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	04/21/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences (a collaborative care plan meeting where a resident's care is discussed and coordinated by a team of health care providers, family members and residents) for 2 of 6 sampled residents (Residents 325 and 329) reviewed for participation in care planning. This failure placed residents at risk of not being allowed to be involved and informed about care and services and a diminished quality of life. Findings included . Review of the facility policy titled, Care Planning-Resident Participation, revised date January 2025, documented the facility will encourage and assist the resident and/or resident representative to participate in choosing care and treatment options including initial decisions about treatment .The facility will honor the resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. <RESIDENT 325> Resident 325 was admitted to the facility on [DATE]. According to the Admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident had minimal cognitive impairment. In an interview on 04/15/2025 at 12:10 PM, Resident 325 stated they were not sure about their discharge planning. The resident stated they were not told of a care plan meeting and were not involved in discussions regarding their person-centered care and unsure what the goal was for their care. Review of Resident 325's Electronic Medical Record (EMR) since admission to 04/20/2025, documented no correlating documentation of any interdisciplinary care plan meeting with the resident or representative to discuss the initial comprehensive admission care plan or to establish resident specific goals of care or initiate discharge planning. Review of Resident 325's care plan, dated 04/20/2025, documented no focus area addressing discharge planning. <RESIDENT 329> (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 329 was admitted to the facility on [DATE]. According to the admission nursing assessment dated [DATE], the resident was alert and oriented. In an interview on 04/15/2025 at 11:31 AM, Resident 329 stated during admission, no one explained to them about their medications, treatment or care. The residenrt stated they were not told of a care plan meeting and were not involved in discussions regarding the goals of their person-centered care and not sure about their discharge planning. Review of Resident 329's EMR since admission to 04/17/2025, documented no correlating documentation of any interdisciplinary care plan meeting with the resident or representative to discuss the initial comprehensive admission care plan or establishing resident specific goals of care or initiating a discharge planning. Review of Resident 329's care plan, dated 04/20/2025, revealed no focus area addressing discharge planning. In an interview on 04/18/2025 at 9:35 AM, Staff E, Licensed Practical Nurse/Resident Care Manager, stated social service was responsible for arranging the initial care plan meetings for newly admitted residents and the initial care plan meeting was supposed to be conducted with the resident and/or their resident representatives and multidisciplinary team during the first 72 hours. Staff E stated the initial care plan meeting should be documented under assessments in EMR and they were not sure why there was no documentation of the initial care plan meeting for Resident 329. In a record review and interview on 04/22/2025 at 10:24 AM, Staff B, Director of Nursing, stated they reach out to residents and/or their representatives to set up the initial admission care plan meeting within the first three days. Staff B stated the initial care plan meeting included discussing the resident and family's needs, the baseline functional level, the goals of care and discharge planning. Staff B stated they could not see the documentation of the initial care plan meetings for Resident 325 or Resident 329 during the first three days of admission. Reference WAC 388-97-1020 (2)(f)(4)(d)(e)

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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 - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care [a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so]) was obtained and completed for 3 of 24 residents (Residents 325, 329 and 55), reviewed for advance directives. This failure placed the residents and/or their representatives at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice. Findings included . Review of the facility policy titled, Advance Directive Policy and Procedure, dated 2017, showed the Social Services, at the time of admission, will ask if there are any current Advance Directives. If so, copies will be obtained and placed in the resident's chart under the admission tab and scanned into PC documents. <RESIDENT 325> Resident 325 was admitted to the facility on [DATE]. According to the Admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident had minimal cognitive impairment. Review of Resident 325's medical record document titled Advance Directive Receipt of Information in admission package dated 04/16/2025 documented Resident 325 was unsure if they had a living will or directive to physician. Review of Resident 325's electronic health record (EHR) showed no AD documentation or Resident 325 had been provided with assistance to formulate an AD. Review of Resident 325's care plan, print date 04/20/2025 did not document a focus area addressing an AD. <Resident 329> Resident 329 admitted to the facility on [DATE]. According to the admission nursing assessment dated [DATE], Resident 329 was alert and oriented. Review of Resident 329's medical record document titled Advance Directive Receipt of Information in admission package dated 04/15/2025 documented Resident 329 had no Durable Power of Attorney and was unsure if they had a living will or directive to physician. Review of Resident 329's electronic health record (EHR) showed no AD documentation or that the resident had been provided with assistance to formulate an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 329's care plan, print date 04/20/2025 did not document a focus area addressing an AD. In an interview on 04/16/2025 at 11:23 AM, Staff K, Medical Records stated they could not locate any AD documentation in Resident 329's EHR. <RESIDENT 55> Resident 55 was admitted to the facility on [DATE]. According to the quarterly MDS assessment dated [DATE], the resident had moderate cognitive impairment. Review of Resident 55's medical record document titled Advance Directive Receipt of Information in the admission packet dated 10/03/2024, showed that the resident had a DPOA. Review of Resident 55's EHR showed no copy of the DPOA form. Review of Resident 55's care conference notes dated 10/08/2024 showed no mention of AD or DPOA. In an interview on 4/17/2025 at 3:10 PM, Staff C, Assistant Director of Nursing Services stated that they were not able to find any documentation regarding resident's DPOA. They stated that Social Services were supposed to follow up on AD. In an interview on 04/18/2025 at 9:35 AM, Staff E, Licensed Practical Nurse/Resident Care Manager, stated the admission staff asked resident and/or family to bring in the AD during admission and the AD would be uploaded into EHR once the facility received it. Staff E stated if there was no AD, the social service would follow up during the first initial care conference which happened the first 72 hours after admission. Staff E stated they were not sure why no AD documentation. In a record review and interview on 04/22/2025 at 10:24 AM, Staff B, Director of Nursing, stated they could not find copy of AD copy or information/documentation that an AD was reviewed or residents were assisted in formulating an AD for Resident 325 and Resident 329 in their EHRs. Staff B stated they expected the admission nurse to request a copy of AD and upload it into EHR once received and social services would follow up during the first initial care conference within the first three days of admission. This is a repeat deficiency from 06/12/2024. Reference WAC 388-97-0280 (1) (3)(a)(c)(ii)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37890 Based on interview and record review, the facility failed to ensure residents were informed in writing of their potential liability for payment related to Medicare services ending for 1 of 3 sampled residents (Resident 45) reviewed for Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN). This failure placed the residents at risk of not having adequate information to make care and financial decisions during their continued stay. Findings included . Resident 45 was admitted to the facility and was receiving skilled services under their Medicare Part A benefit. Review of the most recent Minimum Data Set assessment (a required assessment tool) dated 03/09/2025 (end of Med A stay) showed the resident had mild cognitive impairment. The resident record showed they had an Advance Directive in place designating Collateral Contact 5 (CC5) as their representative. Review of Resident 45's record documented a Notice of Medicare Non-Coverage (NOMNC) was communicated by phone to CC5 on 03/07/2025, which informed the resident and the representative that skilled nursing services would end on 03/09/2025. The notice informed the resident Medicare would probably no longer cover skilled services, and they may have to pay for any services occurring after 03/09/2025. Further review of the record documented the SNF/ABN was not issued to the resident or representative as required. This form would have explained the amount the resident would be liable to pay if they remained in the facility for long-term care after 03/09/2025. In an interview on 04/18/2025 at 12:21 PM, CC5 was in Resident 45's room visiting, and stated the facility had called them and stated the resident was done with therapy and would be transitioning off of Medicare. CC5 stated they were not told about the right to appeal that decision, and they were not told about any other specific costs or asked to sign any forms. CC5 stated they came to visit every week and would have been available. Resident 45 confirmed that they prefer CC5 to be the one to sign forms for them. In an interview on 04/18/2025 01:56 PM, Staff A, Administrator, stated the forms should be provided to the resident or representative in person when possible, and if they were communicated by phone, the facility should still provide a copy by mail or email, and obtain a physical signature as soon as possible. Staff A stated Resident 45 should have been provided with both the notice of non-coverage and the ABN notice. Reference WAC 388-97-0300 (1)(e)(5)(6)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review the facility failed to have a system in place that ensured grievances were addressed and resolved in response to residents' verbal conveyance of concerns for 2 of 3 resident council's (February and March 2025), who verbalized complaints during a Resident Council (RC) meeting and failed to follow the grievance process for 2 of 2 residents (Resident 12 and 35) who voiced grievances. These failures led to residents repeatedly reporting the same care issues without resolution and placed them at risk of feeling frustrated, unimportant, with diminished self-worth and decreased quality of life. Findings Included . Review of the facility policy titled Resident and Family Grievances dated October 2024 showed the social services director was designated as the Grievance Official and was responsible for overseeing the grievance process. The grievance procedure showed staff members who received the grievance would record the nature and specifics of the grievance on the designated grievance form and a written decision regarding the grievance would be provided at the conclusion of the investigation. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance. <RESIDENT COUNCIL> Review of resident council minutes for February and March 2025 showed there were complaints of the garbage not being routinely emptied in their rooms. There was no documented resolution to this grievance. Review of resident council minutes for March 2025 showed there were several residents who inquired as to the time frame of the refresh (painting) of resident rooms. There was no documented resolution to the question. There were other residents who voiced concern/request to have their rooms picked up and clothing put away by the nursing assistant staff. There was no documented resolution. In an interview on 04/16/2025 at 2:41 PM Staff S, Activity Director, stated if there is a grievance or an issue that is brought up in Resident Council then they would do a grievance but if it was something for like maintenance, they would write a note and give it to maintenance. Staff S stated they discuss grievances in the morning meetings. <RESIDENT 35> Resident 35 admitted to the facility on [DATE] with diagnoses to include depressive disorder and high blood pressure, and atrial fibrillation (rapid/irregular heartbeat). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/16/2025 at 10:02 AM Resident 35 stated their [NAME] blanket had been missing almost a year and was given to them by their family member. Resident 35 stated they had told their nursing aide (NAC) at the time, Collateral Contact 3 (CC3) and they looked everywhere for the blanket and were not able to find it. Resident 35 stated the blanket had not ever been returned to them and they had not been reimbursed or replaced. In a review of the grievance logs from October 2024 through March 2024 showed no entries related to Resident 35. In an interview on 04/17/2025 at 11:30 AM Staff A, Administrator, stated they were unable to find any grievances related to Resident 35 and would initiate one for their missing blanket. In an interview on 04/21/2025 at 10:25 AM CC3, Resident 35's previously assigned NAC, stated they recalled Resident 35 missing two blankets: a gray one and a blue one. CC3 stated they were able to locate the gray blanket but not the blue blanket. CC3 stated they informed the nurse manager at the time. CC3 stated they did not fill out a grievance form related to the missing blue blanket and would have only done so if the resident needed the item replaced right away or was upset over it. 51551 <RESIDENT 12> Resident 12 readmitted to the facility on [DATE] with diagnoses to include bilateral osteoarthritis of hips (a degenerative joint disease affects both side of hips) and morbid obesity with alveolar hypoventilation (a severe form of obesity leads to chronic inadequate breathing). According to the annual Minimum Data Set (MDS - an assessment tool) assessment, dated 03/18/2025, the resident had moderate cognitive impairment, both upper and lower extremities impairment and was dependent on shower and bathe. Review of resident council meeting minutes, date 02/26/2025, documented Resident 12 complained they had not received a shower for four weeks. The meeting minutes also documented the grievance form was completed and sent to social services. Review of Resident 12's grievance form date 02/26/2025, documented the resident had not had a shower for four weeks for a variety of reasons which included no staff available and no shower chair available. Under grievance resolution, it documented shower to be given on 02/27/2025 and if Resident 12 missed a shower in the morning would be reoffered for the evening shift or other day by different staff. The date of resolution was 02/27/2025. Review of the electronic health record (EHR) showed Resident 12 had no documentation the resident had received a shower on 02/27/2025. In an interview on 04/21/2025 at 9:07 AM, Resident 12 stated they did not have a shower on the following day but waited for a couple of weeks after they complained during the resident council meeting. Resident 12 stated they were told the facility had no shower aide and no shower bench available. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a record review and interview on 04/21/2025 at 10:24 AM, Staff B, Director of Nursing, stated the expectation of grievance resolution should occur within 24 to 48 hours if it occurs on a weekend. Staff B stated the shower record showed Resident 12 did not receive a shower until 03/04/2025 (7 days after the grievance occurred). Staff B stated the resident should not have had to wait that long to receive a shower. Reference WAC 388-97-0460(2)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observation, interview, and record review the facility failed to ensure that potential restraints were appropriately assessed for safety, consented, and care planned for 1 of 2 residents (Resident 28) reviewed for physical restraints. This failure placed residents at risk for unidentified risks and care needs, and for a diminished quality of life. Findings included . Review of the facility policy titled, Restraint Free Environment, reviewed 04/2025 a physical restraint refers to any manual methods of physical or mechanical device, mater, or equipment attach or adjacent to the the residents body that the individual cannot remove which restricts freedom of movement .facility was responsible for the appropriateness of the physical restraint . medical symptoms warranting the use of restraints should be documented in the medical record . care plan updated accordingly to include development and implementation of interventions. Resident 28 admitted to the facility on [DATE], they have diagnoses that include Parkinson's, Alzheimer's, and cognitive communication deficit. The quarterly Minimum Data Set (MDS- an assessment tool) dated 01/21/2025 showed the resident had sever impaired cognition, and was fully dependent on staff for transfers, mobility, and toileting. The MDS stated the resident had no known physical restraints. Review of Resident 28's physician orders on 04/15/2024, there were no orders for a recliner to elevate the residents' legs. Review of Resident 28's medical record there was no documentation of an evaluation for safety, assessment and consent, that addressed the residents use of a recliner that restricted their movement. In an observation and interview on 04/15/2025 at 11:26 AM, Resident 28 was observed to be sitting in a recliner with the feet of the recliner in the up position, and the over-the-bed table across their lap. There were no controls visible to regulate the legs of the recliner. Resident 28 was asked if they could control the chair, the resident appeared confused and did not understand the question. In an observation on 04/15/2025 at 1:28 PM, Resident 28 was observed with legs elevated in the recliner, and the over-the-bed table across their lap. The resident was asked to demonstrate how they put their legs down in the chair, they picked up the television remote and started to press buttons. In observations on 04/16/2025 from 1:25 PM - 1:33 PM, Resident 28's call light was triggered, each time the staff entered the resident was unaware of their actions. In observation on 04/17/2025 at 12:43 PM, Resident 28 was observed to be sitting in a recliner with the feet of the recliner in the up position, and the over-the-bed table across their lap. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/18/2025 at 9:28 AM, Staff G, Nursing Assistant Certified (NAC) stated they have worked on and off at the facility for about two years. Staff G stated that Resident 28 required full assistance from staff for almost all their activities of daily living (ADLs). Staff G stated Resident 28 will sit in their recliner often throughout the day. Staff G stated there are no controls for the chair and the staff manually must pull the legs of the chair up, the resident does not control. In an interview on 04/18/2025 at 10:22 AM, Staff H, NAC stated they have worked on and off at the facility for over five years. Staff H stated Resident 28 will sit in their recliner often. Staff H confirmed staff manually must pull the legs of the recliner out and up, as the residents were not able to manage on their own. In an interview on 04/18/2025 at 12:14 PM, Staff D, Licensed Practical Nurse (LPN)/Staff Development Coordinator (SDC) stated they had been helping with the nurse management task for Unit 3 South since around February 9th, 2025. Staff D stated when a resident required the use of equipment or device that could hinder their movement the facility was required to have therapy assess that device for safety, complete an evaluation of the use of the device, obtain consent from the resident or responsible party, and update the plan of care. Staff D stated they were familiar with Resident 28, and that they did sit in their recliner often. Staff D was asked if there was an assessment, evaluation, and consent for the use of the recliner in Resident 28's medical record. Staff D was unable to locate one, and confirmed there should be. In an interview on 04/19/2025 at 9:04 AM, Staff B, Director of Nursing Services stated that Resident 28 required two staff to assist with transfers and used a mechanical lift. Staff B stated that if a resident required any device or equipment that could be a restraint they were required to obtain a therapy assessment for safety, complete and evaluation, and consent for the use of the device/equipment. Staff B was asked if that was complete for Resident 28's use of the recliner, and that the staff manually pull the leg of the chair out, so that the resident's movement from the chair re restricted. Staff B confirmed there was no assessment for safety, evaluation or consent for the recliner. Staff B confirmed that Resident 28 was not able to get out of the chair and that their cognition was poor. Reference WAC 388-97-0620(4)(a)(b)(c)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interviews and record review the facility failed to identify and report an allegation of abuse and/or neglect for 3 of 5 sampled residents (Residents 28, 54, and 276) when reviewed for abuse/neglect. This failure placed the residents at risk of further abuse, psychological distress, and diminished quality of life. Findings included . Review of the facility policy titled, Abuse, Neglect, and Exploitation, reviewed 05/01/2024 stated will develop and implement policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident's property staff will be able to identify different types of abuse an immediate investigation will be completed when there is suspicion of any type of abuse and or neglect all allegations will be reported immediately, but not later than two hours. <RESIDENT 28> Resident 28 admitted to the facility on [DATE], diagnoses that include Alzheimer's, and cognitive communication deficit. The quarterly Minimum Data Set (MDS- an assessment tool) dated 01/21/2025, showed the resident had sever impaired cognition. In a phone interview on 04/15/2025 at 2:13 PM, Collateral Contact (CC) 1 stated they wrote up a concern form a couple months ago, as Resident 28's roommate had been overly touchy with their family member to the point that one day they had kissed their family member on the lips in front of them. CC1 stated the day they wrote the concern form; the previous social worker called them on the phone about an hour afterwards to say they had investigated their concerns and were not able to substantiate the claim. In a review of a facility grievance form dated 02/19/2025, CC1 wrote that on frequent visits to see Resident 28, the roommate (Resident 51) has caressed their family member as well they had witnessed them kissing their family member on the lips. The grievance expressed concerns related to the roommates' behaviors. The form documented under resolution that the social worker had interviewed Resident 28 who stated their roommate was just wonderful and the resident showed no signs of psycho-social distress. Other residents were interviewed with no findings, a room change was offered and declined. Review of the facility state reporting log dated February 2025 showed no report for Resident 28 and their roommate that was reported on 02/19/2025. In an interview on 04/18/2025 at 9:28 AM, Staff G, Nursing Assistant Certified (NAC) stated that all facility staff are considered mandated reporters and must report allegations of potential abuse and/or neglect. Staff G stated if they witnessed a resident kiss another resident that would be something they would need to report. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/18/2025 at 10:22 AM, Staff H, NAC stated they were a mandated reporter and must report allegations of potential abuse and/or neglect to the Abuse Officer (Administrator), their direct supervisor, and the state. Staff G stated if they witnessed a resident kiss another resident that would be something they would need to report. In an interview on 04/18/2025 at 12:14 PM, Staff D, Licensed Practical Nurse (LPN)/Staff Development Coordinator (SDC) stated that the expectation was all staff were reporting and protecting residents right away from abuse and/or neglect allegations. All staff are responsible for reporting to the state. Staff D was not aware of the grievance from a family member for Resident 28 that was written on 02/19/2025 and agreed that it should have been reported to the state. In an interview on 04/18/2025 at 2:18 PM, Staff A, Administrator, confirmed that the grievance dated 02/19/2025 for Resident 28, should have been escalated to an allegation of abuse, and reported to the state. In an interview on 04/19/2025 at 9:04 AM, Staff B, Director of Nursing Services stated that the facility should have ruled out any psychological harm for Resident 28 related to the grievance written on 02/19/2025. The facility should have ruled out abuse and neglect and reported the incident. 50725 <RESIDENT 276> Resident 276 was admitted to the facility on [DATE]. The resident was alert, oriented and able to make needs known. In an interview on 04/15/2025 at 10:12 AM, Resident 276 stated that they waited 30 minutes for their call light to be answered last night. They needed to use the bathroom and they were scared to lose their bladder control and urinate on the bed. The resident stated it was distressing to wait that long to use the bathroom. Review of the facility investigation on 04/21/2025 showed that it was documented on a grievance form. The investigation documented that abuse and neglect were ruled out. It was determined that the NAC went on a break and did not inform the nurse, and the nurse was in another room/station when Resident 276's call light was on. In an interview on 04/21/2025 Staff D, LPN/SDC, who completed the investigation stated they did not call the state and was not sure why it was on a grievance form. Staff D stated it was handed to them to investigate, and they just did that. They stated this was an allegation of neglect but was ruled out. In an interview on 04/21/2025 at 2:40 PM, Staff A, Administrator, stated that they were not sure that the allegation was reported to the state and that they want to review the investigation file again and get back with me. On 04/21/2025 at 3:10 PM Staff A, Administrator, provided a copy of the Online Incident Report that was submitted on 04/21/2025 at 3:00 PM. (continued on next page)

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	505404	A. Building B. Wing	04/21/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51551 <RESIDENT 54> Resident 54 admitted to the facility on [DATE] and discharged on [DATE], with diagnoses to include contusion and laceration of cerebrum (bruises and tears of brain tissue caused by blunt force trauma to the head). According to the discharge MDS assessment dated [DATE], the resident had moderate cognitive impairment and required moderate assistance with toilet transfer. Review of the resident council meeting minutes dated 02/26/2025, documented Resident 54 complained they had a call light waiting for more than 30 minutes at around 4:00 AM on 02/26/2025 for going to bathroom. The minutes revealed Resident 54 self-transferred to the toilet eventually and an aide responded to the call light after Resident 54 self-transferred and scolded Resident 54. Review of the facility state reporting log for February 2025 showed no report for Resident 54 was reported on 02/26/2025. Review of Resident 54's electronic health record (EHR) from 02/24/2025 to 03/07/2025, showed no documentation of this allegation. In an interview on 04/21/2025 at 9:12 AM, Staff N, NAC, stated if a resident complained about waiting for more than 30 minutes call light and staff scolded the resident, they would consider as a verbal abuse and report to the floor manager. In an interview on 04/21/2025 at 9:22 AM, Staff M, NAC, stated all staff must immediately report allegations of potential abuse and/or neglect to the supervisor and state. Staff M stated they would report if a resident was scolded by staff, and it could be an abuse or neglect. In an interview on 04/22/2025 at 9:30 AM, Staff J, Registered Nurse, stated they were mandatory reporters and must report all types of abuse and/or neglect. Staff J stated if a resident waited for more than 30 minutes for their call light to be answered and was scolded by a staff member, they must report to the supervisor or the state. In a joint interview on 04/22/2025 at 10:24 AM, Staff B stated it would be an allegation if a resident had to wait for more than 30 minutes for a call light and was scolded by a staff. Staff O, Director of Clinical Operation, stated Resident 54's complaint should be escalated into an allegation and reported to the state immediately. Reference WAC 388-97- 0640(3)(a)(5)(a)(7)(a)(b)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on observation, interview and record review, the facility failed to conduct a thorough investigation for 3 of 5 resident investigations (Resident 28, 44 and 54) reviewed for accidents and allegations of potential abuse and/or neglect. The facility failed to identify the root cause, and all contributing factors related to allegations of abuse and/or neglect placed residents at risk for injury, and additional abuse/neglect. Findings included . Review of the facility policy titled, Abuse, Neglect, and Exploitation, reviewed 05/01/2024, stated the facility will investigate and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .provide complete and thorough documentation of the investigations .provide emotional support and counselling to the resident during and after the investigation. <RESIDENT 44> Resident 44 admitted to the facility on [DATE] with diagnoses to include fracture of surgical neck of left humerus (broken bone of left upper arm). According to the quarterly MDS assessment dated [DATE], Resident 44 had moderate cognitive impairment. During the resident council meeting on 04/17/2025 at 2:27 PM, Resident 44 stated they had to wait for two hours for staff to answer call lights and it happened in daytime often and any other time during the day as well. This surveyor immediately reported the allegation to Staff A, administrator, and Staff B, Director of Nursing. Review of updated facility state reporting log on 04/21/2025 at 10:00 AM, showed no log for Resident 44's allegation on 04/17/2025. Review of Resident 44's electronic health record (EHR) from 04/17/2025 to 04/21/2025, showed no documentation about this allegation. Received Resident 44's investigation report right after exit. The investigation only included documentation of the state online incident report and other residents' interviews. The incident report documented Resident 44 referred to the night shift for the delaying response of call light but unable to recall on exact date and time on when it happened. On the state online incident report, the actions taken to prevent recurrence indicated staff education and call light audit. However, there was no correlating documentation found. On the state online incident report, under who was notified indicated family and facility provider. However, there was no correlating documentation found. The investigation did not include Resident 44's physical or psychosocial assessment and monitoring, or any social service support during or after investigation. The investigation did not include any documentation of night shift staff statements or interviews. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no additional information to clarify the other concerns in the allegation. The facility failed to provide a thorough investigation at the time frame required. <RESIDENT 54> Resident 54 admitted to the facility on [DATE] and discharged on [DATE], with diagnoses to include contusion and laceration of cerebrum (bruises and tears of brain tissue caused by blunt force trauma to the head). According to the discharge MDS assessment dated [DATE], Resident 54 had moderate cognitive impairment and required moderate assistance with toilet transfer. Review of a facility grievance form dated 02/26/2025, the grievance documented there were concerns that at 4:00 AM, Resident 54 needed to go to bathroom and waited for a call light more than 30 minutes. Resident 54 could not wait any longer and self-transferred to the bathroom and was scolded by a NAC (Nursing Assistant Certified) after Resident 54 self-transferred. Review of the facility state reporting log for February 2025 showed no log for Resident 54 was reported on 02/26/2025. Review of Resident 54's electronic health record (EHR) from 02/24/2025 to 03/07/2025, showed no documentation of this allegation. Review of the facility investigations on a grievance form dated 02/26/2025, completed on 02/28/2025, documented actions done included call light audit and staff education and counselling. There were only two call light audits done on 02/28/2025 day shift and 02/27/2025 evening shift, but no documentation about call light audit on night shift as Resident 54 reported the incident happened at 4:00 AM during night shift. The was call light education to one day shift NAC and one evening shift NAC. There was no documentation about education or training conducted on any night shift NAC. The investigation did not include Resident 54's ongoing physical or psychosocial assessment, care planning revision for appropriate interventions, any social service support during or after investigation, or monitoring Resident 54 with needs and behaviors which might be caused by the allegation. There was no documentation about any other resident' interview. The investigation did not include any documentation of interviews conducted with the staff that worked with Resident 54 at the time of the incident. There were no staff statements about the allegations of their call light not being answered during that shift. There was no staff statement about Resident 54 being scolded. There was no documentation about staff identification or suspension. The investigation included only one Registered Nurse (RN) counselling record. The counseling record was about the RN clocked in and out late and missing from work unit resulting in delayed administration of pain medications. There was no additional information to clarify the other concerns in the allegation. The facility failed to provide a thorough investigation at the time frame required. In an interview on 04/21/2025 at 9:47 AM, Staff S, Activity Director, stated Resident 54's concern was an allegation and should be investigated thoroughly. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview on 04/22/2025 at 10:24 AM, Staff B, Director of Nursing, stated all allegations must be investigated immediately including resident and/or family interview, other residents' interview, staff interview, suspending any staff related to the allegation to ensure residents safe. Staff O, Director of Clinical Operation, stated Resident 54's concern should be investigated thoroughly as an abuse or neglect allegation, not grievance. 44110 <RESIDENT 28> Resident 28 admitted to the facility on [DATE], diagnoses that include Alzheimer's, and cognitive communication deficit. The quarterly Minimum Data Set (MDS- an assessment tool) dated 01/21/2025, showed the resident had sever impaired cognition. In a review of a facility grievance form on 04/16/2025, dated 02/19/2025, the grievance stated that there were concerns that Resident 28's roommate (Resident 51) has caressed and kissed the resident. In a review of the facility investigations on 04/16/2025, completed in February 2025, there was no investigation for Resident 28 and their roommate. In an interview on 04/18/2025 at 12:14 PM, Staff D, Licensed Practical Nurse (LPN)/Staff De-velopment Coordinator (SDC) stated they were assisting with nurse management duties for Unit 3 South (where Residents 28 and 51 reside). Staff D stated all allegations of abuse and/or ne-glect are to be thoroughly investigated. Staff D was unaware of the grievance made on 02/19/2025 for inappropriate touching that involved Resident 28 and their roommate. Staff D stated that the grievance should have been converted into an allegation and investigated [NAME]-oughly. In an interview on 04/19/2025 at 9:04 AM, Staff B, Director of Nursing Services stated the fa-cility should have escalated the grievance into an allegation and completed a thorough investi-gation. Refer to WAC 388-97-0640(6)(a)(b)(c)

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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** 51551 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Reviews (PASARR-an assessment to ensure individuals with Serious Mental Illness [SMI] or Intellectual/Developmental Disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) Level I was completed for 1 of 5 residents (Resident 324), reviewed for PASARR screening. This failure placed the resident at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the facility's policy titled, Resident assessment-Coordination with PASARR program, reviewed in October 2024, showed that all applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. PASARR level I-initial pre-screening that is completed prior to admission .The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. Resident 324 admitted to the facility on [DATE] with a diagnosis of recurrent and unspecified major depressive disorder (constant feeling of sadness). Review of Resident 324's Minimum Data Set (MDS) assessments on 04/08/2025, documented Resident 324 had a diagnosis of depression and was receiving an antidepressant. Review of April 2025 Medication Administration Record showed Resident 324 had been receiving an antidepressant medication daily that was started on 04/03/2025. Review of Resident 324's Level I PASARR dated 04/01/2025 documented, under section 1A. SMI Indicators, none was marked for mood disorder-depressive or bipolar. Under section IV, it documented no level II evaluation indicated because of no SMI indicator. In an interview on 04/18/2025 at 9:35 AM, Staff E, Licensed Practice Nurse/Resident Care Manager, stated the PASRR should be obtained prior to admission and social services should reviewed PASARR forms for accuracy and update if necessary. In an interview on 04/22/2025 at 10:24 AM, Staff B, Director of Nursing, stated Resident 324's level I PASRR was not accurate and should have been reviewed, updated and sent for level II evaluation prior to admission. This is a repeat deficiency from 06/12/2024. Reference WAC 388-97-1915 (1)(2)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were completed for residents following significant change in status or with newly evident or possible serious mental disorders for 1 of 5 residents (Resident 55) reviewed. This failure resulted in a potential delay in access to level 2 PASSR services and decreased quality of life. Findings include . PASSR - a federally required screening of all individuals who has both an intellectual disability or related condition and a serious mental illness prior to admission to a Medicaid-certified nursing facility or a significant change of condition. According to the facility policy titled Resident Assessment- Coordination with PASSR Program review date 10/2024 documented: Any resident who exhibits a newly evident or possible serious mental disorder will be referred promptly to the state mental health or a level II resident review. Examples include: A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting presence of mental disorder . Resident 55 was initially admitted to the facility on [DATE] then readmitted on [DATE] with admitting diagnoses to include depression, psychotic disorder with delusions and dementia. Quarterly Minimum Data Set (MDS - an assessment tool) assessment dated [DATE] showed the resident had moderate cognitive impairment and received antidepressant and antipsychotic medications. Review of Resident 55's PASSR dated 04/25/2024 showed the resident was not on any antidepressant or antipsychotic medications and no Level II recommendation was checked. There were no other PASSR seen in residents' electronic health record (EHR). Review of Resident 55's physician orders showed the resident was taking an antidepressant medication, Sertraline Hydrochloride, order date 11/13/2024 and an antipsychotic medication, Quetiapine Fumarate, order date was 10/23/2024. In an interview on 04/17/2025 at 3:18 PM, Staff Q, Licensed Practical Nurse (LPN) stated that they do admissions for the facility and if they see a psychotropic medication (drugs that affect a person's mental state by altering brain chemistry) ordered, they ensure a consent form is signed and discussed with resident the risk and benefits of taking the medication, then they place a behavior and adverse side effect monitoring in the MAR. The MDS nurse will review it as well. In an interview on 04/18/2025 at 9:50 AM, Staff E, LPN/Resident Care Manager (RCM) stated they review psychotropic medications monthly with the other managers, Director of Nursing, MDS nurse, Social Services and the pharmacy to ensure that the medications were appropriate and has appropriate diagnosis or indications. Social Services would be the ones that look at the PASSR. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/21/2025 at 10:24 AM, Staff B, DNS stated that the Social Services Department were the ones that review the PASSR prior to admission. However, since they don't have a Social Worker at this time, they would be the ones that will be following up on PASSRs. Staff B stated that if a resident started on a psychotropic medication after they got admitted , the nurse should notify the nurse manager so they can review if the resident needs a new PASSR. They were not sure why Resident 55 did not have an updated PASSR. Reference WAC 388-97-1975

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview and record review, the facility failed to ensure professional standards of practice were implemented for 3 or 3 residents (Residents 278, 328, and 329) reviewed for oxygen therapy. Failure to obtain a doctor's order prior to administering oxygen placed residents at risk for potential adverse outcomes. Findings include . Review of the facility policy titled Oxygen Administration, review date 10/2024 documented: Oxygen is administered under orders of a physician, change oxygen tubing and mask/cannula weekly and as needed. <RESIDENT 278> Resident 278 was admitted to the facility on [DATE] with admitting diagnoses to include Chronic Obstructive Pulmonary Disease (COPD - a type of progressive lung disease). According to the Admission Minimum Date Set (MDS - an assessment tool) assessment dated [DATE], the resident had moderately impaired cognition and was on oxygen therapy. In an observation on 04/15/2025 at 2:05 PM, Resident 278's oxygen tubing was on the floor under the left side of their bed. In an observation on 04/16/2025 at 1:50 PM, Resident 278's oxygen tubing was on the floor under the left side of their bed. In an observation and interview on 04/17/2025 at 12:50 PM, Resident 278 was in bed and had oxygen on via nasal cannula at 1 liter per minute (lpm). The resident stated they were short of breath, that's why they were on oxygen. Review of Resident 278's doctor's order documented: Apply oxygen (per nasal cannula) 1-2 lpm continuous to keep sats >or equal to 90% every night shift. Start date 03/24/2025. In an interview on 04/17/2025 at 12:58 PM, Staff N, Nursing Assistant Certified (NAC) stated that when they see oxygen tubing on the floor, they pick it up and put it on the bedside table or nightstand. In an interview on 04/17/2025 at 3:18 PM, Staff Q, Licensed Practical Nurse (LPN) stated that they were not sure how often they were supposed to change the oxygen tubing but if they see oxygen tubing on the floor, they will dispose of it and get a new one. In an interview on 04/18/2025 at 8:50 AM, Staff R, NAC, stated that if they see oxygen tubing on the floor, they pick it up, clean it and place it back at the bedside table or nightstand. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/18/2025 at 10:50 AM, Staff E, LPN/Resident Care Manager (RCM) stated that oxygen tubing was changed every 2 weeks on Sunday evening, there's usually a doctor's order and a date should be placed on the tubing. Staff E stated that if oxygen tubing is found on the floor it should be disposed of and replaced with a new one. Staff E stated that staff just had an in-service training about that. Requested Staff E to review Resident 278's oxygen order and after they read it, they stated that the oxygen order was saying the resident was only supposed to use oxygen at nighttime. Staff E also stated that there should be a and PRN on the order as well and they would clarify the order. In a joint interview on 04/21/2024 at 12:24 AM, Staff O, Director of Clinical Operation and Staff B, Director of Nursing Services (DNS), Staff B, stated they were unsure of when the oxygen tubing needs to be changed, it's in their oxygen policy. Staff do not need to date the tubing, their signature in the MAR is proof that they have changed the tubing. Storage of oxygen tubing should be in a clear plastic bag dedicated to oxygen tubing when the tubing is not in use. Requested both Staff O and Staff B review the oxygen order for Resident 278, and they stated that the order was not correct. Staff B stated that the provider sometimes puts in their own orders and it's not usually the right way. The order was not put in right and should be revised. They stated the order stated the resident will only have oxygen at night and not as needed. 51551 <RESIDENT 328> Resident 328 was admitted to the facility on [DATE], with diagnoses to include COPD and chronic respiratory failure with hypoxia (a condition where the lungs are unable to effectively exchange oxygen and carbon dioxide resulting in chronically low oxygen levels in the blood). According to the admission MDS assessment dated [DATE], the resident had moderate cognitive impairment and required oxygen therapy. In an interview and observation on 04/15/2025 at 11:58 AM, Resident 328 stated they had been using a nasal cannula and oxygen every night and the oxygen tube had not been changed since admission. Observed the oxygen flow meter that was set at 2.5 lpm and there was no date on the oxygen tubing. In an interview and observation on 04/17/2025 at 9:37 AM, Resident 328 stated they had been using oxygen every night at 1.5 lpm. Observed the oxygen flow meter was 3 lpm and no date on the oxygen tube. Review of Resident 328's Medication Administration Record (MAR), copy date 04/17/2025 at 11:00 AM, documented an order of applying oxygen (per nasal cannula) 1 liter/min as needed to keep saturation more or equal to 89% started on 03/27/2025. Another order showed to change and date oxygen tube twice a month every night shift every Sunday started on 03/30/2025. Review of Resident 328's MAR, copy date 04/18/2025, the order was revised to change oxygen tubing on night shift every 14 days started on 04/17/2025. Review of Resident 328's care plan, copy date 04/17/2025 at 11:20 AM, showed PRN (when necessary) orders for oxygen 1L via nasal cannula during bedtime to keep saturation above 89%. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation, interview and record review on 04/17/2025 at 1:07 PM, with Staff Y, Registered Nurse, Resident 328's oxygen flow meter was observed to be set at 2.5 lpm. Staff Y reviewed the MAR and stated the provider order was for oxygen 1 lpm. Staff Y stated they changed the oxygen tube once a week and they were supposed to put a date on the new oxygen tube as per order. In an interview and record review on 04/17/2025 at 1:25 PM, Staff V, Registered Nurse/Resident Care Manager, stated Resident 328's oxygen order was 1lpm and nurse supposed to change the oxygen tube every two weeks and date the new tube as per order. Staff V stated they would have to check the facility policy. No further information provided. In an interview on 04/17/2025 at 3:21 PM, Staff B, Director of Nursing, stated they expected all oxygen administration and oxygen tube changing to have orders in the MAR and expected all nurses to follow the order. Staff B stated the oxygen tube was supposed to be changed once a week. Staff B stated it was standard practice to put a date on the new tube but if the nurse signed the MAR, it meant the nurse changed the tube. <RESIDENT 329> Resident 329 admitted to the facility on [DATE] with diagnoses to include aftercare respiratory system surgery, asthma (long-term inflammatory disease of the airways in the lungs), acute respiratory failure with hypoxia (a condition where a person does not have enough oxygen or too much carbon dioxide in the body). According to the admission nursing assessment dated [DATE], Resident 329 was alert and oriented. In an observation and interview on 04/15/2025 at 11:16 AM, observed Resident 329 was using oxygen via nasal cannula at 2lpm. There was no date on the oxygen tube. Resident 329 stated they did not know when the tube was changed. In an observation and interview on 04/17/2025 at 8:57 AM, observed Resident 329 was using oxygen via nasal cannula at 2lpm. Resident 329 stated they were using oxygen all the time because of their short breath due to their asthma and lung biopsy. Review of Resident 329's Medication Administration Record (MAR), copy date 04/17/2025 at 11:00 AM, showed orders of oxygen administration 1lpm and changing of oxygen tube were discontinued on 04/10/2025. There were no oxygen orders after that. Review of Resident 329's care plan, copy date 04/17/2025 at 11:20 AM, showed no focus area addressing oxygen use. In an interview and record review on 04/17/2025 at 11:44 AM, Staff Z, NAC, stated NACs followed instruction from Kardex (a tool used to provide direction on how to care for a resident) to take care of residents. Staff Z reviewed Resident 329's Kardex and stated there was no information about oxygen use. In an interview and record review on 04/17/2025 at 11:49 AM, Staff Y stated Resident 329 was using oxygen this morning but there was no order in the MAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a following interview on 04/17/2025 at 12:58 PM, Staff Y stated Resident 329 told Staff Y that Resident 329 needed oxygen for 24 hours. Staff Y stated they were not sure why there were no orders in the MAR, and they told RCM to add the order. Staff Y stated that since there was no oxygen tube changing order in the MAR nor a date on the oxygen tube, they had no idea when the oxygen tube was changed. In an interview on 04/17/2025 at 1:25 PM, Staff V, RN/RCM, stated Resident 329 had been using oxygen and there should be orders of oxygen administration and tube changing in the MAR. Staff V stated the care plan should be updated to include oxygen therapy. In an interview on 04/17/2025 at 3:21PM, Staff B stated all oxygen administration needed orders in the MAR and all nurses needed to follow the order. Staff B stated the oxygen therapy needed to be included in the care plan. Reference WAC 388-97-1620 (2)(b)(i)(ii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to ensure treatment and care was provided in accordance with professional standards of practice for 1 of 1 resident (Resident 20) reviewed for mood and behavior. The facility failed to ensure a psychiatric evaluation was reviewed, and implementation of mental health recommendations for treatment of depression. These failures placed the residents at risk for declining their mental health and diminished quality of life. Findings included . Resident 20 admitted to the facility on [DATE] with diagnoses that included depression, and insomnia. The Admission Minimum Data Set (MDS- an assessment tool) dated 03/04/2025 showed the resident had moderately impaired cognition, with moderate depression. Review of Resident 20's care plan showed a focus area dated 03/04/2025 that the resident had a behavior problem of refusal of care related to their depression and anxiety. Interventions included administering medications as ordered and documenting effectiveness. Review of Resident 20's progress notes, on 03/28/2025 the resident had been seen for a psychological evaluation. The evaluation documented that the resident presented with persistent depressive disorder (longstanding depression with medical stressors), psychophysiological insomnia (difficulty sleeping with current treatment), and cognitive disorder. The evaluation recommended the resident start on an anti-depression, discontinue the current sleep medication, further psychological testing, with follow up in two weeks or sooner if no change. In an observation and interview on 04/15/2025 at 10:19 AM, Resident 20 was observed lying in their bed. The resident stated they had a rough night, and they felt very grumpy. The resident then became tearful, stated today was their brother's birthday, but they passed away [AGE] years ago but it still made them sad. Resident 20 stated it's hard, they have no visitors, their family was not speaking to them, they continued to be tearful and sad. Review of Resident 20's medical record on 04/18/2025 (21 days since the recommendations were made) showed none of the recommendations made by the mental health provider had been implemented into the plan of care for Resident 20. In an interview on 04/18/2025 at 12:14 PM, Staff D, Licensed Practical Nurse (LPN)/Staff Development Coordinator (SDC) stated they had been helping with the nurse management task for Unit 3 South since around February 9th, 2025. Staff D stated when a resident had a consultation any documentation would be passed to nursing to review of updated orders or other recommendations. Staff D was not aware that Resident 20 had been seen by a mental health provider and was unaware of any recommendations that had been made for Resident 20. Staff D stated the mental health providers were documenting directly into the medical record, and that was a new process. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/19/2025 at 9:04 AM, Staff B, Director of Nursing Services stated they discuss visits and appointments for residents in their clinical meeting every day. After an appointment the documentation was to be reviewed, implement any recommendations, and pass on to medical records for uploading. Their expectation was that the nurse on the cart as well as the nurse manager would be reviewing that information. Staff B stated their expectation was that the nurse manager should have reviewed the documentation for Resident 20, and that the mental health providers are now entering information directly into the medical record, it was a new process. Staff B confirmed that Resident 20's recommendations were missed and not reviewed. Refer to WAC 388-97-1060(1)(3)(e)(k)

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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** 47047 Based on interview and record review, the facility failed to ensure restorative therapy services (a personalized training program to help people maintain or regain their ability to do everyday tasks, like walking, dressing, and eating) were implemented to prevent avoidable reduction of range of motion (ROM, how far you can move a joint in any direction) for 1 of 1 residents (Resident 35), reviewed for restorative therapy and limited ROM. This failure placed residents at risk for loss of ROM, deconditioning, and loss of independence. Findings included . Review of the facility policy titled, Restorative Nursing Programs dated 07/01/2024 showed the interdisciplinary team, with the support and guidance from the physician, would assure ongoing review, evaluation, and decision making regarding the services needed to maintain or improve a resident's abilities in accordance with the resident's comprehensive assessment, goals, and preferences. Resident 35 admitted to the facility on [DATE] with diagnoses to include peripheral vascular disease (circulatory condition involving narrowing of the blood vessels), high blood pressure, and atrial fibrillation (rapid/irregular heartbeat). In an interview on 04/16/2025 at 9:54 AM Resident 35 stated they had not had any therapy since moving from the 6th floor to the 3rd floor, about a year ago. Resident 35 stated they were able to use their walker, sit on the toilet, and get around more. Resident 35 stated it was explained to them that their insurance no longer covered therapy, and they were moved to the 3rd floor. Resident 35 stated they had spoken to a lady about restarting therapy. In a review of the Admission Minimum Data Set (MDS-an assessment tool) dated 05/02/2023 showed Resident 35 required two-person physical assistance for transfers and bed mobility and required one-person physical assistance to walk in their room. Review of the Annual MDS dated [DATE], documented Resident 35 was dependent for transfers and did not walk in their room. There was no significant change MDS completed for Resident 35 from their admission on 04/26/2023 to 03/24/2025 even though they had a change in their abilities and an increase in their need for assistance from care staff. Review of Resident 35's care plan dated 04/26/2023 documented they had a deficit in activities of daily living (ADL's) self-care performance deficit related to activity intolerance, recent acute urinary tract infection, impaired balance, and obesity. There were several resolved interventions for restorative nursing services starting 6/28/2024 and resolved 07/02/2024 for upper and lower extremity exercises, bed mobility, and walking in the hallway. Review of Resident 35's progress notes dated 03/15/2024 to 04/15/2025 showed no documentation regarding restorative nursing services when implemented or resolved as identified on the care plan. (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 04/17/2025 at 10:23 AM Staff M, Nursing Assistant Certified (NAC) stated Resident 35 was dependent on staff for all care except for things they could do for themselves with their upper extremities. Staff M was unable to state if Resident 35 received therapy or restorative services and deferred to the nurse. In an interview on 04/17/2025 at 2:05 PM Staff L, Registered Nurse-MDS/Restorative Nurse stated Resident 35 had refused their Restorative Nursing Programs (RNP) and were removed from the program in July 2024 and was not currently receiving the services on the program. When asked how residents who are taken off the RNP were reassessed and reapproached, they stated it would be a good idea to implement a system to do so. In an interview on 04/21/2025 at 12:00 PM Staff B, Director of Nurses Services, stated they had a performance improvement plan related to restorative nursing services; however it was not currently active and did not address reassessment of resident's who had been on the program. No other information was provided. This is a repeat deficiency from 06/12/2024. Reference WAC 388-97-1060(2)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review, the facility failed to ensure appropriate safety interventions were developed and implemented for 2 of 3 residents (Resident 234 and 328) who had dysphasia (difficulty swallowing) and were at risk for aspiration (inhalation of food). This failure placed residents at risk for aspiration, increased health complications and a diminished quality of life. Findings Included . Review of the facility policy titled, Refusal of Medications, and Treatment Refusal or Non-compliance with Care, dated 08/22/2011, showed: Documentation pertaining to a resident's refusal of treatment shall include each time the resident refused his or her treatment and resident's condition and any adverse effects due to such refusal. The date and time the physician was notified as well as the physician's response. All pertinent observations and the signature and title of the person recording data. Resident's legal representative must be notified of the resident's refusal. Referral must also be made to social services to rule out underlying issues, i.e. depression, etc. Resident's plan of care must address refusal or non-compliance if it remains an issue. <RESIDENT 234> Resident 234 admitted to the facility on [DATE] with diagnoses to include stroke, heart failure, and facial weakness. On 04/16/2025 at 8:07 AM observed Resident 234's room number written on a white board in the nurse's station, which read 647 feed assist. Observed Resident 234 in their room eating breakfast with no assistance. On 04/16/2025 at 1:09 PM observed Resident 234 in their room, their overbed table in front of them, with the lunch meal tray. Resident 234 was eating without assistance. Observed Staff T, Nursing Assistant Certified (NAC), pick of Resident 234's meal tray from their room, checked the nutritional shake by shaking it, and placed the meal tray in tray cart. In a review of Resident 234's care plan dated 03/26/2025 showed they were on aspiration precautions with the directive for nursing and nursing assistants to check for oral pocketing after meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a review of Resident 234's Treatment Administration Record (TAR) showed a physician order dated 03/26/2025 that they were on aspiration precautions and to check for oral pocketing after meals and at bedtime. In a review of Speech and Language Pathologist (SLP) therapy notes dated 03/13/2025 showed a recommendation Resident 234 be placed on aspiration precautions with an assessment of dysphasia and cognition issues. Review of the SLP notes on 03/26/2025 showed Resident 234 presented with prolonged mastication (increased chewing time) and oral pocketing with signs and symptoms of aspiration and their diet was downgraded. In an interview on 04/17/2025 at 8:00 AM Staff T, NAC, stated the residents on their hall, including Resident 234 had not required any assistance with eating their meal and required only set up for meals. When asked what the notation on the whiteboard meant for Resident 234, Staff T, deferred to Staff U, NAC stating they were the assigned NAC for Resident 234. In an interview on 04/17/2025 at 8:01 AM Staff W, NAC stated the whiteboard located in the nurse's station was used for the staff to communicate with each other. In an interview on 04/17/2025 at 8:09 AM Staff U, NAC stated Resident 234 was provided supervision with eating because they did not like to be assisted. Staff U stated they had informed the Resident Care Manager of Resident 234 was being supervised with eating their meals. In an interview on 04/17/2025 at 8:17 AM Staff X, Registered Nurse stated the residents on their hall, including Resident 234 were set up assistance with eating, did not require assistance with feeding, and had no swallow issues. Staff X stated Resident 234 ate by themselves and did not have any issues with swallowing their pills. Staff X stated they relied on the Medication Administration Record (MAR) and (TAR) as well as information found in the electronic medical record to know how to take care of residents. In an interview on 04/17/2025 at 9:27 AM Staff V, RN-Resident Care Manager stated Resident 234 was able to eat by themselves. When asked what the care plan showed, Staff V stated it showed Resident 234 required substantial maximum assistance. Staff V stated they expected the staff to follow the care plan for each resident. In an interview on 04/17/2025 at 1:03 PM Collateral Contact 4 (CC4), Speech Language Pathologist stated Resident 234 had a stroke and was having difficulty with swallowing and chewing textures. CC4 stated they had NAC's checking Resident 234 to see if they were pocketing their food after meals. CC4 stated they communicated recommendations and changes for residents with resident care managers through a communication form. 51551 <RESIDENT 328> Resident 328 admitted to the facility on [DATE], with diagnoses to include dysphagia (difficult swallowing). According to the admission MDS assessment dated [DATE], the resident had moderate cognitive impairment and required feeding tube and no oral diet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 04/15/2025 at 11:48 AM, Resident 328 stated the facility did not give them meals since 04/12/2025 and they had to order their own food from outside restaurants. Observed Resident 328 was eating peaches brought from their spouses. In an interview on 04/16/2025 at 9:23 AM, Resident 328 stated the facility did not offer them any food yesterday and this morning. Resident 328 stated they ordered their own spaghetti from restaurant last night and delivered it to their rooms. In an interview on 04/17/2025 at 9:29 AM, Resident 328 stated the facility offered them breakfast but no liquid. Resident 328 stated their spouses brought him watermelon yesterday and they got water with the watermelon. Resident 328 stated they already signed a waiver on 04/11/2025 from SLP and did not understand why the facility did not offer them any meal until 04/17/2025. Review of diet order on 04/16/2025 at 11:30 AM, showed Resident 328's was NPO (Nothing by Mouth) and TF (tube feeding). Review of a risk and benefit form dated 04/11/2025, showed Resident 328 understood the risk and did not want to follow SLP's recommendation of NPO. There was no signature from the family/legal representative. Review of a SLP's progress report dated 04/17/2025 at 1:27 PM, showed Resident 328 had coughing and choking during meals or when swallowing medication, and coughing involuntarily before, during, or after swallowing solid. Review of a SLP's treatment encounter note dated 04/15/2025, showed Resident 328 reported they ordered spaghetti and observed moderate sign and symptoms of aspiration coughing post swallow and occasional coughing during conversation suspected poor salvia management. The note showed SLP recommended no thin liquid but extremely thick consistency. Review of a SLP's treatment encounter note dated 04/11/2025, showed Resident 328 continued to intake regular texture food outside of the facility and brought back grapes and banana. The note showed SLP communicated with Resident 328 and delivered the risk and benefit paper to RCM and administrator and attempted to call the spouse however spouse did not answer the phone. Review of a SLP's treatment encounter note dated 04/10/2025, showed Resident 328 reported they planned to eat cheeseburger after their appointment. Review of a SLP's treatment encounter note dated 04/09/2025, showed Resident 328 did report they ate a slide of pepperoni pizza while they were out of the facility. Review of care plan dated 04/16/2025, showed Resident 328 receives enteral nutrition to meet 100% nutrition needs while diet status remained as NPO. There was no focus of area addressing Resident 328's refusal or non-compliance of being NPO. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes from 04/11/2025 to 04/16/2025, showed no documentation about Resident 328's refusal of being NPO or had been taking their own home food and outside food. There was no documentation for any monitoring of swallowing or risk of aspiration. There was no alert charting about Resident 328 had been taking regular diet. There was no documentation of whether the physician was notified. There was no documentation of whether the family/legal representative was notified. There was no documentation of whether the social service was referred to. In an interview on 04/16/2025 at 11:29 AM, Staff J, RN, stated Resident 328 was a tube feeder and they were not aware Resident 328 had been eating regular home food or outside ordered food. In an interview on 04/16/2025 at 11:41 AM, Staff Z, NAC, stated they were not aware Resident 328 had been eating home and delivered outside food. In an interview on 04/17/2025 at 10:30 AM, Staff AA, Dietary Manager, stated Resident was strict tube feeder until yesterday they updated their diet order to regular texture diet with no thin liquid. Staff AA stated Resident 328 did voice out they wanted to have liquid but they told them no since that was what the SLP recommended. Staff AA stated Resident 328 asked for gravy but the kitchen did not apply because the diet order indicated extremely thick liquid. Staff AA stated they were aware Resident 328 signed the risk and benefit form and they were sure Resident 328 ate outside food. In an interview and record review on 04/17/25 at 1:13 PM, Staff Y, RN, stated Resident 328 always mentioned they wanted to order outside food. Staff Y stated nurse and NAC obtained care instructions from the care plan and Kardex (a tool used to provide direction on how to care for a resident) but both care plan and Kardex showed Resident 328 was totally dependent on staff for tube feeding and nothing else by mouth except ice chips. Staff Y stated the care plan and Kardex needed to be updated. Staff Y stated they did not have monitoring order or any alert charting of swallowing for safety documented in progress notes. In an interview on 04/17/2025 at 1:25 PM, Staff V, RN/RCM, stated they were aware Resident 328 had been eating home food and the facility had offered Resident 328 whatever snacks on the snack list since Resident 328 signed the waiver on 04/11/2025. Staff V stated they did not update the diet order until 04/16/2025 afternoon. Staff V stated they could not see any documentation about Resident 328 refusal of treatment or the facility offered snacks or meals. Staff V stated they could not see any alert charting of swallowing/aspiration and choking risk in progress notes. Staff V stated there was no monitoring to make sure Resident 328 was safe. Staff V stated the care plan and Kardex did not reflect the diet change and did not include Resident 328's refusal of recommendation. Staff V stated Resident 328 should be monitored and the care plan needed to be updated. In an interview on 04/17/2025 at 1:43 PM, CC4 stated Resident 328 had high aspiration risk based on the assessment. CC4 stated they tried to contact the spouse when Resident 328 signed the risk and benefit form but did not get chance to talk to the spouse. CC4 stated they witnessed Resident 328 having been eating outside food including banana and grapes and Resident 328 was telling everyone including nurses they ordered spaghetti and ate pizza and watermelon. CC4 stated Resident 328 needed to be monitored by nursing to make sure they were safe as the aspiration and choking risk was high. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and record review on 04/17/2025 at 3:21 PM, Staff B, Director of Nursing, stated they expected nurse should know Resident 328 had been eating outside food and nurse needed to monitor the risk of aspiration and choking and to start alert charting to make sure Resident 328 was safe. Staff B stated they did not see any documentation about the risk of aspiration and choking monitoring. Staff B stated the diet order was not changed in the electronic medical record until yesterday afternoon so the meals were not delivered. Staff B stated Resident 328's care plan and Kardex needed to be updated to reflect the diet change and alert and monitoring and refusal of treatment. Refer to WAC 388-97-1060 (3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interviews and record reviews, the facility failed to ensure that 1 of 1 residents (Resident 35) who were incontinent of bladder and continent of bowel received appropriate treatment and services to restore continence to the extent possible. This failure placed residents at an increased risk of urinary tract infections, discomfort, loss of dignity, and decreased quality of life. Findings included . Resident 35 admitted to the facility on [DATE] with diagnoses to include peripheral vascular disease (circulatory condition involving narrowing of the blood vessels), high blood pressure, and atrial fibrillation (rapid/irregular heartbeat). In an interview on 04/16/2025 at 9:54 AM Resident 35 stated they had been getting therapy and was able to use the toilet to have bowel movements, but was told the insurance would not cover anymore therapy and was moved to the third floor, at which time they were told there was no bathroom, and they would need to use their brief to urinate and defecate. In a review of Resident 35's initial minimum data set (MDS-an assessment tool) dated 05/9/2023 showed they were frequently incontinent of bowel and bladder and required extensive assistance of two staff to use the toilet. In a review of Resident 35's most recent annual MDS assessment dated [DATE] showed they were dependent on staff for their toileting hygiene and transfers to the toilet did not occur. In a review of Resident 35's electronic medical record there was no significant change MDS completed to explain their progression from extensive assistance of 2 staff for toileting to dependent. In a review of Resident 35's completed bowel and bladder assessments showed on 3/31/2025 a quarterly assessment was completed with a score of 12 indicating they were a possible candidate for bowel and bladder retraining. Bowel and bladder quarterly assessment dated [DATE], 4/12/2024, 01/07/2024, and 10/03/2023 showed a score of 17 indicating they were not a candidate for bowel and bladder retraining. On 08/02/2023 there were two assessments with conflicting scores of 17 and 8. Their admission assessment showed a score of 8 indicating they were a likely candidate for bowel and bladder retraining. In review of Resident 35's progress notes dated 03/15/2023 through 04/16/2025 showed no documentation of them being assessed for a bowel/bladder retraining program. In a review of Resident 35's physical therapy (PT) discharge summary note dated 05/19/2023 showed they had progressed slowly, had been independent with basic activities of daily living prior to hospitalization and nursing home placement, and was able to ambulate, transfer and required moderate assistance to go from lying to sitting in bed. The discharge summary noted Resident 35 would benefit from restorative nursing services. Resident 35 had not received any additional PT services since 05/19/2023. (continued on next page)

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	505404	A. Building B. Wing	04/21/2025

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a review of Resident 35's occupational therapy discharge therapy note dated 05/22/2023 showed they were using a raised toilet seat, required maximum assistance with toilet hygiene and transfers, and used a front wheeled walker to get to and from the bathroom. Resident 35 had not received any additional OT services since 05/22/2023. In a review of Resident 35's care plan dated 04/27/2023 showed they were incontinent and directed staff to check for incontinence and change their brief as needed every two to three hours. In an interview on 04/17/2025 at 12:51 PM Staff E, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated residents are assessed for bowel and training programs through quarterly, annual, and as needed. Staff E stated Resident 35 was not a bowel and bladder training program as they were incontinent. When asked about the most recent bowel and bladder assessment, which showed Resident 35 was continent, Staff E stated they had not completed the assessment, and it was likely an error. Staff E stated Resident 35 had been incontinent since their admission to the facility. Staff E stated they had not recently spoken to Resident 35 about toilet use. In an interview on 04/17/2025 at 1:50 PM Staff C, Assistant Director of Nurses (ADON)/Registered Nurse (RN) stated they completed the most recent bowel and bladder assessment for Resident 35 and gathered the information for the assessment from interviews with staff and review of the electronic medical record. Staff C stated they did not interview Resident 35. Staff C stated they are filling in for the RCM role and with the information from the assessment Resident 35 should have had a toileting program set up. In an interview on 04/17/2025 at 10:23 AM Staff M, Nursing Assistant Certified (NAC) stated Resident 35 was dependent apart from their upper extremity. When asked if Resident 35 requested to use the bathroom, Staff M stated they could not use the bathroom and they are incontinent. Staff M stated Resident 35 uses a Hoyer lift (a medical device used to transfer individuals with limited mobility). Staff M stated they care for Resident 35 based on their care plan and check and change them every two to three hours. In an interview joint interview on 04/21/2025 at 12:00 PM Staff B stated Hoyer lifts do not fit in the bathrooms on the third floor and they would refer Resident 35 for therapy to evaluate for a different medical device. Staff O, Director of Clinical Operations stated if a resident had the urge to urinate/defecate then a toileting program would be indicated. Refer to WAC 388-97-1060(3)(c)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44110 Based on interviews and record review, the facility failed to ensure medically related social services were provided for 8 of 8 residents (Residents 20, 28, 39, 277, 278, 324, 325, and 329) reviewed for social services. The facility failed to ensure residents received support with care planning process (Residents 28, 39, 325, and 329), failed to ensure residents were provided support to formulate their advanced directive options (Residents 325, and 329), failed to ensure residents received support with discharge planning (Residents 277, and 278), and failed to ensure referrals and recommendations for appropriate mental health services were completed (Residents 20 and 324). This failure placed residents at risk of unmet social service needs, unsafe care, psychosocial decline, and a diminished quality of life. Findings included . <RESIDENT 20> Resident 20 admitted to the facility on [DATE] with diagnoses that included depression, and insomnia. The Admission Minimum Data Set (MDS- an assessment tool) dated 03/04/2025 showed the resident had moderately impaired cognition, with moderate depression. Review of Resident 20's progress notes, on 03/28/2025 the resident had been seen for a psychological evaluation and recommendations of treatment and follow-up care. Review of Resident 20's medical record on 04/15/2025 no update to the plan of care had been completed by social services related to the resident mental health recommendations and approaches. <RESIDENT 28> Resident 28 admitted to the facility on [DATE], diagnoses that include Alzheimer's, and cognitive communication deficit. The quarterly MDS dated [DATE], showed the resident had sever impaired cognition. In a phone interview on 04/15/2025 at 2:13 PM, Collateral Contact (CC) 1 stated they were the power of attorney for Resident 28. CC1 stated in the past, they had received regular communication with the facility on updates, and plan of care for Resident 28, lately they have not had any. CC1 stated they had requested a care conference and updates with the previous social services and were told that unless something was wrong, they would not be able to provide regular updates to them. CC1 stated Resident 28 has been declining, losing weight and they were really worried about them. Review of Resident 28's medical record on 04/15/2025, the resident had a care conference document dated 10/21/2024, the form was blank and not completed. The last documented care conference for Resident 28 was dated 06/26/2024. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 28's care plan on 04/15/2025 showed a focus area revised on 06/20/2024 that the resident and family wished the resident to remain at the facility with an intervention that staff will offer care meetings and reviews as the family desires in addition to quarterly, annually and any change in conditions. <RESIDENT 39> Resident 39 admitted to the facility 05/15/2024 with diagnoses that included major depression, cognitive communication disorder (difficulty communicating), and osteoarthritis (inflammation and pain to joints) in both hands. The quarterly MDS dated [DATE] documented that the resident had intact cognition, with moderate depression In an interview on 04/15/2025 at 1:49 PM, Resident 39 stated they have been trying to get assistance from social services regarding a letter that they received from Medicaid. Resident 39 stated they have tried to write back to them, but the pain in their hands just will not allow them to write anymore. Resident 39 expressed they were frustrated and worried. Resident 39 was asked if they had told anyone they needed to speak with social services, they stated they tell the nurse all the time, I don't think we even have one anymore. The resident stated they had not had a care conference for a long time. Review of Resident 39's medical record on 04/15/2025, there were no care conferences documented in the last 6 months. Review of the facility assessment dated [DATE] documented that the facility average census was 72 residents. The average weekly admissions and discharges were six to eight. The facility requires a social services director and assistant to manage the resident case load and requirements to meet their needs. In an interview on 04/17/2025 at 11:38 AM, Staff B, Director of Nursing Services (DNS) stated the social service director and assistant were no longer employed at the facility and they were currently interviewing for new candidates. They are receiving some support from another facility for social services tasks. In an interview on 04/17/2025 at 2:15 PM, CC 2 stated they were from another facility and were assisting with social work tasks. CC2 stated they were doing there best to assist and help cover things. 50725 <RESIDENT 277> Resident 277 was admitted to the facility on [DATE]. According to the quarterly MDS, dated [DATE], resident had moderate cognitive impairment. In an interview on 04/15/2025 at 3:39 PM. Resident 277 stated that they had a care conference once but nobody from the facility had updated them regarding their discharge (dc) plan. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 277's Electronic Health Record (EHR), under progress notes for Social Services showed on 04/02/2025, it stated that resident's payor changed to Medicaid effective 04/05/2025 and that niece was notified. The other note from Social Services dated 03/27/2025 stated, referral was made to Case Worker for an Adult Family Home (AFH) Assessment. There were no other notes regarding resident's dc plan. In an interview on 04/18/2025 at 10:50 AM, Staff E, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated that they were not assigned to the 3rd floor as the RCM but was only there to orient a newly hired RCM. They added that one Social Worker (SW) no longer works at the facility and the other SW was on emergency leave so the SW's from another facility were helping them. Staff E stated that Resident 277's discharge plan was to go to an AFH, but they were waiting on the assessment from DSHS. Staff E was not sure why resident was not updated regarding the dc plan. They will go and talk to the resident to update them. <RESIDENT 278> Resident 278 was admitted to the facility on [DATE]. According to the admission MDS, dated [DATE], resident had moderate cognitive impairment. In an interview on 04/15/2025, Resident 278 stated they were worried about when the facility will start taking money from her. They had not been updated about their discharge plan. Review of Resident 278's EHR under progress note for Social Services dated 04/07/2025, documented: Discharge 04/10/2025. Daughter is figuring out who will pick up. Also called Case Worker about Caregivers. Daughter will call too. No other notes from Social Services after this. In an interview on 04/21/2025 at 10:24 AM Staff B, DNS stated that dc planning process was challenging at this time due to changes in the Social Services Department. Every Wednesday, their team review residents and determine who will be able to dc back to the community, they review the therapy notes and if a resident plateau, and no nursing needs they initiate dc plan. Staff B stated, SW from another facility were helping them with the dc process. Staff B stated they will investigate Resident 278's dc plan. 51551 <RESIDENT 324> Resident 324 admitted to the facility on [DATE] with a diagnosis of recurrent and unspecified major depressive disorder (constant feeling of sadness). According to the MDS assessment dated [DATE], Resident 324 had a diagnosis of depression and was using antidepressant. Review of April 2025 Medication Administration Record showed Resident 324 had been taking an antidepressant medication daily started from 04/03/2025. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 324's Level I PASARR (Preadmission Screening and Resident Reviews -an assessment to ensure individuals with Serious Mental Illness [SMI] or intellectual/Developmental Disabilities [ID/DD]) dated 04/01/2025, showed no level II evaluation referral because of no depression marked under SMI indicator. In an interview on 04/18/2025 at 09:35 AM, Staff E, Licensed Practice Nurse/Resident Care Manager, social services reviewed PASARR forms for accuracy and update if necessary. In an interview on 04/22/2025 at 10:24 AM, Staff B, Director of Nursing, stated Resident 324's level I PASRR was not accurate and should be reviewed, updated and sent for level II evaluation prior to admission. <RESIDENT 325> Resident 325 admitted to the facility on [DATE]. According to the Admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], Resident 325 had minimal cognitive impairment. In an interview on 04/15/2025 at 12:10 AM, Resident 325 stated they were not sure about their discharge planning. Resident 325 stated they were not told of a care plan meeting. Review of Resident 325's electronic health record (EHR) showed no documentation about the initial care planning conference. Review of Resident 325's electronic health record (EHR) showed no AD documentation or Resident 325 had been provided with assistance to formulate an AD. Review of Resident 325's care plan, print date 04/20/2025 did not document a focus area addressing an AD or discharge planning. <RESIDENT 329> Resident 329 admitted to the facility on [DATE]. According to the admission nursing assessment dated [DATE], Resident 329 was alert and oriented. In an interview on 04/15/2025 at 11:31 AM, Resident 329 stated they were not told of a care plan meeting and were not involved in discussions regarding the goals of their person-centered care and not sure about their discharge planning. Review of Resident 329's EMR since admission to 04/17/2025, revealed no correlating documentation of any interdisciplinary care plan meeting with the resident. Review of Resident 329's electronic health record (EHR) showed no AD documentation or Resident 329 had been provided with assistance to formulate an AD. Review of Resident 329's care plan, dated 04/20/2025, revealed no focus area of addressing discharge planning or AD. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/2025 at 9:35 AM, Staff E, Licensed Practical Nurse/Resident Care Manager, stated social service was responsible for arranging initial care plan meetings for newly admitted residents during the first 72 hours. Staff E stated the social service would follow up on AD during the first initial care conference as well. Staff E stated the social service should document the initial care plan meeting in electronic health record. In a record review and interview on 04/22/2025 at 10:24 AM, Staff B, Director of Nursing, stated they expected social service to set up the first initial care plan meeting within three days of admission and to follow up on AD during the first initial care conference. Reference WAC 388-97-0960(1) This is a repeat deficiency from 06/12/2024.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44110 Based on observation, interview and record review, the facility failed to ensure a treatment cart (containing prescribed topicals, ointments, and wound cleaning agents) was secured in a locked storage area and inaccessible to unauthorized staff and residents for 1 of 4 treatment carts (3 South Unit) observed for medication cart review. These failures placed residents at risk for unauthorized access to medications and treatments that should be securely stored. Findings included . Review of the facility policy titled, Storage of Medications, dated 01/2023, medications, and other biologicals are stored properly the supply shall be only accessible to licensed nursing personnel supplies should remain locked when not in use or unattended. In an observation on 04/18/2025 at 10:38 AM, the treatment cart on unit 3 South was observed to be unlocked, and no licensed staff around. The drawers were accessible to anyone that walked by, observed in some of the drawers was a tube of topical pain gel (that must be prescribed by a doctor), three 16 ounce bottles of Dakin's solution (a prescribed chemical solution used to clean wounds), multiple tubes of Medi honey (prescribed wound ointment), several iodine swabs, five bottles of nystatin powder (prescribed anti-fungal powder), several hypodermic needles, and miscellaneous wound bandages. In an observation on 04/18/2025 at 10:54 AM, residents were observed ambulating and moving past unlocked cart that was accessible to anyone with no licensed staff around. In an observation and interview on 04/18/2025 at 11:00 AM, Staff J, Registered Nurse was observed to be stationed on the other side of the unit, unlocked treatment cart was not visible to them. Staff J was asked to assess the treatment cart. Staff J was shown that all drawers were accessible to anyone, and reviewed items in drawers with Staff. Staff J stated the cart was supposed to be always locked. In an interview on 04/18/2025 at 12:56 PM, Staff C, Assistant Director of Nursing Services (DNS)/Infection Preventionist stated that the treatment carts should always be locked. In an interview on 04/21/2025 at 12:00 PM Staff B, DNS stated the expectation was that the treatment cart should be locked when not in use. Staff B was not aware the treatment cart on Unit 3 South was left unlocked and unattended for 22 minutes. Reference WAC 388-97-1300(2)