STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505416	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foss Home & Village	13023 Greenwood Avenue North Seattle, WA 98133

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to provide care and services in a manner that maintained and promoted dignity while entering a resident's room for 1 of 6 residents (Resident 34), use of urinary catheter (a flexible tube inserted into the bladder to drain urine) drainage bag for 2 of 3 residents (Residents 110 & 17), use of a mechanical lift sling for 1 of 1 resident (Resident 99), and meal assistance for 3 of 5 residents (Residents 99, 46 & 16) reviewed for dignity. These failures placed the residents at risk for a diminished self-worth and over-all well-being. Findings included . Review of the facility's undated policy titled, Promoting/Maintaining Resident Dignity, showed it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, which maintains or enhances resident's quality of life by recognizing each resident's individuality. The policy further showed that they will maintain resident privacy. Review of the facility's undated policy titled, Catheter Care/Bags, showed, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. It further showed that all catheter bags will be covered with a catheter bag cover to maintain resident privacy. KNOCKING ON RESIDENT DOOR PRIOR TO ENTERING RESIDENT 34 Resident 34 admitted to the facility on [DATE]. Observations on 04/25/2024 at 8:02 AM and at 8:04 AM, showed Staff O, Certified Nursing Assistant (CNA), entered Resident 34's room without knocking or identifying themselves to the resident prior to entering. On 04/25/2024 at 8:15 AM, Staff O stated before they entered a resident's room, they would knock, ask permission to enter and identify themselves. Staff O stated that they should have knocked, identified themself, and asked for permission prior to going inside Resident 34's room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/2024 at 2:05 PM, Staff H, Registered Nurse (RN), stated prior to entering resident rooms, staff should knock, introduce themselves and let the resident know why they were there for. Staff H stated that Staff O should have knocked and introduced themselves prior to entering Resident 34's room. On 04/29/2024 at 1:10 PM, Staff B, Director of Nursing Services, stated they expected staff to knock on the resident's door, observe for any precautions, introduce themselves, let the residents know why they were there for and perform hand hygiene. Staff B further stated that Staff O should have knocked and introduced themselves prior to entering Resident 34's room. USE OF URINARY DRAINAGE BAG RESIDENT 110 Resident 110 admitted to the facility on [DATE] with diagnoses that included obstructive and reflex uropathy (a condition in which the flow of urine is blocked and causes the urine to flow backwards). Review of the admission Minimum Data Set (MDS-an assessment tool) dated 02/13/2024, showed Resident 110 had an indwelling foley catheter. Observations on 04/22/2024 at 2:25 PM, on 04/23/2024 at 9:11 AM, on 04/24/2024 at 8:20 AM, and on 04/25/2024 at 8:01 AM, showed Resident 110's catheter bag was covered with a blue covering with the bottom of the catheter bag exposed and visible from the hallway. During a joint observation and interview on 04/25/2024 at 9:03 AM with Staff J, CNA, showed Resident 110's catheter bag was exposed and was touching the ground. Staff J stated that the blue covering was what they had, and that the bottom of the catheter bag was not covered. Staff J further stated that they were aware that the catheter bag was not completely covered for privacy. On 04/25/2024 at 9:13 AM, Staff H stated that they were aware that the bottom of the catheter privacy bag was opened and that it did not provide the best privacy. Staff H stated that the catheter bag covers are not the best and that the catheter privacy bag should have been completely covered for privacy. On 04/29/2024 at 1:18 PM, Staff B stated that Resident 110's catheter bag should have been covered for privacy. 43392 RESIDENT 17 Resident 17 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of bladder (lack of bladder control due to a nerve problem in the brain or spinal cord) and had an indwelling urinary catheter. Observation on 04/24/2024 at 8:27 AM, showed Resident 17's urinary catheter drainage bag with amber colored urine, and it was visible to Resident 17's roommate and from the hallway. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation and interview on 04/24/2024 at 8:35 AM with Staff Q, RN, showed Resident 17's urinary catheter bag was not covered with a privacy bag and was visible to Resident 17's roommate and from the hallway. Staff Q stated the urinary catheter bag should have been covered with a privacy bag. On 04/30/2024 at 10:21 AM, Staff B stated they expected Resident 17's urinary catheter bag to have been covered with a privacy bag. 45146 MECHANICAL LIFT SLING RESIDENT 99 Resident 99 admitted to the facility on [DATE]. Review of the quarterly MDS dated [DATE], showed that Resident 99 had severely impaired cognition, dependent on the staff with meal intake and with transfer to/from a bed to a wheelchair. Observation on 04/25/2024 at 12:49 PM and on 04/26/2024 at 11:14 AM, showed Resident 99 was sitting up in their wheelchair at the second-floor nursing station located by their room. Further observation showed Resident 99 was sitting on purple colored mechanical lift sling left underneath the resident. On 04/26/2024 at 1:26 PM, Staff O, CNA, and Staff EEE, CNA, stated that they never removed Resident 99's mechanical lift sling after the resident was transferred to their wheelchair because it was hard to put it back on when they transferred the resident from their wheelchair to their bed. On 04/29/2024 at 1:09 PM, Staff GGG, RN, stated that Resident 99's mechanical lift sling should be removed after the resident transferred to their wheelchair. On 04/30/2024 at 9:44 AM, Staff B stated that mechanical lift sling should be removed after Resident 99 was transferred to their wheelchair and the staff should have not left the mechanical lift sling underneath the resident. MEAL ASSISTANCE RESIDENT 99 Observation on 04/26/2024 at 7:50 AM, showed Staff JJJ, CNA, was assisting Resident 99 with their breakfast while standing over the resident in the 700-unit dining room. On 04/26/2024 at 7:54 AM, Staff JJJ stated they were assisting while standing over Resident 99 because the resident was tall. On 04/30/2024 at 9:00 AM, Staff PP, Resident Care Manager, stated that staff should have been seated while assisting residents with meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2024 at 9:32 AM, Staff B stated that they expected staff to sit down while assisting resident with meals. 48899 RESIDENT 46 Resident 46 admitted to the facility on [DATE]. Review of the activities of daily living self-care needs care plan revised on 09/09/2020 showed that Resident 46 required set up assistance by one staff to eat and may need cueing or one person extensive assistance to start eating. Observation on 04/30/2024 at 8:50 AM, showed Staff P, CNA, was standing while assisting Resident 46 with their breakfast in their room. Staff P stood the entire time they assisted Resident 46 with their breakfast. On 04/30/2024 at 8:58 AM, Staff P stated that the facility trained them to be eye level with the residents but were not trained to sit down when assisting resident with meals. Staff P stated that it was their choice if they wanted to sit or stand. Staff P further stated that they usually sit down and that they decided to stand up while assisting Resident 46 with their breakfast. On 04/30/2024 at 9:04 AM, Staff H stated that staff should be sitting when they were assisting residents with their meal and that Staff P should have been sitting when assisting Resident 46 with their meal. On 04/30/2024 at 9:10 AM, Staff B stated that they expected staff to be sitting at eye level when assisting residents with their meal. RESIDENT 16 Resident 16 admitted to the facility on [DATE] with diagnoses that included blindness on both eyes. Review of the annual MDS dated [DATE], showed Resident 16 had moderately impaired cognition and required substantial/maximal (the helper does more than half the effort) assistance with eating. Observation on 04/26/2024 at 8:21 AM, showed Resident 16 was eating breakfast and Staff V, CNA, was standing while assisting Resident 16 with their breakfast meal. On 04/26/2024 at 8:33 AM, Staff V stated that they only need to be seated when assisting residents in the dining room. Staff V stated that when they were in the resident's room, I prefer to raise the bed and assist them [with eating] standing. Staff V further stated, personally, that is what I like, I do not use chair because I chose standing. On 04/29/2024 at 11:43 AM, Staff B stated when staff assist residents with their meals in the dining and resident rooms, they should be seated next to them. Staff B further stated that they would not expect staff to assist residents with their meals while standing. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2024 at 8:23 AM, Staff A, Administrator, stated staff should be seated with residents when they assist residents with eating. Reference: (WAC) 388-97-0180(1)(2)(3)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to inform residents and/or their representatives of risks and benefits before placement of bed against the wall for 2 of 2 residents (Residents 73 & 74), use of tilt in space (a type of wheelchair that can lower the seated person's head and raises their feet at the same time) wheelchair for 1 of 1 resident (Resident 74), installation of a transfer pole for 1 of 2 residents (Resident 5), and prior to starting psychotropic (mind-altering) medications for 1 of 5 residents (Resident 99), reviewed for resident rights. These failures placed the residents at risk for not being fully informed before making decisions regarding their health care, alternative treatment options, and the right to refuse care. Findings included . Review of the undated facility's policy titled, Safety Devices/Restraints, showed bed against the wall, tilt in space wheelchair, and transfer poles were safety devices. The policy showed the facility shall explain to the resident/resident's representative, the potential risks, and benefits of using the device, not using a device, and alternatives to use. The policy further showed a consent should be obtained from the resident/resident's representative prior to initiating a device, and that potential negative outcomes should also be explained. BED AGAINST THE WALL RESIDENT 73 Resident 73 admitted to the facility on [DATE]. Multiple observations on 04/22/2024 at 10:01AM, on 04/23/2024 at 8:06 AM and at 12:58PM, on 04/24/2024 at 8:39 AM, and on 04/26/2024 at 8:37 AM, showed Resident 73 had their bed against the wall. On 04/24/2024 at 8:39 AM, Resident 73 stated they liked their bed against the wall. Review of Resident 73's electronic clinical records did not show a consent and/or risks and benefits document for their bed against the wall. On 04/26/2024 at 12:34 PM, Staff XX, Certified Nursing Assistant (CNA), stated that Resident 73 liked their bed by the wall. During an interview and joint record review on 04/26/2024 at 12:38 PM with Staff Q, Registered Nurse (RN), stated that Resident 73's bed had always been against the wall. Staff Q further stated that prior to placing a bed against the wall an assessment and consent were required from the residents and/or residents' representative. Joint record review of Resident 73's electronic clinical records with Staff Q did not show an assessment and/or consent for their bed against the wall. Staff Q stated they did not see a consent for Resident 73's bed against the wall. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and joint record review on 04/29/2024 at 3:37 PM with Staff B, Director of Nursing Services, stated they expected residents to have an assessment and a consent with explanation of risk and benefits be completed prior to placing a resident's bed against the wall. Joint record review of Resident 73's electronic clinical records did not show a consent for bed against the wall. Staff B stated there should have been a consent done prior to placing Resident 73's bed against the wall. 46912 RESIDENT 74 Resident 74 admitted to the facility on [DATE]. Observations on 04/22/2024 at 10:44 AM and on 04/23/2024 at 9:32 AM, showed Resident 74's bed was placed against the wall. On 04/25/2024 at 2:33 PM, Resident 74 stated, no one asked if I care if my bed is against the wall and that no one asked them to sign anything. On 04/29/2024 at 1:42 PM, Staff W, Licensed Practical Nurse, stated they expected that prior to having a bed against the wall there should be an assessment done and risks and benefits provided to residents. During an interview and joint record review on 04/29/2024 at 2:07 PM, Staff B stated that before a resident had a bed against the wall there should be an assessment done by nursing, a physician order, and a consent that provided risks and benefits. Joint record review of Resident 74's electronic clinical record with Staff B showed no consent signed by Resident 74 and/or their representative. Staff B stated there was no consent signed by Resident 74 and/or their representative. USE OF TILT-IN-SPACE WHEELCHAIR RESIDENT 120 Resident 120 admitted to the facility on [DATE]. Observations on 04/22/2024 at 11:13 AM and on 04/26/2024 at 1:27 PM, showed Resident 120 was sitting in their tilt-in-space wheelchair. On 04/29/2024 at 1:42 PM, Staff W stated that before a resident used a tilt-in-space wheelchair, there needed to be consent from the resident and/or their representative. During an interview and joint record review on 04/29/2024 at 2:07 PM, Staff B stated that before a resident had a tilt-in-space wheelchair there should be an assessment done by nursing, a physician order, and a consent that provided risks and benefits. Joint record review of Resident 120's electronic clinical record had no documentation that Resident 120 was given the risks and benefits of using a tilt-in-space wheelchair. Staff B stated there was no documentation to show Resident 120 was given risks and benefits of using a tilt-in-space wheelchair. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43392 USE OF TRANSFER POLE RESIDENT 5 Review of the facility updated policy titled, Mobility Devices, revised in March 2021, showed, To allow residents to maintain or improve bed mobility or transfer ability using a halo device (a type of bed rail shaped like a ring) or transfer pole as an enabler, Nursing must assure that all devices used for mobility are care planned and consent obtained. Resident 5 was admitted to the facility on [DATE] with multiple diagnoses including a stroke (restriction of blood flow or sudden burst of blood vessel in the brain) with left-sided hemiparesis (weakness or inability to move the left side of the body). Review of the annual Minimum Data Set Assessment (MDS-an assessment tool), dated 02/12/2024, showed Resident 5 was moderately impaired and required staff assistance with transfer to/from their bed to wheelchair. Observation and interview on 04/22/2024 at 10:14 AM, showed Resident 5 had a transfer pole next to the left side of their bed. The pole ran from the floor and was secured to the ceiling wall. Resident 5 stated they used the transfer pole every day to transfer in and out of bed from his wheelchair. Observation on 04/22/2024 at 10:22 AM, showed Resident 5 was transferring themself from wheelchair to the bed using the transfer pole. Observation on 04/26/2024 at 12:04 PM, showed Resident 5 was transferring from their wheelchair to bed using the transfer pole with the assistance of Staff AA, CNA. During an interview and joint record review on 04/26/2024 at 10:56 AM with Staff Q, stated Resident 5 used their transfer pole every day to get in and out of bed. Joint record review of Resident 5's electronic clinical records did not show a consent for the use of a transfer pole. Staff Q stated there should have been a signed consent for Resident 5 for the use of a transfer pole device. On 04/30/2024 at 10:21 AM, Staff B stated they expected residents using a transfer pole to have a signed consent. 45146 USE PSYCHOACTIVE MEDICATION RESIDENT 99 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Informed Consent for psychoactive [a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior] Drugs revised in April 2017, showed that when the physician has ordered the use of Anti-Depressant drug (a type of medicine used to treat depression), the center per Federal and State Regulations and Center policy obtain informed consent from the resident or responsible party (when resident is not competent). An informed consent is obtained before drug prescribed is administered. The center's staff will place the signed Psychoactive Drugs Disclosure and Consent in the medical record under the Consent tab. Resident 99 admitted to the facility on [DATE]. Review of the quarterly MDS dated [DATE], showed that Resident 99 had severely impaired cognition. Review of the February 2024, March 2024, and April 2024 Medication Administration Record showed Resident 99 was taking sertraline (an antidepressant drug) 25 milligram once a day with an order start date of 09/21/2023. Review of Resident 99's informed consent for psychoactive medication showed that verbal consent was received for sertraline from Resident 99's representative on 09/21/2023. Further record review of Resident 99's medical record did not show a signed consent for sertraline use. On 04/29/2024 at 1:43 PM, during an interview and joint record review with Staff PP, Resident Care Manager, stated that after a verbal consent for a psychoactive drug was received, a signed consent should be obtained as soon as possible. Joint record review of Resident 99's consent document showed no signed consent for sertraline. Staff PP stated signed consent should have been obtained for sertraline. On 04/30/2024 at 11:21 AM, Staff B stated they would expect a signed consent should be obtained prior to psychoactive drug administration. Reference: (WAC) 388-97-0260 (2)(a-d)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure call light (an alerting device for staff to assist residents in need) was within reach for 1 of 2 residents (Resident 115), reviewed for accommodation of needs. This failure placed the resident at risk for delayed care, accidents/falls, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Call Lights: Accessibility and Timely Response, showed that Staff will ensure the call light is within reach of resident and secured, as needed and The call system will be accessible to residents while in their bed. Resident 115 admitted to the facility on [DATE] with diagnoses that included hemiplegia (unable to move one side of the body) affecting their left side. Review of the falls care plan revised on 03/12/2024, showed the resident [Resident 115] needs a safe environment .a working and reachable call light. Observations on 04/22/2024 at 8:46 AM and on 04/22/2024 at 11:37 AM, showed Resident 115's call light was hung up on the wall and not within reach. Additional observations on 04/23/2024 at 9:16 AM and on 04/23/2024 at 11:26 AM, showed Resident 115's call light was hung up on the wall and not within reach. In an interview and joint observation on 04/23/2024 at 11:28 AM with Staff AAA, Certified Nursing Assistant, stated they would expect Resident 115's call light to be within reach on their strong side. Joint observation showed the call light was hung up on the wall. Staff AAA stated the call light should not be there but should be within reach. On 04/23/2024 at 11:37 AM, Staff W, Licensed Practical Nurse, stated that the call light should be within reach of residents and that staff should be checking frequently. Staff W stated they would not expect Resident 115's call light to be hung up on the wall and that it must have been forgotten. On 04/30/2024 at 2:14 PM, Staff B, Director of Nursing Services, stated they expected staff to be checking call light placement every time they go in a room and leave the room. Staff B further stated they expected the call lights to be within residents' reach and not be hung up on the wall. Reference: (WAC) 388-97-0860 (2)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. 48899 Based on interview and record review, the facility failed to periodically review resident rights with residents during their stay at the facility for 16 of 16 residents (Residents 91, 6, 7, 10, 16, 20, 39, 42, 61, 63, 64, 78, 80, 100, 122 & 379) reviewed for resident rights. This failure placed the residents at risk of not understanding their rights and a reduced ability to self-advocate. Findings included . Review of the February 2023 to April 2024 Resident Council minutes did not show that the resident rights were being reviewed during Resident Council meetings. During an interview on 04/26/2024 at 10:15 AM with Residents 91, stated the facility staff did not review resident rights with them. Residents 6, 7, 10, 16, 20, 39, 42, 61, 63, 64, 78, 80, 100, 122 and 379 stated they agree with Resident 91. On 04/29/2024 at 10:16 AM, Staff DD, Social Worker, stated they did not review resident rights during resident council meetings. Staff DD stated they used to review it in the past but could not recall the last time they reviewed residents' rights during resident council meeting. On 04/30/2024 at 8:23 AM, Staff A, Administrator, stated, I think they should review them yearly. Staff A stated that residents rights used to be one of the agenda in the residents' council meetings in the past. Staff A further stated they should have reviewed it periodically. Reference: (WAC) 388-97-0300 (1)(a)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 48899 Based on observation, interview, and record review, the facility failed to provide the website address of the Washington State Long-Term Care Ombudsman (an advocacy group for residents in a nursing home) on the posted contact information in 7 of 7 facility areas (notice boards in units 100, 300, 400, 500, 600, 700, and inside of one elevator), reviewed for residents' rights. This failure placed the residents at risk for not being able to report their concerns online to the State Long-Term Care Ombudsman. Findings included . Observations on 04/26/2024 at 9:54 AM, at 11:59 AM, at 12:04 PM, at 12:10 PM, at 12:25 PM, and at 12:29 PM, showed that the posted State Long-Term Care Ombudsman information did not include the website address. During a joint observation and interview on 04/29/2024 at 9:03 AM with Staff A, Administrator, showed the posted State Long-Term Care Ombudsman information in the seven facility areas did not have a website address on it. Staff A stated they did not recall the last time they updated the contact information. Staff A further stated that the contact information should have been updated at least annually. Reference: (WAC) 388-97-0300 (7)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505416	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foss Home & Village	13023 Greenwood Avenue North Seattle, WA 98133

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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** 46912 Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or durable power of attorney for health care) was obtained from the resident and/or their representative and ensure a copy was readily available in the medical records for 1 of 3 residents (Resident 120), reviewed for advance directives. This failure placed the resident and/or their representative at risk for losing their right to have their preferences honored to receive care according to their choice. Findings included . Review of the facility's undated policy titled, Residents' Rights Regarding Treatment and Advance Directives, showed, On admission, the facility will determine if the resident has executed an advance directive and should the resident have an advance directive, copies will be made and placed on the chart. Resident 120 admitted to the facility on [DATE]. Review of Resident 120's clinical record did now show documentation that a copy of their advance directive was obtained. On 04/24/2024 at 9:46 AM, Resident 120's representative stated that Resident 120 had an advance directive and stated that I don't remember if they [the facility] asked for a copy of it or not. On 04/25/2024 at 1:17 PM, Staff BBB, Admission Coordinator, stated that if a resident had an advance directive, they would request a copy of it and there should be a copy in the resident's medical record. Staff BBB reviewed Resident 120's clinical record and stated they did not see that there was a copy of an advance directive for Resident 120 in their medical records. Staff BBB further stated, If she [Resident 120's representative] said there is one [advance directive], we should request for it. On 04/30/2024 at 2:40 PM, Staff A, Administrator, stated, Admissions [Admission Coordinator] is supposed to obtain one [advance directive] if a resident has one. Staff A stated that if a resident had an advance directive, they would expect there to be a copy of it in the residents' medical records. Reference: (WAC) 388-97-0280 (3)(a)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure privacy and confidential information were maintained regarding residents' weights for 9 of 9 rooms (Rooms 306B, 308A, 312B, 305B, 203, 205, 302B, 303A & 307B), and failed to ensure residents' medical records and representatives' information were maintained for 4 of 5 residents (Residents 67, 17, 16 & 100), reviewed for privacy. These failures placed the residents at risk for having their medical and personal information not kept confidential and a diminished quality of life. Findings included . Review of the facility's undated policy, Promoting/Maintaining Resident Dignity, showed that it was their policy to Maintain resident privacy. RESIDENT WEIGHTS Observation on 04/29/2024 at 8:21 AM, showed a piece of paper posted outside the shower room on the 300 unit dated 4/29 [04/29/2024]. The paper showed the following list of room numbers with residents' weights: - room [ROOM NUMBER]B 125 lbs. (pounds-a measurement of weight) - room [ROOM NUMBER]A 204 lbs. - room [ROOM NUMBER]B 123 lbs. with wheelchair and footrest - room [ROOM NUMBER]B 138 lbs. Observation on 04/30/2024 at 8:50 AM, showed a piece of paper posted outside the shower room on the 300 unit dated, 4/30/24 [04/30/2024]. The paper showed the following list of room numbers with residents' weights: - room [ROOM NUMBER] 148 lbs. - room [ROOM NUMBER] 166 lbs. - room [ROOM NUMBER]B 162 lbs. - room [ROOM NUMBER]A 175-50 =125 lbs. wheelchair with footrest and armrest - room [ROOM NUMBER]B 240 lbs. On 04/30/2024 at 9:05 AM, Staff ZZ, Certified Nursing Assistant (CNA)/Shower Aide, stated that resident weights were private information and shouldn't be on there [on the paper outside the shower room] and maybe put inside the shower room. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2024 at 9:11 AM, Staff YY, Resident Care Manager, stated that resident weights were considered private information and should not have been posted in the hallway. On 04/30/2024 at 2:26 PM, Staff B, Director of Nursing Services, stated that resident weights were private information and that they would not expect that information to be posted in the hallway. 43392 UNATTENDED COMPUTER SCREEN Resident 67 Observation of the Unit 400 Central Medication Cart on 04/24/2024 at 9:01 AM, showed a computer screen was left open showing Resident 67's Medical Administration Record (MAR) with no staff around. During a joint observation and interview on 04/24/2024 at 9:04 AM with Staff Z, Registered Nurse (RN), showed the computer screen was left open with no staff around and Resident 67's MAR was visible to anyone in the hallway. Staff Z stated they forgot to lock the computer screen and it should have been locked when staff was not using it. On 04/30/2024 at 10:21 AM, Staff B stated they expected that the computer screen containing residents' information be locked when staff were not around RESIDENT'S REPRESENTATIVES INFORMATION POSTED ON THE WALL RESIDENT 17 Resident 17 was admitted to the facility on [DATE]. Observation on 04/24/2024 at 8:27 AM, showed Resident 17's representatives' names and phone numbers were written on a white board and posted on the wall above the sink. The contact information was visible with Resident 17's roommate and in the hallway. During a joint observation and interview on 04/24/2024 at 8:30 AM with Staff Q, RN, showed Resident 17's representatives names and contact information were visible to Resident 17's roommate and from the hallway. Staff Q stated Resident 17's personal information should have been posted somewhere else in the room to provide privacy. On 04/30/2024 at 10:21 AM, Staff B stated they expected that Resident 17's representatives' contact information should have been posted somewhere in the room that could not be seen by other people to ensure privacy. 48899 RESIDENT 16 Resident 16 admitted to the facility on [DATE] with diagnoses that included blindness on both eyes. (continued on next page)

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	505416	A. Building B. Wing	04/30/2024

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the annual Minimum Data Set (an assessment tool) dated 03/19/2024, showed Resident 16 had moderately impaired cognition. Observation and interview on 04/22/2024 at 1:58 PM with Resident 16 showed there were five names with phone numbers posted on the wall by their bed and by the sink. Resident 16 stated the names and phone numbers posted on their walls were of their family members. The names and phone numbers were visible from the hallway. Further observations on 04/23/2024 at 7:50 AM, and on 04/24/2024 at 11:01 AM, showed Resident 16's room continued to have the five names with phone numbers posted on the wall by their bed and by the sink. The names and phone numbers posted by the sink were visible from the hallway. Observation on 04/24/2024 at 1:17 PM, showed the names and phone numbers were removed and placed on Resident 16's bedside nightstand. On 04/24/2024 at 1:39 PM, Staff CC, CNA, stated when Resident 16 needs assistance with calling on to family, they report it to the nurse and/or front desk staff. Staff CC stated, for me I do not call myself, I have never done it before. On 04/24/2024 at 1:43 PM, Staff BB, RN, stated that they did not encourage posting personal information in residents' room. Staff BB stated that Resident 16's representative had posted those names with phone numbers, and they knew the information was visible from the hallway. Staff BB further stated that there was no discussion with Resident 16's representative regarding whether this could be a concern for privacy. On 04/24/2024 at 1:53 PM, Staff AA, Resident Care Manager, stated posting personal information in Resident 16's room was concerning. Staff AA stated they removed the information from the wall and placed it on bedside nightstand. Staff AA further stated, I guess everybody has access to it, but if it is on the nightstand, I do not think people can see it unless they search for it. On 04/29/2024 at 11:43 AM, Staff B stated they saw the list of names with phone numbers in Resident 16's room and told the staff to remove it. Staff B further stated they did not expect Resident 16's and/or family members' personal information be displayed on their wall. 45146 MEDICATION ADMINISTRATION IN THE DINING ROOM RESIDENT 100 Resident 100 admitted to the facility on [DATE]. Review of the quarterly MDS dated [DATE], showed Resident 100 was cognitively intact. Review of the April 2024 Medication Administration Record showed Resident 100 had an order to apply a patch of Aspercreme Lidocaine (a product used to help reduce itching and pain) to lower back/neck topically (applied on the skin) in the morning for pain. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/29/2024 at 11:44 AM, showed Resident 100 was sitting in the 700 Hall dining room for lunch. Staff GGG, RN, came to the dining room and applied the Aspercreme Lidocaine patch to Resident 100's lower back while the resident was standing, lifted their shirt up, and exposing their back. During the application of the patch to Resident 100's lower back, there were three staff and three residents in the dining room. On 04/29/2024 at 11:50 AM, Resident 100 stated that they would prefer the patch was applied while they were in their room. On 04/29/2024 at 2:56 PM, Staff GGG stated residents should have privacy during care and treatments. Staff GGG stated they asked Resident 100 to go to their room for the patch application, but the resident asked them to apply the patch in the dining room. On 04/30/2024 at 9:29 AM, Staff B stated that they would expect staff to provide privacy during any treatment or care. Reference: (WAC) 388-97-0360 (1)

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	505416	A. Building B. Wing	04/30/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47680 Based on observation, interview, and record review, the facility failed to provide a homelike environment when residents were served their meals on trays for 2 of 6 dining rooms (100 Unit Dining Room & 500 Unit Dining Room), reviewed for dining observations. This failure placed the residents at risk for a less than homelike environment and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Serving a Meal, showed to place served meal items on dining table or the full tray on the overbed table if the resident eats in their room. 100 UNIT DINING ROOM-BREAKFAST Observation on 04/23/2024 at 8:20 AM in the 100 Unit Dining Room, showed Resident 14, Resident 53, Resident 26 and Resident 38 were eating their breakfast on the tray. 100 UNIT DINING ROOM-LUNCH Observation on 04/23/2024 at 11:56 AM in the 100 Unit Dining Room showed Staff J, Certified Nursing Assistant (CNA), delivered Resident 14's lunch tray. Staff J placed the tray on the table, removed the cups from the tray and placed it on the table. Resident 14's plate remained on the tray and Resident 14 was eating their lunch on the tray. In another observation on 04/23/2024 at 11:58 AM in the 100 Unit Dining Room showed, Staff I, CNA, delivered a lunch tray to Resident 53. Staff I did not remove the plates off the tray and Resident 53 was eating their lunch on the tray. Further observation at 12:01 PM, showed Resident 93 and Resident 68 were eating their lunch on the tray. Joint observation and interview on 04/23/2024 at 12:35 PM with Staff I, showed Resident 53's lunch was on the tray. Staff I stated that they did not remove the tray when residents were served in the dining room. Staff I further stated that they were not trained to remove the tray. On 04/23/2024 at 12:42 PM, Staff K, Culinary Service Aide, stated that the plates and cups should come off the tray when they deliver the tray to the residents. Staff K further stated that the CNAs preferred to leave the trays on and that it was easier for them to deliver the trays. On 04/29/2024 at 10:35 AM, Staff D, Culinary Director, stated that staff should remove the trays when serving residents in the dining room. Staff D further stated that they could use the tray to serve residents, but they had to remove it after their meals were served. On 04/29/2024 at 1:05 PM, Staff B, Director of Nursing, stated that they expected staff to remove the trays when serving residents in the dining room. 48899 (continued on next page)

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	505416	A. Building B. Wing	04/30/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	500 UNIT DINING ROOM-LUNCH Observation of the 500 Unit Dining Room on 04/22/2024 at 12:02 PM, showed Resident 73, Resident 77, Resident 84, Resident 98, and Resident 41 were eating their food on their lunch tray. In another observation of the 500 Unit Dining Room on 04/23/24 at 12:16 PM, showed Resident 73, Resident 77, Resident 84, Resident 98, Resident 41, Resident 49, and Resident 17 were eating their food on their lunch tray. On 04/23/2024 at 12:27 PM, Staff EE, Culinary Services Aide, stated, I think we get used to using trays in room due to COVID-19 (an infectious disease-causing respiratory illness) and we kept doing it in the dining rooms too, and I think that is not right. On 04/23/2024 at 12:58 PM, Staff FF, CNA, stated that the trays were only intended for transporting meals to the residents. Staff FF stated, I do not think we should leave the tray with residents. On 04/29/2024 at 10:04 AM, Staff D stated that residents should not eat their meals on meal trays. Staff D further stated they would not expect the staff to leave trays with residents after they delivered the meals. On 04/29/2024 at 11:43 AM, Staff B stated they expected staff to remove the tray after they delivered their meal and that they should not leave it on the table. Reference: (WAC) 388-97-0880 (1)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46912 Based on interview and record review, the facility failed to ensure bed-hold notices were provided at the time of transfer to the hospital for 1 of 3 residents (Resident 71), reviewed for hospitalization . This failure placed the resident at risk of lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Review of the facility's undated policy titled, Bed Hold, showed that the facility will hold a bed for a discharged resident who expected to return to the facility. It showed that if the resident's absence from the facility exceeds the grace period [3 days] the designated personnel will contact the resident or the resident's responsible party to offer a Bed-Hold to guarantee the resident's bed at time of discharge. It further showed that a copy of the Bed Hold policy will be sent with the resident's paperwork at time of discharge. Resident 71 admitted to the facility on [DATE]. Review of the progress notes dated 04/01/2024, showed Resident 71 was transferred to the hospital for further evaluation. Review of Resident 71's clinical record (electronic record and physical chart) did not show documentation that a bed-hold notice was provided to Resident 71 and/or their representative. In an interview and joint record review on 04/25/2024 at 1:01 PM with Staff L, Social Worker (SW), stated they were responsible for providing the bed-hold notice to residents. Joint record review of Resident 71's clinical record showed no documentation that a bed-hold was provided to Resident 71 and/or their representative. Staff L stated that there should have been one. Joint record review and interview on 04/25/2024 at 2:20 PM with Staff FFF, SW, showed no documentation that a bed-hold was provided to Resident 71 and/or their representative. Staff FFF stated they could not find any bed-hold documentation. On 04/30/2024 at 2:40 PM, Staff A, Administrator, stated that there should have been documentation that a bed-hold was provided to Resident 71 and/or their representative. Reference: (WAC) 388-97-0120 (4)(a)(b)(c)

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	505416	A. Building B. Wing	04/30/2024

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS- an assessment tool) was completed timely for 4 of 23 residents (Residents 86, 14, 90 & 99), reviewed for significant change in condition. This failure placed the residents at risk for delayed care planning, further Activities of Daily Living (ADL) decline, unmet care needs, and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed that a significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting,' 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary [involving two or more different subjects or areas of knowledge] review and/or revision of the care plan. The RAI showed that a SCSA is required to be performed when a terminally ill resident enrolls in a hospice program or changes hospice providers and remains a resident at the nursing home. The RAI manual further showed that the assessment should be completed no later than 14 days after the determination was made (determination date plus 14 calendar days). The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 86 Resident 86 admitted to the facility on [DATE]. Review of the nursing progress note dated 10/31/2023 showed Resident 86 was admitted to hospice for comfort care. Review of Resident 86's SCSA MDS with an ARD of 11/14/2023 showed a completion date of 11/28/2023, which was 14 days late. RESIDENT 14 Resident 14 admitted to the facility on [DATE]. Review of the nursing progress note dated 03/10/2024, showed Resident 14 admitted to hospice care. Review of Resident 14's SCSA MDS with an ARD of 03/18/2024, showed a completion date of 04/01/2024, which was eight days late. (continued on next page)

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	505416	A. Building B. Wing	04/30/2024

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 04/25/2024 at 11:32 AM with Staff G, MDS/Registered Nurse, stated that they followed the RAI manual for MDS completion. Staff G stated they would complete a SCSA MDS when residents were admitted on or discharged off hospice and if there was a weight loss, change in their ADLs, skin issue and/or if the whole care plan needed to be revised. Staff G stated that once a significant change was identified, they would set the ARD within 14 days and would have 14 days to complete the SCSA MDS. Joint record review of Resident 14's SCSA MDS with an ARD of 03/18/2024 showed a completion date of 04/01/2024. Staff G stated that they signed/completed Resident 14's SCSA MDS within 2 weeks of the ARD and that they did not think the SCSA MDS was completed late. Joint record review of Resident 86's SCSA MDS with an ARD of 11/14/2023 showed a completion date of 11/28/2023. Staff G stated that Resident 86's SCSA MDS was set right and that this was their process. On 04/25/2024 at 11:49 AM, Staff F, MDS Coordinator, stated that their process would be to set the SCSA MDS ARD within 14 days from hospice admission and complete the assessment within 14 days from the ARD. Staff F stated that they have been an MDS nurse for a long time, and this was the first time they have heard that the SCSA MDS had to be completed within 14 days from hospice admission. When asked if hospice admission was when it was determined that a resident had a significant change, Staff F stated, yes, it would certainly seem so. On 04/25/2024 at 12:12 PM, Staff B, Director of Nursing, stated that Resident 86 and Resident 14's SCSA MDS should have been completed within 14 days of hospice admission. 45146 RESIDENT 90 Resident 90 admitted to the facility on [DATE]. Review of the electronic health record under the Census Page, showed Resident 90 was admitted to hospice care on 01/05/2024. Review of Resident 90's SCSA MDS with an ARD of 01/16/2024, showed it was signed and completed on 01/26/2024, which was seven days late. During a joint record review and interview on 04/29/2024 at 2:50 PM with Staff G, showed Resident 90 was admitted to hospice care on 01/05/2023 and their SCSA MDS was completed on 01/26/2024. Staff G stated that Resident 90's SCSA MDS was completed late per the RAI manual. On 04/30/2024 at 9:48 AM, Staff B stated that staff should have followed the RAI manual and completed Resident 90's SCSA MDS timely. RESIDENT 99 Resident 99 admitted to the facility on [DATE]. Review of the quarterly MDS dated [DATE], showed Resident 99 had a weight loss and a stage 3 pressure ulcer (a full thickness tissue loss to an area of the skin caused by constant pressure on the area for a long time). (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment look up showed there was no SCSA MDS completed for Resident 99. Joint record review and interview on 04/29/2024 at 2:34 PM with Staff G, showed Resident 99's quarterly MDS assessment dated [DATE] had two areas of decline. Staff G stated that when there were two areas of decline, a SCSA would be completed but no SCSA MDS was completed for Resident 99. On 04/30/2024 at 9:41 AM, Staff B stated they expected staff to complete a SCSA MDS for Resident 99 because the resident had two areas of decline. Reference: (WAC) 388-97-1000 (3)(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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to accurately assess 2 of 27 residents (Residents 14 & 99), reviewed for Minimum Data Set (MDS - an assessment tool). The failure to ensure accurate hospice and medication coding placed the residents at risk for unidentified or unmet care needs, and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed, code residents identified as being in a hospice program for terminally ill person where an array of services is provided for the palliation and management of terminal illness and related conditions. It further showed coding instructions to code all high risk drug class medications according to their pharmacological (drug's uses, effects, and modes of actions) classification and not how they are being used. It showed to check if the resident is taking any medication by pharmacological classification during the 7-day observation period. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 14 Resident 14 admitted to the facility on [DATE]. Review of the nursing progress notes dated 03/10/2024 showed Resident 14 admitted to hospice. Review of the significant change in status (SCSA) MDS with an ARD of 03/18/2024, showed Resident 14 was not coded (marked) for hospice. In an interview and joint record review on 04/25/2024 at 11:37 AM, Staff G, MDS/Registered Nurse, stated that they followed the RAI manual for MDS completion. Joint record review showed Resident 14's SCSA MDS was not coded for hospice. Staff G stated that Resident 14's SCSA MDS should have been coded for hospice and that it would need to be modified. On 04/25/2024 at 12:12 PM, Staff B, Director of Nursing Services, stated they expected staff to complete the SCSA MDS per the RAI manual and that the MDS be completed accurately. Staff B further stated that Resident 14's SCSA MDS should have been coded for hospice. 45146 RESIDENT 99 Resident 99 admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505416	A. Building B. Wing	04/30/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2024 medication administration record showed Resident 99 was on insulin (a drug that lowers the level of glucose [a type of sugar] in the blood). Review of the quarterly MDS with an ARD of 03/15/2024, showed Resident 99's insulin was not coded under the MDS medication section. During an interview and joint record review on 04/29/2024 at 3:33 PM with Staff G, stated that Resident 99 was taking insulin during the look back period. Joint record review of Resident 99's quarterly MDS with an ARD of 03/15/2024, showed insulin was not coded under medication section for Hypoglycemic (medications that lowers or regulate blood sugar in the body) and stated that it should have been coded. On 04/30/2024 at 11:21 AM, Staff B stated they expected MDS assessments to be completed accurately. Reference: (WAC) 388-97-1000 (1)(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to develop comprehensive care plans for 5 of 23 residents (Residents 73, 74, 120, 95 & 39), reviewed for care plans. The failure to develop care plans for bed against the wall, tilt-in space (a type of wheelchair that can lower the seated person's head and raises their feet at the same time) wheelchair, bed enablers (bed rails)/halos (type of bed rail shaped like a ring), and vision placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Safety Devices/Restraints, showed that bed against the wall, tilt in space wheelchair, and bed enablers/halos were safety devices. The policy further showed that care plans should be updated accordingly to include the development and implementation of interventions to address any risks related to the use of the device. Review of the facility's undated document titled, Process for Halos, Bed Rails, showed to update the care plan where most appropriate. The policy further showed that if the Halos were for transfers or mobility, to care plan under the Activities of Daily Living (ADL) focus care plan. BED AGAINST THE WALL RESIDENT 73 Resident 73 admitted to the facility on [DATE]. Multiple observations on 04/22/2024 at 10:01AM, on 04/23/2024 at 8:06 AM and at 12:58PM, on 04/24/2024 at 8:39 AM, and on 04/26/2024 at 8:37 AM, showed Resident 73 had their bed against the wall. On 04/24/2024 at 8:39 AM, Resident 73 stated they liked their bed against the wall. On 04/26/2024 at 12:34 PM, Staff XX, Certified Nursing Assistant (CNA), stated Resident 73 liked their bed by the wall. Review of Resident 73's comprehensive care plan printed on 04/23/2024 did not show a care plan for bed against the wall. On 04/26/2024 at 12:38 PM, Staff Q, Registered Nurse (RN), stated Resident 73's bed had always been against the wall. Staff Q further stated that residents with bed against the wall should have a care plan. During an interview and joint record review on 04/29/2024 at 3:27 PM with Staff B, Director of Nursing Services, stated they expected residents with bed against the wall to have a care plan. Joint record review of Resident 73's care plan did not show a care plan for bed against the wall, Staff B stated there should have been one. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46912 RESIDENT 74 Resident 74 admitted to the facility on [DATE]. Observations on 04/22/2024 at 10:44 AM and on 04/23/2024 at 9:32 AM, showed Resident 74 had their bed against the wall. Review of Resident 74's comprehensive care plan printed on 04/23/2024, showed no care plan initiated for having their bed against the wall. On 04/29/2024 at 1:42 PM, Staff W, Licensed Practical Nurse, stated that before a resident had their bed against the wall, they would assess for safety and provide risks and benefits. Staff W stated, I'm assuming there should be a care plan for having a bed against the wall. On 04/29/2024 at 1:51 PM, Staff YY, Resident Care Manager (RCM), stated that they, along with the admission nurse were responsible for initiating care plans for residents. Staff YY stated that they were unsure if there should be a care plan for having a bed against the wall. During an interview and joint record review on 04/29/2024 at 2:07 PM with Staff B, stated that there should be a care plan for residents who had their bed against the wall. Joint record review of Resident 74's comprehensive care plan showed no care plan for bed against the wall. Staff B stated, I don't see one [care plan] for bed against the wall and that they expected there to be one. TILT-IN-SPACE WHEELCHAIR Resident 120 admitted to the facility on [DATE]. Observations on 04/22/2024 at 11:13 AM and on 04/26/2024 at 1:27 PM, showed Resident 120 was sitting in their tilt-in-space wheelchair. Review of Resident 120's comprehensive care plan printed on 04/23/2024, showed no care plan initiated for a tilt-in-space wheelchair. Joint observation and interview on 04/29/2024 at 1:42 PM with Staff W, showed Resident 120 was sitting in their tilt-in-space wheelchair. Staff W stated there should be care plan for tilt-in-space wheelchair. An interview and joint record review on 04/29/2024 at 1:51 PM with Staff YY, stated there should be a care plan for use of a tilt-in-space wheelchair. Joint record review of Resident 120's comprehensive care plan, showed no care plan for the tilt-n-space wheelchair. Staff YY stated there was no care plan for Resident 120's tilt-in-space wheelchair. An interview and joint record review on 04/29/2024 at 2:07 PM with Staff B, stated that they expected there to be a care plan for tilt-in-space wheelchair. Joint record review of Resident 120's comprehensive care plan showed no care plan for their tilt-in-space wheelchair, Staff B stated there should have been one. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49619 BED RAILS/HALOS Resident 95 admitted to the facility on [DATE]. Review of Resident 95's physician's order showed an order, initiated on 02/23/2024 for Halos/Bed Enabler-Bilateral [both sides] for bed mobility. Review of Resident 95's care plan printed on 04/22/2024, showed no care plan for halos/bed enablers. Observations on 04/22/2024 at 12:44 PM and on 04/24/2024 at 9:15 AM, showed Resident 95 had halo bed rails. Interview and joint record review on 04/24/2024 at 1:31 PM with Staff II, RN, stated that halo bed rails should be included in the care plan. Joint record review showed Resident 95 had no halo bed rails care plan. Staff II stated that they could not find a care plan for Resident 95's halo bed rails. Interview and joint record review on 04/24/2024 at 2:16 PM with Staff PP, RCM, stated that bed rails/halos should be included in the care plan. Joint record review showed Resident 95 had no halo bed rails care plan. Staff PP stated they could not find a care plan for Resident 95's bed rails/halos and that there should have been one. Interview and joint record review on 04/30/2024 at 12:32 PM with Staff B, stated that there should be a care plan for bed rails/halos. Joint record review of Resident 95's care plan showed a new intervention for bed rails/halos was initiated on 04/24/2024. Staff B stated that there should have been a care plan for Resident 95's bed rails/halos prior to 04/24/2024. VISION Resident 39 admitted to the facility on [DATE]. Review of Resident 39's quarterly Minimum Data Set (an assessment tool), dated 12/05/2023, showed Resident 39's vision was moderately impaired and wore corrective lenses (glasses). Review of Resident 39's impaired vision care plan printed on 04/23/2024, stated Resident 39 wore glasses while awake. The care plan further showed interventions that read, Ensure that eyeglasses are in place and being worn by resident, Arrange consultation with eye care practitioner as required, and Staff to make sure resident's glasses are labeled. Observations on 04/24/2024 at 8:38 AM, on 04/26/2024 at 11:47 AM, and on 04/29/2024 at 8:29 AM, showed Resident 39 was awake and not wearing their glasses. On 04/24/2024 at 8:39 AM, Resident 39 stated that they had not worn their glasses for two months because they needed new glasses. (continued on next page)

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	505416	A. Building B. Wing	04/30/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation of Resident 39's glasses on 04/26/2024 at 1:00 PM with Staff QQ, CNA, showed the frame of the glasses were without lenses. Staff QQ stated that the last time they saw Resident 39 wear their glasses was almost more than a month ago. On 04/26/2024 at 2:44 PM, Staff II stated that if a resident wore glasses, it should be included in the care plan and Kardex (care plan for CNAs) and expected staff to follow it. On 04/30/2024 at 12:53 PM, Staff B stated they expected staff to follow and review residents' care plans daily. Staff B stated staff could not follow the care plan if Resident 39's glasses were broken, and the lenses were missing. Staff B further stated that staff should have reported that Resident 39 was not wearing their glasses or that they were broken. Reference: (WAC) 388-97-1020 (1)(2)(a)

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	505416	A. Building B. Wing	04/30/2024

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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** 45146 Based on interview and record review, the facility failed to ensure residents and/or their representatives were invited to participate in care plan meetings/care conferences for 2 of 2 residents (Residents 89 & 42), reviewed for care planning. This failure placed the residents at risk for not having input regarding care goals, unmet needs, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Care Planning-Care Conference-Resident Participation, showed it was the facility's policy to support the resident's right to be informed and participate in their care planning and treatment (implementation of care). The policy further showed that the facility will make an effort to schedule a care conference at the best time for the resident/representative and that if the resident/representative were determined not practicable for the development of the resident's care plan, an explanation would be documented in the resident's medical record. RESIDENT 89 Resident 89 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated 01/26/2024, showed Resident 89 was cognitively intact. On 04/22/2024 at 2:15 PM, Resident 89 stated that the facility never included them in their care plan decision. Review of Resident 89's clinical records under assessments titled, Care Conference Summary showed that their last care conference was on 05/30/2023. On 04/29/2024 at 9:16 AM, Staff DD, Social Worker, stated that care conferences would be held on admission, change of conditions, every six months, and annually. Staff DD stated that during care conference resident or resident representative would be invited and participate. After reviewing Resident 89's electronic clinical record, Staff DD stated that Resident 89's last care conference was on 05/30/2023. On 04/30/2024 at 9:58 AM, Staff A, Administrator, stated that residents should be involved in their care plan decisions. 49619 RESIDENT 42 Resident 42 admitted to the facility on [DATE]. Review of Resident 42's quarterly MDS dated [DATE], showed Resident 42 was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/2024 at 11:12 AM, Resident 42 stated that they had not had a care conference and were waiting for something to happen. Interview and joint record review of Resident 42's electronic clinical record on 04/26/2024 at 11:01 AM, Staff DD, stated care conferences were offered to residents upon admission, twice a year, or anytime as needed. Staff DD stated that if a resident was offered a care conference, they would expect to have a care conference meeting within two weeks. Joint record review of the electronic clinical records showed Resident 42's last care conference meeting was in July 2023. Staff DD stated that there should have been a care conference for Resident 42 but were waiting for a legal guardian. Staff DD stated their guess was that Resident 42 declined a care conference, further stating, I can't prove that based on what I wrote. On 04/30/2024 at 1:12 PM, Staff B stated that they expected care conferences to take place quarterly, annually, and as needed. Staff B stated that if a resident did not have a legal guardian appointed, they would still expect a care conference to be made with the resident. Staff B further stated that Resident 42 should have had a care conference. Reference: (WAC) 388-97-0120 (2)(f)(4)(b)

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	505416	A. Building B. Wing	04/30/2024

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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** 45146 Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) assistance were consistently provided for 2 of 8 residents (Residents 89 & 81), reviewed for ADLs. This failure placed the residents at risk for poor hygiene, decreased self-esteem, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Activities of Daily Living (ADL's), showed, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, the facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. The policy further showed that a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. RESIDENT 89 Resident 89 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS- an assessment tool) dated 01/26/2024, showed Resident 89 was cognitively intact and required substantial/maximal assistance (the helper does more than half the effort) with personal hygiene. Observation on 04/22/2024 at 8:52 AM, showed Resident 89's fingernails were long and had brown debris underneath the nails. Resident 89 stated, I would like to have them trimmed. Further observations on 04/23/2024 at 12:22 PM and on 04/24/2024 at 9:20 AM, showed Resident 89's fingernails were long and had brown debris underneath them. Review of the ADL care plan revised on 04/22/2024, showed Resident 89 required set up to one-person extensive assist with personal hygiene. On 04/25/2024 at 1:32 PM, Staff NN, Certified Nursing Assistant (CNA), stated fingernail care would be provided by the shower aid. On 04/26/2024 at 10:59 AM, Staff OO, CNA/Shower Aid, stated that fingernail care would be provided during shower unless the resident had diagnosis of diabetes (when a body doesn't make enough insulin [a hormone that lowers the level of glucose (a type of sugar)] in the blood or can't use it as well as it should). Staff OO further stated Resident 89 had refused fingernail care and they have had reported to nursing in the past. Joint observation and interview on 04/26/2024 at 11:05 AM with Staff OO, showed Resident 89's fingernails were long and had brown debris underneath them. Staff OO stated that the resident's fingernails were long and should have been trimmed. (continued on next page)

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	505416	A. Building B. Wing	04/30/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/2024 at 1:33 PM, Staff PP, Resident Care Manager, stated shower aids and CNAs should provide fingernail care unless residents have diabetes. Staff PP further stated they were not aware of Resident 89's refusal of fingernail care. On 04/30/2024 at 9:23 AM, Staff B, Director of Nursing, stated they expected fingernail care to be provided during showers. RESIDENT 81 Resident 81 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction (damage to the brain due to a loss of oxygen to the area), Hemiparesis (weakness or the inability to move on one side of the body), and Dysarthria (speech sound disorder). Review of the quarterly MDS dated [DATE], showed Resident 81 had severely impaired cognition and depended on staff for transfers. Review of the ADL care plan revised on 02/16/2024, showed Resident 81 required maximum assistance of two staff for transfers. Observation on 04/22/2024 at 11:22 AM, showed Resident 81 was lying in their bed and their collateral contact (CC) was sitting at the resident's bed side. Resident 81's CC stated that the resident was always in bed and that they have requested for the resident to be up on their wheelchair. Observations on 04/23/2024 at 8:33 AM and at 11:31 AM, on 04/24/2024 at 8:31 AM, at 11:33 AM, and at 1:35 PM, showed Resident 81 was lying in bed. On 04/24/2024 at 11:27 AM, Resident 81's CC was at bed side and stated that they have been asking staff for the last several days to have Resident 81 up on their wheelchair. Resident 81's CC further stated that the resident was never assisted out of their bed and into their wheelchair. On 04/24/2024 at 1:38 PM, Resident 81's CC stated that nobody came to the resident's room to transfer them onto their wheelchair. On 04/25/2024 at 1:33 PM, Staff NN, CNA, stated that Resident 81's CC requested to only get the resident up once a week in their wheelchair and Resident 81's CC did not ask them that day. In an interview and joint record review on 04/26/2024 at 10:50 AM, Staff EEE, CNA, stated that they would provide care for Resident 81 based on their care plan on the Kardex (a care guide for CNAs). Staff EEE further stated that other staff told them that Resident 81 would get up on their wheelchair once a week. A joint record review of Resident 81's Kardex showed no care plan to get Resident 81 up on their wheelchair once a week. On 04/29/2024 at 1:14 PM, Staff GGG, Registered Nurse, stated that Resident 81 should be up on their wheelchair daily. On 04/29/2024 at 1:33 PM, Staff PP stated Resident 81 should be up on their wheelchair when their CC requests it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/2024 at 9:26 AM, Staff B, Director of Nursing, stated they expected staff to get Resident 81 up on their wheelchair unless they refused. Reference: (WAC) 388-97-1060 (1)(2)(c)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on observation and interview, the facility failed to ensure resident environment remained free from accident hazards for 2 of 2 offices (Transitional Care Unit [TCU]/Resident Care Manager] RCM] office and the office next to the TCU/RCM office), reviewed for accident hazard. This failure placed residents at risk for avoidable accident and/or injury and a diminished quality of life. Findings included . Observation on 04/24/2024 at 9:42 AM, showed the TCU-RCM office and another office next to it were opened, and unsupervised. The offices had both powered and non-powered tools that included two saws, two drillers, electrical wiring, and a brazing (joining process that uses a filler metal to join two base metals together at temperatures above 840 degrees Fahrenheit) solder (a process that involves heating a specialized [NAME] composed of lead and tin to form a bond between two metals) machine. On 04/24/2024 at 9:44 AM, Collateral Contact 1 (CC1), stated that when they go for break or bathroom, they leave the doors open and unsupervised. CC1 stated that nobody informed them of the precautions they should take to keep residents safe during maintenance work. On 04/24/2024 at 9:49 AM, Collateral Contact 2 (CC2), stated, If we are going for break, bathroom or to bring things from somewhere we leave it open. CC2 stated that they did not know whether they needed to close the door and/or supervise the offices when they were away. On 04/24/2024 at 10:28 AM, Staff C, Facilities Director, stated CC1 and CC2 were doing air conditioning installation in two offices [TCU/RCM office and the office next to it]. Staff C stated that to leave those two offices open and unsupervised is not the ideal way to do it, that is not the way we expect them to do it. Staff C further stated that the offices should not have been left open and unsupervised. On 04/29/2024 at 11:43 AM, Staff B, Director of Nursing Services, stated that the two offices in repair should have been closed/supervised. On 04/30/2024 at 8:23 AM, Staff A, Administrator, stated those offices in repair should not have been left opened and/or unsupervised. Reference: (WAC) 388-97-1060(3)(g)

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	505416	A. Building B. Wing	04/30/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to ensure residents with urinary catheters (a flexible tube inserted into the bladder to drain urine) received appropriate care and services for 2 of 3 residents (Residents 110 & 17), reviewed for urinary catheter. The failure to ensure urinary catheters were off the floor placed the residents at risk for infections and related complications. Findings included . Review of the facility's undated policy titled, Catheter Care/Bags, showed, It is the policy of this facility to ensure residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. RESIDENT 110 Resident 110 admitted to the facility on [DATE] with diagnoses that included obstructive and reflux uropathy (a condition in which the flow of urine is blocked and causes the urine to flow backwards). Review of the admission Minimum Data Set (MDS- an assessment tool) dated 02/13/2024 showed Resident 110 had an indwelling foley catheter. Review of the urinary catheter care plan revised on 02/09/2024, showed a goal that Resident 110 will show no signs and symptoms of urinary infection (infection in the urine). Observation on 04/23/2024 at 9:11 AM, showed Resident 110's bed was in the low position and their catheter bag was hooked onto the bed frame with the bottom of the catheter bag touching the floor. In another observation on 04/25/2024 at 8:47 AM, showed Resident 110's catheter bag was partly covered with a blue privacy covering, and the bottom of the catheter bag was exposed and touching the floor. During a joint observation and interview on 04/25/2024 at 9:03 AM with Staff J, Certified Nursing Assistant (CNA), showed Resident 110's catheter bag was exposed and touching the floor. Staff J stated Resident 110's catheter bag should not be touching the floor. On 04/29/2024 at 11:20 AM, Staff E, Infection Preventionist, stated that Resident 110's catheter bag should not be touching the floor, and it should be covered with a protection [privacy] bag. On 04/29/2024 at 1:18 PM, Staff B, Director of Nursing, stated Resident 110's catheter bag should be covered for privacy and that their catheter bag should not have been touching the floor. 43392 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505416	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foss Home & Village	13023 Greenwood Avenue North Seattle, WA 98133

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 17 Resident 17 admitted to the facility on [DATE] with diagnosis that included neurogenic bladder (lack of bladder control due to a nerve problem in the brain or spinal cord) and had an indwelling urinary catheter. Observation on 04/24/2024 at 8:27 AM, showed Resident 17's bed was in a low position, their urinary catheter drainage bag was touching the floor, and the lower one-third part of the catheter drainage bag was not covered by a privacy bag. During a joint observation and interview on 04/24/2024 at 8:35 AM with Staff Q, Registered Nurse, showed Resident 17's urinary catheter drainage bag was touching the floor. Staff Q stated that the resident's urinary catheter drainage bag should was touching the floor, and it should not have been. On 04/30/2024 at 10:21 AM, Staff B stated that urinary catheter drainage bag should not be touching the floor. Reference: (WAC) 388-97-1060 (3)(c)

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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** 43392 Based on observation, interview, and record review, the facility failed to ensure tube feeding (a medical device used to provide nutrition into the stomach if resident is unable to swallow safely) supplies (tubing set) including the irrigation syringe were labeled/dated for 1 of 2 residents (Resident 4), reviewed for tube feeding management. This failure placed the residents at risk for infection and related complications. Finding included Review of the facility's undated policy titled, Care and Treatment of Feeding Tubes, showed it was the policy of the facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Resident 4 admitted to the facility on [DATE] with diagnoses that included stroke (restriction of blood flow or sudden burst of blood vessel in the brain), dysphagia (difficulty swallowing), and protein-calorie malnutrition (a condition that result from lack of sufficient nutrients in the body). Review of the quarterly Minimum Data Set assessment (an assessment tool), dated 03/13/2024, showed Resident 4 was totally dependent with tube feeding management for nutrition/hydration. Observation on 04/22/2024 at 9:01 AM, showed Resident 4 was receiving Jevity (that provides complete, balanced nutrition for long- or short-term tube feeding) 1.5 Cal [calorically dense, fiber-fortified therapeutic nutrition] running at 50 milliliters per hour for a total of 18 hours. Further observation showed the tube feeding's set and irrigation syringe did not have a date or label when it was first used. During a joint observation and record review on 04/22/2024 at 12:30 PM with Staff II, Registered Nurse, showed the tubing and irrigation syringe were not labeled/dated. Staff II stated the tubing and irrigation syringe were not dated or initialed as it should have been. On 04/30/2024 at 10:21 AM, Staff B, Director of Nursing Services, stated that it was their expectation that the tube feeding set and/or the irrigation syringe should be dated, labeled, and initialed when new tubing and syringe were first used or opened. Reference: (WAC) 388-97-1060 (3)(f)

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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** 45146 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided according to professional standards of practice for 1 of 1 resident (Resident 90), reviewed for respiratory care. The failure to have an oxygen administration order, maintain, label/date, and properly store oxygen nasal cannula (flexible tubing that sits inside the nose and delivers oxygen) properly placed the resident at risk for unmet care needs, respiratory infections, and related complications. Findings included . Review of the facility's undated policy titled, Oxygen Administration, showed oxygen is administered under orders of a physician, except in the case of an emergency. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders. Staff shall change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Keep delivery devices covered in plastic bag when not in use. Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use. Resident 90 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (an assessment tool) dated 04/09/2024, showed Resident 90 was cognitively intact. Observation on 04/22/2024 at 10:56 AM, showed Resident 90 had an oxygen concentrator in their room that was not in use. Resident 90 had a long oxygen tubing connected to the concentrator and the nasal canula was sitting in the resident's nightstand drawer. Further observation showed the oxygen tubing was not labeled/dated and not stored in a bag. Resident 90 stated that they used oxygen once or twice a day. Observation on 04/23/2024 at 10:11 AM, on 04/24/2024 at 12:57 PM, and on 04/25/2024 at 8:18 AM, showed Resident 90's oxygen was not in use and the nasal canula was hanging down from the resident's nightstand. The oxygen tubing was not labeled or stored in a bag when not in use. On 04/24/2024 at 1:03 PM, Resident 90 stated that due to their shortness of breath during the night, they were using oxygen by themselves. Observation on 04/26/2024 at 8:00 AM, showed Resident 90 was using their oxygen. Resident 90's oxygen concentrator was on and running at 1.5 liters per minute. Review of Resident 90's physician's order printed on 04/24/2024, showed Resident 90 had no oxygen order. In an interview on 04/26/2024 at 8:02 AM, Staff HHH, Licensed Practical Nurse, stated that Resident 90 had an oxygen concentrator in their room, but they had never seen them using it. Staff HHH stated Resident 90 had no physician's order for oxygen use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Joint observation and interview on 04/26/2024 at 8:07 AM with Staff HHH, showed Resident 90 was using oxygen at 1.5 liters per minute, and the oxygen tubing was not labeled or dated. Staff HHH stated that Resident 90 was using oxygen, and the tubing was not labeled. On 04/26/2024 at 10:15 AM, Staff PP, Resident Care Manager, stated that a resident should have an oxygen order before use. Staff PP also stated that oxygen tubing should be changed weekly and labeled with the date it was changed. Staff PP further stated that Resident 90 had no oxygen order. On 04/30/2024 at 9:35 AM, Staff B, Director of Nursing Services, stated that they would expect a resident to have an oxygen order prior administering it. Staff B stated oxygen tubing should be changed and labeled weekly. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility failed to comprehensively assess and evaluate the need for bed rails for 1 of 3 residents (Resident 95), reviewed for bed rail use. This failure placed the resident at risk for entrapment, injury, and a diminished quality of life. Findings included . Review of the facility's undated form titled, Process for halos [a type of bed rail shaped like a ring], bed rails, showed a nursing assessment was required regardless of prior function or use. Resident 95 admitted to the facility on [DATE]. Review of Resident 95's physician's order showed an order initiated on 02/23/2024 for Halos/Bed Enabler-Bilateral [both] for bed mobility. Review of a nursing progress notes dated 02/23/2024 at 12:40 PM, showed, halos requested by Resident 95's representative for bed mobility and support. Observations on 04/22/2024 at 12:44 PM and on 04/24/2024 at 9:15 AM, showed Resident 95's bed rails were loose, the left rail was looser than the right rail. Joint record review and interview on 04/24/2024 at 1:31 PM with Staff II, Registered Nurse, showed Resident 95's Initial Device assessment dated [DATE] [and was printed on 04/24/2024], did not have documentation that previous interventions/alternatives were attempted prior to the use of bed rails. Staff II stated that there should have been documentation. On 04/30/2024 at 10:03 AM, Staff RR, Rehab Director, stated that there should be a safety evaluation/assessment done prior to installation or use of bed rails. Staff RR stated that they did not see documentation for a safety evaluation/assessment for Resident 95 and that it should have been documented prior to bed rail use. During an interview and joint record review on 04/30/2024 at 12:32 PM with Staff B, Director of Nursing Services, stated that they expected staff to complete an assessment and consent prior to installing the bed rails. Staff B stated that the assessment should address safety and that Resident 95's assessment did not specify whether that was assessed. Joint record review of Resident 95's Initial Device assessment dated [DATE], showed there were new interventions added to the assessment. Staff B stated that they should have been documented prior to installation of the bed rails. Reference: (WAC) 388-97-1060 (3)(g)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49619 Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) had the appropriate competencies, skills set and proficiencies to apply a condom catheter (external flexible tube that is used to collect urine from the body) for 1 of 5 nursing staff (Staff S), reviewed for competent nursing staffing. This failure placed the resident at risk for infection, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Competency Evaluation, showed, It is the policy of this facility to evaluate each employee to assure appropriate competencies and skills for performing his or her job and to meet the needs of facility residents. The policy further stated that checklists were to be used to document training and competency evaluations. Review of the facility's undated policy titled, Condom Catheter Care Policy, showed, It is the policy of this facility to ensure that condom catheters are applied appropriately, cared for and removed consistent with current standards of practice. Staff S, CNA, was hired on 02/14/2022. Review of facility provided employee training file for Staff S did not show a condom catheter competency skills assessment. On 04/25/2024 at 9:13 AM, Staff S, wore gloves to assist Resident 39 with peri-care (cleaning of private parts) in the resident's bathroom. Staff S with the same used gloves, pulled the resident's pants up and transferred Resident 39 into their wheelchair while touching multiple surfaces of the wheelchair. Staff S touched Resident 39's bedside table, their hand, the TV remote control, bedside drawer, wheelchair brakes, and walker. Staff S assisted Resident 39 to transfer from their wheelchair into their bed. Staff S then assisted Staff II, Registered Nurse, with applying a condom catheter on Resident 39. Staff S stretched the condom catheter and applied it to Resident 39. Staff S did not do hand hygiene and/or changed their used gloves in between task, after assisting Resident 39 in the bathroom or after assisting the resident back into their bed. On 04/25/2024 at 10:24 AM, Staff S stated they should have removed their used gloves and washed their hands after assisting Resident 39 in the bathroom. Staff S stated they should have applied new gloves to assist the resident with transfers, and then completed hand hygiene and changed their gloves prior to assisting with the condom catheter. Staff S further stated that the nurse was responsible for changing the resident's condom catheter, but if the nurses were not around then CNAs could do it. On 04/30/2024 at 1:05 PM, Staff B, Director of Nursing Services, stated that under the direction of a nurse a CNA was able to apply a condom catheter. Staff B further stated that Staff S did not have staff training and competency evaluation for condom catheters in their skills check list and that there should have been one. Reference: (WAC) 388-97-1680 (2)(b)

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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. 49619 Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed the total number of staff and actual number of hours worked for each shift for 1 of 7 days reviewed for posted nurse staffing information. This failure placed the residents and residents' representatives at risk of not being fully informed of the current staffing levels. Findings included . Review of the facility's undated policy titled, Nurse Staffing Post Information, showed the nurse staffing sheet would be posted daily, with the total number and the actual hours worked per shift for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Aides. The policy further showed that the information posted would be in a prominent place readily accessible to residents and visitors. Observations on 04/30/2024 at 7:51 AM, showed the facility's Daily Nurse Staffing Form that day did not include the total number of staff and the total hours worked for evening and night shift. Joint observation and interview on 04/30/2024 at 9:07 AM with Staff Y, Staffing Coordinator, showed the Daily Nurse Staffing Form dated 04/30/2024 did not include the total number of staff and the total hours worked for evening and night shift. Staff Y stated that the nurse staffing post was to be posted in the entrance daily and that the receptionist was responsible for filling it out once they received the daily schedule. Staff Y further stated that it should be posted first thing in the morning and expected it to be filled out per shift. On 04/30/2024 at 1:55 PM, Staff B, Director of Nursing Services, stated they expected the nurse staffing form to be completed for the whole day and that it should be current. Staff B further stated they would expect to see the nurse staffing form posted on both floors of the facility. No associated WAC

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	505416	A. Building B. Wing	04/30/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to ensure monthly pharmacy recommendations were followed up on for 2 of 5 residents (Resident 90 & 57), reviewed for unnecessary medications. This failure placed the residents at risk of receiving unnecessary medications, medication-related adverse consequences, and a diminished quality of life. Findings included . RESIDENT 90 Resident 90 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (an assessment tool) dated 04/09/2024, showed Resident 90 was cognitively intact. Review of the physician's order summary report printed on 04/24/2024, showed Resident 90 was receiving insulin Glargine (a drug that lowers the level of glucose (a type of sugar) in the blood) 46 units two times a day with an order date of 04/03/2024. Review of the pharmacist Medication Regiment Review (MRR), dated 04/08/2024, showed there was a recommendation from the pharmacist to consider increasing insulin glargine to 50 units twice daily for better control of blood glucose/sugar. Further review the MRR showed Resident 90's physician agreed with the pharmacist's recommendation and signed it on 04/11/2024. Review of the April 2024 Medication Administration Record (MAR) showed that the pharmacist recommendation was not followed, and Resident 90 continued receiving Glargine 46 units two times a day. Joint record review and interview on 04/30/2024 at 9:07 AM with Staff PP, Resident Care Manager (RCM), showed the MRR dated 04/08/2024 had a recommendation from the pharmacist to increase the insulin glargine 50 units twice daily, signed by Resident 90's physician. Staff PP stated that Resident 90 at time refuses changed on their medications. When asked if they had documentation to show regarding the refusal. Staff PP stated they would check it but did not provide the documentation for resident refusal. On 04/30/2024 at 9:39 AM, Staff B, Director of Nursing, stated they would expect the pharmacy recommendations implemented timely. 46912 RESIDENT 57 Resident 57 admitted to the facility on [DATE]. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 57's November 2023 MAR showed Resident 57 was taking Depakote (a medication to treat seizures [a sudden, uncontrolled burst of electrical activity in the brain] and bipolar disorder [a disorder associated with mood swings) two times a day. Review of the November 2023 MRR showed that the pharmacist documented, Please consider documenting risks/benefits for Depakote therapy or consider tapering to remove. Review of Resident 57's clinical record showed no documentation that there was follow up on the pharmacy recommendation. Review of Resident 57's February 2024 MAR showed Resident 57 was taking Seroquel (medication used to treat certain mental/mood disorders) two times a day. It also showed that Resident 57 was taking Venlafaxine (a medication to treat depression) once a day. Review of the February 2024 MRR showed that the pharmacist documented, The patient is currently taking Seroquel 25 mg [milligram-a unit of measurement] BID [twice a day] for MDD [Major Depression Disorder] agitation and Venlafaxine 250 mg QAM [every morning] for MDD. Current PHQ-9 [a tool used to assess depression] is 15, indicating moderate to severe depression. Recommend increasing Venlafaxine dose or adding adjunctive [additional treatment] therapy. Documented goal of therapy is PHQ-9 < [less than] 3, please consider optimizing patient's [resident's] therapy or clarify current goal of therapy. Review of Resident 57's March 2024 MAR showed Resident 57 was taking guaifenesin (a medication to relieve chest congestion) as needed. Review of the March 2024 MRR showed that the pharmacist documented, Patient has an order for guaifenesin 100mg/5mL [milliliter-a unit of measurement] 20mL Q6H [every 6 hours] as needed for cough. He has not been using guaifenesin and does not have a cough. Please consider discontinuation if no longer indicated. Further review of Resident 57's clinical record did not address the pharmacy recommendations for November 2023, February 2024, or March 2024. On 04/30/2024 at 1:22 PM, Staff YY, RCM, stated that the process for the monthly medication review was that the RCMs get the recommendations from the pharmacy, tell the physician, and sometimes they [physicians] agree or disagree. During a joint record review and interview on 04/30/2024 at 1:40 PM with Staff X, Pharmacist, stated that looking at the pharmacy recommendations for Resident 57 for the months of November 2023, February 2024, and March 2024, we didn't get a follow up from the doctor. In an interview and joint record review on 04/30/2024 at 2:28 PM, Staff B stated that the process for the monthly pharmacy review was that the pharmacy reviews resident's medications, the physician reviews the recommendations, and then staff implement the orders. Staff B stated they expected a follow up from the physician. Joint record review of Resident 57's clinical record showed Resident 57's clinical record did not address the pharmacy recommendations for November 2023, February 2024, or March 2024. Resident 57's clinical record did not address the pharmacy recommendations for November 2023, February 2024, or March 2024. Staff B stated the last one [physician response to pharmacy recommendation] is a follow up from August [2023] and I don't see any additional follow up from the doctor. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-98-1300 (4)(c)

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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. 43392 Based on observation, interview, and record review, the facility failed to discard expired medication for 1 of 4 medication carts (Unit 200 Medication Cart), reviewed for medication storage. This failure placed the resident at risk to receiving expired or compromised medication. Findings included . Review of the facility's policy titled, Medication Storage in the Facility, reviewed on 12/24/2019, showed medication and biologicals are stored safely, secure, and properly, following manufacturer's recommendations or those of the supplier. It further showed that outdated or expired medications are immediately removed from stocks, disposed of according to procedure for medication disposal and reordered from the pharmacy if current order exists. During a joint observation and interview on 04/25/2024 at 3:56 PM with Staff W, Licensed Practical Nurse, showed the Unit 200 Medication Cart had one Lispro insulin pen (medication given to lower blood sugar) for Resident 120 that was opened on 03/22/2024 during resident's admission and had been used for 35 days. Staff W stated that the Insulin pen was good for 28 days after opening, the medication was expired, and it should have been properly disposed. On 04/26/2024 at 1:01 PM, Staff X, Pharmacist, stated Lispro pen were good for 28 days after opening and that the Lispro pen was expired. On 04/30/2024 at 11:28 AM, Staff B, Director of Nursing Services, stated the Lispro pen was good for 28 days after it was first opened and that it was expired. Reference: (WAC) 388-97-1300(2)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 49619 Based on observation, interview, and record review, the facility failed to offer/serve food substitutes and/or serve food that accommodated preferences for 1 of 2 residents (Resident 35), reviewed for food preferences. This failure placed the resident at risk for dissatisfaction with food, weight loss, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Serving a Meal, showed the facility should serve meals that meet the nutritional needs of the residents. The policy further stated that staff should, check to be sure everything is served that is required by the menu ticket, and the resident's preference. Review of the facility's policy titled, Resident Rights: Accommodation of Needs and Preferences and Homelike Environment Policy, dated January 2019, showed that it was the facility policy to identify and provide reasonable accommodation of the resident's needs and preferences. Review of Resident 35's nutrition care plan printed on 04/22/2024, showed an undated intervention that stated, Meal Ticket selections will be monitored with Food items known that Resident enjoys added if no Entree is selected. The care plan further showed an undated intervention that Resident 35 disliked melon-like berries, grapes, and tangerines. Observation and interview on 04/24/2024 at 11:49 AM with Resident 35, showed they were served a glass of water, a glass of apple juice, a slice of garlic bread, a slice of iced lemon loaf cake, and a fruit cup. Resident 35 let Staff UU, Certified Nursing Assistant, know that they did not want the garlic bread and it was taken away. Resident 35 then requested a banana. Resident 35 stated they were not going to eat the lemon loaf cake as they had several pieces on their bedside table. Resident 35 further stated that the fruit cup had melons, cantaloupe, honey dew, grapes, and watermelon, and that they disliked melons. Resident 35 stated, So I guess I will have a banana and apple juice for lunch. Resident 35 stated that the staff, made a big deal of writing down their food preferences but was all talk and no answers. Another observation and interview on 04/25/2024 at 11:48 AM with Resident 35, showed they were served a glass of water, a glass of apple juice, a dessert, and an iced lemon loaf cake. Resident 35 stated that they had crossed everything off their menu and when this happened, they would get an iced lemon loaf cake or sometimes a dessert. During an interview and joint record review on 04/29/2024 at 1:54 PM with Staff UU, stated they would normally ask the resident if there was something else that they would prefer to eat and offer an alternative. Staff UU stated that Resident 35 had received grapes for lunch that day and that they offered them two bananas. Joint record review of Resident 35's undated Kardex (care plan for CNAs), showed the resident disliked grapes. Staff UU stated that the server had served grapes because there was nothing else for fresh fruit. Staff UU stated that they would not expect to see a food item the resident dislikes on their meal tray. (continued on next page)

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	505416	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foss Home & Village	13023 Greenwood Avenue North Seattle, WA 98133

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/2024 at 8:22 AM, Staff D, Culinary Director, stated that when a resident crossed everything off their menu or left it blank, the server or aide would talk with the resident and work with their requests or preferences. Staff D stated that they were unaware that Resident 35 disliked melons or grapes. Staff D further stated that the cook had a list of items Resident 35 preferred to eat in these cases. During an interview and joint record review on 04/30/2024 at 11:58 AM with Staff VV, Registered Dietician, stated that when a resident did not pick something on their menu, or crossed items off, they or the dietary manager would talk with the resident and inform them that they could order off menu. Joint record review of Resident 35's nutritional care plan revised on 09/19/2022, showed the resident's food dislikes. Staff VV stated that they would have expected the resident to have been offered an alternative. Staff VV further stated that there seemed to be a disconnect in communication in getting the resident the right thing. On 04/30/2024 at 12:46 PM, Staff B, Director of Nursing Services, stated that they expected staff to go over the menu with the residents and that they expected their food preferences to be documented on the meal ticket and in their care plan. Staff B stated that they expected staff to serve a full meal based on the resident's preferences and diet. Staff B further stated that they expected staff to follow the care plan and take the food the resident disliked and replace it with an alternative. Reference: (WAC) 388-97-1140 (6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47680 Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 2 of 3 walk-in kitchen refrigerators (Produce Walk-in Refrigerator & Dessert Walk-in Refrigerator), for 1 of 1 dry storage room, for 1 of 3 resident refrigerators (100 Unit Resident Refrigerator), for 1 of 1 kitchen, for 2 of 2 dining rooms (400 Unit Dining Room and 100 Unit Dining Room), and for 1 of 7 units (600 Unit) reviewed for food service. The failure to label, date, and discard food items, sanitize thermometers between use, and perform hand hygiene placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Food Safety and Storage Requirements, showed that food will be stored, prepared, distributed and served in accordance with professional standards for food service safety. The policy showed that labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen, (where applicable) discarded; and keeping foods covered or in tight containers. The policy further showed that foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone (temperatures where bacteria can grow rapidly). Strategies include but are not limited to washing hands properly before distributing trays, washing hands between contact with residents and after collecting soiled plates and food waste, and use of gloves when touching and assisting with ready-to-eat foods. Review of the facility's undated policy titled, Record of Food Temperatures, showed, Food temperatures will be verified using a thermometer which is both clean, sanitized and calibrated to ensure accuracy. Review of the facility's policy titled, Food Brought in from an Outside Source, dated February 2024, showed, Foods or beverages brought in from the outside will be labeled with the resident's name, room number and dated by staff with the current date the item(s) are brought into the facility for storage. FOOD ITEMS IN THE PRODUCE WALK-IN REFRIGERATOR Joint observation and interview on [DATE] at 8:34 AM with Staff D, Culinary Director, showed the Produce Walk-in Refrigerator had one plastic container of romaine lettuce dated ,d+[DATE] [[DATE]] with no use by date, one clear plastic container labeled salad with preparation date of ,d+[DATE] [[DATE]] with no use by date, and one plastic container of chopped carrots with no label or use by date. Staff D stated the romaine lettuce and salad mix should have been used within three days and discarded after the third day. Staff D further stated that the container of carrots should have been labeled and dated with use by date. FOOD ITEMS IN THE DESSERT WALK-IN REFRIGERATOR (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation of the Dessert Walk-in Refrigerator on [DATE] at 8:44 AM with Staff D, showed 12 trays that contained slices of chocolate cream pie, which were uncovered. Staff D stated that the staff was not done preparing desserts and that they would cover the slices of chocolate cream pie when they were done. Staff D further stated that they expected the staff to cover it as the dish was done. FOOD ITEMS IN THE DRY STORAGE ROOM Joint observation and interview on [DATE] at 9:35 AM with Staff D, showed the Dry Storage Room had the following food items: -One opened bag of rainbow sprinkles with best before date of [DATE] -Two unopened bags of peanuts with best by date of [DATE] -Six unopened boxes of Quaker (brand name) Grits with best by date of [DATE] -Three unopened boxes of Quaker Grits with best by date of [DATE] Staff D stated that their process was to discard food items that were past the use by date. Staff D further stated that the rainbow sprinkles, peanuts, and grits should have been discarded. FOOD ITEMS IN THE 100 UNIT RESIDENT REFRIGERATOR Observation of the 100 Unit Resident Refrigerator on [DATE] at 1:36 PM, showed a signage outside the refrigerator door that read, opened/saved items need a date written on them. No date, they get thrown out. Further observation of the third refrigerator shelf contained one plastic container of pasta, one plastic container of salad mix, and one fast food paper bag labeled with Resident 46's name. Additional observation of the bottom closed compartment of the refrigerator showed one over ripe banana, two containers of cooked rice, one package of bread, and one plastic storage bag of injera (sour fermented pancake) that were unlabeled and undated. During an interview and joint observation on [DATE] at 1:48 PM, Staff H, Registered Nurse, stated that the 100 Unit refrigerator were for residents and that food brought in from home should be labeled with resident's name and dated. Joint observation of the 100 Unit Refrigerator showed two undated containers and one undated paper bag labeled with Resident 46's name. Staff H stated that they were the residents' personal containers and that they didn't date them. Staff H stated that the food in the bottom closed compartment refrigerator belonged to staff. Joint observation showed two containers of rice, one package of bread, and one brown banana that were unlabeled and undated. At 1:54 PM, Staff H spoke to Staff B, Director of Nursing Services, and stated that staff should have a separate refrigerator to place their personal food items. On [DATE] at 10:32 AM, Staff D stated that the CNAs [Certified Nursing Assistant] should label and date resident's food that was brought in from home. Staff D further stated that staff should not store their food in resident refrigerators and that they have staff refrigerators in the break room where staff should be storing their food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:10 PM, Staff B stated that they expected staff to label resident's food brought from home with the resident's name and date. Staff B further stated that staff should not be storing their food in the residents' refrigerators. HAND HYGIENE WITH FOOD PREPARATION IN THE KITCHEN Observation and interview on [DATE] at 9:20 AM showed Staff N, Culinary Service Prep, removed their used gloves, placed a bag of salad greens in a container, covered it with plastic wrap and labeled it. Staff N did this three times and when they were done, they went inside the two walk-in refrigerators [Produce Walk-in and the Dairy Refrigerators]. Staff N did not perform hand hygiene after removing their used gloves. Staff N stated that they perform hand hygiene when they come into the kitchen. When asked if they performed hand hygiene before and after glove use, Staff N stated, Not often. Staff N further stated that they should have performed hand hygiene after they removed their used gloves. On [DATE] at 1:05 PM, Staff D stated that Staff N should have performed hand hygiene after they removed their used gloves. HAND HYGIENE DURING MEAL TRAY AND THERMOMETER SANITIZATION IN THE 400 UNIT DINING ROOM Observation in the 400 Unit Dining Room on [DATE] at 11:31 AM, showed Staff M, Culinary Service Aide, applied gloves, took the temperature of the Salisbury steak using a thermometer. Staff M did not sanitize the thermometer prior and/or after use. Staff M then took the temperature of the pork chop and wiped the thermometer with a paper towel. Staff M continued to use the thermometer to take the temperatures of the potatoes, puree potatoes, zucchini, tomato soup and gravy, and wiped the thermometer using the same used paper towel between food items. Staff M did not sanitize the thermometer between food items. Observation on [DATE] at 12:06 PM, showed Staff M returned to the 400 Unit Dining Room, applied gloves, returned to the tray line, and prepared a resident's tray. Staff M did not perform hand hygiene prior to applying gloves or returning to the tray line. On [DATE] at 12:09 PM, Staff M stated that they performed hand hygiene when they come to work, before serving, and before/after glove use. Staff M stated they should have washed their hands before glove use. Staff M further stated that the facility taught them how to use/clean the thermometer but that they did not teach them what to clean the thermometer with. Staff M stated they used paper towels and that they did not want to use alcohol wipes because they did not want the alcohol to get in the food. On [DATE] at 1:05 PM, Staff D stated staff should perform hand hygiene before and after glove use and as soon as they entered the dining room. Staff D stated that Staff M should have performed hand hygiene before glove use and when they entered the dining room. Staff D stated that their process was to sanitize the thermometer with alcohol prep pads (wipes) before and after taking food temperatures. Staff D further stated that Staff M should have sanitized the thermometer before and between food items with alcohol wipes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:48 AM, Staff A, Administrator, stated they expected food items to be labeled/dated, covered/sealed, and expired/past use by date to be discarded. Staff A stated that they expected staff to perform hand hygiene before and after glove use, sanitize the thermometer between use and staff to store their food in the staff refrigerators. Staff A further stated residents' food brought from home should have been labeled/dated and anything that was not labeled/dated in the refrigerator should have been discarded. HAND HYGIENE IN THE 100 UNIT DINING ROOM Observation in the 100 Unit Dining Room on [DATE] at 11:55 AM, showed Staff I, CNA, delivered Resident 47's tray and provided set up assistance. Staff I then moved Resident 47's walker, got milk from the drink cart, and gave it Resident 47. Without performing hand hygiene, Staff I went to the tray line and placed utensils on multiple trays. Staff I took a lunch tray and gave it to Resident 53. Staff I touched Resident 53's bread with bare hands and put butter on it. Staff I then took the bread with their bare hands and placed it on Resident 53's hands. On [DATE] at 12:40 PM, Staff I stated that they performed hand hygiene before/after care, after touching anything dirty and that they must wear gloves or use utensils when preparing residents food. Staff I stated they held Resident 53's bread with bare hands and stated that they performed hand hygiene prior to touching the bread with their bare hands. Staff I further stated that they should have performed hand hygiene after touching Resident 47's walker. On [DATE] at 11:20 AM, Staff E, Infection Preventionist, stated that staff should perform hand hygiene before/after care and before/after glove use. Staff E stated that Staff I should have performed hand hygiene after touching the walker and should not have been touching food with bare hands. Staff E further stated if Staff I were to touch food, they expected them to wear gloves. On [DATE] at 1:05 PM, Staff B stated they expected Staff I to perform hand hygiene after they touched Resident 47's walker and before they went to the tray line. Staff B further stated that staff should not be touching residents' food with bare hands. 49619 UNDATED FOOD ITEMS IN THE 600 UNIT RESIDENT 35 Observation on [DATE] at 11:57 AM, showed seven iced lemon loaf cakes in Resident 35's room, including one iced lemon loaf cake with mold (often fuzzy surface growth of fungus especially on damp or rotting matter). Joint observation and interview on [DATE] at 12:06 PM with Staff S, CNA, showed seven iced lemon loaf cakes had no expiration or use by date and one of them had mold on it. Staff S stated the cake was spoiled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation and interview on [DATE] at 12:22 PM with Staff D showed seven iced lemon loaf cakes had no expiration or use by date and one of them had mold on it. Staff D stated that once the cake was thawed (defrosted) from the freezer it was good for five days according to manufacturer's instructions. Staff D stated that there was no process in place for the nursing staff to know this and that there should have been. Staff D further stated that the moldy iced lemon loaf cake should not have been in Resident 35's room. On [DATE] at 9:21 AM, Staff D stated that eating moldy food could put the resident at risk of getting sick. Staff D further stated that the cakes should have been labeled with a use by date. On [DATE] at 12:45 PM, Staff B stated that they would not expect to have moldy food in a resident's room. Staff B stated that the food should be labeled and discarded within three days, or if unlabeled, discarded. Staff B further stated that the iced lemon loaf cakes should have been labeled. Reference (WAC) [DATE] (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to store clean linens appropriately for 1 of 7 units (200 Unit) and failed to ensure hand hygiene practices and/or proper use of gloves were followed before, during, and after resident care and with meals trays for 6 of 7 staff (Staff CCC, LLL, ZZ, S, TT & V), reviewed for infection control. In addition, the facility failed to ensure Contact Precautions (measures put in place to prevent spread of infection by direct or indirect contact with the resident or environment by staff wearing gown and gloves before entering a resident's room or environment) and/or Enhanced Barrier Precautions (EBP- precaution to protect residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections]) practices were followed for 3 of 6 residents (Residents 27, 99 & 110), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . Review of the facility's policy titled, Infection Prevention and Control Program, dated 03/21/2024, showed, Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets. Review of the facility's undated policy titled, Hand Hygiene, showed that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy showed that use of gloves does not replace hand hygiene, to perform hand hygiene prior to donning [putting on] gloves, and immediately after removing gloves. The policy further showed that hand hygiene should be performed between resident contacts, after handling contaminated objects, before applying and after removing personal protective equipment (PPE), including gloves, after handling items potentially contaminated with blood/body fluids/secretions/or excretions, during resident care, moving from a contaminated body site to a clean body site, and after assistance with personal body functions such as elimination and hair grooming. LINEN STORAGE Observations on 04/25/2024 at 1:42 PM, on 04/26/2024 at 8:49 AM, on 04/26/2024 at 10:49 AM, and on 04/26/2024 at 12:40 PM, showed folded clean towels that were uncovered and stored on a table in the 200 Unit hallway. Additional observation on 04/29/2024 at 11:08 AM, showed a housekeeping cart with a garbage container parked next to the clean uncovered towels. During an interview and joint observation on 04/29/2024 at 8:45 AM with Staff III, Certified Nursing Assistant (CNA), stated that the towels were used as clothing protectors for residents when eating. Joint observation of the clean towels showed they were uncovered. Staff III stated that the towels were uncovered. On 04/29/2024 at 3:30 PM, Staff WW, Infection Preventionist (IP), stated that clean linens should be stored in a covered area and not uncovered in the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/2024 at 2:14 PM, Staff B, Director of Nursing Services, stated clean linens should be stored in covered areas like the clean utility rooms. HAND HYGIENE/GLOVE USE STAFF CCC Observation on 04/24/2024 at 10:31 AM, showed Staff CCC, Occupational Therapist, was helping Resident 71 get set up for brushing their teeth. Staff CCC left the room to get a cup from the medication cart in the hall and did not perform hand hygiene when they left and/or re-entered Resident 71's room. Additional observation on 04/24/2024 at 10:39 AM, showed Staff CCC left Resident 71's room and took a container of sanitizing wipes located at the nurse's station and re-entered the room without performing hand hygiene. On 04/24/2024 at 2:32 PM, Staff CCC stated they should perform hand hygiene before entering and when leaving a resident's room. Staff CCC stated they should have performed hand hygiene before and after providing care in Resident 71's room. STAFF LLL Observation on 04/29/2024 at 9:30 AM, showed Staff LLL, Laundry Lead, removed their used gloves and did not perform hand hygiene before touching surfaces in the laundry room and outside the laundry room. On 04/29/2024 at 9:30 AM, Staff LLL stated their process was to do hand hygiene after taking off their gloves and no, I didn't wash my hands. On 04/29/2024 at 3:30 PM, Staff WW stated they expected staff to wash their hands every time they enter and exit a resident's room. Staff WW stated that hand hygiene should be done as soon as staff removed their gloves. On 04/30/2024 at 2:14 PM, Staff B stated they expected hand hygiene to be done before and after touching a contaminated surface, in addition to entering and leaving the [residents] room. Staff B further stated that hand hygiene should be done immediately after removing gloves. STAFF ZZ Observation on 04/25/2024 at 10:05 AM, showed Staff W, Licensed Practical Nurse, was cleaning Resident 71's pressure ulcer (bed sore). Staff ZZ, CNA, assisted Staff W by helping Resident 71 turn to their side and continued holding them during the wound care process. Staff W put on new gloves to apply the Hydrofera Blue [a type of moist wound dressing] to the wound, which would not stay in place. Staff ZZ was wearing the same gloves and assisted Staff W to hold Resident 71's wound dressing. On 04/25/2024 at 10:40 AM, Staff ZZ stated that when they helped with the dressing change for Resident 71, they weren't touching anything dirty and that they were assuming that the resident's gown was clean prior to touching the clean Hydrofera Blue dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/2024 at 10:47 AM, Staff W stated that Staff ZZ should have changed their gloves and wash their hands before helping to hold the Hydrofera Blue dressing on the cleaned area. On 04/29/2024 at 3:30 PM, Staff WW stated that either Staff W should have been the one touching the Hydrofera Blue dressing or Staff ZZ should have changed their gloves before touching the cleaned area. On 04/30/2024 at 2:14 PM, Staff B stated that Staff ZZ should have changed their gloves and performed hand hygiene prior to touching the Hydrofera Blue dressing. 49619 STAFF S On 04/25/2024 at 9:13 AM, Staff S, wore gloves to assist Resident 39 with peri-care (cleaning of private parts) in the resident's bathroom. Staff S with the same used gloves, pulled the resident's pants up and transferred Resident 39 into their wheelchair while touching multiple surfaces of the wheelchair. Staff S touched Resident 39's bedside table, their hand, the TV remote control, bedside drawer, wheelchair brakes, and walker. Staff S assisted Resident 39 to transfer from their wheelchair into their bed. Staff S then assisted Staff II, Registered Nurse (RN), with applying a condom catheter on Resident 39. Staff S stretched the condom catheter and applied it to Resident 39. Staff S did not do hand hygiene and/or changed their used gloves in between task, after assisting Resident 39 in the bathroom or after assisting the resident back into their bed. On 04/25/2024 at 10:24 AM, Staff S stated they should have removed their used gloves and washed their hands after assisting Resident 39 in the bathroom. Staff S stated they should have applied new gloves to assist the resident with transfers, and then completed hand hygiene and changed their gloves prior to assisting with the condom catheter. On 04/25/2024 at 10:51 AM, Staff II stated that hand hygiene should be completed before and after assisting a resident with peri-care. Staff II stated that Staff S should have done hand hygiene and put on a new pair of gloves as it put the resident at risk for, contamination and infection. On 04/29/2024 at 4:54 PM, Staff WW stated that Staff S should have removed their used gloves after care, performed hand hygiene, assisted with resident transfer, performed hand hygiene again, and put on a new pair of gloves prior to assisting with applying a condom catheter. Staff WW stated that contamination happened in multiple areas. On 04/30/2024 at 12:28 PM, Staff B stated that Staff S should have performed hand hygiene after assisting the resident with peri-care, remove their used gloves, and performed hand hygiene again prior to the next task. 47218 STAFF TT (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/22/2024 at 8:37 AM, showed Staff TT, CNA, was coming out of room [ROOM NUMBER] holding a soiled hospital gown with their bare hand. The soiled hospital gown was not in a bag. Staff TT went to room [ROOM NUMBER] and brought with them the soiled gown from room [ROOM NUMBER]. Staff TT went to room [ROOM NUMBER] holding the soiled gown with their bare hand and placed it in a clear plastic bag with a soiled gown from room [ROOM NUMBER]. Staff TT went to room [ROOM NUMBER] with soiled gowns in a plastic bag, then went to room [ROOM NUMBER]. Staff TT then placed the bag of soiled gowns on Resident 114's (room [ROOM NUMBER]) bedside table and put more soiled gowns in it. Staff TT then took the bag of soiled gowns to the soiled utility room. Staff TT did not do hand hygiene before entering or after leaving these rooms. HAND HYGIENE/MEAL TRAYS STAFF TT On 04/23/2024 at 8:17 AM, Staff TT brought a breakfast meal tray to room [ROOM NUMBER]-A and placed it on Resident 279's side table. Staff TT then donned gloves without doing hand hygiene and assisted Resident 279 to the bathroom, removed their soiled gloves, and did not do hand hygiene. Staff TT then assisted Resident 279 with their breakfast tray, removed a lid from an oatmeal bowl, opened a package of sugar and poured it into Resident 279's oatmeal bowl. Staff TT did not do hand hygiene in between these tasks. Another observation on 04/23/2024 at 8:45 AM, showed Staff TT took one used pink pitcher from the 300 Dining Room, washed it with hand soap and water, then filled it with ice and water, and took it to Resident 281 (room [ROOM NUMBER]-B). On 04/23/2024 at 8:57AM, Staff TT stated they should have not taken soiled gown from room [ROOM NUMBER] to Rooms 302, 301 & 303 and that they should have performed hand hygiene before entering and after leaving those rooms. Staff TT further stated that they should have not washed the used water pitcher in the sink with hand soap and water. On 04/26/2024 at 11:55 AM, Staff YY, Resident Care Manager (RCM), stated that staff should perform hand hygiene in between tasks, after glove use, and before entering/after leaving residents' rooms. Staff YY further stated that staff [Staff TT] should have not taken residents personal used items into other residents' rooms, soiled items should have been bagged before coming out of residents' rooms, and that water pitchers should be washed in the kitchen and not with hand soap and water. On 04/29/2024 at 11:50 AM, Staff D, Culinary Director, stated that used water pitchers should be washed in the kitchen's dishwasher with hot temperature water and not in the dining room sinks. On 04/29/2024 at 3:16 PM, Staff B stated that used residents' personal items should not be taken into other residents' rooms and that residents' used items should have been contained in a bag prior to leaving residents' room. Staff B stated that staff [Staff TT] should perform hand hygiene before entering/after leaving residents' rooms, in between tasks, after providing toileting care, and before putting/after glove use. Staff B further stated that residents' water pitchers should have been washed in the kitchen. 43392 (continued on next page)

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	505416	A. Building B. Wing	04/30/2024

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Foss Home & Village	13023 Greenwood Avenue North Seattle, WA 98133

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/22/2024 at 12:39 PM, showed Staff V, CNA, delivered five food trays to different residents in the 400 Dining Room while touching a resident's wheelchair, table surfaces and picked something off the floor using a paper towel without performing hand hygiene. On 04/22/2024 at 12:39 PM, Staff V stated that they had performed hand hygiene outside the dining room but not while inside. Staff V stated that the policy encouraged them to perform frequent hand hygiene when serving food between residents. CONTACT PRECAUTIONS Resident 27 Review of the progress note dated 04/28/2024, showed Resident 27 was placed on contact precaution (measures put in place to prevent spread of infection by direct or indirect contact with the resident or environment by staff wearing gown and gloves before entering a resident's room or environment) for a lesion to their right armpit due to history of methicillin-resistant staphylococcus aureus (bacteria that is resistant to several antibiotics) to the back area. Observation on 04/29/2024 at 12:04 PM, showed Staff KK, CNA, entered Resident 27's room with a meal tray without wearing a gown or gloves. Resident 27's door had a contact precaution signage posted. Staff KK came out of the room, performed hand hygiene, and continued to deliver meal trays to other residents. On 04/29/2024 at 12:10 PM, Staff KK stated they did not put on a gown or gloves since they were only delivering a meal tray to the resident and were not providing care. Observation and interview on 04/29/2024 at 12:05 PM, showed Staff U, Laundry Staff, entered Resident 27's room without wearing a gown or gloves. Staff U came out of the room and hand sanitized their hands and proceeded to deliver laundry to other rooms. Staff U stated they did not wear a gown or gloves because they were only delivering clean laundry to the resident and did not provide care. Observation on 04/29/2024 at 1:29 PM, showed, Staff T, Housekeeper, enter Resident 27's room without putting on a gown or gloves. On 04/29/2024 at 1:35 PM, Staff T stated they did not wear a gown or gloves because they went in to clean Resident 27's room and did not have contact with the resident. On 04/30/2024 at 10:21 AM, Staff B stated staff were required to perform hand hygiene before they start passing meal trays and in between serving meals. Staff B further stated they expected staff to wear a gown and gloves before they entered a contact precaution resident room. 45146 ENHANCED BARRIER PRECAUTIONS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Centers for Disease Control and Prevention (CDC) website, last reviewed on 08/01/2024, high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use such as wound care, and any skin opening requiring a dressing. RESIDENT 99 Review of a wound consult note dated 04/18/2024, showed Resident 99 had a wound on their sacrum (an area above tailbone) and left second toe that required a dressing. Review of the April 2024 treatment administration record showed Resident 99 had an order for wound care for their sacrum and left second toe wounds. Observations on 04/24/2024 at 3:30 PM, on 04/25/2024 at 1:36 PM, and on 04/29/2024 at 11:24 AM, showed no EBP sign on Resident 99's room door or Personal Protective Equipment (PPE) cart was placed by the resident's room. Observation on 04/26/2024 at 1:03 PM, showed Staff O, CNA, and Staff EEE, CNA, were transferring Resident 99 from their wheelchair to their bed without wearing a gown. On 04/26/2024 at 1:26 PM, Staff O and Staff EEE stated they used gloves only during Resident 99's transfer and did not know if other PPE was required other than gloves. Observation on 04/29/2024 at 12:42 PM, showed Staff GG, RN, was providing wound care for Resident 99's sacrum wound and was not wearing a gown during wound care. Observation on 04/29/2024 at 1:04 PM, showed Staff MMM, CNA, was applying incontinence brief for Resident 99 without wearing a gown during the incontinence care. On 04/29/2024 at 1:06 PM, Staff MMM stated they did not know that Resident 99 was on precaution. On 04/29/2024 at 1:09 PM, Staff GG stated that Resident 99 was not on precaution. On 04/29/2024 at 1:37 PM, Staff PP, RCM, stated that Resident 99 was on EBP, and staff should wear gown and gloves during high contact resident care activities. Joint observation with Staff PP showed there was no signage posted on the resident's room door that showed Resident 99 was on EBP. Staff PP stated there should be an EBP signage on Resident 99's room door. On 04/29/2024 at 1:56 PM, Staff E, IP, stated that for residents on EBP, wearing gloves and gown were required during high contact resident care activities. Staff E further stated that Resident 99 should have been placed on EBP. On 04/30/2024 at 9:45 AM, Staff B stated Resident 99 should have been placed on EBP. 47680 RESIDENT 110 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 110's physician's order with a start date of 04/15/2024 showed an order for enhanced barrier precaution for foley catheter (a flexible tube inserted into the bladder to drain urine). Staff to wear gown and gloves with high-contact resident care activities (dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or toileting) every shift. Observations on 04/24/2024 at 11:03 AM, on 04/25/2024 at 1:43 PM, and on 04/26/2024 at 1:32 PM, did not show an enhanced barrier precaution signage on Resident 110's door and/or a PPE cart in the hallway. Observations on 04/29/2024 at 8:15 AM, did not show an enhanced barrier precaution signage on Resident 110's door. Staff I, CNA, attempted to reposition Resident 110 in bed. Staff I removed Resident 110's pillow and attempted to reposition the resident again. When Staff I was unable to reposition Resident 110, Staff I removed their used gloves, threw it in the thrash and left Resident 110's room to call for help without performing hand hygiene. Shortly after, Staff I and Staff MM, CNA, went inside Resident 110's room and closed the door to assist the resident without applying a gown or gloves prior to entering the room. On 04/29/2024 at 8:23 AM, Staff I stated that they assisted Resident 110 with repositioning, washed their face and provided oral care. Staff I stated Resident 110 was not on barrier precautions and that they were not instructed to wear a gown and gloves when providing care to Resident 110. Staff I stated that they would look in the Kardex (care guide for CNAs) to know if residents were on barrier precautions. Staff I further stated that they should have performed hand hygiene after removing their used gloves. On 04/29/2024 at 9:05 AM, Staff H, RN, stated that their process for residents on barrier precautions would be to place a signage on the resident's door and a PPE cart by the resident's room. Staff I stated that barrier precautions were communicated to everyone and that it should be in the resident's care plan. Staff H further stated Resident 110 was on enhanced barrier precaution and that staff should be wearing gowns and gloves during care. Joint observation with Staff H showed that Resident 110 did not have an enhanced barrier precaution signage on their door and the PPE cart that was in front of the soiled utility room and did not have gowns available for use. Staff H stated that there should have been an enhanced barrier precaution signage on Resident 110's door and gowns available in the PPE cart. On 04/29/2024 at 11:20 AM, Staff E stated that residents on precautions should have a signage on their door, an orange sticker by their name and a PPE cart in the hallway. Staff E stated that Staff I should have worn a gown and gloves during high contact care and performed hand hygiene after removing their used gloves. Staff E further stated that Resident 110's should have had an enhanced barrier precaution signage on their door and a PPE cart in the hallway. On 04/29/2024 at 1:13 PM, Staff B stated that they expected there to be an enhanced barrier precaution signage on Resident 110's door, staff to use appropriate PPE and staff to perform hand hygiene after removing their used gloves. Reference: (WAC) 388-97-1320 (1)(c)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility failed to conduct routine maintenance to ensure bed rails and/or halos (type of bed rail shaped like a ring) were safe for 3 of 5 residents (Residents 35, 95 & 74), reviewed for bed rails safety. This failure placed the residents at risk for injury and/or entrapment. Findings included . Review of the facility's undated policy titled, Halo Ring Installation and Maintenance Policy, showed, Maintenance shall inspect all Halo Rings monthly to ensure proper installation and usage. This check shall be logged into the work order system. The policy further showed if any deficiency was found with the Halo Ring, maintenance staff would remove the affected hardware and replace it. RESIDENT 35 Resident 35 admitted to the facility on [DATE]. Review of Resident 35's transfers care plan showed an intervention, revised on 09/20/2022, showed, Assistive devices; Right and left Halo to assist in bed mobility [movement in bed]/ transfer; Staff to report to LN [Licensed Nurse] immediately if problem noted with Halo use or there is a problem with the equipment. Observations on 04/22/2024 at 9:59 AM and at 2:38 PM, and on 04/24/2024 at 9:06 AM, showed Resident 35's bed had two bed rails, a halo on the right side of the resident and a different type of bed rail on the left side of the resident. Observation and interview with Resident 35 on 04/24/2024 at 9:06 AM, showed both bed rails were wobbly. Resident 35 stated that they used them every day for turning and support. Resident 35 further stated that no one had assessed them. Joint observation and interview on 04/24/2024 at 1:19 PM with Staff UU, Certified Nursing Assistant (CNA), showed the bed rails were wobbly. Staff UU stated that the bed rails should not be wobbly, they should be firm, and tight at the bottom, maybe they have gotten loose. On 04/24/2024 at 3:11 PM, Staff C, Facility Director, stated that there was no documentation showing the maintenance of the facility's bed rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Joint observation and interview on 04/24/2024 at 3:37 PM with Staff C, showed the left bed rail was wobblier than the right one. Staff C stated they did not know where the left bed rail came from as it did not belong to the facility, and they had not seen a bed rail like that. Staff C stated that the left bed rail appeared to have more play [movement] than it should. Staff C further stated that the right halo had more movement than they felt comfortable with. Staff C stated that they would expect the facility to be using their bed rails and have them have a tighter feeling, not have the whole extension moving with the rail. Staff C further stated that there was no way to know when the last routine maintenance occurred as there was no documentation. RESIDENT 95 Resident 95 admitted to the facility on [DATE]. Review of Resident 95's physician's order showed an order initiated on 02/23/2024 for Halos/Bed Enabler [rail]- Bilateral [both sides] for bed mobility. Observations on 04/22/2024 at 12:44 PM and on 04/24/2024 at 9:15 AM, showed Resident 95's bed rails were loose, the left was looser than the right rail. Joint observation and interview on 04/24/2024 at 3:11 PM with Staff C, showed Resident 95's left bed rail was flared out. Staff C stated that the halo ring, did not appear to be parallel, and that they would recommend replacing the bracket. On 04/30/2024 at 12:32 PM, Staff B, Director of Nursing Services, stated that the bed rails for Resident 35 and 95 should not have been wobbly. Staff B stated that Resident 35 should not have had a bed rail that did not belong to the facility. Staff B further stated that they expected maintenance staff to be checking the bed rails for function and tightness and expected there to be documentation. 46912 RESIDENT 74 Resident 74 admitted to the facility on [DATE]. Review of Resident 74's activities of daily living care plan revised on 04/19/2024, showed Resident 74 used bilateral bed enablers for bed mobility (moving in bed) and transfers. Observation on 04/23/2024 at 9:18 AM, showed bilateral bed rails in the raised position on Resident 74's bed, and the left bed rail was loose. On 04/23/2024 at 9:32 AM, Resident 74 stated they used their bed rails for turning in bed. On 04/24/2024 at 2:53 PM, Resident 74 stated there had been no routine checks done for their bed rails. On 04/24/2024 at 12:51 PM, Staff AAA, CNA, stated Resident 74 used their bed rails for pulling up in bed and when getting out of bed. Staff AAA stated they tell maintenance if they noticed a problem with resident's bed rails. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/2024 at 3:09 PM, Staff C stated, currently there was no documentation that showed bed rails/halos were being checked routinely. Staff C further stated there should be documentation of routine maintenance for the bed rails/halos. During a joint observation and interview on 04/24/2024 at 3:31 PM with Staff C, showed Resident 74's left rail was wobbly, Staff C stated that the left side [rail] is too loose. On 04/30/2024 at 2:40 PM, Staff A, Administrator, stated that they would expect regular, preventative maintenance for the Halos. Staff A stated they expect documentation for routine maintenance of the bed rails/halos from here on out. Reference: (WAC) 388-97-2100 (1)