| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505417 | A. Building<br>B. Wing | 11/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Saint Anne Nursing and Rehabilitation Center | 3540 Northeast 110th Street<br>Seattle, WA 98125 |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>50891<br><br>Based on observation, interview, and record review, the facility failed to ensure survey results were posted in a place readily accessible to residents and residents' legal representatives. This failure prevented residents, residents' representatives and visitors from exercising their right to review past survey results and the facility's plan of correction.<br><br>Findings included .<br><br>Observations on 10/28/2024 at 10:00 AM, on 10/29/2024 at 9:41 AM, and on 0/30/2024 at 9:56 AM, the facility lobby did not show a survey binder was readily available and accessible to all residents and their residents' legal representatives.<br><br>In an interview on 10/31/2024 at 3:34 PM, Resident 11 stated that they would have to ask the business office to see the survey results. Resident 11 stated that they had not seen a survey binder book in the lobby.<br><br>In an interview and joint observation on 11/04/2024 at 5:26 PM, Staff A, Administrator, stated that they kept the survey binder right by the opening of the business office window at the lobby. Staff A stated that the book was not out because they had the book in their office to prepare for the survey.<br><br>Reference: (WAC) 388-97-0480(1)(b)(5)(a)(b) |

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

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

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>47218<br><br>Based on observation, interview, and record review, the facility failed to ensure a homelike dining experience was provided for 1 of 8 residents (Resident 94), reviewed for dignity/privacy during dining. This failure placed the resident at risk for dignity issues and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Administering Medications, revised in April 2019, showed that medications were administered in a safe and timely manner, and as prescribed. The policy further showed that medication administration times were determined by resident need and benefit, not staff convenience.<br><br>Observation on 10/29/2024 at 8:52 AM, showed Staff N, Registered Nurse, giving Resident 94 their oral medications in the main dining room during the breakfast meal. Staff N was observed telling Resident 94 what medications they were taking and what they were for in front of seven other residents in the dining room.<br><br>On 10/29/2024 at 4:08 PM, Staff N, stated that they gave Resident 94 their five oral medications in the dining room and that they should not have.<br><br>On 11/04/2024 at 2:46 PM, Staff B, Director of Nursing, stated they did not expect medications were given to residents in the dining room unless it was indicated in their care plan. Staff B further stated that Staff N should not have given Resident 94's medications in the dining room.<br><br>Reference: (WAC) 399-97-0880 (1) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on interview and record review, the facility failed to ensure allegation of abuse and/or neglect were thoroughly investigated for 2 of 4 residents (Resident 3 & 31), reviewed for abuse investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions.<br><br>Findings included .<br><br>Review of the facility's policy titled, Abuse/Neglect Prevention Program Policy, dated April 2021, showed that residents had the right to be free from abuse/neglect, including freedom from physical abuse. The policy further showed that the facility would identify and investigate allegations of abuse, report any allegations within time frames required by the Federal Government, and protect residents from further harm during investigations.<br><br>According to the Washington State Reporting Guidelines for Nursing Homes (The Purple Book), dated October 2015, All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated.<br><br>RESIDENT 3<br><br>Review of the admission Minimum Data Set (MDS - an assessment tool) dated 10/03/2024 showed that Resident 3 was cognitively intact.<br><br>Review of Resident 3's incident investigation showed that on 10/27/2024 at 10:47 AM, one of the housekeeping staff saw Resident 3 in another resident's room, informed one of the aides [nursing assistants], and that t aide took Resident 3 back to their room, and called the nurse. Further review of the incident investigation showed that Resident 3 stated that Resident 29 patted their cheek and head yesterday [10/26/2024] at [the] dining room at dinner time and that Resident 29 repeated it [patted Resident 3's cheek and hair] this morning [10/27/2024] too. Further review of the investigation data analysis did not show the following: 1) Resident 29 was interviewed and/or other witnesses' statements; 2) documentation of the last time Resident 3 had been checked and/or provided care; 3) documentation to show what care plan interventions were followed or what care plan was reviewed; 4) skin assessments to show Resident 3 had no injuries related to the incident; and 5) documentation to show the facility ruled out abuse/neglect.<br><br>On 11/01/2024 at 1:38 PM, Resident 3 stated that Resident 29 touched their hair, tried to be my friend, and that Resident 29 made them feel uncomfortable. Resident 3 further stated that Resident 29 had not tried to touch them again after that.<br><br>RESIDENT 31<br><br>Review of the incident log from May 2024 to October 2024 showed that Resident 31 had a fall incident on 07/30/2024 and another fall incident on 09/12/2024.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the admission MDS dated [DATE] showed Resident 31 had severe cognitive impairment.<br><br>FALL INCIDENT INVESTIGATION 07/30/2024<br><br>Review of Resident 31's fall incident investigation showed that on 07/30/2024 at 8:00PM, Resident 31 was found lying on the floor in supine [on their back] position and Resident 31 stated that they were trying to reach for their jacket from their chair, lost their balance, and fell . Further review of Resident 31's incident investigation did not include the following: 1) witnesses' (residents/staff) statements; 2) documentation of when the last time Resident 31 had been checked and/or provided with care; 3) skin assessments to show Resident 31 abrasion to their left eyebrow; 4) documentation to show what care plan interventions were followed, reviewed or updated; and 5) documentation to show the facility ruled out abuse/neglect.<br><br>FALL INCIDENT INVESTIGATION 09/12/2024<br><br>Review of Resident 31's fall incident investigation showed that on 09/12/2024 at 5:16 AM, Resident 31 was found next to their bed and that Resident 31 hit their head when they fell .<br><br>Further review of Resident 31's incident investigation did not include the following: 1) witnesses' (residents/staff) statements; 2) documentation of the last time Resident 31 had been checked and/or provided with care; 3) skin assessments to show Resident 31's hematoma (a solid swelling of the clotted blood within the tissues) to left cheek; 4) documentation to show neurological checks were conducted; and 5) documentation to show what care plan interventions were followed, reviewed or updated.<br><br>On 11/04/2024 at 4:19 PM, Staff B stated that they followed the purple book for completion of investigations, and they expected incident investigations had witnesses' statements, residents' interviews, reviewed and/or updated the care plans. Staff B further stated that they did not get staff or other residents' statements for Resident 3's allegation of abuse investigation and/or for both of Resident 31's fall incident investigations.<br><br>On 11/04/2024 at 5:13 PM, Staff A, Administrator, stated they expected residents' incident investigations had a summary related to the incident, care plans and resident's diagnoses were reviewed, an investigation questionnaire was completed, that residents were protected, educate, monitor, and follow up until substantial compliance was achieved. Staff A further stated they expected fall incidents were investigated for potential abuse or neglect, residents were assessed to prevent from falling, and that the interdisciplinary team was involved to come up with a plan to prevent further falls.<br><br>Reference: (WAC) 388-97-0640 (6)(a)(b) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident and/or their representative for 1 of 2 residents (Resident 28), reviewed for hospitalization . This failure placed the resident and/or their representative at risk for not having an opportunity to make informed decisions about transfers/discharges.<br><br>Findings included .<br><br>Review of the facility's policy titled, Transfer or Discharge Notice, revised in October 2024, showed, Emergency Transfers: When a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon practicable.<br><br>A review of the nursing progress notes showed Resident 28 discharged to the hospital on 08/17/2024. Another review of the nursing progress notes showed Resident 28 readmitted to the facility on [DATE].<br><br>A review of the electronic health record did not show documentation that Resident 28 was offered and/or provided a transfer/discharge notice when they discharged to the hospital on 08/17/2024.<br><br>During a joint record review and an interview on 11/04/2024 at 9:48 AM with Staff D, Social Services Director, showed Resident 28's electronic health records (miscellaneous tab) had no documentation to show that a transfer/discharge notice was provided when they were sent to the hospital on 08/17/2024. Staff D stated that it was a weekend on 08/17/2024 and that the nurses should have provided Resident 28 a transfer/discharge notice.<br><br>On 11/04/2024 at 10:19 AM, Staff O, Registered Nurse, stated that residents who discharge to the hospital should be provided a transfer/discharge notice at time of discharge.<br><br>On 11/04/2024 at 3:16 PM, Staff B, Director of Nursing, stated that they expected transfer/discharge notices were provided to residents when they discharge to the hospital. Staff B further stated that Resident 28 should have been provided a transfer/discharge notice.<br><br>Reference: (WAC) 388-97-0120 (2) (a-d) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>47218<br><br>Based on interview and record review, the facility failed to ensure bed hold (the opportunity to reserve a resident's current occupied bed while out of the facility to ensure their room was available when ready to return) notice was offered for 1 of 2 residents (Resident 28), reviewed for hospitalization . This failure placed the resident or their representative at risk for lack of knowledge regarding the right to hold their bed while in the hospital.<br><br>Findings included .<br><br>Review of the facility's policy titled, Bed Holds and Returns, revised in November 2024, showed Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. 1. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours).<br><br>A review of the nursing progress notes showed Resident 28 discharged to the hospital on 08/17/2024.<br><br>A review of the electronic health record under the miscellaneous tab for August 2024 did not show documentation that Resident 28 was offered a bed hold notice for their transfer to the hospital.<br><br>A joint record review and an interview on 11/04/2024 at 9:48 AM with Staff D, Social Services Director, showed Resident 28's electronic health records (miscellaneous tab) had no documentation to show that a bed hold notice was provided when they discharged to the hospital on 08/17/2024. Staff D stated that the bed hold notice should have been provided to Resident 28 if it was in the facility's policy.<br><br>On 11/04/2024 at 3:16 PM, Staff B, Director of Nursing, stated that they expected bed hold notices were provided to residents when they discharge to the hospital. Staff B also stated that Resident 28 should have been provided a written bed hold notice.<br><br>Reference: (WAC) 388-97-0120 (4)(a) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298<br><br>Based on interview and record review, the facility failed to accurately assess 5 of 16 residents (Residents 9, 17, 3, 31 & 4), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding use of antibiotic (medication to inhibit growth of bacteria), use of insulin (medication/hormone that regulates blood sugar levels) injections, use of anticoagulant (medication to prevent blood clot), use of intrathecal pump (administration of medication through an injection into the spinal canal), use of diuretic (medication to increase urination), and tube feeding (a medical device used to provide nutrients through a tube directly into the stomach) placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life.<br><br>Findings included .<br><br>According to 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, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. It further showed, intrathecal and baclofen [pain medication] pumps [device that is implanted under the skin and is connected to a catheter (tube) that ends in the spinal fluid] may be coded here, as they are similar to IV [Intravenous - a flexible tube is inserted into a vein, to deliver medicine or fluids into the bloodstream] medications in that they must be monitored frequently, and they involve continuous administration of a substance.<br><br>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).<br><br>RESIDENT 9<br><br>Resident 9 admitted to the facility on [DATE] with diagnoses that included liver disease.<br><br>A review of Resident 9's quarterly MDS dated [DATE], showed Section N0415F (High-Risk Drug Classes that included antibiotic use and indication during the look-back period) was not marked.<br><br>Review of the September 2024 Medication Administration Record (MAR) showed Resident 9 received Rifaximin [an antibiotic] during the look-back period.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview and joint record review on 11/04/2024 at 8:18 AM, Staff G, Admission/MDS Coordinator, stated they followed the RAI manual for MDS completion. Joint record review of Resident 9's quarterly MDS dated [DATE], showed use of antibiotic was not marked. Joint record review of the September 2024 MAR showed Resident 9 received antibiotic during the look-back period. Staff G stated that Resident 9's quarterly MDS was not coded accurately, and that use of antibiotic should have been marked.<br><br>RESIDENT 17<br><br>Review of Resident 17's admission MDS dated [DATE], showed Section N0350A (the number of days during the 7-day look-back period [or since admission/entry or reentry if less than 7 days] that insulin injections were received) was marked a seven. Further review of the admission MDS, showed Section N0415E (High-Risk Drug Classes that included anticoagulant use and indication during the look-back period) was not marked.<br><br>Review of the August 2024 MAR showed Resident 17 received six insulin injections during the 7-day look-back period from 08/06/2024 to 08/12/2024. Further review of the MAR showed Resident 17 received an anticoagulant.<br><br>An interview and joint record review on 11/04/2024 at 8:40 AM, Staff G stated they followed the RAI manual for MDS completion. Joint record review of Resident 17's admission MDS dated [DATE], showed insulin injection was coded a 7 (seven) and anticoagulant was not marked. Joint record review of Resident 17's August 2024 MAR showed Resident 17 received anticoagulant medication and six insulin injections during the look-back period. Staff G stated that Resident 17's admission MDS was not coded accurately. Staff G further stated that insulin injection should have been coded as 6 (six) and that the anticoagulant should have been marked.<br><br>On 11/04/2024 at 12:04 PM, Staff B, Director of Nursing, stated they expected the MDS to be coded accurately.<br><br>47218<br><br>RESIDENT 3<br><br>Review of the physician orders showed Resident 3 had an order dated 09/27/2024 for intrathecal pain medication pump on their abdomen area.<br><br>Review of the admission MDS dated [DATE] showed that Resident 3's pain medication was not marked as IV medication in Section O (Special Treatments, Procedures, and Programs).<br><br>Joint record review and interview on 11/04/2024 at 8:17 AM with Staff G, showed Resident 3's physician order had an intrathecal pain medication pump order dated 09/27/2024. Staff G stated that Resident 3 had the pain medication since admission. Joint record review of Resident 3's admission MDS dated [DATE], showed that IV medication was not marked in Section O. Staff G stated that the MDS was inaccurate, and that the IV medication should have been marked in Resident 3's MDS.<br><br>On 11/04/2024 at 3:30 PM, Staff B stated they expected the MDS to be accurate and that IV medication should have been marked in Resident 3's MDS assessment.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | RESIDENT 31<br><br>Review of the physician orders showed Resident 31 had an order dated 06/16/2024 for a diuretic medication.<br><br>Joint record review and interview on 11/04/2024 at 3:19 PM with Staff B, showed Resident 31 had an order for a diuretic medication dated 06/16/2024. Staff B stated that Resident 31 was on diuretic. Joint record review of Resident 31's admission MDS dated [DATE], showed the diuretic medication was not marked in Section N (Medications). Staff B stated that diuretic use should have been marked and Resident 31's MDS was inaccurate.<br><br>50891<br><br>RESIDENT 4<br><br>Resident admitted to the facility on [DATE] with multiple diagnoses that included dysphagia (difficulty in swallowing).<br><br>A review of the quarterly MDS dated [DATE], showed Resident 4's MDS under Section GG (Functional Abilities) was marked as 01 (dependent-another person completed the activity for the resident) with eating.<br><br>A joint record review and interview on 11/04/2024 at 8:57 AM with Staff G, showed Resident 4's quarterly MDS was marked as 01 for eating. Staff G stated that Resident 4 received 100% of their sustenance through tube feeding and they marked 01 for eating. Staff G further stated that Resident 4's MDS was marked incorrectly for eating and that should have been marked either 09(not applicable) or 88 (not attempted due to medical conditions or safety concerns).<br><br>On 11/04/2024 at 2:46 PM, Staff B stated that they expected the MDS to be done correctly. Staff B further stated that Resident 4's MDS should had been marked as 09 for not applicable for eating.<br><br>Reference: (WAC) 388-97-1000 (1)(b)(h)(n)(o) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891<br><br>Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Reviews (PASARR-an assessment to ensure individuals with Serious Mental Illness [SMI] or Intellectual/Developmental Disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) Level I was completed for 1 of 6 residents (Resident 17), reviewed for unnecessary medications. This failure placed the resident at risk for not receiving the care and services appropriate for their needs.<br><br>Findings included .<br><br>Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled Clarification to the Pre-Admission Screening and Resident Review (PASARR OR PASRR) Level I Screening Process, dated 07/06/2024 and amended on 08/23/2024, showed a positive Level I PASARR screen (that would then require a referral for a Level II PASARR) was if Any of the questions in Section 1A (1, 2, and/or 3) are marked Yes.<br><br>Review of the facility's policy titled, Admission Criteria, revised on March 2019, showed all new admissions and readmissions were screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid PASARR process. The policy further showed that if the Level I screen indicates that the individual may meet the criteria for a mental disorder, intellectual disabilities or related disorder, he or she was referred to the state PASARR representative for the Level II (evaluation and determination screening process. When a resident was identified as having a MD, ID, or RD, the admitting nurse would notify the social services department. The social worker was responsible for making referrals to the appropriate state-designated authority.<br><br>A review of Resident 17's face sheet showed Resident admitted to the facility on [DATE].<br><br>A review of Resident 17's PASARR, signed on 08/06/2024, was marked yes for SMI under Section IA, and yes for mood disorders. Further record review showed PASARR Section IV (Services Needs and Assessor Data) was not filled out.<br><br>In an interview and joint record review on 11/04/2024 at 8:27 AM with Staff D, Social Services Director, stated that they reviewed the PASARR forms for completion when they receive them from the hospital. Staff D stated that we get them [PASARR forms] from the hospital, then modify them [PASARR forms] as needed. Any changes needed; we will request for a PASARR [Level] II. Joint record review of Resident 17's Electronic Health Record (EHR) did not show a PASARR Level II evaluation. Staff D stated that they sent a bunch of them [multiple Level II PASSRs) and that did not know why they would not have sent it.<br><br>On 11/04/2024 at 5:26 PM, Staff A, Administrator, stated that they expected PASARR Level I form was completed prior to residents' admission to the facility.<br><br>Reference: (WAC) 388-97-1915 (1)(2) (a-c) (4), 1975(1)(4) |

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| | 505417 | A. Building<br>B. Wing | 11/04/2024 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on interview and record review, the facility failed to develop and implement care plans for 2 of 16 residents (Residents 31 & 17), reviewed for comprehensive care plan. The failure to develop care plans for diuretic (reduce swelling/fluid buildup in the body) medications placed the residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in November 2024, showed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set - an assessment tool] assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.<br><br>RESIDENT 31<br><br>Review of the face sheet printed on 10/30/2024 showed Resident 31 admitted to the facility on [DATE].<br><br>Review of the physician orders showed Resident 31 had an order for diuretic medication dated 06/16/2024.<br><br>Review of the care plan printed on 10/30/2024 showed Resident 31 did not have a care plan for use of diuretic medication.<br><br>Joint record review and interview on 11/04/2024 at 10:46 AM with Staff O, Registered Nurse, showed Resident 31's physician orders for a diuretic medication. Staff O stated Resident 31 started on a diuretic medication on 06/16/2024. Joint record review showed Resident 31 had no care plan for use of diuretic medication. Staff O stated that Resident 31 did not have a diuretic care plan and that it should have been care planned.<br><br>On 11/04/2024 at 3:29 PM, Staff B, Director of Nursing, stated that they expected medications that were in Section N [Medications] of the MDS, for example diuretics were care planned. Staff B further stated that Resident 31 was on diuretics and that the use of diuretic medication should have been care planned.<br><br>50891<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RESIDENT 17<br><br>A review of the face sheet showed Resident 17 admitted to the facility on [DATE] with diagnoses including essential hypertension (high blood pressure) and end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids).<br><br>A review of the physician orders dated 08/06/2024, showed Resident 17 admitted with orders for a diuretic medication twice a day.<br><br>A review of Resident 17's care plan, printed on 10/31/2024, showed use of diuretic medication care plan was added on 10/30/2024, over two months after Resident 17 had admitted .<br><br>A joint record review and interview on 11/04/2024 at 2:46 PM with Staff B, showed no care plan for use of diuretic medication for Resident 17 prior to 10/30/2024. Staff B stated that the diuretic care plan should have been included on 08/06/2024.<br><br>Reference: (WAC) 388-97-1020 (1) (2)(a)(3) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) assistance were consistently provided for 2 of 3 residents (Residents 34 & 26), reviewed for ADLs. The failure to provide residents who were dependent on staff for assistance with showers/bathing placed the residents at risk for poor hygiene, decreased self-esteem, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Activities of Daily Living, revised in October 2024, showed that appropriate care and services were provided for residents who were unable to carry out ADL independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, bathing, dressing, grooming, and oral care.<br><br>RESIDENT 34<br><br>On 10/28/2024 at 3:43 PM, Resident 34 stated they wanted to have more showers than once a week and that they have talked to facility staff numerous times that they have not gotten an answer.<br><br>A review of the admission Minimum Data Set (MDS - an assessment tool) dated 08/07/2024 showed Resident 34 required partial/moderate assist (helper [or staff] does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with showers/bathing.<br><br>Review of the shower schedule from 10/28/2024 to 11/03/2024 showed Resident 34 was scheduled to have showers on Saturdays.<br><br>Review of the October 2024 bathing task printed on 10/30/2024, showed Resident 34 received one shower on 10/20/2024 (Sunday) and on 10/26/2024 (Saturday). Further review of the bathing task showed a shower was refused on 10/19/2024 (Saturday), no other documentation to show that Resident 34 refused showers on prior Saturdays for the month of October 2024.<br><br>Review of Resident 34's ADL care plan initiated on 08/01/2024 showed, Give (bath/shower) per resident preference on scheduled days(s) Q [every] week and as needed. Prefers showers after breakfast 2 to 3 times a week.<br><br>On 11/01/2024 at 2:17 PM, Staff P, Certified Nurse Assistant, stated that they follow the shower schedule to provide residents with their showers and that they would document when they provide the shower and/or when the residents refused the shower. When asked why Resident 34 was not given their showers, Staff P stated they worked a different shift.<br><br>On 11/04/2024 at 10:22 AM, Staff O, Registered Nurse, stated that they expected staff to provide showers to the residents following the shower schedule and to document showers given and/or refused. Joint record review and interview with Staff O showed Resident 34 was scheduled for showers on Saturdays. Staff O stated that Resident 34 should be provided with showers on Saturdays.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Another joint record review and interview on 11/04/2024 at 10:33 AM with Staff O, showed the bathing task in the last 30 days for Resident 34's revealed they had showers on 10/20/2024 and on 10/26/2024. Staff O stated that that there were no other showers documented or refused on prior weeks. Joint record review of Resident 34's ADL care plan showed Resident 34 would get showers on scheduled days and additional showers two to three times a week per their preference. Staff O stated that Resident 34 should have had a least four showers a month or more according to their care plan.<br><br>A joint record review and interview on 11/04/2024 at 4:06 PM with Staff B, Director of Nursing, showed the October 2024 shower/bathing task for Resident 34 revealed they had showers on 10/12/2024, on 10/20/2024, and on 10/26/2024, Staff B stated that Resident 34 should have received at least four showers or more for the month of October 2024.<br><br>RESIDENT 26<br><br>On 10/28/2024 at 2:47 PM, Resident 26 stated that they have had three showers since they admitted to the facility. Resident 26 further stated that the last time they received a shower was a month ago.<br><br>Review of the admission MDS dated [DATE] showed that Resident 26 required dependent [total] assist with showers/bathing.<br><br>Review of the October 2024 bathing task printed on 10/30/2024, showed Resident 26 received one shower on 10/27/2024 (Sunday). Further review of the document did not show Resident 26 had other showers provided and/or had refusal of showers for October 2024.<br><br>Review of the shower/bath schedule from 10/28/2024 to 11/03/2024, showed Resident 26 was scheduler for shower for Saturdays Evening (offer around 2:00 PM).<br><br>On 11/01/2024 at 2:23 PM, Staff P stated that they followed the shower schedule to provide showers to the residents. Staff P stated that they had provided showers and bed baths to Resident 26 in the past and that Resident 26 preferred bed baths. Staff P further stated that Resident 26 had not refused bed baths from them.<br><br>A joint record review and interview on 11/04/2024 at 10:27 AM with Staff O, showed that Resident 26 was scheduled for showers on Saturdays. Staff O stated that they expected showers and refusal of showers be documented in the residents' records. Joint record review of the October 2024 bathing task, printed on 10/30/2024, showed Resident 26 had a shower on 10/27/2024 and no other documentation to show that a shower was provided or refused on previous Saturdays on 10/05/2024, on 10/12/2024, and on 10/19/2024. Staff O stated that Resident 26 should have gotten four showers in October 2024.<br><br>On 11/04/2024 at 3:33 PM, Staff B stated that there was no documentation to show that Resident 26 was provided showers and/or refused showers on 10/05/2024, on 10/12/2024, and on 10/19/2024. Staff B further stated that Resident 26 should have had at least four showers in October 2024.<br><br>Reference: (WAC) 388-97-1060 (2)(c) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on interview and record review, the facility failed to ensure diabetic [diabetes - a disease that occurs when blood sugar level is too high] nail care was provided for 1 of 6 residents (Resident 34), reviewed for quality of care. In addition, the facility failed to ensure residents on diuretic (that helps with edema [swelling] to reduce fluid buildup in the body) and/or anticoagulant medications (that stops blood from clotting too easily to help stop life-threatening conditions) were monitored for adverse side effects for 2 of 6 residents (Residents 31 & 32), reviewed for unnecessary medications. These failures placed the residents at risk for unmet care needs and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Medication Therapy, revised in November 2024, showed Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks . Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments . All medication orders will be supported by appropriate care processes and practices.<br><br>Review of the facility's policy titled, Anticoagulation - Clinical Protocol, revised in November 2024, showed that as part of the initial assessment, the physician and staff would identify individuals who are currently anticoagulated; for example: atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots, stroke [blood flow to the brain is blocked/reduced] and heart failure). It further showed that the residents would be assessed for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications.<br><br>DIABETIC NAIL CARE<br><br>Resident 34 admitted to the facility on [DATE] with diagnosis that included diabetes.<br><br>Review of the activities of daily living care plan initiated on 08/01/2024 showed Resident 34 would have diabetic nail care on bath/shower days and as needed.<br><br>An interview and joint record review on 11/04/2024 at 10:22 AM, Staff O, Registered Nurse (RN), stated that they would provide the resident's diabetic nail care when there were orders for it in the treatment administration records. A joint record review of shower schedule from 10/28/2024 to 11/03/2024 showed Resident 34 was scheduled for Saturdays, and review of the ADL care plan, initiated on 08/01/2024, showed an intervention for diabetic nail care to be done on bath/shower days and as needed. Staff O sated that Resident 34's diabetic nail care should have been scheduled for Saturdays.<br><br>A joint record review and interview on 11/04/2024 at 10:28 AM with Staff O, showed Resident 34's physician orders did not have an order for diabetic nail care. Staff O stated that they did not see Resident 34's diabetic nail care in their orders and that it should have been there.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/04/2024 at 4:16 PM, Staff B, Director of Nursing, stated that they expected Resident 34's diabetic nail care in their Medication Administration Record (MAR) and that the nurses documented nail care provided.<br><br>USE OF MEDICATIONS/MONITORING<br><br>RESIDENT 31<br><br>Resident 31 admitted to the facility on [DATE] with diagnoses that included atrial fibrillation and end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids).<br><br>Review of the October 2024 MAR showed Resident 31 had an order for an anticoagulant medication every 12 hours and a diuretic medication twice a day that started on 06/16/2024. Further review of the MAR did not show Resident 31 was being monitored for adverse side effects related to the use of the diuretic and anticoagulant medications.<br><br>A joint record review and interview on 11/04/2024 at 10:46 AM with Staff O, showed Resident 31 had physician orders for diuretic and anticoagulant medications. Staff O stated that Resident 31's diuretic and anticoagulant medication were started on 06/16/2024. Further review of the physician orders showed Resident 31 did not have orders to monitor adverse side effects related to the use of diuretic and anticoagulant medications. Staff O stated that Resident 31 should have had orders to monitor adverse side effects for use of diuretic and anticoagulant medications.<br><br>On 11/04/2024 at 3:19 PM, Staff B stated they expected residents using diuretic and anticoagulant medications were monitored for adverse side effects and that Resident 31 should have had orders to monitor adverse side effects.<br><br>50891<br><br>RESIDENT 32<br><br>Review of the face sheet showed Resident 32 was admitted to the facility on [DATE] with diagnoses that included nontraumatic subarachnoid hemorrhage (bleeding in the space between the brain and the tissues that cover the brain).<br><br>A review of the October 2024 MAR showed Resident 32 had an order for an anticoagulant medication every 12 hours, and did not include orders to monitor for adverse side effects.<br><br>A joint record review and interview on 11/04/2024 at 12:50 PM with Staff M, RN, showed Resident 32's October 2024 MAR did not have orders to monitor for adverse side effects related to the use of anticoagulant medication. Staff M stated Resident 32 did not have orders to monitor for adverse side effects in their MAR.<br><br>On 11/04/2024 at 2:46 PM, Staff B stated that Resident 32's MAR did not include orders to monitor for adverse side effects of anticoagulant medication.<br><br>Reference: (WAC) 388-97-1060 (1)(3)(k)(4) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298<br><br>Based on observation, interview, and record review, the facility failed to maintain, label/date, and properly store oxygen tubing/supplies and nasal cannula (flexible tubing that sits inside the nose and delivers oxygen) for 4 of 4 residents (Residents 9, 22, 32 & 28), reviewed for respiratory care. This failure placed the residents at risk for unmet care needs, respiratory infections, and related complications.<br><br>Findings included .<br><br>Review of the facility's policy titled, Oxygen Use, revised in October 2024, showed, It is the policy of this facility to promote resident safety in administering oxygen. The policy further showed that oxygen cannula or mask should be changed per orders or when visibly soiled, oxygen equipment should be cleaned regularly, and routine oxygen equipment inspection and maintenance should be performed based on manufacturer's recommendations.<br><br>RESIDENT 9<br><br>Resident 9 admitted to the facility on [DATE] with diagnosis that included heart failure (affects the heart's ability to pump blood to the rest of the body).<br><br>Review of Resident 9's oxygen therapy care plan initiated on 06/19/2024 showed oxygen at 2-4 liters (unit of measurement) per minute via nasal cannula or mask every shift.<br><br>Observation on 10/28/2024 at 4:18 PM, showed Resident 9 was on a continuous oxygen via nasal cannula that was connected to an oxygen concentrator. Further observation showed Resident 9's oxygen tubing/nasal cannula was not labeled or dated.<br><br>Observation and interview on 10/29/2024 at 8:28 AM, showed Resident 9 was having breakfast and was on a continuous oxygen via nasal cannula that was connected to an oxygen concentrator. Further observation showed Resident 9's oxygen tubing/nasal cannula was not labeled or dated. Resident 9 stated that they did not know if or when their oxygen tubing/nasal cannula was changed.<br><br>Joint observation and interview on 10/29/2024 at 3:33 PM with Staff M, Registered Nurse (RN), showed Resident 9 was on a continuous oxygen via nasal cannula that was connected to an oxygen concentrator. Further joint observation showed the oxygen tubing/nasal cannula was not labeled or dated. Staff M stated they did not know when the oxygen tubing/nasal cannula was changed and that there should be a date to show when it was changed.<br><br>On 11/04/2024 at 12:04 PM, Staff B, Director of Nursing, stated, nasal cannula should be changed at least weekly and dated.<br><br>50891<br><br>RESIDENT 22<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the face sheet showed Resident 22 admitted to the facility on [DATE] with diagnosis that included respiratory failure with hypoxia (a condition where there is not enough oxygen in the tissues in your body).<br><br>A review of the physician orders dated 7/15/2024 showed Resident 22 had an order for continuous Oxygen 2-6 Liters per minute.<br><br>Observation on 10/29/2024 at 3:23 PM, showed Resident 22 was on continuous oxygen via nasal cannula connected to an oxygen concentrator. Resident 22's oxygen tubing/cannula was not labeled or dated. Further observation showed another nasal cannula was on Resident 22's wheelchair seat connected to a portable oxygen concentrator. This nasal cannula was not in a bag and was undated.<br><br>Joint observation and interview on 10/29/2024 at 3:29 PM with Staff N, RN, showed Resident 22 was using an undated nasal cannula tubing that was connected to the oxygen concentrator. Further joint observation showed another undated nasal cannula tubing on Resident 22's wheelchair seat, and it was not properly stored [not stored in a bag]. Staff N stated that the nasal cannula should be tucked in the pocket behind the wheelchair when not in use. Staff N further stated that they did not see a label/date on both nasal cannulas.<br><br>On 11/04/2024 at 2:46 PM, Staff B stated that they expected the nasal cannulas to be changed weekly and as needed. Staff B further stated that staff should date the nasal cannula when they change it and place the nasal cannula in a bag when not in use.<br><br>RESIDENT 32<br><br>Review of Resident 32's face sheet showed they admitted to the facility on [DATE] with diagnosis that included respiratory failure with hypoxia.<br><br>A review of the October 2024 Medication Administration Record (MAR) showed Resident 32 had orders to start oxygen therapy if their oxygen levels decreased below 90%. The MAR showed that Resident 32 had an oxygen level at 88% on 10/29/2024 and oxygen was administered as ordered by the physician.<br><br>Joint observation and interview on 10/29/2024 at 3:38 PM with Staff N, showed Resident 32 was on oxygen therapy with an undated oxygen tubing. Staff N stated that they did not label it [oxygen tubing] since they had just started the oxygen therapy and that the tubing was brand new.<br><br>On 11/04/2024 at 2:46 PM, Staff B stated that they expected oxygen tubing labeled and dated. Staff B further stated that they were not aware that Resident 32 had an order for oxygen.<br><br>47218<br><br>RESIDENT 28<br><br>A review of a face sheet printed on 10/28/2024 showed Resident 28 had diagnoses that included respiratory failure and congestive heart failure (a heart condition that affects the heart's ability to pump blood to the rest of the body).<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the physician orders printed on 10/28/2024 did not show Resident 28 had orders for oxygen and it did not include when to change the oxygen tubing/nasal cannula.<br><br>On 10/28/2024 at 4:04 PM, Resident 28 stated that they have been using oxygen for a few months at 1 1/2 to 2 liters per minute mostly at night. Observation showed Resident 28's oxygen cannula connected to the oxygen concentrator was on the floor. The oxygen tubing from both the oxygen concentrator and portable oxygen tank were not in use and they were undated and not properly stored. Resident 28 stated that they did not know when the last time was their oxygen tubing from both the oxygen concentrator and the portable oxygen tank were changed.<br><br>Another observation on 10/29/2024 at 3:11 PM, showed Resident 28's nasal cannula [connected to oxygen concentrator] was undated, not properly stored and was on the floor.<br><br>Joint observation and interview on 10/29/2024 at 3:33 PM with Staff M, showed Resident 28's oxygen cannula was laying on the floor, undated, and not properly stored. The nasal cannula tubing attached to the portable oxygen tank was undated and properly stored. Staff M stated that both oxygen tubing from the concentrator and portable oxygen tank were undated and not stored in a bag. Staff M further stated that Resident 28's nasal cannula should not have been on the floor and that their oxygen tubing should have been dated when they were last changed.<br><br>Joint record review and interview on 10/29/2024 at 3:37 PM with Staff M, showed Resident 28 had no physician orders for oxygen use in the MAR and in the Treatment Administration Record. Staff M stated that there should have been an order of oxygen with how much oxygen Resident 28 received and to change the oxygen tubing regularly.<br><br>Joint record review and interview on 10/30/2024 at 1:39 PM with Staff O, RN, showed no documentation when Resident 28's oxygen tubing was last changed, no orders for oxygen, and/or when to change the oxygen tubing. Staff O stated that they did not know when Resident 28's oxygen tubing was last changed and that there should have been orders for oxygen and when to change the oxygen tubing. Joint record review of the nursing progress notes showed Resident 28 started using oxygen on 04/03/2024. Staff O stated that Resident 28 should have had oxygen orders and when to change the oxygen tubing.<br><br>Joint observation and interview on 10/30/2024 at 1:55 PM with Staff O, showed Resident 28's oxygen cannula was on top of Resident 28's bed, it was not properly stored, and it was undated. Staff O stated Resident 28's nasal cannula should have been dated and stored in a bag when not in use.<br><br>On 11/04/2024 at 3:01 PM, Staff B stated that Resident 28 should have had orders for oxygen and for changing of their oxygen tubing weekly. Staff B further stated that Resident 28's oxygen cannula should have been dated, should not have been on the floor, and should have been stored in a bag when not in use.<br><br>Reference: (WAC) 388-97-1060 (3)(j)(vi) |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Post nurse staffing information every day.<br><br>48298<br><br>Based on observation and interview, the facility failed to ensure the daily nurse staffing form was placed in a prominent place accessible to residents, residents' representatives and visitors. This failure placed the residents, their representatives and visitors at risk of not being fully informed of the current staffing levels.<br><br>Findings included .<br><br>Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised in November 2024, showed that within two (2) hours of the beginning of each shift, the number of licensed nurses (Registered Nurses, Licensed Practical Nurses, and Licensed Vocational Nurses) and the number of unlicensed nursing personnel (Certified Nursing Assistants and Nursing Assistants) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.<br><br>Observations on 10/28/2024 at 11:18 AM and on 10/29/2024 at 10:52 AM, showed a daily nurse staffing form was posted along with other facility notices in the south area of the facility that was not visible, Further observation of the facility areas showed no other daily nurse staffing form posted.<br><br>In an interview on 11/04/2024 at 8:49 AM, Resident 11 stated they had been in the facility for a long time [eight years], and they were not aware of or had seen any daily nurse staffing postings. Resident 11 further stated, I can tell how many nurses or aides there are because I count them. When asked about the location of the daily nurse staffing postings, Resident 11 stated they were not aware and did not see them.<br><br>In an interview on 11/04/2024 at 9:01 AM, Resident 34 stated they had been in the facility for about three months and had not seen the daily nurse staffing postings. Resident 34 further stated that they were not informed or oriented about it.<br><br>In an interview on 11/04/2024 at 9:24 AM, Staff F, Medical Records, stated they were the one completing and posting the daily nurse staffing forms on the board located in the south area of the facility. Staff F further stated that there were no daily nurse staffing postings in other locations in the facility.<br><br>In an interview on 11/04/2024 at 11:24 AM, Staff A, Administrator, stated that the daily nurse staffing postings must be in a prominent place accessible to residents, their representatives, and visitors.<br><br>No associated WAC |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>50891<br><br>Based on interview and record review, the facility failed to ensure monitoring of antibiotic (medication to treat infection) side effects and use of antibiotic use had an appropriate diagnosis for 1 of 5 residents (Resident 22), reviewed for unnecessary medications. This failure placed the resident at risk for receiving unnecessary medication and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Antibiotic Stewardship, revised in December 2016, showed that the purpose of the antibiotic stewardship program was to monitor the use of antibiotic in their residents. The policy showed that training and education would include how inappropriate use of antibiotics affects individual residents. The training would include emphasis on the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections, medication interactions, and the evolution of drug-resistant pathogens. The policy further showed that the prescriber would provide complete antibiotic orders including the following elements: drug name, dose, frequency of administration, duration of treatment, route, and indication for use.<br><br>A review of Resident 22's October 2024 Medication Administration Record (MAR) showed Resident 22 had an order for Levofloxacin (an antibiotic) 750 milligrams (mg-a unit of measurement) one tab a day for prevention. The MAR did not show Resident 22 was not being monitored for adverse side effects to the use of antibiotic medication.<br><br>A joint record review and interview on 11/04/2024 at 2:46 PM with Staff B, Director of Nursing, showed Resident 22's Electronic Health Record [October 2024 MAR and progress notes] had no indication for the antibiotic use. Staff B stated they had to get clarification from the physician and that they did not add adverse side effect monitoring for antibiotics on Resident 22's MAR.<br><br>Reference: (WAC) 388-97-1060(3)(k)(i)<br><br>. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298<br><br>Based on observation, interview, and record review, the facility failed to appropriately label and store drugs or biologicals (diverse group of medicines made from natural sources) for 1 of 1 Medication Storage Room and 1 of 2 medication carts (South Medication Cart), reviewed for medication storage and labeling. In addition, the facility failed to ensure the Medication Storage Room was free of expired medical supplies and tube feeding (TF-the delivery of nutrients through a tube directly into the stomach to provide nutrition) formulas. These failures placed the residents at risk for receiving compromised and ineffective medications.<br><br>Findings included .<br><br>Review of the facility's policy titled, Medication Labeling and Storage, revised in [DATE], showed, multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.<br><br>Review of the facility's policy titled, Administering Medications, revised in [DATE], showed, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.<br><br>UNDATED MULTI-DOSE VIAL IN THE MEDICATION ROOM REFRIGERATOR<br><br>During a joint observation and interview on [DATE] at 7:40 AM with Staff S, Registered Nurse (RN), showed an open and undated multi-dose vial of Tuberculin PPD (Purified Protein Derivative-a skin test to help diagnose Tuberculosis [a potentially serious bacterial infection that mainly affects the lungs]) was found in the refrigerator in the medication room. Staff S stated that it had no open date and that it [Tuberculin vial] should have been dated.<br><br>UNDATED MEDICATIONS IN THE SOUTH MEDICATION CART<br><br>A joint observation and interview on [DATE] at 8:27 AM with Staff S, showed the following medications were opened and undated:<br><br>- One bottle of Artificial Tears (eye drops).<br><br>- One bottle of Muro 128 [brand name] ophthalmic (eye drops to reduce swelling) solution.<br><br>- One bottle of Fluticasone [medication used to relieve allergy and non-allergic nasal symptoms] nasal spray.<br><br>- One Refresh Tears (brand name-eye drops) and had no resident's name. Staff S stated that medications should be labeled with resident's name and dated when first opened.<br><br>EXPIRED MEDICAL SUPPLIES IN THE MEDICATION STORAGE ROOM<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A joint observation and interview on [DATE] at 7:40 AM with Staff S, showed one unopened pack of foam dressing with an expiration date of [DATE] and one opened box of unused 3cc (cubic centimeter-type of measurement) disposable syringes [used for injections] with an expiration date of [DATE]. Staff S stated that they did not know any active residents who used foam dressings. Staff S further stated that the expired foam dressing and the open box of disposable syringes should have been discarded.<br><br>EXPIRED TUBE FEEDING FORMULAS IN THE MEDICATION STORAGE ROOM<br><br>Joint observation and interview on [DATE] at 10:45 AM with Staff M, RN, showed the medication storage room had three bottles of tube feeding formulas labeled Promote with Fiber [brand name] with expiration date of [DATE], and another TF formula [same brand] with an expiration date of [DATE]. Staff M stated that expired TF formulas should have been discarded.<br><br>On [DATE] at 12:04 PM, Staff B, Director of Nursing, stated they expected medications and/or biologicals should be dated when first opened. Staff B stated, For over the counter [no prescription] drugs such as eye drops, they should have the resident's name and date when opened. Staff B further stated that expired TF formulas should have been discarded.<br><br>Reference: (WAC) [DATE] (2) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>47218<br><br>Based on observation, interview, and record review, the facility failed to periodically test the sanitizing solution/agent used to ensure proper sanitation of food preparation surfaces in accordance with professional standards for food service safety for 1 of 1 kitchen and failed to consistently monitor and document refrigerator temperatures for 1 of 5 refrigerators (Snack Refrigerator), reviewed for food services. In addition, the facility failed to properly label, date, and/or discard nutritional supplements in the Food Refrigerator in the Medication Storage Room. These failures placed the residents at risk for food borne illness [caused by the ingestion of contaminated food or beverages] and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Sanitization, revised in November 2024, showed that the food service area was maintained in a clean and sanitary manner. That kitchen areas and dining areas were kept clear, free from garbage and debris, protected from rodents and insects. The policy further showed that when cleaning fixed equipment- they were washed and sanitized and non-removable parts cleaned with detergent and hot water, rinsed, air-dried and sprayed with a sanitizing solution at the effective concentration, and service area wiping cloths were cleaned and dried or placed in a chemical sanitizing solution at appropriate concentration.<br><br>Review of the facility's provided document titled, Shurguard Plus [brand name- sanitizing solution] - Quaternary Based Sanitizer for Institutional Use - Technical Data Sheet, dated February 2024, showed that to sanitize precleaned and potable water-rinsed, nonporous food contact surfaces, prepare a 200-400 ppm [or PPM-parts per million - unit of measure for concentration] active quaternary solution. When used as directed this product is formulated to disinfect hard non-porous, inanimate environment surfaces: floors, walls, glazed porcelain, glazed ceramic tile, plastic surfaces, bathrooms, cabinets, tables and chairs.<br><br>Review of the facility's policy titled, Food Receiving and Storage, revised in November 2024, showed that foods and snacks kept on Nursing Units were kept at or below 41 F [degrees Fahrenheit - scale used to measure temperature] were placed in the refrigerator located at the nurses' station and labeled with a use by" date. Refrigerators must have working thermometers and were monitored for temperature according to state specific guidelines. The policy further showed that foods stored in the refrigerator or freezer were covered, labeled and dated, monitored so they are used by their use-by date, frozen, or discarded. Refrigerators must have working thermometers and are monitored for temperature according to state specific guidelines . Beverages are dated when opened and discarded after twenty-four (24) hours . Other opened containers are dated and sealed or covered during storage.<br><br>SANITIZING SOLUTION/AGENT<br><br>Joint observation and interview on 10/28/2024 at 8:20 AM with Staff U, Cook, showed the October 2024 Three-Compartment Sink Sanitizing Solution PPM Log form was blank for 10/27/2024. Staff U stated it was empty for 10/27/2024.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Joint observation and interview on 10/31/2024 at 9:25 AM with Staff E, Dietary Manager, showed the facility used Hydrion (brand name - test strips to check ppm of sanitizing solution) test strips, which had a column with colors and numbers that showed the following: 0 (zero), 100, 200, 300, and 400 ppm. Staff E stated that the sanitizing solution needs to be at least 200 ppm to be used for sanitizing surfaces and that if it was lower than 200 ppm, they would change the sanitizing bucket and obtain another mixture of the sanitizing solution and water to retest the sanitizer level. Staff E further stated that the facility used Shurguard Plus [brand name] sanitizing solution/agent and that staff documented in the Three-Compartment Sink Sanitizing Solution PPM Log, every morning, mid-morning, and evening.<br><br>Joint record review and interview on 10/31/2024 at 2:25 PM with Staff E, showed the Shurguard Plus sanitizer data sheet recommended using a level of 200-400 ppm to sanitize nonporous food contact surfaces. Staff E stated the facility should follow the sanitizing solution manufacturer's recommendations of using 200-400 ppm. Another joint record review and interview with Staff E showed the October 2024 Three-Compartment Sink Sanitizing Solution PPM Log had missing documentation ppm levels for 10/27/2024. Staff E stated that their weekend staff did not document the sanitizing solution ppm level results and that they should have. Further joint record review of the document showed the sanitizing solution ppm levels on the following dates were below 200 ppm for which the sanitizing bucket was not replaced and/or changed:<br><br>- On 10/02/2024, 150 ppm at mid-morning.<br><br>- On 10/04/2024, 150 ppm at mid-morning and 150 ppm in the evening.<br><br>- On 10/07/2024, 100 ppm in the morning and 150 ppm at mid-morning.<br><br>- On 10/08/2024, 100 ppm in the morning, 150 ppm at mid-morning, and 100 ppm in the evening.<br><br>- On 10/09/2024, 100 ppm in the morning and 150 ppm at mid-morning.<br><br>- On 10/16/2024, 100 ppm in the morning.<br><br>- On 10/21/2024, 150 ppm at mid-morning and 150 ppm in the evening.<br><br>- On10/23/2024, 150 ppm at mid-morning.<br><br>- On 10/25/2024, 150 ppm at mid-morning and 150 ppm in the evening.<br><br>Staff E stated that the 150 ppm readings were guesstimations [guesstimates] and that the sanitizing solution levels results below 200 ppm should have been replaced and retested according to recommended sanitizing ppm levels.<br><br>On 11/01/2024 at 5:53 PM, Staff A, Administrator, stated that the facility should have followed the manufacturer's recommendations for their sanitizing solution to meet the range of 200 ppm to 400 ppm.<br><br>SNACK REFRIGERATOR IN THE NURSE STATION<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Joint observation and interview on 10/31/2024 at 12:54 PM with Staff E, showed the snack refrigerator had food items in it (unopened yogurts, unopened ensure bottles, unopened non-alcoholic beers, unopened protein shakes, and unopened four packs of Jell-O), there was no thermometer, and/or documentation to show the refrigerator temperatures were checked. Staff E stated that they did not know who checked the refrigerator's temperature and/or where the temperature was documented.<br><br>On 11/01/2024 at 4:34 PM, Staff B, Director of Nursing, stated that the nurses checked the temperature of the snack refrigerator. Staff B stated that they did not have the temperature logs for the snack refrigerator for October 2024 and/or prior months.<br><br>On 11/01/2024 at 5:26 PM, Staff A stated that there was no documentation to show the refrigerator temperatures were checked for October 2024 and/or previous months.<br><br>48298<br><br>FOOD REFRIGERATOR IN THE MEDICATION STORAGE ROOM<br><br>Joint observation and interview on 11/01/2024 at 7:40 AM with Staff S, Registered Nurse, showed an undated open container of Ensure (brand name-a nutritional supplement drink). Further joint observation with Staff S showed the Ensure container label read, once opened, reclose, and use within 48 hours. Staff S stated they did not know when the Ensure container was opened and that it should have been dated when opened.<br><br>On 11/04/2024 at 12:04 PM, Staff B stated they expected staff to date food items such as Ensure when opened and to discard them if undated.<br><br>Reference: (WAC) 388-97-1100 (3) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891<br><br>Based on observation, interview, and record review, the facility failed to have a comprehensive water management program that assessed, measured, and/or monitored potential risk for exposure to Legionnaire's disease (or Legionella - a potentially dangerous bacteria that grows in water, which could cause a serious lung infection) or other waterborne pathogens (a bacterium, virus, or other microorganisms that can cause a disease). In addition, the facility failed to ensure to follow Enhanced Barrier Precautions (EBP- infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs - germs that are resistant to medications that treat infections] in nursing homes) during hygiene care and tube feeding (a medical device used to provide nutrients through a tube directly into the stomach) manipulation for 1 of 1 resident (Resident 4), and failed to sanitize the transfer lift equipment for 2 of 2 staff (Staff J and K), reviewed for infection control. These failures placed the residents at risk for facility acquired or healthcare-associated infections and related complications.<br><br>Findings included .<br><br>Review of the facility's policy titled, Legionella Water Management Program, revised in October 2024, showed the facility would have a water management team as part of the infection prevention and control program. The policy described the purposes of the water management program were to identify areas in the water system where Legionella bacteria can grow and spread and reduce the risk Legionnaire's disease. The policy showed it included a detailed description and diagram of the water system in the facility, the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, identification of situations that can lead to Legionella growth, specific measures used to control the introduction and/or spread of legionella, specific measures used to control the introduction of legionella, a diagram of where control measures are applied, a system to monitor control limits and effectiveness of control measures are not effective, and documentation of the program. The policy further showed that the water management program would be reviewed at least once a year or sooner if needed.<br><br>Review of the facility's policy titled, Enhanced Barrier Precautions, revised in November 2024, showed that EBPs are utilized to prevent the spread of MDROs to residents. The policy showed that EBPs employ gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high contact resident care activities that require EBP include dressing, bathing, transferring, providing hygiene, changing briefs, device care (includes feeding tube) and wound care.<br><br>Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised in October 2024, showed, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Center for Disease Control and Prevention - a government agency that focuses on preventing and controlling disease and promoting environmental health in the United States) recommendations for disinfection . The policy further stated that reusable items are cleaned and disinfected or sterilized between residents.<br><br>WATER MANAGEMENT PROGRAM<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 11/01/2024 at 9:52 PM, Staff C, Maintenance Supervisor, stated that they did not do any testing for water management because they did not have standing water in the facility.<br><br>In an interview on 11/01/2024 at 10:42 AM, Staff B, Director of Nursing/Infection Preventionist, stated that they reviewed the facility's plumbing blueprints and found there was no standing water in the building. Staff B stated that testing was not required since the building received city water and not infected water.<br><br>A joint record review and interview on 11/01/2024 at 4:26 PM with Staff Q, Regional MDS Nurse, showed the facility's schematic or flow diagram of their building water system and written water flow details. Staff Q stated that they just finished creating it [schematic or flow diagram].<br><br>In an interview on 11/01/2024 at 5:26 PM, Staff A, Administrator, stated that Staff Q had completed the schematic flow diagram for the building water system and wanted to make sure it was provided to the surveyors.<br><br>In another interview on 11/04/2024 at 5:26 PM, Staff A, stated that the goal for the water management plan was to make sure the water system was free of Legionella. Staff A further stated that checks were supposed to be happening to ensure the facility's water system was clean.<br><br>ENHANCED BARRIER PRECAUTIONS<br><br>RESIDENT 4<br><br>Review of the face sheet showed Resident 4 admitted to the facility on [DATE] with diagnosis that included gastrostomy (a surgical procedure that creates an opening in the abdomen that allows a feeding tube to be inserted directly into the stomach).<br><br>Observation on 10/28/2024 at 10:53 AM, showed there was EBP signage outside of Resident 4's room. Further observation showed there was no Personal Protection Equipment (PPE-protective devices, garments, or covering like gloves, gown and mask) cart outside Resident 4's room.<br><br>Observation on 10/28/2024 at 10:54 AM, Staff R, Registered Nurse, showed they disconnected Resident 4's feeding tube from their feeding formula and used a syringe to flush Resident 4's feeding tube. Staff R was wearing gloves on both hands and not wearing a gown during the procedure.<br><br>In an interview on 10/29/2024 at 11:05 AM, Staff R, stated that they should have worn a gown when providing tube feeding care for Resident 4. Staff R further stated that the facility did not have all the PPE carts set up.<br><br>Observation on 10/30/2024 at 10:15 AM, showed Staff V, Certified Nurse Assistant (CNA), and Staff P, CNA, were providing incontinent care to Resident 4. Staff P and Staff V were not wearing their gown as they changed Resident 4's incontinent brief. Staff P and Staff V were observed placing the Hoyer Lift (or transfer lift-mechanical device for lifting residents) sling under Resident 4 to transfer them onto their wheelchair.<br><br>(continued on next page) |

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| | 505417 | A. Building<br>B. Wing | 11/04/2024 |

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| Saint Anne Nursing and Rehabilitation Center | 3540 Northeast 110th Street<br>Seattle, WA 98125 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A joint observation and interview on 10/30/2024 at 10:36 AM, showed Staff P pointed to the EBP sign outside of Resident 4's door and stated they put on the gown when Resident 4 received tube feeding. Staff P further stated they did not need to wear a gown to change Resident 4's incontinent brief or their clothes.<br><br>On 11/04/2024 at 2:46 PM, Staff B stated that they expected staff to wear PPE when providing direct care to residents on EBP and when providing tube feeding care.<br><br>48298<br><br>SANITIZING OF CARE EQUIPMENT<br><br>STAFF J<br><br>Observation on 10/30/2024 at 9:30 AM, showed Staff J, CNA, pulled a Hoyer lift while getting out of room [ROOM NUMBER]. Staff J then pushed the Hoyer lift down the hallway to a room where two other Hoyer lift equipment were placed.<br><br>Another observation on 10/30/2024 at 10:44 AM, showed Staff J pushed a Hoyer lift back to a room where Hoyer lifts equipment was being kept. Staff J went out of the room after a minute and was not observed sanitizing the Hoyer lift.<br><br>An interview and joint observation on 10/30/2024 at 10:49 AM, Staff J stated that they used wipes to sanitize Hoyer lifts after use. Staff J went to room [ROOM NUMBER] and showed a blue pack of washcloth. Staff J stated, This is what I use when I sanitize the Hoyer lift. Joint observation with of the blue pack washcloth showed it was intended to use for adult perineal (personal) area. When asked if there were other wipes they used to sanitize or disinfect the residents' care equipment, Staff J stated, no.<br><br>STAFF K<br><br>An interview and joint observation on 10/30/2024 at 11:03 AM, Staff K, CNA, stated that they used ordinary wipes to clean Hoyer lifts. Staff K showed the same blue pack washcloth, which they used to sanitize the Hoyer lift. Joint observation with Staff K showed the blue pack washcloth it was intended to use for adult perineal area. When asked if there were other wipes they used to sanitize or disinfect the residents' care equipment, Staff K stated, no.<br><br>In an interview and joint observation on 10/31/2024 at 4:08 PM with Staff S, RN, stated they used disinfectant wipes to sanitize resident care equipment after use. Joint observation with Staff S, showed a container of disinfectant wipes labeled CaviWipes [brand name] was available at the nurse's station.<br><br>On 11/04/2024 at 12:04 PM, Staff B stated, Hoyer lift must be cleaned and sanitized in between patient [resident] care. The CNAs are the ones sanitizing it [Hoyer lift]. Staff B further stated, I expect them [staff] to disinfect or sanitize residents' equipment in between residents' care and use the correct disinfectant.<br><br>Reference: (WAC) 388-97-1320 (1)(a)(5)(c)(e) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891<br><br>Based on interview and record review, the facility failed to consistently maintain an established Antibiotic (medications to treat infection) Stewardship Program to promote the appropriate use of antibiotics for 1 of 3 residents (Resident 26), and failed to ensure standardized tools and criteria were utilized for Antibiotic Stewardship Program (such as Loeb Minimum Criteria [minimum set of signs/ symptoms used to determine whether to treat an infection with antibiotic resistance). These failures placed the residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics.<br><br>Findings included .<br><br>Review of the facility's policy titled, Antibiotic Stewardship, revised in December 2016, showed the stewardship program's purpose was to monitor the use of antibiotics for residents.<br><br>Review of the facility's policy titled, Staff and Clinician Training and Roles, revised in December 2016, showed that the Director of Nursing (DON) and Infection Preventionist (IP) will be trained on how to use surveillance tools to monitor infection rates, antibiotic usage patterns and outcomes, and review measures of antibiotic use, antibiotic susceptibility patterns, and negative outcomes related to antibiotic use.<br><br>Review of the facility's policy titled, Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, revised in December 2016, showed antibiotic usage and outcome data would be collected and documented using a facility-approved antibiotic surveillance tracking form. The policy further showed that resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information would include resident name, symptoms, name of antibiotic, the start date of antibiotic, site of the infection, date of culture, stop date, total days of therapy, outcome, and adverse events.<br><br>Review of face sheet showed that Resident 26 admitted to the facility on [DATE] with diagnosis that included hidradenitis suppurativa, (a condition that causes small, painful lumps to form under the skin).<br><br>Review of the physician orders showed Resident 26 was prescribed the following two antibiotics on 05/09/2024 to treat hidradenitis suppurativa: Doxycycline (an antibiotic) 100 milligrams (mg-a unit of measurement) two times a day and Clindamycin (an antibiotic) external gel 1% apply topically two times a day. Further review of Resident 26's physician orders did not show duration of antibiotics' use.<br><br>Review of the facility's Antibiotic Infection Control Log from April 2024 to October 2024 did not include Resident 26 on the list.<br><br>Review of Resident 26's October 2024 Medication Administration Record (MAR) showed Resident 26 was not being monitored for adverse side effects of antibiotic use.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A joint record review and interview on 11/04/2024 at 11:14 AM with Staff B, Director of Nursing, showed Resident 26 was not included in the Antibiotic Infection Control Log/Line list for April 2024 to October 2024. Staff B stated that Resident 26 should have been included in the antibiotic line list. Staff B stated that Resident 26 may have been taken [removed] from the list because it [hidradenitis suppurativa] was not a real infection and that they did not monitor for adverse side effects for Resident 26 on the MAR. Staff B further stated they used the McGeer criteria (a surveillance tool used for retrospectively counting true infections) to initiate antibiotic use.<br><br>Reference: (WAC) 388-97-1320(1)(2) (a-c) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891<br><br>Based on interview and record review, the facility failed to ensure pneumococcal vaccine (used to prevent pneumonia [a lung infection]) and the COVID-19 vaccine (used to prevent an infectious disease caused by coronavirus) were provided for 1 of 5 residents (Resident 9), reviewed for immunizations. This failure placed the resident at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from pneumococcal and/or COVID-19.<br><br>Findings included .<br><br>Review of the facility's policy titled, Vaccination of Residents, revised in May 2023, showed all residents would be offered vaccines. The policy showed that prior to receiving vaccination, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccination. It further showed that if the vaccines were refused, then than it shall be documented in the resident's medical record.<br><br>Review of the face sheet showed Resident 9 admitted to the facility on [DATE].<br><br>Review of Resident 9's undated immunization records showed Resident 9 had refused the pneumococcal immunization and COVID-19 vaccine. Further review of Resident 9's Electronic Health Record (EHR-miscellaneous/document tab) showed no documentation that risks and benefits were provided when Resident 9 had refused pneumococcal and COVID-19 vaccine.<br><br>During a joint record review and interview on 11/04/2024 at 11:16 AM with Staff B, Director of Nursing, Resident 9's EHR under the miscellaneous, document, and immunization tab) did not show consent forms related to their refusal of pneumococcal and COVID-19 vaccines. Staff B stated that they don't see it [consents] in here [EHR], and that Resident 9 hadn't wanted any of the vaccines for 2022 and 2023.<br><br>Reference: (WAC)388-97-1340(1)(2) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>50891<br><br>Based on observation, interview, and record review, the facility failed to conduct routine maintenance to ensure side rails were safe to use for 3 of 4 Residents (Residents 32, 5 & 25), reviewed for accident hazards. This failure placed the residents at risk for injury and/or entrapment.<br><br>Findings included .<br><br>Review of the facility's policy titled, Bed Safety and Bed Rails, revised in November 2024, showed that consideration is given to the resident's safety. The policy showed that the bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. The policy further stated that maintenance staff would routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks. The maintenance department would then provide a copy of inspections to the administrator.<br><br>RESIDENT 32<br><br>Joint observation and interview on 11/04/2024 at 8:47 AM with Staff M, Registered Nurse, showed Resident 32's left half bed rail was loose and moved side to side for six to eight inches. Staff M stated that Resident 32's left bed rail felt loose and did not know if it was supposed to be that way.<br><br>Joint observation and interview on 11/04/2024 at 9:12 AM with Staff C, Maintenance Supervisor, showed Resident 32's left bed rail was loose and stated that it would always be loose because the bed rail is attached with clips instead of screws. Staff C stated that since these bed rails can be positioned in an up position and a down position, it was not as tight. Staff C further stated they did not have a record of maintenance for Resident 32's bed rails.<br><br>RESIDENT 5<br><br>Joint observation and interview on 11/04/2024 at 9:15 AM with Staff C, showed Resident 5's left bed rail was found to be loose upon checking. Staff C stated the bed rail was attached to the bed with the same loose clips and that the main thing they check was the connection to the bed. Staff C stated that they would install the bed rail as soon as they get permission from the therapy department and did not do any maintenance with the bed rails after they were installed.<br><br>RESIDENT 25<br><br>Joint observation and interview on 11/04/2024 at 9:19 AM with Staff C, showed Resident 25's left side bed rail was loose. It further showed there was a gap between the mattress and the left bed rail, which was approximately five to six inches wide. The right side bed rail was sturdy and had an approximately two to three inch gap between the mattress and the bed rail. Staff C stated that the right bed rail was sturdy because it had less of a gap. Staff C further stated that they did not do maintenance on Resident 25's bed rail.<br><br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/04/2024 at 2:46 PM, Staff B, Director of Nursing, stated that the bed rails were checked routinely by the maintenance department. Staff B stated that they were not sure if the bedrails were checked once a week or once a month. Staff B further stated that the maintenance department would make sure that there were no gaps between the mattress and that the bed rails were in good repair.<br><br>On 11/04/2024 at 5:26 PM, Staff A, Administrator, stated they expected bed rails were checked for safety. Staff A stated that they were not sure if the bed rails were checked routinely. Staff A further stated that they had no documentation that residents' bed rails were maintained and/or checked.<br><br>Reference: (WAC) 388-97-2100 (1) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>47218<br><br>Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was maintained to keep the facility free of houseflies for 3 of 3 residents (Residents 29, 93 & 5), for 1 of 1 dining room, and for 1 of 1 kitchen, reviewed for dining and kitchen. This failure placed the residents at risk for infection, maggot infestation (small, worm like bugs that hatch from fly eggs), and related complications.<br><br>Findings included .<br><br>Review of the facility's policy titled, Pest Control, revised in October 2024, showed that the facility would maintain an effective pest control program and that the facility would have a pest control contract that provided treatment of the environment for pests.<br><br>RESIDENT ROOMS/RESIDENTS<br><br>RESIDENT 29<br><br>Observation on 10/28/2024 at 9:47 AM, showed a fly on Resident 29's bedside table. Resident 29 shooed the fly away and the fly moved to Resident 29's bed. Resident 29 stated I don't know where the fly came from.<br><br>RESIDENT 93<br><br>On 10/28/2024 at 9:49 AM, Resident 93 stated that they had seen flies around in their room, a big fly yesterday [10/27/2024] was trying to get in my ear.<br><br>RESIDENT 5<br><br>Observation on 10/28/2024 at 10:12 AM, showed a fly on top of Resident 5's forehead, Resident 5 was on the hallway self-propelling in their wheelchair.<br><br>DINING ROOM<br><br>Multiple observations on 10/28/2024 from 12:14 PM to 12:59 PM during residents' lunch meal, showed there were flies flying over the trash can, over resident's meal trays, on the dining room tables, and on the residents. Further observations showed there were 14 residents and a total of 15 flies in the dining room.<br><br>On 10/28/2024 at 12:37 PM, Staff W, Certified Nuse Assistant (CNA), stated that they saw flies in the facility since yesterday [10/27/2024].<br><br>On 10/28/2024 at 12:41 PM, Resident 24 stated that they have seen flies in the facility for the past week or so.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 10/28/2024 at 12:42 PM, Resident 39 stated that flies landed on their straw yesterday [10/27/2024] and they had to get a new one [straw]. Resident 39 further stated that they have seen flies in the dining room since a few days ago.<br><br>On 10/28/2024 at 12:43 PM, Resident 94 stated they had seen flies in the dining room for a few days. Resident 94 was observed shooing one fly away from their table.<br><br>On 10/28/2024 at 12:47 PM, Resident 7 stated that they had seen a lot of flies for about a week. Resident 7 was observed shooing a fly away from their table.<br><br>On 10/28/2024 at 12:59 PM, Staff E, Dietary Manager, stated that they noticed flies in the kitchen yesterday [10/27/2024]. Staff E further stated that they had notified the maintenance staff about the flies in the facility.<br><br>Multiple observations on 10/29/2024 from 8:22 AM to 8:54 AM during residents' breakfast meal, and from 12:11 PM to 12:54 PM during residents' lunch meal, showed there were flies in the dining room flying over residents, residents' meals, and residents' tables.<br><br>Observation on 10/29/2024 at 8:25 AM, showed there were eight residents in the dining room during their breakfast meal.<br><br>A joint observation and interview on 10/29/2024 at 12:54 PM with Staff E showed there were a total of 32 flies in the dining room. Staff E stated, the pest control people came here and treated the dining room over an hour ago.<br><br>Multiple observations on 10/30/2024 from 8:01 AM to 9:19 AM during residents' breakfast meal, showed there were flies flying over residents, residents' meals, and residents' tables. Further observation showed there were 12 residents and a total of eight flies in the dining room.<br><br>A joint observation and interview on 10/31/2024 at 12:32 PM with Staff W, showed two flies were on Resident 2's glass' rim that had orange juice in it. Staff W stated that there were two flies on top of the orange juice glass, and they replaced Resident 2's orange juice.<br><br>On 10/31/2024 at 12:37 PM, Resident 24 stated, there are flies in this place. Resident 24 was sitting with Resident 39 and both residents started to shoo away three flies from their plates.<br><br>Observation on 11/01/2024 at 8:01 AM, showed there were three flies flying around in the dining room and one spider in the dining room's ceiling.<br><br>KITCHEN<br><br>Observation on 10/31/2024 at 9:17 AM, showed a fly flying inside the kitchen area.<br><br>Joint observation and interview on 10/31/2024 at 9:14 AM with Staff E, showed there were two flies in their office, which was located inside the kitchen. Staff E stated that there were less flies after the pest control treatment that was done on 10/29/2024.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Another observation on 10/31/2024 at 9:17 AM and at 10:39 AM, showed a fly flew around the kitchen and another fly was on top of the sink hose handle next to the dishwasher.<br><br>On 11/01/2024 at 5:58 PM, Staff A, Administrator, stated that the facility never had fly issues before, and that they were made aware about flies in the building on 10/28/2024 after a resident reported about a fly in their drink. Staff A stated that the flies were mostly in the dining room and some in the kitchen, and that they had pest control staff checked the facility for fly point of entry. Staff A further stated that there should not have been flies in the dining room, in the kitchen, and/or in the facility.<br><br>Reference: (WAC) 388-97-3360 (1) |