STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505431	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bothell Health Care	707 - 228th Southwest Bothell, WA 98021

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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 - Few	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** 50891 Based on observation, interview, and record review, the facility failed to ensure staff provided care and services in a manner that maintained and promoted dignity while providing meal assistance for 1 of 2 residents (Resident 70), reviewed for meal observations. This failure placed the resident at risk for a diminished self-worth and overall well-being. Findings included . Review of the facility's undated document titled, Resident Handbook included the resident bill of rights which showed that residents had the right to be treated with respect and dignity. Resident 70 admitted to the facility on [DATE]. Observation and interview on 03/28/2025 at 1:00 PM, showed Staff Z, Certified Nursing Assistant (CNA) was standing while assisting Resident 70 with their lunch who was sitting in their wheelchair. Staff Z stated that they usually do not sit while they assisted residents with their meals. Staff Z stated that sitting when feeding a resident would be better because then the residents would not feel they are rushed. Staff Z further stated that they were trained to provide meal assistance for residents at eye level. Observation and interview on 03/31/2025 at 2:02 PM, Staff AA, CNA, showed Resident 70 in bed with their lunch in front of them. Further observation showed Staff AA standing next to Resident 70's bed while they assisted them with their meal. Staff AA stated they were standing while assisting Resident 70 with their meal because [Resident 70's] bed was too high. In an interview on 04/02/2025 at 4:12 PM, Staff B, Director of Nursing, stated that they expected staff to be seated next to the resident while assisting with their meals. In an interview on 04/02/2025 at 4:39 PM, Staff A, Administrator, stated that staff [Staff Z and Staff AA] should be seated and at eye level when assisting residents with their meals. Reference: (WAC) 388-97-0180(1)(2)(3)

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 50891 Based on interview and record review, the facility failed to inform the resident and/or their representative before administering psychotropic (mind altering) medications for 1 of 5 residents (Resident 34), reviewed for unnecessary medications. This failure placed the resident and/or their representative at risk of not being fully informed of the risks and benefits before making decisions about their medications. Findings included . Review of the facility's undated document titled, Admission Agreement, showed, Consent for Medical Treatment: The resident has the right to make health care decisions, including consenting to or refusing treatment. Review of the facility's undated document titled, Resident Handbook, showed, Residents have the right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Review of the psychiatric progress note dated 04/17/2024 showed Resident 34 had diagnoses of Parkinson's psychosis (symptom of losing touch with reality), delusions (fixed false belief about something), and visual hallucination (the experience of seeing, hearing, feeling, or smelling something that does not exist). Further review showed Resident 34 started on Nuplazid (an antipsychotic -mind altering) medication on 09/21/2023. Review of the Electronic Health Record (EHR) showed Resident 34 did not have consent for Nuplazid when it was initiated on 09/21/2023. Further review of the EHR showed Resident 34 had a consent for Nuplazid a year later dated 10/09/2024. In an interview and joint record review on 04/02/2025 at 3:28 PM with Staff E, Resident Care Manager, stated that Resident 34 was given the first dose of Nuplazid on 09/22/2023. A joint record review of Resident 34's EHR did not show consent for Nuplazid when it was initiated on 09/21/2023. Staff E stated that Resident 34 had a consent for Nuplazid dated 10/09/2024 and that there was no consent that was completed in 2023. Reference: (WAC) 388-97-0300(3)(a)(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on observation, interview, and record review, the facility failed to ensure residents were evaluated, assessed, received physician orders for self-medication administration, and educated to keep medications in a lockable storage for 4 of 15 residents (Residents 50, 7, 76 & 90), reviewed for self-medication administration. The failure to complete a self-administration of medication assessment and store medications in a lockable unit placed the residents at risk for medication errors, adverse reactions, and related complications. Findings included . Review of the facility's policy titled, Medication Storage, revised in May 2024, showed that this facility would ensure all medications housed on our premises would be stored in the medication rooms to ensure security. The general guidelines included all drugs and biologicals would be stored in locked compartments. RESIDENT 50 A review of Resident 50's April 2025 Medication Administration Record (MAR) showed they were admitted to the facility on [DATE] and had an order for albuterol sulfate (an inhaler used to open the airways to increase air flow to the lungs). The MAR did not include a self-medication order. An observation and interview on 03/31/2025 at 9:12 AM, showed Resident 50 had an albuterol inhaler sitting on the shelf next to the sink in the resident's room. Resident 50 stated that they used the inhaler every day. A joint record review and interview on 04/02/2025 at 8:54 AM with Staff E, Resident Care Manager (RCM), showed that Resident 50 did not have a self-administration assessment. Staff E stated that they did not find a self-administration medication assessment for Resident 50. RESIDENT 7 Review of Resident 7's physician orders, printed on 04/01/2025, showed there were orders for nine oral medications and three eye drop medications. Review of Resident 7's Self-Administration of Medications assessment dated [DATE] did not show an assessment for oral medications. An observation and interview on 03/27/2025 at 1:13 PM showed a medication organizer was on Resident 7's bedside table. It further showed that there were seven different pills in the medication organizer and there were three different bottles of prescription eye drops in Resident 7's nightstand drawer. Resident 7 stated that Staff E would be working with them [on learning on how to manage their own medications] in the morning. Resident 7 further stated that nightstand drawer remained unlocked. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another observation and interview on 04/02/2025 at 8:31 AM, showed Resident 7 was sitting up in their recliner with the bedside table in front of them and their medication organizer contained seven different pills and three different prescription eye drops on the bedside table. Resident 7 stated that they had taken [their] morning medications before eating [breakfast] and without supervision. In a joint record review and interview on 04/02/2025 at 8:40 AM with Staff E, did not show a self-medication assessment for Resident 7's oral medications. Staff E stated that residents on a self-medication plan store their medications in a locked drawer in their room. Staff E stated that getting a key for the locked drawer was optional and that Resident 7 did not have one. RESIDENT 76 In an observation and interview on 03/25/2025 at 3:15 PM showed a brown bottle with a handwritten label with Chinese characters was on the shelf in Resident 76's room and the bottle was half full of oblong shaped pills. Resident 76 stated that the pills from the bottle were Chinese herbs and would take them once in a while. Further observation showed a red box on the shelf by the sink, containing an opened tube of cream with Chinese characters written. Resident 76 stated that they used this cream to treat itching. In an interview and joint record review on 04/02/2025 at 8:40 AM, Staff E stated that they would complete a self-medication assessment for residents on the self-medication program. In a joint record review of Resident 76's EHR did not show a self-medication assessment was completed. Staff E stated that a self-medication assessment was not done. In a joint observation and interview on 04/02/2025 at 8:57 AM Staff E showed Resident 76 had a brown bottle of pills sitting on their shelf and a red box with a tube of cream in them. Staff E stated that Resident 76 was not on a self-medication administration program. RESIDENT 90 A review of Resident 90's March 2025 MAR showed they were admitted to the facility on [DATE]. Further review of the MAR did not include an order for the Afrin (brand name-treats nasal congestion) nasal spray and hydrocortisone cream (a topical cream that treats inflamed or itchy skin). In an observation on 03/26/2025 at 8:51 AM, showed a bottle of Afrin nasal spray on a shelf by the sink in Resident 90's room. Resident 90 stated they administered the nasal spray on their own. Further observation showed a half-used tube of hydrocortisone cream was observed on their nightstand. Resident 90 stated that they used hydrocortisone cream on their feet to treat itching. A review of Resident 90's EHR did not show a self-medication assessment or a physician's order for self-medication administration. In a joint record review and interview on 04/02/2025 at 3:18 PM with Staff E showed Resident 90 did not have a self-medication assessment or a physician's order for self-medication administration in their EHR. Staff E stated that they have not initiated a self-medication assessment with Resident 90. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/02/2024 at 4:12 PM, Staff B, Director of Nursing, stated their expectations included that residents on self-medication administration would start with a self-medication assessment and that their medications should be in a locked drawer. Reference: (WAC) 388-97-0440, 1060 (3)(k)(l)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 50891 Based on observation, interview, and record review, the facility failed to provide the website address of the Washington State Long-Term Care Ombudsman (an advocacy group for residents in a nursing home) on the posted contact information in 4 of 4 facility areas (100-Wing, 400-Wing, across the conference room, and the library), reviewed for residents' rights. This failure placed the residents at risk of not being able to report their concerns online to the State Long-Term Care Ombudsman. Findings included . Review of the facility's undated document titled, Admission Agreement, showed Residents had the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. Review of the facility's undated document titled, Resident Handbook, showed information and contact information for State and local advocacy organizations, including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program and the protection and advocacy system. Further review of the handbook showed that the resident has the right to receive notices in writing including addresses (mailing and email) of all pertinent State regulatory and informational agencies, such as Long-Term Care Ombudsman. Multiple observations on 03/31/2025 at 11:59 AM of the 400-Wing Nurses Station, on 04/20/2025 at 4:00 PM of the 100-Wing Nurses Station, at 4:02 PM of the hallway across the conference room, and at 4:04 PM of the library did not show the Long-Term Care Ombudsman information posted included the website address. In an interview on 04/02/2025 at 5:26 PM, Staff A, Administrator, stated that the ombudsman information posting did not include the website address. Reference: (WAC) 388-97-0300(7)(c)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care [a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so]) was obtained and completed for 1 of 3 residents (Resident 70), reviewed for advance directives. This failure placed the resident and/or their representative at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice. Findings included . Review of the facility's undated document titled, Admission Agreement, showed that Residents/Legal Representatives have been given written materials about resident's right to accept to or refuse medical treatments as provided by state law and has been informed of resident's right to formulate Advance Directives. Review of Resident 70's Social Service History & Initial assessment dated [DATE], showed Resident 70 made their own decisions with support from daughters when needed. It further showed the assessment did not indicate whether Resident 70 had a DPOA for health care or if they chose not to execute an Advance Directive document at that time. Review of Resident 70's comprehensive care plan printed on 03/30/2025, did not show an advance directive care plan. In an interview on 03/28/2025 at 8:51 AM Resident 70 stated that they had advance directive and that their relative was their DPOA. In a joint record review and interview on 03/28/2025 at 10:15 AM with Staff M, Social Services Assistant, did not show Resident 70 had an advance directive document in their Electronic Health Records (EHR). Staff M stated that they did not see Resident 70's advance directive or anyone listed as DPOA in their EHR. In an interview and joint record review on 03/28/2025 at 10:33 AM, Staff BB, Unit Manager, stated that a copy of resident's advance directive would be uploaded into the resident's EHR, and that they would keep a copy in the three-ring binder in the nursing station. Staff BB stated they did not find a copy of Resident 70's advance directive in a three-ring binder kept at the nursing station. In an interview and joint record review on 04/01/2025 at 1:07 PM, Staff N, Social Services Director, stated that the resident's advance directive would be obtained on admission and would be part of the Social Service Assessment. A joint record review with Staff N did not show Resident 70 had an advance directive document in their EHR. Staff N stated that Resident 70 did not have one [advance directive]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/02/2025 at 5:26 PM, Staff A, Administrator, stated that they expected residents to have them [advance directive]. Reference: (WAC) 388-97-0280(3)(c) (i-ii)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on interview and record review, the facility failed to issue Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNF ABN) and Notification of Medicare (federal health insurance program for people age 65 or older) Non-Coverage (NOMNC- a required form notifying the resident that their skilled services coverage was ending and would no longer be covered by their Medicare A benefits) at least two calendar days before the Medicare coverage ended for 2 of 3 residents (Resident 25 & 73), reviewed for beneficiary notification. These failures placed the residents and/or their representatives at risk of not being fully informed and losing their right to an appeals process. Findings included . Review of the facility's undated document titled, Resident Handbook, showed that the residents have the right to receive notices in writing. Further review of the document showed that the resident has the right to be informed about Medicare eligibility and coverage. Review of the undated NOMNC Form from the Centers for Medicare and Medicaid Services (CMS) -10123, showed the NOMNC must be delivered at least two calendar days before Medicare covered services end. Review of the SNF ABN Form CMS-10055, dated 2024, showed the SNF required to issue the SNF ABN to Medicare residents prior to providing services that Medicare may not cover. Further review of the document showed the SNF ABN provided information to the residents so that they could decide whether to get the care that may not be paid for by Medicare and assume financial responsibility. RESIDENT 25 Review of the SNF Beneficiary Notification Review form dated 04/02/2025 showed Resident 25 received Medicare Part A Skilled Services from 01/20/2025 to 02/22/2025. Further review of the document did not show that an ABN and/or a NOMNC were provided to Resident 25. There was no explanation written to explain why either one of these was not given. Review of Resident 25's Electronic Health Record (EHR) did not show documentation that an SNF ABN and/or a NOMNC were provided to Resident 25, two days before their last covered day. RESIDENT 73 Review of the face sheet printed on 03/25/2025, showed Resident 73 admitted to the facility on [DATE]. Review of the SNF Beneficiary Notification Review showed that Resident 73 received Medicare Part A skilled services from 11/14/2024 to 02/25/2025 and remained in the facility after skilled services ended. Further review of the document showed that SNF ABN was not issued to Resident 73. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 73's EHR did not show documentation that an SNF ABN was provided to Resident 73 two days before their last covered day. In an interview on 04/01/2025 at 2:15 PM, Staff M, Social Services Assistant, stated that the SNF ABN were not provided for Resident 25 and 73. Staff M further stated that NOMNC was not provided for Resident 25. In an interview on 04/02/2025 at 4:39 PM, Staff A, Administrator, stated that they expected Residents 25 and 73 to be provided with their SNF ABN and/or NOMNC before the end of their last day of Medicare Coverage. Reference: (WAC) 388-97-0300 (1)(e)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50891 Based on observation, interview, and record review, the facility failed to provide a homelike environment when residents were served their meals on trays for 2 of 2 residents (Residents 34 & 70) and signage of medical information were posted in residents' rooms for 2 of 15 residents (Residents 70 & 301), reviewed for homelike environment. These failures placed the residents at risk for a less than homelike environment and a diminished quality of life. Findings included . Review of the facility's undated document titled, Resident Handbook, showed that residents have a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. ROOM TRAYS In an observation on 3/27/2025 at 12:33 PM, showed Resident 34 was eating their lunch off a serving tray. In an observation on 03/31/2025 at 2:25 PM, showed Resident 70 was eating their lunch off a serving tray. In an interview on 03/28/2025 at 12:28 PM, Staff BB, Unit Coordinator, stated that they did not think leaving meals on the serving tray was homelike. Staff BB further stated that they remove the meals off the tray when serving in the dining room. In an interview on 04/02/2025 at 9:30 AM, Staff E, Resident Care Manager, stated that they leave meals on the tray when residents were served in their rooms. Staff E further stated, I don't think it makes a difference with or without the tray unless they had a preference. In an interview on 04/02/2025 at 4:12 PM, Staff B, Director of Nursing, stated that when they deliver room trays, they leave the meals on the tray. Staff B further stated that the meals are removed off the tray when they serve in the dining room. In an interview on 04/02/2025 at 4:39 PM, Staff A, Administrator, stated that they expected that resident room trays to be served on the trays and that meals served in the dining room would be removed off the trays. SIGNAGE RESIDENT 70 In an observation on 3/26/2025 at 4:07 PM, a sign that read, No blood pressure or lab draws on the right arm was posted behind Resident 70's bed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/28/2025 at 4:07 PM, Resident 70 stated that they would like the sign that was posted behind his bed to be removed since blood can be drawn on the left arm. RESIDENT 301 An observation and interview on 03/30/2025 at 3:03 PM, Resident 301 showed a sign behind their bed that reads, No BP [blood pressure]/IV [intravenous-in the vein] on L [left] arm. Resident 301 stated they did not know anything about it [the sign] then stated it was there because they had lymphedema (a condition that results in swelling of the leg or arm) and staff needed to know to avoid using Resident 301's left arm to check for their blood pressure. In an interview on 04/02/2025 at 9:30 AM, Staff E stated that the sign on the wall in residents' rooms make a good visual as in reminders for staff. When asked if the signs created a homelike environment, Staff E stated that they did not think it made a difference since the signs were short and sweet. In an interview on 04/02/2025 at 4:12 PM, Staff B stated that the signs were posted for safety and that residents were aware of the signage before they were implemented. Staff B further stated that residents would say whether they would like the sign to be posted or not. In an interview on 04/02/2025 at 4:39 PM, Staff A stated they did not feel the signs posted on the wall would take away from a homelike environment. Reference: (WAC) 388-97-0880

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to transmit the resident Minimum Data Set (MDS - an assessment tool) to the Centers for Medicare & Medicaid Service (CMS) within the required timeframe for 1 of 22 residents (Resident 69), reviewed for transmitting MDS assessments. This failure placed the residents at risk for unmet care needs and diminished quality of life. Findings included . Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.11, revised in October 2024, showed all Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications. For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. Review of the electronic health record showed Resident 69 was admitted to the facility on [DATE] and discharged on [DATE]. Review of Resident 69's discharge MDS dated [DATE] showed it was completed on 11/18/2024 and was not submitted/transmitted to the CMS. In a joint record review and interview on 03/28/2025 at 1:56 PM with Staff H, MDS Nurse, showed Resident 69's discharge MDS dated [DATE] was completed on 11/18/2025 and not transmitted/submitted. Staff H stated that the MDS was completed but not transmitted and it should have been. Staff H further stated that Resident 69's MDS should have been transmitted by 12/02/2024, 14 days after completion of the MDS. In an interview on 04/02/2025 at 11:45 AM, Staff B, Director of Nursing, stated they expected MDS to be completed and transmitted in a timely manner. Staff B further stated that Resident 69's discharge MDS should have been transmitted after completion. Reference: (WAC) 388-97-1000(5)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or related conditions are not inappropriately placed in nursing homes for long-term care) Level I form was completed accurately and Level II PASARR referrals were made for 2 of 5 residents (Residents 55 & 34), reviewed for PASARR screening. In addition, the facility failed to complete Level I PASARR screening form for an exempted hospital discharge resident who remained in the facility for more than 30 days for 1 of 5 residents (Resident 2). These failures placed the residents at risk of not receiving the appropriate care and services for their needs and/or lacking access to specialized services for individuals with identified mental health diagnoses or disabilities. Findings included . Review of the facility's policy titled, Resident Assessment - Coordination with PASARR Program, revised in September 2024, showed the facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy showed all applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with States's Medicaid rules for screening. The policy show A record of the prescreened shall be maintained in the resident's medical record. The policy further showed If a resident who was not screened due to an exception .and the resident remains in the facility longer than 30 days, the facility must screen the individual using the State's Level I screening process and refer a resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. RESIDENT 55 Review of the face sheet printed on 03/28/2025 showed Resident 55 initially admitted to the facility on [DATE] with diagnosis that included depression (feeling of loneliness, sadness). Further review of the face sheet showed Resident 55 had a diagnosis of delusional (fixed false belief about something) disorder on 02/19/2025. Review of Resident 55's Level I PASARR dated 08/24/2022, showed the diagnosis of depression was not marked in Section I (SMI/ID/RC). In a joint record review and interview on 04/01/2025 at 12:25 PM with Staff N, Social Services Director, showed the diagnosis of depression was not marked in Resident 55's Level I PASARR in Section I. A joint record review of Resident 55's face sheet showed the diagnosis of delusional disorder on 02/19/2025. Staff N stated that depression should have been marked in Resident 55's Level I PASARR in Section I. Staff N stated Resident 55's Level I PASARR should have been updated to reflect the new diagnosis of delusional disorder. Staff N further stated that Resident 55's Level I PASARR should have been correctly completed from the initial admission, updated to reflect the new diagnosis, and followed by a Level II PASARR referral. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/01/2025 at 2:17 PM, Staff A, Administrator, stated they expected the PASARR forms to be accurate. Staff A further stated that Resident 55's most current Level I PASARR form should have had a diagnosis of depression and delusional disorder marked in the SMI section and that it should have been sent to a PASARR level II evaluation upon completion. 50891 RESIDENT 34 Review of Resident 34's PASARR showed Level I was completed on 01/28/2022 and no referral for Level II was indicated. Review of the psychiatric progress note dated 04/17/2024 showed Resident 34 had diagnoses of Parkinson's (a movement disorder of the nervous system that worsens over time) psychosis (symptom of losing touch with reality), delusions, and visual hallucination (the experience of seeing, hearing, feeling, or smelling something that does not exist). It further showed Resident 34 started on Nuplazid (an antipsychotic [mind altering] medication used to treat hallucinations and delusions related to Parkinson's disease) on 09/21/2023. Review of Resident 34's Electronic Health Record (EHR) did not show a new Level I PASARR screening and referral for Level II were completed. In an interview and joint record review on 04/01/2025 at 2:15 PM, Staff M, Social Services Assistant, stated that upon admission, they would review the resident's PASARR, their diagnoses, and their medications to see if a PASARR Level II evaluation was needed. Staff M further stated that if Resident 34 was exhibiting new behaviors then they would do a referral for Level II evaluation. A joint record review of Resident 34's PASARR, Staff M stated that Resident 34 doesn't experience any hallucinations and did not think [Resident 34] would qualify for a PASARR Level II. Staff M further stated they did not complete a new Level I PASARR and referral for Level II evaluation for Resident 34. In an interview on 04/02/2025 at 4:39 PM, Staff A stated that Resident 34 did not have any suicidal ideations, therefore they did not expect to complete a new Level I PASARR with a Level II PASARR referral for Resident 34. 48298 RESIDENT 2 Resident 2 admitted to the facility on [DATE] with diagnoses that included affective mood disorder (affects a person's emotional state) and anxiety disorder (having excessive/persistent worry and fear). Review of Level I PASARR form dated 01/24/2025 showed Resident 2 had an exempted hospital discharge and had no Level I PASARR screening completed prior to admission to the facility. Review of Resident 2's Electronic Health Record (EHR-census) dated 03/31/2025 showed Resident 2 remained in the facility for 50 days from day of admission until Resident 2 was discharged to the hospital on 03/15/2025 and returned to the facility on [DATE]. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's EHR (documents) did not show a Level I PASARR screening was completed when Resident 2 had remained in the facility for more than 30 days. In an interview and joint record review on 03/31/2025 at 10:38 AM, Staff M, Social Services Assistant, stated that if a resident came with an exempted hospital discharge PASARR, they would send a fax to the PASARR coordinator and would inform them that a resident was expected to stay in the facility greater than 30 days. When asked, when do they determine that a resident would stay beyond 30 days in the facility, Staff M stated, Me and [Staff N] would usually talk about it, and we make sure to send the completed [Level I] PASARR screening before the 30th day. A joint record review of Resident 2's EHR did not show a Level I PASARR screening was completed prior to Resident 2's hospital discharged on [DATE]. Staff M stated that they had sent an email to the PASARR coordinator about it (Level I PASARR screening). In another interview on 04/01/2025 at 10:38 AM, Staff M stated that they had emailed the PASARR coordinator about Resident 2's Level I PASARR screening and referral for Level II PASARR. When asked for a copy of the correspondence to the PASARR coordinator, Staff M stated, I will check my files. At 3:38 PM, Staff M stated that there was no Level I PASARR screening completed and no PASARR level II referral sent to the PASARR coordinator prior to Resident 2's hospital discharged on [DATE]. In an interview on 04/01/2025 at 4:11 PM, Staff A stated that they expected Level I PASARR screening should have been done for [Resident 2] who remained more than 30 days in the facility and that if there was a need for a Level II then a referral should have been sent [to the PASARR Coordinator]. Reference: (WAC) 388-97-1975(1-5)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 47218 Based on observation, interview, and record review, the facility failed to ensure staff document medications in accordance with professional standards of practice for 3 of 10 residents (Residents 148, 28 & 8), failed to ensure medications were not handled with bare hands for 1 of 10 residents (Resident 2), and failed to ensure insulin (medication that works by lowering levels of sugar in the blood) pens were wiped with alcohol pads before use and the skin was pinched prior to insulin administration for 2 of 2 residents (Residents 20 & 19), reviewed for medication administrations. In addition, the facility failed to ensure feeding tube (enteral tube - a medical device used to provide nutrition to people who cannot obtain nutrition by mouth or need nutritional supplementation) was checked for placement or patency prior to administering medications for 1 of 1 resident (Resident 16). These failures placed the residents at risk for medication errors, unmet care needs and other negative outcomes. Findings included . Review of the facility's policy titled, Medication Administration, revised in May 2024, showed that medications were administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy further showed that medications were not to be touched with bare hands and that staff should sign the MAR after medications were administered. Review of the facility's policy titled, Insulin Pen, revised in May 2024, showed that the insulin pens' rubber seal should be wiped with an alcohol pad after the insulin pen cap was removed from the insulin pen and prior connecting the pen needle onto the insulin pen. The policy further showed to gently pinch up the skin at the injection site and hold, and to inject the needle straight at a 90-degree angle to the skin. Review of the facility's policy titled, Verifying Placement of Feeding Tube, revised in September 2024, showed, It is the practice of this facility to ensure proper placement of feeding tubes prior to beginning a feeding, flushing the tube, or before administering medications via feeding tube. The policy further showed, For gastrostomy [a flexible tube used for feeding] tubes, check that the enteral retention device is properly approximated to the abdominal wall by gently tugging on the tube and taking note of the marking on the tube . Check and record the length of the tube prior to feeding as per facility policy. Notify supervisor and/or practitioner if abnormal finding . If unable to confirm placement, notify supervisor and/or physician. Do not proceed with feeding, flush, or medication administration until tube placement is verified. SIGNING BEFORE MEDICATION ADMINISTRATION RESIDENT 148 Observation on 03/31/2025 at 9:31 AM, showed Staff L, Registered Nurse (RN), signed Resident 148's March 2025 Medication Administration Record (MAR) as given prior to administering their four medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 28 Observation on 03/31/2025 at 10:13 AM, showed Staff L had already signed Resident 28's MAR as given prior to administering their 11 medications. Staff L took a medication cup with medications in it from the medication cart and gave them to Resident 28. Staff L stated that Resident 28 was not in their room earlier that day when they tried to give their medications. RESIDENT 8 Observation on 03/31/2025 at 10:18 AM, showed Staff L had already signed Resident 8's MAR as given prior to administering their seven medications. Staff L took a medication cup with medications in it from the medication cart and a pain patch and took them to Resident 8. In an interview on 03/31/2025 at 10:37 AM, Staff L stated that they knew the residents usually took their medications and that was why they signed the MAR for Residents 148, 28 & 8 prior to administering their medications. Staff L further stated that they should have waited for Residents 148, 28 & 8 to take their medications prior to signing their MAR. In an interview on 04/02/2025 at 12:31 PM, Staff D, Resident Care Manager (RCM), stated they expected staff to sign the MAR after the medications were administered to the residents. Staff D further stated that Staff L should not have signed the MAR for Residents 148, 28 & 8 prior to administering their medications. TOUCHING MEDICATIONS WITH BARE HANDS Review of the March 2025 MAR showed Resident 148 had an order for Vitamin D (supplement) to take one tablet a day by mouth. Observation on 03/31/2025 at 9:39 AM, showed Staff L dropped one of Resident 2's Vitamin D tablet on the flat surface of the medication cart, Staff L then picked it up with bare hands and placed it in a medication cup. Observation further showed Resident 2 took their Vitamin D tablet. Staff L stated that they should have disposed the Vitamin D as they touched it with their bare hands. In an interview on 03/31/2025 at 12:31 PM, Staff D stated they expected medications to be disposed of if they fall on the medication cart surface. Staff D further stated that Staff L should not have touched Resident 2's Vitamin D with their bare hands and should have given Resident 2 a new Vitamin D tablet. INSULIN ADMINISTRATION RESIDENT 20 Review of the March 2025 MAR showed that Resident 20 had an order for insulin Lispro to be injected subcutaneously (placed under the skin) before lunch. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/28/2025 at 11:57 AM, showed Staff K, RN, prepared Resident 20's insulin dose. Staff K removed the cap from Resident 20's insulin pen, screwed a new insulin needle in, and administered it to Resident 20's abdominal (belly) area. Staff K did not clean Resident 20's insulin pen rubber seal prior to connecting the insulin pen needle and did not pinch their skin site prior to administering their insulin. RESIDENT 19 Review of the March 2025 MAR showed Resident 19 had an order for insulin Lispro to be injected subcutaneously before lunch. Observation on 03/28/2025 at 12:12 PM, showed Staff K prepared Resident 19's insulin dose. Staff K removed the cap from Resident 19's insulin pen, screwed a new insulin needle in, and administered it to Resident 19's abdominal area. Staff K did not clean Resident 19's insulin pen rubber seal prior to connecting the insulin pen needle and did not pinch their skin site prior to administering their insulin. In an interview on 03/28/2025 at 12:42 PM, Staff K stated that they did not clean the insulin pen rubber seals for Residents 20 & 19 and that they did not know if they should have. In an interview on 04/02/2025 at 12:02 PM, Staff D stated that they expected staff to clean the insulin pen rubber seals with alcohol wipes prior to attaching the needles. Staff D stated that Staff K should have cleaned the insulin pen rubber seals for Residents 20 & 19 with alcohol wipes prior to connecting the pen needles. Staff D further stated that Staff K should have pinched the skin site areas for Resident 20 & 19 prior to injecting their insulin. VERIFYING FEEDING TUBE PLACEMENT Observation and interview on 04/02/2025 at 8:43 AM, showed Staff G, RCM, was administering medications to Resident 16 via feeding tube. Staff G did not check the feeding tube for placement prior to administering Resident 16's medications. Staff G stated that they do not need to check for feeding tube placement prior to administering medications and that it was done by a staff who placed the feeding tube supplement. Staff G further stated that they did not check Resident 16's feeding tube placement prior to administering their medications. In an interview on 04/02/2025 at 2:40 PM, Staff C, Infection Preventionist, stated they expected staff to verify feeding tube placement by checking the mark on the feeding tube to make sure that the tube had not moved prior to administering medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/02/2025 at 3:01 PM, Staff B, Director of Nursing, stated they expected nurses to sign the MAR after administering medications to the residents. Staff B stated that Staff L should not have signed the MAR for Residents 148, 28 and 8 prior to administering their medications. Staff B stated they expected staff to wipe insulin pen rubber seals with alcohol wipes prior to attaching the needle and to pinch the resident's skin area prior to injecting insulin. Staff B stated that Staff K should have cleaned the insulin pen rubber seals with alcohol wipes prior to connecting the needle and should have pinched the skin areas for Residents 20 and 19 prior to injecting their insulin. Staff B stated they expected staff to check for feeding tube placement by checking the red mark on the feeding tube to make sure it has not moved. Staff B further stated that Staff G should have checked feeding tube placement for Resident 16. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on observation, interview, and record review, the facility failed to implement and/or provide activity plan for 1 of 1 resident (Resident 45), reviewed for activities. This failure placed the resident at risk of boredom, decreased mood, and a diminished quality of life. Findings included . Review of the facility's policy titled, Activities, revised in February 2025, showed, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Resident 45 was admitted to the facility on [DATE] with a diagnosis that included Dementia (a medical condition affecting memory, thinking and social abilities). Review of the quarterly Minimum Data Set (an assessment tool) dated 02/20/2025, showed Resident 45's preferred language was Mandarin (Chinese language) and activity preferences that included reading and keeping up with the news. Review of the activity care plan initiated on 12/28/2024, showed Resident 45 enjoyed independent activities that included reading and watching TV/ Chinese news programs. The activity care plan further showed that staff should offer opportunities for engagement that align with [their] cultural background and interests, providing access to Chinese-language media, reading materials . Observation on 03/27/2025 at 10:58 AM, showed Resident 45 on their wheelchair with their relative at bedside. It further showed Resident 45's TV was not on and there were no reading materials in Resident 45's room that were related to their Chinese culture or ethnicity. Observations on 03/28/2025 at 10:30 AM did not show Resident 45 had been offered or provided activities that aligned with their cultural background and interests. Another observation at 2:50 PM, showed Resident 45 was audibly speaking by themselves in their native language while looking out their window. It further showed Resident 45's TV was not on while their roommate's TV was on in an English-speaking channel with its volume audibly set. In an interview on 03/27/2025 at 10:59 AM, Resident 45's relative stated that they come every day at 10 in the morning up to 1 [one o'clock PM]. When asked if Resident 45 had been provided activities other than performing exercises in the rehabilitation gym, Resident 45's relative stated no. In an interview on 03/28/2025 at 12:47 PM, Staff Y, Certified Nursing Assistant, stated that they speak Mandarin and helped staff to communicate with Resident 45. When asked if they provided activities to Resident 45 that included Chinese reading materials or setting their TV on Chinese channel or programs, Staff Y stated, The family is always here every day. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 03/28/2025 at 4:02 PM, Staff P, Activity Director, stated they provided Resident 45 Mandarin newspaper from another resident in the facility and that was about two weeks ago. A joint record review of Resident 45's activity care plan showed Resident 45 enjoyed watching TV/Chinese news programs and it further showed intervention about providing access to Chinese-language media, reading materials . When asked if Resident 45 had been provided with activities as stated in their care plan, Staff P stated, The family is always there. Staff P further stated, To tell you I have not done it [providing activities to Resident 45] lately since this COVID [a respiratory infectious disease] thing. In an interview on 03/31/2025 at 3:47 PM, Staff A, Administrator, stated that they expected staff to have implemented their care plan and provided activities to Resident 45. Reference: (WAC) 388-97-0940(1)(2)

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F 0684 Level of Harm - Minimal harm or potential for 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** 48899 Based on interview and record review, the facility failed to ensure consistent communication and collaboration of care occurred between the facility and hospice care for 1 of 1 resident (Resident 15), reviewed for hospice services. This failure placed the resident at risk of not receiving the necessary hospice care services, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Coordination of Hospice Services, revised in September 2024, showed the facility will maintain communication with hospice and identify, communicate, follow, and document all interventions put into place by hospice and the facility. Review of the face sheet printed on 04/01/2025 showed Resident 15 admitted to the facility on [DATE]. Review of the hospice order dated 01/30/2025, showed that Resident 15's hospice referral was made. Review of Resident 15's medical records (electronic and paper charting) did not show documentation of hospice care visit notes. In an interview on 03/28/2025 at 12:44 PM, Staff X, Licensed Practical Nurse, stated that the hospice nurse communicated to them before or after meeting with Resident 15. Staff X stated that communication with hospice staff was mainly verbal or by phone. Staff X further stated they did not see the hospice visit notes for Resident 15 on their medical records. In an interview and joint record review on 03/28/2025 at 12:52 PM with Staff G, Resident Care Manager, stated that Resident 15 had been receiving hospice services since January 2025. A joint record review of the Electronic Health Record (EHR) showed no documentation of hospice visit notes. Staff G stated the hospice notes should have been uploaded into Resident 15's EHR. In an interview on 04/01/2025 at 1:33 PM, Staff B, Director of Nursing, stated that there was verbal communication between the facility and hospice agency staff. Staff B stated that there should have been both verbal and written communication to coordinate care between the facility and hospice. Staff B further stated that the hospice visit notes should have been uploaded to Resident 15's EHR and were made accessible for the facility staff. Reference: (WAC) 388-97-1060 (1)

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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** 48899 Based on interview and record review, the facility failed to ensure residents who were trauma survivors and diagnosed with Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event that was either experienced or witnessed) received trauma informed care, trigger assessment, and trauma-informed care assessment in accordance with professional standards of practice for 3 of 4 residents (Residents 8, 34 & 76), reviewed for mood/behavior. These failures placed residents at risk for unidentified triggers, re-traumatization, and a decreased quality of life. Findings included . Review of the facility's policy titled, Trauma Informed Care, revised in May 2024, showed that it was the policy of the facility to ensure residents who are trauma survivors received culturally competent, trauma informed care in accordance with professional standards of practice. The policy showed, Each resident will be screened for a history of trauma upon admission. The policy further stated that if the screening indicates that the resident has a history of trauma and/or trauma related symptoms, the facility will identify triggers which may re-traumatize residents with a history of trauma. RESIDENT 8 Review of the face sheet printed on 03/25/2025 showed Resident 8 admitted to the facility on [DATE] with a diagnosis that included PTSD. Review of the comprehensive care plan printed on 03/25/2025, showed no documentation that Resident 8 had history of trauma and/or identified triggers. During a joint record review and interview on 04/01/2025 at 12:25 PM with Staff N, Social Service Director, showed Resident 8's face sheet listed a diagnosis of PTSD. A joint record review of the trauma informed care assessment dated [DATE] showed Resident 8 had a history of PTSD. Staff N stated that if the resident's trauma assessment results showed positive for PTSD, the facility should assess triggers and include it in the resident's care plan. Staff N stated that Resident 8's trauma informed care assessment came positive for PTSD, the trigger assessment was not completed, and the care plan did not reflect what Resident 8's triggers were. Staff N stated that trauma triggers for Resident 8 should have been identified, their care plan should have been updated to incorporate strategies for managing PTSD and address the identified triggers. In an interview on 04/01/2025 at 2:17 PM, Staff A, Administrator, stated that their expectation was for trauma informed care assessment to be completed for any resident with the history of PTSD. Staff A further stated that if Resident 8 had a history of trauma, a trigger assessment should have been completed, and the care plan should have been developed to address it. 50891 RESIDENT 34 (continued on next page)

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	505431	A. Building B. Wing	04/02/2025

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Bothell Health Care	707 - 228th Southwest Bothell, WA 98021

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the psychiatric progress note dated 04/17/2024 showed Resident 34 had diagnoses of Parkinson's (a movement disorder of the nervous system that worsens over time) psychosis (symptom of losing touch with reality), delusions (fixed false belief about something), and visual hallucination (the experience of seeing, hearing, feeling, or smelling something that does not exist). It further review showed Resident 34 started on Nuplazid (an antipsychotic -mind altering) medication on 09/21/2023. In a joint record review and interview on 04/01/2025 at 2:15 PM with Staff M, Social Services Assistant, Resident 34's Electronic Health Record (EHR) did not show a trauma informed care assessment. Staff M stated that Resident 34 was a retired police officer [worked in law enforcement] and that there was no indication of PTSD. In an interview on 04/02/2025 at 4:39 PM, Staff A stated they could not find a Trauma Informed Care Assessment for Resident 34. RESIDENT 76 Review of care plan printed on 03/30/2025, showed Resident 76 had a diagnosis of malignant neoplasm of the frontal lobe (a cancerous tumor that can significantly affect brain function including behavioral and emotional changes). In an interview on 04/02/2025 at 8:37 AM, Staff N, Social Services Director, stated that they would complete a trauma informed consent care assessment for new residents and that if there has been a traumatic event, they would assess the need for mental health services. Staff N further stated that they had a conversation with Resident 76's relatives and that they did not have knowledge of past traumas for Resident 76. In a joint record review with Staff N, Resident 76's EHR did not show a record of a trauma informed care assessment. Staff N stated, I don't see one [trauma informed care assessment] here. In an interview on 04/02/2025 at 4:39 PM, Staff A stated that they expected the trauma informed care assessments done for the residents. Reference: (WAC) 388-97-1060(3)(e)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure adequate monitoring was conducted for use of anticoagulants (medication that prevent blood clot) for 2 of 5 residents (Residents 55 & 45), reviewed for unnecessary medications. This failure placed the residents at risk for receiving unnecessary medications, adverse side effects, and related complications. Findings included . Review of the facility's policy titled, Medication Monitoring, revised in January 2025, showed, the facility takes a collaborative, systemic approach to medication management, including the monitoring of medications for efficacy and adverse side consequences. The policy further showed licensed nurses with periodic oversight by nurse managers shall adhere to facility policies and current standards of practice for administration and monitoring of medications. RESIDENT 55 Review of the face sheet printed on 03/28/2025 showed Resident 55 initially admitted to the facility on [DATE]. Review of the January 2025 to March 2025 Medication Administration Record (MAR) showed Resident 55 had an order for apixaban (anticoagulant medication) 5 milligrams (mg-a unit of measurement) to be given twice a day to treat atrial fibrillation (A-Fib - an irregular and often very rapid heart rhythm). Review of the nursing progress notes from 01/07/2025 to 03/31/2025 did not show Resident 55's anticoagulant use was adequately monitored. In a joint record review and interview on 04/01/2025 at 9:15 AM with Staff G, Resident Care Manager (RCM), showed the January 2025 to March 2025 MAR did not show Resident 55 was being monitored for anticoagulant use. Staff G stated that residents on anticoagulant medication needed to be monitored for adverse side effects. Staff G further stated monitoring for adverse side effects of anticoagulant medication for Resident 55 should have been started when they started the medication. In an interview on 04/01/2025 at 1:57 PM, Staff B, Director of Nursing, stated that monitoring for side effects of anticoagulant medication use was required to ensure residents safety and appropriate intervention if complications arose. Staff B stated that Resident 55's anticoagulant side effects monitoring should have been started when it was first ordered by the physician. 48298 RESIDENT 45 Review of the physician progress note dated 12/09/2024 showed Resident 45 had apixaban five mg to be given twice a day for A-Fib. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of March 2025 MAR did not show Resident 45 was monitored for the anticoagulant use. In an interview on 03/31/2025 at 1:14 PM, Staff L, Registered Nurse, stated that they monitored residents for side effects of anticoagulant. When asked about Resident 45's monitoring for anticoagulant use, Staff L stated that Resident 45 was on apixaban. Staff L further stated, If we see symptoms then that's [that is] the only time we document. If we don't [do not] see anything then we don't [do not] chart. In an interview and joint record review on 03/31/2025 at 1:26 PM, Staff F, RCM, stated that they monitored residents on anticoagulant for its side effects. Staff F stated, We monitor for bleeding, bruising and we also monitor their stool. When asked how they monitored for side effects of anticoagulant, Staff F stated, there is a prompt that tells us to monitor and document. A joint record review of the March 2025 physician orders and MAR did not show Resident 45 was monitored for anticoagulant use. Staff F stated Resident 45 was not monitored for side effects of anticoagulant. In an interview and joint record review on 03/31/2025 at 2:15 PM, Staff B stated, Monitoring entails documentation. If it is not documented, it is not done. Staff B stated that they monitored residents for side effects of anticoagulant. A joint record review of the physician orders showed Resident 45 was on an anticoagulant and a physician order for anticoagulant side effects monitoring was started on 03/31/2025. Staff B stated that there had been an order for monitoring of side effects of anticoagulant but it was discontinued. Staff B further stated, there should have been continuous monitoring for side effects of anticoagulant for [Resident 45]. Reference: (WAC) 388-97-1060 (3)(k)(i)(4)

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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. 50891 Based on observation, interview, and record review, the facility failed to appropriately label and store drugs and/or biologicals (diverse group of medicines made from natural sources) for 1 of 2 refrigerators (Medication Storage A), reviewed for medication storage. This failure placed the residents at risk of receiving compromised and ineffective medications. Findings included . Review of the facility's policy titled, Medication Storage, revised in May 2024, showed that the facility would ensure all medications housed on the premises would be stored in the medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Review of the undated package insert document for Tubersol (tuberculin - purified protein derivative, is a combination of proteins that are used in the diagnosis of tuberculosis [a serious illness caused by a type of bacteria that mainly affects the lungs]) showed an open multi-dose vial of Tubersol which has been opened and in use for 30 days should be discarded. In a joint observation and interview on 04/01/2025 at 9:39 AM with Staff G, Resident Care Manager, showed the refrigerator in Medication Storage A had one multi-dose vial of tuberculin that was a quarter full. Further observation showed the multi-dose vial had no open date. Staff G stated that the tuberculin multi-dose vial had no open date and that it should have been discarded. In an interview on 04/01/2025 at 3:34 PM with Staff B, Director of Nursing, stated that when the multi-dose vial of tuberculin was not marked with the open date, then we cannot be certain of the date it was open. Reference: (WAC) 388-97-1300 (2)

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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. 48899 Based on observation, interview, and record review, the facility failed to ensure foods items were handled appropriately in accordance with professional standards of food safety for 1 of 3 refrigerators (Walk-In Refrigerator) and 1 of 1 Shelf (Shelf below steamer table), reviewed for food services. Additionally, the facility failed to ensure 1 of 5 kitchen staff (Staff W) was wearing a beard net. These failures placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Date Marking for Food Safety, revised in November 2022, showed, the facility adheres to a date marking system to ensure the safety of ready to eat time/temperature control for safety food. The policy further showed, the food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The marking system shall consist of the day/time of opening, and the day/time the item must be consumed or discarded. FOOD ITEMS IN THE WALK-IN REFRIGERATOR During a joint observation and interview on 03/25/2025 at 8:33 AM with Staff O, Dietary Manager, showed a half package of cheese with a use by date of 03/31/2025 without an open date, a package of provolone cheese with an open date of 03/18/2025 without a use by date, and an opened bag of iceberg lettuce that had brownish leaves. Staff O stated the iceberg lettuce was unusable, and it should have been discarded. Staff O further stated that a half package of cheese should have had an open date and the provolone cheese should have had a use by date. FOOD ITEMS ON THE SHELF BELOW THE STEAMER TABLE During a joint observation and interview on 03/31/2025 at 8:13 AM, Staff O showed a container of baking powder with an unreadable open date and with an expiration date of 03/26/2025, four jugs of opened honey and three -quarter bottle of red wine vinegar without open and/or use by date. Staff O stated the baking powder should have had a clear and readable open date. Staff O further stated the jugs of honey, and the red wine vinegar should have had an open and use by date. WEARING A BEARD NET IN THE KITCHEN During a joint observation and interview on 03/31/2025 at 8:13 AM with Staff O showed Staff W, Dishwasher, was washing dishes in the kitchen. Staff W was wearing a surgical mask that did not completely cover their beard. Staff O stated that the facility had no specific policy regarding beard net requirement and was unaware that wearing a beard net in the kitchen was required. In an interview on 04/01/2025 at 2:17 PM, Staff A, Administrator, stated that they expected the kitchen staff to regularly inspect food items, label and date them upon opening, and to discard unusable food items. Staff A stated that they expected the facility staff to wear beard nets if they have long beards. Staff A further stated Staff W should have worn a beard net. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1100 (3)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 48298 Based on interview and record review, the facility failed to ensure the facility assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) was updated to include and consider specific staffing needs for each resident unit/each shift and to identify contracts or agreements with third parties such as Hospice (specialized care for residents requiring comfort care) and Hemodialysis (treatment for residents whose kidneys are failing) services. These failures placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Facility Assessment, revised in May 2024, showed, The facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident competently during both day-to-day operation and emergencies. It also showed the facilities resources that included contracts, memorandums of understanding [MOUs], or other agreements with third parties to provide services . In an interview and joint record review on 04/02/2025 at 11:32 AM, Staff A, Administrator, stated they updated their facility assessment on 03/13/2025. Joint record review of the facility assessment showed no documentation about specific staffing needs for each resident unit/each shift and contract, MOUs or agreements with hospice and dialysis services. When asked about specific staffing needs for each resident unit, each shift (day, evening, night) and about facility's contract, MOUs or agreements with third parties, Staff A stated that they were not included in the facility assessment. No associated WAC

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47218 Based on observation, interview, and record review, the facility failed to ensure glucometer (device that measures the concentration of sugar in the blood) control testing reading numbers were documented accurately for 5 of 5 residents (Residents 20, 19, 92, 24 & 47), reviewed for resident records. This failure placed the residents at risk of medical complications, unmet care needs, and diminished quality of life. Findings included . Review of the facility's policy titled, Glucometer Cleaning, revised in April 2025, showed that glucometers should be cleaned after each use with Mycolio [brand name] disinfectant wipes. The document showed that glucometers and glucometer bins were cleaned weekly using Mycolio disinfectant wipes and that glucometer control testing was done in the EMAR [Electronic Medication Administration Record] by performing both low and high testing, comparing the readings to the range printed on the test strip bottle. Document (+) [plus] accurate reading (-) [minus] inaccurate reading, repeat the test, if still inaccurate, replace with a new glucometer. Further review of the document did not show the exact reading numbers for the low and high solution control test. RESIDENT 20 Review of January 2025 to March 2025 Medication Administration Record (MAR) showed an order for Glucometer Control Testing: perform both low and high testing every night shift. Compare reading to the range printed in the container. The document further showed Resident 20's January 2025 to March 2025 MAR had a check mark, which per the MAR meant administered, and did not show the exact reading numbers for low and high control testing of their glucometer. RESIDENT 19 Review of January 2025 to March 2025 MAR showed Resident 19 had orders for Glucometer Control Testing: perform both low and high testing every night shift. Compare reading to the range printed in the bottle. Doc [document] (+) accurate reading (-) inaccurate reading, repeat the test, if still inaccurate, replace with a new glucometer. Further review of Resident 19's January 2025 to March 2025 MAR showed a + were documented daily, and the MARs did not show the exact reading numbers for low and high control testing of their glucometer. RESIDENT 92 Review of March 2025 MAR showed Resident 92 had an order for Glucometer Control Testing: perform both low and high testing every night shift Compare reading to the range printed in the bottle. Doc (+) accurate reading (-) inaccurate reading, repeat the test, if still inaccurate, replace with a new glucometer. Further review of Resident 92's March 2025 MAR showed a + were documented daily for the glucometer control testing check and the MAR did not show the exact reading numbers for low and high control testing of their glucometer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 24 Review of January 2025 to March 2025 MAR showed Resident 24 had an order for Glucometer Control Testing: perform both low and high testing every night shift. Compare reading to the range printed in the bottle. Doc (+) accurate reading (-) inaccurate reading, repeat the test, if still inaccurate, replace with a new glucometer. Further review of Resident 24's January 2025 to March 2025 MAR showed a + were documented daily for the glucometer control testing check and the MAR did not show the exact reading numbers for low and high control testing of their glucometer. RESIDENT 47 Review of February 2025 and March 2025 MAR showed Resident 47 had an order for Glucometer Control Testing: perform both low and high testing every night shift. Compare reading to the range printed in the bottle. Doc [document] (+) accurate reading (-) inaccurate reading, repeat the test, if still inaccurate, replace with a new glucometer. Further review of Resident 47's February 2025 and March 2025 MAR showed a + were documented daily for the glucometer control testing check and the MAR did not show the exact reading numbers for low and high control testing of their glucometer. In an interview and joint observation on 04/02/2025 at 5:30 PM, Staff B, Director of Nursing, stated they checked the residents' glucometer for control testing every night and that they documented it in the residents' MAR. Joint observation of the Evencare G2 (brand name -glucometer system) high and low testing bottle solutions for glucometers showed that the reading numbers from 35 to 65 were for low range and the reading numbers from 160 to 216 were for high range. Staff B stated that staff checks the control testing for residents' glucometers and if the results were within the ranges of the low- and high-level solutions, staff would document with a plus symbol to note that the results were within range. Staff B further stated that the results of the low- and high-level reading numbers were not documented in the residents' MAR. A joint record review and interview with Staff B showed that the multiple MARs for Residents 20, 19, 92, 24 and 47 did not have the reading numbers for low and high level tests documented. Staff B stated that the facility did not document the reading numbers for the low and high test solution of control testing in the MAR for Residents 20, 19, 92, 24 and 47. Reference: WAC 388-97-1720(1)(a)(ii) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47218 Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases by: 1. Not having a water management program that assessed the potential growth of Legionella (a waterborne bacteria that can cause pneumonia [a lung infection]) or other waterborne pathogens (an organism that can cause disease) was completed for the decorative water fountain. 2. Touching medications with bare hands during medication administration for 1 of 10 residents (Resident 2), reviewed medication administration. 3. Not performing hand hygiene and disinfection of glucometers (device used to check blood sugar levels) for 3 of 3 residents (Residents 20, 92 & 19), reviewed for blood glucose (blood sugar) monitoring. 4. Not cleaning insulin (a hormone that helps regulate blood sugar levels) pens (administration device) prior to medication administration for 2 of 2 residents (Residents 20 & 19), reviewed for insulin administration. 5. Not following Enhanced Barrier Precautions (EBP- precaution to protect the spread of infectious organisms for 1 of 1 resident (Resident 16), reviewed for EBP. 6. Not performing hand hygiene and proper use of Personal Protective Equipment (PPE-use of gown, gloves, face shield, N95 masks for 4 of 4 residents (Residents 31, 150, 83 & 38), reviewed for transmission based precautions (TBP-to help stop the spread of germs from one person to another). 7. Not discarding full sharp containers (limited capacity puncture-resistant, leak-proof container designed to dispose of needles/sharps) for 2 of 16 sharps containers for (Resident 7 & Medication Storage A), reviewed for use of sharps containers. These failures placed the residents, visitors, and staff at an increased risk of acquiring infection, related complications, and personal injury. Findings included . Review of the facility's policy titled, Legionella Surveillance, revised in May 2024, showed that Legionella surveillance was one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens (organisms that normally do not harm their host but can cause disease when the host's resistance is low) in the facility's water systems. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Water Management Program, revised in May 2024, showed that a risk assessment would be conducted annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The policy further showed that a variety of measures would be used, including physical control, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. Review of the facility's policy titled, Medication Administration, revised in May 2024, showed that medications were administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Further review of the policy showed that medications were not to be touched with bare hands. Review of the facility's policy titled, Hand Hygiene, revised in May 2024, showed that staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy further showed that hand hygiene should be performed between residents; before applying and after removing PPE including gloves; before performing resident care procedures; before and after providing care to residents in isolation; and after handling items potentially contaminated with blood, body fluids, secretions, or excretions. Review of the facility's policy titled, Glucometer Disinfection, revised in May 2024, showed that glucometers were disinfected to prevent transmission of blood borne diseases to residents and employees. The policy further showed that the facility would ensure that glucometers were cleaned and disinfected after each use and according to the manufacturer's instructions. The glucometers should be disinfected with a wipe pre-saturated with an Environmental Protection Agency (EPA - a federal agency that protects human and environmental health by regulating pollutants and enforcing laws) - registered healthcare disinfectants that were effective against viruses that were transmitted by blood and other fluids. Review of the facility's policy titled, Insulin Pen, revised in May 2024, showed that the insulin pens' rubber seal should be wiped with an alcohol pad after the insulin pen cap was removed from the insulin pen and prior to placing the pen needle onto the insulin pen. Review of the facility's policy titled, Transmission-Based (Isolation) Precautions, revised in May 2024, showed the facility would follows Centers for Disease Control (CDC) guidance. The policy further showed that Aerosol Contact Precautions (prevent transmission of infectious pathogens through droplets and very small particles containing the virus) was used for conditions that included COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases can cause difficulty breathing and could result in impairment or death) where it instructed staff to wear a fit-tested N95 or higher-level [mask] or respirator [air-purifying respirator certified by the National Institute for Occupational Safety and Health (NIOSH)/ filter/fitted masks that fit over the nose and mouth, and when properly fitted, can filter 95% of smoke particles]) and other appropriate PPE while delivering care to the residents. The policy further showed that the facility used Quarantine Precautions [to reduce/prevent transmission of potential or suspected infectious agents spread through droplets and very small particles that contain the virus] that is used with asymptomatic residents with known exposure to COVID-19 for an extended period of time, and instructed staff to wear a fit-tested N95 or higher-level respirator and other appropriate PPE while delivering care to the resident. WATER MANAGEMENT (continued on next page)

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	505431	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bothell Health Care	707 - 228th Southwest Bothell, WA 98021

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's water management program updated on 11/29/2024, showed that the water temperature of the outdoor decorative water fountain would be checked weekly. Further review of the document showed that if the water fountain temperature was over 70 degrees Fahrenheit (F), the facility would add chlorine [chemical element used as a bleach, oxidizing agent, and a disinfectant in water purification] until 0.5 milligrams (a unit of measurement) per liter of free chlorine was measured. Review of the facility provided document titled, Legionella Risk Assessment, dated 03/29/2021, 05/02/2022 and 06/26/2023. Further review of the document showed that it included the assessment of the facility's decorative [water] fountain and did not show that an assessment risk for Legionella was completed for 2024. In a joint record review and interview on 04/02/2025 at 1:34 PM with Staff A, Administrator, showed the legionella risk assessment was last dated 06/26/2023. Staff A stated the facility used the same legionella risk assessment form and added the dates when the assessments were completed on the same sheet and use a different sheet if there were changes. Staff A stated they completed the legionella risk assessments annually [and it was not done for 2024]. In another joint record review and interview on 04/02/2025 at 1:39 PM with Staff A, did not show a control test documentation for the facility's decorative water fountain in the water management program binder. Staff A stated that the facility water fountain runs only in the summertime and that the facility performed weekly temperature checks and PH [a measure of how acidic or basic a substance is] testing of the water during that time. Staff A further stated that there was no documentation to show control testing of the water fountain was done after year 2020. TOUCHING MEDICATIONS WITH BARE HANDS Review of the March 2025 Medication Administration Record (MAR) showed Resident 2 had an order for Vitamin D (supplement) to take one tablet a day by mouth. Observation on 03/31/2025 at 9:39 AM, showed Staff L, Registered Nurse (RN), dropped Resident 2's Vitamin D tablet on the flat surface of the medication cart and then picked it up with their bare hands into a medication cup. Further observation showed Resident 2 took their Vitamin D tablet. In an interview on 03/31/2025 at 12:31 PM, Staff D, Resident Care Manager (RCM), stated they expected medications to be disposed of if they fell on the medication cart and should not be touched with bare hands. Staff D further stated that Staff L should not have touched Resident 2's Vitamin D tablet with their bare hands and should have given Resident 2 a new Vitamin D tablet. HAND HYGIENE AND GLUCOMETER DISINFECTION Review of the facility's provided document titled, EVENCARE G2 [brand name] Blood Glucose [sugar] Monitoring System, dated 2018, showed glucometers would be disinfected and cleaned with one of the validated EPA-registered disinfecting wipes. RESIDENT 20 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/28/2025 at 11:43 AM, showed Staff K, RN, entered Resident 20's room and put on clean gloves without performing hand hygiene. Staff K then used a glucometer to check Resident 20's blood sugar level, removed their soiled gloves, and proceeded to put a pair of new gloves on. Staff K then used an alcohol wipe to clean Resident 20's glucometer. Staff K did not do hand hygiene in between glove change. RESIDENT 92 Observation on 03/28/2025 at 11:46 AM, showed Staff K removed their soiled gloves and put on a clean pair of gloves after they checked Resident 92's blood sugar. Staff K then used an alcohol wipe to clean Resident 92's glucometer. Staff K did not do hand hygiene in between glove change. RESIDENT19 Observation on 03/28/2025 at 11:50 AM, showed Staff K entered Resident 19's room and put on clean gloves without performing hand hygiene. Staff K then used a glucometer to check Resident 19's blood sugar level, removed their soiled gloves, and proceeded to put a new pair of gloves. Staff K then used an alcohol wipe to clean Resident 19's glucometer. Staff K did not do hand hygiene in between glove change. In an interview on 03/28/2025 at 12:08 PM, Staff K stated their practice was to clean the resident's glucometer with alcohol wipes. Staff K stated that they cleaned Residents 20, 92, and 19's glucometers with alcohol wipes. In another interview on 03/28/2025 at 12:42 PM, Staff K stated that they would do hand hygiene between glove change. Staff K further stated that they should have performed hand hygiene prior to entering Resident 20 and 19's rooms and/or in between glove change for Residents 20, 19 and 92. CLEANING OF INSULIN PENS RESIDENT 20 Observation on 03/28/2025 at 11:57 AM, showed Staff K was preparing for Resident 20's insulin dose. Staff K removed the cap from Resident 20's insulin pen, placed a new pen needle in and administered it to Resident 20. Staff K did not clean Resident 20's insulin pen rubber seal [with alcohol pads] before placing the new needle onto the insulin pen. RESIDENT19 Observation on 03/28/2025 at 12:12 PM, showed Staff K was preparing Resident 19's insulin dose. Staff K removed the cap from Resident 19's insulin pen, placed a new pen needle in, and administered it to Resident 19. Staff K did not clean Resident 19's insulin pen rubber seal before placing the needle onto the insulin pen. In an interview on 03/28/2025 at 12:42 PM, Staff K stated they did not clean the insulin pen rubber seals for Residents 20 and 19 prior to insulin administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/02/2025 at 12:02 PM, Staff D stated they expected staff to do hand hygiene before entering and after leaving residents' rooms, before putting on PPE and after removing PPE, and in between glove change. Staff D stated that Staff K should have done hand hygiene before entering Residents 20 and 19's rooms, and in between glove change during Residents 20, 92 and 19's blood sugar checks. Staff D stated they expected staff to disinfect residents' glucometers using two Mycolio sanitizing wipes and that Staff K should have used the sanitizing wipes to clean Residents 20, 92, and 19's glucometers. Staff D further stated that Staff K should have cleaned Residents 20 and 19's insulin pen rubber seals with alcohol wipes prior to connecting the pen needles. EBP Review of the undated facility provided signage titled, Enhanced Barrier Precautions, showed that providers and staff must wear gloves and a gown for high contact resident care activities that included feeding tube (flexible tube that delivers nutrients directly to the stomach) care or use. Observation on 04/02/2025 at 8:27 AM, showed an EBP signage outside Resident 16's room. Observation on 04/02/2025 at 8:43 AM, showed Staff G, RCM, was administering medications to Resident 16 via feeding tube without wearing a gown. Joint record review and interview showed Resident 16 had an EBP signage outside their room that instructed staff to wear a gown for high contact care including feeding tube care. Staff G stated that they did not wear a gown prior to administering Resident 16 their medications and they should have since [Resident 16] has a feeding tube. HAND HYGIENE AND PUTTING ON AND REMOVING PPE FOR TBP AND EBP Review of the facility provided signage titled, Aerosol Contact Precautions, dated 08/14/2024, showed that providers and staff should wash or gel hands, wear a gown and gloves, use an N95, and wear eye protection. Other requirements included the use of resident dedicated or disposable equipment; and to clean and disinfect shared equipment per manufacturer instructions. The signage further showed that staff should perform hand hygiene prior to putting on PPE and after removing PPE. RESIDENT 31 Review of the physician orders printed on 03/26/2025 showed Resident 31 was on aerosol contact precautions due to positive COVID-19 and that their door should remain closed. Observation on 03/26/2025 at 2:29 PM showed Resident 31's room was open and had an Aerosol Contact Precaution signage outside their door. Further observation showed Resident 31 was outside their room and not wearing their mask. Observation on 03/26/2025 at 2:38 PM, showed Staff I, Certified Nursing Assistant (CNA), wearing an N95 respirator, entered Resident 31's room holding a blood pressure cuff and a pair of gloves. Further observation showed Staff I exited Resident 31's room with the blood pressure cuff under their left arm and entered Resident 150's room (an EBP room). Staff I did not perform hand hygiene prior to entering Resident 150's room. Staff I then exited Resident 150's room, donned a gown and gloves without doing hand hygiene, and went back to provide care to Resident 150. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 03/26/2025 at 2:50 PM with Staff I showed an aerosol contact precaution signage outside of Resident 31's room. Staff I stated that Resident 31 had COVID-19 and that they did not perform hand hygiene before entering and after exiting Resident 31's room. Staff I further stated that they should have worn a gown, face shield, and/or gloves prior to entering Resident 31's room. Staff I stated they should have removed their soiled N95 and put a new one on after exiting Resident 31's room. Staff I further stated that they should have sanitized the blood pressure cuff after they used it for Resident 31 and that they should have done hand hygiene prior to entering Resident 150's room. In an interview on 04/02/2025 at 12:19 PM Staff D stated that prior to entering Resident 31's room, Staff I should have performed hand hygiene and put on their gown, gloves, and face shield. Staff D stated that Staff I should have removed their soiled N95 after exiting Resident 31's room and put a new N95. Staff D stated that Staff I should have sanitized the blood pressure cuff after they used it for Resident 31. Staff D stated that Staff I should have done hand hygiene prior to entering Resident 150's room. Staff D further stated that Resident 31 should have remained closed. In an interview on 04/02/2025 at 2:35 PM, Staff C, Infection Preventionist, stated that Staff K should have used a blue top sanitizing wipes to clean the glucometers for Residents 20, 92, and 19. Staff C stated Staff K should have performed hand hygiene before entering Resident 20 and 19 rooms and between glove change. Staff C stated that Staff K should have wiped Residents 20 and 19's insulin pen rubber seals prior to placing the pen needles. Staff C stated that Staff G should have worn a gown prior to administering Resident 16's medications via feeding tube. Staff C stated that Staff L should not have touched Resident 2's Vitamin D tablet with their bare hands. Staff C stated that Staff I should have performed hand hygiene before entering and after exiting Resident 31 and 150's room. Staff C stated that Staff I should have put on PPE prior to entering Resident 31's room and should have changed their soiled N95. Staff C further stated that Resident 31's room should not have been open. In an interview on 04/02/2025 at 3:01 PM, Staff B, Director of Nursing, stated that they expected staff to follow infection control protocol regarding hand hygiene, putting on and removing PPE, medication administration, disinfection of glucometers, cleaning of insulin pen rubber seals, and EBP/TBP precautions. 48298 RESIDENT 83 An observation on 03/27/2025 at 12:54 PM showed Staff R, CNA, went out of Resident 83's room (a TBP/COVID-19 room) wearing their N95 and face shield. Staff R removed their face shield, placed it in the trash bin outside Resident 83's room and performed hand hygiene. Staff R then walked towards the unit nurses' station. Staff R did not remove and/or change their N95. In an interview on 03/27/2025 at 12:57 PM, Staff R stated that they were expected to remove and change their N95 after exiting a TBP/COVID room. When asked if they had removed and changed their N95 after they exited Resident 83's room, Staff R stated, No, I did not. Staff R further stated that they should have changed their N95 when exiting Resident 83's room. RESIDENT 38 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 03/27/2025 at 1:35 PM, Staff S, RN, went out of Resident 38's room (a quarantine precaution room) wearing their N95 and face shield. Staff S removed their face shield and their N95 then threw them in the trash bin. Staff S then opened the clean PPE bin and put on new N95. Staff S did not perform hand hygiene after removing their soiled face shield and N95. In an interview on 03/27/2025 at 1:37 PM, Staff S stated that Resident 38 had COVID exposure due to COVID positive roommate who had been transferred to another unit. When asked about hand hygiene after removing their soiled face shield and N95 and before putting on a new N95, Staff S stated, I was in a hurry, and I think I forgot that [perform hand hygiene]. In an interview on 03/28/2025 at 9:08 AM, Staff F, RCM, stated they expected staff to remove and change their soiled N95 after they exited a TBP/COVID room and to perform hand hygiene. In an interview on 04/01/2025 at 4:15 PM, Staff C stated they expected staff to remove and change their N95 after wearing them in a TBP/COVID room and to perform hand hygiene after removing their soiled PPE. In an interview on 04/01/2025 at 4:34 PM, Staff B stated they expected staff to follow infection control practices such as changing N95 and performing hand hygiene. 50891 RESIDENT 7 In an observation on 03/25/2025 at 8:53 AM showed that the sharps container in Resident 7's bathroom was filled to the fill line. MEDICATION STORAGE A In a joint observation and interview on 04/01/2025 at 9:39 AM with Staff G, showed that the sharps container in Medication Storage A was filled above the fill line. Staff G stated that they would have the sharps container replaced. Staff G further stated that the housekeepers were responsible for emptying the sharps container in the medication room. In an interview on 04/01/2025 at 3:34 PM, Staff B stated that they expected sharps containers to be replaced when they were three-quarters full. Staff B stated that the housekeepers were responsible for replacing sharps containers in the residents' rooms. Staff B further stated that the nurses were responsible for sharps containers on the medication carts and in the medication rooms. Reference: (WAC) 388-97- 1320 (1)(a)(c)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 47218 Based on observation, interview, and record review, the facility failed to maintain glucometer (a device for measuring the concentration of sugar in the blood) disinfection per manufacturers' recommendations for 4 of 4 glucometers in Wing 300, reviewed for safe operating condition. This failure placed residents at risk of inaccurate blood sugar readings and potential negative outcomes. Findings included . Review of the facility's policy titled, Glucometer Disinfection, revised in May 2024, showed that glucometers were disinfected to prevent transmission of blood borne (can be spread through contamination by blood and other body fluids) diseases to residents and employees. The policy further showed that the facility would ensure that glucometers were cleaned and disinfected after each use and according to the manufacturer's instructions. The glucometers should be disinfected with a wipe pre-saturated with an Environmental Protection Agency (EPA - a federal agency that protects human and environmental health by regulating pollutants and enforcing laws) - registered healthcare disinfectants that were effective against viruses that were transmitted by blood and other fluids. Review of the facility's provided document titled, EVENCARE G2 [brand name] Blood Glucose [sugar] Monitoring System, dated 2018, showed glucometers would be disinfected and cleaned with one of the validated EPA-registered disinfecting wipes: - Dispatch Hospital Cleaner Disinfectant towels with Bleach - Medline Micro-Kill Disinfecting, Deodorizing, Cleaning Wipes with Alcohol - Clorox Healthcare Bleach Germicidal and Disinfectant Wipes - Medline Micro-Kill Bleach Germicidal Bleach Wipes Further review of the document showed, Other EPA registered wipes may be used for disinfecting the EVENCARE G2 system, however these other wipes [Mycolio disinfecting wipes] have not been validated and could affect the performance of the meter [glucometer]. Review of the facility's policy titled, Glucometer Cleaning, revised in April 2025, showed that glucometers should be cleaned after each use with Mycolio [brand name] disinfectant wipes. Review of the undated facility's document titled, Weekly Glucometer Cleaning, showed the Wing 300's glucometers and glucometer bin were cleaned weekly using Medline Micro Kill [brand name] (red top) disinfectant wipes. Further review of the document showed glucometers and glucometer bins were cleaned weekly from 07/03/2024 to 04/02/2025. Observation on 03/28/2025 at 11:43 AM, showed Staff K, Registered Nurse, cleaned the glucometer with an alcohol wipe after they used it to check Resident 20's blood sugar. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/28/2025 at 11:46 AM, showed Staff K cleaned the glucometer with an alcohol wipe after they used it to check Resident 92's blood sugar. Observation on 03/28/2025 at 11:50 AM, showed Staff K cleaned the glucometer with an alcohol wipe after they used it to check Resident 19's blood sugar. Observation on 04/01/2025 11:50 AM, showed in Wing 300 an unknown staff was cleaning a glucometer using Mycolio [not validated to sanitize EVENCARE G2 glucometers] disinfectant wipes. In an interview on 03/28/2025 at 12:08 PM, Staff K stated their practice was to clean residents' glucometers with alcohol wipes. Staff K stated that they cleaned Residents 20, 92, and 19's glucometers with alcohol wipes. In an interview and joint record review on 03/28/2025 at 3:54 PM, Staff C, Infection Preventionist, stated that glucometers were cleaned with the blue top disinfectant wipes Mycolio (brand name) and expected staff to use two wipes. Staff C stated that cleaning glucometers with alcohol wipes were not appropriate as they would not kill bloodborne pathogens (organisms that cause diseases). Staff C stated that the facility used EVENCARE G2 glucometers. A joint record review showed that the EVENCARE G2 glucometers manufacturers' user guide did not include Mycolio as a validated EPA product for disinfecting the glucometers. Staff C stated that the manufacturer's guide did not list Mycolio as a product to disinfect EVENCARE G2 glucometers. In an interview on 04/02/2025 at 12:02 PM, Staff D, Resident Care Manager, stated they expected staff to disinfect residents' glucometers using two Mycolio sanitizing wipes. Staff D further stated that Staff K should have used the sanitizing wipes to clean Residents 20, 19 and 92's glucometer after checking their blood sugar levels. A joint record review and interview on 04/02/2025 at 4:37 PM with Staff B, Director of Nursing, showed the EVENCARE G2 glucometer manufacturer's guide did not include Mycolio as a validated EPA product to disinfect the glucometers. Staff B stated that the residents' glucometers have not had any discrepancies with the readings [blood sugar levels] and that the facility does a glucometer control test every night. In a follow up interview and joint observation on 04/02/2025 at 5:30 PM, Staff B stated that residents' glucometers control testing results were documented in their MAR. Joint observation of the EVENCARE G2 low-and high-testing solutions for glucometers showed the reading numbers from 35 to 65 were for low range and reading numbers from 160 to 216 were for high range. Staff B stated that the reading number results were not documented in the residents' MARs and that if the results were within the ranges of the low- and high-level, staff would document + with a plus symbol to show that the results were within range. A joint record review did not show that the MARs for Residents 20, 19, 92, 24 and 47 had the reading numbers. Staff B stated that Residents 20, 19, 92, 24, and 47 MARs did not have documentation of the reading numbers of their glucometers. Reference: (WAC) 388-97- 2100(1)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48298 Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) had the required dementia (memory loss) management training upon hire for 2 of 5 staff (Staff U & Staff V), reviewed for sufficient and competent Nurse staffing. This failure placed the residents at risk for potential negative outcomes and unmet care needs. Findings included . Review of the facility's policy titled, Required Training, Certification and Continuing Education of Nurse Aides, revised in September 2024, showed, It is the policy of this facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. STAFF U Review of the undated facility's employee record showed Staff U, CNA, was hired on 07/09/2024. It further showed no documentation that Staff U received the required dementia management training. STAFF V Review of the undated facility's employee record showed Staff V, CNA, was hired on 04/23/2024. It further showed no documentation that Staff V received the required dementia management training. In an interview and joint record review on 04/02/2025 at 10:16 AM, Staff C, Infection Preventionist/Staff Development Coordinator, stated that they provided dementia management training for staff upon hire and annually through Relias (online training). A joint record review of the online training with Staff C did not show Staff U and Staff V had completed their dementia management training. When asked if Staff U and Staff V had received the dementia management training, Staff C stated, It does not look like they had completed it [dementia training] upon hire. In an interview on 04/02/2025 at 10:31 AM, Staff B, Director of Nursing, stated they expected Staff U and Staff V to complete their dementia management training upon their hire. Reference: (WAC) 388-97-1680 (2)(b)