STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505436	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gig Harbor Health and Rehabilitation	3309 45th Street Court Northwest Gig Harbor, WA 98335

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to provide risks/benefits and obtain consent for the use of an antidepressant for 1 of 5 sampled residents (Resident 53) when reviewed for unnecessary medication. This failure placed the resident at risk of unknown side effects of the medication, lack of decision-making power in treatment decisions, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 53 admitted to the facility on [DATE] with diagnoses of acquired absence of right leg above knee and depression. Resident 53 was able to make needs known. Review of the medication list showed Resident 53 received duloxetine (an antidepressant) for depression daily. Review of the EHR showed no risks/benefits for the use of duloxetine was provided to Resident 53 and consent to receive this medication was not obtained. During an interview on 12/10/2024 at 11:02 AM, Staff G, Unit Manager, stated before starting a resident on an antidepressant nursing staff would provide the risks/benefits of the medication and obtain a signed consent for its use. Staff G stated Resident 53 was currently taking duloxetine, but the resident was not provided the risks/benefits of the antidepressant and a consent to use the medication was not obtained. Staff G stated this did not meet the expectation. During an interview on 12/11/2024 at 9:58 AM, Staff B, Director of Nursing Services, stated before starting a resident on an antidepressant nursing staff would provide the risks/benefits of the medication and obtain a signed consent for its use. Staff B stated nursing staff did not provide the risks/benefits of Resident 53's duloxetine and did not obtain consent, and this did not meet expectation. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to initiate, investigate, and resolve a grievance for 2 of 2 sampled residents (Residents 14 and 66) reviewed for personal property and grievances. This failure placed the residents at risk for emotional distress and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 14 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and chronic obstructive pulmonary disease (COPD, a progressive lung disease causing obstructed airflow and breathing difficulties). Resident 14 was able to make needs known. During an interview on 12/06/2024 at 1:30 PM, Resident 14 stated they informed staff that their roommate constantly disrupted their sleep and increased their anxiety. Resident 14 stated they were offered ear plugs as a resolution, but stated they were still unhappy. Review of an alert charting progress note, dated 11/19/2024 at 4:40 PM, showed Resident 14 expressed feeling increased anxiety with new roommates continual talking and outburst. Review of a second progress note dated 11/19/2024 showed Resident 14 stated they were anxious, agitated and unable to stay in the room with roommate's behaviors. Staff provided earplugs to Resident 14 to minimize noise. Review of a progress note, dated 11/20/2024 at 5:46 AM, showed Resident 14 was very dissatisfied with the roommate. Resident 14 reported their roommate talked non-stop and that they did not get good rest. Staff informed Resident 14 there was no available bed to move the roommate. Review of the grievance logs for September, October, and November 2024 showed no grievances filed for Resident 14. During an interview on 12/06/2024 at 2:06 PM Staff F, Social Services Director (SSD), stated they were unaware of the situation. Staff F stated a grievance should have been completed and Resident 14 should have been offered a room change or offered the first one room available if there were none available at the time. During an interview on 12/11/2024 at 10:32 AM Staff A, Administrator (ADM), stated the expectation was that staff would initiate a grievance for concerns expressed by residents. Staff A stated residents who expressed emotional concerns should have been interviewed by the social services. 46148 Resident 66 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 66 admitted to the facility on [DATE] with diagnoses of left below knee amputation and diabetes. The resident was able to make needs known. During an interview on 12/05/2024 at 9:11 AM, Resident 66 stated they had been missing two coats and they had told a nurse aide, a nurse, and the laundry person. Resident 66 stated it was a black leather jacket and a long brown jacket, and they had been missing for a few weeks. During an interview on 12/09/2024 at 9:41 AM, Staff P, Laundry Staff, stated Resident 66 had told them about the missing jackets a few days ago. He had looked around the laundry room but had not seen them. Staff P stated they had not filled out a grievance form. Review of the grievance logs for September, October, and November 2024 showed Resident 66 had no grievances filed for missing jackets. During an interview on 12/10/2024 at 11:22 AM, Staff A, ADM, stated their expectation was for the staff to assist residents with grievance forms if they have missing items and Resident 66's grievance should have been received by now but had not been. Reference WAC 388-97-0460

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to ensure an environment free from verbal abuse for 1 of 3 sampled residents (Resident 45) reviewed for abuse. This failure placed residents at risk for ongoing abuse and neglect, unmet needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Abuse Prevention Program, dated April 2023, showed, As part of the resident abuse prevention, the administration will: Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff . Review of the electronic health record (EHR) showed Resident 45 admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the legs and lower body) and cognitive communication deficit (difficulty communicating). Resident 45 was able to make needs known. During an interview on 12/05/2024 at 10:18 AM, Resident 45 stated there was an incident where an unnamed staff member accused them of buying out all the potato chips from the vending machine. Resident 45 stated the unnamed staff member and additional staff members who were present were laughing at him and the unnamed staff member also questioned them about being in a gang and breaking into the staff member's car while parked at the facility. Resident 45 reported the incident to a staff member. Review of EHR showed a progress note dated 11/17/2024 that Resident 45 was in tears and clearly upset when they reported that they felt mistreated verbally by staff on another unit while he was just trying to go around building doing laps for exercise. The resident provided a statement and was placed on alert. Review of the incident report did not have documentation of findings, action taken nor all witnesses. During an interview on 12/11/2024 at 10:36 AM, Staff A, Administrator (ADM), stated they had spoken to Resident 45 and believed the situation was a misunderstanding. Staff A stated they did not identify the complaint as an allegation of abuse but should have after reading the progress note from staff. See F609 for more information. Reference WAC 388-97-0640(6)(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to identify and report an allegation of abuse for 1 of 3 sampled residents (Resident 45) reviewed for abuse. This failure placed residents at risk for unidentified and repeated potential abuse, neglect, or mistreatment, and a diminished quality of life. Findings included . Review of the facility's policy titled, Abuse Prevention Program, dated April 2023 showed, As part of the resident abuse prevention, the administration will . identify and assess all possible incidents of abuse . report any allegations of abuse within timeframes as required by federal requirements. Review of the electronic health record (EHR) showed Resident 45 admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the legs and lower body) and cognitive communication deficit. Resident 45 was able to make needs known. During an interview on 12/05/2024 at 10:18 AM, Resident 45 stated there was an incident where an unnamed staff member accused them of buying out all the potato chips out in the vending machine. Resident 45 stated the unnamed staff member and additional staff members who were present were laughing at him and the unnamed staff member also questioned them about being in a gang and breaking into the staff member's car while parked at the facility. Resident 45 reported the incident to a staff member on 11/17/2024. Review of the facility's Accident and Incident Log for November 2024 showed there was no incident report logged regarding Resident 45's allegation of abuse. Review of the incident report did not have documentation of findings, action taken nor all witnesses. During an interview on 12/11/2024 at 10:36 AM, Staff A, Administrator (ADM), stated they had spoken to Resident 45 and believed the situation was a misunderstanding. Staff A stated they did not identify the complaint as an allegation of abuse but should have after reading the progress note from staff. Staff A stated the incident should have also been reported to the state. Reference WAC 388-97-0640(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to thoroughly report allegations of abuse for 1 of 3 sampled residents (Residents 85) reviewed for abuse. This failure placed residents at risk repeated potential abuse, neglect, or mistreatment, and a diminished quality of life. Findings included . 49926 Resident 85 Review of the EHR showed Resident 85 was admitted to the facility on [DATE] with diagnoses of fracture of right lower leg, injury of right ankle, and diabetes (too much sugar in the blood). Resident 85 was able to make needs known and needed assistance to get up from bed. Observation and interview on 12/04/2024 at 9:56 AM, showed Resident 85 laid in bed with a worried facial expression. Resident 85 stated, I don't feel safe in here. Resident 85 stated early in the morning a male resident was walking towards the room in the hallway, and they could hear the footsteps coming close. Resident 85 stated they started yelling for everyone to get up. Resident 85 stated they reported this to Staff U. Review of Incident log showed no investigations or reports for Resident 85 for November 2024 or December 2024. During an interview on 12/06/2024 at 10:06 AM, Staff U, Receptionist, stated that Resident 85 had a concern about a new resident that was walking and yelling at 1:30 AM and Resident 85 was scared. Staff U stated they thought they reported the occurrence but could not recall exactly who to. During an interview on 12/10/2024 at 1:43 PM, Staff B, DNS, stated the incident was not reported and investigated timely to rule out abuse, and this did not meet expectations. Reference WAC 388-97-0640(6)(a)(c)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide written notification of the reason for transfer/discharge to the resident or responsible party of discharges to the hospital for 2 of 2 sampled residents (Residents 38 and 66) reviewed for hospitalization . This failure denied the resident or responsible party knowledge of their rights regarding transfer/discharge from the facility. Findings included . Resident 38 Review of the electronic health records (EHR) showed Resident 38 readmitted to the facility on [DATE] with diagnoses to include a stroke, high blood pressure, and paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs in brief episodes). Resident 8 was able to make needs known. Review of form titled, SNF -NF [Skilled Nursing Facility/Nursing Facility] to Hospital Transfer Form, dated 11/29/2024 showed Resident 38 was transferred to the hospital on 11/29/2024. Review of Resident 38's EHR showed no documentation a written notice of transfer/discharge was provided to Resident 38 and/or a responsible party for the transfer to the hospital on 11/29/2024. During an interview on 12/10/2024 at 1:38 PM, Staff G, Unit Manager (UM), stated they were not aware of a written form that they would provide to the resident or responsible party; however, they documented in the resident's progress note of the notification and reason for the transfer to the hospital. During an interview on 12/11/2024 at 9:29 AM, Staff B, Director of Nursing Services (DNS), stated they called the responsible party on the phone and/or inform the resident and responsible party in person if they were in the facility; however, they had not been providing written documentation to give to the resident or responsible party for transfer/discharges to the hospital. 46148 Resident 66 Review of the EHR showed Resident 66 admitted to the facility on [DATE] with diagnoses of left below knee amputation, infection, and diabetes. The resident was able to make needs known. Review of the EHR showed Resident 66 was sent to the hospital on 08/22/2024 for evaluation. No documentation was found of the resident, or their representative being notified of the reason for transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/2024 at 9:41 AM, Staff B, Director of Nursing Services, stated they did not provide a notice in writing to the resident or their representative when transferred to the hospital. Reference WAC 388-97 -0120 (2)(a-d) -0140 (1)(a)(b)(c)(i-iii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected the status for 2 of 20 sampled residents (Residents 69 and 346) reviewed for accuracy of assessments. Failure to accurately code Resident 69's use of corrective lenses, and Resident 346's antibiotic therapy and continuous oxygen therapy, placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Resident 69 Review of the electronic health record (EHR) showed Resident 69 admitted to the facility on [DATE] with diagnoses to include systemic lupus erythematosus (an illness that occurs when the immune system attacks healthy tissues and organs), depression, and was able to make needs known. Review of the quarterly minimum data set (MDS), an assessment tool, dated 09/03/2024, showed Resident 69 had adequate vision with no corrective lenses. During an interview on 12/11/2024 at 10:30 AM, Staff F, Social Services Director (SSD), stated Resident 69 received new glasses around June 2024. Staff F had a copy of Resident 69's optometrist follow-up visit form dated 08/23/2024 that showed the resident was happy with their new prescription glasses. During an interview on 12/11/2024 at 10:59 AM, Staff K, MDS Coordinator, stated they had not seen Resident 69 with glasses and completed the MDS by observation and had not asked the resident if they wore glasses and probably should have. Staff K stated Resident 69's MDS needed to be modified. During an interview on 12/11/2024 at 11:44 AM, Staff C, Assistant Director of Nursing (ADON), stated Resident 69's quarterly MDS dated [DATE] for vision did not meet expectations and should have been coded for corrective lenses. 51907 Resident 346 Review of the EHR showed Resident 346 admitted to the facility on [DATE] with diagnoses that included sepsis (the body's life-threatening response to infection), local infection of the skin and subcutaneous tissue (the tissue under the skin), and chronic obstructive pulmonary disease (COPD, a long-term lung condition that causes breathing difficulties). The admission MDS, dated [DATE], showed Resident 346 was able to make their needs known. Observation on 12/05/2024 at 4:26 PM showed Resident 346 had a peripherally inserted central catheter (PICC, a tube that is inserted through the arm and to the heart) in place. Resident 346 was receiving intravenous (IV, through a vein) antibiotic therapy. The resident was also receiving oxygen at 2 liters per minute via nasal cannula (tube inserted into the nose). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR on 12/05/2024 showed Resident 346 had an order for ampicillin IV (an antibiotic) for sepsis. The resident had orders for oxygen at 2 liters per minute continuously via nasal cannula. Review of Resident 346's admission MDS, dated [DATE], showed High Risk Medication was not coded for antibiotic therapy. Review showed the MDS was coded for intermittent oxygen use (not coded continuous). During an interview on 12/06/2024 at 11:45 AM, Staff K, MDS Coordinator, stated the antibiotics were not coded accurately in Resident 346's MDS and it should have been. Staff K stated the oxygen was coded for intermittent use when it should have been coded for continuous use for Resident 346. During an interview on 12/06/2024 at 1:58 PM, Staff B, Director of Nursing Services, stated the MDS should be coded correctly for Resident 346's antibiotic and oxygen therapy. Reference WAC 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to ensure residents with mental health disorders were screened for the need of additional mental health supports for 4 of 7 sampled residents (Resident 53, 5, 8, and 66) when reviewed for Preadmission Screening and Resident Review (PASRR, a mental health screening tool). This failure placed residents at risk of lacking needed mental health supports, avoidable adverse behaviors, and a diminished quality of life. Findings included . Resident 53 Review of the electronic health record (EHR) showed Resident 53 admitted to the facility on [DATE] with a diagnosis of depression. Resident 53 was able to make needs known. Review of the PASRR level one, dated 03/30/2024, showed Resident 53 had depression and needed referral for PASRR level two. During an interview on 12/10/2024 at 9:21 AM, Staff F, Social Services Director (SSD), stated residents were screened on admission for additional mental health supports by using the PASRR level one and would be referred for a PASRR level two, if indicated. Staff F stated Resident 53 should have been referred for a PASRR level 2 prior to 12/09/2024. Staff F stated Resident 53's screening for mental health supports did not meet expectation. During an interview on 12/10/2024 at 10:42 AM, Staff A, Administrator, stated the facility would screen for mental health supports using the PASRR level one and, if indicated, referral for PASRR level two should occur. Staff A stated Resident 53's lack of PASRR level two did not meet expectation. 38344 Resident 5 Review of the EHR showed Resident 5 readmitted to the facility on [DATE] with diagnoses to included anxiety disorder, depression, and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs). Resident 5 was able to make needs known. Review of the PASRR level one, dated 05/18/2022, showed Resident 5 had mood disorder- depressive, bipolar disorder and anxiety disorder; however, it showed No Level II [two] evaluation indicated. During an interview on 12/09/2024 at 9:22 AM, Staff F, SSD, stated Resident 5's PASRR level one dated 05/09/2024 showed the resident had serious mental illness indicators marked and should have had a referral for a PASRR level two evaluation. During an interview on 12/09/2024 at 9:33 AM Staff A, Administrator, stated Resident 5's PASRR level one dated 05/09/2024 did not meet expectations and should have been referred for a PASRR level two evaluation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 8 Review of the EHR showed Resident 8 readmitted to the facility on [DATE] with diagnoses to included anxiety disorder and depression. Resident 8 was able to make needs known. Review of the PASRR level one, dated 03/30/2024, showed Resident 8 had mood disorder- depressive and anxiety disorder; however, it showed No Level II evaluation indicated. During an interview on 12/09/2024 at 9:26 AM, Staff F, SSD, stated Resident 8's PASRR level one dated 03/30/2024 should have been referred for a PASRR level two evaluation and that did not happen for Resident 8. During an interview on 12/09/2024 at 9:40 AM, Staff A, Administrator (ADM), stated Resident 8 should have had a referral for a PASRR level two evaluation and this did not meet expectations. 46148 Resident 66 Review of the EHR showed Resident 66 admitted to the facility on [DATE] with a diagnosis of depression. The resident was able to make needs known. Review of the EHR showed Resident 66 had an order for an antidepressant from admitted [DATE] until 10/17/2024. Review of the PASRR level one form completed on re-admission on 09/13/2024 showed depression not marked and no level two PASRR was required. During an interview on 12/09/2024 at 11:13 AM, Staff F, SSD, stated if a resident was admitted to the facility with a diagnosis of depression and received an antidepressant medication, they should be marked on the PASRR level one for serious mental illness and referred for a level two. Resident 66's PASRR was incorrect and needed to be re-done. During an interview on 12/10/2024 at 11:18 AM, Staff A, ADM, stated it was their expectation that PASRRs included depression and if a PASRR was done incorrectly/missing a diagnosis the SSD should have submitted a new one. Reference WAC 388-97 -1915 (1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview and record review, the facility failed to develop and/or implement a comprehensive care plan for 4 of 20 sampled residents (Residents 17, 35, 20, and 346) when reviewed for care plan. Failure to develop and implement care plans that were individualized, and accurately reflected resident care needs related to, limited range of motion/impaired mobility, restorative nursing services, palm guard and/or splint application, peripherally inserted central catheter (PICC, a tube inserted through the arm and into the heart), antibiotic therapy, and sepsis (a life-threatening complication of an infection), placed residents at risk for unmet care needs and potential negative outcomes. Findings included . Resident 17 Review of the electronic health record (EHR) showed Resident 17 readmitted on [DATE] with diagnoses to include arthritis (swelling of the joints), muscle weakness, spinal stenosis of the lower back with neurogenic claudication (a condition when the spinal canal narrows in the lower back putting pressure on the spinal cord and nerves). Resident 17 was able to make needs known. Review of the annual minimum data set (MDS), an assessment tool, dated 10/08/2024, showed Resident 17 utilized a wheelchair for mobility, had lower extremity (LE, hip, knee, ankle, foot) impairment on both sides, and was dependent on staff for transfers to and from the bed. No therapy or restorative nursing programs were provided. Review of Resident 17's care plan on 12/11/2024 showed no focused care plan for restorative nursing programs or interventions to provided range of motion (ROM) to both LE to maintain function related to impaired mobility/limited ROM. Resident 35 Review of the EHR showed Resident 35 readmitted on [DATE] with diagnoses to include contracture (permanent tightening of muscle, tendons and skin, leading to deformity) of the right hand, muscle weakness, difficulty in walking, and age-related physical debility (a condition that affects a person's mobility, physical capacity, stamina [the ability to sustain prolonged physical or mental effort], or dexterity [the ability to use hands, fingers, and arms to perform a task with skill and ease]). Resident 35 was able to make needs known. Review of the quarterly MDS, dated [DATE], showed Resident 35 had upper extremity (shoulder, elbow, wrist, hand) impairment on one side and did not receive restorative nursing programs/services. (continued on next page)

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	505436	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gig Harbor Health and Rehabilitation	3309 45th Street Court Northwest Gig Harbor, WA 98335

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/11/2024 at 12:23 PM showed Resident 35 sat at the bedside with fingers of the right hand curled inward while clinching the edge of a washcloth with their thumb and slightly tucked under the index/first finger; however, there was no space under the other curled fingers to hold onto the washcloth. There was a blue soft therapy carrot (a device used to prevent fingers from digging into the palm and to prevent skin damage and prevent further deformity) located on the overbed table. Resident 35 stated that their family member used to help with application of the carrot in the past. Resident 35 attempted to place carrot in the right hand but was unsuccessful and stated their fingers were sore. Review of Resident 35's document titled, Occupational Therapy Evaluation and Plan of Treatment, dated 03/28/2024 showed, Functional Limitations as Result of Contracture(s): Unable to open R [right] hand. Nursing assists with washing and drying. Pt [patient] performs SROM [self-range of motion] and uses carrot with assistance. It showed, Nursing is managing patient's contracture impairment. It showed, Due to pt's age and resistance to PROM [passive range of motion, outside force/moving the joints for a person], recommend continued use of carrot and regular hygiene to maintain R hand skin integrity. Review of Resident 35's care plan on 12/11/2024 showed no focused care plan for restorative nursing programs and no interventions in place for the use of a carrot for the right-hand contracture or to address Resident 35's limited mobility to the right upper extremities. During an interview on 12/11/2024 at 3:51 PM, Staff B, Director of Nursing Services (DNS), stated residents with limited ROM/impaired mobility and/or a contracture, should be addressed in the resident's care plan with interventions to maintain function. Staff B stated they were not made aware until today (12/11/2024) that Resident 17 and Resident 35 did not have care plans in place with interventions for limited ROM and/or contracture and should have. Please refer to F688 for additional information. 46067 Resident 20 Review of EHR showed Resident 20 admitted to the facility on [DATE] with diagnoses to include right side hemiplegia (severe or complete unilateral loss of strength or paralysis) and osteoarthritis (long-term degenerative joint condition). Resident 20 required extensive assistance with activities of daily living. Review of the EHR showed Resident 20 was assessed to have both upper and lower extremity impairments. Review of the care plan dated 01/11/2023 showed no intervention for range of motion related to Resident 20's extremity impairment. During an interview on 12/11/2024 at 1:51 PM, Staff G, Unit Manager (UM), stated when a resident had limited ROM it should be addressed in the care plan. Staff G stated the facility currently did not have a restorative nursing program and that restorative was not being addressed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 2:25 PM, Staff B, DNS, stated the expectation was that mobility and ROM should have been addressed in the care plan. 51907 Resident 346 Review of the EHR showed Resident 346 admitted to the facility on [DATE] with diagnoses that included sepsis and local infection of the skin and subcutaneous tissue (tissue under the skin). The admission MDS, dated [DATE], showed Resident 346 was able to make their needs known. Observation on 12/05/2024 at 4:26 PM, showed that Resident 346 had a PICC line in place and was receiving intravenous (IV) antibiotic therapy. Review of the EHR on 12/05/2024 showed that Resident 346 had an order for Ampicillin (an antibiotic) for sepsis. No active care plan was found for the PICC line or for sepsis. During an interview on 12/06/2024 at 11:15 AM, Staff J, Resident Care Manager, stated they could not find a care plan for the antibiotics, IV line, or infection. Staff J stated these should have all been care planned. During an interview on 12/6/2024 at 1:58 PM, Staff B, DNS stated that the care plan should be completed accurately. Reference WAC 388-97-1020(1),(2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to conduct timely care conferences with the resident/responsible party for 4 of 17 sampled residents (Residents 17, 35, 47, and 65) when reviewed for care planning. This failure placed the residents at risk for unmet needs, not being involved or informed of their plan of care, and a diminished quality of life. Findings included . Resident 17 Review of the electronic health record (EHR) showed Resident 17 readmitted on [DATE]. Resident 17 was able to make their needs known. During an interview on 12/04/2024 at 2:56 PM, Resident 17 stated, I don't remember going to a care conference. Review of Resident 17's EHR showed the most recent care conference occurred 07/22/2024. Resident 35 Review of the EHR showed Resident 35 readmitted on [DATE]. Resident 35 was able to make their needs known. During an interview on 12/05/2024 at 9:30 AM, Resident 35 stated, I went to a care conference a long time ago. I don't remember going to one recently. Review of Resident 35's EHR showed the most recent care conference occurred 03/21/2024. Resident 47 Review of the EHR showed Resident 47 admitted to the facility on [DATE] with diagnoses to include chronic pain and dementia. During an interview on 12/04/2024 at 2:16 PM, Collateral Contact 1 (CC1), stated they did not recall Resident 47 having a care conference. Review of Resident 47's EHR showed the most recent care conference occurred 04/18/2024. Resident 65 Review of EHR showed Resident 65 readmitted to the facility on [DATE]. Resident 65 was able to make their needs known. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/2024 at 8:40 AM, Resident 65 stated, I don't remember going to a care conference. Review of Resident 65's EHR showed the most recent care conference occurred 05/16/2024. During an interview on 12/05/2024 at 1:32 PM, Staff F, Social Services Director, stated care conferences were offered to residents on admission and then quarterly. Staff F stated they were behind on care conferences for long-term residents; however, the expectation was that they were completed quarterly. During an interview on 12/11/2024 at 10:21 AM, Staff A, Administrator, stated the expectation was for residents to be offered care conferences on admission and quarterly. Reference WAC 388-97-1020(2)(c)(d) (5)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to provide and accurately document the necessary care and services to ensure that a resident received showers as scheduled and had facial hair removed for 1 of 4 sampled residents (Resident 35) reviewed for activities of daily living (ADLs). This failure placed the resident at risk for continued unmet needs and a poor quality of life. Findings included . Review of Resident 35's electronic health records (EHR) showed Resident 35 readmitted to the facility on [DATE] with diagnoses to include contracture of the right hand (permanent tightening of muscle, tendons and skin, leading to deformity), muscle weakness, and difficulty in walking. The quarterly minimum data set, an assessment tool, dated 10/29/2024, showed Resident 35 required partial/moderate assistance with shower/bathing and was able to make needs known. Observations on 12/04/2024, 12/05/2024, 12/06/2024, 12/09/2024, and 12/10/2024 showed Residet 35 with multiple long (approximately one inch long) white facial hairs on their chin. Observation and interview on 12/05/2024 at 9:27 AM showed Resident 35 with facial hair on their chin. Resident 35 stated they had a lot of hair on their chin and did not remember anyone ever asking to remove the hair. Resident 35 stated they were to receive a shower every Monday and Thursday; however, that did not always happen. During a follow-up interview and observation on 12/06/2024 Resident 35 stated they did not get a shower yesterday (Thursday 12/05/2024) and continued to have facial hair on chin. Review of Resident 35's ADL care plan intervention, initiated on 12/07/2023, showed Resident 35 required partial assistance by one staff with showering two times weekly and as necessary. Review of Resident 35's shower/bathing task in the prior 30 days documentation from 11/06/2024 through 12/05/2024 had two questions that were to be answered: 1) Bathing type completed? which showed Resident 35 had received baths on 11/10/2024, 11/14/2024, 11/22/2024, and 11/24/2024 (four days out of 30 days). It showed, No bath provided on Thursday 12/05/2024. 2) Type of bathing? which showed Resident 35 had a shower twice a day almost every day. During an interview on 12/09/2024 at 1:17 PM, Staff Z, Certified Nursing Assistant, stated the shower schedule showed that Resident 35 was to have a shower on Mondays and Thursdays, and they had not showered Resident 35 today; however, the shower/bathing task documentation showed, Not Applicable was documented for today and they were not sure why. Staff Z stated Resident 35 had facial hair on their chin and Resident 35 told Staff Z that they wanted their facial hair on the chin removed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 10:55 AM, Staff AA, Registered Nurse, stated Resident 35 was scheduled to have showers on Mondays and Thursdays. Staff AA stated Resident 35 had facial hair on their chin and asked Resident 35 if they wanted the hair removed/shaved and Resident 35 stated, Yes. Staff Z stated the shower/bathing task documentation looked like Resident 35 was getting a shower a couple time a day and that was not accurate. Staff AA could not explain why Not applicable was documented on 12/09/2024 when that was Resident 35's scheduled shower day. During an interview on 12/10/2024 at 11:16 AM, Staff B, Director of Nursing Services, stated Resident 35's shower/bathing task documentation looked like the resident was getting a shower a couple times a day almost every day for bathing type; however, for bathing completed it did not look like Resident 35 received showers twice a week per schedule. Staff B stated documenting Not applicable, on a scheduled shower day did not meet expectations. Staff Z stated Resident 35 should have been shaved and provided showers per schedule on Mondays and Thursdays and/or refusals documented. Reference WAC 388-97 -1060 (2)(c)

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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 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** 46148 Based on observation, interview, and record review, the facility failed to follow provider's orders for 2 of 7 sampled residents (Residents 66 and 8) when reviewed for non-pressure related skin conditions and unnecessary medications and failed to evaluate wheelchair positioning for 1 of 5 residents (Resident 17) when reviewed for positioning/mobility. These failures placed the residents at risk for poor clinical outcomes and a decreased quality of life. Findings included . Resident 66 Review of the EHR showed Resident 66 admitted to the facility on [DATE] with diagnoses of left below knee amputation, infection, and diabetes. The resident was able to make needs known. During an interview and observation on 12/05/2024 at 9:37 AM, Resident 66 stated they had wounds on their right foot and calf and on the left leg amputation site. There was a bandage present on both lower extremities. Resident 66 stated the dressing was not changed on 12/04/2024, and they had to ask staff to change it multiple times, but staff had put it off to the next shift and it never got done. Resident 66 stated this was a big concern for them. Review of the treatment administration record on 12/06/2024 showed provider's orders for daily dressing changes to Resident 66's right lower leg and foot/toe. Review showed no dressing change for the right lower leg and foot/toe was documented as completed for the dates of 12/03/2024 and 12/04/2024. During an interview on 12/05/2024 at 1:33 PM, Staff C, Assistant Director of Nursing (ADON), stated Resident 66 should have had their dressings changed to the right lower leg and toe every day. During an interview on 12/10/2024 at 9:59 AM, Resident 66 stated they did not have their dressing changed 12/09/2024 to their right foot. During an interview on 12/10/2024 at 11:01 AM, Staff B, Director of Nursing Services, stated it was their expectation that the assigned nurses follow the provider's orders and completed all scheduled dressing changes. Staff B stated if the nurse was unable to complete the dressing change on their shift, they should have let the next shift or manager know and made a progress note. Staff B stated Resident 66 not receiving their scheduled dressing changes did not meet their expectations. 38344 Resident 8 Review of the EHR showed Resident 8 readmitted on [DATE] with diagnoses to include anxiety disorder, depression, and paroxysmal atrial fibrillation (a type of irregular heartbeat that occurs in brief episodes). Resident 8 was able to make needs known. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provider order dated 06/07/2024 showed Resident 8 was prescribed to have orthostatic blood pressures (the measurement of a blood pressure when a person stands up from a lying or sitting position) obtained while lying and while standing monthly. The blood pressures were to be entered into the weights and vitals tab in the EHR to assess and evaluate both recordings for potential orthostatic hypotension (a drop in blood pressure when moving from a lying position to a standing position). It showed to document occurrence and action taken in progress notes. Review of Resident 8's EHR showed the November and December 2024 medication administration records (MAR) had documented staff initials that orthostatic BP had been obtained per provider orders; however, Resident 8's weights and vitals tab showed no documented orthostatic BP for standing. During an interview on 12/09/2024 at 10:18 AM, Staff G, Unit Manager (UM), stated orthostatic BP orders were entered into the MAR and were to be documented as completed and the results entered in the weights and vitals tab in the resident's EHR. Staff G stated they were unable to locate Resident 8's orthostatic BP for standing for November or December 2024 and this did not meet expectations. During an interview on 12/09/2024 at 10:28 AM, Staff B, Director of Nursing Services (DNS), stated Resident 8's November and December 2024 MAR showed documentation (staff initials) that orthostatic BP were obtained; however, Resident 8's standing orthostatic BPs were not located in the weights and vitals tab. Staff B stated staff should have obtained the orthostatic BP for standing or documented the resident refused and that did not happen for Resident 8. Resident 17 Review of the EHR showed Resident 17 readmitted on [DATE] with diagnoses to include arthritis (swelling of the joints), muscle weakness, spinal stenosis of the lower back with neurogenic claudication (a condition when the spinal canal narrows in the lower back putting pressure on the spinal cord and nerves). Resident 17 was able to make needs known. Review of the annual Minimum Data Set, an assessment tool, dated 10/08/2024, showed Resident 17 utilized a wheelchair for mobility, had lower extremity (LE, hip, knee, ankle, foot) impairment on both sides, and was dependent on staff for transfers to and from the bed. During an interview on 12/04/2024 at 10:13 AM, Resident 17 stated the length of the footrests on their wheelchair did not fit them correctly and were too far apart. Observation and interview on 12/05/2024 at 1:43 PM showed Resident 17 sat in their wheelchair with feet dangling in between their footrests. Resident 17 stated they were unable to place feet on the footrests and was unable to place feet flat on the floor; however, they were able to touch the floor with the tips of toes. Resident 17's head was below the attached head rest support. An attached lateral support (a device used to support a person from leaning to one side) to the right side of the back of the wheelchair was sticking out and not in place to provide support. During an interview on 12/06/2024 at 8:40 AM, Resident 17 stated staff were aware that they were unable to maintain correct position in their wheelchair; however, it never got fixed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 2:08 PM, Resident 17 stated when they got initially placed in their wheelchair, they were properly positioned; however, after a while they slid out of position and staff were aware. During an interview and observation on 12/11/2024 at 1:33 PM, Staff E, Director of Rehabilitation (DOR), stated they had checked out Resident 17's wheelchair positioning last week and it was appropriate at that time; however, they had not documented that and should have. Staff E stated Resident 17 was not currently positioned appropriately in their wheelchair because their bottom was not far enough back in the wheelchair. Resident 17 stated they slid out of position shortly after being up for a while. Staff E stated it was not okay for Resident 17 to slide shortly after being placed in the wheelchair and needed an order to evaluate and treat related to wheelchair positioning. During an interview on 12/11/2024 at 1:55 PM, Staff S, Certified Nursing Assistant, stated Resident 17 requested to be repositioned in their wheelchair frequently because they would no longer be positioned up right. During an interview on 12/11/2024 at 3:51 PM, Staff B, Director of Nursing Services, stated they were not aware that Resident 17 had not been positioned appropriately in their wheelchair. Staff B stated there should have been a referral obtained for therapy to evaluate and treat regarding wheelchair positioning. Reference WAC 388-97-1060 (1)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide services to maintain vision for 1 of 3 residents (Resident 65) reviewed for communication sensory. This failure placed the resident at risk of unmet vision needs, inability to perform activities of daily living, inability to participate in leisure activities and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 65 readmitted to the facility on [DATE] with diagnoses to include stroke, diabetes (too much sugar in the blood), and kidney failure. Resident 65 was able to make needs known. During an interview on 12/05/2024 at 8:45 AM, Resident 65 stated they needed new glasses because they were nearsighted, and they had told staff about a month ago. Review of Resident 65's document titled, Attending Physician Request for Services and/or Consultation, dated 03/25/2024, showed the form for eye care/referral was completed and signed by the provider on 03/25/2024. During an interview on 12/10/2024 at 1:29 PM, Staff G, Unit Manager, stated they were unable to locate any follow up documentation in Resident 65's EHR related to the 03/25/2024 Attending Physician Request for Services and/or Consultation eye care referral. During an interview on 12/11/2024 at 8:38 AM, Staff F, Social Services Director, stated Resident 65's eye care referral dated 03/25/2024 was sent to the facility's optometrist and an appointment was scheduled for Resident 65 to be seen in August 2024; however, a progress note dated 08/23/2024 showed the appointment was rescheduled for September 2024. Staff F stated the optometrist was not available to see Resident 65 at that time and they had been trying to reschedule another appointment; however, they were unable to show documentation of attempts to reschedule. Staff F stated Resident 65 should have been seen by an optometrist and this did not meet expectations. During an interview on 12/11/2024 at 11:13 AM, Staff A, Administrator, stated Resident 65 should have had vision issues taken care of back in March of 2024 and this did not meet expectations. Staff A stated Resident 65 needed to be seen and vision evaluated for glasses. Reference WAC 388-97-1060 (3)(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to ensure care and services to ensure residents increased or maintained range of motion (ROM) were provided for 3 of 5 sampled residents (Resident 17, 35, and 20) reviewed for position, range of motion/mobility. This failure placed the residents at risk for worsening mobility, developing of contractures (permanent tightening of muscle, tendons and skin, leading to deformity), and diminished quality of life. Findings included . Resident 17 Review of the electronic health record (EHR) showed Resident 17 readmitted on [DATE] with diagnoses to include arthritis (swelling of the joints), muscle weakness, and spinal stenosis of the lower back with neurogenic claudication (a condition when the spinal canal narrows in the lower back putting pressure on the spinal cord and nerves). Resident 17 was able to make needs known. Review of the annual minimum data set assessment (MDS), an assessment tool, dated 10/08/2024, showed Resident 17 utilized a wheelchair for mobility, had lower extremity (LE, hip, knee, ankle, or foot) impairment on both sides, and was dependent on staff for transferers to and from bed. Observation and interview on 12/05/2024 at 1:43 PM, showed Resident 17 sat up in wheelchair with feet dangling in between the footrests and the resident stated that they could swing their feet back and forth in between the footrests for exercise. Resident 17 was able to move both upper extremities (UE, shoulder, elbow, wrist, or hand). Review of Resident 17's care plan on 12/11/2024 showed no interventions for a restorative nursing program to maintain function of LE. Review of Resident 17's document titled, Physical Therapy PT Evaluation & Plan of Treatment, dated 07/13/2023, showed, Pt [patient] is appropriate for RNA [restorative nursing assistant] program to mobilize BLE [both lower extremities] and gently progress strengthening in supine/seated position in WC [wheelchair]. It showed, Suitable for LE ROM/strength with RNA. Review of Resident 17's EHR showed a restorative program progress note, dated 09/05/2023, which documented Resident 17 had exercised both lower extremities (ankles, knees, hips) with active assisted range of motion (AAROM). It showed both UE were exercised with AAROM at right upper extremity (RUE). This was the last restorative program progress note located in the resident's EHR. During an interview on 12/11/2024 at 3:06 PM, Staff G, Unit Manager (UM), stated Resident 17 was not on a restorative nursing program for their limited mobility to both lower extremities and should have been to maintain function. Resident 35 (continued on next page)

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	505436	A. Building B. Wing	12/11/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 35 readmitted on [DATE] with diagnoses to include contracture of the right hand, muscle weakness, difficulty in walking, and age-related physical debility (a condition that affects a person's mobility, physical capacity, stamina [the ability to sustain prolonged physical or mental effort], or dexterity [the ability to use hands, fingers, and arms to perform a task with skill and ease]). Resident 35 was able to make needs known. Review of the quarterly MDS, dated [DATE], showed Resident 35 had upper extremity (shoulder, elbow, wrist, hand) impairment on one side, and required partial/moderate assistance with dressing the upper body, toileting, shower/bathing, and required substantial/maximal assistance with dressing their lower body. Resident 35 did not exhibit behavior of rejection of care and did not receive restorative nursing programs/services. Observation and interview on 12/11/2024 at 12:23 PM showed Resident 35 sat at the bedside with fingers of the right hand curled inward while clinching the edge of a washcloth with their thumb and slightly tucked under the index/first finger; however, there was no space under the other curled fingers to hold onto the washcloth. There was a blue soft therapy carrot (a device used to prevent fingers from digging into the palm and to prevent skin damage and prevent further deformity) located on the overbed table. Resident 35 stated that their family member used to help with application of the carrot in the past. Resident 35 attempted to place carrot in the right hand but was unsuccessful and stated their fingers were sore. Review of Resident 35's document titled, Occupation Therapy Treatment Encounter Note(s), dated 03/28/2024, showed, Eval [evaluation] only, skilled OT [Occupational Therapy] not indicted at this time. Pt is resistant to handling of [their] R [right] hand (with contractures) by others and does not want to address ADLs [activities of daily living] at this time. It showed, Patient and Caregiver Training: Instructed pt in use of 'threading tool' to be used with 'carrot', and prolonged stretch in SROM [self-range of motion] to hand. Review of Resident 35's document titled, Occupational Therapy Evaluation and Plan of Treatment, dated 03/28/2024 showed, Functional Limitations as Result of Contracture(s): Unable to open R hand. Nursing assists with washing and drying. Pt performs SROM and uses carrot with assistance. It showed, Nursing is managing patient's contracture impairment. It showed, Due to pt's age and resistance to PROM [passive range of motion, outside force/moving the joints for a person], recommend continued use of 'carrot' and regular hygiene to maintain R hand skin integrity. Review of Resident 35's care plan on 12/11/2024 showed no interventions in place for the use of a carrot for the right-hand contracture or limited mobility to the right upper extremities and no focus care plan documented of the resident being non-compliant or resistive to care. During an interview on 12/11/2024 at 12:37 PM, Staff H, Certified Nursing Assistant (CNA), stated they did not apply a carrot to Resident 35's right hand and was not aware if the facility had a restorative program. During an interview and joint observation on 12/11/2024 at 1:59 PM, Staff E, Director of Rehabilitation (DOR), asked Resident 35 if they were able to put the carrot in place to the right hand and Resident 35 was unable to do so. Staff E stated there was no intervention care planned to protect the right palm and to prevent further contracture. Staff E stated Resident 35 should have been receiving restorative nursing care for the management of the right-hand contracture. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/2024 at 3:51 PM, Staff A, Administrator (ADM), and Staff B, Director of Nursing Services (DNS), both stated they did not have a restorative nursing program in place. Staff A stated the facility had a short time in the Spring (2024) that they had a restorative program; however, it stopped in April 2024. Staff A stated residents that needed restorative care should have had it documented in their tasks in the computer system for the CNAs to provide ROM or brace/splint application for functional maintenance, and Staff B stated it should be care planned. Staff A stated Resident 17 did not have a ROM program in tasks to maintain lower extremity function and there should have been. Staff A stated Resident 35 did not have a restorative nursing program or a task for the resident's right-hand contracture and there should have been. 46067 Resident 20 Review of EHR showed Resident 20 admitted to the facility on [DATE] with diagnoses to include right side hemiplegia (severe or complete unilateral loss of strength or paralysis) and osteoarthritis (long-term degenerative joint condition). Resident 20 required extensive assistance with activities of daily living. Review of the EHR showed Resident 20 to have both upper and lower extremity impairments. Observation and interview on 12/11/2024 at 1:42 PM, showed Resident 20 laid in bed. A pair of foot drop boots were observed on the floor in the corner. Resident 20 stated staff rarely put the boots on for them and they were supposed to have their splint on for the day. Resident 20 stated they mostly laid in the bed and did not participate in any restorative therapy. Review of the care plan, dated 01/11/2023, showed no intervention for ROM related to Resident 20's extremity impairment. Review of a care plan, initiated on 02/24/2023, showed a focus area for restorative for contractures related to right fingers, elbows and both knees. Resident 20 to participate in restorative program to manage contractures and increase ROM and strength for functional. Further review showed this focus was resolved on 01/11/2024. Review of the most recent Occupational Therapy Discharge Summary dated 04/03/2024-05/29/2024 showed discharge recommendations as follows: Home exercise program, Environmental modifications, Functional Maintenance Program and Restorative Nursing Program. During an interview on 12/11/2024 at 1:51 PM, Staff G, Unit Manager (UM), stated when a resident had limited range of motion it should be addressed in the care plan. Staff G stated the facility currently did not have a restorative nursing program and that restorative was not being addressed. Staff G was unable to provide a reason for Resident 20's restorative being discontinued but stated it may have been due to no longer having the restorative program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/09/2024 at 1:44 PM with Staff E, Director of Rehabilitation (DOR), stated the facility no longer recommended restorative upon discharge from therapy because they did not have adequate staff to run the program. Staff E stated the discharge recommendation was usually a home exercise program, participation in the exercise classes activities provided or residents who were able could use the gym. Staff E stated, We really need a restorative program for residents to maintain levels of functioning when they complete therapy. Reference WAC 388-97-1060 (3)(d)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to ensure residents received necessary care and assistance to maintain continence for 1 of 6 sampled residents (Resident 394) reviewed for bowel and bladder incontinence, and unnecessary medications. This failure placed the resident at risk for incontinence, skin injuries, and diminished quality of life. Findings included . Review of electronic health record (EHR) showed Resident 394 was admitted to the facility on [DATE] with diagnoses of fracture of left leg, asthma, and muscle weakness. Resident 394 was able to make needs known and needed assistance to move out of bed. Observation and interview on 12/04/2024 at 11:22 AM showed Resident 394 in bed with a device on their left leg. Resident 394 stated they needed assistance to go to bathroom and by the time the staff came, they were fully soiled. Resident 394 stated therapy had assisted them to use the toilet on 11/28/2024 and told them two strong staff could assist and transfer them to the bathroom. Resident 394 stated last weekend there were two strong staff members, and they were willing to help and started to do it, but the weekend charge nurse stopped them, and told them they were not allowed. Yesterday morning [12/03/2024], I had to have a bowel movement and had to use my briefs, as the staff could not help me. Review of Resident 394's care plan showed a focus area for continence, initiated 11/28/2024. The goal of the resident would be to remain independent, and interventions included: 1) One person assist with bed pan, 2) Observe for different signs of infection, and 3) Provide with toileting supplies as needed. There was no formal plan or directions to staff on how or when to provide toileting services, or care to minimize incontinence. [NAME] an interview on 12/10/2024 at 10:08 AM, Staff E, Director of Rehabilitation, stated therapy developed a therapy communication form on admission that described basic transferring instructions for each new resident and passed that to nursing. Review of therapy communication form dated 11/28/2024 for Resident 394 stated 2-person maximum assistance with stand pivot (provide most of the assist during the transfer) and toileting 2-person assistance. During an interview on 12/10/2024 at 1:34 PM, Staff B, Director of Nursing Services, stated the process was for the nursing department to update the care plan with the instructions from therapy, the nursing department to provide needed services to maintain continence, this did not occur for Resident 394, and it did not meet expectation. Reference WAC 388-97-1060(3)(c)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to ensure residents received the correct amounts of supplemental nutrition for 2 of 2 sampled residents (Residents 34 and 81) and failed ensure diet recomendations and fluid restrictions were implemented for 2 of 5 sampled residents (Residents 19 and 74) reviewed for nutrition. These failures placed residents at risk for medical complications, unmet care needs, and a diminished quality of life. Findings included . Resident 19 Review of the electronic health record (EHR) showed Resident 19 admitted to the facility on [DATE] with diagnoses that included kidney disease, heart failure, and depression. Resident 19 was able to make needs known. During an interview on 12/05/2024 at 9:58 AM, Resident 19 stated the facility did not follow the recommendations of their provider related to their diet and fluids. Resident 19 stated they were offered cinnamon rolls for breakfast and foods high in sodium. Review of a provider's order, dated 05/13/2024, showed to push fluids 300 milliliters (ML's) five times daily and document the amount consumed. Review of Resident 19's diet order on 12/06/2024 showed the resident was prescribed carbohydrate control, regular texture, thin consistency liquids. Review of a providers after care assessment summary dated 12/02/2024 showed recommendations for a low salt diet, no more than two grams of sodium daily and no more than two liters of fluid daily. During an interview on 12/10/2024 at 2:25 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was that the recommendations should have been presented to the provider to accept the recommendations. Staff B stated the recommendations were never forwarded to the provider and that it did not meet their expectations. 46148 Resident 34 Review of the EHR showed Resident 34 admitted to the facility on [DATE] with diagnoses of hemiplegia (inability to move one side of the body), malnutrition (lack of proper nutrition), neoplasm of the oropharynx (throat cancer) and dysphagia (difficulty swallowing) and had a gastrostomy tube (a tube inserted through the abdomen into the stomach for nutrition). The resident was able to make needs known. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/04/2024 at 11:51 AM showed Resident 34 laid in bed. There was a gastrostomy tube present in the resident's stomach. Resident 34 stated staff provided them with liquid nutrition through the tube multiple times a day and sometimes the resident would administer it themselves. Review of a registered dietitian nutrition note dated 11/08/2024 showed the resident was assessed to require 325 milliliters (ml) of 1.4 calorie/ml nutritional formula four times a day to equal 1820 calories (kcal) with 80 grams protein. Review of a provider's order, dated 11/08/2024, showed staff were to provide 325 (ml) of nutritional formula four times a day via bolus (given through the gastrostomy tube). Review of the medication administration record (MAR) showed Resident 34 received 237 ml three times and 325 ml one time to equal 1450 kcal on 12/03/2024, and 237 ml four times to equal 1327.2 kcal on 12/04/2024. Review of the EHR showed the resident weighed 159.6 pounds on 10/05/2024, 152.8 pounds on 11/02/2024 and 149.4 pounds on 12/09/2024 (a total of 10 pounds lost over 60 days). During an interview on 12/06/2024 at 11:13 AM, Staff J, Resident Care Manager (RCM), stated Resident 34 should have been receiving the ordered amount of formula but did not. During an interview on 12/06/2024 at 2:06 PM, Staff B, Director of Nursing Services (DNS,) stated staff should have been providing the amount that was ordered. Staff B stated Resident 34 received less than what was ordered, and this did not meet expectations. 49926 Resident 81 Review of the EHR showed Resident 81 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (a condition that occurs when the blood flow to the brain is blocked causing brain cells to die), muscle weakness, and diabetes (too much sugar in the blood). Resident 81 was dependent on staff for nutrition via artificial route and by mouth. Observation and interview on 12/05/2024 at 9:25 AM showed Resident 81 in bed and stated, I am getting formula in the tube and looked towards the brown colored bottle at the sink area. Review of Resident 81's provider's orders showed an order for Jevity 474 ml (a nutritional formula, 2 cartons) in the morning at 8:00 AM. Review of Resident 81's medication administration record (MAR) for November 2024 showed the resident received one carton for Jevity at 8:00 AM for 16 of 30 opportunities. Review of Resident 81's MAR for December 2024 through 12/06/2024 showed the resident received one carton for Jevity at 8:00 AM for four of six opportunities. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 1:50 PM, Staff B, DNS, stated the nurse was not paying attention, made an error, and this did not meet expectation. Resident 74 Review of the EHR showed Resident 74 was admitted to the facility on [DATE] with diagnoses of heart failure, endocarditis (infection of the heart) and kidney failure with dependance of kidney dialysis (medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do). Resident 74 was able to make needs known. During an observation and interview on 12/04/2024 at 8:53 AM, Resident 74 was in bed with a pink water pitcher on the overbed table. Resident 74 stated their renal doctor wanted them on a fluid restriction. Review of Resident 's 74's orders and care plan showed no orders or instructions on fluid restriction. Review of Resident 74's registered dietician assessment, dated 11/15/2024, showed a one litter fluid restriction was needed. Review of Resident 74's nephrology inpatient progress note, dated 11/08/2024, showed a fluid restriction of one liter per day. During an interview on 12/10/2024 at 1:39 PM, Staff B, Director of Nursing Services (DNS), stated the process was to follow up on the fluid restrictions and either have an order or explain why there was not an order, and this did not meet expectations. Reference WAC 388-97-1060(3)(i)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to provide respiratory care according to professional standards of practice for 1 of 3 sampled residents (Resident 74) reviewed for respiratory care. This failure placed the resident at risk for infection, unmet needs, and diminished quality of life. Findings included . Review of the EHR showed Resident 74 was admitted to the facility on [DATE] with diagnoses of heart failure, endocarditis (infection of the heart), and kidney failure with dependance of kidney dialysis (medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to do). Resident 74 was able to make needs known. Observation and interview on 12/05/2024 at 9:00 AM showed Resident 74 laid in bed with a continuous positive airway pressure machine (CPAP, device to keep airway open while a person sleeps) next to them. Resident 74 stated, My only problem is, the aids do not want to add water in my machine, and it takes a long time to get a nurse in here. Review of Resident 74's EHR showed no order or care plan about the CPAP machine or instructions on how to care for the machine. Observation on 12/09/2024 at 1:44 PM showed the CPAP machine's water chamber was full of unclear water with particles of white/grayish color that were floating inside the fluid mass. During an interview on 12/09/2024 at 1:49 PM, Staff C, Assistant Director of Nursing, stated It's yucky and initiated cleaning of the water chamber of the CPAP machine. During an interview on 12/10/2024 at 1:42 PM, Staff B, Director of Nursing Services, stated the nurses were to monitor for personal CPAP machines and initiate orders and care plans when they were used, and this does not meet expectations. Reference WAC 388-97-1060(3)(j)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to consistently conduct and document pre and post dialysis (treatment to filter wastes and water from the blood) assessments and ensure consistent ongoing communication and collaboration with the dialysis center regarding dialysis care and services for 2 of 2 sampled residents (Residents 65 and 66) reviewed for dialysis. This failure placed the residents at risk for unmet care needs and medical complications. Findings included . Resident 65 Review of the electronic health record (EHR) showed Resident 65 readmitted to the facility on [DATE] with diagnoses to include stroke, diabetes (too much sugar in the blood), kidney failure and required dialysis. Resident 65 was able to make needs known. Review of the provider's order dated 05/16/2024 showed Resident 65 was to receive dialysis treatment at a dialysis center on Mondays, Wednesdays, and Fridays. Review of Resident 65's dialysis binder on 12/10/2024 showed forms titled, Hemodialysis [also known as dialysis] Communication Record, dated 12/02/2024, 12/04/2024, 12/06/2024, and 12/09/2024 that had several blanks and were not filled out completely and/or had missing signatures. During an interview on 12/10/2024 at 1:35 PM Staff G, Unit Manager (UM), stated Resident 65's dialysis communication forms dated 12/02/2024, 12/04/2024, 12/06/2024, and 12/09/2024 were not filled out completely and did not meet expectations. During an interview on 12/10/2024 at 2:02 PM, Staff B, Director of Nursing Services (DNS), stated Resident 65's Hemodialysis Communication Records were not filled out completely and they should have been. 46148 Resident 66 Review of the EHR showed Resident 66 admitted to the facility on [DATE] with diagnoses of diabetes, end stage kidney disease and required dialysis. The resident was able to make needs known. Review of the EHR showed a provider's order dated 09/13/2024 for dialysis services on Mondays, Wednesdays and Fridays. Review of Resident 66's dialysis binder on 12/09/2024 showed forms dated 11/27/2024 and 12/2/2024. The follow-up sections for facility staff to complete on return from dialysis were blank. The form dated for 11/29/2024 showed a blank section for the dialysis center to complete and the follow-up section for facility staff to complete on return from dialysis was blank. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/2024 at 10:12 AM, Staff V, Licensed Practical Nurse Agency, stated the assigned nurse should complete the top section of the dialysis communication form prior to dialysis and when they returned the nurse should make sure the dialysis center section was completed, assess the resident and document the follow-up monitoring on the form. Staff V stated if the dialysis section was not completed the staff should call the center and fill it in or do a progress note. During an interview on 12/10/2024 at 10:57 AM, Staff B, DNS, stated it was their expectation that the dialysis center completed the middle section and when the resident returned the nurse on the floor should complete the bottom section. If it was not completed by the dialysis center, the nurse should call them and fill it in or complete a progress note. Staff B stated Resident 66's dialysis communication forms for the dates of 11/27/2024, 11/29/2024, and 12/02/2024 should have been completed accurately. Reference WAC 388-97 -1900 (1), (6)(a-c)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 3 sampled residents (Resident 85) reviewed for abuse. The facility failed to recognize and follow-up on a resident after a traumatic experience in their room. This failure placed the residents at risk for unmet needs, continued emotional disturbance, and diminished quality of life. Findings included . Review of a policy titled, Social Services Policy, undated, showed medically related social services were provided to maintain or improve each's resident's ability to control everyday physical needs and mental and psychosocial needs. It described in detail how social services was responsible for identifying emotional needs, providing corrective action, maintaining individualized care plans, and making regular progress notes. Review of the electronic health record (EHR) showed Resident 85 was admitted to the facility on [DATE] with diagnoses of fracture of right lower leg, injury of right ankle, and diabetes (too much sugar in the blood). Resident 85 was able to make needs known and needed assistance to get up from bed. Observation and interview on 12/04/2024 at 9:56 AM showed Resident 85 laid in bed with a worried facial expression. Resident 85 stated, I don't feel safe in here. Resident 85 stated early in the morning a male resident was walking towards the room in the hallway, and they could hear the footsteps coming close. Resident 85 stated they started yelling for everyone to get up. Resident 85 stated that there was a prior occurrence that frightened them very much, too. It was their previous roommate's visitor that was arrested by the police in front of them. Resident 85 stated the staff told them that they were arrested for attempted murder. When Resident 85 was asked if staff came and talked to them and checked of how they were doing, they stated I am ignored and mentally exhausted from this place. During an interview on 12/06/2024 at 10:06 AM, Staff F, Social Service Director (SSD), stated they got the information about wellbeing and emotional needs of the residents from the behavior monitors and progress notes, and stated they were not aware of Resident 85's concerns. Review of a progress note dated 11/18/2024 showed, [Resident 85] is highly motivated to do therapy today because [they] missed some days last week due to diarrhea caused by stress and anxiety. During an interview on 12/10/2024 at 1:43 PM, Staff B, Director of Nursing Services, stated the arrest event was a stressful event, and the expectation was for social services to provide visits and follow-up with Resident 85 and their emotional needs. During an interview on 12/11/2024 at 9:46 AM, Staff A, Administrator, stated the arrest event was stressful, and residents were protected as much as possible, social services was to follow-up with Resident 85 and document. Staff A stated this did not occur and this did not meet expectations. (continued on next page)

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	505436	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gig Harbor Health and Rehabilitation	3309 45th Street Court Northwest Gig Harbor, WA 98335

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0960(1)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to use nonpharmacological interventions (NPI, nonmedicated methods of achieving an outcome) prior to the use of as needed (PRN) pain medications for 3 of 5 sampled residents (Residents 53, 14, and 66) when reviewed for unnecessary medications. This failure placed residents at risk of avoidable side effects, taking unneeded medications, and a diminished quality of life. Findings included . Resident 53 Review of the electronic health record (EHR) showed Resident 53 admitted to the facility on [DATE] with diagnoses of acquired absence of right leg above knee and depression. Resident 53 was able to make needs known. Review of the medication list showed Resident 53 was prescribed a pain medication PRN. Review showed an order for NPI to be used before PRN pain medications and document effectiveness. Review of the medication administration record (MAR) for November 2024 showed Resident 53 received the PRN pain medication 14 times and was provided with no NPI. Review of the MAR for December 2024 showed Resident 53 received the PRN pain medication two times and was provided with no NPI. During an interview on 12/10/2024 at 11:06 AM, Staff G, Unit Manager, stated residents should receive NPI prior to being provided PRN pain medications to ensure the pain medications were needed. Staff G stated Resident 53 was prescribed PRN pain medications and the use of NPI prior to their use. Staff G stated nursing staff had not provided Resident 53 NPI, and this did not meet expectation. During an interview on 12/11/2024 at 10:01 AM, Staff B, Director of Nursing Services (DNS), stated residents should receive NPI prior to being provided PRN pain medications to ensure the pain medications were needed. Staff B stated this did not happen for Resident 53 and it did not meet expectation. 46067 Resident 14 Review of the EHR showed Resident 14 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and chronic obstructive pulmonary disease (COPD, a progressive lung disease causing obstructed airflow and breathing difficulties). Resident 14 was able to make needs known. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed the resident had an order for acetaminophen PRN for pain/temperature with a start date of 01/12/2024. Review of the EHR showed Resident 14 had no elevated temperature during November 2024. Review of the November 2024 MAR showed Resident 14 received 18 doses of acetaminophen without NPI documentation. During an interview on 12/10/2024 at 2:29 PM, Staff B, DNS, stated if the medication was administered for temperature, then NPIs would not have been documented; however, if administered for pain NPIs, should have been documented. 46148 Resident 66 Review of the EHR showed Resident 66 readmitted to the facility on [DATE] with diagnoses of left below knee amputation, infection and diabetes. The resident was able to make needs known. Review of the EHR showed the resident had an order for acetaminophen PRN for pain with a start date of 09/13/2024. Review of the November 2024 MAR showed Resident 66 received a dose on 11/02/2024 and 11/19/2024. NPI were marked not applicable (NA) for the dates of 11/02/2024 and 11/19/2024. During an interview on 12/06/2024 at 11:13 AM, Staff J, Resident Care Manager (RCM), stated staff should have attempted NPI prior to administering pain medications to Resident 66. Reference WAC 388-97 -1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to monitor for behaviors for 2 of 5 sampled residents (Residents 57 and 8) review for use of psychotropic medications (medications that affect a person's mental status). This failure placed the residents at risk for adverse side effects, unknown behaviors, and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 57 was admitted to the facility on [DATE] with diagnoses including anxiety and post-traumatic stress disorder. Resident 57 was able to make needs known. Observation and interview on 12/04/2024 at 1:40 PM showed Resident 57 sat in a dark room on the bed. They stated, I have night terrors and don't like to be awaken or touched. Review of Resident 57's medication administration record for November 2024 and December 2024 showed the resident was administered multiple antidepressant medications and an antianxiety medication. There was no behavior monitor to monitor what behaviors Resident 57 was experiencing and if the medications were effective. During an interview on 12/10/2024 at 1:53 PM, Staff B, Director of Nursing Services (DNS), stated behavior monitors were missing and that did not meet expectations. 38344 Resident 8 Review of the EHR showed Resident 8 readmitted to the facility on [DATE] with diagnoses to included anxiety disorder and depression. Resident 8 was able to make needs known. Review of the December 2024 MAR from 12/01/2024 - 12/05/2024 showed Resident 8 received antidepressant and antipsychotic medications per provider orders; however, there were no orders to monitor behaviors related to use of antidepressant and antipsychotic medications documented. There was an order dated 03/14/2024 to monitor for various behaviors but it did not indicate for what reason. During an interview on 12/10/2024 at 1:18 PM, Staff G, Unit Manager, stated Resident 8's behavior monitoring documentation in the December 2024 MAR for the specific use of antidepressant and antipsychotic medications were not being monitored from 12/01/2024 through 12/05/2024 and should have been. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 1:54 PM, Staff B, DNS, stated Resident 8's December 2024 MAR behavior monitoring related to antidepressant and antipsychotic medications use did not meet expectations. Staff B stated behaviors monitoring specifically related to antidepressant and antipsychotic medications use should have been monitored and documented in the MAR and that did not happen for Resident 8. Reference WAC 388-97-1060(3)(k)(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49926 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of 13 errors were made in 31 opportunities during a medication administration for 1 of 3 sampled residents (Resident 396) reviewed for medication administration. This placed the residents at risk for receiving medications that were not effective or less effective and a diminished quality of life. Findings included . Observation of medication administration on 12/06/2024 at 9:19 AM showed Staff V, Licensed Practical Nurse (LPN), prepared and administered metoclopramide (a medication to treat stomach problems) and 12 other medications to Resident 396. Review of provider's orders for Resident 396 showed the order for metoclopramide have a specific time and instructions to be given at 7:00 AM with meals and the orders for the 12 other medications had a specific time to be given at 8:00 AM. During an interview on 12/11/2024 at 9:34 AM, Staff B, Director of Nursing Services, stated the expectation was for nurses to follow orders including the correct time of administration and this did not happen for Resident 396. Reference WAC 388-97-1060(3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49926 Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 3 of 3 medication carts (Run 3, Peak 1, and Run 4) and 2 of 2 medication rooms (South and North) when reviewed for medication storage. The facility failed to have prescription medications locked in the medication room for 1 of 2 nurses' stations (North Nurses' Station). This failure placed residents at risk for receiving expired medications, ineffective treatment, accidental ingestion of medication, and a diminished quality of life. Findings included . Observation on 12/04/2024 at 10:40 AM showed medications belonging to Resident 3 left unsupervised on the North Nurses' Station counter. Observation showed the medications were 8 packets (bingo) cards of the medication Seroquel (medication used to treat mental illness), and 4 bingo cards of Tamsulosin (medication prescribed to treat kidney stones). During an interview on 12/04/2024 at 10:51 AM, Staff X, Licensed Practical Nurse (LPN), stated they should have been locked away, and took the medications to the medication room. Observation of South medication room on 12/10/2024 at 2:23 PM with Staff J, Resident Care Manager (RCM), showed the temperature log of the medication storage refrigerator did not document temperatures for 26 of 60 opportunities for November 2024. Observation of North medication room on 12/11/2024 at 8:21 AM with Staff J, RCM, showed the temperature log of the medication storage refrigerator did not document temperatures for 17 of 60 opportunities for November 2024. During an interview on 12/11/2024 at 8:24 AM, Staff J, RCM, stated the temperature should have been documented by the assigned nurses. Observation and interview of Run 3 medication cart, on 12/10/2024 at 2:43 PM with Staff W, Registered Nurse (RN), showed a bottle of atropine sulfate (an eye medication) with no date of opening or label of who it belonged to. Observation showed a bottle of refresh eye drops not dated when opened. Staff W stated the eye drops should have been dated when opened. Observation and interview of Peak 1 medication cart on 12/11/2024 at 8:17 AM with Staff V, LPN, showed insulin opened on 11/10/2024. Staff V stated the insulin was expired. Observation and interview of Run 4 medication cart on 12/11/2024 at 8:25 AM with Staff Y, RN, showed Olopatadine eye drops opened and not dated, latanoprost eye drops opened on 11/09/2024, and atropine eye drops opened on 11/08/2024. Staff Y, RN, did not know when the eye drops expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/2024 at 9:25 AM, Staff B, Director of Nursing Services, stated medication refrigerators should be monitored for temperature twice a day and medications that were multidose medication should be dated when opened and discarded when expired. Staff B stated Run 3, Peak 1, and Run 4 medication carts and North and South medications rooms did not meet expectations. Staff B stated all medications should be secured behind a lock and not left unsupervised. Reference WAC 388-97-1300(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40817 Based on observation, interview, and record review, the facility failed to monitored refrigerator temperatures and take corrective action as needed for 1 of 3 resident refrigerators (South Clean Utility Fridge) when reviewed for kitchen. This failure placed residents at risk of consuming spoiled food goods, avoidable foodborne illnesses, and a diminished quality of life. Findings included . Observation of the South Clean Utility Fridge on 12/10/2024 showed temperature logs for November 2024 and December 2024 hung to the front. Review of the temperature logs showed spaces for AM and PM temperatures to be recorded and written at the bottom was, NOTE: [.] Refrigerator temperature should not exceed 40 [degrees]. Notify supervisor if temperature exceeds these guidelines. Review showed a space for comments to be written. Review of the November 2024 South Clean Utility Fridge temperature log showed 11 of 31 AM temperatures and 16 of 31 PM temperatures were recorded as above 40 degrees. Review showed no comments had been made for these temperatures. Review of the December 2024 South Clean Utility Fridge temperature log through 12/10/2024 showed 3 of 10 AM temperatures and 1 of 10 PM temperatures were recorded as above 40 degrees. Review showed no comments had been made for these temperatures. During an interview on 12/10/2024 at 2:06 PM, Staff L, Dietary Manager, stated the South Clean Utility Fridge was monitored for temperature by housekeeping staff and kitchen staff would ensure the temperatures were correct. Staff L stated the South Clean Utility Fridge temperature log showed numerous entries above 40 degrees and this did not meet expectation. During an interview on 12/11/2024 at 9:40 AM, Staff M, Environmental Services Director, stated they monitored the South Clean Utility Fridge Monday through Friday and temperatures should be 40 degrees or less. Staff M stated if the temperature was too high, they would notify maintenance. Staff L stated the South Clean Utility Fridge had temperatures over 40 degrees numerous times in November 2024 and they had informed maintenance. During an interview on 12/10/2024 at 1:20 PM, Staff N, Maintenance Assistant, stated the maintenance department was unaware the South Clean Utility Fridge had temperatures above 40 degrees. During an interview on 12/11/2024 at 12:43 PM, Staff A, Administrator, stated the South Clean Utility Fridge was monitored by housekeeping and any temperature above 40 degrees should be reported to the maintenance department. Staff A stated the monitoring of the South Clean Utility Fridge for November 2024 did not meet expectation. Reference WAC 388-97-1100 (3), -2980

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed explain and ensure residents understood the arbitration agreement for 3 of 3 residents (Residents 75, 14, and 31) when reviewed for arbitration agreement. This failure placed residents at risk of forfeiting their right to a jury trial, inability to seek restitution for errors made by the facility, and a diminished quality of life. Findings included . Resident 75 Review of the electronic health record (EHR) showed Resident 75 admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis (weakness on one side of the body) and cognitive communication deficit (difficulty with communication). Review showed Resident 75 was able to sign their own documents and make needs know. Review of the arbitration agreement showed Resident 75 signed the document but did not date it. During an interview on 12/06/2024 at 11:24 AM, Resident 75 stated they did not know what an arbitration agreement was and did not recall anyone explaining it to them. Resident 75 stated they were very sick when the admitted to the facility and would not have been able to sign legal documents. After the arbitration agreement was shown to Resident 75, they stated they would not have wanted to sign an arbitration agreement. Resident 14 Review of the EHR showed Resident 14 admitted to the facility on [DATE] with diagnoses of bipolar disorder (a mental illness that causes extreme mood swings) and cognitive communication deficit. Review showed Resident 14 was able to sign their own documents and make needs know. Review of the arbitration agreement showed Resident 14 signed the document but did not date it. During an interview on 12/06/2024 at 11:24 AM, Resident 14 stated they recalled signing an arbitration agreement but did not know what it was. Resident 14 stated they were not in a state to be signing documents when admitted to the facility because they were very sick and did not have a representative to sign the admission documents. After the arbitration agreement was shown to Resident 14, they stated they would not have wanted to sign an arbitration agreement. Resident 31 Review of the EHR showed Resident 31 admitted to the facility on [DATE] with diagnoses of dementia (a group of neurological conditions that cause a decline in mental ability and interfere with daily life) and cognitive communication deficit. Resident 31 was able to make needs known. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the arbitration agreement showed Resident 31 signed the document on both the signature and date lines, and did not date the document. During an interview on 12/09/2024 at 1:33 PM, Staff T, Admission Director, stated the facility presented the arbitration agreement with the admission paperwork packet and ensured residents were able to sign by noticing whether they were confused or not. Staff T stated the previous admissions coordinator had obtained arbitration agreement signatures from Residents 75, 14, and 31. Staff T stated the previous admissions coordinator had not adequately completed their work duties, to include arbitration agreements. During an interview on 12/10/2024 at 9:31 AM, Staff A, Administrator, stated arbitration agreements were presented with the admission packet and the admission staff would get a good feel of whether the resident could sign their own documents. No Associated WAC

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 38344 Based on interview and record review, the facility failed to ensure that the Quality Assessment and Performance Improvement (QAPI) program self-identified deficiencies and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Failure to have an effectively functioning QAPI program that consistently self-identified deficient practices led to repeated deficiencies, a pattern of deficiencies, widespread deficiencies, and a pattern of actual harm that placed residents at repeated risk for unmet needs that could negatively impact their safety, quality of life and quality of care. Findings included . During an interview on 12/12/2024 at 10:33 AM, Staff B, Director of Nursing Services (DNS), stated they took over the DNS position in July 2024 and had been informed of issues related to infection control; however, the systems were supposed to have been fixed by the time they took over the DNS position. Staff B stated they could do a better job with the QAPI process to decrease repeated deficiencies. During an interview on 12/12/2024 at 10:58 AM, when asked if they had reviewed the [NAME] report (a report with previously cited deficiencies) to identify any repeat deficiencies that needed to be addressed, Staff A, Administrator, stated, Yes. Staff A stated they had made improvements in some areas and not in other areas. When asked why the QAPI Committee had not self-identified repeated issues, Staff A stated they did not know; however, some may be due to changes in staff. Staff A stated that they needed to be more in turned to the QAPI process and make better changes from that. Staff A stated there was room for improvement in the QAPI process. Although the facility conducted QAPI meetings, the facility failed to self-identify deficiencies, identify that they did not sustain corrections of previously identified deficiencies, and/or make timely revisions to previous action plans to ensure corrections were sustained. Refer to the following citations from the current survey cycle which were not identified, were identified and not addressed, or had ineffective plans of correction to sustain correction by the QAPI program which led to repeated deficiencies, pattern or widespread of deficiencies, and harm. (D = Isolated, E = Pattern, F = Widespread, and G = harm): REFER TO F552 (D) Right To Be Informed/make Treatment Decisions: Previous deficiency dated 02/28/2024 (E) REFER TO F585 (E) Grievances: Previous deficiency dated 02/28/2024 (D) REFER TO F600 (D) (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Free From Abuse and Neglect: Previous deficiency dated 02/28/2024 (D) REFER TO F609 (D) Reporting Of Alleged Violations: Previous deficiency dated 02/28/2024 (E) REFER TO F610 (D) Investigate/prevent/correct Alleged Violation: Previous deficiency dated 02/28/2024 (D) REFER TO F623 (E) Notice Requirements Before Transfer/Discharge. REFER TO F645 (E) Pre-admission Screening and Resident Review: Previous deficiency dated 02/28/2024 (D) REFER TO F657 (E) Care Plan Timing and Revision: Previous deficiency dated 02/28/2024 (E) REFER TO F677 (D) Activities of Daily Living Care Provided for Dependent Residents: Previous deficiency dated 02/28/2024 (D) REFER TO F684 (D) Quality Of Care: Previous deficiency dated 02/28/2024 (G) and 07/17/2024 (D) REFER TO F685 (D) Treatment/devices To Maintain Hearing/vision: Previous deficiency dated 02/28/2024 (D) REFER TO F688 (E) Increase/Prevent Decrease in ROM/Mobility REFER TO F692 (D) Nutrition/Hydration Status Maintenance: Previous deficiency dated 02/28/2024 (D) REFER TO F695 (D) Respiratory/tracheostomy Care and Suctioning: Previous deficiency dated 01/2023 (D) and 02/28/2024 (D) (continued on next page)

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	505436	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	REFER TO F698 (E) Dialysis: Previous deficiency dated 02/28/2024 (D) REFER TO F757 (E) Drug Regimen Is Free from Unnecessary Drugs: Previous deficiency dated 02/28/2024 (E) REFER TO F758 (D) Free from Unnecessary Psychotropic Medications/as need (PRN) use: Previous deficiency dated 02/28/2024 (E) REFER TO F759 (E) Free of Medication Error Rates 5 Percent or More REFER TO F761 (E) Label/Store Drugs and Biologicals REFER TO F812 (D) Food Procurement, store/prepare/serve-Sanitary: Previous deficiency dated 02/28/2024 (F) REFER TO F847 (E) Entering Into Binding Arbitration Agreement REFER TO F880 (H) Infection Prevention & Control: Previous deficiency dated 07/2018 (D), 10/2019 (D), 01/2023 (D) and 02/28/2024 (F). REFER TO F881 (E) Antibiotic Stewardship Program: Previous deficiency dated 02/28/2024 (D) Reference WAC 388-97-1760(1)(2)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to prevent the transmission of a communicable disease by implementing facility policies and/or outbreak protocols timely for 10 of 94 sampled residents (Residents 15, 14, 83, 352, 9, 351, 91, 344, 346 and 81) when reviewed for infection control/outbreak management. Residents 14, 83 and 9 experienced harm when they were sent to the hospital for illness and/or treated for complications after the facility failed to recognize an illness related to an infectious disease. The facility failed to implement transmission-based precautions (TBP) for 2 of 4 halls (100 and 200 Halls) when reviewed for TBP and ensure sanitary use of washing machines when reviewed for laundry. These failures contributed to one third of the resident population to become ill with respiratory symptoms and placed residents, visitors, and staff at risk for communicable diseases, related complications, and potential death. <Outbreak Management> Review of the facility policy titled Outbreak of Communicable Diseases, dated 07/2023, showed An outbreak of influenza is defined as a single case if unusual for the facility and to report it to the local health jurisdiction. It showed that the infection preventionist and director of nursing was responsible for initiating TBP and communicating with the medical director. The medical director was responsible for overseeing the management of the outbreak. Review of an email communication with Staff C, Infection Preventionist (IP), dated 12/06/2024, showed the LHJ made recommendations to follow the Centers for Disease Control (CDC) Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities which showed Influenza testing should occur when any resident has signs and symptoms of acute respiratory illness or influenza-like illness. Implement Droplet Precautions for all residents with suspected or confirmed influenza. And, if exposed, residents on units or wards with influenza cases in the long-term care facility (currently impacted wards) should receive chemoprophylaxis (antiviral/Tamiflu) as soon as an influenza outbreak is determined . Antiviral chemoprophylaxis is meant for residents who are not exhibiting influenza-like illness but who may be exposed to prevent transmission. During an interview on 12/11/2024 at 11:33 AM, Staff Q, Nurse Practitioner, stated they followed the 2024-2025 Minnesota Association of Geriatrics Inspired Clinicians (MAGIC) Alliance for Clinical Excellence (ACE) influenza protocol and Staff R, Medical Director, had decided to not follow the LHJ recommendations and only provided antiviral/Tamiflu to residents with current symptoms. Review of the MAGIC ACE influenza protocol showed residents should be screened for new onset nonproductive cough, fever over 100 degrees Fahrenheit or myalgia (muscle aches), headache, nasal congestion, or new fatigue. If symptoms were identified, the resident should be tested for influenza and Covid-19. If positive or pending results, antiviral/Tamiflu should be started within 48 hours of symptom onset and place the resident on droplet precautions until no symptoms were present for 24 hours. Resident 14 (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	Review of the EHR showed Resident 14 readmitted to the facility on [DATE] with diagnoses of pneumonia and sepsis (the body's life threatening response to infection). The resident was able to make needs known. Review of the progress note, dated 12/07/2024, showed Resident 14 stated they did not feel well with nausea, vomiting, wheezing, and shortness of breath. No documentation was found that the resident was tested for influenza or Covid-19, was placed on droplet precautions, or administered Tamiflu. Review of a progress note, dated 12/09/2024, showed Resident 14 started receiving fluids by clysis (administration of fluids through the skin) for dehydration. Review of a progress note, dated 12/10/2024 at 7:07 AM, showed Resident 14 had a decline in condition and oxygen saturation levels dropped to 90%. The resident was sent to the emergency room . Review of an emergency room visit note, dated 12/10/2024, showed the resident was admitted to the hospital for influenza, pneumonia, acute kidney injury, and hypoxia (lack of oxygen in the blood). Resident 83 Review of the EHR showed Resident 83 admitted to the facility on [DATE] with diagnoses of epilepsy (a chronic brain disorder that causes people to have recurrent seizures) and altered mental status. The resident was not able to make needs known. Review of a provider note, dated 12/05/2024, showed Resident 83 had new onset cough and a chest congestion. Review of the EHR showed a chest x-ray was obtained on 12/06/2024, but no follow-up documentation was found. No documentation was found that the resident was tested for influenza or Covid-19 infection or was placed on droplet precautions. Review of a progress note dated 12/09/2024 at 10:40 PM showed Resident 83 was assessed for fever, chills and malaise and was ordered chemoprophylaxis (Tamiflu), greater than 48 hours after symptom onset. Observation on 12/10/2024 at 8:59 AM showed Resident 83 was in bed coughing without being able to stop. Resident 83 yelled out, Help me! Review of a progress note, dated 12/10/2024 at 4:30 PM, showed Resident 83 had a decline in condition when their oxygen levels dropped to 85%. Resident 83 was sent to the emergency room for low oxygen levels and confusion. Review of EHR on 12/12/2024 showed Resident 83 had not returned from the hospital. Resident 9 Review of the EHR showed Resident 9 admitted to the facility on [DATE] with diagnoses of Alzheimer's and chronic kidney disease. The resident was unable to make needs known. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	Review of the EHR showed, on 12/07/2024, Resident 9 was ordered Levaquin (an antibiotic) to rule out infection and Ceftriaxone (an antibiotic) for possible infection on 12/09/2024, two days later. Review of the December infection control line listing for Resident 9 did not include Levaquin, did not include a symptoms onset date, or if criteria were met to be given an antibiotic. Review of the EHR showed Resident 9 was sent to the emergency roiagnom on [DATE] for a change in mental status. Resident 9 was noted to slide out of her wheelchair and be lethargic with a decreased level of alertness. Resident 9 returned with a diagnosis of influenza at 1:20 AM on 12/12/2024. Review of progress note, dated 12/12/2024 at 7:03 AM, showed Resident 9 was not placed on droplet precautions for six hours after return from hospital. Resident 15 Review of the electronic health record (EHR) showed Resident 15 admitted to the facility on [DATE] with diagnoses of diabetes, chronic obstructive pulmonary disease, and heart failure. The resident was able to make needs known. Review of a progress note, dated 11/26/2024 at 2:41 PM, showed Resident 15 complained of a non-productive cough, congestion, fatigue, generalized malaise (a general feeling of discomfort), and lung sounds with upper lobe wheezing and diminished bases (decreased lung sounds in lower lung). There was no documentation the resident was assessed for influenza or Covid-19, Tamiflu being started, or droplet precautions being implemented. Review of a progress note dated 12/02/2024 at 11:53 PM showed Resident continues on [antibiotic without any adverse side effects] reported. had an occasional moist cough. Cough drops were somewhat helpful. There was no documentation the resident was tested for influenza or Covid-19, Tamiflu being started, or droplet precautions being implemented. Review of a progress note, dated 12/07/2024 at 5:14 PM, showed Resident 15 complained of still not feeling well s/p abx [after antibiotic] therapy for URI [upper respiratory infection]. Resident with decreased appetite and poor hydration. Review of the electronic health record (EHR) on 12/10/2024 showed Resident 15 required clysis for dehydration and still had not been treated per facility protocol. Review on 12/10/2024 of the respiratory outbreak line listing showed Resident 15 was not included. Resident 352 Review of the EHR showed Resident 352 admitted to the facility on [DATE] with a diagnosis of acute kidney failure. Review of a progress note, dated 12/08/2024, showed the resident had complained of not feeling well and their oxygen saturation dropped to 85% and had wheezing breath sounds. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	Interview at 12/11/2024 at 9:43 AM, Staff DD, Licensed Practical Nurse, stated Resident 352 was having respiratory symptoms but was not isolated. Observation of Resident 352's door showed no signage for precautions and personal protectice equipment (PPE) was not available at the door. Observation at 10:34 AM showed housekeeping staff enter Resident 352's room without PPE use. Interview with Staff EE, Certified Nursing Assistant, stated Resident 352 was not on isolation precautions. Staff EE stated he provided assistance with the breakfast meal to Resident 352 without wearing PPE that morning. Review on 12/11/2024 (three days after symptom onset) showed no documentation that Resident 352 was tested for influenza or Covid-19, placed on droplet precautions or started on Tamiflu. Observation on 12/11/2024 at 10:40 AM showed staff entering room [ROOM NUMBER] without personal protective equipment which was required for droplet precautions. Resident 351 Review of the EHR showed Resident 351 admitted to the facility on [DATE] with a diagnosis of amyotrophic lateral sclerosis (ALS, a nervous system disease that affects nerve cells in the brain and spinal cord. ALS causes loss of muscle control.) The resident was able to make needs known. Review of a provider note, dated 12/02/2024, showed the resident had new respiratory symptoms of a cough and an order for Mucinex for congestion of respiratory tract was added. No documentation was found that the resident was tested for influenza or Covid-19 infection, was placed on droplet precautions, or administered Tamiflu. Observation on 12/05/2024 at 10:22 AM showed Resident 351 was laying in bed. They were flushed red and complained of a headache. The resident could be heard coughing and blowing their nose. Observation showed a staff in the room with a family member. There was no droplet precautions sign on the door. Review of the EHR on 12/07/2024 showed Resident 351 had not been started on Tamiflu. Resident 91 Review of the EHR showed Resident 91 admitted to the facility on [DATE] with diagnoses of breast cancer and left hip replacement. The resident was able to make needs known. Review of a provider note, dated 12/02/2024, showed Resident 91 was complaining of cough for past 2 days plus congestion. No documentation was found that the resident was tested for influenza or Covid-19, placed on droplet precautions, or started on Tamiflu. Review of an updated respiratory outbreak line listing, dated 12/12/2024, showed a total of 31 out of 94 residents with respiratory symptoms. During an interview on 12/06/2024 at 9:13 AM, Staff D, IP, stated it was their expectation that staff who identified new respiratory symptoms in residents would have notified the provider, tested for influenza and Covid-19 and placed the resident on droplet precautions but this had not happened. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	During an interview on 12/11/2024 at 12:04 PM, Staff D stated they had identified a higher number of residents receiving orders for chest x-rays and antibiotics for pneumonia but did not think of influenza or Covid-19. During an interview on 12/11/2024 at 12:28 PM, Staff D stated Resident 15's complications could have been prevented if treated sooner and Resident 14 and 83's complications could have been prevented if the outbreak protocols were implemented sooner. During an interview on 12/11/2024 at 12:12 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that when a pattern of new onset respiratory symptoms was identified, the staff should have notified the provider, performed tests, and placed the residents on droplet precautions. Staff B stated it was their expectation that Staff D would start the outbreak protocol, notify the LHJ, and follow their recommendations. Review of the respiratory outbreak line listing, dated 12/10/2024, showed 31 residents were included for respiratory illness symptoms and assumed positive for influenza A. <Transmission Based Precautions> Review of the facility form posted on residents' doors titled Droplet Precautions, dated 08/10/2023, showed staff were to perform hand hygiene, wear a mask and wear eye protection prior to entering the room. Use patient dedicated equipment or clean and disinfect shared equipment. Residents should wear masks if transport out of the room is needed. Review of the Centers for Disease Control guidance for enhanced barrier precautions (EBP) showed Nursing facilities should use EBP for residents with infection or colonization with a targeted multidrug resistant organism (MDRO) when Contact Precautions did not otherwise apply and/or Wounds and/or indwelling medical devices even if the resident was not known to be colonized or infected with an MDRO. Observation on 12/05/2024 at 1:28 PM showed Resident 344 standing at their bedside. The resident had a tube attached to their side draining dark fluid. Observation showed the resident had a drain inserted into the side of their abdomen. No enhanced barrier precautions sign was posted on the door. Observation on 12/05/2024 at 1:29 PM showed Resident 346 was lying in bed. They had a urinary catheter attached to the side of the bed with clear yellow liquid. Resident 346 stated they had a large wound in their groin that required daily bandage changes. No enhanced barrier precautions sign was posted on the door. Observation on 12/05/2024 at 1:32 PM, showed Resident 81 was lying in bed. There was a tube connected into the resident's stomach for nutrition. No enhanced barrier precautions sign was posted on the door. During an interview on 12/05/2024 at 1:28 PM, Staff D, IP, stated Resident 344, 346 and 81 should have been placed on enhanced barrier precautions, but they were not and this did not meet expectations. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	Observation on 12/05/2024 at 1:29 PM showed a contact precautions sign posted outside of room [ROOM NUMBER] which showed staff were to wear a gown and gloves when entering the resident's room. Staff C, Assistant Director of Nursing, entered the room and set-up supplies for wound care, exited the room, performed hand hygiene, and obtained towels. Staff C then entered the room and set-up towels and supplies on the resident's bed. They exited the room and performed hand hygiene. No gown or gloves were used. Observation on 12/06/2024 at 8:12 AM showed room [ROOM NUMBER] with a droplet precautions sign on the door. Resident 351 was heard coughing from the hallway with the door open. Staff BB, Licensed Practical Nurse (LPN), entered the room wearing only a mask, no eye protection. When Staff BB exited the room, they did not change their mask and went back to the medication cart. At 8:19 AM, Staff H, Certified Nursing Assistant, entered the room to assist Staff BB with moving Resident 351 up in bed. Neither staff were observed wearing eye protection. Staff H left the room and failed to remove their mask. Staff H was observed to enter room [ROOM NUMBER] with the same mask. At 8:22 AM, Staff BB stated they did not wear eye protection because it was optional. Staff BB said they did not change their mask and should have. At 8:28 AM, Staff H said they did not know they had to wear full personal protective equipment adding they thought a surgical mask was fine. Staff H failed to identify the need to discard used masks when exiting a room with droplet precautions and wear eye protection. Observation on 12/09/2024 at 10:22 AM showed room [ROOM NUMBER] with a droplet precautions sign on the door. Unidentified staff was in the room in gown and gloves assisting the resident in the window bed and went from that resident to the resident in the bed by the door and assisted them to reposition in bed. They did not perform hand hygiene, change their gown or gloves, and did not wear eye protection. Observation on 12/11/2024 at 9:15 AM showed staff exiting room [ROOM NUMBER] with a Hoyer lift (a mechanical device to transfer residents). There was a droplet precautions sign on the door. The staff took the lift directly across the hall to room [ROOM NUMBER] and used the lift to transfer another resident. They Hoyer lift was not sanitized between residents. During an interview on 12/11/2024 at 9:37 AM, Staff O, Certified Nursing Assistant, stated they would usually use purple wipes for cleaning the lifts but they could not find any, and stated, There is none available at the moment. Observation on 12/11/2024 at 10:33 AM showed no purple wipes available for use on the 100/200 hall. Observations on 12/11/2024 at 11:45 AM showed in room [ROOM NUMBER] a staff member delivered a meal tray, exited the room and retrieved another lunch tray from the meal cart and delivered it to room [ROOM NUMBER]. Both rooms had droplet precautions signs posted on the doors. Hand hygiene was not performed, and the staff was not wearing eye protection. The staff member then went to room [ROOM NUMBER] and delivered a meal tray. There was no droplet precautions sign on room [ROOM NUMBER]'s door. (continued on next page)

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F 0880 Level of Harm - Actual harm Residents Affected - Some	During an interview on 12/05/2024 at 1:32 PM, Staff D, IP, stated it was their expectation that staff always followed the directions on the precautions signs and wiped down any shared equipment between patients. <Laundry> During an observation and interview on 12/09/2024 at 9:41 AM, Staff P, Laundry Worker, demonstrated the process for loading and unloading the front load washing machines. Staff P stated they did not sanitize the door/gasket between loads of laundry. There was a visible layer of debris in the edges of the door and on the seal gasket. Staff P began to pick out the debris and stated they did not feel it needed to be cleaned. During an observation and interview on 12/09/2024 at 9:48 AM, Staff M, Environmental Services Director, observed lint and grime buildup on the gasket and in the edges of the door and stated it did not meet their expectations and the gasket and door should have been wiped down and sanitized with each load. During an interview on 12/11/2024 at 12:14 PM, Staff B, DNS, stated the facility's outbreak response, enhanced barrier precautions, transmission based precautions, and the laundry machine sanitation did not meet their expectations. Reference WAC 388-97 -1320 (1) (c), (2)(a)(b), (3)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 46148 Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use, and decrease the development of antibiotic resistance by not ensuring criteria were met for the use of antibiotics and an indication for use/type of infection was included in the provider orders for 6 of 10 sampled residents (Residents 9, 45, 15, 14 , 63 and 26) when reviewed for antibiotic stewardship. These failures placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics, and a decreased quality of life. Findings included . Review of the facility policy titled Antibiotic Stewardship, dated 04/2023, showed the infection preventionist (IP) would review antibiotic utilization daily to identify inappropriate use of antibiotics to include: indications for use that do not meet the criteria for clinical definition of an active infection, and if an antibiotic is indicated, prescribers will provide complete antibiotic orders including (F.) Indication for use. Resident 9 Review of the EHR on 12/10/2024 showed Resident 9 was ordered Levaquin (an antibiotic) to rule out infection on 12/07/2024 and Ceftriaxone (an antibiotic) for possible infection on 12/09/2024. Review of the December 2024 infection control line listing did not include Levaquin for Resident 9. It did not include a symptoms onset date, or if criteria were met. Resident 45 Review of the EHR on 12/10/2024 showed Resident 45 was ordered Clindamycin (an antibiotic) for Infection on 11/21/2024. Review of the November 2024 infection control line listing showed criteria were not met. Resident 15 Review of the EHR on 12/10/2024 showed Resident 15 was ordered doxycycline for upper respiratory infection on 11/27/2024. Review of the November 2024 infection control line listing showed criteria were not met. Resident 14 Review of the EHR on 12/10/2024 showed Resident 14 received an order for Bactrim DS (an antibiotic) every 12 hours for antibiotic on 09/29/2024 and an order for Daptomycin intravenously for Antibiotic on 10/10/2024. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the September 2024 and October 2024 infection control line listing showed both antibiotics were not included. Resident 63 Review of the EHR showed Resident 63 received an order for the following antibiotics: 1. Daptomycin Intravenous for infection on 11/04/2024 -11/15/2024. 2. Doxycycline for infection on 10/28/2024-11/25/2024. 3. Rifampin for Infection on 10/12/2024 - 10/28/2024. This antibiotic was not included in the October 2024 infection control log. Resident 26 Review of the EHR showed Resident 26 was ordered Bactrim (an antibiotic) for a urinary tract infection on 11/23/2024. Review of the November 2024 Infection control line listing showed criteria were not met. Review of a provider note, dated 11/22/2024, showed Resident was complaining about urinary tract infection (UTI) symptoms last month, but culture did not grow enough bacteria to treat. [Resident 26] is planning to discharge home next week and there have been some concerns about the safety of the discharge. It seems prudent at this point to treat likely UTI, to help improve functional status. No culture was obtained, and no documented criteria was found in the EHR. During an interview on 12/11/2024 at 9:27 AM, Staff Q, Nurse Practitioner, stated the orders should include the specific indication for use, not just infection. Staff Q stated Resident 26 almost had a UTI so they treated them just in case. On 12/11/2024 at 12:10 PM, during a co-interview with Staff D, IP, and Staff B, Director of Nursing Services, Staff D stated they should have reviewed and logged all new antibiotics daily for indications for use and culture results but did not. Staff D stated the orders should have included the reason for the antibiotic and possible infection, Antibiotic or infection which did not meet expectation. Staff B stated this did not meet their expectations. No associated WAC