STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Rehabilitation and Care Center	5925 47th Avenue NE Marysville, WA 98270

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview, and record review, the facility failed to maintain a safe, clean, and homelike comfortable environment. The facility failed to provide necessary housekeeping and maintenance of resident rooms, bathrooms, and hallways; failed to ensure comfortable sound levels were maintained, failed to ensure resident rooms were individualized with items to provide a homelike environment, and failed to ensure residents were afforded adequate living space. These failures placed residents at risk for a diminished quality of life. Findings included . Review of the facility policy titled homelike environment dated 2024 showed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Cleanliness and orderly environment in rooms Privacy Curtains. Comfortable (minimum glare) yet adequate (suitable to the task) lighting; Inviting colors and decor; Personalized furniture and room arrangements; Pleasant, neutral scents; Comfortable temperatures; and Comfortable noise levels. <COMFORTABLE SOUND LEVELS> Residents 8, 13, and 53 were roommates in a 3 bed room. Resident 13 admitted [DATE] and was alert and oriented. Resident 13 was in the window bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 53 admitted [DATE] and according to the 11/04/2024 Quarterly Minimum Data Set (MDS) assessment (a required tool), Resident 53 was cognitively impaired and required extensive assistance for care. Resident 53 was in the center bed. Resident 8 admitted [DATE] and was alert and oriented. Resident 8 was in the door bed. In an observation on 01/02/2025 at 9:51 AM Resident 53 was in their bed yelling out in a repetitive distressed manner. Several staff responded in attempts to determine Resident 53's need and just after staff would exit the room, Resident 53 would resume repetitive yelling. In an interview and observation on 01/02/2025 at 10:51 AM, Resident 53 was yelling and banging on the side of their bed. Resident 13 was lying in their bed with headphones on and stated this goes on all day and all night and they had not slept well since they admitted . Resident 13 stated they ask the nurses, can you do something? and one nurse finally gave them a paper (grievance form) they could fill out but stated they felt that the staff should do that; they were frustrated and tired and felt like someone should be doing something more for them (Resident 53). In an interview and observation on 01/03/2025 at 12:59 PM, Resident 8 was lying in bed with the privacy curtain closed between their bed and the middle bed and stated (Resident 53) yells, the nurses come in and out constantly, and as soon as they leave it starts over, (Resident 53) will start yelling again and nobody cares. Resident 53 was observed to begin grabbing the privacy curtain and pulling it open while yelling out. Resident 8 stated there was an agreement about the privacy curtain and that yesterday (Resident 53) had it open and today was their day to have it closed and (Resident 53) is not following the agreement. <HOMELIKE ENVIRONMENT> In an observation on Resident 53's personal space on 01/03/2025 at 1:04 PM, the resident was in the center bed with both privacy curtains pulled on either side of them. The privacy curtains were pale yellow solid colored curtains. The space where resident 53's bed was measured just over 68 square feet. The resident had no personal wall space other than behind their head which was not visible to them. In front of them on the wall there was a TV mounted close to the ceiling and the only other item in view was an institutional Personal Protective Equipment plastic rolling cart against the wall which was stacked with bed pads and a package of cleansing wipes. Residents 8 and 13 (on either side of the resident) preferred the privacy curtains closed, which resulted in Resident 53 being in a small, enclosed space when the privacy curtains were closed. In an interview and observation on 01/03/2025 at 1:04 PM, Resident 53 was pulling on the privacy curtain to attempt to open it and yelling repetitively. Resident 8 grabbed the privacy curtain and began pulling it back to closed stating (they) want it open and I want it closed, this is all the time, it is my curtain too. Both residents had a grip on the privacy curtain attempting to pull it in opposite directions. Staff R, Certified Nursing Assistant, attempted to intervene, and attempted to close the curtain as Resident 8 requested, but stated (Resident 53) won't let go, they want it to be open. Staff R called for assistance from management and social services. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident records on 01/03/2025 showed no documentation of resident preferences related to personal space or privacy curtains. Review of the grievance log on 01/03/2025 for the prior 6 months showed no documented grievances related to room or room mate concerns for either resident. Applying the reasonable person concept, a reasonable person would desire or expect some personalization for a homelike environment such as space for personal items or decoration and control over their limited personal space, such as being able to have the privacy curtains open or closed, when desired, and for the facility to intervene and mitigate on behalf of each resident when incompatibility was evident. 51312 <RESIDENT ROOMS> In an observation on 01/02/25 at 9:52 AM, room [ROOM NUMBER]'s flooring next to resident 5's bed was sticky. The wall under the residents' TVs had scraped areas along the entire wall with exposed drywall and multiple nail-sized holes. In an observation on 01/03/25 at 12:39 PM, room [ROOM NUMBER]'s flooring next to resident 5's bed was sticky. Resident 5's overhead light had a thick layer of dust on it. There was no trash bag in resident 5's trash can. <FACILITY> In an observation on 01/02/25 at 10:16 AM of the hallway for rooms 1-28, showed the ceiling was dusty around the vents, there was dust on the wall around the fire door, and the utility room doors in the hallway had areas around the doorknobs that were discolored and splotchy. The light fixtures had black globs with wings inside of them. The walls and ceiling had multiple spots that were dark and had particulate matter on them. In an observation/interview on 1/3/2025 at 2:04 PM, Staff A, Administrator, stated the stains on the wall by room [ROOM NUMBER] was ketchup, the discolored and splotchy spots on the utility room door was old tape residue, the dark areas splattered on the walls and the ceiling was more food. Staff A stated the walls adjacent to the fire door, the personal protective equipment containers, and the light fixtures were dusty, and the staff was going to have a dusting party. During resident counsel on 01/06/25 1:00 PM, Resident 330 stated the facility was dirty and needed to be deep cleaned. 44110 In an observation on 01/02/2025 at 11:09 AM, surveyor observed gnats at the nurse's station. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 01/02/2025 at 2:14 PM, Resident 16 was lying in bed talking to surveyor when they started to swat at the air. Resident 16 then said there are always gnats flying around, then pointed to a bug catcher (long strip with sticky adhesive with pictures of bugs on it) attached to the wall next to the resident's head of the bed. Resident 16 said the gnats are horrible, and that was why they had the bug catcher. In an observation on 01/06/2025 at 9:25 AM, room [ROOM NUMBER] had three residents listed as occupants in the room. In the room each resident's personal space was separated by a fabric privacy curtain that hung from the ceiling. The resident (Resident 380) that had their bed in the middle of the room (they had other residents on either side of them), their bed was observed to be pushed next to the resident's space near the door to allow for the resident to sit in the chair to eat breakfast. The privacy curtain between the two residents was observed to be snagged as it was wedged between the two beds with no individual space between the resident's belongings and beds. In an observation on 01/06/2025 at 2:05 PM, Fire Marshall was asked to measure the space for the resident that was in the middle of the room in room [ROOM NUMBER]. The Fire Marshall measured the width of the room from wall to wall which measured 11.6 feet, and then measured between the two privacy curtains, which measured 5.9 feet. The privacy curtains were observed to be pushed in on both sides of the middle resident's personal space, which decreased the space for the resident to have their belongings. The total square footage of usable space for Resident 380 was 68.44 square feet, less than the 80 square feet that was required for a home like environment. In an observation on 01/07/2025 at 8:56 AM, room [ROOM NUMBER] was observed that the middle bed and the bed near the door had less than 6 inches of space between the two beds and was only separated by a fabric privacy curtain. It was observed that both residents were in their beds. In an observation and interview on 01/07/2025 at 1:09 PM, room [ROOM NUMBER], which presented with three residents in the room separated by only fabric privacy curtains, Resident 533 was lying in the bed in the middle spot. Resident 533 was asked if we could measure their space, and they agreed and then stated its really narrow in here, not a lot of space. The space was 11.6 feet in width and 6 feet in length, total square footage of 69.6 feet, less than 80 square feet to provide a home like environment. In an interview on 01/08/2025 at 10:00 AM, Staff W, Maintenance Supervisor stated they were aware of the gnat problem in Resident 16's room. They stated they hung up the bug catcher to deter the gnats. In a joint interview on 01/09/2025 at 9:20 AM, Staff A, Administrator and Staff B, Director of Nursing Services, Staff A stated they agreed to the bug catcher for Resident 16, per a grievance request. Staff B stated they try not to store food in the resident's room. Staff A stated they were aware of the concern for lack of personal space in the three person rooms. 51551 <BATHROOM CLEANLINESS> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 01/02/2025 at 9:42 AM, in the bathroom between rooms [ROOM NUMBERS], the sink had yellowish rust stains and had large amount of dark hair. The drain was partly clogged and the water drainage was slow. The toilet high rise seat was soiled with multiple brown substances. There were two square grey contaners,not in plastic bags and not labeled, on the floor and a female urinal, not in plastic bag and unlabeled, on the top of the toilet water tank. In an observation on 01/02/2025 at 10:02 AM, in the bathroom between rooms [ROOM NUMBERS], there was a piece of feces floating and multiple yellowish rust stais in the toilet bowel. There were one basin, two bed pans, one urinal, and one big container piled together on the floor under the sink, not were in plastic bags nor labeled. There were two toothpastes and one toothbrush on the floor in between the sink and toilet bowl. There was a hair brush on the edge of the sink that was not labeled with a resident name. There was a bottle of periwash spray on the back of the toilet tank that was not labeled with a resident name. In an observation on 01/02/2025 at 3:01 PM, the bathroom between room [ROOM NUMBER] and 36 looked the same as what it was at 10:02 AM. In an observation on 01/03/2025 at 8:59 AM, in the bathroom between rooms [ROOM NUMBERS], there was a denture cup in the sink that had no resident name. There toilet bowl contained yellow fluid. There was a bottle of periwash spray on the back of the toilet tank that was not labeled with a resident name. In an observation on 01/03/2025 at 9:02 AM, in the bathroom between rooms [ROOM NUMBERS], there was a female urinal on top of the toilet tank, not in a plastic bag or labeled. There were two grey square containers on the floor below the sink. There were still multiple brown spots on the toilet high rise seat. In an observation and interview on 01/03/2025 at 12:08 PM, in the bathroom between rooms [ROOM NUMBERS], Staff B observed the bathroom with surveyor. There were a bottle of peri wash spray that had no resident name and a bottle of odor eliminator spray on the top of the toilet tank. There was a denture cup in the sink that did not have a resident name. Staff B stated they were not sure whom these items belonged to. Staff B stated they expected any toileting items (bedpan/urinal) in the bathroom needed to be in a plastic bag and labeled with resident's names. Staff B stated they were encouraging staff to not to leave any grooming items in the bathroom. In an observation on 01/08/2025 at 10:20 AM, in the bathroom between rooms [ROOM NUMBERS], there was a basin on the floor under the sink. 47047 <PRIVACY CURTAINS> In an observation on 01/02/2025 at 9:52 AM, room [ROOM NUMBER]'s privacy curtain was visibly soiled with multiple areas of brown particulate matter. In an observation on 01/02/2025 at 10:16 AM, room [ROOM NUMBER]'s privacy curtain was visibly soiled with multiple areas of particulate matter. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation in 01/03/2025 at 1:08 PM room [ROOM NUMBER]'s privacy curtain was visibly soiled with multiple brown stains toward the bottom of the curtain. In an observation on 01/03/2025 at 1:45 PM room [ROOM NUMBER]'s privacy curtain between the beds was visibly soiled with a brown stain, circular in shape, near the middle of the curtain. In an observation on 01/03/2025 at 1:08 PM room [ROOM NUMBER]'s privacy curtain between the beds was visibly soiled with brown matter in circular patterns near the middle of the curtain. In an interview on 01/03/2025 at 1:08 PM Staff BB, Housekeeper, stated they knock on door and identify themselves before entering. Staff BB stated they empty the trash, make sure that there is nothing on the floor, pick up dirty linens and send to the soiled linens, and mop and sweep floor. When asked if how they manage cleaning of soiled curtains, Staff BB stated they make a note in their notebook and inform their supervisor of it. Staff BB entered room [ROOM NUMBER] and stated they had not seen the soiled curtain and would make a note to tell their supervisor. In an interview on 01/03/2025 at 1:14 PM Staff R, Housekeeping Supervisor, stated the housekeepers tell them when a privacy curtain was soiled and required to be changed. Staff R stated at least monthly they complete a check of all the privacy curtains to ensure cleanliness. Staff R stated they were only informed of room [ROOM NUMBER] that needed their privacy curtain changed. In an interview on 01/03/2025 at 1:27 PM Staff A, Administrator, stated soiled privacy curtains would be changed that day. Staff A stated privacy curtains were done during their deep cleaning schedule and an inservice would be completed with staff. In an observation on 01/08/2024 at 2:00 PM room [ROOM NUMBER]'s privacy curtain remained soiled, in the same spot as observed on 01/03/2025, on the curtain between the beds, circular in shape and near the middle of the curtain. 42927 During a phone interview on 01/02/2025 at 2:01 PM, Collateral Contact 1(CC1), Resident 229's family member, stated Resident 229's privacy curtains were dirty. CC1 stated everytime they visit Resident 229 complains about the privacy curtain being dirty. During an interview and observation on 01/02/2025 at 2:54 PM, Resident 229 stated there were dead bugs on the privacy curtain. Observed two pea sized areas of brown particulate matter and a large area of dried brown splatter along the bottom of the privacy curtain on the right side of the bed. There were various small spots of dried liquid on the privacy curtain on the left side of the bed. During an observation on 01/03/2025 at 9:37 AM, the privacy curtains around Resident 229's bed still had the areas of brown particulate matter and dried splash spots. During an interview and observation on 01/03/2025 at 12:12 PM, Staff B observed the brown particulate matter on the privacy curtain. Staff B stated they did not know what the particulate matter was, but the privacy curtain needed to be changed. Staff B was not aware of how often the privacy curtains were changed or if they were washed when soiled. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to WAC 388-97-0880

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to ensure the Resident Assessment Instrument (RAI), an assessment of a resident's needs, strengths, goals, and preferences, were completed within the required timeframes and/or included thorough summaries of the Care Area Assessments (CAA's), an assessment of a specific resident care or medical issue, to holistically analyze the plan of care for 9 of 22 residents (4, 5, 20, 55, 51, 62, 66, 70 and 179) reviewed for comprehensive assessments. This failure placed the residents at risk of not having appropriate services provided based on the resident's individualized needs and placed all other residents at risk of their needs and preferences not met. Findings included . Review of the facility's policy, Resident Assessment and Associated Processed, revised/reviewed August 2024, showed CAA's will be made of the residents needs, strengths, goals, life history and preferences using the RAI and will include at least the following: Identification and demographic information Customary routine Cognitive patterns Communication Vision Mood and behavior patterns Psychological well-being Physical functioning and structural problems Continence Disease diagnosis and health conditions Dental and nutritional status Skin conditions Activity pursuit Medications (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Special treatments and procedures Discharge planning Documentation of summary information regarding additional assessment performed on the care areas triggered by the completion of the MDS Documentation of resident participation in the assessment process Review of the facility policy titled, Resident Assessment and Associated Process, revised August 2024, showed a comprehensive assessment and completion of the CAA process will be conducted within 14 days of admission. A significant change in status assessment will be completed within 14 days of identification. Review of the RAI manual, Version 1.19.1, dated October 2024, showed that a Significant Change in Status Assessment (SCSA) was required to be performed within 14 days of when a resident enrolled in a hospice program. <RESIDENT 70> Resident 70 admitted on [DATE] with diagnoses to include edema, heart failure ad Gastro -Esophageal Reflux Disease. The admission MDS assessment, dated 10/20/2024, included the following triggered CAA's: cognitive loss, psychosocial wellbeing, activities, Activities of Daily Living (ADL), pressure ulcer (PU), nutritional status, urinary, falls, pain, and return to the community. Review of the MDS assessment, dated 10/24/2024, showed the psychosocial well-being, activities and return to community CAA's did not contain comprehensive summaries or analysis that included the current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's CP was needed. <RESIDENT 179> Resident 179 admitted on [DATE] with diagnoses to include diagnoses to include stroke with hemiparesis (inability to move one side of body) and hemiplegia (paralysis on one side of the body), mild neurocognitive disorder with behavioral disturbances , depression and limitation of activities. The Annual MDS assessment, dated 06/27/2024, included the following triggered CAA's: cognitive loss, communication, urinary incontinence and indwelling catheter, psychosocial wellbeing, , mood, activities, falls, nutrition, dehydration/fluid maintenance, pressure ulcer/injury and psychotropic drug use. Review of the admission MDS assessment, dated 06/27/2024, showed the psychotropic drug use, cognitive loss, mood, CAA's did not contain comprehensive summaries or analysis that included the resident's current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's CP was needed. <RESIDENT 20> (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 20 admitted on [DATE] with diagnoses to include post-traumatic stress disorder, autistic disorder, bipolar disorder and anxiety disorder. The Annual MDS assessment, dated 12/16/2024, included the following triggered CAA's: psychotropic drug use, cognitive loss/dementia, behavioral symptoms, psychosocial wellbeing, nutrition, and pressure ulcers. Review of the Annual MDS assessment, dated 12/16/2024, showed the psychosocial CAA did not contain comprehensive summaries or analysis that included the resident's current goals, preferences, limitations, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's CP was needed. The CAA's had documentation of Resident 20's history of depression and autism, but no assessment of how those diagnoses affected the specific care areas. In an interview on 01/07/2024 at 1:47 PM with Staff H, Licensed Practical Nurse (LPN)/MDS Coordinator stated the CAA's should be completed with a summary. Staff H stated that Staff B, Director of Nursing and they audit the CAA's to ensure completion. In an interview on 01/09/2025 at 9:48 AM, Staff G, Social Services, stated they had been in their position for a year and a half and were responsible for the cognition, psychotropic meds and psychosocial wellbeing CAA's for the facility. Staff G stated they identified issues with the CAA's a couple months ago and they started training on the CAA process. Staff G stated they did not complete the areas that were necessary for Resident's 20, 70, 179. Staff G stated Resident 5's nutrition and unnecessary medication CAA's were blank. Staff G stated Resident 4's MDS was not completed timely. Staff G stated they requested training from their complaint nurse last night. 51312 <RESIDENT 5> Resident 5 was admitted on [DATE] and readmitted on [DATE]. A record review of Resident 5's MDS, dated [DATE], showed that the resident had blank triggered CAAs in the areas of pain, activities, and psychotropic medications. In an interview on 01/07/2025 at 1:46 PM, Staff H, stated that they were unaware they were required to fill out CAAs and thought they could just refer to the care plan. 51551 <RESIDENT 4> Resident 4 admitted to the facility on [DATE] and were not receiving hospice services. Review of the Hospice Certification and Plan of Care showed Resident 4 elected their hospice benefit on 11/01/2024. Review of Resident 4's MDS assessments, showed a SCSA dated 11/19/2024 was completed on 12/03/2024, 33 days after hospice service started. <RESIDENT 62> (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 62 admitted to the facility on [DATE] and were not receiving hospice services. Review of Hospice Certification and Plan of Care showed Resident 62 elected their hospice benefit on 08/06/2024. Review of Resident 62's MDS assessments, showed a SCSA dated 08/19/2024 was completed on 09/05/2024, 31 days after hospice service started. In an interview on 01/07/2025 at 1:46 PM, Staff H stated a SCSA was required when a resident started hospice benefit. In a joint record review and interview on 01/08/2025 at 4:11 PM, Staff B and Staff H stated Resident 4 and 62 were on hospice and their SCSA were completed late. <RESIDENT 66> Resident 66 admitted to the facility on [DATE]. Review of Resident 66's admission MDS assessment dated [DATE], showed the assessment completion date was 09/08/2024, 16 days after admission. Review of CMS (Centers for Medicare and Medicaid Services) MDS 3.0 NH (nursing home) Final Validation report dated 09/10/2024, showed a warning message that Resident 66's assessment care areas were completed late, more than 13 days after admission. Review of Resident 66's Medicare discharge assessment dated [DATE], showed the assessment completion date was 10/10/2024, 16 days after Medicare services ended. Review of CMS MDS 3.0 NH Final Validation report dated 10/11/2024, showed a warning message that Resident 66's Medicare discharge assessment was completed late and the completion date was more than 14 days after Medicare services ended. Review of Resident 66's discharge assessment dated [DATE], showed the assessment completion date was 10/13/2024, 18 days after discharge. <RESIDENT 61> Resident 61 admitted to the facility on [DATE]. Review of Resident 61's comprehensive admission assessment dated [DATE], showed the assessment completion date was 07/18/2024, 18 days after admission. <RESIDENT 55> Resident 55 admitted to the facility on [DATE]. Review of Resident 55's quarterly MDS assessment, dated 08/31/2024, showed the assessment completion date was 09/16/2024, 17 days after MDS date. (continued on next page)

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	505407	A. Building B. Wing	01/09/2025

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CMS MDS 3.0 NH Final Validation report on 09/17/2024, showed a warning message that Resident 55's assessment was completed late, more than 14 days after MDS date. In a joint record review and interview on 01/08/2025 at 4:11PM, Staff B and Staff H stated the validation reports showed the assessments were completed late for Residents 66, 61 and 55. Staff B stated they were aware of the late MDS assessments. 47047 Reference: (WAC) 388-97-1000 (b)(c)(ii)(2)(f)(g)(p)(3)(a)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on interview and record review, the facility failed to identify a Significant Change in Status for 1 of 3 sampled residents (Resident 229) reviewed for hospice services. Failure to identify and complete a Significant Change in Status (SCSA) assessment placed residents at risk for inadequate care planning and a diminished quality of life. Findings included . Review of the Long-Term Care Facility Resident Assessment Instrument, User's Manual, V1.19.1, dated October 2024, showed that a SCSA was required to be performed within 14 days when a resident enrolled in a hospice program. Review of the facility policy titled, Resident Assessment and Associated Process, revised August 2024, showed significant change in status assessments must be completed within 14 days of identification. Resident 229 admitted on [DATE] and were not receiving hospice services. Review of a Hospice Certification and Plan of Care showed Resident 229 elected their hospice benefit on 12/20/2024. Review of Resident 229's Minimum Data Set (MDS, assessment of care needs) assessments since admission showed no SCSA had been completed. In an interview on 01/07/2025 at 1:46 PM, Staff H, Licensed Practical Nurse/MDS Coordinator, stated a SCSA was required when a resident started hospice benefit. In a joint interview on 01/08/2025 at 4:11 PM, Staff B, Director of Nursing, and Staff H stated Resident 229 was on hospice and a SCSA had not been done. Staff H stated they were not sure why the SCSA was not done. Refer to WAC 388-97-1000(3)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) accurately reflected the current status for two of seven residents (Residents 45 and 50) and failed to ensure two of seven residents (Resident 5 and 56) were referred for level two evaluations. These failures placed the residents at risk for inappropriate placement and not receiving timely and necessary services to meet mental health care needs. <RESIDENT 50> Resident 50 admitted to the facility 11/01/2023 with diagnoses that included depression and [NAME] Syndrome (genetic condition in which a male has an extra X chromosome which may delay developmental milestones). In a review of Resident 50's provider progress note dated 11/02/2023 showed they had a diagnosis of depression and was taking an psychoactive (medication that can alter thoughts/behaviors) medication for treatment. In a review of Resident 50's care plan, dated 11/06/2023, showed they were prescribed a medication to treat their depression with the goal to reduce the medication at the review date. Interventions included a monitor for behaviors associated with their depression, specifically pacing, wandering, disrobing, inappropriate response to verbal communication, and violence/aggression towards staff/others. In a review of Resident 50's completed level one PASRR, dated 10/26/2023 showed they had not shown serious mental illness indicators, had a serious mental illness or intellectual disability related conditional indicators. In an interview on 01/07/2025 at 10:21 AM, Staff G, Social Services Supervisor, stated they review PASRR's with Staff A, Administrator. Staff G stated the director of admissions reviewed the PASRR prior to a resident's admission. Staff G stated they look for any errors or any missing diagnoses on the PASRR received prior to admission and if any errors were found would complete a new and updated PASRR. Staff G stated that Resident 50, upon admission, had not carried the diagnoses of depression or [NAME]'s syndrome. Staff G stated that PASRR's are reviewed for all residents quarterly and with significant changes for accuracy. In an interview on 01/07/2025 at 12:45 PM Staff A, Administrator, stated Resident 50's PASRR was completed, and the diagnosis of depression was added later. Staff A stated [NAME] Syndrome was not a qualifying diagnosis to indicate an intellectual disability per their discussions with the PASRR coordinator. Staff A stated a new PASRR had been completed to address Resident 50's diagnosis of depression. <RESIDENT 45> Resident 45 admitted to the facility on [DATE] with diagnoses that included adult failure to thrive, post traumatic stress disorder, and major depressive disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of Resident 45's electronic medical record on 01/06/2024 showed no completed level one PASRR. Reviewed Resident 45's PASRR Level 2 Invalidation assessment dated [DATE] showed they did not require a level two evaluation as they were discharged from the nursing facility. Review of Resident 45's Level 2 Invalidation assessment dated [DATE] showed that resident was admitted to a different nursing facility and contained conflicting information regarding their diagnoses and indicators of serious mental illness. In an interview on 01/07/2025 at 10:21 AM, Staff G, Social Services Supervisor stated they review PASRR's with Staff A, Administrator. Staff G stated the director of admissions reviewed the PASRR prior to a resident's admission. Staff G stated they look for any errors or any missing diagnoses on the PASRR received prior to admission and if any errors were found would complete a new and updated PASRR. Staff G deferred to Staff A, Administrator related to Resident 45's level one PASRR. In an interview on 01/07/2025 at 12:45 PM Staff A, Administrator stated Resident 45 had a completed level one PASRR, was part of the admission record, and would provide the PASRR once located. No other information was provided or received. In review of Resident 45's medical record on 01/09/2025 a level one PASRR was uploaded on 01/07/2025. The level one PASRR was dated 04/25/2024 and showed Resident 45 was discharged to a different nursing facility. 51551 <RESIDENT 56> Resident 56 admitted to the facility on [DATE] with diagnoses to include depression. Review of Resident 56's provider admission visit note dated 07/30/2024, showed Resident 56 was taking an antidepressant every day for depression. Review of Resident 56's Minimum Data Set (MDS, assessment of care needs) assessments dated 08/04/2024, showed Resident 56 was taking an antidepressant. Review of Resident 56's Level I PASRR dated 07/18/2024, Section IA showed Resident 56 had serious mental illness indicators which included anxiety and depression. Section IV indicated a level II evaluation referral was required for serious mental illness. Review of Resident 56's medical record showed no Level II PASRR was completed prior to the Resident 56's admission to the facility. In an interview on 01/06/2025 at 4:01 PM, Staff A stated there was no PASRR level II evaluation done for Resident 56. 51312 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 5> Resident 5 was admitted on [DATE] and again on 12/11/2024. During an interview on 01/07/2025 at 1:28 PM, Staff G, stated that only Staff A reviews PASARR. During an interview on 01/06/2025 at 4:00 PM Staff A, stated that Resident 5's PASSAR was in their email and it showed an invalidation for PASSR Level II. During a review of Resident 5s records showed they were referred for a PASARR level II 19 days after initial admit to the facility. WAC 388-97-1915 (1)(2)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to ensure a resident with a hearing impairment had a base line care plan developed and implemented to provide effective and person-centered care for 1 of 1 resident (Resident 380) reviewed for base line care plans. This failure placed residents at risk of not being informed of their initial plan for delivery of care and services and placed them at risk for unmet needs and possible complications. Findings included . Resident 380 admitted to the facility 12/26/2024, with diagnoses that included paranoid schizophrenia (chronic mental illness that affects a person's thoughts, feelings, and behaviors) and anxiety. The Minimum Data Set (MDS) Assessment (an assessment tool), dated 01/01/2025, showed the resident had mild cognition impairment and had moderate difficulty hearing with no devices. Review of Resident 380's nursing admission assessment dated [DATE], showed the resident had difficulty hearing with no devices to assist. Review of Resident 380's nursing progress notes dated 12/28/2024, 12/30/2024, 01/02/2025, 01/03/2025, and 01/04/2025 showed nursing documentation that the resident had difficulty hearing. Review of Resident 380's care plan on 01/02/2025, showed no focus area for the residents hearing impairment. In an interview on 01/02/2025 at 10:07 AM, Resident 380 was observed sitting in their wheelchair next to their bed. Resident responded to a question I cannot hear very well. The resident was asked if they used hearing aids with an elevated voice, they stated they were not here at the facility. In an interview on 01/07/2025 at 10:32 AM, Staff D, Nursing Assistant Certified (NAC) they determine what level of care to provide to each resident based on the care plan. In an interview on 01/07/2025 at 10:46 AM, Staff E, NAC stated the staff will self-report to each other, however ultimately, they we rely on the care plan for determining the needs of the residents. In an interview on 01/07/2025 at 2:42 PM, Staff F License Practical Nurse (LPN)/Resident Care Manager (RCM) stated that the nursing manager who completes the admission was the responsible for starting the base line care plan. Staff F stated, they use the admission nursing assessments, the discharge report from the discharging facility, the residents' medications, their diagnoses, and needs to build the base line care plan. Staff F, confirmed after reviewing Resident 380's admission nursing assessment, and the MDS that the resident was documented had moderate difficulty with their hearing. Staff F confirmed the resident's hearing impairment was not included in their base line care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/09/2025 at 9:20 AM, Staff A, Administrator stated that the nursing admission assessment was a template, and the nurse was supposed to individualize the interventions for the resident as needed. Staff A stated they do not complete a base line care plan the nurses build the care plan from the start of the admission. Refer to WAC 388-97-1020(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to review and revise care plans for 1 of 3 residents for falls (179), and 1 of 5 residents for nutrition (20). The failure to review and revise care plans by the interdisciplinary team after each assessment placed the residents at risk for unmet care needs, feelings of boredom, agitation and a diminished quality of life. Findings included: Review of the facility policy titled, Fall Best Practice Guidelines dated 08/2024 showed a post fall assessment/evaluation including recommendations and care plan changes will be completed for all residents who have experienced a fall. The care plan will be completed/updated to include newly identified factors that may have contributed to the fall. The facility will develop an action plan or approaches to be taken in an attempt to prevent further falls based on newly identified facts or risk factors. The facility is to update the resident care guide. <RESIDENT 179> Resident 179 admitted [DATE] with diagnoses to include stroke with hemiparesis (inability to move one side of body) and hemiplegia (paralysis on one side of the body) neurocognitive disorder with behavioral disturbance, seizure disorder, limitation of activities due to disability and impaired mobility. Review of the clinical record showed the resident had 15 falls since admission (06/21/2024, 07/01/2024, 07/16/2024, 07/24/2024, 07/27/2024, 08/31/2024, 09/18/2024, 10/12/2024, 10/17/2024, 11/03/2024, 12/06/2024, 12/10/2024, 12/19/2024, 12/25/2024, and 01/06/2025. Review of the 07/01/2024 at 5:27 AM fall investigation included an additional intervention to check the resident's position and check for incontinence every two hours. These interventions were not added to the care plan. Review of the 08/31/2024 at 5:27 AM fall investigation included an additional intervention to check the residents position every 30 minutes and check for incontinence every 2 hours. These interventions were not added to the care plan. Review of the 10/12/2024 6:45 AM fall investigation included an additional intervention to check the residents position every 30 minutes and check for incontinence every hour. These interventions were not added to the care plan. <RESIDENT 20> Resident 20 admitted on [DATE] with diagnosis to include diabetes. Review of the December 2024 Medication Administration Record showed the resident received Ozempic from 10/24/2024 until it was discontinued on 12/12/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the expected weight loss care plan showed the resident was receiving Ozempic (medication prescribed to assist with weight loss). In an interview on 01/08/2025 at 1:54 AM, Staff J, Registered Nurse said that care plans were revised by the resident care managers. In an interview on 01/09/2025 at 9:15 AM, Staff A stated care plans were to be reviewed and updated as needed and also quarterly. No additional information was provided. Reference: (WAC) 388-97-1020 (5) (b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to provide assistance with 2 of 3 dependent residents including meal assistance for resident (4) and bathing for resident (179) reviewed for activities of daily living (ADL's). Facility failure to provide resident's, who were dependent on staff for assistance with hygiene including eating assistance and showers placed residents and others at risk for embarrassment, poor hygiene, unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy, Activities of Daily Living , revised July 2015, showed the policy was that nursing assistants will provide assistance with ADL's based on the resident's individualized plan of care. These interventions will be on the Kardex, which Is accessed in Point of Care (POC). <RESIDENT 179> Resident 179 admitted [DATE] with diagnoses to include stroke with hemiparesis (inability to move one side of body) and hemiplegia (paralysis on one side of the body) neurocognitive disorder with behavioral disturbance, seizure disorder, limitation of activities due to disability and impaired mobility. Review of the Quarterly Minimum Data Set assessment, dated 09/27/2024, showed Resident 179 did not reject care. Review of the care plan showed the resident required maximum assistance of one staff for bathing as necessary two times a week. Review of Resident 179's shower records, dated 12/30/2024 through 01/07/2025, showed the resident did not receive showers twice weekly. The resident received a shower on 12/30/2024 and the next shower was 01/07/2025 at 1:59 PM. In an interview of 01/09/2025 at 9:15 AM, Staff A, Administrator stated their expectation was showers were provided as the resident preferred and at least once a week. 47047 Resident 4 admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a progressive disease that destroys memory and other mental functions), dysphagia (difficulty swallowing food or liquids), and need for assistance with personal care. <EATING> (continued on next page)

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	505407	A. Building B. Wing	01/09/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 01/02/2024 at 11:15 AM Resident 4 sat a a round table with three other residents. Observed Staff D, Nursing Assistant Certified (NAC) assisting another resident at the same table as Resident 4. Observed Resident 4 with their meal in front of them until 11:30 AM when Staff T, NAC arrived to assist them. In an observation on 01/03/2024 at 8:55 AM Resident 4 was laying in their bed, low position, and lights off with her breakfast meal tray sitting on their overbed table. Observed Staff U, NAC enter Resident 4's room and stated they were there to assist Resident 4 with their breakfast. In an interview on 01/03/2024 at 9:40 AM Staff U, NAC stated they did not know when Resident 4's breakfast tray was brought to them. Staff U stated they were not sure what time the breakfast trays arrived on the hall and asked Staff S, Licensed Practical Nurse (LPN), when they arrived. Staff S stated they thought trays arrived at 7:30 AM. Staff U stated breakfast trays typically arrive on the hall between 7:30 AM and 8:00 AM. Staff U stated they were Resident 4's assigned NAC. Staff U stated another NAC had delivered Resident 4's tray to their room. When asked if Resident 4 is able to feed themselves without assistance, Staff U stated they needed assistance, and their hands were shaky. Staff U stated Resident 4 required one to one feeding assistance from an aide. When asked why Resident 4 had not been assisted until 8:55 AM they stated they did not believe Resident 4 had waited that long. Staff U stated when they have a resident who required one on one assistance, they leave their meal in the meal cart until they are ready to assist them to eat. Staff U stated Resident 4 had pancakes, eggs, cream of wheat, and orange juice and did not eat their meal until they were assisted by them. Review of Resident 4's care plan dated 02/20/2019 showed they required assistance from staff for their activities of daily living (ADL) and care. Resident 4's care plan showed they required set up assistance to eat. Review of Resident 4's Kardex (resident specific guide that nursing assistants how to provide care) as of 01/08/2025 showed they required set up assistance to eat. Review of Resident 4's Annual MDS dated [DATE] showed they received set up assistance with eating. Review of Resident 4 progress notes dated 09/04/2024 showed resident required assistance with meals. Review of documentation completed by NAC's for eating for January 2025 showed Resident 4 was dependent on staff for eating 14 out of 24 opportunities. In an interview on 01/08/2025 at 4:06 PM Staff B, Director of Nursing Services, stated Resident 4 required maximum assistance. When asked about assistance Resident 4 required for eating, Staff B stated per nursing aide documentation, they were dependent on staff for eating. Staff B stated they did not know if Resident 4 could participate in any ADL and would need to research it further. Staff B stated care plans are changed and updated as facility assessments are done and through any changes in the resident's condition. <CALL LIGHT> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/03/2025 at 9:35 AM observed Resident 4's call light clipped to the lower left portion of their pillowcase, out of reach of the resident, and hanging past the mattress close to the floor. On 01/08/2025 at 11:49 AM observed Resident 4 lying in bed, their call light on the floor, several feet from their bed. On 01/08/2025 at 4:17 PM observed Resident 4's call light on the floor in the same spot as 11:49 AM. Resident 4 was not in their room. On 01/09/2025 at 9:00 AM Resident 4 was observed sleeping in their bed and the call light was out of reach; observed hanging on the wall. In an interview on 01/08/2024 at 4:17 PM Staff V, Registered Nurse, stated Resident 4 used their call light at times. Staff V stated Resident 4 should have their call light clipped to their sheet and always be within reach of the resident. Review of Resident 4's care plan dated 03/04/2019 directed nursing to have the call light within reach of the resident. Refer to WAC 388-97-1060(1)(2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview, and record review, the facility failed to ensure three (5, 20, and 50) of six residents reviewed for unnecessary medications, staff failed to followed provider orders in regard to weights and blood sugar (the amount of glucose in your blood) monitoring. These failures placed residents at potential risk of a decline in medical status and quality of life-related to unmet care needs. Findings included . <BOWEL MONITORING> <RESIDENT 20> Resident 20 admitted to the facility on [DATE]. Review of Resident 20's physician's orders showed the resident received Milk of Magnesia (laxative), twice daily and Docusate Sodium (stool softener) once a day for constipation. Review of Resident 20's bowel record showed the resident had no bowel movements (BM) from 12/29/2024 at 9:51 PM until 01/06/2025 at 9:59 PM. Review of Resident 20's progress notes from 12/29/2024 through 01/09/2025 showed no documentation about the constipation, abdominal assessment, or new order for Lactulose (laxative) twice daily ordered on 01/06/2025. In an interview on 01/08/2025 at 1:54 PM, Staff J, Registered Nurse (RN) stated the electronic health record showed them when a resident had not had a BM for 3 days then they would look to see what bowel medications they could administer to them. Staff J stated the nurses were to assess their interventions until the resident had a bowel movement. Staff J stated Resident 20 did not go to the bathroom on their own so if there was no BM documented, they had not had a BM. Staff J reviewed the residents bowel documentation from 12/30/2024 through 01/06/2024 and stated the resident had not had any BMs, so the nurses kept giving them laxatives and laxatives and now they finally had a very, very large BM. <WEIGHT MONITORING> <RESIDENT 20> Resident 20 admitted to the facility on [DATE]. Review of the Weight Committee Interdisciplinary Team (IDT) note dated 11/29/2024, showed Resident 20 had active orders for weekly weights indefinitely. Review of Resident 20's October 2024 Medication Administration Record (MAR) showed no weight entry documented for 10/31/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505407	A. Building B. Wing	01/09/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 20's November 2024 MAR showed no weight entry documented for 11/07/2024. Review of Resident 20's December 2024 MAR showed no weight entry documented for 12/10/2024 and 12/17/2024. In an interview on 01/08/2025 at 12:32 PM, Staff L, Licensed Practical Nurse (LPN) stated residents were to be weighed the first three days after admission, then once a week for the first month then the weights are scheduled once a monthly after that. In an interview on 01/08/2025 at 1:46 PM, Staff K, Nurse Aide Certified (NAC) stated some resident's weights were obtained weekly, some daily on admit or monthly. Staff K stated they were told by nurses when to weigh the residents. 47047 Review of the facility policy titled, Diabetes Mellitus Resident/Washington State dated 05/2007; revised 03/2015; 04/2016 showed the facility would recognize and assist in the treatment of complications commonly associated with diabetes notify the resident's physician when blood sugar were out of range per orders, insulin needing to be held, and monitor blood sugar as needed for any change in behavior or symptoms of hyper/hypoglycemia. <RESIDENT 50> Resident 50 admitted to the facility 11/01/2023 with diagnoses that included Type II Diabetes Mellitus (DM, a common disease that occurs when the body doesn't use insulin properly, resulting in high blood sugar levels) and high blood pressure. In an interview on 01/02/2025 at 2:44 PM Resident 50 stated their blood sugar levels were often high, were allowed to get too high, and were a concern to them. Review of Resident 50's care plan as of 01/06/2025 showed no identified focus area related to their diagnosis of type 2 diabetes mellitus. Review of Resident 50's recorded blood glucose (BG-measure of glucose in the blood) for December 2024 showed no entries for the following dates: 12/11/2024, 12/12/2024, 12/13/2024, 12/14/2024, 12/19/2024, 12/20/2024 12/21/2024, 12/22/2024, 12/27/2024, 12/28/2024, 12/29/2024, 12/30/2024, 12/31/2024 and 01/01/2025 through 01/05/2025. Review of Resident 50's MAR for December 2024 showed discontinued physician orders as of 12/10/2024 for Insulin Glargine Subcutaneous Solution 100 UNIT/Milliliter (ML) Inject 31 unit subcutaneously at bedtime for DM hold if BG below 90 and Insulin Glargine Subcutaneous Solution 100 UNIT/ML Inject 44 unit subcutaneously one time a day for DM hold if BG below 90. On 12/10/2024 the MAR showed new orders; Lantus Subcutaneous Solution 100 UNIT/ML Inject 40 unit subcutaneously at bedtime for diabetes Lantus Subcutaneous Solution 100 UNIT/ML Inject 44 unit subcutaneously in the morning for diabetes mellitus type 2 insulin dependent. The MAR showed Resident 50 had not received any insulin at bedtime as ordered on 12/10/2024 and no blood glucose values were documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The December 2024 MAR included orders as needed for HYPERGLYCEMIC PROTOCOL: Notify physician Immediately if BG is above 400 parameters or too high for meter to read for insulin coverage adjustment. Call Medical Director if unable to reach other physicians. Recheck BG as directed by physician. The December 2024 MAR included as needed orders for HYPOGLYCEMIA PROTOCOL BG below 60: If resident alert, offer fast acting carbohydrate (such as 4 ounces (oz) orange juice, 4 oz Apple Juice, 4 oz, water with two teaspoons sugar added, 1 Tube Glucose Gel, or 3 Glucose Tablets). Check BS every 15 minutes and repeat steps one and three as necessary until BG is above 90. Notify physician of occurrence. Document what is given and notify physician as needed. There were no documented instances on the MAR. Review of Resident 50's provider progress note dated 12/10/2024 showed their blood glucose levels were reviewed from 12/07/2024 through12/09/2024, their insulin was increased, and the plan was to continue to monitor closely. Review of Resident 50's progress note dated 01/06/2025 showed they complained to an aide they felt they had low blood sugar, and their BG was checked and noted to be elevated at 304. In an interview on 01/08/2025 at 11:32 AM Staff S, LPN, stated the protocol for diabetic management with residents who had orders for insulin included a prompt in the electronic medical record to check BG prior to administering which was not dependent on the use of long acting or short acting insulins. Staff S stated Resident 50's insulin was administered in the morning and the BG was checked prior to them being administered insulin. In joint interview on 01/08/2025 at 11:51 AM with Staff F, LPN/Resident Care Manager (RCM) was asked for the policy on insulin management and blood glucose checks, but no information was provided. Staff I, Corporate Registered Nurse, stated there was a direction in the body of Resident 50's insulin order to check BG and then stated it did not look like they had BG checks because they were on a long-acting insulin. Staff I stated they would review Resident 50's clinical record to find information regarding the missing BG checks and would provide additional information. No additional information was provided. In an interview on 01/08/2025 at 2:34 PM Staff B, Director of Nursing stated there was typically supplementary documentation in electronic medical record to document BG based on the physician order. When asked about Resident 50's missing BG checks, Staff B stated Resident 50 had an order for the supplementary document cues to check BG prior to administration of the insulin until they had undergone changes in their insulin dose on 12/10/2024. Staff B stated they would need to speak with the provider to get additional information as to why the BG checks were not added to the supplemental documentation. Staff B stated Resident 50's care plan did not need to contain information about their diagnosis of type two diabetes mellitus and their insulin use because nursing assistants provided personal care to residents only and would not be assessing any symptoms of diabetes. 51312 <RESIDENT 5> Resident 5 was admitted to the facility on [DATE] with a readmitted [DATE]. Review of Resident 5's admission physician orders showed an entry dated 12/11/2024 for weights for three days, and then once a week for four weeks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Residents 5's December 2024 MAR showed that the first weights were completed on 12/13/2024, the second on 12/14/2024, and the third on 12/21/2024. In an interview on 01/08/2025 at 10:19 AM, Staff X, LPN, stated aids were to be notified when a resident needed weight by looking at the KARDEX (worksheet that includes a summary of patient information and tasks). Staff X stated that when a resident had dramatic weight loss, nursing should notify nutrition services and assess the resident's needs. In an interview on 01/08/2025 at 10:45 AM, Staff CC, NAC, stated that when residents are admitted to the facility from the hospital, weights are to be taken 3 days in a row; if a resident has a dramatic weight loss, the nurse should be notified. In an interview on 01/08/2024 at 12:10 PM, Staff F, LPN/RCM, stated aides should be told by nursing staff when a weight was required on a resident. If there are drastic weight changes, staff should automatically re-weight residents. In an interview on 01/08/2025 at 1:56 PM, Staff O, LPN stated nursing staff would tell aides when residents should be weighed, and if there is a drastic change in weight, nursing should notify the provider and try to figure out why it changed. In an interview on 01/08/2025 at 2:17 PM Staff B, stated provider orders for Resident 5 were not followed and that weights should have been verified. Refer to WAC 388-97-1060(1)(2)(b)(3)(h)(i)(4)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 1 residents (Resident 45) reviewed for respiratory care. Failure to follow provider's orders for oxygen (O2) therapy placed the resident at risk for unmet needs, potential negative outcomes and a diminished quality of life. Findings included . Review of the facility policy titled, Oxygen Administration dated 05/2007, revised 04/2016; 07/2019 showed it was the policy of the facility that oxygen therapy is administered as ordered by the physician or as an emergency measure until the order could be obtained. Resident 45 admitted to the facility on [DATE] with diagnoses that included pulmonary fibrosis (a lung disease that causes scaring in the lungs making it difficult to breathe) and congestive heart failure (CHF-a chronic condition in which the heart doesn't pump blood as quickly as the body needs). In an interview on 01/02/2025 at 2:12 PM Resident 45 stated the concentrator (a medical device that administers O2) settings for their O2 should be set to 3 liters per minute (lpm). Resident 45 stated they do not change the settings on their concentrator and the concentrator was in the bathroom to decrease the noise it makes. In an observation on 01/02/2025 at 2:12 PM Resident 45 was wearing a nasal cannula (device used to deliver supplemental oxygen through the nose) plugged into the concentrator which was in the bathroom. The settings on the concentrator were set at 3.5 lpm. In an observation on 01/06/2025 at 9:57 AM Resident 45 was in their bed, lying flat, wearing a nasal cannula attached to the concentrator, the concentrator set at 3.5 lpm. In a review of Resident 45's care plan dated 11/24/2024 showed they had oxygen therapy related to a diagnosis of CHF; interventions included the application of O2 by nasal cannula at 3 lpm continuously to keep their O2 saturations (amount of O2 in the blood) above 88 percent (%). In a review of Resident 45's progress note dated 01/03/2025 showed they refused their O2, wanted the concentrator in the bathroom, had a O2 saturation of 85%, and was given 4 lpm of O2 to increase their saturations. Review of Resident 45's January 2025 Treatment Administration Record (TAR) showed they had a physician order dated 12/11/2024 for O2 by nasal cannula at 3 lpm continuous. In an interview on 01/07/2025 at 2:15 PM Staff AA, Registered Nurse, stated when there is an order for O2 a concentrator is obtained for the resident, made sure there is an O2 sign placed on their door, checked O2 settings every shift, and checked O2 saturations every shift. Staff AA stated the functioning of the concentrator is checked every shift and the settings are checked to make sure they are set per the physician order. (continued on next page)

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	505407	A. Building B. Wing	01/09/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 01/07/2025 at 2:33 PM Staff F, Licensed Practical Nurse/Resident Care Manager stated Resident 45's physician orders for O2 was 3 lpm. Observed Staff F review the settings on Resident 45's concentrator and stated the settings were set to 3.25 lpm. Observed Staff F adjust the setting on Resident 45's concentrator to 3 lpm. In an interview on 01/08/2025 at 10:30 AM Staff A, Administrator, stated Resident 45 adjusted their settings on their concentrator and the care plan and notes had been updated. No other information was provided or obtained. Refer to WAC 388-97-1060(3)(j)(vi)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 44110 Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed with actual hours worked for each shift for 5 of 6 days (01/02/2025, 01/03/2025, 01/06/2025, 01/07/2025, and 01/08/2025), reviewed for sufficient and competent staffing. This failure placed the residents and residents' representatives at risk of not being fully informed of the current staffing levels. Findings included . In observations on 01/02/2025 at 9:46 AM, 11:06 AM, 1:55 PM, and 3:05 PM, the facility's daily nursing staffing form posted did not show the actual hours worked for nursing staff. In observations on 01/03/2025 at 9:11 AM, 12:06 PM, and 2:48 PM, the facility's daily nursing staffing form posted did not show the actual hours worked for nursing staff. In observations on 01/06/2025 at 9:48 AM, 12:33 PM, and 3:02 PM, the facility's daily nursing staffing form posted did not show the actual hours worked for nursing staff. In observations on 01/07/2025 at 10:50 AM, and 2:27 PM, showed that the facility's daily nursing staffing form posted did not show the actual hours worked for nursing staff. In an interview on 01/07/2025 at 2:28 PM, Staff C, Staffing Coordinator stated they were responsible for posting the daily staffing at the nurse's station daily. Staff C stated that they update the sheet with the actual hours worked the following day with the exact hours worked based on the time punches. A request for the previous last seven days was requested. In observation on 01/08/2025 at 8:55 AM, showed that the facility's daily nursing staffing form posted did not show the actual hours worked for nursing staff. In an interview on 01/08/2025 at 9:47 AM, Staff C stated they had been able to locate the sheets for the daily actual staffing hours. Staff C was asked again when they update the actual section of the daily sheet, Staff C stated the following day when they can calculate the total time punches from all the staff. Staff C was asked if they were aware that the section (on the staffing sheet) for actual hours worked was to be updated at the beginning of each shift. Staff C stated they were not aware that was required. In an interview on 01/09/2025 at 11:10 AM, Staff A stated that the daily staffing posting was updated every 12 hours, as they had some staff that worked 12-hour shifts. Staff A was advised that on all observations during the survey period, and that there had been no updates observed to the daily staffing sheet, nor did the staffing coordinator understand the requirement that they were to update in real time after each shift. No further information was provided. No associated WAC

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview, and record review, the facility failed to address emotional and psychosocial well-being through assessment, care plan development and implementation for one of two residents (53), reviewed for individualized behavioral health needs. This failure placed residents at risk of unmet emotional and psychosocial health needs, unwanted behaviors, and a decreased quality of life. Findings included . Resident 53 admitted [DATE] with diagnoses which included a stroke and aphasia (effect of a stroke causing difficulty with verbal expression and/or comprehension) and dementia without behavioral disturbance. The resident's most recent entry following a hospitalization was 11/29/2024. According to the most recent Quarterly Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], showed Resident 53 did not participate in the cognitive interview documented as rarely or never understood, with short term and long-term memory problems, no verbal or physical behaviors directed toward others and no other behaviors (not directed toward others) which included verbal/vocal symptoms such as screaming or other disruptive sounds. Review of Resident 53's care plan on 01/03/2024 showed the facility would: - Monitor/report/document signs and symptoms of depression and obtain mental health consult as needed. - Stop and return if agitated. - Avoid isolation. - Monitor and document effectiveness of communication and indicators of distress. - Refer to psychiatry. Review of resident 53's progress notes dated 11/29/2024 through 01/03/2024 showed one progress note on 12/27/2024 stating the resident yelled intermittently throughout the shift and one note on 12/28/2024 stating the resident yells out at times. Review of the task documentation for nursing assistants on 01/03/2024 showed no option for nursing assistants to document behavioral symptoms for Resident 53. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication and Treatment Administration records since Resident 53's re-admission on 11/29/2024 showed there was a space for nurses to document target behaviors for the resident's antidepressant medication which included agitation, aggression, psychosis, and inappropriate behaviors. The monitor showed day shift and evening shift had an option to chart the number of instances of target behavior but there was no option to specify which behavior was exhibited. Night shift had only check marks with no specific data of any kind. The monitor showed on 12/05/2024 there were three instance of target behavior (unspecified), one instance on 12/06/2024, one instance on 12/17/2024, and one instance on 12/23/2024. There were no corresponding progress notes for those dates to specify what behavior was exhibited or any interventions attempted. Review of Resident 53's administration record further included as needed documentation of interventions for staff to implement, which included: activity, adjust room temperature, back rub, change position, give fluids, give food, redirect, refer to nurses' notes, remove from environment, return to room, toilet, and other. There was no documentation of any interventions attempted since 11/29/2024. In an observation on 01/02/2025 at 9:51 AM Resident 53 was in their bed yelling out in a repetitive distressed manner. Several staff responded in attempts to determine Resident 53's need and just after staff would exit the room, Resident 53 would resume repetitive yelling. In an interview and observation on 01/02/2025 at 10:51 AM, Resident 53 was yelling and banging on the side of their bed. Resident 13 (Resident 53's roommate) was lying in their bed with headphones on and stated this goes on all day and all night since they admitted on [DATE]. Resident 13 stated they were frustrated and tired and felt like someone should be doing something more for them (Resident 53). In an observation on 01/02/2025 at 10:53 AM, Resident 53 was calling out in a distressed manner chanting ah ah ah ah ah. In an observation on 01/02/2025 at 10:58 AM, Resident 53 yelling hello, hello. In an observation on 01/03/2025 at 8:56 AM, Resident 53 was sitting upright in bed yelling out hello, hello, holding their right hand up in the air, hand in flexed position and pushing on the overbed table. Staff P, Certified Nursing Assistant, responded and lowered the table and the resident was observed to nod. In an observation on 01/03/2025 at 9:14 AM, Resident53 was yelling hello, hello no call light on, the call light was observed clipped on the top of corner of the resident's mattress. In an observation and interview on 01/03/2025 at 9:16 AM, began yelling hello, hello. Staff Q, Certified Nursing Assistant, entered the room and was observed talking to the resident. Staff Q exited the room and stated Resident 53 does not like to get out of bed. Staff Q stated the staff can usually figure out what the resident is asking for but sometimes they get upset. It is typically the same kinds of things like wanting water or moving their table or changing their television channels. Staff Q stated this is normal for the resident; to yell out . they are used to it. In an interview on 01/03/2025 at 9:25 AM, Resident 53 was observed to use their bed controller to self-adjust the head of their bed. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 01/03/2025 at 9:26 AM, Resident 53 began yelling hello, hello. Staff P, Certified Nursing Assistant responded and assisted the resident to change the TV channel, Resident 53 was observed to laugh and smile at the TV. Staff P stated Resident 53 just yells out, (they) can use their call light, but they won't use it. It can be right next to their hand, but they won't use it, stated Staff P. Resident 53 again yelled out hello, Staff P stated, like that .they will just yell. Staff P stated they did not know if there was a place to chart Resident 53's disruptive behavior. In an interview and observation on 01/03/2025 at 12:59 PM, Resident 8 was lying in bed with the privacy curtain closed between their bed and the middle bed and stated (Resident 53) yells, the nurses come in and out constantly, and as soon as they leave it starts over, (Resident 53) will start yelling again and nobody cares. Resident 53 was observed to begin grabbing the privacy curtain and pulling it open while yelling out. Resident 8 stated there was an agreement about the privacy curtain and that yesterday (Resident 53) had it open and today was their day to have it closed and (Resident 53) is not following the agreement. Staff R, Certified Nursing Assistant, attempted to intervene, and attempted to close the curtain as Resident 8 requested, but stated (Resident 53) won't let go, they want it to be open. Staff R called for assistance from management and social services. In an interview and observation on 01/03/2025 at 1:04 PM, Resident 53 was pulling on the privacy curtain to attempt to open it and yelling repetitively. Resident 8 grabbed the privacy curtain and began pulling it back to closed stating (they) want it open and I want it closed, this is all the time, it is my curtain too. Both residents had a grip on the privacy curtain attempting to pull it in opposite directions. In an interview on Staff A on 01/03/2025 at 1: 10 PM, Staff A stated they were reaching out to the family of Resident 53 to facilitate a room change for Resident 53 to a more compatible roommate. Staff A stated the family of Resident 53 had not been agreeable to a mental health consultation earlier on. In an interview on 01/09/2025 at 08:45 AM, Staff A and Staff B, Director of Nursing Services were made aware of the lack of consistent assessment, monitoring, documentation and evaluation of interventions related to Resident 53's behaviors and Staff A stated they had received approval from the resident's family to pursue behavioral health support. Refer to WAC 388-97-1060 (3)(e)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to ensure adequate indications for use of an antipsychotic medication (medications that affect the mind or behavior) for 3 of 6 residents (Residents 5, 179 and 380), failed to ensure residents were monitored for adverse consequences of psychotic medication use for 2 of 6 residents (Residents 45 and 380), failed to ensure behaviors were monitored for 2 of 6 residents (Residents 45 and 380) and failed to obtain consents timely for 1 of 6 residents (Resident 179) reviewed for unnecessary medications. These failures put the residents at risk for experiencing adverse side-effects from unnecessary medication use. Findings included . As referenced in the Food and Drugs/Drug (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. <RESIDENT 179> Resident 179 admitted to the facility on [DATE] with diagnoses to include mild neurocognitive disorder due to known physiological condition with behavioral disturbance (condition caused by an underlying medical condition). Review of Resident 179's quarterly Minimum Data Set (MDS- an assessment tool) assessment, dated 09/27/2024, showed the resident was rarely or never understood with severe cognitive impairment. The resident was coded not to have had any mood, behavior concerns or signs of psychosis such as hallucinations (perceptual experiences in the absence of real external sensory stimuli) or delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident was not receiving any antipsychotic medication. Review of Resident 179's physician's orders showed the resident began receiving Hydroxyzine (anti-anxiety medication) every 8 hours as needed for anxiety and agitation initiated on 03/24/2024 and Seroquel (anti-psychotic medication) at bedtime for agitation initiated on 11/11/2024. Review of the Atypical Antipsychotic consent form dated 12/03/2024 for Seroquel, showed Staff G, Social Services Supervisor obtained verbal consent for this medication on 12/04/2024, 23 days after the medication was administered. The indication for the antipsychotic use was listed as confusion, anxiety, and depression, which were not appropriate indications for antipsychotic medication use. (continued on next page)

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	505407	A. Building B. Wing	01/09/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 179's clinical record showed a consent form for Vistaril/Hydroxyzine dated 06/24/2024 that did not include a diagnosis/indication for use of the anti-anxiety drug. The consent was obtained 3 months after the resident began receiving Vistaril/Hydroxyzine. Review of Resident 179's psychotropic care plan showed Seroquel was used related to behavior management. In an observation on 01/02/2025 at 2:34 PM, Resident 179 was asleep and reclined in their wheelchair at the nurse's station. In an observation on 01/03/2025 at 9:14 AM, Resident 179 was asleep in their wheelchair at the nurse's station. In an observation on 01/06/2025 at 9:40 AM, Resident 179 was sitting in a tilt in space wheelchair that was positioned upright. Resident 179 was observed to be restless and pushed off with their right hand from the nurse's station counter and moved their right leg to the side. Resident repetitively moved their right arm and leaned to the right and back. Resident was pushing up on the wheelchair arm with a look of discomfort. In an observation on 01/07/2025 at 8:19 AM, Resident 179 was reclined in their wheelchair, positioned slightly against the wall at nurse's station. The resident was asleep, and their right slipper was on the floor. In an observation on 01/07/2025 at 9:48 AM, Resident 179 remained in their wheelchair asleep, lightly snoring. In an interview on 01/08/2025 at 1:54 PM, Staff J, Registered Nurse (RN) stated consents need to be obtained prior to administration of psychotropic medications. Staff J stated Resident 179 could be agitated and restless at times and they could administer Seroquel for the resident's depression. In an interview on 01/09/2025 at 9:15 AM, Staff A, Administrator stated they had a performance improvement plan in place for this as they identified psychotropic management as an issue. Staff A stated the expectation was that the interdisciplinary team review orders, care plans and consents during their weekly psychotropic meetings. No additional information was provided. 44110 <RESIDENT 380> Resident 380 admitted to the facility on [DATE], with diagnoses that included paranoid schizophrenia (chronic mental illness that affects a person's thoughts, feelings, and behaviors) and anxiety. The MDS assessment, dated 01/01/2025, showed the resident had mild cognition impairment. Review of Resident 380's physician orders dated 12/26/2024 showed an order for Seroquel (antipsychotic) 25 milligram (mg) tablet one time a day, and 50 mgs at bedtime. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 380's physician order dated 12/26/2024 showed the resident was to be monitored for anti-psychotic target behaviors. The order showed a blank space for what those target behaviors were. The order was not individualized or personalized and did not reflect an area to monitor the efficacy of the interventions used. Review of Resident 380's current care plan on 01/02/2025, showed it did not direct staff to monitor the efficacy of the antipsychotic medication. In an observation and interview on 01/02/2025 at 10:07 AM, Resident 380 was observed sitting in their wheelchair next to their bed. When asked how the resident was, Resident 380 burst into a loud wail, and started to cry and threw themselves across the over the bed table and started crying hysterically and stating they are sending me up repeatedly. A staff member, Staff K, Nursing Assistant Certified (NAC) entered the room and stated they were looking for the nurse. Staff K stated they were not aware of the resident's behavior as this was the first time working with the resident, but that the resident did appear confused. In an observation on 01/02/2025 at 1:33 PM, Resident 380 was observed sitting in their wheelchair in their room with their head resting on a pillow that was placed on top of the over the bed table. Resident immediately burst into tears, and stated it just not good, resident was unable to elaborate any further and continued to cry. Review of Resident 380's clinical record on 01/06/2025 at 8:59 AM, showed the resident had been moved to another room on 01/05/2025 due to the resident being paranoid and believed their roommate was accusing them of stealing personal items. Review of a fall investigation for Resident 380, showed the resident had a witnessed fall with therapy on 01/02/2025. The witness statement from the therapist stated they were discussing therapy interventions with the resident when the resident began talking off topic about random subjects, and occurrences from the past. The therapist documented they attempted to redirect the resident; however, the resident became agitated, screaming no one was telling them the truth. The therapist documented attempts to de-escalate the resident were unsuccessful and the resident fell from the wheelchair. In an interview on 01/07/2025 at 11:24 AM, Staff X, Licensed Practical Nurse (LPN) stated they are instructed to monitor resident behaviors and document in the EMAR system. Staff X stated that the Resident Care Managers (RCMs) are the ones that ensure the monitoring was individualized and personalized to each resident. In an interview on 01/07/2025 at 2:42 PM, Staff F, LPN/RCM stated the admitting nurse, which was usually one of the RCM's was responsible for ensure the psychotropic behavior monitoring was personalized to the resident with proper monitoring of episodes and interventions. Staff F confirmed that Resident 380 was lacking the target behaviors for the behavior monitoring orders, and there was no way to monitor the effectiveness of the interventions used. Review of Resident 380's electronic medical record administration (EMAR) on 01/08/2025 showed the resident had been administered both medications as ordered every day since their admission on 12/26/2024. The behaviors displayed on 01/02/2025 and 01/05/2025 were not documented in the medical record for monitoring of the anti-psychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/09/2025 at 9:20 AM, Staff A, Administrator stated they needed to complete more education with the staff on ensuring the orders are complete. 47047 <RESIDENT 45> Resident 45 admitted to the facility on [DATE] with diagnoses that included adult failure to thrive, post-traumatic stress disorder (PTSD), and major depressive disorder. In a review of Resident 45's Medication Administration Record (MAR) dated January 2025 showed they had a physician order dated 11/23/2024 for duloxetine (an anti-depressant medication) to treat major depressive disorder and hydroxyzine (an antianxiety medication) to treat anxiety. There was no monitor in place for adverse consequences or behaviors related to the use of duloxetine and no monitor in place for adverse consequences for the use of hydroxyzine. Review of Resident 45's care plan dated 12/08/2024 showed they were at risk for depression and mood problems related to antidepressant use and anxiety. Interventions for depression included observation for side effects of anti-depressant medication. Interventions for anxiety included to administer medications as ordered and monitor and document side effects and effectiveness. Review of Resident 45's electronic medical record from 11/23/2024 through 01/05/2025 showed no documentation or monitor for adverse consequences related to the use of an antidepressant and anti-anxiety medication. Review of Resident 45's Kardex (resident specific guide for nursing assistants to provide care) dated as of 01/06/2025 directed nursing assistants to monitor, document, and/or report to the physician ongoing signs and symptoms of depression unaltered by antidepressant medications. In an interview on 01/07/2025 at 11:50 AM Staff G, Social Services Supervisor, stated the admitting nurse adds any monitors needed for residents who had psychoactive medications. Staff G stated they try to review residents every 30 days to ensure monitors are in place. In an interview on 01/07/2025 at 12:45 PM Staff A, Administrator, stated there was not a monitor in place for Resident 45's antidepressant use and a monitor was put into place that day. In an interview on 01/08/2024 at 2:34 PM Staff B, Director of Nursing Services, stated the nursing aides are not to assess or monitor as those are nursing tasks and are responsible for personal care only. 51312 <RESIDENT 5> Resident 5 admitted to the facility on [DATE] and readmitted on [DATE]. During the record review on 01/06/2025, Resident 5's provider orders included an 'antipsychotic drug to be administered for dementia.' (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/08/2025 at 1:56 PM, Staff O, LPN, stated that an antipsychotic drug was used for schizophrenia behavior issues, not dementia. In an interview on 01/08/2025 at 2:17 PM Staff B, DNS, stated that the order was in the process of being changed on 01/08/2025. In an interview on 01/07/ 2025 at 1:43 PM, Staff A, Administrator stated that dementia is not a proper diagnosis for an antipsychotic medication. Refer to WAC 388-97-1060(3)(k)(i)(4)

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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. 36787 Based on observation, and interview the facility failed to ensure one of four medication carts had unsecured medications. In addition, the facility failed to ensure medications were secured and not accessible to residents for two of two (70 and 75) residents. These failures placed residents at risk for unauthorized access to medications and biologicals, and potential drug misuse. Findings included . Review of the facility policy titled, Storage if Medications dated May 2022 showed Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Review of the facility policy titled, Bedside Medication Storage effective May 2022 showed bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. <MEDICATION CART A> In an observation and interview on 01/08/2025 at 1:56 PM, Staff O, LPN left an insulin pen unattended on the cart under the computer screen. The pen had medication in it but is not labeled with a resident name. At 1:58 PM, Staff O returned to the cart and was alerted to the unattended unlabeled insulin pen. Staff O said they would look at all the insulin lids in the drawer in order to find out who has a missing lid in the drawer. Was looking for that. Found it and put a pen in a drawer with resident label. <UNATTENDED MEDICATIONS> <RESIDENT 70> In an observation on 01/02/2025 at 10:27 AM, Resident 70 was in bed and located on their nightstand to their right were artificial eye drops, nasal spray, Walgreens oral throat spray, antifungal powder, and Diclofenac Sodium External Gel (Topical pain reliever). Resident 70 stated Those are just medications the nurses can use if they need to after they assess me. I put the Diclofenac gel on my knees to help the pain. Review of the physician's orders showed no orders for the eye drops, nasal spray, antifungal powder. In an observation on 01/03/2025 at 10:29 AM, the resident was in bed and the eye drops, nasal spray, Walgreens oral throat spray, antifungal powder, Diclofenac Sodium External Gel, remained in the same location at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 01/06/2025 at 8:35 AM, the resident was in bed watching TV and the eye drops, nasal spray, Walgreens oral throat spray, antifungal powder, Diclofenac Sodium External Gel remained in the same location at bedside. In an observation on 01/07/2025 at 8:20 AM, the resident was in bed on their right side and the eye drops, nasal spray, Walgreens oral throat spray, antifungal powder, Diclofenac Sodium External Gel remained in the same location at bedside. In an observation on 01/08/2025 at 9:08 AM, the resident was in bed watching TV and the eye drops, nasal spray, Walgreens oral throat spray, antifungal powder, Diclofenac Sodium External Gel remained in the same location at bedside. In an observation on 01/09/2025 at 8:52 AM, Resident 70 was in bed asleep on their side with the medications still present. Review of the clinical record showed there was no self-medication program assessment, physician order or self-medication administration care plan for Resident 70. <RESIDENT 75> In an observation on 01/02/2025 at 11:27 AM, Resident 75 was resting in bed. There was Albuterol inhaler on their overbed table. Resident 75 said they kept the inhaler there for when they need it. In an observation on 01/03/2025 at 9:38 AM, Resident 75 was in bed and the Albuterol inhaler remained in the same location on the overbed table. In an observation on 01/06/2025 at 10:01 AM, Resident 75 was in bed asleep. The Albuterol inhaler was partially covered with a napkin. In an interview and observation on 01/06/2025 at 12:50 PM, Resident 75 was in bed watching TV with the Albuterol inhaler at bedside. The resident said they used the inhaler several times a day and wanted to keep it at bedside, to so they didn't have to wait 40 minutes for it when they needed it. They stated, When I need it, I need it. The resident said staff told then to put the inhaler away, but they wanted to keep it nearby. In a similar observation on 01/06/2025 at 2:28 PM, Resident 75 was resting in bed with the inhaler on their overbed table. Review of the clinical record showed there was no self-medication program assessment, physician order or self-medication administration care plan for Resident 75. In an interview on 01/08/2025 at 12:32 PM, Staff L, Licensed Practical Nurse said there were no residents on self-medication programs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/08/2025 at 1:54 PM, Staff J, Registered Nurse said they had no residents on self-medication program. Staff J said if a resident were on Self Medication Program, the nurses would need to talk to the provider, assess the resident and care plan if they were safe to self-administer their medications. Staff J said they would not leave the medications in the room with the resident. They would bring the resident the medications when they would be taking the meds. In an interview on 01/09/2025 at 9:15 AM, Staff A, Administrator was notified Resident 75's Albuterol inhaler at bedside and Resident 70's medications at bedside. Staff A said family was supposed to be picking up Resident 70's medications. Staff A said the expectation was residents should be assessed for self-medication program; the care plan should reflect that, and the medications should be safely stored. Reference: (WAC) 388-97-1300 (2)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on observation, interview, and record review the facility failed to ensure prompt dental services were provided for 2 of 3 sampled residents (Residents 33 and 56) reviewed for dental services. This failure placed residents at increased risk for continued dental problems, difficulty chewing, associated health complications, and diminished quality of life. Findings included . <RESIDENT 33> Resident 33 admitted to the facility on [DATE]. According to the Admission Minimum Data Set (MDS - an assessment of care needs) assessment, dated 02/13/2024, showed Resident 33 had obvious or likely cavity or broken natural teeth. In an interview and observation on 01/02/2025 at 10:34 PM, Resident 33 stated they had missing teeth, and their teeth hurt when eating and they needed to see a dentist. Observation showed Resident 33 only had two upper teeth and three lower teeth with some yellow-brownish debris on them. Review of Resident 33's current care plan with a focus area initiated on 05/16/2024 showed Resident 33 had oral/dental health problem related to poor nutrition, poor oral hygiene, and failure to thrive. The care plan intervention showed the staff would coordinate arrangements for dental care, and transportation as needed/as ordered. Review of a report from a consulting dentist, dated 05/29/2024, showed Resident 33 would like teeth extraction and dentures. Review of progress notes dated 05/29/2024 through 01/06/2025, showed no documentation was that Resident 33 had been referred for teeth extractions. In an interview on 01/06/2025 at 1:55 PM, Staff G, Social Services Supervisor, stated the facility would assist to arrange an appointment for dentures and assist to schedule an appointment as soon as possible if resident complained of tooth pain. Staff G could not find any documentation that a dental care referral had been arranged for Resident 33. In an interview on 01/08/2025 at 9:01 AM, Staff A, Administrator, stated they were not able to find any documentation that the facility had offered assistance in setting up dental appointment for teeth extractions. <RESIDENT 56> Resident 56 admitted to the facility on [DATE]. According to the admission MDS assessment, dated 08/04/2024, Resident 56 was cognitively intact. (continued on next page)

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	505407	A. Building B. Wing	01/09/2025

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an initial admission record, dated 07/29/2024, showed Resident 56 had broken teeth. In an interview on 01/02/2025 at 11:45 AM, Resident 56 stated they had several broken and missing teeth, and they had not seen a dentist since admission in July 2024. In an observation and interview on 01/06/2025 at 10:15 AM, Resident 56 was observed to have several missing and broken teeth, and the partial denture had dark spots on them. Resident 56 stated they had never seen a dentist since being admitted to the facility. Resident 56 stated they told several staff that they would like to see a dentist. Review of Resident 56's current care plan with a focus area initiated on 08/14/2024 showed Resident 56 had oral/dental health problem related to injury and poor oral hygiene. The care plan intervention showed the staff would coordinate arrangements for dental care, transportation as needed/as ordered. Review of a social services progress note dated 09/22/2024 at 12:06 PM, showed Resident 56 would like to see a dentist due to the resident having 10-12 broken teeth, and the broken teeth were sore. Review of progress notes from 09/22/2024 through 01/06/2025, showed no documentation that Resident 56 had been seen or evaluated by a dentist. In an interview on 01/06/2025 at 1:55 PM, Staff G, stated the facility should assist to schedule an appointment as soon as possible if resident complained of tooth pain. Staff G could not find any documentation showing Resident 56 had been seen or evaluated by a dentist since admission. In an interview on 01/08/2024 at 9:01 AM, Staff A, stated they did not find any documentation that Resident 56 had received assistance or follow up with their concern of poor dental conditions. WAC 388-97-1060 (3)(j)(vii)

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	505407	A. Building B. Wing	01/09/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42927 Based on observation, interview and record review, the facility failed to ensure staff followed infection control procedures and practices for 1 of 2 residents (Resident 229) on enhanced barrier precautions (EBP) that were observed for care. The facility also failed to disinfect resident care equipment between resident use. These failures placed residents at risk of cross contamination and/or the spread of disease. Findings included . <ENHANCED BARRIER PRECAUTIONS> During an observation on 01/06/2025 at 8:16 AM, a sign was posted outside Resident 229's room [ROOM NUMBER] that instructed staff they must wear gloves and gown for high contact resident care activities to include dressing, transferring, changing briefs or assisting with toileting. The sign had an 'M' written on it. room [ROOM NUMBER] had three occupants. Review of Resident 229's care plan showed an intervention that the resident required EBP during high contact resident care activities, dated 01/03/2025. During an observation on 01/06/2025 at 1:28 PM, Staff Z, Nursing Assistant Certified (NAC) and Staff Y, NAC, provided incontinent care to Resident 229 who resided in the middle bed in room [ROOM NUMBER]. Staff Z and Staff Y wore gloves during care but did not wear a gown. During an interview on 01/06/2025 at 1:36 PM, Staff Z and Staff Y reviewed the EBP sign outside the door of room [ROOM NUMBER]. Staff Y stated the 'M' indicated the middle bed and that they should have worn a gown and gloves to do incontinent care on Resident 229. During an interview on 01/06/2025 at 2:41 PM, Staff B, Director of Nursing, stated the EBP sign with the 'M' on it meant that staff were to wear gown and gloves when providing close contact with the resident in the middle bed (Resident 229). <EQUIPMENT SANITATION> During an observation on 01/02/2025 at 10:40 AM, Staff T, NAC, was observed pushing the mechanical lift (machine to lift patient) from room [ROOM NUMBER] which had an EBP sign outside the doorway to room. Staff T reported that they had just used the mechanical lift to weigh the resident in 38-M. Staff T pushed the mechanical lift along the wall in the hallway and did not sanitize it. 51312 In an observation/interview on 01/02/2025 at 11:42 Staff DD, NAC, was seen taking a mechanical lift out of room [ROOM NUMBER] and placed it in the hall. Staff DD did not sanitize the mechanical lift. Staff DD stated they placed the mechanical lift in the hall for the next resident. Staff DD was asked if anything should be done with the mechanical lift before it was used for another resident and Staff DD was not able to state that it needed to be disinfected. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/02/2025 at 11:44 Staff R, NAC, stated that mechanical lifts should be sanitized before and after resident use and that disinfectant wipes are located on housekeeper carts and at the nurse station. In an interview on 01/08/2025 at 10:19 AM, Staff X, Licensed Practical Nurse (LPN), stated they were unsure of the process for cleaning the mechanical lift. In an interview on 01/08/2025 at 1:56 PM Staff O, LPN, stated mechanical lifts should be sanitized before and after use. In an interview on 01/08/2025 at 12:10 PM Staff F, LPN/Resident care manager, stated the mechanical lift should be cleaned after resident use and if visibly contaminated. In an interview on 01/08/2025 at 2:17 PM Staff B, DNS, stated that Hoyer should be sanitized prior to use and after use, and spot checked. Refer to WAC 388-97-1320 (1)(a), (5)(c)(e)