STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505421	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Odd Fellows Home	534 Boyer Avenue Walla Walla, WA 99362

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview, and record review, the facility failed to ensure residents received dignified care and services related to the lack of 1) timely assistance with toileting needs for 1 of 2 residents (Resident 10) reviewed for embarrassment after an incontinent episode; 2) serving meals at the same time at their dining table for 4 of 22 residents (Residents 10, 11, 33, and 36) reviewed for dining; and 3) providing dignity and respect during the admission process for 2 of 2 residents (Residents 217 and 208) reviewed for admissions. These failures placed the residents at risk for not attaining their highest practicable level of well-being. Findings included . Review of the policy titled, Resident Rights, dated 03/14/2024, showed the resident had the right to a dignified existence, self-determination, and the right to be treated with respect and dignity. <Toileting Assistance> <Resident 10> Review of Resident 10's medical record showed they were admitted to the facility with a diagnosis of dementia (a brain disease that causes memory impairment). Review of the most recent comprehensive assessment dated [DATE] showed the resident had severely impaired cognition and was on a toileting program (a program to provide consistent assistance with elimination needs). Review of the Kardex (a care plan that gave care directions for daily activities such as grooming, toileting, transfers and mobility) with a revised date of 07/18/2024, showed Resident 10 required assistance from staff for their toileting needs. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/18/2024 at 9:10 AM, showed Resident 10 approach the east nurse ' s station and stated loudly to Staff I, Licensed Practical Nurse (LPN), I have to go, I have to go. Staff K, Medical Records who was also at the east nurse ' s station stated, I will take care of it and used their two-way radio (a small portable device that can send and receive messages) and called for staff assistance for Resident 10. During the same observation at 9:31 AM (21 minutes later), Staff S, Activities Coordinator, walked by Resident 10 and the resident stated to them I have to go to the bathroom please, oh please. Staff S informed the resident I will take you to your room and turn your call light on. As Staff S wheeled the resident down the hall to their room a strong fecal odor was noted coming from Resident 10. Staff S placed the resident in their room turned their call light on and stated, someone will be here soon. During continued observation showed at 9:55 AM (35 minutes after Resident 10 had requested assistance with toileting) Staff T, Nursing Assistant (NA), and Staff U, NA, assisted Resident 10 into their bathroom and onto the toilet. Resident 10 stated oh no oh no as they had been incontinent of stool. <East Dining Observation> During an observation on 07/17/2024 at 12:18 PM, showed Resident 11 sitting in the East dining room (EDR) with two other residents at their table. The two residents at the table had been served their lunch trays and were eating. Resident 11 did not have a lunch tray and was watching the others eat, and stated where is my food? At 12:39 PM, Resident 11 was served their lunch tray (21 minutes after the other residents had been served). Resident 11 further stated I don't know why I have to wait so long to eat. No staff responded to the residents concern. During an observation on 07/18/2024 at 12:22 PM, showed lunch trays were served to the residents in the EDR, except for Resident's 10, 11, 33, and 36. Resident 33 stated loudly Where's my lunch? During a continued observation on 07/18/2024 at 12:39 PM, a second cart arrived in the EDR and Residents 10, 11, 33, and 36 were served their lunch trays (17 minutes after the other residents had been served). Resident 11 stated It's about time, I'm so hungry. During an observation on 07/22/2024 at 12:10 PM, showed residents in the EDR being served their lunch trays and had begun eating. Residents 11, 33 and 36 had not received their food and were watching the other residents eat at other dining tables. Resident 11 stated where's my food, where's my food? At 12:28 PM Residents 11, 33 and 36 received their lunch trays (18 minutes after the other residents had been served and were eating). During an interview on 07/22/2024 at 12:30 PM, Staff A, Administrator, stated it was their expectation that all the residents at a table received their trays at the same time, so the other residents did not have to watch other residents eat while they waited. <Admissions> <Resident 208> Review of the medical record showed Resident 208 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a series of brain dysfunction caused by illness), high blood pressure and anemia. The 07/13/2024 incomplete comprehensive assessment showed Resident 208 had a moderately impaired cognition. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/15/2024 at 1:22 PM, Resident 208's Representative, (RR) stated they had planned to arrive at the facility prior to Resident 208's arrival, as it was important that the resident did not arrive alone. They stated they had expressed this plan to the facility staff and had coordinated the arrival time and signing of the admission paperwork to ensure a smooth admission. The RR stated they were in Staff H's, Executive [NAME] President of Marketing (EVPM), office signing paperwork at the prearranged time. They stated they had finished signing the paperwork and were just chatting with Staff H while they waited for Resident 208 to arrive. Resident 208's RR stated Staff H casually informed them that the resident had already been in the facility for at least an hour, despite the prearranged plan for admission. During a follow up interview on 07/23/2024 at 4:28 PM, the Resident 208's RR stated they had promised the resident that they would be waiting for the resident in their room when they arrived because they knew the resident was still in an altered mental state from the trauma of their accident at home. The RR stated they were so angry that Staff H knew the resident had already been in the facility for at least an hour while Staff H had kept them chatting after signing the admission paperwork, especially since they had pre-planned for a smooth admission. The RR stated when Staff H told them the resident was already in the facility, they immediately went to the resident's room and found them sitting in a wheelchair in an empty room, wearing a hospital gown, not knowing where they were at. The RR stated they were unsure if anyone had checked on or greeted Resident 208 upon their arrival since they were not present when they arrived as planned. <Resident 217> Review of the medical record showed Resident 217 was admitted to the facility on [DATE] with diagnoses including acute kidney failure (a condition in which the kidneys suddenly stop filtering waste from the blood), Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and adjustment disorder with depressed mood (a mental health condition that occurs within a few months of a major stressor). The 07/18/2024 Admission Assessment showed Resident 217 required extensive assistance with activities of daily living. Review of a hospital progress noted dated 07/17/2024 showed the resident was disoriented and confused. During an interview on 07/19/2024 at 10:38 AM, the RR for Resident 217's stated the resident was picked up by the facility transport from the hospital at 11:30 AM and they had met the resident at the facility for their admission. The RR stated there was no one from admissions to greet the resident or the RR when they arrived. They stated staff had asked them how to transfer the resident to the bed and obtained a lunch tray for them. The RR stated they had been in the facility for at least two hours before Staff E, Charge Nurse, came in to visit with them. During that time, Staff H came to Resident 217's room and left a packet of admission paperwork on the bedside table. The RR stated Staff H did not give them any instructions for the paperwork. They stated at 4:45 PM, they went to Staff C's, Assistant Director of Nursing Services (ADON), office and asked if they were supposed to sign the paperwork. The RR stated Staff C called Staff H and overheard that they were ready to leave for the day. Staff H then met the RR in Resident 217's room to complete the admission paperwork. They stated Staff H did not ask for additional contact information for Resident 217's family or their Power of Attorney and Advance Directive documents. During that same interview, the RR stated they were afraid to leave the resident alone in the facility as there had been no evaluation by the therapy department and felt staff did not know how to care for the resident. They stated Resident 217 had specific preferences for their care and staff were unaware because no one had been in to gather that information. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 07/23/2024 at 4:43 PM, the RR for Resident 217's stated they were not very impressed with the admission process. They stated there was confusion as to which room the resident was admitted to and were unsure that they were in the correct room as there was a different resident's name posted at the door. The RR stated they felt the resident was ignored, there was no formal meeting. They stated the facility was very unorganized and that left both the resident and their representative frustrated and upset. During an interview on 07/19/2024 at 11:55 AM, Staff C, ADON, stated Staff E was responsible for admitting new residents, but the day Resident 217 was admitted , Staff E had been busy with other residents when Resident 217 arrived. Staff C stated it was the expectation that the admission nurse was present when residents arrived. During an interview on 07/22/2024 at 11:09 AM, Staff D, Resident Care Manager, stated the normal process for admissions included the admissions nurse meeting the resident upon arrival, along with Staff B, Director of Nursing Services (DNS), and Staff C providing the resident and their RR with business cards and welcomed them to the facility. Staff D stated the admission process for Resident 217 was not the normal process. During an interview on 07/23/2024 at 7:50 AM, Staff A, Administrator, stated that the process of admissions began with Staff H greeting the newly admitted resident upon arrival to the facility, with the charge nurse to follow to complete the assessments. Staff A agreed the process was not followed for Residents 208 and 217. Reference: WAC 388-97-0180(1)(2) 45117

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to issue a Notice of Medicare Non-Coverage [(NOMNC) a notice that indicates when your care is set to end from a skilled nursing facility] as required for 1 of 3 residents (Resident 215) reviewed for beneficiary notification. Additionally, the facility failed to provide a Skilled Nursing Facility (SNF) Advance Beneficiary Notice [(ABN) a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare; beneficiaries may choose to continue services but may be financially liable] for 3 of 3 residents (Residents 215, 50, and 52) reviewed for SNF ABN requirements. These failures placed the residents at risk for the inability to make informed financial and care decisions related to their continued stay. Findings included . Review of a policy titled, Advance Beneficiary Notices, dated 09/14/2023, showed the facility would inform Medicare beneficiaries of their potential liability for payment upon admission or during a resident's stay. Additionally, notices would be issued if a reduction in care occurred and the beneficiary wanted to continue to receive the care that was no longer considered medically reasonable and necessary, if services were being terminated and the beneficiary wanted to receive the care, or if a resident had skilled benefit days remaining and elected the hospice benefit. The facility would issue the notice at least two days before the end of a Medicare A stay. <Resident 215 > Review of the medical record showed Resident 215 was admitted to the facility on [DATE] with diagnoses including kidney failure, weakness, and assistance with personal cares. The 02/05/2024 comprehensive assessment showed Resident 215 was independent with activities of daily living (ADLs). The assessment also showed Resident 215 had a moderately impaired cognition. Review of Resident 215's medical record showed their Medicare Part A skilled services began on 01/10/2024 and their last covered day was 01/22/2024. Resident 215 had not exhausted their Medicare Part A benefits. A NOMNC was issued with the first date of non-coverage on 01/23/2024, despite the requirement to provide at least two days' notice. Additionally, there was no documentation that a SNF ABN had been provided at that time. During an interview on 07/22/2024 at 1:39, Staff C, Assistant Director of Nursing Services, stated NOMNCs were typically completed by the Social Services department. Staff C stated they needed to be completed and issued to the resident at least three days prior to their last covered day. Staff C stated Resident 215 was not issued their NOMNC in a timely manner. They stated they were not familiar with the process of issuing ABN's. <Resident 50> (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 50 was admitted to the facility on [DATE] with diagnoses including pneumonia (an infection that inflames the air sacs in one or both lungs), dysphagia (difficulty swallowing), and depression. The 05/03/2024 comprehensive assessment showed Resident 50 was dependent on one to two staff members for ADLs. The assessment also showed Resident 50 had a severely impaired cognition. Record review a nursing progress note (PN) dated 03/27/2024, showed Resident 50 would be admitted to hospice (a special way of caring for people who were terminally ill) services on 03/28/2024. The PN showed admission staff would follow up with the resident on 03/28/2024 next day regarding pay status. Record review of a provider note dated 04/08/2024, showed Resident 50 had graduated from hospice services and was in the facility for skilled therapy. Record review of Resident 50's primary payer source showed Medicare A benefits started on 04/06/2024 and the last covered day was 05/03/2024. A NOMNC was issued to the resident on 04/30/2024, however there was no issuance of a SNF ABN on either 04/06/2024 or 04/30/2024. <Resident 52> Review of the medical record showed Resident 52 was admitted to the facility on [DATE] with diagnoses including a stroke, heart failure, and difficulty swallowing. The 06/14/2024 comprehensive assessment showed Resident 52 required maximum assistance of one to two staff members for ADLs. The assessment also showed Resident 52 had an intact cognition. Review of Resident 52's medical record showed their Medicare Part A skilled services began on 04/26/2024, and their last covered day was 06/14/2024. Resident 52 had not exhausted their Medicare Part A benefits. A SNF ABN was issued to Resident 52 on 04/26/2024, the day of admission to the facility, however there was no documentation that an ABN was issued prior to their last covered day of Medicare Part A benefits. During an interview on 07/23/2024 at 7:56 AM, Staff A, Administrator, stated the late NOMNC for Resident 215 was a one off. Staff A stated they were not aware of the regulation for issuance of ABN's. Reference: WAC 388-97-0300(1)(e)(5)(6)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31168 Based on interview and record review, the facility failed to ensure an allegation of abuse/neglect was reported to the State Agency in the required 24-hour time frame, for 1 of 1 resident (Resident 28) reviewed for abuse/neglect. Resident 28 was found with significant bruising to their left hand and forearm. Failure to report abuse/neglect in a timely manner placed the resident at risk for additional abuse. Findings included . Review of the Nursing Home Guidelines, The Purple Book, sixth edition, Chapter 1 Facility Reporting Requirements, dated October 2015, showed the facility was required to report substantial injuries of unknown source within 24 hours. <Resident 28> Review of the Resident's 28 medical record showed the resident was admitted with diagnoses including dementia (disease which causes loss of memory, skills and functions), heart disease and depression. The 04/29/2024 comprehensive assessment showed the resident was dependent on one to two staff members for activities of daily living (ADLs) and mobility. The assessment also showed Resident 28 had difficulty recalling events, unable to fully express themselves and a severely impaired cognition. During an observation on 07/15/2024 at 12:10 PM, Resident 28 was seated at the assisted dining table with staff. The back of Resident 28's left hand was black and purple, from the base of their fingers to the top area of their left wrist. Additionally, the resident's left forearm, from the base of the left wrist to the outer top of the forearm to the elbow, had green, purple bruising. The resident's left hand was swollen as well as their fingers. The resident had their left hand flat on top of the table and had not used that hand to eat their meal. Resident 28 was unable to recall what happened to their left hand and forearm. Review of the 07/17/2024 facility's investigative report showed Resident 28 was found with 10 centimeters (cm-unit of measurement) by 8 cm dark purple bruise on top of their left hand on 07/14/2024. Staff reported to facility provider on 07/14/2024. Staff interviewed Resident 28 and they were unable to recall how they received the bruise. The provider ordered a left hand/wrist x-ray that was completed on 07/16/2024, (two days after the identification of the bruising). Per the facility investigative report, the provider did not believe there was a fracture to Resident 28 and requested a follow-up x-ray to completed in two weeks. The facility was unable to determine how the injury occurred. Review of Resident 28's 07/16/2024 left hand/wrist x-ray results showed impression of lucency (light spot) in the base of the ring finger that may have represented a non-displaced fracture (a break in a bone where the bone typically stays aligned in an acceptable position for healing). During an interview on 07/17/2024 at 10:45 AM, Staff C, Assistant Director of Nursing Services, stated they had not notified the State Agency to report the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Repeat citation from 03/05/2024 and 04/19/2024 Reference WAC 388-97-0640(5)(a)

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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. 31168 Based on observation, interviews and record review, the facility failed to thoroughly investigate an allegation of abuse which resulted in a significant bruise of unknown origin for 1 of 1 resident (Resident 28) reviewed for abuse. This failure placed residents at risk for unidentified abuse, neglect, and unmet care needs. Findings included . Review of the policy titled, Abuse, Neglect and Exploitation, dated 09/05/2023, showed an immediate investigation was warranted when suspicion of abuse or reports of abuse occurred. The written procedures would include identifying and interviewing all involved persons, alleged victim, alleged perpetrator, witnesses, and others who might have had knowledge of the allegation. The policy also showed the facility would provide a complete thorough documentation of the investigation. <Resident 28> Review of the Resident 28's medical record showed the resident was admitted with diagnoses including dementia (disease which causes loss of memory, skills and functions), heart disease and rheumatica polymyalgia (inflammatory disease that causes muscle pain and stiffness of joints especially in the shoulders and hips). The 04/29/2024 comprehensive assessment showed the resident was dependent on one to two staff members for activities of daily living (ADLs) and mobility. The assessment also showed Resident 28 had difficulty recalling events, unable to fully express themselves and a severely impaired cognition. During an observation on 07/15/2024 at 12:10 PM, showed Resident 28 seated at the assisted dining table during lunch with staff. The resident's left hand and fingers were swollen with the backside of their left hand with black and purple bruising from the base of their fingers to the top area of their left wrist. There was also a green and purple 5 inch [(in) unit of measure] by 3 in bruised area from the base of the resident's left wrist to the top side of the left forearm. During an interview on 07/15/2024 at 12:42 PM, Staff E, Charge Nurse, stated they were aware of Resident's 28 bruising to the resident's left hand and forearm and did not know what caused the bruising. Staff E asked Staff HH, Medical Director, for an order to x-ray Resident 28's left hand. During the interview at 12:55 PM, Staff HH came into Staff E's office. Staff HH stated that Resident 28's left hand bruise was probably caused by trauma by the resident hitting their hand against a surface. Review of the 07/16/2024 x-ray report showed Resident 28's left hand/wrist had mild tissue swelling and an area of lucency (light spot) in the base of the ring finger that may have represented a non-displaced fracture (a break in a bone where the bone typically stays aligned in an acceptable position for healing). During an interview on 07/15/2024 at 1:25 PM, Resident 28's Power of Attorney (POA-a person who has legal authority to make decisions on behalf of an individual), stated they visited the resident on 07/14/2024 and saw a large bruise on their left hand. The POA stated they reported the bruise to the nurse and received no further information of what caused the left-hand bruise. (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 07/17/2024 Incident follow up report, showed Resident 28's range of motion did not change and had no complaints of pain and was able to hold the bars during transfers with the mechanical lift. Staff thought maybe the resident's clothing was too tight around their arms or maybe bumped their arm on the dining table. Resident 28 had been administered aspirin and prednisone (medication to decrease inflammation) that may have caused increased bruising. The report further showed staff were to monitor Resident 28's bruises. During an interview on 07/22/2024 at 1:48 PM, Staff C, Assistant Director of Nursing, stated during the investigation they ruled out abuse by interviews with staff. Staff C stated they had not completed all staff or resident interviews to ensure there were no other incidents of abuse. Repeat citation from 04/19/2024 Reference WAC 388-97--0640 (6)(a)(b)

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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. 45117 Based on interview and record review, the facility failed to provide a written notice to the resident and their representative of the facility's intention and justification for the discharge of 2 of 2 residents (Residents 39 and 55) reviewed for facility-initiated discharges. Additionally, the facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a person that advocates for residents in nursing homes). This failed practice disallowed the resident and/or their representative an opportunity to fully understand the rationale and resident rights associated with the discharge. This failure also placed the residents at risk for diminished protection, lack of access to an advocate that could inform them of their options and rights, and to ensure the resident advocacy agency was aware of the facility practices and activities related to a transfer or discharge. Findings included . Review of a policy titled, Transfer and Discharge (including AMA [against medical advice]), dated 02/05/2024, showed the facility would provide a notice of transfer/discharge to the resident and/or their representative. The Social Services Director, or designee, would provide copies of notices for emergency transfers to the Ombudsman. <Resident 39> Review of the medical record showed Resident 39 was readmitted to the facility with diagnoses including clostridium difficile [(C-diff) a bacterium that causes an infection of the colon], kidney failure, and gastrointestinal hemorrhage (internal bleeding from the mouth to the rectum). The 07/01/2024 comprehensive assessment showed Resident 39 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed the resident had a severely impaired cognition. Review of Resident 39's medical record showed the resident was transferred to the hospital on 06/17/2024 for nausea, vomiting, diarrhea, dehydration, and possible C-diff. There was no documentation in the medical record that showed a notice of transfer/discharge had been provided to the resident and/or their representative or the LTC Ombudsman. <Resident 55> Review of the medical record showed Resident 55 was admitted to the facility with diagnoses including a urinary tract infection, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and diabetes (a group of diseases that result in too much sugar in the blood). The 04/25/2024 comprehensive assessment showed the resident required maximum assistance of one staff member for ADLs. Review of Resident 55's medical record showed they were transferred to the hospital on 04/25/2024 due to unresponsiveness. There was no documentation in the medical record that showed a notice of transfer/discharge had been provided to the resident and/or their representative or the LTC Ombudsman. (continued on next page)

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	505421	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/22/2024 at 9:09 AM, the LTC Ombudsman stated they had not received any notifications of transfers/discharges , for any resident, from the facility. During an interview on 07/22/2024 at 3:12 PM, Staff A, Administrator, stated they were aware of the regulation for notification to the Office of the State LTC Ombudsman. They stated they did not know who was responsible for the notification and it was not being completed. Reference: WAC 388-97-0120(2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to issue a written notice of bed-hold (holding or reserving a resident's bed while the resident was absent from the facility) at the time of hospital transfer for 2 of 2 residents (Residents 39 and 55) reviewed for hospital transfers. This failure placed residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed-hold while in the hospital. Findings included . Review of a policy titled, Transfer and Discharge (including AMA [against medical advice]), dated 02/05/2024, showed the facility would provide a notice of bed-hold policy to the resident and/or their representative upon transfer to the hospital. <Resident 39> Review of the medical record showed Resident 39 was readmitted to the facility on [DATE] with diagnoses including clostridium difficile [(C-diff) a bacterium that causes an infection of the colon], kidney failure, and gastrointestinal hemorrhage (internal bleeding from the mouth to the rectum). The 07/01/2024 comprehensive assessment showed Resident 39 was dependent on one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 39 had a severely impaired cognition. During an interview on 07/15/2024 at 10:48 AM, Resident 39's representative stated the resident had been transferred to the hospital in June 2024, for nausea, vomiting, and diarrhea. They stated the facility notified them of the transfer but did not provide them with any bed-hold information. Review of the medical record showed a notice of Bed Hold and Hospital Discharge, dated 06/17/2024 was issued to Resident 39 and was delivered to the Resident's Power of Attorney via phone call. The notice did not contain the required written information including how long the facility would hold the bed, how reserve bed payments would be made, and the conditions upon which the resident would return to the facility. Additionally, there was no documentation that a first notice of bed-hold had been issued in advance of the transfer . <Resident 55> Review of the medical record showed Resident 55 was admitted to the facility with diagnoses including a urinary tract infection, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and diabetes (a group of diseases that result in too much sugar in the blood). The 04/25/2024 comprehensive assessment showed the resident required maximum assistance of one staff member for ADLs. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed a notice of Bed Hold and Hospital Discharge, dated 04/25/2024 was issued to Resident 55 and was hand delivered to the Resident's Power of Attorney. The notice did not contain the required written information including how long the facility would hold the bed, how reserve bed payments would be made, and the conditions upon which the resident would return to the facility. Additionally, there was no documentation that a first notice of bed-hold had been issued in advance of the transfer. During an interview on 07/22/2024 at 1:53 PM, Staff C, Assistant Director Nursing Services, stated the facility had an assessment that generated the bed-hold notification, that stated the resident could pay to have their bed held and it would be available when they returned to the facility. During an interview on 07/22/2024 at 3:22 PM, Staff H, Executive [NAME] President of Marketing, stated they explained the bed-hold policy to residents on admission to the facility. They stated they did not provide a written copy of the policy for bed-hold. During an interview on 07/23/2024 at 8:00 AM, Staff A, Administrator, stated they were not aware that the notice of bed-hold had to be provided to the resident and/or their representative before and upon transfers out of the facility. Reference: WAC 388-97-0120(4)

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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** 39652 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review [(PASARR) - a federally required form that is used to help ensure individuals receive appropriate mental health services after admission to a skilled nursing facility] was completed correctly for 4 of 6 residents (Residents 6, 11, 210 and 23) reviewed for PASARR accuracy. This failure placed the residents at risk for not receiving appropriate mental health services. Findings included . <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility on [DATE] with mental health diagnoses including, major depression and delusional disorder (a disorder that causes altered beliefs which are not reality). Review of the most recent comprehensive assessment dated [DATE] showed the resident was able to make their needs known and had mild cognitive impairment. Additional review showed Resident 6 had experienced mental health symptoms during the assessment period, including feelings of depression, hopelessness, lack of pleasure, or energy in doing things and the inability to stay asleep. Record review of Resident 6's most recent PASARR completed on re-admission to the facility, dated 06/24/2024, showed the assessment did not identify Resident 6's mental health diagnoses of major depression or delusion disorder. <Resident 11> Review of the medical record showed Resident 11 was admitted to the facility with a diagnosis of dementia with agitation and behavioral disturbances (negative behaviors associated with cognitive impairment). Review of the most recent comprehensive assessment dated [DATE], showed the resident had severe cognitive impairment and had exhibited mental health symptoms during the assessment period including feelings of depression and hopelessness, lack of pleasure or energy, and poor appetite. Record review of Resident 11's most recent PASARR did not identify their diagnosis of dementia with agitation and behavior disturbances. <Resident 210> Review of the medical record showed Resident 210 was admitted to the facility on [DATE] with diagnoses including an anxiety disorder and depression. The resident required assistance of one staff member for mobility and was able to make their needs known. Review of Resident 210's PASARR dated 07/10/2024 did not reflect their diagnoses of anxiety or depression. <Resident 23> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 23 was admitted to the facility on [DATE] with diagnoses including stroke, depression, psychoactive substance abuse, and severe dementia with mood disturbance. The 6/14/2024 admission assessment showed Resident 23 was dependent on two staff members for activities of daily living and had a moderately impaired cognition. Record review of Resident 23's hospital completed PASARR dated 6/10/2024, showed they had no diagnoses related to serious mental illness, intellectual disability, or additional relevant information. Review of Resident 23's admission medical diagnoses list, dated 6/11/2024 , showed the resident had depression, psychoactive substance abuse, and dementia with mood disturbance. Further review of their record showed that an updated PASARR to include these diagnoses had not been completed. During an interview on 07/22/2024 at 12:00 PM, Staff A, Administrator stated the inaccurate PASARR assessments were related to not currently having a Social Services Director, as they would be responsible to ensure the accuracy of the PASARR assessments for residents on admission to the facility. Reference WAC [PHONE NUMBER](1)(2)(a-c) 31168 45117 46722

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to develop and implement an effective discharge planning process that addressed the resident's goals and needs and involved the resident and/or their representative and the interdisciplinary team [(IDT) a group of healthcare professionals from different disciplines to help residents receive the care they need] for 2 of 3 residents (Resident 208 and 38) reviewed for discharge planning process. The failure to develop and implement a plan consistent with the resident's needs and expressed discharge goals, placed the residents at risk for decreased self-worth and dissatisfaction with their living situation. Findings included . <Resident 208> Review of the medical record showed Resident 208 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a series of brain dysfunction caused by illness), high blood pressure, and depression. Resident 208 was able to make their needs known. Record review of the Discharge Planning Review form dated 07/09/2024, showed the anticipated length of stay as N/A (not applicable), the resident lived alone, and had no family or support network to provide assistance post-discharge. Record review of Resident 208's care plan revised on 07/15/2024, showed no comprehensive, person-centered discharge plan had been initiated for the resident. The care plan did not include information that identified the resident's discharge goals, needs, barriers to discharge, or the potential discharge location. During an interview on 07/17/2024 at 10:45 AM, Resident 208's Representative (RR), stated they were very involved in the resident's care and had done all of the initiation for discharge. They stated they found an assisted living facility willing to accept the resident and the RR had arranged for them to meet the resident and assess them for admission. The RR stated they had arranged for an outside primary care provider to come into the facility to coordinate Resident 208's care. They stated no one at the facility assisted with the discharge planning or process. The RR stated Staff E, Charge Nurse, was the only staff member that had spoken to them about any type of discharge planning and that conversation was a request for the RR to provide them with a date and time of discharge. There were no other meetings or discussions around discharge from the facility. During an interview on 07/17/2024 at 11:15 AM, Staff E stated there were no discussions regarding discharge planning for Resident 208 because they were not having stand up meetings due to state surveyors in the building. They stated Social Services (SS) was responsible for driving the discharge process but that had been spotty lately. Staff E stated the process for discharge was difficult. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2024 at 11:56 AM, Staff P, Physical Therapy Assistant/Rehab Director, stated Resident 208 was on the therapy caseload and had rapidly improved over a few days. They stated Resident 208 was appropriate for admission to an assisted living facility, but therapy was not involved in the discharge plan. They stated they were not aware that the discharge was occurring until they saw the resident's name on a communications board. <Resident 38> Review of the medical record showed Resident 38 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (a long-term condition in which your heart can't pump blood well enough to meet the body's needs), high blood pressure, and anxiety. The 06/16/2024 comprehensive assessment showed Resident 38 required partial/moderate assistance of one staff member for activities of daily living. The assessment also showed Resident 38 was cognitively intact. Record review of the Discharge Planning Review form dated 06/18/2024, showed the anticipated length of stay was possibly long term and treatment/care needs included an in home caregiver. Record review of a document titled, Quarterly Care Summary 2.8, dated 06/18/2024, showed the resident was here to get strong enough to move back home or an assisted living facility. The care conference meeting was attended by the Charge Nurse and the Resident Care Manager. Resident 38 was not in attendance. Record review of Resident 38's care plan dated 06/27/2024, showed the discharge plan included I am planning on staying long term but may be able to go home with caregivers. The care plan did not include information that clearly identified the resident's discharge goals, needs, barriers to discharge, or potential discharge location. During an interview on 07/15/2024 at 1:15 PM, Resident 38 stated they would like to go home. They stated no one at the facility had discussed the option to go home with them. During a follow up interview on 07/17/2024 at 8:33 AM, Resident 38 stated I think I am going to the assisted living. I would prefer to go home. They stated someone came to their room and asked if they wanted to see the assisted living facility. Resident 38 stated I am a little bit in the dark about what is happening, I am not certain as to what the plan is. I don't recall any home health services being offered as an option for me to go home. During an interview on 07/17/2024 at 1:11 PM, Resident 38's Representative stated they had not been contacted regarding the discharge prior to that morning (07/17/2024). The Resident's Representative stated they did not know if Resident 38 had been offered other options for discharge. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2024 at 11:03 AM, Staff E, stated the process for discharge was care planned upon admit. Physical therapy, (PT), determined how many weeks the resident would need therapy to meet their goals and they planned from there. Staff E stated the potential discharges were discussed during the morning stand up meetings to determine placement and what services would be needed. The PT decided if a resident was safe to go home or if they needed a higher level of care. When a resident wanted to go home, the therapy department would go to their home and complete a home safety inspection and facility staff assisted with home health services, if needed. Staff E stated Resident 38 wanted to go home. Staff E stated they did not believe a home assessment was completed for them. Resident 38 would not have qualified for home health and would have needed private caregivers. Staff E stated they did not know if that had been discussed with the resident. During an interview on 07/17/2024 at 11:33 AM, Staff B, Director of Nursing Services (DNS) stated the discharge process started upon admission to the facility. SS was responsible to start the process, however the facility did not have a SS person right now. SS would discuss the discharge plan with the resident, length of time they would be in the facility, and when it was time for discharge, the facility would assist with home care needs. The process included having a care conference within the first week of admission and the discharge assessment was done on the first day. Discharge was decided by the resident, the physician, and therapy department. PT had suggested Resident 38 discharge to the assisted living facility. Staff B stated they thought that discharge to home was assessed by therapy and that the RR had been involved in Resident 38's discharge planning. During an interview on 07/17/2024 at 11:56 AM, Staff P, stated their role in the discharge process included working with the IDT team to identify what the discharge plan would be, starting with the resident's therapy evaluation and initial discussions with the resident and their family. The resident's progress was discussed at weekly therapy meetings, along with their discharge plan, and at that time there may be discussions that the discharge plan might be unrealistic. Staff P stated usually therapy made a recommendation for discharge, but at times there was input from the clinical staff that would affect the final decision. They stated there may be input from the RR but that was not consistent. Staff P stated the intention was to have a care conference with the resident and their representative when the resident first arrived at the facility, along with the IDT members that included the Resident Care Manager, usually the DNS or Assistant Director of Nursing Services, (ADON), maybe the Administrator, and SS when they had one available. The therapy recommendation was for Resident 38 not to go home, but they could have with home health services. Resident 38 would have been safe at home with daily checks and medication management. Staff P stated some discharges were done well and sometimes there were hiccups. They stated, I feel like I tell them my recommendations and they do it. During an interview on 07/22/2024 at 2:15 PM, Staff C, ADON, stated the discharge plan for Resident 38 upon admission was to return home. The team had discussed this with the therapy department. Staff C stated therapy had sent out an email that said the resident could be discharged home with medication management and a few other things. During a concurrent interview on 07/17/2024 at 11:46 AM, Staff B stated based on the recent discharges, the facility did not have a strong process for discharges. Staff A, Administrator, stated our process could be better. Reference: WAC 388-97-0080

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on observation, interview and record review the facility failed to ensure 2 of 2 residents (Residents 11 and 10) reviewed for dependence with activities of daily living received care and services to meet their elimination needs. Residents 11 and 10 had specific care directives for toileting programs and did not receive timely assistance as required. This failure placed the residents at risk for incontinence unmet care care needs. Findings included . <Resident 11> Review of Resident 11's medical record showed the resident was admitted with diagnoses including dementia (a brain disease that causes memory loss with poor judgement) and type 2 diabetes (a chronic disease which results in a build up of too much sugar in the blood). Review of the most recent comprehensive assessment dated [DATE] showed the resident had severe cognitive impairment and was on a timed toileting program (a specific program to provide scheduled times to provide assistance to help remain continent of bowel and bladder). Record review of Resident 11's Kardex (a care plan which gives directives for basic care needs) with a revised date of 07/17/2024 showed the resident was scheduled for assistance with toileting at 12:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 2:00 PM, 4:00 PM and 6:00 PM. During an observation on 07/17/2024 from 7:45 AM to 1:45 PM (6 hours) showed the resident had been up in their wheel chair and had not been provided assistance to the bathroom for their elimination needs per their timed toileting program. During an interview on 07/17/2024 at 2:16 PM Staff BB, Nursing Assistant (NA), stated that Resident 11 would ask if they wanted assistance with toileting, otherwise the resident would just stay up in their wheelchair until they informed staff they wanted to use the bathroom. Staff BB stated they were not aware that Resident 11 had a specific toileting program for elimination needs. During an observation on 07/18/2024 from 8:40 AM to 1:10 PM showed Resident 11 up in their wheelchair. The resident had not been assisted to the bathroom during this time frame (four hours and 30 minutes). At 1:10 PM Resident 11 was pushed to their room by Staff S, Activities Coordinator, who stated the resident had requested to use the bathroom. Staff S turned on Resident 11's call light. Staff U, NA, responded to the call light and assisted Resident 11 to the bathroom. Resident 11 stated to Staff U you better bring a mop, I'm really wet. Observation of the resident's incontinent brief showed it was saturated with urine. During an interview on 07/18/2024 at 10:03 AM Staff T, NA, stated they were the routine caregiver for Resident 11. I get the resident up about 7:30 AM every day. Staff T further stated Resident 11 was not on a timed toileting program and sometimes the resident would ask to go to the bathroom which was how they knew to provide Resident 11 with toileting assistance. <Resident 10> (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 Resident 10's medical record showed they were admitted to the facility with a diagnosis of dementia. Review of the most recent comprehensive assessment dated [DATE] showed the resident was cognitively impaired and was on a timed toileting program. Review of the Kardex with a revised date of 07/18/2024 showed Resident 10 required assistance from one staff for elimination needs. The Kardex showed staff were to provide Resident 10 with toileting assistance every two hours during day and evening shifts and every three hours at night to help the resident to maintain some continence with bowel and bladder. Further review of the Kardex showed to anticipate the residents needs related to cognitive impairment. During an observation on 07/18/2024 at 9:10 AM, Resident 10 approached the East nurse's station and requested assistance with using the bathroom. At 9:55 AM the resident was assisted to the bathroom by Staff T, NA, and Staff U, NA. Resident 10 had been incontinent of stool and as they were assisted onto the toilet and stated oh no, oh no. Resident 10 had waited 35 minutes to be assisted with their elimination needs which had resulted in an incontinence of stool. During an interview on 07/22/2024 at 12:10 PM, Staff B, Director of Nurses, stated they expected staff to follow all residents Kardex directives for elimination needs. Reference WAC 388-97-1060(2)(c)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to ensure treatment and care was provided in accordance with professional standards of practice and the comprehensive, person-centered care plan for 5 of 5 residents (Residents 54, 11, 38, 36, and 13) reviewed for quality of care, in the areas of constipation/urinary bladder assessment, fluid restrictions, and timely implementation of physician orders. Resident 54 experienced harm when they did not have a bowel movement for four days and did not have a timely urinary bladder assessment, that resulted in pain, constipation, a small bowel obstruction (a blockage in the intestines), and a urinary bladder infection that required hospitalization . These failed practices placed residents at risk for a delay in treatment and unmet care needs. Findings included . Review of the facility policy titled, Bowel Routine for Preventing Constipation, dated 09/23/2023, showed that scheduled medicines for bowel routine helps with regular bowel movements. Being constipated can make residents feel ill. Constipation can be a side effect of pain medication and other medications. Things that make constipation worse were not drinking enough fluids, some anti-nausea medications and eating less than normal. Prevention of constipation is easier than treating it. The goal was to have a bowel movement every three days. Before each shift, the licensed nurse was to obtain a bowel list in the computer. If there were no bowel movements and/or no medium normal bowel movements, the licensed nurse would initiate the bowel protocol. <Constipation/Urinary Bladder Infection> <Resident 54> Review of the medical record showed the resident admitted to the facility with diagnoses including diarrhea, urinary retention, falls with fractures, and high blood pressure. Review of the 06/16/2024 comprehensive assessment showed Resident 54 was cognitively impaired but able to make most needs known. Resident 54 needed staff assistance and oversight for transfers and assistance to the bathroom. During an observation on 07/15/2024 at 9:00 AM, the resident was lying in their bed with eyes closed, and stated they had pain in their lower back and stomach. Resident 54 stated they felt bad and preferred to just rest. Review of the July 2024 Medication Administration Record (MAR), showed Resident 54 received a narcotic pain medication on 07/15/2024 at 6:16 AM. The 07/15/2024 8:02 AM MAR entry showed a narcotic pain medication was ineffective. Resident 54 received additional doses of the narcotic pain medication on 07/15/2024 at 4:25 PM, and on 07/16/2024 at 1:20 AM, 10:04 AM, and 6:34 PM. During an observation and concurrent interview on 07/16/2024 at 10:00 AM, showed Resident 54 was in bed lying on their left side and stated they had pain in their lower back that was very uncomfortable. The resident also stated they felt ill. The resident stated they were unable to eat food. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the July 2024 MAR showed on 07/16/2024 at 1:06 AM, the resident complained of general pain all over and a narcotic pain reliever was given. During an observation and concurrent interview on 07/17/2024 at 8:39 AM, Resident 54 was in bed with their eyes closed and a plastic basin beside them. The resident stated they had been nauseated and throwing up since the previous night. The resident's breakfast tray at their bedside was untouched and the resident stated they were not hungry. The plastic basin at the bedside contained some vomitus of yellow type of fluid. The resident stated they were miserable and complained of right upper side pain. Staff I, Licensed Practical Nurse (LPN), gave a medication for dizziness and nausea. During an observation on 07/17/2024 at 11:55 AM, Resident 54 stated they had tenderness and sensitivity in their right side, severe pain, and their stomach and back hurt. The resident stated they were feeling worse. During an interview on 07/17/2024 at 12:00 PM, Staff E, Charge Nurse, was asked to look at Resident 54. Staff E then documented that the resident was in pain and nauseated and called for an order from the provider for an anti-nausea medication to give to the resident. Staff E asked Resident 54 if they had their gall bladder and the resident stated it was removed. There was no documentation of further assessment in the medical record and there were no other licensed nurse assessments. The resident complained of pain and a narcotic pain reliever was given to the resident. Review of Resident 54's bowel movements showed the resident had not had a bowel movement since 07/14/2024 and still had no bowel movement on 07/18/2024. Additionally, the resident had been nauseated and did not eat or drink many fluids. There were no bowel protocols initiated or thorough assessments of Resident 54's complaints of pain. During an interview on 07/18/2024 at 11:51 AM, Staff O, Nursing Assistant (NA), stated the resident would say they had a bowel movement, and they did not. Staff O stated that morning, the resident did not have a bowel movement when they took Resident 54 to the bathroom. Staff O stated they told the nurse that the resident was constipated and in pain. Staff O stated the resident got more confused when they were in pain. Staff O stated the resident probably had an impaction. Review of the July 2024 MAR, showed an entry on 7/18/2024 that the resident received Colace (a stool softener) at 6:20 AM. There were no entries of a bowel movement. Review of a nursing progress note dated 07/18/2024 at 12:53 PM, showed Resident 54 was transferred to the hospital for abdominal pain. Review of the 07/18/2024 hospital emergency department notes showed the resident had nausea and vomiting with a small bowel obstruction and a urinary tract infection. Review of the 07/22/2024 hospital physician's progress note showed the resident had an abnormal heartbeat and had to be cardioverted (a procedure where electroshock and medications are used to convert irregular heartbeats back to normal). <Fluid Restriction> <Resident 11> (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 11's medical record showed the resident was admitted with diagnoses including dementia, chronic kidney failure (chronic disease of the kidneys causing kidney failure), and congestive heart failure (a condition in which the heart doesn't pump enough blood to meet the needs of the body which can lead to fluid overload). Review of the most recent comprehensive assessment, dated 6/11/2024, showed the resident was cognitively impaired and exhibited poor judgement and decision-making skills. Review of a physician's order dated 06/11/2024, showed the resident had orders to restrict their daily fluid intake to 1800 milliliters (ml - a unit of fluid measurement). The orders showed nursing was allotted 1080 ml and dietary 720 ml, including meals. During multiple observations on 07/15/2024 at 9:30 AM, 07/16/2024 at 8:40 AM, 07/17/2024 at 8:30 AM, 07/18/2024 at 1:00 PM, and 07/19/2024 at 10:15 AM showed Resident 11 had a pitcher containing 950 ml of water on their bedside table. The bedside water was not calculated in their current fluid restrictions and put them potentially over 950 ml per day. During an interview on 07/17/2024 at 11:46 AM, Staff G, Registered Nurse, stated Resident 11 was not on an official intake monitoring. Staff G stated the resident was on a slightly restricted fluid intake which did not require monitoring. Staff G further stated they were not aware that Resident 11 had a water pitcher at their bedside as their fluid intake was already calculated and did not include any additional fluids. <Resident 38> Review of the medical record showed Resident 38 was admitted to the facility on [DATE] with diagnoses including congestive heart failure, high blood pressure, and anxiety. The 06/16/2024 comprehensive assessment showed Resident 38 required partial/moderate assistance of one staff member for activities of daily living (ADLs). The assessment also showed Resident 38 was cognitively intact. An observation on 07/15/2024 at 1:15 PM, showed Resident 38 sitting in a recliner in their room. There was a 32-ounce cup of water on the bedside table. Resident 38 stated the staff came by and filled it up a few times a day. Resident 38 stated they had access to fluids throughout the day and did not know if they had a fluid restriction. Review of a physician order dated 06/25/2024, showed Resident 38 had an 1800 ml fluid restriction (720 ml from dietary and 1080 ml from nursing). Review of Resident 38's fluid intake records dated 06/26/2024 through 07/15/2024, from dietary and nursing, showed Resident 38 exceeded the maximum recommended fluid intake 15 out of 20 days. During an interview on 07/23/2024 at 8:34 AM, Staff E, Charge Nurse, stated fluid intake was monitored by the floor nurses. They stated Resident 38 was non-compliant with fluid intake and a risk/benefit with education should have been completed. Staff E stated the physician should have been notified. Review of Resident 38's medical record showed there was no documentation that risks and benefits were discussed with the resident. There was no documentation of a risk/benefit form or that the resident's physician had been notified. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<Physician Orders> <Resident 13> Review of the medical record showed Resident 13 was readmitted to the facility on [DATE] with diagnoses including heart failure, iron deficiency anemia, and hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone, disrupting such things as heart rate and body temperature). The 04/29/2024 comprehensive assessment showed Resident 13 required substantial assistance of one to two staff members for ADL's and had a severely impaired cognition. Review of a physician progress note dated 02/05/2024 at 3:23 PM, showed orders for lab work, that included rechecking Resident 13's thyroid stimulating hormone [(TSH) a test that measures the amount of thyroid hormone in the blood), iron studies (blood tests that measure the amount of iron in the blood and other cells), and a medication change. Review of Resident 13's medical record showed no results for the ordered lab work, and the medication change had not been completed. During an interview on 07/22/2024 at 10:28 AM, Staff E stated Resident 13 often refused to have lab work completed. Staff E stated they typically tried to get the labs twice, then another nurse would try. Staff E stated it looked like that process had not been done. During an interview on 07/22/2024 at 11:27 AM, Staff D, Resident Care Manager, stated all provider notes were reviewed by the charge nurse. Any new orders would be updated by the end of the day by the charge nurse. Staff D stated when a resident refused to have lab work done by facility staff, they would send them out to the lab for completion of the orders. Staff D stated they did not see the medication change or the completed lab work in the record. During an interview on 07/22/2024 at 2:10 PM, Staff C, Assistant Director of Nursing Services, stated the process for obtaining lab work for difficult residents included multiple attempts at different times by different staff. If the staff were still unable to obtain the sample, the facility would send the resident out to the lab to obtain the sample. Staff C stated they did not see documentation on that missed lab draw in the system. Staff C stated the Charge Nurse was responsible for reviewing physician notes after they round in the facility. They stated the physician typically entered their own orders into the system, but the charge nurse should go back and review the notes to make sure those orders were completed. Staff C stated they did not see that the medication order had been changed and that the charge nurse should have caught that. <Resident 36> Review of Resident 36's medical record showed they were admitted to the facility on [DATE] with diagnoses including fracture of left leg, peripheral vascular disease (PVD-a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and diabetes (a group of diseases that result in too much sugar in the blood). The 04/16/2024 comprehensive assessment showed Resident 36 was dependent on two staff members for ADLs and mobility. The assessment also showed the resident had an unstageable (full-thickness tissue loss covered by dead tissue and/or scab) pressure injury (PI-localized injury to skin and underlying tissues) and an intact cognition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident 36's wound assessment dated [DATE], showed the provider's plan was to refer the resident to an outside wound care clinic to establish care and receive further treatment for their unstageable pressure ulcer (PU-injury to skin and underlying tissue resulting from prolonged pressure) on their left heel. Further review of Resident 36's record showed a signed, 05/29/2024, physician's order for the referral to the outside wound care clinic. Review of Resident 36's medical record showed their first appointment with the outside wound care clinic was on 07/18/2024, 50 days after the physician referral. During an interview on 07/15/2024 at 1:29 PM, Resident 36's Representative (RR), stated the resident had developed their left heel pressure wound since they had been at the facility and were waiting for an appointment to see the outside wound clinic for treatment. The RR stated the plan was to have Resident 36 move back home with them when their PU was healed. During an interview on 07/18/2024 at 11:09 AM, Staff E, Charge Nurse, stated the process for referrals for residents was reviewing the providers notes, filling out an order slip and having the provider sign it. They would then give the order slip to Staff K, Medical Records, to complete the referral. Staff E further stated that 07/18/2024 was Resident 36's first appointment to the wound clinic and the delay was on the facility but was unsure why there was a delay. During an interview on 07/19/2024 at 10:39 AM, Staff K stated they sent in four different resident referrals, including Resident 36's, to the outside wound clinic in early June 2024. Staff K stated all the residents were scheduled in June for their appointments and were unsure why it took so long for Resident 36 to be scheduled. Staff K stated they did not call the wound clinic to inquire about the delay, as it was their process to have the wound clinic call the facility when they were ready to schedule. Reference: WAC 388-97-1060(1) 39652 45117 46722

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on observation, interview, and record review the facility failed to provide services and assistive devices to maintain vision abilities for 1 of 1 resident (Resident 23) reviewed for vision. The failure to provide vision care and assistive devices placed the resident at risk for worsening vision. Findings included . <Resident 23> Review of Resident 23's medical record showed they were admitted to the facility on [DATE] with diagnoses including stroke and depression. The 06/14/2024 comprehensive assessment showed Resident 23 was dependent on two staff members for activities of daily living (ADLs) and had moderately impaired vision and cognition. During and observation and interview on 07/15/2024 at 10:42 AM, Resident 23 was lying in their bed with the lights off and curtains closed. Resident 23 stated they used to wear glasses and their eyes hurt and would like to see an eye doctor. During an interview on 07/17/2024 at 9:46 AM, Resident 23 stated they were unsure why they could not have any eyeglasses. Resident 23 stated they could not see the buttons on the television remote to operate the television and they were unable to read anything without eyeglasses. Review of Resident 23's medical record showed a 07/08/2024 physician's order to refer the resident to optometry (specialized health care for the examination of eyes) for eye vision evaluation. During an interview on 07/19/2024 at 10:39 AM, Staff K, Medical Records, stated they were responsible for obtaining optometry appointments for residents. Staff K stated the process was once the order was signed by the provider, the charge nurse would send the order to medical records and medical records would schedule the appointment. Once the appointment was created, they scanned the physician's referral order into the resident's medical record which meant the process was completed. Staff K stated they were unaware of Resident 23's order for an eye vision appointment and they must have missed Resident 23's referral order. During an interview on 07/22/2024 at 1:45 PM, Staff B, Director of Nursing Services, stated the process for physician orders for outside facility appointments was the charge nurse was to obtain the order from the provider, have the provider sign the order and submit the order to Staff K to obtain appointment date and time and scan the referral order into the resident's medical record. Reference WAC: 388-97-1060(1)(3)(a)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services to prevent the occurrence of an avoidable pressure ulcer (PU-injury to skin and underlying tissue resulting from prolonged pressure) and implement wound care and services timely to avoid worsening of a PU for 3 of 5 residents (Residents 48, 108, and 13) reviewed for PU's. Resident 48 experienced harm when the facility failed to follow physician orders to ensure healing of their avoidable Stage 4 PU (a full thickness tissue loss of tissue with exposed bone, tendon, or muscle) to their coccyx (tailbone) and obtain pain control measures during wound care. Resident 108 experienced harm when the facility failed to recognize and modify treatment of an unstageable PU (full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen) on their left great toe and a Stage 2 PU [partial thickness skin loss with exposed dermis (the top inner layers of skin)] on their left heel. These failures placed residents at risk for PU development, continued deterioration of pressure ulcers, infection, and pain. Findings included . Review of the National Pressure Injury (ulcer) Advisory Panel (leading expert in pressure ulcer/injuries/wounds) guidance, dated September 2016, defines pressure ulcer/injury stages as follows: Stage 1 Pressure Injury has intact skin with a localized area of non-blanchable erythema (redness). Stage 2 Pressure Injury is partial thickness skin loss with exposed dermis (the top inner layers of skin). Stage 3 Pressure Injury is full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and/or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may be present, with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which may be shallow or deep and impairs wound closure). Stage 4 Pressure Injury is full thickness loss of skin and tissue, with exposed or directly palpable fascia (a layer of connective tissue), muscle, tendon, ligament, cartilage, or bone in the ulcer. Epibole, undermining and tunneling often occur. Unstageable Pressure Injury is full thickness skin and tissue loss to which the extent of the tissue damage cannot be seen. Review of the facility's policy titled, Pressure Injury Prevention and Management, dated 02/14/2024, showed the facility would provide treatment and services to heal pressure ulcers and prevent the development of additional pressure ulcers. The policy also showed an avoidable pressure ulcer meant the resident developed the pressure ulcer at the facility and did not .implement interventions consistent with resident needs, goals and professional standards of practice .monitor or evaluate the impact of interventions . and/or revise the interventions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<Resident 48> Review of Resident 48's medical record showed they were admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Chronic Inflammatory Demyelinating Polyneuropathy [(CIDP) - a disorder that damages the protective layer of nerves, causing weakness, numbness, and pain in the limbs), and diabetes (a group of diseases that results in too much sugar in the blood). The 07/01/2024 comprehensive assessment showed Resident 48 required maximal assistance of one to two staff members for activities of daily living (ADLs) and dependent of two staff members for transfers. The assessment also showed Resident 48 had moderately impaired cognition. Review of Resident 48's 04/05/2023 admission comprehensive assessment. showed they did not have a PU and were at risk of development of PUs. Review of the 01/03/2024 comprehensive assessment showed the resident had an unstageable (full-thickness tissue loss covered by dead tissue and/or scab) PU. Further review of the resident's 04/05/2024 comprehensive assessment showed the resident had a Stage 4 PU. Review of Resident 48's 12/13/2023 skin/wound evaluation, showed the resident had an in-house acquired unstageable coccyx (tailbone area) PU that presented with slough covering the wound bed. Additional review of Resident 48's skin/wound evaluations showed their coccyx PU was documented as a Stage 4 and not an unstageable PU. Review of Resident 48's 03/01/2024 Staff GG, Advanced Registered Nurse Practitioner, (ARNP) note, showed nursing management confirmed a wound vac (a machine that helps wound healing by pulling wound edges together) had been ordered for the resident. Further review of the medical record showed no documentation that the wound vac had been ordered. Review of Resident 48's physician orders showed a referral, dated 04/25/2024, to obtain a surgical consult to evaluate and treat their Stage 4 coccyx PU (56 days after the practitioner's note that a wound vac had been ordered). Further review of the medical record showed no documentation the resident had a surgical consult. An observation and interview on 07/16/2024 at 9:02 AM, showed Resident 48 lying in their bed, on their back, with pillows under each side of their rib area. Resident 48 stated they had been to the wound clinic yesterday, their bottom was very sore, and their pain was a 10 out of 10 on the pain scale (a measurement of pain, 0 no pain and 10 is severe pain). Resident 48 stated that if they did not move their position much, their pain would remain a 5 out of 10. Resident 48 further stated when the nurses changed their wound dressing on their bottom, they did not provide pain medications before or after and it was a painful process. During an interview on 07/16/2024 at 2:12 PM, an outside wound care consultant (OWCC), stated Resident 48's first appointment with the wound clinic was on 06/17/2024 (53 days after the surgical consult was ordered). The OWCC stated Resident 48 stated they were in pain during their wound care treatments at the facility. The OWCC stated during the treatment at the wound clinic, the resident did moan and groan during the clinic treatment. The OWCC continued to state that the provider at the wound clinic had ordered a wound vac on this appointment and called the facility nursing director for instructions for submitting the wound vac order. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 07/17/2024 at 8:54 AM, Resident 48 was lying in bed on their back with the head of their bed up. Resident 48 stated they had a wound dressing change earlier that morning and it was very painful, above a 10 on the pain scale. Resident 48 stated they told the nurse it hurt, yet they did not receive pain medication. During an interview on 07/17/2024 at 9:23 AM, Staff Y, Nursing Assistant (NA), stated they assisted the nurses with wound dressing changes. Staff Y stated Resident 48 would complain of pain during the wound dressing change. During an interview on 07/17/2024 at 9:51 AM, Staff I, Licensed Practical Nurse (LPN), stated Resident 48's pain medications consisted of scheduled Tylenol (a medication to treat mild to moderate pain) 1000 milligrams (mg-unit of measure) three times a day. During an observation and concurrent interview on 07/17/2024 at 10:19 AM, Staff G, Registered Nurse (RN), and Staff Q, Infection Control Nurse (ICRN), performed Resident 48's pressure ulcer dressing change. Staff Q stated they had been performing the pressure wound treatment for a month and stated the wound had remained the same. Staff Q stated that healing was slow. During the pressure wound treatment, Resident 48 yelled out in pain when Staff Q was measuring the wound tunnelling. Staff Q continued with the wound care treatment and did not address Resident 48's pain. After the pressure wound treatment, Resident 48 stated to Staff G and Staff Q their pain during the procedure was a 12/10 and Tylenol did not help with their pain during the procedure. Staff Q and Staff G did not acknowledge Resident 48's complaint. During an interview on 07/17/2024 at 10:56 AM, Staff G, stated they were aware the PU wound dressing changes were painful for Resident 48. Staff G stated the resident should have pain medication prior to the dressing changes and their current pain management was not effective. During an observation, interview, record review, on 07/17/2024 at 2:12 PM, Resident 48 was in their bed, on their back, and the head of their bed elevated. Resident 48 stated their pain level was an 8/10 on their bottom where their wound was. Resident 48 stated they did not receive any additional medication for pain. Review of Resident 48's Medication Administration record showed they were administerd Tylenol 1000 miligrams (unit of measure) at 8:00 AM, 12:00 PM and their next dose was due at 6:00PM. During an interview on 07/17/2024 at 2:27 PM, Staff G stated they did follow up with Resident 48 for their pain after the earlier wound care. Staff G stated when they asked the resident how their pain was, Resident 48 just looked at them and gave no response. Staff G stated the resident received scheduled Tylenol for pain and the upcoming dose was close to being administered. During an interview on 07/18/2024 at 9:29 AM, Resident 48's Representative, (RR), stated the resident's PU had developed at the facility and had been worsening without improvement. The RR stated Resident 48 did complain of pain during the wound care treatments and the resident was not provided any additional pain medications. Resident 48's RR stated they had observed the resident decline in their health, as the resident did not want to get out of bed and participate in any activities or visit outside like they used to due to their pain. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/19/2024 at 8:53 AM, Staff D, Resident Care Manager, stated Resident 48's coccyx PU healing had stalled (stopped making progress). Staff D also stated they had performed the resident's wound dressing changes, and they were aware Resident 48 was in pain during the wound care, as the resident would grunt and tell them to be careful. Staff D stated pain medications had not been administered before or after the wound care and they had not requested any additional pain medication from the provider for Resident 48. During an interview on 07/19/2024 at 12:10 PM, Staff E, Charge Nurse, stated the process for referrals was to send to the referral to medical records for completion. Staff E stated they were unaware of Staff GG notes dated 03/01/2024, for Resident 48's ordered wound vac that was confirmed by nursing management. Additionally, Staff E stated they were aware of the order placed for the surgical consultation referral on 04/25/2024 but did not follow-up and was unsure of the outcome of the referral. 31168 <Resident 108> Review of the medical record showed the resident resided at the facility for many years. Resident 108's last readmission was 07/01/2024, with diagnoses including dementia (cognitive impairment), heart disease, kidney disease, diabetes (when the body does not enough produce insulin-a hormone that regulates blood sugar), and pressure ulcers to the resident's left heel and left great toe with ongoing cellulitis (bacterial infection of the skin layers) to their left heel/foot. The 07/04/2024 comprehensive assessment showed that Resident 108 was cognitively impaired but could make their needs known, such as pain. Resident 108 required assistance to transfer to and from different areas, such bed to wheelchair, bathing, oral care and personal hygienic care. During an observation and concurrent interview on 07/16/2024 at 9:50 AM, Resident 108 was in bed and watching television. Their left foot had a dressing over it and the foot was elevated on a pillow. The resident stated they were sleepy and wanted to take a nap. During an observation on 07/17/2024 at 9:02 AM, Staff Q, during a wound dressing change, removed the old dressing on the resident's left heel. The resident's left heel PU wound bed was white in color (could not visualize the wound bed). Additionally, the skin that surrounded the wound was red with extremely dry with flakey skin. The treatment was applied, and the dressing covered the left heel PU. Staff Q then cleansed the resident's scabbed left great toe and applied the treatment. Staff Q stated that the resident's pressure ulcer to the left great toe had gotten worse and had not improved. During an observation on 07/17/2024 at 9:27 AM, Resident 108 complained of significant pain in their left heel. The resident became restless and moaning that their foot was cold and freezing. Staff Q went to the get Tylenol and gave it to the resident. Staff Q stated they did not pre-medicate the resident before the dressing change. Continuing the 07/17/2024 observation at 10:20 AM, Resident 108 was pleading and crying in pain in their left foot and for someone to help them. The Director of Nursing Services (DNS) was notified and obtained a physician's order for a narcotic pain reliever for the resident. During an interview on 07/17/2024 at 10:50 AM, Resident 108 stated the pain increased in intensity from intermittent to constant stabbing pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Odd Fellows Home	534 Boyer Avenue Walla Walla, WA 99362

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/17/2024 11:40 AM, Staff C, Assistant Director of Nursing Services (ADON), stated the resident had developed a left foot PU to their heel due to their shoes being too tight on their left heel and it rubbed against their heel. The resident was not to wear the shoes again, but the tight shoes were not removed from Resident 108's room and the resident continued to wear them. This was around the end of January 2024. The Resident Representative (RR) was notified of this, and the facility asked them to bring different shoes for Resident 108. The RR brought new shoes according to Staff C, but the new shoes were open toe shoes and rubbed against the large great toe, which caused another PU to the left great toe that had not improved. The left heel pressure ulcer and the left great toe pressure ulcer were acquired at the facility. Staff C stated the left great toe PU was discovered around 02/25/2024. Review of the 02/06/2024 interdisciplinary meeting notes, showed the resident developed a Stage 2 pressure ulcer on their left heel. Additionally, the 02/05/2024 and 02/06/2024 nurses progress note showed the RR was notified that Resident 108 needed larger sized shoes. Review of the 01/26/2024 Clinical Skin and Wound Evaluation (CSWE), showed identification of a Deep Tissue Injury [(DTI) - purple or maroon area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear] to the left heel. The 07/17/2024 CSWE showed the left heel was a Stage 2 PU. Additionally, the CSWE, dated March 26, 2024, showed the DTI to the left great toe. The 07/17/2024 showed Resident 108's left great toe PU had not improved. The updated care plan dated 07/08/2024 through 07/23/2024, showed the resident had acquired two PUs to the left foot, an unstageable PU to the left great toe, and a Stage 2 PU to the left heel. The resident's care plan goal was to have intact skin, free of redness, blisters, or discoloration by/through the review date. A Velcro boot to the left foot and air overlay for the mattress were added to the care plan. There were previously no identified PU on the care plan. There was a statement to use the preventative measures policy for checking feet for diabetes. Review of the 03/27/2024 wound nurse health status note showed the wounds to the left heel, left great toe, and the middle of the left foot was red/purple in color with swelling. There was suspected cellulitis (a bacterial infection of the skin that becomes red, swollen and painful) to the toe and an antibiotic was ordered for seven days. The resident had to change their shoes. Review of the 04/22/2024 nursing progress note showed wounds to Resident 108's left great toe and left heel since March 2024. They had progressively gotten worse to the point of needing further treatment that day. The resident had cellulitis and was sent to the emergency room for treatment. Review of a 07/11/2024 x-ray showed the resident's left foot had osteomyelitis (infection of the bone spreading from nearby tissue.) During an interview on 07/16/2024 at 9:40 AM, Staff B, Director of Nursing Services (DNS) stated Resident 108 had declined and saw a physician who recommended amputation of the left foot due to the decline. Staff B stated the resident's RR would probably not want Resident 108 to have that surgery. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/19/2024 08:26 AM Staff D, stated Resident 108's PU started on the heel due to the resident's tight shoes. The podiatrist (foot doctor) worked on the residents' foot and there were no preventative interventions to keep the shoes away from Resident 108 or from having the shoes placed on the resident's feet. The RR was the one who removed the shoes from the resident's room. The resident had edema (swelling) and continued to have edematous feet, which caused tightness of the shoes. The new shoes that were brought by the resident's RR were used and continued to be placed on the resident's feet, which resulted in the left great toe's skin break down and PU. 45117 <Resident 13> Review of the medical record showed Resident 13 was readmitted to the facility with diagnoses including Alzheimer's disease, dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), and weakness. The 04/29/2024 comprehensive assessment showed Resident 13 required substantial assistance of one to two staff members for ADLs and had a had a severely impaired cognition. Record review of a nursing progress note dated 06/22/2024, showed Resident 13 had two deep PU along their outer right foot, one slightly above their lateral (to the side of or away from the body) ankle and one along the outer middle of the right foot, with a red circle slightly below their pinky toe. The provider was notified and ordered float feet using pillows and monitor. Record review of a physician order dated 06/24/2024, showed Apply Opti-Foam (a foam dressing used to cover the wound and reduce friction) to right lateral foot on all three sites, every day shift, every three day(s) for wound care. During observations on 07/15/2024 at 10:10 AM, 07/16/2024 at 9:26 AM, 07/18/2024 at 2:03 PM, and 07/19/2024 at 10:30 AM, showed Resident 13 lying in bed on their right side with their right outer foot against the mattress. Their feet were not floated on pillows and there were no padded boots on their feet. A concurrent observation and interview on 07/16/2024 at 3:15 PM, showed Resident 13 sitting in their wheelchair in their room. Staff R, RN, removed the resident's sock from their right foot. There was a foam dressing on the outer middle right foot. There was no dressing on the outer right ankle or toe wounds. Staff R peeled back the foam dressing and exposed a dime size area on the outer middle right foot that had yellow slough and a small amount of drainage. The right ankle had a dime size reddened area, and a red area at the base of the right small toe. Staff R stated they tried to float the resident's feet on pillows or put the padded boots on, but the resident kicked them off. Staff R stated they had asked Staff D, Resident Care Manager, for a specialized air mattress several weeks ago but was unsure why the resident did not receive one. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of a skin and wound assessment dated [DATE], showed new wounds were identified as pressure, deep tissue injury, and facility acquired. The wound on the outer right foot measured 0.94 centimeters [(cm) a unit of measurement] long and 0.63 cm wide. The surrounding tissue was fragile with erythema (an abnormal redness of the skin) and pain/tenderness to the touch. There were additional areas of concern on the right ankle and outer base of the right small toe. There were no measurements of these additional wounds. The document showed there was no dressing applied to the wound area, and the residents' feet were to float on pillows. Review of a skin and wound assessment dated [DATE], showed the outer right foot wound measured 15 cm in length and 1.91 cm in width. The wound was described as a deep pressure sore with the middle open. The surrounding tissue was described as fragile with erythema. The document showed the deep pressure sores were painful to the touch. Treatment orders showed the primary dressing was foam and to float both feet with pillows. The progress was described as deteriorating. Review of a skin and wound assessment dated [DATE], showed the outer right foot wound had measured 13. 42 cm long and 1.3 cm wide. The wound was 80% slough with a light amount of exudate (fluid that leaks out of blood vessels into nearby tissues). The treatment included use of a foam dressing and float both feet using pillows. The progress was described as deteriorating. Review of a nursing progress note dated 06/22/2024, showed Resident 13 refused to float their feet on pillows and nursing staff placed their feet in padded boots for pressure relief. During an interview on 07/22/2024 at 11:22 AM, Staff D stated Resident 13 was non-compliant with the use of pillows and padded boots. Staff D stated an air mattress might help - they could probably use one. Staff D stated there were additional interventions that could have been implemented besides the pillows and padded boots. During an interview on 07/22/2024 at 2:05 PM, Staff C, stated the provider had reassessed the wound that day and were changing the treatment to a medicated ointment and gauze dressing. Staff C stated an air overlay mattress would be beneficial since Resident 13 was non-compliant with the pillow positioning or padded boots. Staff C stated if interventions for pressure relief were not working, they expected the staff to notify the physician and advocate for the resident for increased interventions. During an interview on 07/22/2024 at 3:17 PM, Staff B, DNS stated they would have expected nursing staff to report the concerns with non-compliance with the pressure relieving interventions. Reference: WAC 388-97-1060(3)(b) This is a recurring deficiency previously cited in the Statement of Deficiencies dated September 14, 2023.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31168 Based on observation, interview, and record review, the facility failed to provide the assessed level of supervision required to prevent avoidable accidents for 1 of 1 resident (Resident 54) reviewed for falls with injuries. Additionally, the facility failed to identify active smokers, and the level of supervision required to smoke safely, for 3 of 3 residents (Resident 214, 216, and 212) reviewed for smoking. Resident 54 experienced harm when they fell while using their front wheel walker with a right sided platform attachment (a support that attaches to the walker to support the forearm and shoulder) when walking to the bathroom unsupervised that resulted in a laceration above the right eyebrow and fractured right ribs. The failure to identify potential hazards and implement adequate supervision placed the residents at risk for falls, injury, and an unsafe living environment. Findings included . <Fall With Injury> Review of the policy titled Fall Prevention Program dated 09/05/2023, showed the facility was to ensure each resident would be assessed for fall risk and receive care services in accordance with their individualized level of risk to minimize their likelihood of falls. <Resident 54> Review of the medical record showed Resident 54 was admitted to the facility on [DATE] with diagnoses including osteopenia (a reduction of bone mass that causes brittle bones), therapy after a significant fall with multiple fractures of the right wrist, lower spine and the lower pelvic bone, thrombocytopenia (a low platelet count which can lead to excessive bleeding during an injury), high blood pressure and a urinary bladder infection. The 06/16/2024 comprehensive assessment showed the resident was impaired cognitively but able to voice their needs. The resident needed help/partial assistance with activities, such as directions on use of their walker. Resident 54 was impaired physically on one side due to a previous fracture and had unsteadiness when walking. The resident was frequently incontinent of bladder. During an observation and concurrent interview on 07/15/2024 at 9:00 AM, Resident 54 was lying in their bed moaning. The resident was curled up and complained of right upper side and back pain. There was a laceration over their right eyebrow and a Velcro wrist brace to their right wrist. The resident's head of the bed was up, and the resident's wheelchair was located by their bed within the resident's reach. The resident's walker was located on the other side of the resident's bedside table. The resident stated they had their walker by the bed and tried to get out of bed to go to the bathroom and fell . Review of the 06/12/2024 care plan showed Resident 54 required assistance with transfers, bed in a low position, hourly safety checks and a scheduled toileting program. The resident wore disposable briefs for dignity for bladder incontinence. The admission fall risk assessment dated [DATE], showed the resident was a moderate risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 07/01/2024 nurses progress notes, showed Resident 54 went to the emergency room (ER) for an unwitnessed fall and sustained a laceration over the right eyebrow, right hand, a bruise to the left knee and had returned to the facility. On 07/02/2024 the resident continued to complain of pain, and an x-ray was ordered. The results from the x-ray showed right rib fractures due to the 07/01/2024 fall. Review of the 07/01/2024 fall investigative report showed Staff L, Licensed Practical Nurse (LPN), entered Resident 54's room at 5:30 AM to give medications. Staff L observed the walker by the resident's bed with the bed control cord wrapped around the legs of the walker and the walker on its side on the floor. The resident was in bed on their side under a blanket. Staff L turned on the light in the room and saw blood on Resident 54's face and hands. The resident stated ouch when the nurse looked at the resident. The 07/01/2024 investigation showed the resident stated, after their fall, they placed themselves back in bed. The 07/01/2024 investigative report showed the last time the resident was observed was at 4:00 AM. Night staff had not heard or observed if the resident had fallen or was bleeding until Staff L entered the resident's room. The 07/01/2024 update to the care plan included a scheduled toileting program, a cue card placed on the resident's room which stated for Resident 54 to use their call light when needing assistance, and to continue safety checks. During an interview on 07/16/2024 at 11:40 AM, Staff P, Physical Therapy Assistant/Rehabilitation Director, stated the resident was on therapy for weakness and falls at home. Resident 54 was given a front wheeled walker with a platform attached to the right side of the walker for stability due to their fractured right wrist. Additionally, the resident had difficulty understanding how to use the platform on the walker to stabilize their right wrist and used poor judgement to safety in ambulation by not carefully walking purposefully, but hurried, and that was unsafe. Staff P continued to try to educate the resident on safety and not placing weight on right wrist, but it was not successful, and they discharged the resident from therapy. Nursing staff was notified. During an interview on 07/18/2024 at 8:58 AM, Staff O, Nursing Assistant (NA), stated Resident 54 had become weaker and now only used a wheelchair. Staff O stated when the resident was first admitted they used a walker and required assistance. Staff O stated that the resident needed more assistance after the fall on 07/01/2024. Additionally, Staff O stated that there was a conversation with the night NAs, and they assisted the resident to bed after the 07/01/2024 fall. During an interview on 07/19/2024 at 8:35 AM, Staff D, Resident Care Manager, (RCM), stated that Resident 54 was unsafe, used their walker in the room, did not wait for staff, and did not use their call light. There were two NAs on the east wing and two NAs on the west end at night, and it was hard to supervise due to the fact they were in two separate buildings. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/19/2024 at 9:02 AM Staff L, stated when they came to work on the morning of 07/01/2024, they went into the resident's room and found Resident 54 with blood on their face and arm. Staff L stated Resident 54 stated they fell on night shift while trying to use the walker to go by themselves to the bathroom. Resident 54 stated they did not use the call light and they usually did not use the call light. Resident 54 stated that the cord was wrapped around the bottom of their walker, and they tried to undo it and fell , hitting their head right above the eyebrow that caused a laceration, and then got back into bed. Staff L was asked if they observed the walker on its side on the floor with the bed cord wrapped around the legs of the walker. Staff L said they did not witness the placement of the walker and the cord around the legs of the walker, but just reported what the resident had stated. <Smoking Hazard> Review of a policy titled, Smoke Free Facility, dated 09/05/2023, showed smoking was prohibited in all areas of the facility and the facility grounds. Residents would be informed of the facility's smoke free policy during the pre-admission/admission process and would be required to sign acknowledgement of the policy upon admission. All residents would be asked about tobacco use during the admission process and those with a history of smoking would be further assessed to determine whether or not interventions were needed to help them cope with the smoke free policy. Review of an undated document titled, Memorandum of Understanding [([NAME]) a type of agreement between two parties that defines how each party will work together and lays out expectations and understandings] Regarding Smoking Policy for Residents at the [NAME] Odd fell ows Home, showed smoking was not permitted anywhere on the premises. Cigarettes and lighters must be stored in a designated locked area when not in use. A risk/benefit form would be completed by a facility team member. A smoking assessment would be completed by a team member. <Resident 214> Review of the medical record showed Resident 214 was admitted to the facility on [DATE] with diagnoses including a urinary tract infection, kidney failure, and psychoactive substance dependence (a strong desire or compulsion to take/use alcohol, caffeine, nicotine, marijuana, and certain pain medications). Resident 214 was able to make their needs known. An observation on 07/15/2024 at 3:45 PM, showed Staff V, NA, escort Resident 214 outside to smoke, off facility property. Resident 214 was observed sitting on their front wheeled walker, with cigarette ash falling onto their sweatpants. When Resident 214 completed their cigarette, they asked Staff V where to put the butt. Staff V stated they would have to throw it away when they returned to the building. Staff V escorted Resident 214 back to the building and waited for facility staff to open the locked door. Resident 214 and Staff V entered the building, Staff V walked towards the left upon entering and Resident 214 walked to their room to the right. During an interview on 07/15/2024 at 4:24 PM, Resident 214 stated Staff V had taken the extinguished cigarette butt, placed it in a glove, and threw it in the trash. Resident 214 stated they had their cigarettes and lighter in their pocket and had planned on smoking while at the facility. Resident 214 stated a man that works here took me out earlier today to smoke. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/15/2024 at 4:26 PM, Staff V stated they took the cigarette butt from Resident 214 and wrapped it in a glove, then threw it in the trash can (and pointed to a trash can at the NA charting station). Staff V asked, was that wrong? During an interview on 07/16/2024 at 9:29 AM, Resident 214 stated they did not know they could not smoke at the facility. They stated no one had asked to hold their cigarettes or lighter in a locked area for them. During an interview on 07/22/2024 at 10:45 AM, Staff D, RCM, stated the process for smoking included identifying current residents that smoked prior to admission. They stated they were aware that Resident 214 smoked cigarettes but did not know they were currently smoking. Staff D stated the facility policy disallowed for staff to escort residents outside to smoke. They stated they were not aware that Resident 214 had cigarettes and a lighter in their possession and had not asked that question on admission. They stated the process for securing cigarettes and lighters included placing them in a locked area until the resident was discharged for safety. Staff D stated my process should have been to ask if they had the cigarettes and lighter and discuss options. Review of the medical record showed an undated [NAME] for smoking had been completed with Resident 214. A smoking assessment was completed on 07/19/2024 at 4:06 PM, that showed Resident 214 required supervision while smoking and the facility needed to store the resident's lighter and cigarettes. <Resident 216> Review of the medical record showed Resident 216 was admitted to the facility on [DATE] with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection), anxiety disorder, and tobacco use. The resident was able to make their needs known. During an observation and interview on 07/17/2024 at 2:05 PM, Resident 214 was observed standing in the doorway of their room with their walker and a cigarette and a lighter in their right hand. Resident 214 stated before that nurse comes back, I am going to sneak outside to smoke - before the alarm goes off. Resident 214 walked to the exit door at the end of the hall near room [ROOM NUMBER], placed the unlit cigarette in their mouth, pushed random buttons on the security keypad and waited for the door lock to release. They walked out of the facility with the cigarette in their mouth, lit the cigarette, and proceeded to smoke outside the facility door. Facility staff responded to the alarming door, Staff W, NA, silenced the alarm, observed Resident 214 outside smoking, and walked away from the door, without addressing the resident or smoking. Resident 214 finished smoking and was escorted back into the building by Staff C. During an interview on 07/17/2024 at 2:34 PM, Staff N, Registered Nurse, (RN), stated they were aware that Resident 214 was going outside to smoke. They stated Resident 214 was okay to smoke outside with family but was not told that they had to go off property. Staff N stated the facility was not storing the resident's cigarettes or lighter. Review of the medical record showed a smoking assessment was completed on 07/19/2024 at 4:13 PM, two days after Resident 214 was observed smoking independently on facility property. The assessment showed the resident required supervision for smoking, and the facility needed to store their cigarettes and lighter. There was an undated [NAME] for smoking in the record signed by the resident and Staff H. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/22/2024 at 11:03 AM, Staff D stated they were not aware that Resident 214 was actively smoking until they received that information during shift hand-off report. Staff D stated they allowed the resident to go outside several times on their shift and observed them going beyond the facility sidewalk. Staff D stated they did not know if Resident 214 had been assessed for safe smoking or if an assessment had been done to allow them to be outside alone. Staff D stated they were not aware that Resident 214 had cigarettes and a lighter. Staff D stated they should have looked at assessing for safety, ambulation, and the resident's cognitive status to ensure they were safe to smoke alone. During an interview on 07/19/2024 at 11:55 AM, Staff C, Assistant Director of Nursing Services (ADON), stated the process was to screen for smoking status during the referral process. They stated Resident 214, and Resident 216 snuck by. Staff C stated they could not have staff escort residents off property to smoke and there was no process in place to secure cigarettes and lighters for residents. <Resident 212> Review of the medical record showed Resident 212 was admitted to the facility 07/12/2024 with diagnoses including schizophrenia (a chronic brain disorder that causes delusions, hallucinations, disorganized speech, trouble thinking, and lack of motivation) and major depressive disorder. Resident 212 was able to make their needs known. During an observation on 07/22/2024 at 12:21 PM, Resident 212 approached Staff N at the medication cart and requested their cigarettes and lighter so they could go outside to smoke. Staff N stated they did not have them. During an interview on 07/22/2024 at 12:37 PM, Resident 212 stated the facility took their cigarettes on 07/21/2024. Resident 212 stated they went out on 07/21/2024 to smoke, and when returning to the facility, the staff stated they needed to take their cigarettes and lighter per state policy. Resident 212 stated they understood that they could not smoke on facility property and had not. They stated staff told them they could have their cigarettes whenever they wanted, but that had not happened yet. Resident 212 stated if they knew they would not have access to their cigarettes, they would not have allowed the facility to take them. Review of the medical record showed an undated [NAME] signed by the resident and Staff H, Executive [NAME] President of Marketing. A smoking assessment dated [DATE] at 1:16 PM, showed the resident did not need supervision for smoking and the facility did not need to store the resident's cigarettes or lighter. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 07/22/2024 at 3:33 PM, Staff H, stated when they reviewed the resident record before admissions, and read they were actively smoking, they let the hospital case managers know that the resident could not smoke in the facility. They stated they did not always look at the case managers notes prior to the residents arriving to the facility to ensure the non-smoking information had been discussed. They stated they reviewed the non-smoking policy during the admission process but did not know Residents 214 and 212 were actively smoking. They stated they were aware that Resident 216 was currently smoking. Staff H stated their process included reviewing the smoking policy and ensuring residents signed the [NAME] regarding smoking. They stated they informed the residents that their cigarettes and lighters would be placed in a locked cabinet and had placed Resident 216's items in a locked cabinet with the resident present. Staff H stated they had notified facility staff of Resident 214's and 216's smoking status after completing the admission paperwork and [NAME]'s. During an interview on 07/23/2024 at 8:17 AM, Staff A, Administrator, stated the facility staff needed to come together as a team to formulate a process for residents that smoke, that included completing the [NAME], the assessment, and communicating the policy to the resident, their representative, and the staff. Reference: WAC 388-97-1060(3)(g) This is a recurring deficiency previously cited in the Statement of Deficiencies dated September 14, 2023. 45117

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on observation, interview, and record review the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care and services in accordance with professional standards of practice for 1 of 1 resident (Resident 23) reviewed for mood and behavior. This failed practice placed residents at risk for unidentified triggers, re-traumatization and unmet care needs. Findings included . <Resident 23> Review of the medical record showed Resident 23 was admitted to the facility on [DATE] with diagnoses including stroke, depression, psychoactive substance abuse (an intense focus or addition to use mind-altering chemical substance such as alcohol, tobacco and/or illicit drugs that alters mood, perceptions, consciousness and cognition), and severe dementia with mood disturbance (a progressive disease that causes memory loss, confusion, sadness, anxiety, and delusions). The 6/14/2024 admission assessment showed Resident 23 was dependent on two staff members for activities of daily living (ADLs) and had moderately impaired cognition. Review of Resident 23's provider notes, dated 07/08/2024, showed the provider was notified to refer the resident for a psychological evaluation and would have like the staff social worker to assess the resident. Additional review of the medical record showed no psychological evaluation or staff social worker assessment was completed. Review of Resident 23's Trauma Informed Care assessment, dated 06/17/2024, showed the resident had no traumatic events in their past that continued to bother them or any causes for distress. The residents answer for when they did experience distress was, they could help themselves. The assessment showed an answer of yes for evidence of trauma for the resident with additional information including trauma from stroke and would often punch their left arm as it would not function well. Review of Resident 23's June 2024 Medication Administration Record (MAR) showed the resident was prescribed a medication for depression to be administered once daily. The MAR for June 2024 showed there were no missed doses. During an observation and interview on 07/15/2024 at 10:51 AM, Resident 23 was in their darkened room, no lights on, window shade pulled down, and lying in their bed. Resident 23 stated their entire life had been traumatic. They stated they were raised in an abusive household. Resident 23 stated they had been an alcoholic their whole life. During the interview Resident 23 began to cry and pull their blanket up to their face. Resident 23 stated they did not want any assistance at the time of the interview and were going to rest. During an observation and interview on 07/16/2024 at 11:47 AM, Resident 23 was lying in their bed, room was dark, window shades closed. Resident 23 stated why would I open the shade? I have nothing to look at, might as well stay in the dark, I have no reason to get up. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 07/18/2024 at 11:09 AM, Staff E, Charge Nurse, stated they completed admission assessments when residents arrived at the facility. Staff E stated they did not perform any trauma assessments for residents even when a resident had a diagnosis of depression or any trauma history. Staff E stated the facility did not have any mental health services for residents. An interview on 07/22/2024 at 11:46 AM, Resident 23 stated that their family problems and their overall life was very upsetting to them. Resident 23 stated they were unsure if they would speak to someone about their trauma as nobody had ever tried. An interview on 07/22/2024 at 1:45 PM, Staff B, Director of Nursing Services, stated they had been completing the Trauma Informed Care (TIC) assessments for residents. Staff B stated they asked the questions on the TIC, and they may have done the assessment incorrectly as they did not review or inquire about the resident's history. Reference WAC: 388-97-1060(3)(e)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45117 Based on observation, interview, and record review, the facility failed to ensure Staff AA, Licensed Practice Nurse (LPN), had the specific competencies and skill sets, which included documented demonstration, necessary to safely and efficiently perform care for residents' needs for intravenous [(IV) a soft, flexible tube placed inside a vein, usually in the hand or arm] medication administration for 1 of 2 residents (Resident 208) through a Peripherally Inserted Central Catheter [(PICC) - a thin, soft tube that is inserted into a vein in the arm, leg, or neck for long-term administration of antibiotics, medications, nutrition, and blood draws] line. This failure placed residents at risk for adverse outcomes related to medication administration and unmet care needs. Findings included . Review of the policy, Medication Administration, dated 02/14/2024, showed medications were administered by licensed nurses, who were legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. <Resident 208> Review of the medical record showed Resident 208 was admitted to the facility with diagnoses including metabolic encephalopathy (a series of brain dysfunctions caused by illness), kidney failure, and anemia (a condition in which the blood doesn't' have enough healthy red blood cells to carry oxygen throughout the body). Resident 208 was alert and able to make their needs known. Review of a physician order dated 07/09/2024, showed administer two grams (unit of measure) of cefazolin sodium intravenous solution (an antibiotic used to treat or prevent serious bacterial infections) for Methicillin-susceptible Staphylococcus aureus bacteria, [(MSSA) an infection caused by bacteria that may be responsive to certain antibiotics], every eight hours, over 30 minutes for eight days. Record review of Resident 208's July 2024 Medication Administration Record documentation showed on 07/17/2024, the 6:00 AM dose of IV medication was not administered. Record review of nursing progress notes dated 07/17/2024 at 6:39 AM, showed Staff AA, Licensed Practical Nurse (LPN), documented LPN nurse not certified to give IV meds. During an interview on 07/28/2024 at 11:08 AM, Staff AA stated they had obtained their LPN licensure in another state and was not certified to administer IV medication s in Washington State. Staff AA stated the facility had not completed competencies with them to ensure they were able to administer the medication. Record review of Staff AA's personnel file showed there were no nursing competencies completed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/18/2024 at 3:24 PM, Staff B, Director of Nursing Services (DNS), stated they were not aware that Staff AA was not certified for administering IV medications. Staff B stated they would have expected the nurse to notify the facility that they were unable to perform the task. During an interview on 07/22/2024 at 12:57 PM, Staff F, Staff Development/Staff Coordinator, stated LPN's that were not IV certified did not care for residents that had IV's. They stated Staff AA was not in a class for certification and should not be doing IV's. During an interview on 07/23/2024 at 8:22 AM, Staff A, Administrator, stated they expected the LPN staff to inform the RN on duty that they were unable to administer the IV medication. They stated Staff AA should have notified the Assistant Director of Nursing Services and the DNS that the medication was not administered. Staff A stated the provider should also have been notified. Reference: WAC 388-97-1080(1)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on interview and record review, the facility failed to provide medically related social services (SS) that met the needs of residents in the areas of Notice of Medicare Non-Coverage (NOMNC- a required notice to Medicare beneficiaries to inform them when their Medicare covered services were ending, and of their right to appeal) for 1 of 3 residents (Resident 215). The facility failed to provide Advanced Beneficiary Notices (ABN- a notice to Medicare beneficiaries informing them of the cost of continued Medicare covered services and services that may not be covered) for 3 of 3 residents (Residents 50, 52 and 215). In the area of Pre-Admission Screening and Resident Review (PASARR, a required assessment prior to admission to a nursing facility to ensure mental illnesses are identified so appropriate treatments and resources are available) for 4 of 6 residents (Residents 6, 11, 210 and 43). Additionally, in the area of discharge planning for 2 of 3 residents (Residents 208 and 38). These identified failures related to the lack of (SS) placed residents at risk for not attaining their highest practicable level of well-being. Findings included . Record review of an undated Social Worker Job Description, showed responsibility to identify the need for medically related SS was provided in accordance with state and federal regulations . <F-582 Medicare/Medicaid Coverage Liability Notice> The facility did not provide the required notification NOMNC's or ABN's which disallowed the resident the right to make informed decisions about their Medicare covered services. <Resident 215> Review of Resident 215's medical record showed their Medicare skilled services began on 01/10/2024 and their last covered day was 01/22/2024. Resident 215 had not been issued a NOMNC in the required time frame, despite the requirement to provide at least two days' notice prior to discontinuation of coverage. Additionally, there was no documentation that an ABN had been provided. <Resident 50> Record review of Resident 50's medical record showed their primary payer source was Medicare which started on 04/06/2024 and their last covered day was 05/03/2024. A NOMNC was issued to the resident on 04/30/2024, however, there was no issuance of an ABN to identify the cost of out-of-pocket expenses for continued Medicare coverage and services that may not have been covered. <Resident 52> Review of the medical record showed Resident 52 was admitted to the facility on [DATE]. Further review showed their Medicare began on 04/26/2024, and their last covered day was 06/14/2024. A ABN was not issued prior to their last covered day of Medicare benefits. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/22/2024 at 1:39 AM, Staff C, Assistant Director of Nursing Services, stated NOMNCs and ABNs were typically completed by the SS department. <F-645 PASARR Assessment> The facility did not ensure accuracy of PASARR assessments prior to admission to the facility. This placed the identified residents at risk for not obtaining treatment and services for their mental health needs. <Resident 6> Record review showed the resident was admitted to the facility with diagnoses including major depression and delusional disorder (a disorder that involves altered thinking and reality). The PASARR assessment dated [DATE] did not accurately identify Resident 6's mental health diagnoses. <Resident 11> Record review showed Resident 11 was admitted with a mental health diagnosis of dementia with agitation and behavioral disturbances (a decline of cognitive abilities with symptoms such as anxiety, psychosis, agitation, aggression, and sleep disturbances). Review of the PASARR assessment dated [DATE] did not accurately identify the resident's dementia diagnosis. <Resident 210> Review of Resident 210's medical record showed they were admitted with a diagnosis of depression and anxiety. Review of the PASARR assessment dated [DATE] did not accurately identify the resident's mental health diagnoses of depression and anxiety. <Resident 43> Review of the Resident 43's medical record showed they were admitted with diagnoses including depression and dementia. Review of the PASARR dated 06/11/2024 did not reflect the residents diagnoses of depression or dementia. During a concurrent interview on 07/22/2024 at 12:10 PM, Staff A, Administrator and Staff B, Director of Nursing Services, stated they currently did not have SS Staff to monitor and ensure the accuracy of PASARR assessments. <F-660 Discharge Planning> The facility failed to provide services for appropriate discharge with residents and/or their representatives prior to discharge back to the community. <Resident 208> Review of the medical record showed Resident 208 was admitted with diagnoses including metabolic encephalopathy (a series of brain dysfunction caused by illness) and depression. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Discharge Planning Review form dated 07/09/2024, showed the anticipated length of stay as N/A (not applicable), the resident lived alone, and had no family or support network to provide assistance post-discharge. During an interview on 07/17/2024 at 10:45 AM, Resident 208's representative stated they had done all of the initiation for discharge. The representative stated no one at the facility had assisted them with any of the discharge planning process. During an interview on 07/17/2024 at 11:15 AM, Staff E, Charge Nurse, stated there were no discussions regarding discharge planning and stated SS was responsible for driving the discharge process. Staff E stated the process for discharge was difficult. <Resident 38> Review of the medical record showed Resident 38 was admitted to the facility with diagnoses including congestive heart failure (a long-term condition in which your heart can't pump blood well enough to meet the body's needs) and high blood pressure. Record review of a Discharge Planning Review form dated 06/18/2024, showed the anticipated length of stay for Resident 38 was unclear possibly long term and treatment/care needs included an in home caregiver. The form did not identify specific goals or needs prior to discharge home. During an interview on 07/15/2024 at 1:15 PM, Resident 38 stated they would like to go home. They stated no one at the facility had discussed the option of going home with them. During an interview on 07/17/2024 at 1:11 PM, Resident 38's representative (RR) stated they had not been contacted regarding the discharge prior to that morning (07/17/2024). The RR stated they did not know if Resident 38 had been offered other options for discharge. During an interview on 07/17/2024 at 11:33 AM, Staff B, Director of Nursing Services (DNS) stated the discharge process started upon admission to the facility and SS was responsible to start the process, however the facility did not have a SS person right now. Reference WAC 388-97-0960(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review the facility failed to ensure 2 of 2 medication storage rooms (East Hall and [NAME] Hall) was free from expired medications. This failed practice placed the residents at risk for receiving expired medication and/or experiencing compromised or ineffective medications. Findings included . Review of the policy titled, Medication Administration, dated 02/14/2024, showed staff were to identify medication expiration dates and notify the nurse manager. During a concurrent observation and interview on 07/18/2024 at 9:29 AM, the [NAME] Hall medication storage room refrigerator contained four COVID-19 [an infectious disease causing respiratory illness with symptoms including cough, fever, new or worsening malaise (a general feeling of discomfort/uneasiness), headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death] vaccinations that had expired on 04/07/2024. Staff N, Registered Nurse (RN), observed the label on the vaccinations and stated nursing staff should be looking at the expiration dates on medications . During an observation on 07/19/2024 at 9:08 AM with Staff B, Director of Nursing Services, the East Hall medication storage room contained the following expired items: 19 povidone iodine swab sticks (cleaning agent to prevent infection), expired 10/2023 Five Pure and Gentle saline enemas, expired 11/2023 One glucagon emergency kit for low blood sugar, expired 01/02/2024; One box of [NAME] Flextend 500ml (a unit of measure) fecal collector bags (six bags), expired 08/2014. One medication card of omeprazole DR (a medication used to treat heartburn) 20 mg (a unit of measure) capsules, 11 capsules remaining, expired 03/31/2024; One medication card of Methenamine Hippurate (an antibiotic medication used to prevent and control urinary tract infections) 1 gram (a unit of measure), 10 pills remaining, expired 11/15/2023, a second card of the same medication with 29 pills remaining, expired 05/13/2029. During an interview on 07/23/2024 at 8:17 AM, Staff A, Administrator, stated the night shift RN was responsible for checking for expired medications and supplies. They stated their expectation would be for the nurses to remove those expired medications. Reference: WAC 388-97-1300 (1)(b)(ii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31168 Based on observation, interview, and record review the facility failed to maintain cleanliness of the kitchen environment to ensure food was stored, prepared and served under sanitary conditions for 1 of 1 kitchen and I of 3 ice machines reviewed for food safety. These failures placed residents at risk for potential food borne illness. Findings included . During an observation and concurrent interview on 07/15/2024 at 8:56 AM, Staff Z, Dietary Manager, opened the janitors closet in the kitchen that contained a mop and bucket filled with chemicals (cleaning and disinfectants) were stored. Staff Z switched on the ventilation fan in the closet and showed the ventilation fan was not operational as it did not ventilate (no exhaust suction from the fan when a paper towel was placed against the vent) the room that had a chemical odor. Staff Z stated they were not aware the ventilation fan was not functioning properly. During an observation on 07/15/2024 at 9:15 AM, showed there were two mounted portable air conditioners (AC) on the upper wall with dirt (dark grime) and the AC vents located on the top of the AC's were dusty. One AC was located over a sink in the food preparation room. The second AC was located over another food preparation area that had a variety of food mixers. The second AC was dirty (dark grime) with accumulation of dust around the AC and top vents. During an observation on 07/15/2024 at 9:30 AM, showed two mounted large black fans on the wall and was blowing air over a food preparation area and the stove serve out area. The fans had accumulated dust and grime on the fan blades and grill cover encasements that held the fan blades and fan motor together. An observation on 07/15/2024 at 9:40 AM, showed the floor in the dry goods room was dirty with a black substance along the baseboards of the flooring along with dirt and sand along the same areas of the baseboards. During an observation on 07/15/2024 at 10:00 AM, showed a storage shelf of kitchen utensils including a silver aluminum tray with tong storage had food crumbs at the bottom of the tray and a white plastic container with gravy/soup ladles with food crumbs in the container. There was food (raisin bread slices) and an open bene-protein powder container with a pitcher on a serving tray with dirt and food crumbs on the tray. An observation on 07/15/2024 at 11:33 AM, showed an ice machine located in the East dining service area had a yellowish slime on the metal plate located inside the ice machine. During an interview and record review on 07/15/2024 at 1:30 PM, Staff Z stated maintenance and dietary staff shared cleaning the fans and air conditioners in the kitchen. Staff Z stated the dietary staff were assigned to clean the kitchen floors by sweeping and mopping daily. The Daily Kitchen Form was signed off daily the last completed task entered was on 07/14/2024. There was no task indicated for the kitchen staff to clean the AC's or the fans in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/16/2024 at 11:45 AM, Staff BB, Director of Environmental Services, stated the ice machines were on a cleaning schedule of every three months. The last cleaning task completion was 05/31/2024. Staff BB was shown the yellowish slime located in the east dining service area. Staff BB stated that the east ice machine was not clean and needed to be serviced. Reference WAC: 388-97-2980