff felt it was unsafe. Staff Z stated they were taught to do this, and they were just doing what they were told. Staff Z stated they would prefer to use N/A rather than refused, because it would be a more accurate representation rather than it appeared the resident refused. Staff Z stated they had reported to the nurse their concerns about Resident 26 and their ambulation program. Refer to WAC 388-97-1060 (3)(d)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview, and record review, the facility failed to assess dietary preferences, maintain accurate documentation of nutritional intake of meals and supplements, consistently offer substitutes or replacement meals when residents ate less than 50% of a meal, notify the physician of significant weight loss, perform consistent and accurate weights, assess and offer culturally appropriate meals, and follow and update care plans as needed, for 1 of 2 sampled residents (Resident 46) reviewed for nutrition/weight loss. Resident 46 experienced severe weight loss of 11.8% weight loss in 34 days. This failed practice placed residents at nutritional risk and diminished quality of life. Findings included . Review of the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, dated 02/03/2023, defined severe weight loss greater than five percent in one month, and greater than 7.5% in three months. Review of the facility policy titled, Weight Monitoring, dated 05/01/2024, showed, facility to accurately assess weight on admission, create a care plan to include resident's goals and preferences, monitor and modify interventions appropriately according to resident's preferences and goals, and professional standards in nutritional status, communicate care instructions to staff and notify physician for any significant weight changes. Significant weight changes defined as: five percent change in weight in one month, 7.5 percent change in weight in three months and ten percent change in weight in six months. Review of the facility policy titled, Nutrition/(Impaired)/Unplanned Weight Loss-Clinical Protocol, dated September 2017, showed the staff to report to the physician any significant weight loss, the nursing staff to monitor and document weight and dietary intake of residents in a format that shows comparison over time, staff and physician to identify resident's risk for impaired nutrition, and identify interventions based on causes and overall condition, prognosis and wishes of the resident. Resident 46 admitted to the facility on [DATE] with diagnosis to include sepsis (life threatening complications of an infection), urinary tract infection, diabetes, muscle wasting, and atrophy (partial or complete wasting away of a part of the body). According to the Admission Minimum Data Set (an assessment tool) assessment, dated 05/05/2024, the resident had no cognitive impairment, and could feed themselves after setup assistance. Review of the physician's History and Physical, dated 04/30/2024, showed Resident 46's weight was 200.2 (no units given) on 04/30/2024. The review of Resident 46's weights (a mechanical lift was used to obtain the resident's weight) showed: - On 04/29/2024, there was no admission weight documented. - On 05/01/2024 at 1:24 PM, the resident weighed 193.1 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- On 05/13/2024 at 7:32 AM, the resident weighed 182.0 lbs., a weight loss of 11.1 lbs. in 12 days. - On 05/29/2024 at 1:41 PM, the resident weighed 174.0 lbs., a significant weight loss of 19.1 lbs. or 9.9% in four weeks. - On 06/04/2024 at 7:53 AM, the resident weighed 170.2 lbs., a significant weight loss of 22.9 lbs. or 11.9% in about five weeks. Review of a dietician's weight change note, dated 06/06/2024, showed: -Resident 46's current weight was 170.2 lbs. -The resident's weight continued to trend down in the past week from 173 lbs. (05/30/2024), and an overall weight loss from 193.1 lbs. (05/01/2024). -Recommended to notify the physician of the significant weight loss of 12% in one month. -The resident's weight changes likely due to scale differences with moves to different units, weight methods and measurement differences and variable meal intakes. Review of the resident's weight record, dated 04/29/2024 to 06/04/2024, showed 13 out of 16 weights, Resident 46 was weighed using a mechanical lift. Reviewed of Resident 46's care plan for nutrition, dated 06/06/2024, showed an intervention to notify the physician for weight loss of more than three lbs. in one week, more than five percent of their body weight in one month, and to weigh the resident at the same time of day. The care plan did not identify any food preferences for the resident. In an interview on 06/05/2024 at 2:59 PM, Resident 46 stated they received the same food all the time and they felt they had lost weight. Resident 46 stated they had experienced weight loss from 215 lbs. (pounds) to 170 lbs. in three weeks. In an observation and interview on 06/07/2024 at 1:03 PM, Resident 46 in bed with their lunch tray in front of them and untouched, there was an unopen carton of chocolate health shake observed next to their plate. They stated their weight loss was making them lose their strength. The resident stated they were from another country and had specific food preferences that they were not receiving at the facility. In an interview on 06/07/2024 at 2:29 PM, Resident 46 was asked about why they did not drink the chocolate shake, they stated it was too sweet and they preferred vanilla. Resident 46 stated that staff had not asked them about their food preferences. Review of the Medication Administration Record, dated 06/07/2024, showed the licensed nurse had documented Resident 46 consumed 100% of their health shake for lunch on 06/07/2024. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview on 06/07/2024 at 2:24 PM, Staff P, Licensed Practical Nurse (LPN), was asked about the health shake documentation that was on Resident 46's lunch tray and was observed unopened. Staff P stated that they gave Resident 46 a health shake that morning and resident drank 237 milliliters and counted that for lunch. Staff P stated they would go give the resident the health shake right now. In an interview on 06/10/2024 at 9:03 AM, Staff Q, Dietary Manager, was asked how they assessed residents' food preferences. Staff Q stated the nurse aides were good about informing them of residents' food preferences. In an interview on 06/10/2024 at 9:06 AM, Staff R, Dietician, stated the Resident Care Manager (RCM) were the ones that notified the physician regarding any weight loss and if they notice weight loss, they will start the resident on a health shake which comes on the resident's tray. In an interview on 06/10/2024 at 9:20 AM, Staff M, LPN/RCM, stated they had not notified Resident 46's physician regarding their weight loss. They have interdisciplinary meetings every Thursdays, where they review residents' weights, attendees were RCM, Dietician, and the Director of Nursing Services (DNS). In an observation/interview on 06/11/2024 at 8:50 AM, Resident 46 stated they only ate a small amount of their breakfast because they did not like the food. The resident stated they liked black beans. Resident 46 stated they ate one piece of bacon and one of the three pancakes. The pancake syrup, butter, salsa, and chocolate health shake were observed unopened on the tray. When asked about the health shake, the resident stated they did not like chocolate, so they told the staff to not even open it as they preferred vanilla. In an observation and interview on 06/11/2024 at 9:05 AM, Staff L, Nursing Assistant Certified (NAC), was observed to pick up Resident 46's breakfast tray and did not offer the resident any alternate/replacement food when they had not eaten more than 50% of their meal. Staff L was asked about not offering the resident an alternate or a meal replacement when they had eaten less than 50% of their breakfast, Staff L stated they felt the resident had eaten enough so they did not ask them. Review of Resident 46's breakfast meal intake in electronic chart, dated 06/11/2024, showed staff documented the resident consumed 75-100% of their meal. In an interview on 06/11/2024 at 9:46 AM, Staff M stated the dietician was responsible for monitoring weight trends, and if there were weight fluctuations, the resident would be put on alert charting (residents' chart is tagged to indicate that special charting procedures/precautions need to be initiated and followed for a specified time). Nursing assistants were supposed to weigh residents between 6:00 AM to 10:00 AM, if there were more than three lbs. of weight loss, the nursing assistant should re-weigh the resident the next day. Staff M did not know why Resident 46 was not re-weighed for four days when they had an 11 lbs. weight loss on 05/13/2024 nor why the nursing assistant did not notify the nurse for Resident 46 of the weight loss. Staff M stated that room changes should not affect the weights because maintenance was supposed to calibrate the scales so there's no differences of the weights on all the scales. If there was a big difference on the weight, around three lbs., then they notify the maintenance staff to re-calibrate the scale. Staff M stated that if a resident does not like the meal, the staff can call the kitchen to get something different, staff don't document if residents were offered snack or replacement. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an observation on 06/11/2024 at 12:23 PM, Resident 46's was observed in bed, their lunch tray was set in front of them, and was uneaten. In an interview on 06/11/2024 at 12:38 PM, Staff S, NAC, stated Resident 46 had eaten less than 50% of their lunch. When asked what they do if a resident ate less than 50%, they stated they offered a snack, provided food choices to the resident, and offered a health shake. Staff S stated the resident does not like chocolate so they would offer Resident 46 vanilla shake. When asked what Staff S does if a resident does not like a certain food or flavor, Staff S stated they would notify the Dietary Manager so it could be put on the tray slip (piece of paper placed on residents' tray with their diet information, allergies, food dislikes) so the resident would no longer get that food/flavor on their meal trays. In an interview 06/11/2024 at 12:43, Staff S stated they had forgotten to go back to Resident 46's room to offer them a food replacement. In an interview on 06/11/2024 at 1:51 PM, Staff B, Registered Nurse/DNS, stated the doctor needed to be notified no matter what for residents with a weight loss of three to five lbs., and placed on alert charting for weight loss. Staff B could not find if Resident 46's had been placed on alert charting for their weight loss. Staff B stated staff were supposed to weigh residents before breakfast, and if a resident ate less than 50% the staff were supposed to offer an alternate meal or food. Staff B stated the dietician were supposed to assess residents for their food preferences. In a phone interview on 06/11/2024 at 2:25 PM, Collateral Contact 1, Advance Registered Nurse Practitioner, on call, reviewed Resident 46 medical record. CC1 was asked about Resident 46's weight loss from 193 lbs. on 05/01/2024 to 170.2 lbs. on 06/04/2024. CC1 stated that was a lot of weight loss and was not able to locate if the resident's provider had been notified. Refer to WAC 388-97-1060 (3)(h)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interviews and record review, the facility failed to obtain needed services from an outside entity for 1 of 2 sampled resident's (Resident 26) reviewed for medically related social services. The facility failed to coordinate and schedule a dermatology appointment after a referral was made for Resident 26 which placed residents at risk for unmet care needs and decrease in their mental, physical, and psychosocial wellbeing. Findings included . Resident 26 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), depression, and cancer. In an interview on 06/05/2024 at 10:28 AM, Resident 26 stated they wanted a second opinion about the rash on his legs. Resident 26 stated the rash on their legs itched and the nurse practitioner had told them that they could not be seen by a skin specialist. In a review of Resident 26's progress note, dated 01/18/2024, showed they had a leg rash and orders for a dermatology recommendation was given. There were no other notes found in Resident 26's progress notes regarding the dermatology appointment/consult. In a review of Resident 26's provider progress note, dated 05/13/2024, showed they had a rash, it was distressing to them because of the itchiness and a dermatology consult was being sought; however, their insurance was making it difficult to find a provider. There were no other provider notes that addressed a dermatology appointment/consult. In an interview on 06/10/2024 at 12:05 PM, Staff M, Licensed Practical Nurse/Resident Care Manager (RCM), stated Resident 26 had a scheduled appointment with a dermatologist, but it had been canceled at the resident's request. Staff M stated medical records would have coordinated and scheduled the appointment. Review of Resident 26's electronic health record showed no other information about a needed or scheduled dermatology appointment. In an interview on 06/11/2024 at 1:17 PM, Staff W, Health Unit Coordinator, stated they were not aware of any referrals for Resident 26 to see the dermatologist. Staff W stated medical records were electronic except for some lab results. Staff W stated when a resident required an appointment, they coordinate the scheduling and if needed the transportation. Staff W stated if Resident 26 was scheduled a dermatology appointment it would be documented in their electronic medical record in progress notes. Staff W stated there was no documentation in Resident 26's the electronic medical record about a dermatology appointment. Staff W contacted their supervisor and stated they would provide additional information if located. No additional information was provided. Refer to WAC: 388-97-0960 (1)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review, the facility failed to ensure the consultant pharmacist conducted thorough monthly medication regimen reviews (MRRs), identified and reported medication-related irregularities for 3 of 5 sampled residents (Resident 18, 21 and 26) reviewed. The failure to act on irregularities identified by the consulting pharmacist placed residents at risk for medication-related adverse consequences and for receiving unnecessary psychotropic medications. Findings included . Six months of the prior pharmacy consultant reviews were requested from the facility on 06/07/2024. The facility provided consultant pharmacy reviews for December 2023, January 2024, February 2024, and May of 2024. In an interview on 06/07/24 at 1:22 PM, Staff B, Registered Nurse (RN)/Director of Nursing Services, stated they did not have March 2024 or April 2024 pharmacy reviews. Staff B stated the consultant pharmacist changed and no pharmacy reviews had been done for March or April. On 06/12/2024 at 10:00 AM, Staff B provided copies of pharmacy consultant visit summaries from the months of March 2024 and April 2024 which had previously been stated to be missing. Staff B stated they had been done but did not know where the reports had gone and did not have documentation that all recommendations had been reviewed and acted upon. 44110 <RESIDENT 18> Resident 18 admitted to the facility on [DATE] with diagnoses including chronic pain syndrome, diabetes with insulin (medication injected into the body to regulate blood sugar) dependence, high blood pressure, anxiety, post-traumatic stress disorder (PTSD), depression, and history of blood clots. Review of Resident 18's June 2024 physician orders showed polypharmacy (simultaneous use of multiple medicines by a patient for their conditions). The medications ordered were four medications for cardiac use, two medications to regulate blood sugar levels, four medications to regulate pain, three medications to regulate mental health, and three medications to regulate bowel movements. Review of Resident 18's medical record showed no documentation that a pharmacist had reviewed the resident's monthly medication regimen. 47047 <RESIDENT 21> (continued on next page)

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	505404	A. Building B. Wing	06/12/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 21 admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mental health disorder where a person has a persistent depressed mood), psychotic disorder (severe mental disorder that causes abnormal thinking and perceptions) with hallucinations (seeing, feeling, or hearing things that others do not), Alzheimer's disease (progressive disease that destroys memory and other mental functions). Review of Resident 21's June 2024 physician orders showed polypharmacy (simultaneous use of multiple medicines by a patient for their conditions). The medications ordered were one diuretic (treatment for excessive fluid accumulation), two medications to regulate blood sugar levels, three medications to regulate mental health, and one medication to thin the blood. Review of Resident 26's medical record showed no documentation that a pharmacist had reviewed the resident's medication regimen since February 2024. <RESIDENT 26> Resident 26 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel), depression, and cancer. Review of Resident 26's June 2024 physician orders showed polypharmacy (simultaneous use of multiple medicines by a patient for their conditions). The medications ordered were one diuretic, one medication to regulate mental health, one medication to regulate pain. Review of Resident 26's medical record showed no documentation that a pharmacist had reviewed the resident's monthly medication regimen. Refer to WAC 388-97-1300 (4)(c)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observation, interview, and record review, the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and national standards of practice for 1 of 1 resident (Resident 14) reviewed for transmission-based precautions (TBP) of a resident that had tested positive for Coronavirus Disease 2019 (COVID-19 -an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise [a general feeling of discomfort/uneasiness], headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death). The facility failed to implement a respiratory protection plan (RPP) for 41 of 119 employed staff (Staff R, Staff U, Staff AA, Staff BB, Staff CC, Staff DD, Staff GG, Staff JJ, Staff NN, Staff PP, Staff QQ, Staff RR, Staff SS, Staff T, Staff EE, Staff FF, Staff HH, Staff II, Staff KK, Staff LL, Staff MM, Staff OO, Staff TT, Staff UU, Staff VV, Staff WW, Staff XX, Staff YY, Staff ZZ, Staff AAA, Staff BBB, Staff CCC, Staff DDD, Staff EEE, Staff FFF, Staff GGG, Staff HHH, Staff III, Staff JJJ, Staff KKK and Staff LLL), and failed to establish an infection surveillance plan for the facility that ensured tracking, analysis, and monitoring for all the facilities infections. The facility's failed to ensure the staff were compliant with appropriate hand hygiene practices during 1 of 2 (Resident 422) observed during wound care, and on 1 of 2 floors (3rd Floor) during meal service. These failures placed all residents and staff at risk for potential infections. Findings included . Review of the facility policy titled, Transmission-Based (Isolation) Precautions, undated, stated residents with COVID-19 infections required a fit-tested Niosha 95 (N95 - type of respirator), gown, face shield/goggles, and gloves for all care. The facility followed all Center for Disease and Control (CDC) guidelines. Review of the facility policy titled, Infection Surveillance, revised 05/29/2024, stated a system of infection surveillance serves as a core activity of the facility's infection prevention and control program. The facility will document infection incidents, monitor facility-wide infections, conduct analysis, interpret the data, and evaluate outcomes and results to ensure all infection prevention and control practices are being followed. Review of the facility policy titled, Respiratory Protection Program, undated, stated that proper respiratory protection is provided and used, when necessary, to protect the health of all employees from respiratory hazards. The program administrator will be the Infection Preventionist, and they are responsible for implementation, management, and support . included duties fit testing, proper use of respirators, training employees on proper use of respirators, and ensuring facial hair does not interfere with proper use of respirators. Review of the facility policy titled, Hand Hygiene, revised 05/01/2024, stated all staff will perform proper hand hygiene procedures to prevent the spread of infection, examples when are but not limited to before and after application of personal protective equipment (PPE) such as gloves, and before and after performing any resident care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the CDC (Centers for Disease Control) document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic, revised March 18, 2024, stated all healthcare workers who enter the room of a resident with suspected or confirmed COVID-19 should wear a National Institute for Occupational Safety and Health (NIOSH) respirator (N95), gown, gloves, and eye protection . When a NIOSH approved respirator such as a N95 respirator was used to provide care for a COVID-19 positive resident they should be removed and discarded after the patient care encounter and a new one should be donned . Facial hair that lies along the sealing area of a respirator, such as beards, sideburns, or some mustaches, will interfere with respirators that rely on a tight facepiece seal to achieve protection. The Occupational Safety and Health Administration (OSHA) regulation was reviewed on 02/07/2024. The guidance for employees of a nursing home states if a respirator was required, employers must implement a written respiratory protection plan that included medical evaluations, fit testing, and training. <TRANSMISSION BASED PRECAUTIONS> RESIDENT 14 Resident 14 admitted to the facility on [DATE] with diagnoses including heart disease, and history of a stroke. The Quarterly Minimum Data Set (MDS- an assessment tool) assessment, dated 05/19/2024, showed the resident had intact cognition, had no active infections, and did not require supplemental oxygen (O2) to assist with breathing. In an interview on 06/10/2024 at 2:03 PM, Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS), stated Resident 14 had tested positive for COVID-19. Review of Resident 14's progress note, dated 06/10/2024 at 10:24 AM, showed the resident reported not feeling well, had nasal congestions, and watery eyes. The resident was tested for COVID-19, and the results were positive. The resident was to be on isolation for 10 days. In a review of Resident 14's physician order, dated 06/11/2024, showed supplemental O2 was ordered for the resident. Review of Resident 14's progress note, dated 06/12/2024, showed the resident required supplemental O2 through a tube to nose at a rate of two liters per minute. In an observation on 06/10/2024 at 2:26 PM, room [ROOM NUMBER] had a sign on door that read aerosol-contact precautions, the resident's door was closed. Outside of the room there was a plastic bin with three drawers, on top was a box of gloves. The top drawer had a box with one N95 respirator (Brand 3M 8200), the second drawer was empty, and the third drawer was full of blue isolation gowns. There was no eye protection in the bin or in the vicinity of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation and interview on 06/11/2024 at 9:22 AM, Staff L, Nursing Assistant Certified (NAC), was observed wearing a baseball hat, and a N95 respirator with the straps on the outside of the hat. Staff L was observed to remove the N95 with their bare hands (no hand hygiene was performed) and place the used N95 on top of the plastic bin outside of room [ROOM NUMBER]. Staff L was observed to remove a new N95 from the top drawer and place it on their face, both straps were visible around the back of their neck. Staff L removed the baseball hat and placed a face shield on their head, placed a pair of gloves on their hands, and then placed on an isolation gown (no hand hygiene was performed). Staff L entered room [ROOM NUMBER] where Resident 14 resided on TBP. Staff L left the door open to the room, Staff L was observed to take a urinal to the restroom inside the room, the toilet was heard flushing, and then returned with an empty urinal. Staff L was observed to grab the resident's food tray, step outside of the room with one leg, place food tray into the food cart, and shut door with a gloved hand. Staff L then removed their gown and gloves in the room, stepped outside of the room, with bare hands removed their face shield, placed it into the trash can inside of the resident's room, and then shut the resident's door. Staff L was observed with bare hands to remove their N95 and set it on top of the plastic bin next to their baseball hat. Staff L, with their bare hands, placed their previous N95 back on (one that was removed prior to entering the room), placed their baseball hat on their head, and performed hand hygiene with hand gel. Staff L was observed to walked down the hall into a closet and retrieved a small trash can, with their bare hands placed their used N95, that was worn in positive COVID-19 room, into the trash can then perform hand hygiene with hand gel. Staff L stated they had worked at the facility for a year and a half. Staff L stated the last time they were educated on the proper donning/doffing (place on/remove) was when they were hired. Staff L was not aware that they had reused a N95, and they were not aware of what proper placement of the N95 straps should be. <INFECTION SURVEILLANCE> On 06/06/2024 at 10:16 AM, a request for the infection surveillance logs, and analysis of the facility infections for the last 90 days was made. On 06/07/2024 at 12:38 PM, the facility provided an infection log of antibiotics prescribed for March 2024 and April of 2024, there was no documentation provided for May 2024. The list included the resident name, room number, onset of their infection, type of infection, and the treatment ordered. The list did not include interpretation or analysis of the data, how the facility had monitored the infection, if there was any epi-linkage (overlap on the same unit or ward, or other patient care location, or having the potential to have been cared for by common healthcare worker within a 7-day time period of each other) to other infections in the facility, or evaluation of outcomes. On 06/07/2024 at 2:34 PM, a second request for the May 2024 infection surveillance log was made. On 06/11/2024 at 2:11 PM, a third request for May 2024 infection surveillance log was made, and nothing was received from the facilty. <RPP> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/07/2024 at 2:25 PM, a review of the facility provided document untitled showed a list of employees for the facility, their department they worked and the respirator they were fit tested for and when. Of the 119 employee names that were listed, 13 (Staff R, Staff U, Staff AA, Staff BB, Staff CC, Staff DD, Staff GG, Staff JJ, Staff NN, Staff PP, Staff QQ, Staff RR, and Staff SS) had not been fit tested for over a year, and 28 (Staff T, Staff EE, Staff FF, Staff HH, Staff II, Staff KK, Staff LL, Staff MM, Staff OO, Staff TT, Staff UU, Staff VV, Staff WW, Staff XX, Staff YY, Staff ZZ, Staff AAA, Staff BBB, Staff CCC, Staff DDD, Staff EEE, Staff FFF, Staff GGG, Staff HHH, Staff III, Staff JJJ, Staff KKK and Staff LLL) employees had never been fit tested . In an observation and interview on 06/10/2024 at 2:28 PM, Staff K, NAC, stated they had worked at the facility for about three years. Staff K was observed to have a black leather baseball hat on their head, facing backwards. Staff K was wearing a N95 respirator, the straps of the respirator were sitting on top of the baseball cap. Staff K was observed to have a full beard with a mustache, the respirator was observed to not touch their skin, and was lying on top of their facial hair. Staff K stated when they were fit tested for a N95 they were clean shaven, so they would be chancing it if they went into room [ROOM NUMBER] to care for Resident 14. Review of the untitled list for employee's who had been fit tested , showed Staff K had been fit tested on [DATE]. In an observation and interview on 06/11/2024 at 9:22 AM, Staff L was observed to continuously touch the front of their N95 during the interview, stated the N95 they were wearing was uncomfortable and painful, and they stated they had requested a different type of a N95 mask, but was told they could not switch. Staff L was not sure who they spoke with about the improper fitting of their N95. In a review of the untitled list for employee's who had been fit tested , showed Staff L was not listed on the employee list. 33954 <HAND HYGIENE> RESIDENT 422 Resident 422 admitted to the facility on [DATE]. In an observation/interview on 06/07/2024 at 7:43 AM, Staff M, Licensed Practical Nurse/Resident Care Manager, was observed performing wound care on Resident 422's left heel pressure injury and did not perform hand hygiene after removing their gloves and donning a new pair of gloves during the procedure. In an interview Staff M was unable to provide any information about their lack of hand hygiene. 47047 TRAY DELIVERY (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/05/2024 at 12:18 PM, Staff N was observed to enter resident rooms on hall three-south with lunchroom trays. Staff N entered room [ROOM NUMBER] without performing hand hygiene, provided the meal tray to the resident, left the room without performing hand hygiene, and removed another resident's meal tray from the meal deliver cart. d Staff N entered room [ROOM NUMBER], 304 and 305 without using hand hygiene in between or after leaving these rooms. In an interview on 06/05/2024 at 12:30 PM Staff N stated they should have completed hand hygiene between entering/exiting rooms and between delivery of the meal trays. Staff N stated they were trying to provide meals to the residents as quickly as possible. Staff N stated they used hand hygiene when required to prevent spread of germs. In an interview on 06/11/2024 at 12:47 PM, Staff C, Registered Nurse (RN)/Infection Preventionist (IP), stated their date of hire was 05/06/2024. Staff C stated they had been made aware that the facility would enter the antibiotics residents had been prescribed into a computer data base. Staff C stated they had not done any surveillance analysis or review of infections yet and was waiting to learn that process. Staff C stated their expectation was all staff followed the CDC guidance for donning and doffing of PPE. Staff C stated they were not aware of who had been managing the RPP at the facility. Staff C stated they will oversee the RPP after they were trained on the process. In an interview on 06/11/2024 at 2:11 PM, Staff B stated their hire date was 05/01/2024. Staff B confirmed the facility had not conducted any infection surveillance other than the reports they submitted. Staff B confirmed there was no analysis done with the data they had submitted. Staff B stated that the IP role would ultimately be responsible for the RPP, at this time the IP (Staff C) had not had any training on the RPP. Staff B stated they were told an outside vendor had provided the service for fit testing in the past. WAC Reference 38-97-1320(1)(a)(c)(2)(a)(c) ,

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 44110 Based on interview and record review, the facility failed to ensure the designated Infection Preventionist (IP) met the qualifications for experience, education, and training or certification for the role to assume responsibility for the facility's Infection Prevention Control Program (IPCP). This failure placed residents, family members, and staff at risk for unmet infection control issues and lack of oversite of the facility staff's infection control practices. Findings included . Review of the facility policy titled, Infection Surveillance, revised 05/29/2024, The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required. Review of the facility's Staff Key Personnel document, updated 06/05/2024, showed Staff C, Registered Nurse (RN), was designated Infection Preventionist (IP) with a date of hire as 05/06/2024. On 06/05/2024 at 9:14 AM, during the entrance conference with Staff A, Administrator, Staff C was named as the facility IP. A request for their credentials was made at that time. On 06/07/2024 at 8:30 AM, Staff B, RN/Director of Nursing Services, provided Staff C's infection credentials. The document showed Staff C completed their credentials on 06/06/2024. Review of the facilities infection surveillance logs on 06/07/2024, showed in March 2024 and April 2024 there was no interpretation or analysis of the data collected on the infections in the facility. The review showed there was not infection surveillance completed for the month of May. In an interview on 06/11/2024 at 12:47 PM, Staff C stated they had been in the role as the IP since they were hired at the facility. Staff C stated they were responsible for all infection control related processes, and education to staff at the facility. Staff C was not aware of when the last time education had been done with staff on infection control policies and procedures. Staff C stated they had not learned what the infection surveillance process for Quality Assurance Improvement Process was for this facility. Staff C stated, there is a lot of training that I still need to learn. In a joint interview on 06/11/2024 at 2:11 PM, Staff A and Staff B were not aware the IP role needed to be occupied by a staff member with experience and credentials that displayed they had completed some specialized training in infection prevention and control. Staff A and Staff B confirmed that Staff C had been the IP since 05/06/2024. Refer to WAC 388-97-1320(1)(a)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 37890 Based on record review, and interview, the facility failed to ensure 3 of 3 Certified Nursing Assistants (NACs) (Staff G, H and I) reviewed for training, had the required 12 hours per year of in-services. This failure placed residents at risk of less than competent care and services from staff. Findings included . Review of Staff G, NAC's, employee file showed their date of hire was 05/19/2019. Review of the in-service education provided did not show evidence of the required 12 hours of in-service education for the prior year. Review of Staff H, NAC's, employee file showed their date of hire was 03/10/2020. Review of the in-service education provided did not show evidence of the required 12 hours of in-service education for the prior year. Review of Staff I, NAC's, employee file showed their date of hire was 12/03/2022. Review of the in-service education provided did not show evidence of the required 12 hours of in-service education for the prior year. In an interview on 06/10/2024 at 8:02 AM, Staff B, Director of Nursing Services stated the education logs from their computer program were mostly from 2022 but other education had taken place recently. Staff B was asked to provide logs for the requested staff showing evidence of the required 12 hours based on hire date and no further information was provided. Refer to WAC 388-97-1680 (2)(a-c)