STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505418	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Marianwood	3725 Providence Point Drive Southeast Issaquah, WA 98029

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 42203 Based on interview and record review, the facility failed to obtain a consent for the use of an Antidepressant (AD) medication for 1 of 5 residents (Resident 79) reviewed for unnecessary medications. This failure placed Resident 79 at risk for receiving unwanted psychotropic medications, altered level of consciousness, and a decreased quality of life. <Facility Policy> The facility's Psychotropic Medications Policy, revised 01/2023, showed psychotropic medications should only be used after careful evaluation of potential risks and benefits. <Resident 79> According to the 07/02/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 79 had impaired memory and an acute onset change in their mental status, with fluctuating attention and consciousness. The MDS showed Resident 79 had medical diagnoses including uncontrolled muscle movements, schizophrenia (a mental disorder), and a history of cancer. The MDS showed Resident 79 received an AD medication during the assessment period. Review of Resident 79's Physician's Orders showed a 07/15/2024 order for an AD medication; to give 7.5 Milligrams at night for schizophrenia. Record review showed no evidence the facility acquired informed consent (a process where the risks and benefits of a treatment were explained so the resident could consent to the treatment with understanding, required for psychotropic medications) prior to administering the AD medication to Resident 79. In an interview on 08/01/2024 at 9:12 AM, Staff B (Director of Nursing) stated informed consent was required prior to the use of an AD medication. Staff B stated they would double check and provide any evidence informed consent was obtained for Resident 79's AD medication use. No further information was provided by the facility. REFERENCE: WAC 388-97-0260.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 43642 Based on interview and record review, the facility failed to notify 1 of 16 residents (Resident 10) who were Medicaid recipients, when their personal fund account balances reached $1800 (i.e. within $200 of the $2, 000 resource limit beneficiaries were permitted to possess without their Medicaid coverage being impacted). This failure placed residents at risk for personal financial liability for their care. Findings included . <Facility Policy> Review of the facility's revised 05/2017 Resident Trust policy stated the facility would notify the resident and/or resident's guardian/durable power of attorney, facility social worker, and the local department of social and health services, in writing, when a resident, who was on Medicaid, reached an individual account balance of two hundred dollars less than the Supplemental Security Income (SSI) resource limit for one individual. The policy stated the notification would advise if the amount in the account exceed the SSI limit, the resident may lose eligibility for Medicaid or SSI. <Resident 10> Review of the facility's Fund Balances report showed Resident 10's balance was over the SSI resource limit, as of 07/23/2024. Resident 10's current balance was at $2496.53, which was $696.53 over the amount where the facility was required to notify the resident they were approaching the SSI resource limit. Resident 10's current trust balance was $496.53 over the SSI resource limit, putting the resident at risk for personal financial liability for their care. In an interview on 07/31/2024 at 11:31 AM, Staff W (Administrative Assistant) confirmed Resident 10 had a current balance over $1800 in their trust account. Staff W stated they were unaware of any Medicaid SSI resource limitations for residents and stated they did not discuss resident trust balances with the social worker. In an interview on 07/31/2024 at 11:48 AM, Staff E (Social Services Director) stated, It has been years since they were notified regarding a resident who was over their SSI resource limits. In an interview on 08/01/2024 at 2:03 PM, Staff A (Administrator) stated they reviewed the facility policy and Resident 10 should have been but was not notified as required when they reached an account balance of two hundred dollars less than the SSI resource limit. REFERENCE: WAC 388-97-0340(4).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to provide timely assistance to formulate an Advanced Directive (AD - documentation explaining the resident's wishes for care if they were unable to speak for themselves) for 5 of 6 residents (Resident 68, 31, 75, 189, & 6) reviewed for ADs. This failure left residents at risk for unmet healthcare needs, unwanted care, and other negative health outcomes. Findings included . <Resident 68> According to the 06/13/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 68 admitted to the facility on [DATE]. The MDS showed Resident 68 had intact memory. Record review showed a document scanned into Resident 68's chart on 07/23/2024 at 12:34 PM (the first day of annual survey, 47 days after admission). This document had only two typed lines. The first read Advanced directive toolkit has been provided to the resident/family. Underneath this line, someone hand wrote, Received. The second line read, Advanced directive toolkit obtained from resident/family and placed in our records. This section was not annotated. The document had Resident 68's room number and no other information. The document did not indicate when the AD toolkit was provided to the resident, whether or not Resident 8 was interested in, or needed assistance to use the toolkit, or who provided the toolkit to Resident 68. In an interview on 08/01/2024 at 11:18 AM, Staff F (Social Services Assistant) stated it was important to capture residents' wishes regarding AD assistance timely. Staff F stated the AD-status document was scanned in on the 07/23/2024. Staff F stated they could not demonstrate it was provided to Resident 68 prior to that date. 43642 <Resident 31> According to a 07/12/2024 Admission MDS, Resident 31 admitted to the facility on [DATE], had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 31 with no memory impairment. Observations on 07/24/2024 at 10:07 AM showed an AD packet sitting on Resident 31's bedside table. In an interview at this time, Resident 31 stated, they just brought me the packet this morning. Resident 31 stated they were not provided the AD packet prior to 07/24/2024. Review of Resident 31's records showed a scanned form from 07/24/2024 which showed the AD toolkit was provided to the resident/family, over two weeks after the resident admitted . This form included a hand-written note that said, provided to patient. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 75> According to a 06/06/2024 Admission MDS, Resident 75 admitted to the facility on [DATE], had no speech, was rarely/never understood, and rarely/never was able to understand others. This MDS showed staff assessed Resident 75 had severely impaired cognitive skills and never/rarely made decisions. Review of the 06/04/2024 Social Services Admission assessment AD status section, showed Resident 75 did not have an AD, did not have the decisional capacity, and was unable to create an AD. This section had an option for staff to mark the AD pamphlet was provided to resident/family, this section was not marked as being completed by staff. The section for staff interview for resident preferences identified the resident prefers family or significant other involvement in care discussions. Review of Resident 75's records showed a scanned form from 07/24/2024 which showed a handwritten note that said the AD toolkit was, provided to patient, almost two months after the resident admitted . There was no indication why staff provided the packet to Resident 75, who was assessed with severe cognitive impairment, rather than the family identified in the resident's records. In an interview on 07/29/2024 at 11:40 AM, Staff E (Social Services Director) stated AD were important so staff would know what to do for a resident if they were to become unable to make their own decisions. Staff E stated it was their expectation if a resident was unable to make their own decisions, staff would reach out to the resident's family to discuss AD. <Resident 189> According to a 06/12/2024 Admission MDS, Resident 189 was admitted to the facility on [DATE], had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 189 with no memory impairment. Review of the 06/12/2024 Social Services Admission assessment AD status section was left blank staff and did not identify Resident 189 had a Power Of Attorney (POA). In an interview on 07/26/2024 at 8:40 AM, Resident 189 stated they had a POA for healthcare. Review of Resident 189's records showed a scanned form from 07/23/2024 which showed an AD toolkit was provided to the resident/family, and included a handwritten note underneath that said, Received. Review of Resident 189's records revealed no POA paperwork. In an interview on 07/29/2024 at 11:40 AM, Staff E stated it was their expectation that AD's were readily available in a resident's records. 50511 <Resident 6> According to the 06/21/2024 Admission MDS, Resident 6 was understood, had clear comprehension, and admitted to the facility on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's medical records on 07/23/2024 at 10:25 AM did not show documentation of an AD or a declination to formulate an AD. The record showed that an AD toolkit was provided to the resident and family on 07/23/2024, with a handwritten note by the facility's social services department that a copy of an advanced directive was requested from the patient and family on 7/23/2024, two months after Resident 6's admission. In an interview on 07/29/2024 at 11:40 AM, Staff E stated it was their expectation that AD's were readily available in a resident's records. REFERENCE: WAC 388-97-0280 (3)(c)(i-ii).

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review, the facility failed to maintain a system to ensure resident grievances were identified, logged, and resolved timely for 4 of 4 residents (Residents 28, 31, 30, 6) reviewed for personal property and living environment. Facility failure to ensure missing personal items were found or replaced and resident environmental concerns were addressed placed residents at risk for missing property, an uncomfortable or less-than-homelike environment, and a decreased quality of life. Findings included . <Facility Policy> According to the 07/2024 Complaint and Grievance Policy, the facility would attempt to resolve all grievances as promptly as possible, but no longer than 10 days. The policy showed the facility would maintain grievance records for no less than three years. <Resident 28> According to the 05/20/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 28 had impaired memory and was dependent on staff for self-care and grooming. The MDS showed Resident 28 had medical conditions including partial weakness to one side of the body and memory impairment. In an interview on 07/24/2024 at 2:39 PM, Resident 28 stated they had lost items [they] didn't get back. Resident 28 identified they were missing an electric razor, nail clippers, and a $350 watch. Resident 28 stated they were told it was facility practice when a resident was missing property for the resident to replace the item and then get reimbursed by the facility. Resident 28 asked, What do you do if you don't have the money up front? I could not cover it. I never got it back. Resident 28 stated the watch went missing about a year ago. Resident 28 was not wearing a watch at the time of the interview. Review of the facility's Grievance Log did not include any grievances related to missing items for Resident 28. In an interview on 07/29/2024 at 12:29 PM, Staff E (Social Services Director) stated they recalled Resident 28 reporting a missing watch a couple years ago during the pandemic. Staff E stated Resident 28 provided them with a picture of the watch at that time. Documentation of the missing watch and picture was requested, but staff was unable to provide the requested information. Staff E stated the facility policy was that the resident was required to come up with the money in order to do the reimbursement. Staff E stated the process was that once a resident provided the receipt, the facility would then reimburse for the missing item. When asked what the plan was for the missing watch, Staff E stated, I do not know. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/01/2024 at 11:07 AM, Staff E stated when a resident had a concern with a missing item, they sent out an email to the appropriate staff to be on the look out for the item. Staff E stated that until survey began on 07/23/2024, they did not add missing items concerns to the Grievance Log. Staff E stated after they sent out an email, either the item was located or the resident replaced the item and was reimbursed. Staff E stated they did not recall a situation where a resident was unable to temporarily cover the cost of an item. In an interview at 08/01/24 11:48 AM, Staff E stated they just (since the prior interview) asked Resident 28 if they told anyone they did not have the means to cover the cost of the missing watch. Staff E stated they could not find evidence the watch was replaced or addressed in their emails. In an interview on 08/01/2024 at 2:03 PM, Staff A (Administrator) stated the grievance process was important so residents receive help with the concerns they had and gave the facility the opportunity to correct things. Staff A stated they considered a grievance or concern something they were unable to fix in a reasonable time, for example less than 24 hours, or on a Monday if occurred over the weekend. Staff A stated they considered a missing item a grievance and would expect staff to notify the social worker and complete a grievance form if the item was not found. Staff A stated the facility would reimburse the resident once they were able to determine an estimate, get guidance from the resident, or a receipt and expected documentation to show the outcome of the missing item. 43642 <Resident 31> According to a 07/12/2024 Admission MDS, Resident 31 admitted to the facility on [DATE], had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 31 with no memory impairment. In an interview on 07/25/2024 at 9:14 AM, Resident 31 stated they were frustrated about missing clothes from a week ago. Resident 31 stated the clothes went to laundry, last Friday. Resident 31 stated they kept asking staff, but nobody was able to find them. Resident 31 stated they had company coming to the facility on [DATE] and they wanted their clothes back for the visit. In an interview on 07/26/2024 at 8:37 AM, Resident 31 stated their clothes were still missing, but staff had helped them find something else to wear for when their visitors arrive. Review of the grievance log on 07/26/2024 showed no grievance reports were logged for Resident 31 regarding their missing clothes. In an interview on 07/29/2024 at 11:40 AM, Staff E stated grievances were important so staff can address any issues a resident may have. Staff E stated it was their expectation staff would come let them know of any concerns/grievances, at times the issue can be resolved on the spot, and if not, Staff E stated they tell staff to fill out a grievance form. Staff E stated once they receive a grievance, their expectation was for staff to resolve and address the concern back with the resident within 10 days. Staff E stated they do not log missing items, but instead they send an email out to staff to be on the lookout for the missing items. When asked how staff track and trend missing items, Staff E stated, we just put it in emails. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Staff E's emails showed the email system was set to delete the emails after two years. When asked if there were currently any missing items for residents, Staff E stated, there was a missing pair of dentures, missing nightgown, and a green dress. Staff E did not have information regarding Resident 31's missing clothes. In an interview on 07/29/2024 at 12:10 PM, Resident 31 stated they finally got their clothes back a couple days ago and stated they were frustrated it took so long. <Resident 30> In an interview on 07/29/2024 at 11:40 AM, Staff E showed an email from 07/15/2024 regarding Resident 30 having a missing bag with about $100 worth of stuff inside. When asked what the outcome of that reported missing item from 14 days ago, Staff E stated, they went home, and they have not reached out to me. Review of a 07/17/2024 Discharge MDS showed Resident 30 discharged from the facility with their return not anticipated. In an interview on 07/31/2024 at 12:28 PM, Resident 30 stated they had not heard from the facility regarding the missing items until just two days prior on 07/29/2024. Resident 30 stated they found the missing bag at home, but stated they were still missing some clothes. Resident 30 stated they told the facility they did not need to replace it. In an interview on 08/01/2024 at 1:03 PM, Staff B (Director of Nursing) stated their expectation was for staff to start an investigation if a resident had a concern or missing item, by first looking for the items, and if unable to locate or resolve within 48 hours, would expect staff to address it as a grievance. Staff B stated there were, some gaps in the grievance process. 50511 <Resident 6> Review of the 06/21/2024 Admission MDS showed Resident 6 was understood and had clear comprehension. Review of care plan dated 05/07/2024 showed the resident was at risk for deterioration in ADL function and medical stability due to paraplegia (loss of function in both legs) and other medical issues, and staff were to respect the resident's preferences. On 07/25/2024 at 9:58 AM, Resident 6 stated the maintenance man took away their Air Conditioner (AC), but they needed it for their legs. Resident 6 stated it should be in their care plan that they needed an AC as their legs do not sufficiently sweat and they needed it to keep their legs cool. On 07/26/2024 at 8:55 AM, Resident 6 stated repeatedly they needed their AC, .I couldn't sleep all night. Resident 6 stated they had an AC unit in their room before the State [surveyors] got there and the facility took away the AC. Resident 6 stated they had verbalized their concern to the nursing staff. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/26/2024 at 10:17 AM, Staff M (Registered Nurse) stated the night shift nurse told them that the resident asked for their AC in their room last night, but it was not reported to the manager yet. However, Staff M did ask maintenance to re-install the AC, but they were waiting. Staff M stated they knew that Resident 6 needed the AC for their legs. On 07/29/2024 at 12:19 PM, Resident 6 stated, I didn't file a grievance report yet, but I asked 2 care aids and a nurse and they didn't know how to file a grievance report. In an interview on 07/29/2024 at 12:40 PM, Staff E stated they were notified by the facility's pastor on 7/25/2024 of Resident 6's concern. In an interview on 07/29/2024 at 11:37 AM, Staff L (Manger Long Term Care Registered Nurse), stated, the usual process for when a resident has an issue is, the nursing staff are notified, and we will address the issue and look further into it. In an interview on 07/30/2024 at 8:46 AM, Staff B stated the staff were to provide the resident with a grievance report if there was an issue, our social workers are then in charge of grievances and in keeping the logs. Staff B stated the nursing staff should report grievances to their nursing managers and interview the resident. REFERENCE: WAC 388-97-0460.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on observations, interviews, and record review, the facility failed to thoroughly investigate incidents for an unwitnessed fall for 1 of 9 residents (Resident 239) whose facility incident report was reviewed to rule out abuse and/or neglect. Facility failure to conduct a complete and thorough investigation as required left residents at risk for unidentified abuse and/or neglect. Findings included . <Facility Policy> The Abuse Prohibition and Prevention facility policy, revised 01/2024, showed a thorough investigation of the alleged violation would be completed and would include conducting interviews with the alleged victim and representative, accused person(s), witnesses, provider, personnel from outside agencies as appropriate. The policy showed the facility would conduct a record review for pertinent information related to the alleged violation such as progress notes and documentation sources as appropriate. The policy showed investigation results of all investigations would be reported to the administrator or designee and to other officials in accordance with State and Federal law within five working days of the incident, and if the alleged violation was substantiated, appropriate corrective action would be taken. <Resident 239> According to the 07/18/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 239 admitted to the facility on [DATE], had clear speech, their memory was intact, and had medical conditions including cancer of the bladder and the lungs extending to the liver, pressure ulcers to the buttocks, malnutrition, and was receiving end-of-life care. The MDS showed Resident 239 was assessed to be totally dependent on two staff for transfers and toileting. Review of the 07/13/2024 Fall Care Plan (CP) showed Resident 239 was at risk for falls due to generalized weakness, malnutrition, and their medical morbidities. A 07/13/2024 CP intervention showed Resident 239 would be provided assistance with their transfers and walking to reduce the risk of falls while in the facility. Observation and interview on 07/24/2024 at 12:09 PM showed Resident 239 was lying in bed, very frail and short of breath despite receiving supplemental oxygen. Resident 239's bed was in low position, and a fall mat was observed in place to the left side of the bed. Resident 239 stated they had two falls since being admitted to the facility. Resident 239 could not recall the details of their falls but stated they believed they were reaching for something while in bed and rolled out of bed. A 07/22/2024 nursing progress note showed Resident 239 sustained a fall around 9:00 AM in their room while attempting to go to the bathroom. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation report of Resident 239's fall, completed on 07/25/2024, showed the resident fell while attempting to ambulate to the bathroom after breakfast. The report showed assistance with the bed pan was offered several times before breakfast but Resident 239 refused. The report showed the staff completing the investigation ruled out abuse and/or neglect. The investigation report did not contain any staff interview(s) or witness statements regarding the incident. The investigation report included conflicting information regarding the fall being witnessed or unwitnessed, and whether neurological (involving the brain) assessment was initiated and/or completed or not for the resident based on the 07/22/2024 nursing progress note that showed staff did, alongside the 07/22/2024 Fall Occurrence User Defined Assessment (UDA) which showed staff did not, it being a witnessed fall. The investigation report did not include a neurological assessment for Resident 239. Further review of the 07/22/2024 Fall Occurrence UDA showed the staff completing the assessment did not identify: (1) the nursing aide who was the last person to observe Resident 239 eating breakfast in the room, and (2) the nursing aide who claimed to have provided the last incontinent care to Resident 239 at 7:30 AM. The Fall Occurrence UDA's instruction for staff completing the assessment read, Please enter (at a minimum) first name and last initial on these line items but only wrote aid/aide on both. In an interview on 07/31/2024 at 1:42 PM, Staff B (Director of Nursing) stated Resident 239's fall was unwitnessed. When asked if there were any documented interviews/testimony from staff who were working at that time when the fall happened, Staff B stated they had conversations with staff but did not document them. Staff B stated they knew an event investigation should be completed within five days of the event occurring, including having all appropriate documentation from record review and staff/witness statements or interviews, but did not have them. The facility was not able to provide any documentation to support staff offered Resident 239 toileting assistance several times as indicated in the investigation report, where Resident 239 declined their assistance prior to the resident's unwitnessed fall. In an interview on 08/01/2024 at 10:13 AM, Staff A (Administrator) stated it was important for facility event investigations to be conducted completely and thoroughly so that resident abuse and/or neglect could be ruled out. Staff A stated they expected the designated staff responsible for facility event investigations to conduct a complete and thorough investigation and report as required. Refer to F657- Care Plan Timing and Revision. REFERENCE: WAC 388-97-0640 (6)(a)(b)(c).

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F 0623 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to provide written transfer/discharge notices and/or complete notification to the Office of the State Long-Term Care Ombudsman (LTCO) as required for 2 of 4 residents (Residents 32 & 20) reviewed for hospitalization . Failure to provide notification to the resident and/or the resident's representative of the reasons for the discharge in writing or notify the LTCO placed residents at risk for a discharge that did not meet the resident's stated goals for care and preferences, and at risk for preventing the Ombudsman from advocating for residents. Findings included . <Facility Policy> According to the facility's 01/2022 Transfer or Discharge and Ombudsman Notification policy, when a facility resident was temporarily/emergently hospitalized , a notice of transfer must be provided to the resident or their representative as soon as practical. The policy showed copies of all transfer notices were provided to the LTCO office on at least a monthly basis. <Resident 32> According to the 05/07/2024 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 32 had severe memory impairment. The MDS showed Resident 32 had diagnoses including Alzheimer's disease (memory impairment) and Diabetes Mellitus (a condition making regulating blood glucose more difficult). According to a 06/14/2024 progress note, at 1:05 PM, Resident 32 experienced an acute change in condition including elevated blood glucose, rapid heart rate, and involuntary movements. The progress note showed Resident 32 was sent to the hospital emergently at 1:35 PM. A 06/18/2024 progress note showed Resident 32 was readmitted to the facility. Record review showed no evidence a transfer notice was completed and given to Resident 32 of their representative as required. In an interview on 07/31/2024 at 12:28 PM, Staff S (Health Information Manager) stated they were unable to find a written transfer notification for Resident 32's 06/14/2024 hospitalization . Staff S stated the facility should have notified the resident or their representative but could not demonstrate this happened. Staff S stated as the notice did not exist, it could not be sent to the LTCO office. 46471 <Resident 20> (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 06/03/2024 Quarterly MDS, Resident 20 had medical conditions including a brain injury with weakness to one side of their body, malnutrition, and difficulty urinating due to organ blockage. The MDS showed Resident 20 had an indwelling Foley catheter (a flexible tube inserted into the bladder to drain urine) in place during the assessment period. On 07/25/2024 at 10:27 AM, Resident 20 stated they recall being sent to the hospital from the facility a few times due to an infection and increasing confusion. Review of the facility census showed Resident 20 was discharged to the hospital on 12/06/2023 and was readmitted to the facility on [DATE]. A 12/06/2023 nursing progress note showed Resident 20 complained of pressure and pain on their lower abdomen and had blood clots in their urine. The note showed the provider was notified and ordered to send Resident 20 to the hospital for further evaluation and treatment. Review of Resident 20's medical records showed an unsigned transfer notice acknowledging the resident and/or their representative was notified of the discharge. The transfer notice was observed incomplete and did not provide an explanation to support Resident 20's discharge to the hospital was warranted as required. In an interview on 07/31/2024 at 10:42 AM, Staff S stated they were responsible for record-keeping transfer/discharge notices and Ombudsman notification. Staff S confirmed the transfer notice had no resident or resident representative signature to acknowledge receipt and understanding of the required written notification and stated the notice should be signed. Staff S stated there was no documentation found to support the Ombudsman was notified of Resident 20's hospital transfer as required. In an interview on 07/31/2024 at 12:39 PM, Staff A (Administrator) stated it was important to provide residents and their representative written transfer/discharge notification to communicate the resident's current location and to ensure the resident and their representative were notified of the rights and regulations associated with their transfer/discharge. Staff A stated the provision of a written transfer/discharge notice went hand in hand with the required Ombudsman notification and that they expected every staff member involved (nursing and medical records) to do their part in the process. REFERENCE: WAC 388-97-0120(2)(a-d), -0140(1)(a)(b)(c)(i-iii).

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 46471 Based on interview and record review, the facility failed to complete Quarterly Minimum Data Set (MDS - an assessment tool) assessments within the regulatory timeframe for 1 of 3 residents (Resident 67) reviewed for resident assessments and timing. The failure to ensure MDS assessments were completed timely placed residents at risk for delayed care planning, unidentified care needs and services, and a decreased quality of life. Findings included . <Resident Assessment Instrument (RAI - instructional guidelines for MDS completion) Manual> The October 2023 RAI Manual showed a Quarterly MDS was a non-comprehensive assessment used to track the resident's status between comprehensive assessments that ensured residents were monitored for critical indicators of a gradual onset of significant change(s) in their status. The RAI outlined a Quarterly MDS must be completed no later than 14 days after the established Assessment Reference Date (ARD) of the assessment and no later than 92 days from the ARD of the most recent prior quarterly or comprehensive assessment (counting ARD to ARD). <Resident 67> Review of Resident 67's MDS schedule showed the comprehensive 03/15/2024 Admission assessment was completed on 03/18/2024. The next scheduled 06/03/2024 Quarterly assessment was not completed until 06/17/2024 as timestamped on the MDS' assessment history report and was three days past the 92 days' regulatory completion timeframe as required. In an interview on 07/29/2024 at 11:31 AM, Staff T (MDS Coordinator) stated it was important to ensure timely completion of MDS assessments because the appropriate and safe care necessary for care planning relied on the timeliness of these assessments. Staff T confirmed Resident 67's Quarterly MDS was late. In an interview on 07/29/2024 at 1:14 PM, Staff A (Administrator) stated they expected the MDS coordinators to complete assessments accurately and timely as required. Refer to F642- Coordination/Certification of Assessments. REFERENCE: WAC 388-97-1000 (4)(a).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation, interview, and record review the facility failed to ensure 3 of 21 residents (Residents 189, 28, & 68) whose Minimum Data Set (MDS - an assessment tool) were completed accurately to reflect the resident's condition at the time of assessment. This failure placed residents at risk for unidentified and/or unmet care needs. Findings included . <Resident 189> According to a 06/12/2024 Admission MDS, Resident 189 admitted to the facility on [DATE]. Review of a 06/23/2024 Discharge MDS showed Resident 189 was transferred to an acute care hospital with their return to the facility anticipated. Upon Resident 189's return to the facility 12 days later, staff completed a 07/05/2024 Entry Tracking MDS and indicated the resident's type of entry was an admission, rather than a reentry as required. In a joint interview with Staff T (MDS Coordinator) and Staff X (MDS Coordinator) on 08/01/2024 at 2:25 PM, Staff X stated it was their expectation an Entry Tracking MDS be coded as a reentry if a resident was hospitalized less than 30 days. Staff X stated it was important to accurately code reentry versus an admission on an Entry Tracking MDS and stated, it is the Medicare rules. Staff X stated having accurate coding also assists with the continuity and coordination of care for a resident. Staff T reviewed Resident 189's 07/05/2024 Entry Tracking MDS and stated, I did it wrong, it should be coded as a reentry. 42203 <Resident 28> According to the 05/20/2024 Quarterly MDS, Resident 28 exhibited no delusions during the assessment period, and had a diagnosis of depression. The MDS did not identify Resident 28 with a diagnosis of psychosis. The MDS showed Resident 28 received an antipsychotic medication. Review of the Physician's Orders showed a 05/25/2023 order for an antipsychotic medication to be given twice daily for delusions. Record review showed Resident 28 had an 04/03/2023 potential for violence due to [.] paranoia/delusions about staff Care Plan (CP), a 07/24/2020 History of delusions . CP, and a 05/31/2022 psychotropic medication CP that addressed Resident 28's use of an antipsychotic medication use. In an interview on 08/01/2024 at 9:05 AM Staff B (Director of Nursing) stated Resident 28 had a diagnosis of a psychosis. Staff B stated this should be reflected on the 05/20/2024 Quarterly MDS but was not. <Resident 68> (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 06/13/2024 Admission MDS showed Resident 15 had intact memory. This MDS included a section for resident interviews on pain, mood, and daily and activity preferences. This activity preferences interview allowed residents to express how important a given activity was from very important to not important at all. All the activity preferences rows were marked with a 9 indicating the resident did not respond or was nonresponsive during the interview. Instead, a staff assessment was completed indicating Resident 28 was interested in keeping up with news. The row showing whether Resident 28 was interested in spending time outdoors was incomplete. In an interview on 07/31/2024 at 10:40 AM Resident 68 stated they had interest in getting outside but was not offered the opportunity. Resident 68 said they had other interests besides just watching television in their room. In an interview on 07/31/2024 at 3:43 PM Staff T stated Resident 68 was sleepy and unresponsive during the resident activity preferences interview. Staff T stated another activities interview was not attempted. When asked why Resident 68 was able to answer questions about their mood, pain, and daily preferences but not activities, Staff T stated that's a good question. Staff T stated that because the staff assessment only captured general interest in a given activity rather than the degree of interest, it provided less detailed information. REFERENCE: WAC 38-97-1000 (1)(b).

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a qualified health professional conducts resident assessments. 46471 Based on interview and record review, the facility failed to ensure the Registered Nurse (RN) responsible for attesting to the accuracy and completeness of resident assessments was knowledgeable of the Minimum Data Set (MDS - an assessment tool) process for 3 of 3 residents (Residents 67, 20, & 45) whose Quarterly MDS assessments were reviewed for accuracy and timeliness. The facility's failure to report accurate MDS data placed residents at risk for violations of the Social Security Act. Findings included . <Resident Assessment Instrument (RAI - instructional guidelines for MDS completion) Manual> The October 2023 RAI Manual showed signatures of persons completing the assessment would certify that the accompanying information accurately reflected resident assessment information. The RAI manual showed, by attesting and signing the MDS, the RN coordinator and its signatories understood these information were used as a basis for ensuring residents receive appropriate and quality care, a basis for payment from federal funds, and that payment of such federal funds and continued participation in the government-funded health care programs was conditioned on the accuracy and truthfulness of the MDS information provided. The RAI manual showed MDS signatories could be personally subjected to or may subject the organization to substantial criminal, civil, and/or administrative penalties for submitting false information. <Resident 67> Review of Resident 67's 06/03/2024 Quarterly MDS showed a completion date of 06/14/2024 in the resident's medical records but the assessment history report showed the RN coordinator completed the assessment on 06/17/2024. <Resident 20> Review of Resident 20's 06/03/2024 Quarterly MDS showed a completion date of 06/07/2024 in the resident's medical records but the assessment history report showed the RN coordinator completed the assessment on 06/11/2024. <Resident 45> Review of Resident 45's 04/01/2024 Quarterly MDS showed a completion date of 04/05/2024 in the resident's medical records but the assessment history report showed the RN coordinator completed the assessment on 04/09/2024. In an interview on 07/29/2024 at 12:42 PM, Staff T (MDS Coordinator) confirmed they refer to the RAI manual for assessment coding and guidance. Staff T stated MDS assessments should be completed accurately and items identified that were coded inaccurately needed to be clarified and corrected. Staff T stated MDS completion dates should not be backdated because it was unethical. Staff T confirmed the completion dates reflected in Residents 67, 20, and 45's Quarterly MDS assessments in the medical records were backdated and not the actual dates of completion and stated they needed MDS education. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/29/2024 at 1:14 PM, Staff A (Administrator) stated backdating MDS completion dates was an unacceptable practice and that Staff T should be educated. Staff A stated they expected the MDS coordinators to attest and document the actual MDS completion date in the resident's medical records. Refer to F638- Quarterly Assessment At Least Every 3 Months. REFERENCE: WAC 388-97-1000 (5)(a).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to ensure Level 1 Preadmission Screening and Resident Reviews (PASRR - a Serious Mental Illness (SMI)/Intellectual Disability (ID) screening for the need for further assessment for outside resources while in a nursing home environment) were accurate upon admission and updated as needed after a significant change as required for 3 of 5 residents (Residents 28, 45, & 32) reviewed for unnecessary medication. This failure left residents at risk for unassessed mental health needs, and other negative health outcomes. <Facility Policy> According to the PASRR facility policy, revised 01/2023, all residents would undergo a Level 1 PASRR screening prior to admission. The policy showed current residents must undergo a Level 1 PASRR if a significant change in their physical or mental condition was identified. <Resident 28> According to the 05/20/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 28 had impaired memory and medical diagnoses including dementia (a memory impairment), anxiety, and depression. The MDS showed Resident 28 received Antipsychotic (AP), Antidepressant (AD), and Antianxiety (AA) medications. Review of the 04/26/2023 Level 1 PASRR showed this PASRR did not include Resident 28's dementia diagnosis. This PASRR included a handwritten note showing reviewed but no dx (diagnosis) of dementia. In an interview on 07/31/2024 at 10:24 AM, Staff E (Social Services Director) stated it was important for PASRRs to be available in the chart and accurately reflect the resident's current condition. In an interview on 08/01/2024 at 11:55 AM Staff E stated it was important for PASRRs to be accurate and updated with changes. <Resident 45> According to the 06/17/2024 Quarterly MDS, Resident 45 admitted to the facility on [DATE] and had medical conditions including depression and anxiety. Review of Resident 45's Physician Orders (POs) showed a 01/12/2024 order for daily administration of AD and AA medications since the resident's facility admission. A 04/11/2024 social services progress note showed staff reviewed and updated Resident 45's Level 1 PASRR and referred the resident to the PASRR office for a Level 2 evaluation due to the presence of SMI. Review of Resident 45's medical records did not show the resident's Level 1 PASRR form was accessible to staff. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/31/2024 at 10:24 AM, Staff E indicated they found Resident 45's updated Level 1 PASRR inside a folder in their office and stated PASRRs should be accessible to staff, but Resident 45's was not. <Resident 32> According to the 05/07/2024 Significant Change MDS, Resident 32 had a severe memory impairment, difficulty focusing, and disorganized thinking. The MDS showed Resident 32 had diagnoses including Alzheimer's disease (a memory impairment) and depression. The MDS showed Resident 32 received AP and AD medications. Review of the (POs) showed a 05/15/2024 order for an AP medication prescribed for dementia, unspecified severity, with behavioral disturbance. Record review showed the facility completed a Significant Change MDS for Resident 32 on 03/07/2024 related to the resident's decision to be placed on hospice services. A second Significant Change MDS for Resident 32's health improvement was completed on 05/07/2024 following their dis-enrollment from hospice services. Record review showed the most current Level 1 PASRR in Resident 32's chart was dated 01/19/2021. This PASRR did not include Resident 32's dementia diagnosis. No Level 1 PASRR screening was completed in relation to Resident 32's 03/07/2024 and 05/07/2024 Significant Change MDSs. In an interview on 08/01/2024 at 11:55 AM, Staff E demonstrated they had a newer Level 1 PASRR dated 04/11/2024 in a file in their office that was more current. Staff E stated they did not know a Level 1 screening was required for a significant change and so did not complete a Level 1 screening after the 05/07/20234 Significant Change MDS as required. REFERENCE: WAC 388-97-1915 (1)(2)(a-c). 46471

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. 42203 Based on observation, interview, and record review, the facility failed to develop and/or implement a comprehensive Care Plan (CP) for 5 of 21 sampled residents (Residents 68, 31, 66, 75, & 189) whose comprehensive CPs were reviewed. The failure to develop comprehensive, individualized CPs with resident-specific goals and/or interventions placed residents at risk for unmet care needs and a decreased quality of life. Findings included . <Facility Policy> According to the 03/2012 Resident Care Plan policy, within 21 days after admission, the facility would develop and implement a comprehensive CP to address all the resident's care needs. The policy showed the CP should include measurable, resident-specific goals. <Resident 68> According to the 06/13/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 68 had intact memory and diagnoses including a wound infection, malnutrition, and depression. The MDS showed Resident 68 was on a physician-prescribed weight loss program. Observation on 07/24/2024 at 1:44 PM showed Resident 68 was very thin. At that time, Resident 68 stated they lost weight they wished to gain back. Review of Resident 68's comprehensive CP showed a 06/14/2024 Severe calorie protein malnutrition related to physiological cause [as exhibited by] physical exam indicates muscle and fat loss CP. This CP did not have any associated goals or interventions. In an interview on 08/01/24 at 9:13 AM, Staff B (Director of Nursing) stated the malnutrition CP should have associated goals and interventions, but did not. 43642 <Resident 31> According to a 07/12/2024 Admission MDS, Resident 31 had multiple medically complex diagnoses including cancer, had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 31 with no memory impairment. In an interview on 07/25/2024 at 9:16 AM, Resident 31 stated they were certain they lost some weight due to their cancer diagnosis. According to the 07/12/2024 nutritional Care Area Assessment Resident 31's nutritional concerns would be addressed in the residents CP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 31's comprehensive CP showed no CP addressing nutrition was developed or implemented. In an interview on 07/30/24 at 10:31 AM, Staff B stated it was important for CPs to be complete to ensure the interventions residents required where in place. Staff B stated they expected CPs to be developed and implemented. <Resident 66> According to the 06/28/2024 Admission MDS, Resident 66 had mild memory impairment, and one unhealed pressure ulcer. There MDS showed Resident 66 had diagnoses including heart disease, high blood pressure, unstable blood sugar level in the body, and malnutrition. Review of Resident 66's comprehensive CP showed a 06/28/2024 severe protein calorie malnutrition CP was initiated, but staff failed to develop any resident goals or interventions. <Resident 75> According to a 06/06/2024 Admission MDS, Resident 75 had medical conditions including the loss of the ability to use one side of their body and required the use of a feeding tube to provide at least half of the resident's nutritional intake. Review of Resident 75's comprehensive CP showed a 06/07/2024 altered nutrition CP was initiated, but staff failed to develop any resident goals or interventions. <Resident 189> According to a 06/12/2024 Admission MDS, Resident 189 had multiple medically complex diagnoses and required the use of a feeding tube to provide at least half of their nutritional intake. Review of Resident 189's comprehensive CP showed a 06/12/2024 altered nutrition CP was initiated, but staff failed to develop any resident goals or interventions. In an interview on 07/30/24 at 10:31 AM, Staff B stated it was important for CPs to be complete to ensure the interventions residents required where in place. Staff B stated they expected CPs to be developed and implemented. REFERENCE: WAC 38-97-1020(1), (2)(a)(b).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review, the facility failed to ensure Care Plans (CP) were revised and updated to reflect residents' current care needs for 6 of 21 sampled residents (Residents 28, 32, 66, 239, 64, & 189) whose CP were reviewed. This failure left residents at risk for unmet care needs, unsafe provision of care, and a decreased quality of life. Findings included . <Facility Policy> Review of the Resident Care Plan policy, revised 03/2012, showed the Resident's CP should be a communication tool for staff to provide consistency and continuity in resident care based on resident needs, values and preferences. The policy showed CPs would describe a specific plan that reflected resident preferences and care needs with measurable, specific, realistic, and achievable goals so the resident could attain or maintain their highest practicable physical, mental, and psychosocial well-being. The policy showed CPs should be revised quarterly and as needed. <Resident 28> According to the 05/20/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 28 had medical conditions including heart failure and a chronic inflammatory lung disease. The MDS showed Resident 28 experienced Shortness of Breath (SOB) with exertion, at rest, and when lying flat, and received supplemental oxygen for these conditions. According to the 05/23/2022 SOB CP, Resident 28 had a goal for clear lung sounds. This CP included an intervention for nurses to administer a nebulizer treatment (a treatment that aerosolizes an inhaled respiratory medication). Observations on 07/24/2024 at 2:51 PM and 07/30/2024 at 8:08 AM showed no nebulizer machine in Resident 28's room. In an interview on 08/01/2024 at 9:05 AM, Staff B (Director of Nursing) verified Resident 28's Physician's Orders (POs) and stated Resident 28 no longer received as needed nebulizer treatments. Staff B stated the SOB CP needed to be revised. <Resident 32> According to the 05/07/2024 Significant Change MDS, Resident 32 had a severe memory impairment and required staff assistance for mobility. The MDS showed Resident 32 had cardiorespiratory (heart/lung) diagnoses including an irregular heart rate, high blood pressure, and weakness. Review of the 06/08/2023 .on continuous oxygen therapy . CP showed Resident 32 received oxygen per the PO. The CP directed staff to monitor for SOB and changes in skin tone. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 07/26/2024 at 8:50 AM, 07/26/2024 at 12:22 PM, and on 07/29/2024 at 8:35 AM and 2:10 PM showed Resident 32 breathing without supplemental oxygen. There was no oxygen therapy equipment seen in Resident 32's room. In an interview on 08/01/2024 at 8:56 AM Staff B stated Resident 32 no longer required continuous oxygen therapy. Staff B stated the CP needed to be updated to reflect Resident 32's current condition. 43642 <Resident 66> According to the 06/28/2024 Admission MDS, Resident 66 had recent surgery and required the use of Intravenous (IV - a tube placed inside a vein to deliver medications) antibiotic medications. Review of Resident 66's 06/24/2024 comprehensive CP showed staff developed a CP related to Resident 66 requiring IV antibiotic medications. This CP gave directions to staff to monitor the residents IV site for redness and swelling and to change the IV dressing as ordered. Review of Resident 66's July 2024 Medication Administration Records (MAR) showed the resident's IV antibiotics were discontinued on 07/11/2024, two weeks earlier. In an interview on 08/01/2024 at 1:03 PM, Staff B stated it was their expectation Resident 66's CP be updated and revised when the IV medication was discontinued. <Resident 189> According to a 06/12/2024 Admission MDS, Resident 189 had multiple medically complex diagnoses and required the use of a feeding tube to provide at least half of their nutritional intake. Review of a 07/21/2024 physician order showed diet orders for Resident 189 to have no food or fluids by mouth. Review of Resident 189's comprehensive CP showed the following: a 06/07/2024 constipation CP which showed directions to staff to encourage fluids; and a 06/07/2024 dehydration CP which showed directions to staff to encourage fluids. In an interview on 08/01/2024 at 1:03 PM, Staff B stated Resident 189's CP should have been updated and revised as staff should not be encouraging fluids to Resident 189. 46471 <Resident 239> According to the 07/18/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 239 had clear speech, intact memory, and had diagnoses including end stage cancer and malnutrition. The MDS showed Resident 239 did not walk and was assessed to be totally dependent on two staff for transfers and toileting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/24/2024 at 12:09 PM showed Resident 239 was lying in bed; the bed was in low position and a fall mat was placed on the left side. Resident 239 stated they had two falls since they admitted to the facility on [DATE]. The same observations of the bed and the fall mat were noted on 07/25/2024 at 2:35 PM and on 07/26/2024 at 9:41 AM. Review of a 07/22/2025 nursing progress note showed Resident 239 had a fall in their room after attempting to go to the bathroom during breakfast. Review of a late entry progress note dated 07/24/2024 showed a Physical Therapy (PT) staff assessed Resident 239's functional mobility post-fall and implemented fall and injury prevention interventions including lowering the bed height and the use of fall mats. Review of Resident 239's Care Plan (CP) showed a 07/13/2024 Fall CP indicating the resident was at risk for falls due to generalized weakness, malnutrition, and their medical diagnoses. The CP did not show the use of a fall mat observed in place. In an interview on 07/30/2024 at 10:31 AM, Staff B (Director of Nursing) stated the CP should be complete, accurate, and revised/updated accordingly to ensure proper interventions were in place, and for Resident 239's case, to prevent recurrent falls and/or injuries. Staff B stated they expected fall interventions identified by the interdisciplinary team to be reflected in Resident 239's CP. Staff B reviewed Resident 239's CP and stated the current use of a fall mat should be listed as an intervention, but was not. 50511 <Resident 64> According to the 03/03/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 64 admitted to the facility on [DATE]. The MDS showed Resident 64 had dementia and for several days would feel down or depressed and often felt lonely or isolated. Resident also had vision impairment and may reject care for 1 to 3 days. Review of Resident 64's CP showed goals for behavior of No injuries related to dementia during facility stay and for rejection of care the goal showed the Resident would not harm self. Interventions shown in the CP were to encourage the resident to participate in daily scheduled activities, spiritual visits, provide one on one listening and to assist resident in identifying enjoyable activities. Review of Kardex (work sheet used by care staff to inform them of key patient information and instructions based on CP) on 7/26/2024 at 9:25 AM, showed no instructions provided to care staff in the following areas on the Kardex, What makes life meaningful to resident, What resident likes to do, Hearing/Vision/Dental and no specific instructions on what to do if the Resident rejected care. Observation on 07/23/2024 at 11:07 AM Resident 64 stated the staff are not doing anything for me, they treat me like I am not even here, they ignore me. Observation on 07/26/2024 at 08:39 AM, Resident 64 started crying and stated I am so lonesome. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/30/2024 at 08:37 AM Staff J stated Resident 64's toenails were long and not of normal length and stated for residents who refuse care, it should have been documented and put in progress notes that the resident refused care. In interviews on 07/30/2024 at 8:42 AM and 08/01/2024, Staff B (Director of Nursing) stated staff still need to encourage residents who continually refuse care, because Resident 64 has dementia, staff still need to do whatever they can. Staff B also said that don't have the time to sit with Resident 64. In an interview on 07/30/2024 at 10:31 AM, Staff B (DNS) stated the CP must be complete, accurate and updated accordingly so proper interventions would be in place to prevent injury and is used for staff to follow in providing resident care. REFERENCE: WAC 388-97-1020(2)(c)(d). 51149

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43642 Based on observation, interview, and record review the facility failed to ensure: Physician's Orders (POs) were followed for 1 (Resident 13) and POs were clarified as needed for 1 (Resident 189) of 21 sampled residents reviewed. These failures placed residents at risk for medication errors, delayed treatment, and adverse outcomes. Findings included . <Following Orders> <Resident 13> During observations of medication pass on 07/29/2024 at 8:56 AM, Staff E was observed to prepare a pain medication gel for Resident 13 by squeezing the tube into a 30-milliliter medication cup until 3/4 of the bottom of the cup was filled with the gel. Staff E did not use a dose measuring card to prepare the dose. Review of Resident 13's July 2024 Medication Administration Records (MAR) showed a 04/04/2024 order to apply four grams of the pain medication gel to the resident's right knee twice daily for pain. In an interview on 08/01/2024 at 11:36 AM, Staff L (Manager Long Term Care, Registered Nurse) stated there was no way for staff to determine how much four grams of the gel was if they used a medication cup to dispense. In an interview on 08/01/2024 at 1:03 PM, Staff B (Director of Nursing) stated in order to measure the correct dose of the pain medication gel, staff would need to use the dosing card provided with the medication. Staff B stated their expectation was for staff to squeeze an even line of the medication from the tube onto the dosing cared, using the marks on the card to measure the prescribed dose. <Clarifying Orders> <Resident 189> According to a 06/12/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 189 had multiple medically complex diagnoses and required the use of a feeding tube to provide at least half of their nutritional intake. Review of a 07/21/2024 PO showed diet orders for Resident 189 to have no food or fluids by mouth, and to take medications through a PEG Tube (Percutaneous Endoscopic Gastrostomy tube; a surgically placed tube allowing artificial nutritional to flow straight into the stomach). Review of Resident 189's July 2024 MAR showed a 07/22/2024 order to administer a blood thinning medication daily by mouth, rather than via the PEG Tube as identified in the 07/21/2024 order to have nothing by mouth. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/01/2024 at 1:03 PM, Staff B stated their expectation was for staff not to give the medication by mouth and stated the order for Resident 189 needed to be clarified. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42203 Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADL) for 2 of 3 residents (Residents 32 & 64) reviewed who were dependent on staff for daily cares. The failure to provide required bathing and grooming assistance placed residents at risk for poor hygiene, diminished feeling of self-worth, and a decreased quality of life. Findings included . <Resident 32> According to the 05/07/2024 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 32 sometimes understood conversation, difficulty focusing, and disorganized thinking. The MDS showed Resident 32 was dependent on staff assistance for bathing and required and substantial to maximal assistance for personal hygiene. The MDS showed Resident 32 had a diagnosis of Alzheimer's disease (a memory impairment). The 06/15/2022 preferences Care Plan (CP) showed Resident 32 preferred showers. This CP showed Resident 32's preferences would be honored. The 06/15/2022 risk for deterioration in ADL function .' CP showed Resident 32 may require assistance and encouragement with ADLs. On 07/24/2024 at 12:39 PM, Resident 32 was observed to have several days of beard growth. On 07/26/2024 at 12:22 PM, Resident 32 was observed to still be unshaven. Resident 32's beard was longer than observed on 07/24/2024. On 07/29/2024 at 2:10 PM, Resident 32 still was unshaven with their beard thicker than previously observed. On 07/31/2024 01:43 PM, Resident 32 was observed to be shaved. In an interview on 07/31/2024 at 3:21 PM, Staff B (Director of Nursing) stated they knew Resident 32 for a long time. Staff B stated Resident 32's Alzheimer's disease progressed to where the resident was less able to express their preferences for grooming than previously. Staff B stated they knew appearance was important to Resident 32. Staff B stated they expected nursing staff to assist Resident 32 to shave as part of their ADL care. Staff B stated Resident 32 should be clean shaven. 50511 <Resident 64> According to the 05/15/2024 Quarterly MDS, Resident 64 needed some help with functional cognition, had visual impairment, was dependent on staff for footwear, and needed moderate assistance with their upper and lower body dressing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the revised 05/20/2024 CP showed staff were to meet the Resident 64's ADL needs daily. On 07/23/2024 at 01:48 PM, Resident 64 stated, I have no clothes, no shoes, only slippers. I don't have socks and I do all my own dressing. I have to wait for staff and then it gets to be too late .at night I freeze because I don't have nothing to keep me warm. On 07/23/2024 at 1:48 PM, observed Resident 64's fingernails were long and extended 1/4 inch past nail bed; their nail polish was mostly chipped off and their toenails were long enough to curl back into the toes. Resident 64 did not have socks on during observation. On 07/26/2024 at 8:39 AM, Resident 64 stated they had the same clothing on from yesterday and they wore the same clothes when they go to bed. On 07/29/2024 at 8:26 AM, Resident 64 stated, I helped myself get dressed this morning, I rarely have help, I would love to sometimes get some help. On 07/30/2024 at 8:37 AM, Resident 64 stated their hair was not combed from the shower the other day and stated, they [staff] do not help me with my hair. On 07/31/2024 at 11:32 AM, observed Resident 64's hair was not combed and was standing straight up on their head. On 08/01/2024 at 8:28 AM, Resident 64 stated, another patient said they would do my hair for me, I like to keep my hair up and I am trying to get it braided. In an interview on 07/30/2024 at 8:42 AM, Staff B stated they still encourage residents who refuse care and staff were to do whatever they can to help. Staff B observed Resident 64's toenails were not cut and stated they should be cut/trimmed. Staff B stated staff should tell us when there were residents with long nails and refusals for care, but did not. REFERENCE: WAC 388-97-1060(2)(c).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 50511 Based on observation, interview, and record review the facility failed to ensure activity programs met the needs of each resident for 1 of 3 residents (Resident 64) reviewed for activities. Failure to provide residents with meaningful activities left residents at risk for boredom, frustration, and a diminished quality of life. Findings included . <Resident 64> According to a 05/15/2024 Quarterly Admission Minimum Data Set (MDS - an assessment tool) showed Resident 64 preferred to have books, newspapers, listen to music, and choose daily activity preferences. The assessment showed Resident 64 had unspecified dementia and behavioral disturbances. Review of a revised 04/16/2/2024 Resident Care Plan (CP) the Problems/Strengths focused area showed Resident 64 needed encouragement to participate in daily scheduled activities. The CP showed that Resident 64 was dependent on staff for locomotion and needed supervision for ambulation and transfers. The CP showed Resident 64 would obtain assistance in choosing and identifying enjoyable activities. Record Review of Physician Orders dated 02/25/2024, showed Resident 64 could participate in therapeutic recreation activities without restrictions unless directed otherwise. Review on 07/26/2024 at 9:26 AM of the Kardex (worksheet used by care staff to inform them of key patient information and instructions based on the CP) did not show any activities listed for Resident 64. On 07/23/2024 at 1:52 PM, Resident 64 stated if I could, I would participate in activities, I don't see how I could if I don't have anything to do. On 07/26/2024 at 8:39 AM, Resident was crying that she could not go anywhere and stated I can't even go outside, they won't let me. Resident was observed sitting in their room with no activities available. On 07/29/2024 at 11:42 AM, Resident 64 stated they were happy to have someone to talk to. In an interview on 07/30/2024 at 1:37 PM, Staff U (Activities Supervisor) stated we don't do group activities if we have units sectioned off. Due to COVID we shut down all group activities. Staff U stated they did pass out newsletters in the mornings. Staff U stated for residents with cognitive impairments, the facility provided activities that stimulated memory and social check-ins. Staff U stated that every person had a CP with specific goals. Staff U stated they did not receive any activity complaints during this current COVID outbreak. Staff U stated on August 6th activities would open up again. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff Q (Infection Preventionist) on 07/30/2024 at 11:36 AM, Staff Q stated that activities should have continued during the current COVID outbreak, although group gathering activities were stopped. Staff Q stated the activities department should still have gone room to room with crossword puzzles, small puzzles, reading and providing one on one discussions. If a resident had active COVID, chaplain visits and activities were still to occur. In an interview with (Director of Nursing) on 08/01/2024 at 10:15 AM, Staff B stated staff did not sit with Resident 64. If the resident moved to another unit, it would be more social for the resident. Staff B stated there were limited interactions in the unit because of the outbreak. Staff B stated staff were encouraged to engage with residents. Staff B stated the activities department should be involved in all activities for Resident 64. Staff B stated their expectation was that one-on-one activities be provided, and for the activity team to touch base with the resident regarding activity preferences. Staff B stated activities were one of the most important interventions for Resident 64 because of their cognitive and behaviors. Staff B stated for residents with dementia, the CP should be individualized for the residents needs. Staff B could not find an activity assessment for Resident 64 and stated, I don't see an activity assessment was done for the resident. Staff B stated more specific activities guidance should be added to the CP for Resident 64. Staff B stated activity assessments were important because they showed the resident's likes and dislikes are which helped with redirection and helped calm residents. <Resident Council> In an interview with Resident Council members on 07/29/2024 at 1:17 PM, council members stated during the current COVID outbreak, no activities were provided. Resident (27) stated there was nothing to do. Resident 27 stated on the daily activity newsletter, there was a puzzle on the back, but Resident 27 stated they found them boring, so they were limited to only phone calls or watching television for recreation. REFERENCE: WAC 388-97-0940 (1).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46471 Based on observation, interview, and record review, the facility failed to ensure 4 of 7 residents (Residents 45, 20, 58, & 239) reviewed for limited Range of Motion (ROM) were evaluated or provided care and services they were assessed to require, including Restorative Nursing Program (RNP). This failure placed residents at risk for decline in mobility and function, increased dependence on staff, and a decreased quality of life. Findings included . <Facility Policy> The RNP facility policy, revised 01/2022, showed the facility would provide restorative nursing services to promote a resident's ability to function at their highest level and live as independently and safely as possible. The policy showed residents who would benefit from RNPs included those who were at risk for functional decline, and residents with identified deficit(s) and had an established need. The Rigid Splint Application facility policy, revised 02/19/2024, showed splints applied incorrectly could cause unnecessary injuries such as skin or soft-tissue complications including pressure injuries and contact dermatitis beneath the splint. The policy showed prompt identification of impaired nerve or circulatory function was critical in preventing patient harm. The policy showed staff were expected to document splint care, skin assessment, and monitoring for complications. <Resident 45> According to the 06/17/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 45 had clear speech, intact memory, and with medical conditions including heart and kidney failure and a brain injury with resulting weakness on the left side of the body. The MDS showed Resident 45 was assessed to have functional limitations in their ROM. Review of Resident 45's 01/16/2024 Restorative Care Plan (CP) showed the resident was at risk for decreased upper and lower extremity mobility and had Active ROM (AROM) exercises in place. A 04/12/2024 CP intervention instructed staff to continue the application of a right ankle splint. Review of the 07/01/2024 Rehabilitation to Restorative Nursing - Nursing Recommendation Form showed Resident 45 was assessed for AROM RNP up to six days a week. The form showed rehabilitation department recommended right ankle splint application for up to 4.5 hours/day and assessed Resident 45 for splinting RNP up to six days a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 07/25/2024 at 9:49 AM showed Resident 45 was lying in bed in the room; their left foot was rotated outwards and their left arm/hand was bent inwards toward their body and was lying on top of their chest with minimal function/movement. There was no splint observed in place. Resident 45 stated they were only able to lift their left arm and leg a little bit off the pillow. When asked if they were provided exercises to help improve and/or maintain mobility and function on the left side of their body, Resident 45 stated, .once a week. Review of Resident 45's AROM RNP documentation 07/01/2024 until 07/26/2024 showed: On the week of 07/01/2024 to 07/06/2024, the RNP was provided once on 07/05/2024 and was declined by the resident twice on 07/01/2024 and 07/03/2024; on the week of 07/07/2024 to 07/13/2024, the RNP was provided once on 07/08/2024 and was declined on 07/11/2024; on the week of 07/14/2024 to 07/20/2024, the RNP was provided once on 07/15/2024 and was declined on 07/16/2024; and on the week of 07/21/2024 to 07/26/2024, the RNP was not provided and was declined by the resident on 07/22/2024 and 07/23/2024. The facility was not able to provide any documentation to support the AROM RNP was offered to Resident 45 by staff up to six days a week as assessed and planned. Review of Resident 45's Splint Training RNP documentation from 07/01/2024 until 07/26/2024 showed: On the week of 07/01/2024 to 07/06/2024, the RNP was provided three times on 07/01/2024, 07/03/2024, and 07/05/2024; on the week of 07/07/2024 to 07/13/2024, the RNP was provided three times on 07/08/2024, 07/09/2024, and 07/11/2024; on the week of 07/14/2024 to 07/20/2024, the RNP was provided two times on 07/15/2024 and 07/16/2024; and on the week of 07/21/2024 to 07/26/2024, the RNP was provided once on 07/23/2024 and was not provided on 07/25/2024 because Resident 45 was sleeping. The facility was not able to provide any documentation to support the Splint Training RNP was offered to Resident 45 by staff up to six days a week as assessed and planned. Review of Resident 45's Physician Orders (PO) showed a 04/12/2024 order for staff to conduct skin checks pre- and post-splint applications and to report any skin issues to the licensed nurse. Review of the July 2024 Treatment Administration Record (TAR) on 07/30/2024 did not show staff were conducting skin checks on Resident 45 before and after the application of their right ankle splint as ordered. There was no orders instructing staff to check Resident 45 for neurovascular (nerve and blood flow) compromise associated with splint application. In an interview on 07/26/2024 at 10:35 AM, Staff K (Licensed Practical Nurse) stated the RNP aide was responsible in applying the right ankle splint for Resident 45. In an interview on 07/26/2024 at 10:56 AM, Staff D (Director of Rehabilitation Services) stated resident RNPs was a shared responsibility between themselves, the MDS Coordinator, and the RNP aide. Staff D stated they were not providing RNP up to six days per the RNP assessment plan because their understanding was, as long as residents were provided at least 1-2 days of RNP and the residents were not declining, it was ok. Staff D stated RNPs were not offered six days in a week by the RNP aide. In an interview on 07/30/2024 at 11:53 AM, Staff B (Director of Nursing) stated skin checks should be performed on residents with splint(s) for early identification of device-related pressure injuries. Staff B stated they expected all staff involved with the facility RNPs to conduct skin checks as ordered. Staff B reviewed Resident 45's POs and stated no skin checks were being documented in Resident 45's TAR in line with the resident's current splint use. (continued on next page)

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	505418	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Marianwood	3725 Providence Point Drive Southeast Issaquah, WA 98029

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 20> According to the 06/03/2024 Quarterly MDS, Resident 20 had clear speech, intact memory, and medical conditions including a brain injury with resulting weakness on the left side of the body. The MDS showed Resident 20 was assessed to have functional limitations in their ROM. Review of Resident 20's 11/21/2023 Restorative CP showed the resident was at risk for decreased ROM to their bilateral upper and lower extremities due to generalized weakness and medical morbidities. The CP showed Resident 20 had AROM exercises and bed mobility RNPs in place. Review of the 01/15/2024 Rehabilitation to Restorative Nursing - Nursing Recommendation Form showed Resident 20 was assessed to tolerate the AROM and bed mobility RNP up to six days a week. Observation and interview on 07/25/2024 at 10:25 AM showed Resident 20's left upper and lower extremities were flaccid (limp and out of tone). Resident 20 stated they were bed bound and that staff provided them arm/leg exercises about three times a week the most. Review of Resident 20's AROM RNP documentation from 07/01/2024 until 07/26/2024 showed: On the week of 07/01/2024 to 07/06/2024, the RNP was provided once on 07/05/2024 and was declined by the resident twice on 07/03/2024; on the week of 07/07/2024 to 07/13/2024, the RNP was provided twice on 07/08/2024 and 07/11/2024; on the week of 07/14/2024 to 07/20/2024, the RNP was provided once on 07/15/2024; and on the week of 07/21/2024 to 07/26/2024, the RNP was provided once on 07/23/2024 and was declined by the resident on 07/22/2024. The facility was not able to provide any documentation to support the AROM RNP was offered to Resident 20 by the staff up to six days a week as assessed and planned. Review of Resident 20's bed mobility RNP documentation from 07/01/2024 until 07/26/2024 showed: On the week of 07/01/2024 to 07/06/2024, the RNP was provided four times on 07/03/2024, 07/04/2024, 07/05/2024, and 07/06/2024; on the week of 07/07/2024 to 07/13/2024, the RNP was provided twice on 07/07/2024 and 07/09/2024; on the week of 07/14/2024 to 07/20/2024, the RNP was provided twice on 07/18/2024 and 07/19/2024; and on the week of 07/21/2024 to 07/26/2024, the RNP was provided twice on 07/23/2024 and 07/25/2024. The facility was not able to provide any documentation to support the bed mobility RNP was offered to Resident 20 by the staff up to six days a week as assessed and planned. In an interview on 07/26/2024 at 10:56 AM, Staff D confirmed there were no documentation to show Resident 20 declined or was not able to participate in their RNPs for the days of the week not accounted for in the RNP documentation. Staff D stated RNPs were not offered to Resident 20 six days in a week as assessed and planned. <Resident 58> According to the 06/25/2024 Significant Change MDS, Resident 58 had clear speech, intact memory, with medical conditions including a brain injury with resulting weakness on the right side of the body, and was on hospice care during the assessment period. The MDS showed Resident 58 was assessed to have functional limitations in their ROM. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 58's 04/23/2024 CP showed the resident had limited function and mobility due to their brain injury, and a CP intervention listed was to have therapy evaluation and/or treatment done per PO. Review of the July 2024 POs showed there was no order for therapy evaluation and/or treatment for Resident 58. Observation and interview on 07/24/2024 at 1:55 PM showed Resident 58 had contracted fingers on their right hand; they were stiff and had limited mobility. Resident 58 stated they were not receiving any exercises for their right hand. Resident 58 stated, I would appreciate exercises from them [staff] but they would not do it [RNP] because I am under hospice. Review of Resident 58's medical records showed the resident was not on any RNP. In an interview on 07/26/2024 at 11:08 AM, Staff D stated RNPs could be provided to hospice residents by the facility if they needed or ask for them. Staff D confirmed there was no PO in place for Resident 58. The facility was not able to provide any documentation to support the Hospice Care team was notified of the need for an RNP evaluation for Resident 58's identified limited ROM and function. In an interview on 07/26/2024 at 12:10 PM, Staff T (MDS Coordinator) reviewed the MDS coding for Resident 58 and confirmed the resident had current functional limitation in their ROM. Staff T stated they did not effectively address the identified issue under the Care Area Assessment and that was why no RNP evaluation or ROM exercises was recommended for Resident 58. <Resident 239> According to the 07/18/2024 Admission MDS, Resident 239 had clear speech, intact memory, and had medical conditions including cancer of the bladder, lungs, and liver and was on hospice care services during the assessment period. The MDS showed Resident 239 had functional limitation in ROM to one side (upper extremity) of their body. Observation and interview on 07/24/2024 at 12:14 PM showed Resident 239 was lying in bed, wearing a brace on their right hand/wrist. Resident 239 stated they sprained their wrist a while back and was unable to use it effectively, .I can move it [right wrist/hand] but it gives out once in a while. Resident 239 stated they were unsure if staff conduct skin checks underneath their splint. A 07/12/2024 Occupational Therapy (OT) note showed Resident 239 had joint contractures (deformity) on both hands from arthritis (joint inflammation). The note showed Resident 239 indicated they wore a right soft wrist support due to an old fracture they sustained in the past. Review of Resident 239's medical records did not show the resident had any current RNP in place. The facility was not able to provide any documentation to support Resident 239's functional limitation in ROM was assessed and/or evaluated for the need for RNP. Review of Resident 239's POs did not show any order for the use of a brace or skin checks. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/26/2024 at 11:08 AM, Staff D reviewed Resident 239's MDS with Staff T and confirmed they have identified Resident 239's functional limitation in ROM in the assessment, but did not address the situation. Staff D confirmed the presence of the 07/12/2024 OT note regarding Resident 239's wrist brace use, and stated they missed it. REFERENCE: WAC 388-97-1060(3)(d).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review, the facility failed to: (1) Ensure water temperatures were maintained to remain within the safe temperature of 110 (+/- 10) degrees Fahrenheit (F) as required for 13 of 13 rooms sampled for hot water temperatures (Rooms 328, 306, 330, 324, 114, 428, 202, 124, 408, 422, 102, 228, & 404); (2) ensure hazardous chemicals were kept locked and secured at all times for 2 of 4 nursing units (Unit A & C); and (3) identify potential risks associated with a resident's care needs and environment to decrease the risk of falling for 1 of 6 residents (Resident 64) reviewed for falls. The facility's failure to complete repairs identified to be necessary to the hot water system and sample hot water temperatures in resident rooms placed residents at risk for serious burn or injury caused by scalding and constituted a Immediate Jeopardy (IJ). The facility's failure to secure hazardous chemicals placed residents at risk for accidental ingestion and/or skin impairment. The facility's failure to identify risks and implement fall interventions placed residents at risk for recurrent falls and a decreased quality of life. On 07/23/2024 at 3:30 PM, the facility was notified of an IJ in F689. The facility removed the immediacy on 07/24/2024 after they immediately contacted the outside vendor to assess and/or repair the boiler, identified other high risk residents, placed temporary caution signs in resident room sinks and shower rooms to mix cold and hot water to reduce/eliminate the risk for burns/scalding, instituted audits to monitor the boiler gauge and all resident rooms- water temperature monitoring, updated the facility's rounding log, and provided education to the Facilities (Maintenance) Manager regarding the domestic water policy, and implemented a plan of correction to sustain ongoing compliance. Findings included . <Hot Water Temperature> <Facility Policy> The facility's Domestic Water Policy, revised 01/2019, showed the facility's domestic hot water would be checked monthly to ensure a hot water temperature of 105 to 115 F was maintained. <Centers for Medicare and Medicaid Service (CMS) Hot Water Guidelines> According to revised 02/03/2023 CMS guidelines: A third-degree burn would occur after five minutes of exposure to a hot water temperature of 120 F, after three minutes of exposure to a hot water temperature of 124 F, after one minute of exposure to a hot water temperature of 127 F, and after 15 seconds of exposure to a hot water temperature of 133 F. Observation on 07/23/2024 at 10:57 AM showed room [ROOM NUMBER] had two sinks, one labeled for Resident 33, and the other for Resident 68 who shared the room. When temperatures were taken, the hot water from Resident 33's sink became hot very quickly after turning on the faucet and felt uncomfortable for hand washing. The temperature measured at that time was 127 F. At the same time, Resident 68's sink's hot water measured 125 F. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following observations of hot water were made: On 07/23/2024 at 10:59 AM, the hot water temperature in room [ROOM NUMBER] was observed at 129 F. On 07/23/2024 at 11:00 AM, the hot water temperature in room [ROOM NUMBER] was observed at 124 F. On 07/23/2024 at 11:01 AM, the hot water temperature in room [ROOM NUMBER] was observed at 126 F. On 07/23/2024 at 11:05 AM, the hot water temperature in room [ROOM NUMBER] was 130 F in one sink and 131 F in the other sink. On 07/23/2024 at 11:07 AM, the hot water temperature in room [ROOM NUMBER] was observed at 127 F. On 07/23/2024 at 11:07 AM, the hot water temperature in room [ROOM NUMBER] was 127 F in one sink and 133 F in the other sink. On 07/23/2024 at 11:10 AM, the hot water temperature in room [ROOM NUMBER] was observed at 127 F. On 07/23/2024 at 11:20 AM, the hot water temperature in room [ROOM NUMBER] was observed at 132 F. On 07/23/2024 at 11:24 AM, the hot water temperature in room [ROOM NUMBER] was observed at 132 F. On 07/23/2024 at 11:45 AM, the hot water temperature in room [ROOM NUMBER] was 133 F in one sink and 134 F in the other sink. On 07/23/2024 at 11:59 AM, the hot water temperature in room [ROOM NUMBER] was observed at 134 F. On 07/23/2024 at 12:47 PM, the hot water temperature in room [ROOM NUMBER] was observed at 130 F. In total, between 10:57 AM and 12:47 PM on 07/23/2024, surveyors observed unsafe water temperatures in multiple rooms on each of the facility's four units. None of the rooms observed had hot water at a safe temperature. In an interview on 07/23/2024 at 1:40 PM, Staff C (Facilities Manager) stated they maintained a hot water temperature log. Staff C stated hot water should be no hotter than 120 F. In an interview on 07/23/2024 at 1:47 PM, Staff C stated hot water temperatures were checked and logged monthly. Staff C stated they checked a couple rooms at the end of the building near the boiler because it serve[d] the whole building. Observation on 07/23/2024 at 2:33 PM showed the facility had two boilers located in the maintenance shop. A sign on the boilers indicated they were installed on 12/31/2020. In an interview at that time, Staff C stated if they identified any problems with excessively hot water, they called a vendor for assistance to identify and repair the problem. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's 2024 Hot Water Temperature Log provided by Staff C on 07/23/2024 showed the hot water should be 110 DEG + or - 10 degrees which was not consistent with the facility's policy for hot water to remain in the 105-115 F range. The log showed, once a month from January through June 2024, Staff C documented two temperatures. For each month, one of those temperature measurements was taken in the maintenance room, and the second was taken in either the staff break room, the facility's main dining room, or rehabilitation gymnasium (gym). No temperatures measurements were made in resident rooms. The 2024 Hot Water Temperature Log showed on 02/27/2024 the hot water was measured at 122 F in the gym, on 05/24/2024 at 121.5 F in the gym, and on 06/24/2024 at 122 F on 06/24/2024 in the maintenance room; all three temperatures were above the maximum temperature limit for hot water as required. In an interview on 07/23/2024 at 2:51 PM, Staff C stated they contacted the vendor to fix the hot water system after identifying hot temperatures exceeded safe limits. Staff C stated they would provide documentation showing when they last contacted the vendor. On 07/23/2024, Staff C provided a 04/11/2024 estimate from the vendor for repair of a failed flow switch. This invoice was signed by Staff C on 04/15/2024. The vendor's signature was left blank. There was no indication that the work was paid for or completed. Observation on 07/23/24 at 3:46 PM with Staff's C and D (Director of Rehabilitation Services) showed the hot water temperature in room [ROOM NUMBER] was at 128 F. Both staff stated the temperature reading was high. At that time, Staff C checked the readout of a digital thermometer measuring the temperature of the pipe where hot water flowed from the hot water tanks to the rest of the facility. This thermometer showed a temperature of 123.8 F. <Resident 33> According to the 04/30/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 33 had impaired memory and needed substantial to maximal assistance from staff for transfers and personal hygiene. The MDS showed Resident 33 had a stroke history and hemiplegia (one-sided partial paralysis) on their right side. In an interview on 07/23/2024 at 10:42 AM, Resident 33 stated sometimes they had to wait a long time for the bathroom. Resident 33 stated if staff did not come quickly enough to assist them, they got themselves up to use the bathroom even though they knew they should wait for help as they could wait no longer. Observation at that time showed Resident 33's right hand had limited range of motion. Resident 33's fingers curled in toward the palm of the hand. Observation of the sink at 07/23/2024 at 10:57 AM showed the faucet had a left lever that controlled hot water and a right lever that controlled the cold water which could impact the ability of a person with a right-hand impairment to adjust the hot water temperature with cold water. In an interview on 07/24/2024 at 11:36 AM, Staff A (Administrator) stated it was important to ensure the hot water temperature in resident rooms were maintained within the safe temperature as required to prevent adverse outcome and resident injury including burns caused by scalding. Staff A stated Staff C knew the water flow switch needed repair last April 2024 based on the facility provided project proposal but did not address the situation appropriately. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 07/24/2024 at 11:48 AM, in the presence of Staff A, Staff C confirmed they knew about the situation and stated they should have acted upon the identified water valve repair needed but did not. 43642 <Unsecured Chemicals> <Unit A> Observations on 07/23/2024 at 1:38 PM showed the shower room door on Unit A was unlocked. Inside the unlocked room was a cabinet with a key in the keyhole. The key was attached to the cabinet by a chain. The cabinet door could be opened without having to turn the key. Inside the cabinet was a spray bottle of disinfectant with a label that stated, DANGER, keep out of reach of children, and identified first aid steps if the chemical was ingested. In an interview on 07/25/2024 at 9:47 AM, Staff C stated the shower room door and chemicals should be locked and secured. Observations at this time showed the door was unlocked and was easily opened when checked. Staff C stated the door should be locked not only to provide privacy for residents, but to assure chemicals are secured to reduce risks of accidents. 46471 <Unit C> Observation on 07/23/2024 at 10:28 AM showed the shower room door across room [ROOM NUMBER] had a sign to keep doors locked at all times but the key combination lock was broken and the door was left unlocked; inside was unsecured chemicals including a gallon of bleach cleaning solution situated next to the toilet and a spray bottle of disinfectant solution hanging from the shower grab bar. On 07/23/2024 at 10:33 AM, Staff G (Certified Nursing Assistant - Shower Aide) came and stated they were getting the shower room ready for a resident. Staff G determined the key combination lock was broken/faulty and the door was left unlocked. Staff G stated the maintenance department should be notified to have the door lock fixed right away. Staff G stated it was important to ensure the door was kept locked at all times so confused and wandering residents could not enter the room and accidentally ingest or apply any chemicals on themselves that were left unsecured inside the shower room. In an interview on 07/23/2024 at 10:43 AM, Staff C confirmed the key combination lock to the shower room in Unit C needed to be repaired and stated the shower door must be kept locked at all times (as indicated by the posted sign on the door) for resident safety. 50511 <Facility Policy> (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the Fall Prevention and Response facility policy, revised 08/2023, the facility would reduce the risk of falls and injury resulting from falls by assessing and periodically reassessing each resident's risk for falling. The policy showed the potential risks associated with increased care needs and the environment and to implement interventions to address identified risks. <Resident 64> According to the 05/15/2024 Quarterly MDS, Resident 64 needed help with functional cognition, had visual impairment, was dependent on staff in wearing their footwear, and needed moderate assistance with dressing and transferring from bed, chair and toilet. The assessment showed Resident 64 admitted to the facility on [DATE] and had two or more falls since their admission to the facility. In an interview and observation on 07/23/24 at 1:48 PM, Resident 64 stated, I have no clothes; no shoes or socks and I only have slippers and my feet hurt when I walk. Resident 64's toenails were observed long enough to curl into bottom of foot and resident had brown suede slippers and no other shoes in the room. On 07/23/2024 at 2:05 PM, Resident 64 stated, .every time I turn around, I am falling, and the toilet commode was loose, if I lean over too much, I might fall. On 07/26/2024 at 8:39 AM, Resident 64 stated, I already got myself up, the staff don't really help me, and they come in after the fact . Observation on 07/30/2024 at 8:34 AM showed Resident 64's bed was tilted downwards to the right; the bed was unbalanced when moved and Residnt 64 stated the bed was broken. On 07/31/2024 at 11:32 AM, the bed table was propped up against bathroom door, the walker was at the foot of the bed, and resident was seated at a chair in front of bed away from walker. Record reviews of the 04/25/2024 facility fall event occurrence investigation report showed Resident 64 had a fall by the room door; the 07/1/2024 investigation report showed Resident 64 sustained a fall near their bed, and the 07/07/2024 investigation report showed another fall sustained by Resident 64 near the bathroom. The fall prevention interventions listed on the investigation reports included the application of two non-slip tape strips placed on the floor by the bedside and a signage was posted to remind resident to call for assistance before attempting to transfer. In an interview on 07/30/2024 at 8:37 AM, Staff J (Licensed Nurse) stated the bed looked broken and did not look normal. Staff J stated the care staff did not get a chance to see Resident 64 yet to notice their bed, and that the resident continually refused care so we [staff] do whatever we can. In an interview on 07/30/2024 at 8:42 AM, Staff B (Director of Nursing) stated care staff still needed to encourage residents with dementia (who refused care) and must do whatever they could to help them. Staff B stated Resident 64's bed did not look normal, and the bed looked broken. Staff B observed Resident 64's long, uncut toenails and confirmed the resident needed podiatry services. Staff B stated staff should notify them when a resident had long nails and were refusing care, as foot care was important to prevent skin injury and accidents. Refer to F677- Activities of Daily Living (ADL) Care Provided for Dependent Residents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46471 Based on observation, interview, and record review, the facility failed to implement the necessary care for 2 of 3 sampled residents (Residents 45 & 26) and 1 supplemental resident (Resident 75) reviewed for Tube Feeding (TF) management including: (1) documentation of the amount of TF being administered, (2) weight monitoring, and (3) maintenance and labeling of TF tubing consistent with professional standards of practice. These failures placed residents at risk of not meeting their nutritional requirements, developing TF complications including infection, and a decreased quality of life. Findings included . <Facility Policy> The Enteral Nutrition policy, revised 01/2023, showed it was a nursing responsibility to document the amount of feeding given on each shift in the Medication Administration Record (MAR). The policy showed the facility would label TF bags with the date, time, initial of the nurse hanging the feeding, and the amount hung to prevent contamination when open feeding systems were used. The policy showed new formula would not be added to formula already hanging, and formula would not hang for longer than eight hours. The Weight and Nutrition Monitoring policy, revised 10/2021, showed the intent was to ensure no resident would have significant unplanned weight loss or gain, unless clinically unavoidable. The policy showed all weights would be recorded in the resident's medical records, to be reviewed and monitored by designated clinicians, including those residents who were identified as at nutritional risk. <TF Volume and Weight Monitoring> <Resident 45> According to the 06/17/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 45 had clear speech, intact memory, and had medical conditions including heart and kidney failure, uncontrolled blood sugar levels in the body, and a brain injury with resulting weakness in one side of the body and difficulty swallowing. The MDS showed Resident 45 received TF via a surgical opening in their stomach during the assessment period. Review of a 01/16/2024 Nutrition Care Plan (CP) showed Resident 45 was on TF for nutritional support because of the resident's swallowing difficulty. A CP intervention directed the nursing staff to administer the TF as ordered. Review of Resident 45's Physician Orders (POs) showed a 05/17/2024 TF order that read: [a type of TF formula] 1.5 Cal Suspension- Soy Protein, Infuse 30 milliliters/hour via Enteral Tube three times daily for supplement from 8:00 PM to 5:00 AM (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2024 MAR showed the TF order was scheduled for all three shifts (Day, Evening, and Night shift) and nurses from all three shifts were signing off on the TF order. From 07/01/2024 until 07/29/2024, there was no documentation found to support Resident 45's TF intake was being monitored or the TF amount was being recorded by nurses during each administration. In an interview on 07/30/2024 at 11:10 AM, Staff B (Director of Nursing) stated TF order must be complete and accurately show how much feeding was infused to effectively evaluate tolerance in line with nutritional needs. Staff B reviewed Resident 45's TF order and stated the documentation was lacking and should show the amount administered from 8:00 PM until 5:00 AM. Staff B stated the PO should be written to show exactly the TF amount needed to be administered per the Registered Dietician's recommendation to ensure Resident 45's nutritional needs were met. Staff B stated the PO should not be scheduled for all three shifts because the timeframe of administration indicated in the PO did not fall within the times worked during Day shift. Review of Resident 45's POs showed a 03/21/2024 order for weight monitoring weekly on Tuesdays. Review of Resident 45's weight history report showed from 02/05/2024 until 07/22/2024 showed the resident was not being weighed weekly as ordered. The report showed Resident 45's weight was fluctuating: Weighed 131 pounds (lbs.) on 04/10/2024 and 124 lbs. on 04/24/2024, a weight loss of 7 lbs. Weighed 129.7 lbs. on 06/11/2024 and 136.6 lbs. on 06/24/2024, a weight gain of 6.9 lbs. Weighed 135.2 lbs. on 07/16/2024 and 146 lbs. on 07/22/2024, a weight gain of 10.8 lbs. In an interview on 07/30/2024 at 11:10 AM, Staff B stated they expected staff to obtain residents' weights as ordered and to validate the weight's accuracy by observing the facility's re-weigh protocol. Staff B stated weight monitoring was important and essential for residents on TF in order to identify if the facility's nutritional intervention was appropriate, .so we [staff] could determine if [Resident 45] needed an increase or decrease in their feeding . [TF needs] is hard to assess without accurate weights . Staff B confirmed Resident 45 was not being weighed weekly as ordered and stated the resident was not re-weighed consistently as they should be. 43642 <Unlabeled Tube Feeding (TF)> <Resident 75> According to a 06/06/2024 Admission MDS, Resident 75 had medical conditions including the loss of the ability to use one side of their body and required the use of a feeding tube to provide at least half of the resident's nutritional intake. Observation and interview on 07/26/2024 at 8:44 AM showed a TF bag was hanging in Resident 75's room that contained some tan colored liquid left in the bag. The bag did not identify Resident 75's name, what product was in the bag, did not include a date/time, or the rate of administration. Staff BB (Licensed Practical Nurse - LPN) entered the room and stated they had just finished administering the TF formula to Resident 75 and hung the bag themselves prior to starting the feeding. Staff BB stated the bag should be, but was not labeled with all of the required information. <Resident 26> (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 05/20/2024 Quarterly MDS, Resident 26 had medical conditions including the loss of the ability to use one side of their body and required the use of a feeding tube to provide at least half of the resident's nutritional intake. Observations on 07/26/2024 at 9:19 AM showed a TF bag with tan colored fluids was hanging on a pole and was being administered to Resident 26. The TF bag was labeled with the date of 07/26/2024, but did not identify what the fluids were in the bag or the rate at which the TF was to be administered. In an interview and observation on 07/26/2024 at 9:19 AM, Staff CC (LPN) confirmed staff was administering a TF formula to Resident 26 and stated the bag should be, but was not labeled with all of the required information. In an interview on 08/01/2024 at 1:03 PM, Staff B stated their expectation was for staff to label the TF bags in resident rooms with the date, time, rate, and the product being administered. REFERENCE: WAC 388-97-1060 (3)(f).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 50511 Based on observation, interview, and record review, the facility failed to ensure 1 of 4 sampled residents (Resident 12) reviewed for pain management received the necessary treatment, services, and follow-up care to manage their pain. This failure placed residents at risk for avoidable pain and a diminished quality of life. Findings included . <Facility Policy> According to the 08/2024 Pain Management Policy, its purpose was to establish how residents would be assessed, care planned, and treated in accordance with professional standards of practice. The policy showed resident choices would be honored related to pain management. The policy showed a resident who had a major change in pain status should be placed on alert charting and their pain should be assessed every shift while on alert. <Resident 12> According to the 05/29/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 12 had clear speech, intact memory, and with medical conditions including chronic pain and discomfort due to osteoarthritis (joint pain and stiffness). The MDS showed Resident 12 had limited range of motion. According to the 05/31/2024 At risk for pain and discomfort due to arthritis Care Plan (CP), Resident 12's goals were for their joint pain to be relieved within one hour of intervention and for staff to administer medications as ordered. The CP included directions for staff to report unrelieved pain, joint stiffness, swelling, and new contractures (irreversible joint stiffening) to the Medical Director with follow-up as indicated. Record review of Resident 12's July 2023 Medication Administration Record (MAR) showed a 03/11/2024 order for a narcotic pain medication 5 milligrams for pain that should be offered as needed. The MAR showed non-pharmaceutical pain interventions should be offered including repositioning, warm packs, one on one visits, and to offer food and drinks. On 07/29/2024 at 11:26 AM, Resident 12 stated, I am in pain every day. In an interview on 07/30/2024 at 12:40 PM, Resident 12 stated they had sharp pain on their left lower leg in the calf area and it hurt to stand on it. Resident 12 stated, nobody is doing anything to help me with my pain. I told the nurses about the constant pain, and I told my doctor and the staff have not followed up with me. If I tell one nurse, I expect them to tell the next nurse and follow through on this. If there is one thing I don't like about this place, it 's that they don't follow-up with me. I haven't heard anything from the doctor or nurse about my calf pain, nobody tells me anything. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/31/2024 at 11:39 AM, Resident 12 stated their left leg really hurt at that time and rated their pain at 8.5 out of 10. Resident 12 stated heat packs, movement, and pain medications helped, so they tried to do their own pain management such as lifting their leg up. Resident 12 stated, nobody comes here and talks to me, and I've been through physical therapy for a long time, but it does not seem to work, I try to live with it when it gets too bad, then I take medicine. Record review of Resident 12's progress notes on 07/30/2024 and 07/31/2024 at 1:00 PM did not reflect documentation of the resident's pain in their left leg. Interviews on 07/30/2024 at 12:30 PM and 12:51 PM, Staff V (Licensed Practical Nurse) stated they were not aware of Resident 12's calf pain. Staff V stated residents must tell the nurses when something was wrong daily so the nurses would take care of it. Staff V stated they did not see pain monitoring on Resident 12's CP or in the progress notes, and not every shift would have known about the resident's concerns. Staff V stated nurses did not document at shift change but verbally report off to the next nurse. Staff V stated Resident 12's pain was not mentioned at shift change. Staff V stated it was up to each resident to tell nurses daily about their pain issues so nurses could put a resident on alert if needed. In an interview on 07/31/2024 at 12:26 PM, Staff B (Director of Nursing) stated they expected nursing staff to document notes of residents' pain, both to the doctor and from nurse to nurse in the progress notes because it alerted the nursing team to review the problem and obtain orders when documentation were captured and seen by the care team. Staff B stated alert charting and progress notes should have, but were not completed for Resident 12. Staff B stated documentation was important so residents' pain could be identified and treated as fast as possible. REFERENCE: WAC 388-97-1060 (1).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50511 Based on observations, interview, and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services for all facility residents including assistance with Activities of Daily Living (ADL) and timliness of call light response in accordance with established clinical standards, Care Plan (CP), and resident preferences. These failures placed residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident Council (RC)> Review of the 01/24/2024 RC meeting notes showed residents reported poor response times. The notes showed the administrator had coordinated with staff members who were unable to perform the needed duties and the short-term plan was for the facility to stack nursing shifts for supervision and the long-term plan was to hire staff to oversee the weekends and night shifts. During an observation on 07/23/2024 at 2:37 PM, two rooms observed to have call lights alarming. At 2:48 PM, the same two call lights were still alarming while day and evening nurses were observed to be in report during shift change. During an observation on 07/25/2024 at 10:16 AM, Staff D (Director of Rehabilitation) was observed telling the shower aide to help answer the call lights. Two rooms had call lights on and only one caregiver was seen working on the floor. <Resident 27> In an interview on 07/29/2024 at 1:17 PM, Resident 27 stated the call light response time could be 10 to 15 minutes or longer. <Resident 11> In an interview on 07/29/2024 at 1:19 PM, Resident 11 stated they waited up to two hours for care staff, especially during shift changes. Resident 11 stated the shift change between evening and night shifts was the worst, but issues would occur during any shift change. Resident 11 stated they believed it was because the facility was understaffed. <Resident 52> In an interview with Resident 52 on 07/24/2024 at 12:08 PM, Resident 52 stated residents had to wait a long time before care staff would help them during shift changes; mostly between day and evening shifts and between night and day shifts. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 07/29/2024 at 9:29 AM, Resident 52 stated there was an occurrence when they put their call light on in the bathroom because of a bladder accident. Resident 52 stated they were afraid they would slip on the wet floor and needed assistance with wiping the floor. Resident 52 stated they waited for care staff, but staff did not come right away, and they began feeling sick and they needed to go back to their bed. Resident 52 stated they could no longer wait for staff and put towels on the ground so they could walk back to their bed. <Resident 12> In an interview on 07/25/2024 at 9:13 AM, Resident 12 stated during shift change was an issue for care staff to respond to call lights. Resident 12 stated on one occurrence, care staff did not respond to their call light for a long time and the resident had to yell out for help to get care staff to answer their call light. In an interview on 07/26/2024 at 1:25 PM, Resident 12 stated they had pain in their hips, and sometimes needed help but the facility was occasionally short staffed. In an interview on 07/30/2024 at 1:08 PM, Staff GG (Staff Development) stated the facility was within required staffing ratios and adjusted schedules for call outs. Staff GG stated they used staffing ratios to ensure there are enough nurses and staff on call. Staff GG also stated the facility used agency staffing and contracted staff to support nursing shortages. In an interview on 08/01/2024 at 8:26 AM, Staff M (Registered Nurse) stated the facility may be short staffed and could use more nursing assistants and licensed practical nurses. Staff M stated staffing should not be based on how many residents the facility had but should be more about the care that residents needed. In an interview on 08/01/2024 at 9:11 AM, Staff FF (Licensed Practical Nurse) stated sometimes there is not enough staff and it gets hard to complete tasks. Staff FF stated tasks could take up to one hour, with a half hour give or take to complete. Staff FF stated,staffing should be based more about how hard a resident's care is rather than the amount of people scheduled. REFERENCE: WAC 388-97-1080(9).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43642 Based on observation and interview, the facility failed to ensure medications were stored, labeled, and dated when opened and/or discarded when expired for 3 of 4 medication carts (Unit A, Unit B, & Unit D) and 2 of 2 medication rooms (Unit A & Unit B) observed. The failure to ensure unneeded medications were returned to the pharmacy, medications carts were secured when not in use by a nurse, and medications were not left at the resident's (Resident 240) bedside placed the residents at risk for receiving unauthorized, compromised, and/or ineffective medications. Findings included . <Facility Policy> Review of a 07/2024 facility Medication Storage and Disposal policy showed all drugs and biological will be stored in locked compartments and access granted to authorized personnel only. This policy stated outdated medications were to be removed from medication carts and disposed of according to procedures for medication disposal. The policy stated all medications were to be properly labeled and stored, separated from other residents medications, and separate from food or toxic chemicals. <Unit A Medication Cart> Observations of Unit A Medication Cart on 07/24/2024 at 10:22 AM showed an open vial of a blood thinning injection medication with no date or resident label indicating who it was for and an unopened vial of insulin for a resident with a label that said to keep refrigerated. In an interview on 07/24/2024 at 10:38 AM, Staff HH (Regional Director of Nursing Services) stated it was their expectation that medications have resident labels and are dated when opened. Staff HH stated the insulin injection medication should have, but was not refrigerated until opened by staff. <Unit B Medication Cart> Observations of Unit B Medication Cart on 07/24/2024 at 10:52 AM showed the following: an eye drop medication used to treat glaucoma (a condition of increased pressure in the eye) with an open date of 05/29/2024; and multiple tubes of creams, ointments, and gels being stored together in one container. There was antifungal cream, pain medication gel, and vaginal creams observed. In an interview at this time, Staff M (Staff Registered Nurse - RN) looked at the list of medication expiration dates on the medication cart, and stated the eye drop medication expired 42 days after it was opened. Staff M stated the medication expired the week before and stated, I missed it, I will discard this. Staff M confirmed the tubes of medications were not separated and were being stored together inside one bin. <Unit D Medication Cart> (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of Unit D Medication Cart on 07/31/2024 at 2:52 PM showed a package of individual unit doses of a cough medication and a bottle of an acid solution used for bladder irrigation being stored up against a container of germicidal alcohol wipes container. In an interview at this time, Staff CC (Licensed Practical Nurse - LPN) confirmed the medications were being stored next to the disinfectant container. <Unit A Medication Room> Observations of Unit A Medication Room on 07/24/2024 at 10:40 AM showed a bin of 5-milliliter syringes that expired on 12/31/2023, over six months earlier and a bin of culture swabs that expired on 05/01/2024, almost two months earlier. In an interview at this time, Staff II (LPN) confirmed the expired supplies and stated they needed to be removed from the medication room. <Unit B Medication Room> Observations of Unit B Medication Room on 07/24/2024 at 11:02 AM showed two bins over full of medication bingo cards and bottles. There were medications in the bin for residents who discharged : on 04/15/2024, over three months earlier; on 06/03/2024, over one month earlier; on 06/13/2024, over one month earlier; and on 07/08/2024, over two weeks earlier. In an interview at this time, Staff M stated the medications needed to go back to the pharmacy. In an interview on 08/01/2024 at 1:03 PM, Staff B (Director of Nursing) stated it was their expectation staff label and date medications, separate medications, refrigerate medications as required, and remove expired medications and/or supplies. Staff B stated medications should be returned to the pharmacy within 30 days of a resident discharging. 46471 <Unlocked Medication Cart> Observations of Unit C Medication Cart on 07/30/2024 at 12:28 PM showed an unlocked medication cart in the hallway with a resident sitting nearby. Staff were passing out lunch trays. Staff EE (RN) came out of a room across from the medication cart. In an interview at this time, Staff EE stated it was their expectation the medication cart be locked at all times when they are not present. In an interview on 08/01/2024 at 9:59 AM, Staff A (Administrator) stated it was important to keep the medications safe and away from residents who could easily access it. Staff A stated they expected all nurses to ensure medication carts were kept locked and secured at all times for resident safety. <Medications Unsecured at Bedside> <Resident 240> Observations on 07/25/2024 at 11:17 AM showed Resident 240 with an inhaler and a medication cup filled with nine pills at their bedside. A second inhaler was sitting on Resident 240's window ledge. In an interview at this time, Resident 240 stated the nurse had brought in the medications but left them when the resident had requested to take a medication for nausea first. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/25/2024 at 11:28 AM, Staff KK (LPN) confirmed the medications were left at Resident 240's bedside and was unsure if the resident had an assessment for self-medications. Staff KK stated it was important not to leave medications unsecured for resident safety and to also ensure the resident took the medications. In an interview on 07/25/2024 at 11:31 AM, Staff B validated Resident 240 did not have a self-medication assessment to have medications at bedside. Staff B stated Resident 240 did have an order to keep the inhaler at bedside but indicated staff should have done an assessment and assured it was care planned. Staff B stated it was their expectation staff would not leave medications unsecured at bedside without an order or being assessed for safety first. REFERENCE: WAC 388-97-1300 (2).

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 43642 Based on observation, interview and record review, the facility failed to provide meals that accommodated resident food preferences for 2 of 4 sampled residents (Resident 31 & 20) reviewed for preferences. This failure placed residents at risk for weight loss, frustration, and a diminished quality of life. Findings included . <Resident 31> According to a 07/12/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 31 had clear speech, was understood, and able to understand others. This MDS showed staff assessed Resident 31 with no memory impairment. In an interview on 07/24/2024 at 10:07 AM, Resident 31 stated they were unhappy with the food and reported they had to keep returning their meal trays to staff as they continued to serve them food they disliked. Resident 31 stated they informed staff many times they did not like sausage or rice, but stated staff continued to serve them those food items. Observations on 07/26/2024 at 8:37 AM showed Resident 31 had a breakfast tray in front of them with only sausage left on their plate. In an interview at this time, Resident 31 stated, I am not going to touch the sausage, I keep telling them I do not like it. Resident 31 explained they read on the daily communication flyer they needed to notify staff before 7:00 AM if a food alternative was desired. Resident 31 stated they were frustrated because they do not get the daily menu until after breakfast, therefore being unable to make changes most days for breakfast or lunch meals. Review of Resident 31's meal tray tickets showed the resident's preference was for, no sausage. According to a 07/08/2024 pressure ulcers Care Plan (CP) showed Resident 31 was at risk for developing pressure ulcers and gave directions to staff to encourage the resident to eat 75-100 percent of their meals. In an interview on 08/01/2024 at 10:31 AM, Staff N (District Manager/Dietary Services) stated, absolutely when asked if staff should follow resident food preferences. Staff N stated it was important to follow resident food preferences because, it ties in to their whole nutritional experience. 46471 <Resident 20> According to the 06/03/2024 Quarterly MDS, Resident 20 had clear speech and their memory was intact. The MDS showed Resident 20 had medical conditions including impaired swallowing following a brain injury and severe malnutrition. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the revised 03/11/2024 Nutrition CP showed Resident 20's nutritional needs were at risk due to their history of weight loss and muscle mass wasting. A 12/26/2023 CP intervention directed staff to assess Resident 20's food preferences and incorporate them into the resident's meals and snacks. In an interview and observation on 07/25/2024 at 9:57 AM, Resident 20 stated the daily food menu comes late to be able to use them, .I am not able to request want I prefer, especially during breakfast . Resident 20 handed the facility's order requests form that instructed residents to turn in their request form at least two hours before food service, so their preferences could be accommodated. Resident 20 stated, their [facility] rule is for menu to come at least 2 hours so we could choose, but this is not happening. There was no weekly menu observed in Resident 20's possession, nor with their roommate. Resident 20 stated provision menus was inconsistent. In an interview on 08/01/2024 at 11:16 AM, Staff N, in the presence of Staff A (Administrator), stated the distribution of the weekly menu was the responsibility of the dietary manager but that employee had left the facility. Staff N confirmed the weekly menu was not being distributed in resident rooms and stated it should be, to ensure residents' food preferences were obtained and honored, but was not. REFERENCE: WAC 388-97-1120 (2)(a).

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	505418	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Marianwood	3725 Providence Point Drive Southeast Issaquah, WA 98029

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review, the facility failed to ensure resident meals were stored, prepared, and served in a sanitary manner for 1 of 1 kitchens and 1 of 4 unit pantries (Unit 400). These failures left residents at risk for spoiled or contaminated foods, and food-borne illness. Findings included . <Facility Policy> According to the facility's 07/2024 Food Storage policy all food items would be labeled with with a manufacturer's expiration date or the date of receipt. The policy showed refrigerated foods would be discarded using either the manufacturer's expiration date or seven days after the written date. The policy showed all refrigerators used for nutrition would be cleaned weekly by dietary staff. The policy showed food in facility refrigerators should be covered. <Dry Storage> Observation of the facility's dry food storage on 07/23/24 at 9:11 AM showed a box of thickening powder (used to alter the fluids for residents with swallowing difficulties) was left open. The plastic liner was torn open and not resealed and the cardboard flaps were wide open leaving the powder exposed. A large container of granulated garlic was observed to be open with no indication of when the container was opened or a use-by date. In an interview at that time Staff Z (Senior Cook) stated the thickening powder was not stored correctly and needed to be discarded. Staff Z stated the granulated garlic should have been labeled to indicate for how long it was safe to use. <Hair Nets> Observation on 07/23/24 01:36 PM showed Staff DD (Dietary Assistant) preparing a drink in the facility's kitchen. Staff DD's hair was long and was not secured by a hairnet or a hat. Staff DD stated they were not required to wear a hat as they were only in the kitchen briefly. At that time Staff AA (Food Service Director) was standing next to Staff DD. Staff AA interjected and stated that all staff were required to secure their hair prior to entering the kitchen to prevent hair contaminating resident meals. Staff AA stated it did not matter why staff entered the kitchen or for how long. <Unit Pantries> Observation of the 400 Unit Pantry on 07/30/2024 at 8:21 AM showed the pantry contained a refrigerator where resident snacks, leftovers, outside food, and cold beverages were stored, and a handwashing sink. This fridge contained a red plate with a half-eaten quesadilla. This quesadilla was partially covered with a paper towel matching the paper towels from the dispenser by the handwashing sink. Someone wrote 5/29 [Resident 24] 416-2 on the paper towel. The refrigerator also contained an opened bottle of lemonade that was not dated and was not labeled to indicate whom it belonged. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 400 Unit Pantry also contained a water and ice dispensing machine. This machine's clear plastic dispensing chute was observed to have a buildup of a yellow-green slime. In an interview at this time Staff B (Director of Nursing) stated the chute needed to be cleaned and the lemonade and quesadilla needed to be discarded as they were not stored appropriately. <Hand Sanitization> Observation during lunch preparation on 07/30/24 at 9:36 AM showed Staff R (Cook) wearing a surgical mask (the facility had a COVID-19 [a communicable respiratory infection] outbreak at the time) that was lowered below their chin while they spoke to another member of the dietary staff. With a gloved hand Staff R raised the surgical mask back over their mouth and nose. Without washing their hands, using the same (now soiled) gloves, Staff R then wrapped a ham with plastic. Observation on 08/01/2024 at 10:30 AM showed Staff R in the kitchen preparing lunch with their surgical mask again placed below their chin. Staff R observed a surveyor through the kitchen window and raised their mask over their mouth and nose. Without performing hand hygiene Staff R immediately continued preparing lunch In an interview on 08/01/2024 at 10:31 AM Staff N (District Dietary Manager) stated they expected all staff to use appropriate hand hygiene. Staff N stated Staff R should have washed hands and changed gloves after contaminating them by touching their surgical mask. Staff N stated Unit Pantries were the joint responsibility of the dietary and nursing departments, and stated they expected the food to be stored appropriately and the ice/water machine to be kept clean. 46471 <Uncovered Food> Observation on 07/23/2024 at 12:18 PM during meal tray service in Unit C showed the meal cart was parked between rooms [ROOM NUMBERS]. Staff O (Certified Nursing Assistant - CNA) was observed serving the meal tray for room [ROOM NUMBER], passing by an isolation room (room [ROOM NUMBER]) with the dessert left uncovered. Observation on 07/23/2024 at 12:23 PM showed Staff C serve the meal tray for room [ROOM NUMBER], again passing by the isolation room (room [ROOM NUMBER]) with the dessert left uncovered. On 07/23/2024 at 12:27, Staff P (CNA) was observed serving the meal tray for room [ROOM NUMBER] with the dessert left uncovered. Observation on 07/23/2024 at 12:29 showed Staff P serve the meal tray for room [ROOM NUMBER] which was located far and around the corner of the unit from where the meal cart was parked, passing along the isolation room (room [ROOM NUMBER]) with the dessert left uncovered. In an interview on 07/23/2024 at 12:40 PM, when Staff P was asked if it was the facility's practice to leave the desserts uncovered during meal tray service, Staff P stated, Yes, for some desserts .I don't know why . maybe because this cake has frosting and it might be a mess if covered . Staff P stated food left uncovered was at risk for contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 07/30/2024 at 2:59 PM, Staff Q (Infection Preventionist) confirmed the facility was in a COVID-19 outbreak. Staff Q stated they expected food to be covered during meal service because they did not want to serve residents contaminated food, .we [staff] don't know what is present in the air . In an interview on 07/30/2024 at 3:05 PM, Staff N stated they expected the dietary staff to ensure food was covered appropriately during meal tray service. Staff N stated it was important to ensure food was covered during meal service for temperature control and to protect the safety of the food and prevent cross-contamination. Observations on 08/01/2024 at 8:17 AM showed staff passing out breakfast trays on Unit A from a meal tray cart located near the nurse's station. Staff pulled a meal tray out of the cart, with an uncovered bowl of fruit, and carried the tray past other rooms and residents in hallway to deliver it to room [ROOM NUMBER], the last room on the unit. REFERENCE: WAC 388-97-1100(3), -2980. 43642

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility: failed to ensure sharps containers were emptied before they reached an unsafe volume for 3 of 16 resident rooms reviewed (room [ROOM NUMBER], 104, & 416); maintain an environment free of uncleanable surfaces for 1 of 16 resident rooms reviewed (room [ROOM NUMBER]); failed to maintain a Water Management Program (WMP) for 1 of 1 buildings; failed to provide wound care within professional standards of infection control for 1 of 5 residents (Resident 68) reviewed for pressure ulcers; failed to ensure urinary catheter placement did not create an infection control risk for 1 supplementary resident (Resident 55) reviewed for catheter care. The failures placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . <Sharps Containers> Observations on 07/23/2024 at 9:26 AM showed room [ROOM NUMBER] with a sharps container full beyond the maximum fill line. Observations on 07/26/2024 at 8:44 AM and 07/31/2024 at 9:05 AM showed room [ROOM NUMBER] with a sharps container full beyond the maximum fill line. Observations on 07/30/2024 at 10:15 AM showed room [ROOM NUMBER] with a sharps container full beyond the maximum fill line. In an interview on 07/30/2024 at 10:49 AM, Staff Q (Infection Preventionist) stated the facility used sharps containers to promote safe injection practices in the facility. In an interview and observation on 08/01/2024 at 10:46 AM, Staff Q confirmed the sharps containers in the identified resident rooms were filled beyond the maximum fill line. Staff Q stated having the sharps containers overfull increased the risk for staff and/or residents to get accidental needle sticks and risk transmission of diseases. <Uncleanable Surfaces> <Resident 26> Observations on 07/26/2024 at 9:19 AM showed floor mats on each side of Resident 26's bed. Both floor mats had corners that were torn and peeling, exposing the foam underneath the vinyl cover. In an interview and observation on 08/01/2024 at 10:46 AM, Staff Q confirmed the floor mats for Resident 26 were uncleanable and increased the risk for infections. <Water Management Program> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a revised 08/2023 facility, .Water Management Program policy showed the purpose of the policy was to establish a standard for identifying points of risk for Legionella growth; prevention control measures; surveillance; and documentation and communication. This policy directed to, See attached facility-specific diagrams. In an interview on 07/30/2024 at 3:34 PM, Staff C (Facilities Manager) stated they did not have a diagram of the facility with identified areas of risk for Legionella (bacteria that can cause severe types of respiratory infections). Staff C reported the only thing they were instructed to do was complete a log and test for chlorine each month. In an interview on 07/30/2024 at 3:50 PM, Staff A (Administrator) provided additional documents of the facility's risk assessment forms, and stated, it appeared staff started the risk assessment, but did not complete it. When asked if the WMP be complete and up to date, Staff A stated yes. 46471 <Wound Care> <Facility Policy> Review of the Hand Hygiene [HH] facility policy, revised 09/2019, showed HH would be performed after removing Personal Protective Equipment (PPE), after contact with patient surroundings, after patient contact, and upon exiting the patient room. The policy showed compliance with the proper HH procedure before and after patient contact was an expectation of all healthcare disciplines. <Resident 68> According to the 06/04/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 68 had medical conditions including a wound infection. The MDS showed Resident 68 admitted with a Stage IV (full thickness) Pressure Ulcer (PU) and was provided PU treatment during the assessment period. On 07/25/2024 at 9:06 AM, the wound care team, together with Staff B (Director of Nursing), was observed providing Resident 68 PU care and treatment to Resident 68's buttocks. When the procedure was completed, Staff Y (Certified Nursing Assistant) removed all their personal protective equipment and left Resident 68's room to retrieve a garbage bag from the clean wound cart without washing their hands. In an interview on 07/25/2024 at 9:23 AM, Staff B stated HH was important in infection control to prevent cross-contamination of bacteria (germs). Staff B stated they expected all staff to wash their hands and/or apply an alcohol-based hand sanitizer after touching dirty surfaces and prior to touching clean areas. 51149 <Resident 55> According to the 06/17/2024 Annual MDS, Resident 55 had a long-term indwelling urinary catheter (tubing to drain urine from the bladder for people with certain urinary problems). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/30/2024 at 8:40 AM, showed Resident 55 lying in bed with their catheter drainage bag lying on the floor. In an interview on 07/30/2024 at 10:50 AM, Staff V (Licensed Practical Nurse) stated the catheter drainage bag should not have touched the floor because of infection control concerns. REFERENCE: WAC 388-97-1320 (1)(a).

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 46471 Based on observation, interview, and record review, the facility failed to ensure resident beds did not have gaps that could pose as an entrapment risk or assess the mattress used and/or obtained/purchased separately from the bed frame to ensure they were well-fitting for 1 of 21 residents (Resident 45) whose beds were observed for accident hazards. This failure placed residents at risk for injury, entrapment, or death. Findings included . <Facility Policy> The Medical Devices and Equipment facility policy, revised 07/2024, showed the facility would establish guidelines for the assessment, use, and maintenance of medical devices and equipment, including beds and mattresses, to ensure the safety and well-being of residents. The policy showed the facility would conduct regular inspections and preventative maintenance of medical devices/equipment. <Food and Drug Administration (FDA) Document> The 03/10/2006 FDA document entitled, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, identified seven potential zones of entrapment: Zone 1- Within the Rail, Zone 2- Under the Rail, Between the Rail Supports or Next to a Single Rail Support, Zone 3- Between the Rail and the Mattress, Zone 4- Under the Rail at the Ends of the Rail, Zone 5- Between Split Bed Rails, Zone 6- Between the End of the Rail and the Side Edge of the Head or Foot Board, and Zone 7- Between the Head or Foot Board and the End of the Mattress. The document showed facilities should determine the proper dimensions and distances apart of various parts of the bed such as the distance between bed frames and mattresses to prevent entrapment by users of the bed. The document suggested facilities determine the level of risk for entrapment and take steps to mitigate and reduce potential life-threatening entrapments associated with the use of hospital bed systems. <Resident 45> According to the 06/17/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 45 had clear speech and intact memory, with multiple medical diagnoses including a condition characterized by elevated levels of blood sugar in the body, heart and kidney failure, and generalized weakness with decreased muscular function on the left side of the body. The MDS showed Resident 45 had functional limitations with their range of motion, and was assessed to require substantial/maximum assistance with most of their activities of daily living including bed mobility. The 04/04/2024 Air Mattress (a type of mattress filled with air used for pressure relief)/Bilateral Side Rails Care Plan (CP) showed the risk and benefits were discussed with Resident 45 and a consent was obtained regarding the use of these high-risk devices. The CP intervention instructed staff to minimize gaps between the mattress and bed frame. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 07/25/2024 at 9:47 AM, Resident 45 was observed to have a bolster air mattress(a type of air mattress with a defined perimeter on the sides to prevent falls) in place and bilateral side rails were installed. Resident 45's bed mattress was observed to be smaller than the bed frame. There was a loose pillow wedged in between the mattress and the foot board. The gap from the bed mattress to the head of the bed measured six inches. Resident 45 stated they did not have any skin issue and did not use the side rails for independent bed mobility. Observation on 07/26/2024 at 9:35 AM with Staff K (Licensed Practical Nurse) showed Resident 45 was angled downward on the bed. Staff K attempted to flatten Resident 45's bed and observed the button that adjusted the food part of the bed on hand-held bed controller was not working. There was no pillow wedged between the bed mattress and the foot board at this time, exposing a gap that measured 10 inches. In an interview on 07/26/2024 at 10:16 AM, Staff C (Facilities Manager) confirmed the gap measurements and stated it was an entrapment risk for Resident 45. Staff C stated it was important to ensure the air mattress was well-fitting on the bed frame to avoid injury and entrapment. Staff C stated the Rehabilitation Department would usually put wedges on both ends of the bed if there was a significant gap but obviously did not see any in place. In an interview on 07/26/2024 at 10:47 AM, Staff D (Director of Rehabilitation) ensuring resident beds were free of significant gaps that could pose as an entrapment risk was a collaborative effort between the interdisciplinary team including the Maintenance Department. Staff D saw the actual gap in Resident 45's bed and stated they were surprised the Rehab Department did not catch it since they see the resident more often than Staff C. Staff D stated, .definitely a miss on our part for this one. REFERENCE: WAC 388-97-2100.