STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505413	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Vista Post-Acute & Rehab Center	625 Okanogan Ave Wenatchee, WA 98801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on interview and record review, the facility failed to address required documentation for Advanced Directives (AD), a legal document in which a person specifies what actions should be taken for their health if they are no longer are able to make decisions for themselves because of illness or incapacity) for 2 of 3 residents (Residents 1 and 10) reviewed for ADs. These failures placed the residents at risk of losing their right of having their preferences and/or decisions followed regarding their end-of-life care. Findings included . <Resident 1> Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include breast cancer (when abnormal breast cells grow out of control and form tumors) and diabetes (a chronic disease that affects how the body uses insulin and glucose). The 07/16/2024 comprehensive assessment showed Resident 1's cognition was intact and able to make their own decisions. During an interview on 09/23/2024 at 11:55 AM, Resident 1 stated they had an AD in place and if they had been sent to the hospital, the facility would know what to do. During a follow-up interview on 09/26/2024 at 9:33 AM, Resident 1 stated the only end-of-life care treatment that had been discussed with them during quarterly care conferences were on a green Physician's Orders for Life Sustaining Treatment [POLST, a form that lets you choose the types of medical treatment you want during serious illness] form that resident 1 had on their bedside table and handed to the Surveyor. Resident 1 stated they had not been talked to or offered any other information regarding their wishes for end-of-life care and as far as they understood, the POLST form was their AD. Review of a document titled Durable Power of Attorney for Healthcare (DPOA, authorizes an agent to make medical decisions on your behalf when you are unable to do so) dated 01/22/2015, showed Resident 1's wishes as expressed in my Living Will would be followed but may not cover all aspects of care so they were designating a DPOA. Review of Resident 1's medical record showed, there were no documents titled Living Will. Review of Resident 1's 08/07/2024 care plan, showed the resident had a DPOA on file for their healthcare needs. The care plan additionally showed Resident 1's POLST reflected their AD wishes. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 10> Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include respiratory failure and a stroke (when blood flow to the brain is interrupted, leading to brain damage) with left sided weakness. The 07/18/2024 comprehensive assessment showed the resident's cognition was severely impaired and unable to make their own decisions. During an interview on 09/25/2024 at 4:39 PM, Staff I, Social Services Director, stated the facility would offer AD forms they could print off the internet to residents or family members upon admission. Staff I stated the residents could then discuss their options with their medical provider and complete the forms. Staff I stated they readdressed the ADs quarterly at care conferences and would document in the quarterly assessment or in a progress note. Review of Resident 10's quarterly assessment dated [DATE], showed the AD had been reviewed and was still appropriate. The assessment showed no information to formulate an AD had been discussed or offered. Review of Resident 10's 07/25/2024 AD care plan, showed Representative stated that the orders on the POLST reflect the treatment wishes and Resident is unable to complete an AD. During an interview on 09/27/2024 at 9:18 AM, Resident 10's Representative stated the facility had gone over the POLST form with them during care conferences but formulating an AD had not been discussed in all the years Resident 10 had been at the facility, nor were they offered information on formulating an AD or how to formulate an AD. During an interview on 09/27/2024 at 10:50 AM, Staff A, Administrator, stated their expectations would be for Social Services to address ADs on admission and quarterly during care conferences, care plan the ADs, and document the outcome if ADs were refused. WAC Reference: 388-97-0300 (1)(b)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of hospital transfer for 2 of 3 residents (Residents 62 and 214) reviewed for hospital transfers. This failure placed residents at risk for lack of knowledge regarding their right to hold their bed and monetary charges associated with the bed hold while in the hospital. Findings included . Review of a policy titled, Bed Hold - [NAME], dated 08/01/2024, showed when a resident was transferred or discharged , the nursing department would provide the resident and/or their representative with a copy of the bed hold policy. If nursing was unable to provide the notice at the time of transfer or discharge, the Social Services Director or designee would contact the resident and/or their representative to notify them of the facility policy and obtain a decision on bed hold. <Resident 62> Review of the medical record showed Resident 62 was admitted to the facility with diagnoses including a stroke, dizziness and giddiness, and a heart attack. The 06/24/2024 comprehensive assessment showed Resident 62 was able to make their own decisions and was independent with all ADLs. Review of a nursing progress note dated 06/29/2024 at 11:35 PM, showed Resident 62 complained of chest pain radiating to their neck and arm. Resident 62 was transferred to the hospital for evaluation on 06/30/2024 at 12:10 AM . The medical record showed no documentation that a notice of bed hold had been given to the resident and/or their representative. <Resident 214> Review of the medical record showed Resident 214 was admitted to the facility with diagnoses including aftercare for surgery on the digestive system, severe protein-calorie malnutrition (a lack of available nutrients in the body that leads to changes in body composition and function), and diabetes (a group of diseases that result in too much sugar in the blood). The 09/17/2024 comprehensive assessment showed Resident 214 required substantial/maximum assistance of one staff member for ADLs. The assessment also showed Resident 214 had a moderately impaired cognition. Review of the medical record showed Resident 214 complained of abdominal pain and was transferred to the emergency room for evaluation on 08/10/2024 at 3:00 PM. There was no documentation that a notice of bed hold was given to the resident and/or their representative. During an interview on 09/26/2024 at 4:40 PM, Staff B, Director of Nursing Services, stated the notice of bed hold should be given to the resident and/or their representative when they were transferred out of the facility. They stated it was the responsibility of the nurse on duty at the time of transfer to provide the resident and/or their representative with the notice of bed hold. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/2024 at 10:15 AM, Staff A, Administrator, stated it was their expectation that a notice of bed hold was completed for residents that transferred to the hospital. Staff A further stated the process for bed hold, effective August 1, 2024, was for the Business Office Manager to fill out the notice of bed hold form and contact the resident and/or their representative to complete the form. Reference: WAC 388-97-0120(4)

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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 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** 44922 Based on observation, interview, and record review, the facility failed to ensure the provision of ongoing assessments and monitoring in accordance with professional standards of practice for 5 of 5 residents (Residents 7, 23, 25, 122 and 1) reviewed for quality of care. The failure to assess and monitor for impaired skin integrity, edema, (swelling caused by presence of excess fluid in the body tissues) and bowel management placed the residents at risk for unmet care needs and negative health outcomes. Findings included . <Skin> Review of a facility policy and procedure document titled Skin at Risk/Skin Breakdown last revised on 09/2020 showed .A full body skin evaluation is completed on admission and weekly by the licensed nurse. Updates of current non-pressure areas coincide with the weekly full body skin audit and monitors bruises, skin tears and abrasions on the resident's Treatment Administration Record (TAR). All other skin impairment concerns are documented on the 'Skin-Wound Form' (an electronic health record form in the assessment section of the resident's medical record). The policy further stated to document on the skin impairment forms to include the measurements of size, color, presence of odor, exudate (wound fluid), pain associated with the skin impairment, and the current type of treatment used. <Resident 7> Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include peripheral vascular disease (a condition in which in which narrowed blood vessels outside the heart cannot deliver enough oxygen and nutrients to the body and could cause chronic wounds to the limbs). The 07/14/2024 comprehensive assessment showed the resident's cognition was intact and could make their own decisions. The assessment also showed Resident 7 had venous/arterial ulcers to their lower extremities. A concurrent observation and interview on 09/23/2024 at 1:53 PM, showed Resident 7 lying in bed, both legs were wrapped from below the toes to below the bend in the knees with brown elastic compression (ace bandages) bandages. There was a foul smell, the smell of rusty wet coins, while standing at the bedside talking to the resident. Resident 7 stated their dressings on their legs had not been changed since the day prior. The date on the dressings on both legs showed 09/22/2024. Resident 7 stated the facility utilized traveling nurses and when they worked, the bandages would not get changed. Resident 7 stated they would normally get changed every third day but were supposed to be changed daily. An observation on 09/24/2024 at 9:58 AM showed the bilateral leg dressings were still the same dressings that were dated 09/22/2024. (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 Resident 7's September 2024 TAR, showed an order on 07/24/2024 for dressing changes to both leg wounds daily. The wounds were to be cleansed with wound cleanser, followed by an oil emulsion dressing (a dressing that keeps draining wounds flowing without sticking to the wound bed), followed by super absorbent pads, and finally, covered with the ace bandages. The order showed the dressing changes had not been completed on seven of the 25 opportunities for the dressing change, in addition to two documented refusals. The order also showed on 09/23/2024, it was documented the dressing had been changed, even though the same dressings were on from 09/22/2024 until 09/25/2024. Additionally, the TAR showed an order on 10/11/2023 for weekly skin checks to be completed and document a (-) for no new skin impairment and a (+) for new skin impairment. Three of the four opportunities for skin checks had not been completed and showed no documentation. A concurrent observation and interview on 09/25/2024 at 10:44 AM, showed the dressings on both legs were still the same dressings dated 09/22/2024. Resident 7 stated they smelled horrible and had asked the nurse to change their dressings before they left the facility for a same-day procedure and was informed by the nurse they did not have time and would have to wait until they returned from their procedure. Resident 7 stated they would be embarrassed if they had to go to their procedure smelling as bad as they did. Resident 7 was being provided incontinent care by Staff L, Nursing Assistant, and the resident had dried areas of dark black/green bowel movement on the top portion of the absorbent pads that were sticking out of the top of the ace bandages along with a new area of wet bowel movement the size of a softball. Also, the middle of the left leg, was a baseball sized, brownish/black leakage that had leaked through the dressings and dried on the outside of the ace bandage. Staff L stated they were leaving the room to go report the bowel movement on the dressings to the nurse and see if that would get them to change the dressings. An observation on 09/25/2024 at 11:06 AM, showed Staff R, Registered Nurse (RN), changing Resident 7's dressings to their lower legs, along with Staff S, Licensed Practical Nurse/Resident Care Manager (LPN/RCM). Staff R and Staff S each used a bottle of wound cleanser to soak the dressings to soften them up for removal and as bandages were being removed, they were saturated with stringy, green and brown slough (a mass or layer of dead tissue separated from the surrounding or underlying tissue) skin. The room was filled with the smell of rusted wet coins. Wounds were cleansed and new dressings placed as ordered. Staff R dated the dressings 09/25/2024 with their initials. An observation on 09/26/2024 at 2:20 PM, Resident 7 was observed lying in bed sleeping, had returned earlier in the day from their same-day procedure on 09/25/2024. Dressings to both legs are still dated 09/25/2024 with Staff R's initials. An observation on 09/27/2024 at 9:00 AM, showed Resident 7 was lying in bed eating breakfast. Resident 7 stated the dressings had not been changed since 09/25/2024 and while standing at the foot of the bed, the same wet, rusty coin smell was present. The dressings were dated 09/25/2024 and had Staff R's initials. During an interview on 09/27/2024 at 10:58 AM, Staff B, Director of Nursing Services, along with Staff K, Regional RN, stated their expectations were for the nurses, including travel/agency nurses to follow the physician orders and change the dressings daily. Staff B stated the nursing staff should have completed weekly skin checks and weekly wound assessments, and they failed to follow that process. <Resident 23> (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 Resident 23's medical record showed the resident admitted to the facility with diagnoses to include cirrhosis (a condition in which the liver is scarred and permanently damaged) and diabetes (a chronic disease that occurs when the body can not properly regulate blood sugar levels). The 06/17/2024 comprehensive assessment showed Resident 23 required the assistance of one staff member for activities of daily living and had an intact cognition. During an observation and concurrent interview on 09/24/2024 at 1:03 PM, showed Resident 23 sitting in their wheelchair, with multiple scattered bruises to their lower arms, wrists and hands. All the bruised areas were yellow/brown/green in color and were in various stages of healing. Resident 23 was noted to have a band aid on an area to their lower right forearm and stated they got a skin tear yesterday from hitting it on a door frame. Resident 23 stated they got bruises on their arms and hands all the time from hitting them on the door frame trying to get outside to the smoking patio. During an observation on 09/26/2024 at 8:48 AM, showed Resident 23 lying in bed with an open skin tear 1 centimeter (cm, a unit of measure) by 0.5 cm to their right lower forearm. Review of the September 2024 Medication Administration Record (MAR) showed Resident 23 was to have weekly skin assessments each Monday and showed no monitoring or skin assessments of the bruised areas, or skin tear to right lower forearm. Review of the September 2024 TAR showed no monitoring of the bruised areas or skin tear. During an interview on 09/26/2024 at 1:08 PM, Staff B stated their expectations for the Licensed Nurses was that all skin issues, including bruises, were to be documented on the weekly skin assessment and were to be monitored until resolved. Staff B further stated that the nursing staff did not follow the correct process for Resident 23's skin issues. <Resident 25> Review of the medical record showed Resident 25 was admitted to the facility on [DATE] with diagnoses including diabetes, bilateral heel ulcers, congestive heart failure (a condition when the heart cannot pump blood well enough to keep up with the body's need), lymphedema (a condition in which lymph fluid builds up in tissue causing swelling, discoloration and hardening of the skin), obesity, and depression. The 09/04/2024 comprehensive assessment, showed Resident 25 required substantial assistance of one to two caregivers for activities of daily living (ADL's) and was cognitively intact. A concurrent observation and interview on 09/24/2024 at 8:49 AM, showed Resident 25 lying on their bed, both of their lower legs were swollen with edema, and pressure relief soft boots were in place on both feet. Resident 25 stated they had deep wounds on the bottom of both heels caused by poor circulation that were being treated by the facility nurses. Review of a provider visit note, dated 09/16/2024, stated the resident had unstageable (a full thickness wound that is covered by a layer of dead tissue that prevents the stage of the wound from being determined) bilateral diabetic ulcers to the heels and three plus edema [a full and swollen extremity that leaves an indentation in the skin when pushed on, that is six millimeters (mm, a unit of measure) deep and takes up to 60 seconds to rebound]. Pictures of the wounds were present in the providers documentation though no size or definitions of the wounds were present. (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 Resident 25's physician orders, dated 08/29/2024, showed the resident was receiving medication to assist with removing fluid from the lower extremities, was on a daily fluid restriction to decrease the amount of fluid intake, and daily weights to assure fluids were not increasing weight in the body. Review of Resident 25's TARs for August and September 2024, showed they received daily monitoring and every three-day dressing changes to the bilateral wounds on the heels by the licensed nursing staff though there were no sizes or condition of the wounds present. Review of Resident 25's nursing progress notes, skin assessment forms, and wound documentation forms from 08/29/2024 through 09/26/2024 , showed no documentation of the size or condition of the wounds to evaluate if the treatments ordered assisted in healing the wounds or if the wounds were worsening. In addition, no documentation was found describing the edema or if measurements were taken to evaluate if the medication and treatments provided to decrease the fluid in the lower extremities was effective. <Resident 122> Review of the medical record showed Resident 122 was admitted to the facility on [DATE] with diagnoses including diabetes, infection of a right foot ulcer, chronic venous stasis (a condition in which veins in the leg have problems moving blood back to the heart causing leg swelling, skin changes and ulcers), severe lymphedema, obesity, and stasis ulcers to the bilateral lower legs. The 09/10/2024 comprehensive assessment showed Resident 122 required substantial assistance of one to two caregivers for ADLs and was cognitively intact. A concurrent observation and interview with Resident 122 on 09/23/2024 at 1:05 PM, showed the resident sitting up on the side of their bed with a wound vac (a treatment that uses negative pressure suction to help heal wounds) in place on the right foot and both legs wrapped from the foot to the knee in dressings. Resident 122 stated they had a wound on the bottom of their right foot and multiple ulcers on both of their lower legs that became infected, and they were currently receiving intravenous (medications administered through a vein) antibiotics four times a day in the facility. Resident 122 further stated that they had their dressings changed by the facility nurses twice a week to all their wounds on their shower days and as needed in between. An observation on 09/24/2024 at 1:50 PM, showed Staff C, (LPN/RCM), changing dressings to Resident 122's bilateral lower leg ulcers and the wound vac treatment to the right foot. Their right side of the foot from mid foot to the heel showed a large unstageable wound. The wounds to both the left and right lower legs were difficult to assess due to excessive appearance of wood like, raised keratosis (a condition of excessive overgrowth and thickening of the skin) on all parts of the lower legs and feet from severe lymphedema. Staff C stated they had not in the past completed any measurements or assessments of the wounds during the dressing changes but would get the size of the wounds during this dressing change and document the results in a nursing progress note. Review of Resident 122's September 2024 TARs from 09/04/2024 through 09/26/2024, showed they received daily monitoring and twice a week dressing changes to the right heel wound and both lower leg ulcers by the licensed nursing staff though there were no sizes or condition of the wounds present in the documentation. (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 Resident 122's nursing progress notes, skin assessment forms, and wound documentation forms from 09/04/2024 through 09/23/2024 , showed no documentation of the size or condition of the wounds to evaluate if the treatments ordered assisted in healing the wounds or if the wounds were worsening. In addition, no documentation was found describing the lymphedema or if measurements were taken to evaluate if the medication and treatments provided to decrease the fluid in the lower extremities was effective. Review of a nursing progress note by Staff C dated 09/24/2024 at 4:17 PM, showed .Residents right lateral (side of foot) plantar (the thick tissue on the bottom of the foot) foot wound had the wound vac replaced today. Wound was cleansed with wound cleaner and patted dry. Wound has granulation tissue (new tissue that forms in wounds during the healing process) present in wound bed, serosanguinous drainage (thin, slightly yellow or pink tinged fluid). Wound this week measures 4.6 cm by 3.2 cm by 0.3 cm. Black foam (a foam used to seal the wound vac treatment) was fitted and bridged created for vac placement on top off foot. Foam secured in place and suction obtained. During an interview on 09/25/2024 at 2:07 PM with Staff C stated the facility was not currently completing wound assessments for skin impairments including what the wounds looked like when a resident was admitted , if a resident developed a skin problem while in the facility, or when assessed at dressing changes. Staff C stated when the current owner of the facility took over on 08/01/2024 they no longer had an assessment form in their electronic medical record to document their assessment of skin conditions on. Staff C stated they would expect the nurses to document their skin assessments in the progress notes if there was no actual assessment form available to document on, like the one they wrote on 09/24/2024 describing the size and condition of the wound and what treatment was used. During an interview with Staff B on 09/27/2024 at 11:30 AM, they stated the facility had not been doing wound assessments on admission, when a skin issue was found, or following dressing changes. Staff B stated documentation to assess if the skin conditions were improving or deteriorating was expected on all skin impairments including edema monitoring. Staff B stated they would expect the licensed staff to document their findings in a progress note if the forms they were accustomed to using were no longer present in the medical record. During an interview with Staff K on 09/27/2024 at 11:35 AM, they stated they were unaware the facility no longer had skin and wound assessment forms or edema monitoring forms in the facility's electronic health record. Staff K stated they were working closely with the new corporation's electronic health records team to assure all needed assessments for resident care were put into practice. <Bowel Management> Review of a policy titled Bowel Protocol dated 09/2024, showed the nurses were to identify residents who had not had a bowel movement (BM) in three days then review the MAR for use of the as needed bowel medication that had been given the shift prior. The policy showed if a resident went greater than four days without a BM, the nurse would complete an abdominal assessment and notify the physician for further orders. <Resident 1> (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 Resident 1's medical record showed they admitted to the facility with diagnoses to include functional quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord). The 07/16/2024 comprehensive assessment showed Resident 1's cognition was intact, was dependent upon staff for their toileting hygiene, and experienced constipation (hard, dry bowel movements or passing stool fewer than three times a week). During an interview on 09/23/2024 at 12:05 PM, Resident 1 stated they had issues with constipation and had not had a BM in at least seven days. Resident 1 stated they received daily medication for their constipation, but it had not worked very well and they would have to sit on a bed pan (a container used as a toilet by a person who is too ill to get out of bed) for an extended length of time waiting to have a BM which was uncomfortable and felt it caused them skin impairment to their bottom. Review of Resident 1's BM tasks (a record that nursing assistants document on every shift) from 08/28/2024 through 09/26/2024 showed as follows; 1) no BM from 09/15/2024 day shift through 09/24/2024 evening shift (greater than nine days with 3 shifts no documentation, 2) no BM from 09/05/2024 night shift through 09/11/2024 night shift (greater than five days with three shifts having no documentation), 3) no BM from 08/28/2024 day shift through 09/01/2024 evening shift (greater than 4 days with two shifts having no documentation). Review of Resident 1's September 2024 MAR showed the resident had seven as needed medications ordered for the bowel protocol with specific directives to allow different routes of administration for constipation management. The record showed the Milk of Magnesia, an as needed medication, was used once on 09/24/2024 (greater than nine days with no BM), no other as needed medications were utilized. Review of Resident 1's 08/07/2024 care plan, showed the resident was at risk for constipation with an intervention to monitor for side effects of constipation and to keep the physician informed of any problems (the record showed no notification to the physician had been made when the resident went greater than 4, 5, and 9 days without a documented BM and the record showed no bowel assessments had been completed to monitor for side effects of the constipation). During an interview on 09/26/2024 at 9:49 AM, Staff V, NA, stated they documented BMs at the end of every shift and if the computer showed the resident had not had a BM in three to four days they would inform the nurse if the resident did or did not have a BM during that shift. Staff V further stated Resident 1 consistently had issues with constipation. During an interview on 09/27/2024 at 8:41 AM, Staff W, LPN, stated they checked their bowel list daily and if a resident did not have a bowel movement within 72 hours they would initiate their standing orders (as needed medications) starting with Metamucil (a brand of medication used for increasing fiber to increase BMs, and was not an as needed medication ordered) and then if that did not work they would go to the enema or suppositories. Staff W stated the residents should not go greater than 72 hours without a BM and after 72 hours they would complete bowel assessments (listen and check for bowel tones and feel for pain or distention in the abdomen) and notify the physician for further directions. Staff W stated they would document in the resident's record any medications given and notification to the physician. (continued on next page)

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	505413	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Vista Post-Acute & Rehab Center	625 Okanogan Ave Wenatchee, WA 98801

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/2024 at 10:18 AM, Staff C, stated they did not believe Resident 1 went 10 days without a BM, the most I have ever seen is four to five days. Staff C stated Resident 1 would often refuse their daily bowel meds and Resident 10 would tell Staff C they did not feel they had a problem with constipation (the MAR showed the Miralax (a brand of medication used for bowel management) was the only daily medication the resident refused on 14 days out of 28). Staff C stated they had notified the physician of the constipation, and they had changed the medications but did not see the physician had been updated on the no BM from 09/15/2024 through 09/24/2024 and had seen no new orders. Staff C felt the issue was not with the resident experiencing constipation but with the staff not accurately documenting (even though the resident could say they knew it was at least seven days they had gone without a BM). Staff C additionally did not see documentation of bowel assessments that had been completed and stated they should have done bowel assessments if Resident 1 went that long without a BM. WAC Reference: 388-97-1060 (1) 35676 48368

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44922 Based on observation, interview, and record review, the facility failed to assess, monitor, or treat skin to prevent the development of facility-acquired pressure injuries (PIs) for 1 of 3 residents (Resident 1) reviewed for PIs. This failed practice placed residents at risk for worsening or new pressure injuries, pain, and unmet care needs. Findings included . Review of the National PI Advisory Panel's (NPIAP, the leading expert in PIs/wounds) guidelines and definitions, dated September 2016, defined PI stages as follows: Stage 1 PI has intact skin with a localized area of non-blanchable erythema (redness). Stage 2 PI is a partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 PI is a full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which may be shallow or deep and impairs wound closure). <Resident 1> Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include diabetes (a chronic disease that affects how the body uses insulin and glucose) and functional quadriplegia (complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the spinal cord). The 07/16/2024 comprehensive assessment showed the resident's cognition was intact and required substantial/maximal staff assistance for bed mobility, toileting, and hygiene. The assessment additionally showed at that time, Resident 1 was being treated for one Stage 3-PI. During an interview on 09/23/2024 at 11:55 AM, Resident 1 stated they had been treated for two PIs to their bottom for greater than a year and one had resolved. Resident 1 stated they received a barrier cream to the remaining PI due to the PI had nearly resolved. Review of Resident 1's 02/07/2024 revised care plan for skin integrity showed the resident had a potential for skin impairment and that the resident was at risk for skin impairment. The care plan showed nursing staff were to monitor and document the location, size, and treatment of the injury, refer to the Medication Administration Record (MAR) and Treatment Administration Records (TAR) for interventions, and weekly skin checks would be completed. Additionally, the care plan showed there would be weekly treatment documentation (length, width, depth, and type of tissue and/or exudate) of any areas of skin impairment and any changes to skin impairment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the September 2024 TAR, showed orders as follows: 1) on 06/29/2024 for Triple Paste (a brand of medication used as a barrier cream) to be applied to the buttocks every morning and at bedtime for skin care, 2) an order on 05/26/2024 to cleanse with normal saline and apply Triple Paste to a PI (did not identify the stage of the PI) to the coccyx (tailbone) daily and as needed until resolved (the order showed no treatment had been completed on 09/15/2024 and 09/22/2024), 3) an order on 05/28/2024 for weekly skin checks every Tuesday and document a (-) for no new skin impairment and a (+) for new skin impairment. The order also read if a new skin impairment was found, staff were to follow the Skin at Risk policy. A weekly skin assessment had been completed on 09/24/2024 with a (-) documented for no new skin impairments. Review of the 07/30/2024 weekly treatment documentation, showed the resident had a Stage 2-PI to their coccyx that measured 0.5 centimeters (cm, a unit of measurement) by 0.1 cm. There were no other weekly treatment documentation notes found as of 07/30/2024. An observation and concurrent interview on 09/26/2024 at 9:33 AM, showed Resident 1 being provided incontinent care by Staff L, Nursing Assistant. Resident 1 was observed to have two opened areas, one to their right buttock the size of a dime with partial thickness skin loss and one to their left buttock half the size of a dime with partial thickness skin loss and cracked opened skin in their gluteal fold (where the right and left buttocks form to create a crease) that had scant amounts of red drainage. Staff L stated the opened areas were not new areas and as far as they knew, the nursing staff were aware the sores were present. Review of a 09/23/2024 nursing progress note, showed sores to bilateral buttocks, treated per orders. The note showed the left buttock open sore was 0.5 cm by 0.5 cm and the right buttock open sore was 1.5 cm by 0.5 cm in size. No further notes or assessments had been completed for skin impairments and there were no ordered treatments or documentation showing the physician had been notified. During an interview on 09/27/2024 at 10:18 AM, Staff C, Resident Care Manager, stated nursing was responsible for completing the weekly skin checks and the NAs were responsible for reporting any new skin impairments they found during showers or care, to the nurses. Staff C stated the facility had a process to complete weekly wound assessments on any skin impairments with descriptions and measurements but when transferring over to their new medical record system, the assessment was not re-created so those assessments had fallen through the cracks. Staff C stated Resident 1 had a history of skin impairments to their bottom off and on and was unaware of the current skin issues observed during care. Staff C stated the nursing staff should have followed the process, notified the physician, obtained treatment orders, and completed assessments. During an interview on 09/27/2024 at 10:58 AM, Staff B, Director of Nursing Services, also present was Staff K, Regional Registered Nurse, stated their expectation was that nursing staff completed weekly skin checks with weekly assessments documented on residents with skin impairments. Staff B stated they would also expect the care plans to be updated to reflect the current status of the resident and for the physician to be notified and orders obtained if needed. WAC Reference: 388-97-1060 (3)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48368 Based on observation, interview, and record review, the facility failed to prevent accidents by not ensuring residents who smoked were assessed for safety and kept their smoking paraphernalia stored in a locked area not accessible to other residents for 3 of 3 residents (Residents 23, 30, and 164) reviewed for smoking. Additionally, the facility failed to store a portable oxygen tank in a safe manner for 1 of 3 oxygen storage rooms (oxygen storage room [ROOM NUMBER]). This failure placed all residents at risk for avoidable accidents, injuries, and the potential risk of fire. Findings included . <Smoking> Review of the Smoking policy dated 08/01/2024, showed residents who smoke independently or require supervision would be evaluated for their ability to smoke safely upon admission or at the time they decide to smoke, and the policy would be signed prior to them smoking. The policy showed residents would be reassessed at least quarterly or with significant changes in condition and that all smoking paraphernalia (cigarettes, electric cigarettes, and lighters) would be locked up. <Resident 23> Review of Resident 23's medical record showed the resident admitted to the facility with diagnoses to include tobacco use. The 06/17/2024 comprehensive assessment showed Resident 23 required the assistance of one staff member for activities of daily living and had an intact cognition. Review of a document titled Smoking Safety Evaluation, showed Resident 23 knew how their smoking materials were to be stored and could demonstrate proper storage of smoking materials. An observation on 09/23/2024 at 10:48 AM, showed Resident 23's coat laying over the back of an unused wheelchair next to the edge of the empty bed in room [ROOM NUMBER] close to the door. Further observation showed a pack of cigarettes and a lighter in the front pocket of their coat. An observation and concurrent interview on 09/27/2024 at 10:32 AM, showed Resident 23 siting up in their wheelchair next to their bed by the window. Resident 23's coat was laying over the back of the unused wheelchair next to the bed closest to the door with a pack of cigarettes and a lighter in the front pocket. Resident 23 stated they put their coat there because no one was using that space or wheelchair, and they did not have anywhere to lock up their cigarettes and lighter. During an Interview on 09/26/2024 at 1:50 PM, Staff A, Administrator, stated they would expect all residents who smoke to have their smoking materials properly stored in a lock box provided for them. Staff A stated they were aware Resident 23's lock box was missing. 44922 <Resident 30> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record showed the resident admitted to the facility with diagnoses to include vascular dementia (problems with reasoning, planning, judgment, memory, and other thought processes caused by brain damage from impaired blood flow to your brain). The 08/30/2024 comprehensive assessment showed Resident 30's cognition was moderately impaired and was independent with wheelchair mobility. During an interview on 09/24/2024 at 10:10 AM, Resident 30 stated they were an independent smoker, smoked several times a day, and kept their cigarettes and lighter in their bedside nightstand drawer. Resident 30 refused to answer any additional questions. An observation and concurrent interview on 09/24/2024 at 1:35 PM, Resident 30 was observed under the gazebo patio outside of the day room, which was the designated smoking area. Resident 30 removed their pack of cigarettes from the front pocket of their shirt along with their lighter and lit their cigarette. Resident 30 stated they had a locked drawer in their room where they kept their cigarettes and lighter locked up but also would just keep them in the pocket of their shirt. Review of a 04/21/2023 smoking evaluation, showed Resident 30 was safe to smoke independently and would ask for their smoking equipment and returned the smoking equipment when finished. There were no other smoking evaluations after 04/21/2023 (17 months since the last evaluation). An observation on 09/26/2024 at 9:42 AM, showed Resident 30 sleeping in bed, they would not arouse when attempted to speak with them. The nightstand to the left side of the bed had an unlocked top drawer that was ajar and Resident 30's cigarettes and lighter could be seen. An observation on 09/27/2024 at 9:08 AM, showed Resident 30 sleeping in bed, does not arouse when spoken to. Their top nightstand drawer is unlocked and ajar and Resident 30's lighter and cigarettes could be seen. <Resident 164> Review of the resident's medical record showed the resident admitted to the facility on [DATE] with diagnoses to include asthma (condition in which your airways narrow and swell and may produce extra mucus). The 09/12/2024 comprehensive assessment showed the resident's cognition was moderately impaired and was dependent on one staff member for transferring and wheelchair mobility. An observation and concurrent interview on 09/23/2024 at 3:33 PM, showed the resident sitting under the gazebo on the patio outside of the day room, unattended. A Nursing Assistant (NA) exited to the patio and assisted Resident 164 back to their room. On their bedside table, in a clear plastic, food storage container there was a black lighter and an electric cigarette in a box (brand named [NAME]). Resident 164 stated they smoked two to three times a day and had a pack of cigarettes and a lighter in their purse that was sitting on their nightstand to the right side of their bed. Review of Resident 164's care plan on 09/23/2024 showed no smoking care plan had been formulated. Review of Resident 164's smoking assessments on 09/23/2024, showed no smoking assessment had been completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and concurrent interview on 09/26/2024 at 9:23 AM, Resident 164 was sitting up in bed, bedside table over the top of the bed, placed in front of the resident, and the same plastic food container with the same contents was on the bedside table as previously seen on 09/23/2024. An observation on 09/27/2024 at 9:13 AM, Resident 164 was assisted outside to the smoking area and left to smoke unattended. During an interview on 09/27/2024 at 10:37 AM, Staff C, Resident Care Manager, stated residents who want to smoke should have been assessed on admission for safety and signed the smoking policy. Staff C stated the resident's cigarettes should be kept locked up on the nurse's medication carts and given to the residents prior to smoking. Staff C stated residents should not have smoking paraphernalia out in the open and should be locked up until discharge, if not in use. Staff C additionally stated residents who smoke would get re-assessed annually for safety. <Oxygen> An observation on 09/24/2024 at 3:25 PM, in an unlocked room that was previously used as an oxygen storage room (oxygen storage room [ROOM NUMBER]), was a small portable oxygen tank, half full, in a black oxygen bag, propped up against the wall behind the door, unsecured. During an interview on 09/24/2024 at 3:34 PM, Staff B, Director of Nursing Services, stated the unlocked storage room had been previously used as the oxygen storage room and had recently been moved to the other end of the hall. Staff B stated they needed to ensure all staff had been in-serviced on the new location of the oxygen storage room. During an interview on 09/25/2024 at 11:44 AM, Staff L, NA, stated the unlocked storage room was previously used as an oxygen storage room and was changed to a Personal Protective Equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) room. Staff L stated they were not provided education on the room changes. During an interview on 09/26/2024 at 8:46 AM, Staff Y, Registered Nurse, stated the unlocked storage room used to be the oxygen room and did not know when that changed. Staff Y stated the storage room was now being used as a storage for PPE and oxygen tanks should not be stored there. Staff Y did not recall being provided education on the room changes. During an interview on 09/26/2024 at 3:31 PM, Staff A stated the unlocked storage room had been an oxygen storage room and was previously moved the week prior. Staff A stated they had provided education to staff of the room changes but apparently needed to provide more. WAC Reference: 388-97-1060 (3)(g)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services related to enteral feedings [(EF) the delivery of nutrients through a tube directly into the stomach to provide nutrition for those who cannot obtain nutrition by mouth, were unable to safely swallow, or need nutritional supplementation] for 1 of 1 resident (Resident 214) reviewed for EF. This failed practice placed the resident at risk for receiving expired and/or inaccurate enteral nutrition, adverse consequences, and complications of tube feeding. Findings included . Review of a policy titled, Enteral Feeding Tubes, dated [DATE], showed the Registered Dietician (RD) calculated the nutritional value of the EF and made recommendations as needed. Upon admission or initiation, the licensed nurse (LN) obtained a physician's order for the recommended EF formula. Additionally, when the EF bag and tubing was hung, the LN labeled the enteral feeding container/bag with the resident's name, date, time, and initials (of the LN). The EF bag and supplies were to be changed every 24 hours to prevent excessive microbial growth. Review of nursing professional standards guidance from Lippincott Nursing Procedures 8th Edition titled, Tube Feedings, dated 2019, showed the enteral formula container was labeled with the patient's identifiers; formula name (and strength if diluted); date and time the formula was hung; administration route; rate of administration; administration duration; initials of who prepared, hung, and checked the enteral formula against the order; expiration date and time; and notation enteral use only. Label the enteral administration set with the date and time that it was first hung. The administration set and tubing could be used continuously for a maximum of 24 hours. <Resident 214> Review of the medical record showed Resident 214 was admitted to the facility with diagnoses including presence of a gastrostomy (an artificial opening in the stomach), aftercare for surgery on the digestive system, and severe protein-calorie nutrition (a lack of available nutrients in the body that leads to changes in body composition and function). The [DATE] comprehensive assessment showed Resident 214 required substantial/maximum assistance of one staff member for activities of daily living. The assessment also showed Resident 214 had a moderately impaired cognition. An observation on [DATE] at 10:14 AM, showed Resident 214 was reclining in their bed. There was an EF pump on a pole next to their bed. There was a container of Jevity 1.2 EF (a high-protein, fiber-fortified formula that provides complete, balanced nutrition of enteral feeding) hanging on the pole. The EF pump was not running and there was residual EF in the tubing. There was no label on the container or tubing that showed the date, time, and initials of the LN that hung the EF. There was an empty container of Jevity 1.2 formula on the bedside table. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on [DATE] at 8:45 AM, showed Resident 214 in bed, a clear bag labeled Kangaroo (a brand of bag used for EF) was hanging on the pole next to the bed. The tubing from the bag was fed through the EF pump and there was residual EF visible in the tubing. The pump was not running, and the bag was empty. The bag label showed a date and time. There was no labeling showing what was in the Kangaroo bag or initials of the LN that hung the bag. An observation on [DATE] at 7:55 AM, showed Resident 214 reclined in bed watching television. There was a Kangaroo bag hanging on the pole next to the bed that was empty, dated and timed. There was residual EF in the tubing. There was no documentation on the bag to identify what EF had been delivered. Review of a physician's order dated [DATE], showed Resident 214 was prescribed Vital AF 1.2 formula (an EF formula for residents that require tube feeding and experience absorption and digestion problems, or have impaired gastrointestinal function) for severe protein-calorie malnutrition. Additional orders dated [DATE], showed Enteral feed, every 24 hours, change gravity bag every 24 hours, label with date/time/resident name. During an interview on [DATE] at 8:59 AM, Staff J, Registered Dietician, stated they were not aware that Resident 214 had not received the prescribed Vital AF 1.2 formula. They stated they were not aware that the facility had substituted the Jevity 1.2 formula (a lower protein dense formula than Vital AF 1.2) since the facility had the Vital AF 1.2 in stock. They stated Resident 214 should have been receiving what was ordered. During an interview on [DATE] at 10:50 AM, Staff A, Administrator, stated they expected the licensed nurses to follow the physician's orders for the EF. If the EF was unavailable, the process would be to call the physician for a substitution. Staff A stated they expected the nursing staff to follow professional standards of practice and label the EF bags appropriately. Reference: WAC [DATE](3)(f)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 48368 Based on observation, interview, and record review, the facility failed to ensure that a resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice for 1 of 5 residents (Resident 34) reviewed for trauma informed care. The facility failed to identify triggers (a stimulus that causes a reaction, often an emotional or physical response) regarding Resident 34's history of Post-Traumatic Stress Disorder (PTSD, a mental health condition that is triggered by a terrifying event). This failure placed the resident at risk for unidentified triggers and re-traumatization. Findings included . Record review of the facility policy titled Trauma-Informed Care, dated 08/01/2024, showed .The facility will recognize how trauma effects individuals through evaluation and identification of triggers during the admissions process. The facility will develop an appropriate plan of care and interventions based upon the residents' triggers and will modify the plan of care for any changes in behavior . <Resident 34> Review of Resident 34's medical record showed the resident admitted to the facility with diagnoses to include PTSD, anxiety (a feeling of fear, dread, or uneasiness) and depression (a prolonged feeling of sadness, hopelessness, or loss of interest in activities). The 08/21/2024 comprehensive assessment showed Resident 34 required the assistance of one staff member for activities of daily living and had an intact cognition. During an interview 09/23/2024 at 3:25 PM, Resident 34 stated they had PTSD stemming from being in the war and they had a father who was not a nice man, he was abusive. Resident 34 stated their triggers included, watching the news, loud noises, and they had a problem with men. During a follow up interview on 09/26/2024 at 2:54 PM, Resident 34 stated they got agitated, tearful, and anxious when they experienced these triggers. Record review of Resident 34's care plan, dated 08/22/2024, showed no trauma informed based plan of care that included Resident 34's triggers, behaviors, or interventions. During an interview on 09/25/2024 at 10:48 AM, Staff I, Social Service Director (SSD), along with Staff O, SSD, stated Resident 34's triggers should have been assessed and placed in the plan of care. Staff O stated Resident 34 did not have a trauma assessment completed that showed the details of their PTSD or their triggers. Staff O further stated they needed a better system in place to care for residents. During an interview on 09/27/2024 at 7:58 AM, Staff B, Director of Nursing Services, stated that trauma-based triggers and interventions were to be in the resident's plan of care so the staff knew how to care for the residents. WAC Reference: 388-97-1060 (3)(e)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Vista Post-Acute & Rehab Center	625 Okanogan Ave Wenatchee, WA 98801

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44922 Based on observation, interview, and record review, the facility failed to maintain safe food holding temperatures for 1 of 2 meal preparations (lunch meal on 9/26/2024) reviewed for safe and sanitary kitchen. This failed practice placed all residents at risk for Food borne illness (caused by consuming foods that are contaminated with harmful pathogens [bacteria that reproduce rapidly once entered in the body and can damage tissues and cause illness]). Findings included . Review of a policy titled Food Preparation and Service dated 11/2022, showed the danger zone for food holding temperatures is below 135 Farenheit (F, a unit of temperature measurement) and the longer food sits below 135 F the higher the risk for the growth of harmful pathogens. A lunch meal preparation observation and concurrent interview on 09/26/2024 at 10:55 AM, showed the prepared food had been stored in the steam table at 11:05 AM for a serve out time of 11:45 AM. The temperatures of the food were as follows; Baked Chicken was at 119 F, ground chicken 134 F, brown gravy 132 F, carrots 127 F. Further temperature checks of the pureed (a texture of food that is soft and pudding like) foods were as follows; green beans 125 F, rice 120 F, and chicken 125 F. Staff Z, Cook, stated the food had been placed in the warmer for about 20 minutes but the pureed and bite sized food was placed about 45 minutes prior to testing the temperatures. Staff Z stated they only checked the food temperatures upon removing them from the oven to ensure the correct cooking temperatures had been reached but did not check the temperatures of the food prior to serve out after they had been sitting in the steam table. During an interview on 09/26/2024 at 11:17 AM, Staff AA, Food Service Manager, stated the food temperatures should have been checked prior to serve out to ensure proper temperatures. Staff AA stated the prepared food should not be put in the steam tables until 20-30 minutes before serving the food out. Staff AA stated Staff Z did not follow the correct process for holding foods and rechecking temperatures of foods to maintain safe temperatures. WAC Reference: 388-97-1100 (2)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44922 Based on observation, interview, and record review, the facility failed to discard expired foods in 1 of 1 dry storage and 1 of 1 walk in refrigerator reviewed for safe and sanitary kitchen. This failed practice placed all residents at risk for Food borne illness (caused by consuming foods that are contaminated with harmful pathogens [bacteria that reproduce rapidly once entered in the body and can damage tissues and cause illness]). Findings included . During the general tour of the kitchen on [DATE] at 10:31 AM, showed expired foods in the dry storage room of the kitchen as follows; 1) three 46-ounce (oz, a unit of measure) containers of orange juice concentrate that expired on [DATE], 2) four 46 oz containers of thickened cranberry cocktail that expired on [DATE], 3) two packages of six-inch (in, a unit of measure) flour tortillas (24 tortillas to a bag) that expired on [DATE] and four packages that expired on [DATE], 4) four packages of eight-in flour tortillas (12 tortillas per package) that expired on [DATE], 5) two packages of 12-in flour tortillas (12 tortillas per package) that expired on [DATE], 6) two packages of yellow corn tortillas (five pound packages) that expired on [DATE], 7) a one gallon (a unit of measure) of Worcestershire (a sauce used for food flavoring) sauce that expired on [DATE], and 8) 20 boxes of 16 oz baking soda (a white powdery substance used in cooking and cleaning) that expired on [DATE]. Additionally, in the walk-in refrigerator, was a box of more than 25 oranges that had a use by date of [DATE]. During an interview on [DATE] at 11:04 AM, Staff BB, Cook, stated it was the responsibility of the dietary staff to ensure foods were monitored and discarded when expired. During an interview on [DATE] at 10:25 AM. Staff AA, Food Service Manager, stated we are all responsible for monitoring the food and the discarding of expired foods. Staff AA stated when we got an order and put it away, the other foods should have been checked for expiration dates, and apparently we have not been doing that. WAC Reference: [DATE] (3)

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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** 45117 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control measures were implemented for hand hygiene/handling medications during medication administration for 1 of 5 staff (Staff M), and use of personal protective equipment when entering a contact precautions (safety measures used by healthcare workers to prevent the spread of infectious agents that can be transmitted through direct or indirect contact) room for 1 of 3 resident rooms (room [ROOM NUMBER]) reviewed for infection control. These failures placed residents, staff, and visitors at risk for exposure to cross contamination of infectious disease. Findings included . Review of a policy titled, Hand Hygiene, dated 08/01/2024, showed hand hygiene was the primary means of preventing the transmission of infection and should be performed as soon as possible after contamination such as before/after direct contact with a resident. Review of a policy titled, Transmission Based Precautions (a set of infection control measures used when a resident may be infected with a certain infectious agent), dated 08/01/2024, showed contact was the most common and most significant mode of transmission of infection and occurred by directly touching the resident and/or their environment. Staff that had contact with the resident should wear gloves and a gown. <Medication Administration> During an observation on 09/25/2024 at 8:21 AM, Staff M, Registered Nurse (RN), was standing at their medication cart. Staff M removed a card of pills from the medication cart and pushed the pill through the foil backed card. The pill fell on to the medication cart. Staff M picked up the pill with their bare hand and placed the pill into a medication cup. Staff M removed a bottle of vitamins from the top drawer of the medication cart, poured three tablets into their bare hand, and placed the tablets into the same medication cup. Staff M added five additional medications to the medication cup, put on gloves, and took the medications, in the cup, into a resident room. Staff M placed the medication cup on the resident's breakfast tray on the over the bed table and assisted the resident to a seated position at the side of the bed. Staff M handed the medication cup to the resident, rearranged a cup and food items on the resident's breakfast tray, handed the resident their water cup, and watched the resident take their medications. Staff M removed their gloves, picked up the empty medication cup, and exited the resident's room. Staff M went to their medication cart, threw away their gloves and medication cup and proceeded to prepare medications for the next resident without performing hand hygiene . During an interview on 09/25/2024 at 2:22 PM, Staff P, Infection Preventionist, stated the expectation was for all staff to use alcohol-based hand rub, at the minimum for, hand hygiene, before and after entering a resident room, between glove changes, before and after administering medications, and before moving on to the next resident when administering medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/27/2024 at 9:57 AM, Staff B, Director of Nursing Services, stated when preparing medications, there should always be a barrier between the medication and the nurse's hands. Staff B further stated the staff needed to perform hand hygiene between each resident when administering medications. During an interview on 09/27/2024 at 10:35 AM, Staff A, Administrator, stated Staff M was an agency nurse. Staff A stated they had high expectations for the agency staff and would have expected them to be trained in hand hygiene practices. <Contact Precautions> An observation on 09/24/2024 at 8:55 AM, showed Staff N, Nursing Assistant (NA), enter resident room [ROOM NUMBER] that had a Contact Precautions sign posted on the door. The sign instructed providers and staff to put on gloves and a gown before entering the room and discard gloves and gown prior to leaving the room. Staff N entered resident room [ROOM NUMBER] and picked up a plate cover that was on the foot of the resident's bed and put it on their meal tray. They picked up the meal tray that was on the over the bed table and exited the room. Staff N did not have on a gown or gloves. During an interview on 09/24/2024 at 12:48 PM, Staff N stated they did not need to wear a gown or gloves in the contact precautions room unless they were going to provide hands on care for the resident in room [ROOM NUMBER]. They stated they were told that was the process by both the charge nurse and the infection preventionist. During a concurrent observation and interview on 09/27/2024 at 8:42 AM, showed Staff O, Social Services Director, enter resident room [ROOM NUMBER] without wearing a gown or gloves. Staff O shut the door and met with the resident in their room. At 8:48 AM, Staff O opened the door to resident room [ROOM NUMBER], exited the room, and proceeded to walk down the hall. At 8:49 AM, Staff O stated they did not need to wear a gown or gloves if they were not doing cares on the resident in room [ROOM NUMBER]. Staff O then read the contact precautions sign and stated the sign showed they should have been wearing a gown and gloves, they made a mistake, and they would talk to the infection preventionist about what personal protective equipment was needed in the contact precautions room. During an interview on 09/27/2024 at 10:44 AM, Staff A stated they expected all staff to follow precautions that were posted on resident rooms. Reference: WAC 388-97-1320(1)(c)(2)(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48368 Based on observation and interview the facility failed to provide a safe and functional environment for residents, staff, and visitors related to the handicap push plate (a button that allows people with disabilities to access an area by the push of a button) being out of service on 1 of 2 doors (main entrance). This failure placed residents, staff, and visitors at risk for accidents and a disrupted environment. Findings included . During an interview on 09/23/2024 at 11:20 AM, Resident 3 stated that the front door handicap push plate opener was not working and had not been for a very long time. Resident 3 stated they had to ask staff to take them outside and they had to ring a bell to get back inside. Resident 3 stated it took a while for someone to come and take them outside when requested and then they had to wait a long time for someone to come and let them back inside. Resident 3 further stated they would like to be able to go out of the facility and come back in when they wanted to as it was their right to do so. During an interview on 09/24/2024 at 3:21 PM, Staff Q, Maintenance Director, stated the handicap push plate on the front entrance door had been out of service maybe since July of last year (July 2023). Staff Q stated they multiple bids to fix the door and had been denied from the corporation related to expense. Staff Q further stated they had expressed to the Administrator, the importance of getting the door fixed for emergency services and for the resident's to be able to safely get in and out of the facility. During an interview on 09/26/2024 at 1:41 PM, Staff A, Administrator, stated the front door handicap push plate had been out of service for about eight months. Staff A stated they had given the corporation quotes and had been denied related to cost. Staff A further stated the residents should be able to leave and re-enter the facility when they wanted without having to wait for staff to assist them. Reference WAC 388-97-3220 (1)