STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505453	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kin on Health Care Center	4416 South Brandon Street Seattle, WA 98118

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility staff failed to provide care and services in a manner that maintained and promoted dignity before entering resident rooms for 4 of 11 rooms (Rooms 121, 122, 126 & 119), reviewed for dignity. This failure placed the residents at risk for a diminished self-worth and over-all well-being. Findings included . Review of the facility's policy titled, Resident Rights, revised on 10/17/2024, showed the resident has a right to be treated with respect and dignity. room [ROOM NUMBER] Multiple observations on 02/20/2025 at 8:55 AM, at 9:01 AM, at 9:11 AM, and at 9:20 AM, showed Staff R, Licensed Practical Nurse, entered room [ROOM NUMBER] without knocking or identifying themselves to the residents prior to entering. room [ROOM NUMBER] Multiple observations on 02/20/2025 at 8:56 AM, at 12:22 PM, and at 12:46 PM, showed Staff R entered room [ROOM NUMBER] without knocking or identifying themselves to the residents prior to entering. room [ROOM NUMBER] Observations on 02/20/2025 at 12:08 PM and at 12:48 PM, showed Staff R entered room [ROOM NUMBER] without knocking or identifying themselves to the residents prior to entering. room [ROOM NUMBER] Observation on 02/20/2025 at 12:54 PM, showed Staff R entered room [ROOM NUMBER] without knocking prior to entering the resident's room. On 02/20/2025 at 1:09 PM, Staff R stated that before they entered a resident's room they would knock on the door and introduce themselves. Staff R stated that they did not knock or introduce themselves prior to entering because some of the residents were sleeping, but that they should have. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/25/2025 at 1:10 PM, Staff D, Resident Care Manager, stated that the resident's room was considered their personal private space. Staff D further stated that prior to entering a resident's room, staff should knock on the door and introduce themselves. On 02/26/2025 at 11:08 AM, Staff B, Director of Nursing, stated it was their expectation for staff to knock and introduce themselves prior to entering a resident room. On 02/26/2025 at 11:30 AM, Staff A, Administrator, stated it was their expectation for staff to knock on the door, call the resident by their name, and introduce themselves prior to entering a resident room. Reference: (WAC) 388-97-0180 (1-2)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 47680 Based on observation, interview, and record review, the facility failed to ensure the survey result binder included the recertification and complaint survey results that resulted in citations for 2 of 3 years (2022 & 2024), reviewed for availability of survey reports. In addition, the facility failed to post notice of the availability of survey reports in areas of the facility that are prominent and accessible to the public. These failures prevented residents, residents' representatives and visitors from exercising their right to review past survey results and the facility's plan of corrections. Findings included . Review of the facility's policy titled, Availability of Survey Results, revised on 02/25/2025, showed, The facility will maintain reports of any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility. This information will be available for any individual to review upon request. The policy further showed, Signs identifying the availability and location of our survey binder and availability of previous survey results are posted throughout the building and public bulletin boards. Review of the State Survey/Inspection Report binder on 02/21/2025 at 9:06 AM, showed that the binder did not contain recertification and complaint surveys that resulted in citations during the three preceding years. Further review showed recertification survey results and associated plan of corrections dated 09/28/2022 and complaint survey results, and associated plans of corrections dated 08/01/2024 and 12/23/2024 were missing. In an interview and joint record review on 02/21/2025 at 2:37 PM, Staff A, Administrator, stated that they were in charge in maintaining the State Survey/Inspection Report binder and that it included recertification and complaint surveys. Staff A stated that they had been in the facility for two years and had been keeping the records in the binder since January 2023. Joint record review of the State Survey/Inspection Report binder did not show recertification survey results and associated plan of corrections dated 09/28/2022 and complaint survey results, and associated plans of corrections dated 08/01/2024 and 12/23/2024. Staff A stated that they should have been included in the binder. Observation on 02/21/2025 at 3:10 PM, showed that the facility did not have a posting of the availability of state survey results in areas of the facility that were prominent and accessible to the public (facility entrance, lobby, hallway by the main dining room, and bulletin board by the Social Services office). (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview on 02/21/2025 at 3:14 PM, Staff A stated that they had a posting of the availability of the state survey reports in areas of the facility that were prominent and accessible to the public and that it was located next to the State Survey/Inspection Report binder (by the bulletin board by the Social Services office). Joint observation of the bulletin board by the Social Services office did not show a posting of the availability of the state survey reports. Staff A stated that they did not have a posting of the availability of the state survey reports and that they should have. Reference: (WAC) 388-97-0480(1)(a)(b)(c)(2)(b)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45146 Based on interview, and record review, the facility failed to initiate and resolve a grievance for 1 of 3 residents (Resident 1), reviewed for grievances. The failure to initiate, investigate, and resolve grievances for missing personal item placed the resident at risk for feelings of frustration, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Resident and Family Grievances, revised on 07/08/2024, showed, The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations .The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. Review of the Quarterly Minimum Data Set (an assessment tool) dated 01/08/2025, showed Resident 1 was cognitively intact. In an interview on 02/18/2025 at 2:00 PM, Resident 1 stated that their lower denture was missing at the facility a year ago and that they did not have a replacement yet. In a follow-up interview on 02/21/2025 at 7:58 AM, Resident 1 stated that they reported their missing denture to the facility, and they did not hear back from them. Review of the nursing progress note dated 05/23/2024 showed that Resident 1 reported that their denture was missing. The note further showed that the Social Worker was aware of it. Review of the facility's grievance log from May 2024 through February 2025 did not show that a grievance was logged for Resident 1's missing denture, or an investigation was completed. In an interview on 02/24/2025 at 9:52 AM, Staff G, Social Services Director/Grievance Official, stated that if a resident's personal item was missing at the facility, they would initiate the grievance form and complete an investigation. Staff G stated that they were aware of Resident 1's missing denture, and they would look for the completed grievance form. In the follow-up interview on 02/25/2025 at 9:57 AM, Staff G stated that they could not find the grievance form completed for Resident 1's missing denture. Staff G further stated that grievance form should have been initiated, and an investigation completed. In an interview on 02/26/2025 at 8:28 AM, Staff A, Administrator, stated that they expected the Grievance Official to track and log grievances, and complete any necessary investigations. Staff A further stated that the facility's goal was to resolve grievances within five days and that Resident 1's missing denture grievance form should have been completed and investigated. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0460 (2)

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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 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** 47680 Based on interview and record review, the facility failed to ensure injuries of unknown source and falls were thoroughly investigated for 2 of 2 residents (Residents 81 & 65), reviewed for abuse investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions. Findings included . Review of the facility's policy titled, Incidents and Accidents, revised on 02/25/2025, showed, It is the policy of this facility for staff to utilize Point Click Care (Risk Management System) to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. The policy showed the purpose of incident reporting included assuring that appropriate and immediate interventions were implemented, corrective actions were taken to prevent recurrences, improve the management of resident care, conducting root cause analysis, and meeting regulatory requirements for analysis and reporting of incidents and accidents. The policy further showed, The following incidents/accidents require an incident/accident report but are not limited to . Falls . Unobserved injuries. Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed that injuries of unknown source meant any injury sustained by a resident where the source of the injury was Not observed directly by a staff person . The resident is not able to report/inform how the injury occurred .Injuries of unknown source may be either superficial or substantial in nature. It showed, Substantial injuries require more than first aid and may require close assessment and monitoring by nursing or medical staff. They [facility] also include injuries occurring in areas not generally vulnerable to trauma .Substantial injuries of unknown source, even if they do not appear to be due to abuse or neglect, must be reported to the Department, because the injuries may have resulted from the failure to take preventative measures. ALL substantial injuries of unknown source must be thoroughly investigated. ALL injuries (regardless of the extent) occurring in nonvulnerable areas of the body will be considered substantial injuries. The abuse guidelines further showed, EXAMPLES of SUBSTANTIAL INJURIES may include, but are not limited to the following: Abrasions, burns, deep lacerations, bruises of deep color and depth, or those occurring in areas not generally vulnerable to trauma, such as the back, face, head . RESIDENT 81 Review of the quarterly Minimum Data Set (an assessment tool) dated 11/27/2024, showed Resident 81 had cognitive impairment and was marked for Non-Alzheimer's Dementia (cognitive disorders that cause memory loss, confusion, and other cognitive impairments) in Section I (Active Diagnosis). Review of Resident 81's progress note dated 12/19/2024 written by Staff R, Licensed Practical Nurse, showed, Observed skin discoloration on right forehead size 2x2 [two by two] cm [centimeters-unit of measurement] in light purple with surrounding in yellowish color, skin is intact, no swelling. Resident is alert, oriented x3 [times three], neurocheck [an evaluation of the nervous system] within baseline. Resident's [Resident 81] unable to explain to this LN [Licensed Nurse]/recall what happened, denied pain or discomfort during assessment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin Observation Tool, dated 12/20/2024 showed that Resident 81 had bruising to the top of their scalp and measuring 3.5 cm by 2.0 cm. Review of the facility's December 2024 incident log did not show a log for Resident 81's bruise on their forehead. In an interview and joint record review on 02/24/2025 at 9:52 AM, Staff R stated that if they observed a bruise on a resident's head/face, and the resident was unable to state what happened, they would complete an investigation, interview staff, and notify Staff D, Resident Care Manager, residents' provider and their representative. Joint record review of the nursing progress note dated 12/19/2024 showed that Resident 81 was observed with a bruise on their forehead. Staff R confirmed that they had written the progress note dated 12/19/2024 and that they had notified Staff D. Staff R stated that they did not remember if an investigation was completed but that they interviewed staff and were told that Resident 81 may have bumped their head on the enabler/bed rail when they were restless/agitated. In an interview on 02/24/2025 at 12:46 PM, Staff D stated that their process was to investigate and inform Staff A, Administrator/Abuse Coordinator, and Staff B, Director of Nursing, when residents were found with a bruise in areas like the head/face and when the resident was unable to report what happened. Staff D stated that they were notified of Resident 81's bruise on their forehead and that they were placed on alert charting. Staff D stated that they were not sure if an incident report [investigation] was completed, and that Staff B was aware of Resident 81's bruise on their forehead. In an interview on 02/24/2025 at 1:00 PM, Staff B stated that if a bruise was found on a residents' forehead and the resident was not able to explain what happened, they would want to figure out why it happened and would complete an investigation. Staff B stated that it was mentioned to them of Resident 81's bruise on their forehead and spoke to Staff D. Staff B stated that the nurse's did an evaluation, and that Resident 81 would hit the enabler/bed rail when they were agitated. Staff B stated that an incident report would not be found because they were able to find the cause of the bruise. Staff B stated that they were told that if they were not able to figure out the cause of the bruise, they would do an incident report, and an investigation would be done. Staff B stated that it was not logged in the facility's incident log because they knew where the bruise came from. Staff B further stated that they did not consider Resident 81's bruise to their forehead a substantial injury, that there was no investigation report and that they only have progress notes and monitoring of the bruise. In an interview and joint record review dated 02/24/2025 at 1:38 PM, Staff A stated that they used the Purple Book for guidance related to abuse/neglect and injuries of unknown source. Staff A stated when a bruise was found on a residents' head and was unable to say what happened, they expected staff to assess/protect the resident, gather interviews/statement from the resident, other residents and staff. Staff A stated if the resident could not state what happened, they had to report it to the State Agency within 24 hours, continue their investigation and log it in the incident log. Joint record review of the December 2024 incident log did not show a log for Resident 81's bruise to their forehead. Joint record review of the Purple Book showed examples of substantial injuries of unknown source. Staff A stated that based on the information that was provided to them regarding Resident 81's bruise and inability to state what happened, Staff A stated that they would have expected it to be logged in the incident log and investigated. Staff A further stated that they reviewed Point Click Care for an investigation for Resident 81 and that they were not about to find one. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49619 RESIDENT 65 Resident 65 admitted to the facility on [DATE]. Review of Resident 65's nursing progress note dated 12/03/2024, showed Resident 65 had a nephrology (branch of medicine that deals with kidney diseases) appointment at a clinic. Further review showed the facility staff received a call from Resident 65's Representative stating that Resident 65 had a fall at the clinic and was in the emergency room (ER). Review of the social service's note dated 12/03/2024 from the ER medical center, showed that the facility staff were notified that Resident 65 was dropped off in the lobby by a medical transportation service and sat in the lobby for approximately 30 minutes and then ended up on the floor necessitating them to be brought into the ER. Further review of the note showed Staff B, was notified that the medical transportation service was not the appropriate level of transportation for the resident without a caregiver to accompany them due to their physical limitations, inability to move their wheelchair, and language barrier. Review of the facility's December 2024 Incident & Event Reporting Log showed no fall incidents were logged for Resident 65 on 12/03/2024. On 02/26/2025 at 9:10 AM, Staff W, Registered Nurse, stated the facility should investigate falls that occurred outside of the facility as the facility was responsible for the resident because they lived there. Staff W stated it was important to investigate falls because they needed to determine the resident's safety, and factors that contributed to the fall, and what they could do to prevent a fall from reoccurring. A joint record review on 02/26/2025 at 9:25 AM with Staff W, showed a nursing progress note dated 12/03/2024, revealed Resident 65 had a fall on 12/03/2024 while they were out on a nephrology appointment. Staff W stated that they did not see any documentation that the provider was notified, and that there was no risk management (investigation) for this fall. Staff W stated that the nurse responsible for the resident at that time should have started an investigation. On 02/26/2025 at 9:47 AM, Staff D stated that when an unwitnessed fall occurred, the investigation would be initiated through risk management. Staff D stated that there was no documentation post fall in the progress notes related to Resident 65's fall on 12/03/2024 and did not know how the fall had occurred as it was not documented in the progress notes. On 02/26/2025 at 10:45 AM, Staff B stated that an incident report was not made for Resident 65's fall on 12/03/2024. Staff B further stated that the facility was responsible for the resident and that they would have expected there to be a fall investigation for Resident 65 and have it logged on their incident log. On 02/26/2025 at 11:32 AM, Staff A stated that their policy Incidents and Accidents applied to any incidents inside or outside of the facility. Staff A further stated that they would expect a fall that occurred out of the facility to be logged, investigated and treated just as if the resident fell in the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0640 (6) (a-c)

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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** 45146 Based on observation, interview and record review, the facility failed to accurately assess 2 of 18 residents (Residents 1 & 57), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments of the MDS Section L (Oral/Dental Status) and Section N (Medications) placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The RAI manual's Oral/Dental Status coding instruction directed to check L0200A (broken or loosely fitting full or partial denture), if the denture or partial is chipped, cracked, uncleanable, or loose. The RAI manual's medications coding instruction showed, In N0450B [Has Gradual Dose Reduction (GDR) been attempted?] and N0450C [Date of last attempted GDR], include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic [a type of medication used to treat a mental health condition characterized by a loss of contact with reality] at the time of admission, or since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted . In N0450E [Date physician documented GDR as clinically contraindicated], enter date the physician documented GDR attempts as clinically contraindicated. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 1 Review of the Quarterly MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Observations on 02/18/2025 at 2:00 PM, on 02/21/2025 at 7:58 AM, and on 02/24/2025 at 8:08 AM, showed Resident 1 was wearing their broken upper denture with two teeth missing. Review of the dental consult note dated 06/21/2024 showed that Resident 1 had a loose or ill-fitting upper denture with teeth that were worn down. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review the annual MDS assessment dated [DATE] and quarterly MDS assessments dated 10/14/2024 and 01/08/2025 showed that the MDS's Oral/Dental Status sections were not marked for broken or loosely fitting full or partial denture. In an interview and joint record review on 02/24/2025 at 3:15 PM, Staff F, MDS Coordinator, stated that the oral/dental section of the MDS would be completed based on the resident's oral/dental assessment and review of the resident's dental consult note. A joint record review of Resident 1's dental consult note dated 06/21/2024 showed that the resident had a loose or ill-fitting upper denture with teeth that were worn down. A joint record review of the Oral/Dental Status sections of Resident 1's annual MDS assessment dated [DATE], quarterly MDS assessments dated 10/14/2024 and 01/08/2025 showed the MDS's Oral/Dental Status sections was not marked for broken or loosely fitting full or partial denture. Staff F stated that they completed Resident 1's MDS assessments based on the resident's response. In an interview on 02/25/2025 at 12:30 PM, Staff B, Director of Nursing, stated that they expected Resident 1's dental status was assessed, their dental consult note was reviewed, and their MDS assessment was completed accurately. 52331 RESIDENT 57 Resident 57 admitted to the facility on [DATE] with diagnoses that included delusions (strong beliefs or thoughts that are not based in reality). Review of Resident 57's February 2025 physician order summary report, active as of 02/20/2025, showed an order for olanzapine (an antipsychotic medication) five milligram (mg- unit of measurement) at bedtime with a start date of 04/05/2023. Record review of Resident 57's annual MDS dated [DATE], showed under Section N, item N0450B was coded as 0, indicating that Resident 57 did not have a GDR attempted. It further showed that item N0450D was coded as 1, indicating that there was a physician documentation of GDR as clinically contraindicated on 04/28/2024. Review of Resident 57's April 2024 medication administration record showed their olanzapine dose was decreased to 3.75 mg between 04/22/2024 to 04/28/2024. It further showed that olanzapine had been increased back to five mg after 04/28/2024 due to increased delusions. Review of Resident 57's progress notes from April 2024 to May 2024 did not show physician documentation of GDR as clinically contraindicated. In an interview and joint record review on 02/25/2025 at 10:29 AM, Staff F stated they followed the RAI Manual for coding accuracy. Joint record review of Resident 57's annual MDS dated on 08/08/2024 showed they coded N0450B as 0 which meant no GDR was attempted. A joint record review of the April 2024 physician order showed that Resident 57's olanzapine dose decreased between 04/22/2024 to 04/28/2024. Staff F stated that in N0450B, I should code yes, it is inaccurate code. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another interview and joint record review 02/25/2025 at 12:19 PM, Staff F stated that a clinically contraindicated GDR meant that the GDR failed to work for the resident. A joint record review of Resident 57's annual MDS dated [DATE] showed that Staff F coded N0450E as 04/28/2024. Further review of the progress note dated 05/06/2024 showed Staff K, Mental Health Advanced Registered Nurse Practitioner, wrote, failed GDR with deteriorating mood/behaviors in a slight decrease of olanzapine five to 3.75 mg in a few days . [Resident 57] is not fully recovered back to their baseline just yet. It is apparent that olanzapine five mg is the minimum effective dose to maintain their quality of life. for one year and could try GDR. When asked for the clinically contraindicated date for Section N0450E, Staff F stated, It should be 05/06/2024, it is not accurate. On 02/25/2025 at 1:20 PM, Staff B, stated that they expected MDS was coded truth and honest. Staff B further stated that they expected MDS assessments to be accurate. 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 - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness (SMI), intellectual disabilities (ID); or related conditions are not inappropriately placed in nursing homes for long term care) form was accurate and sent out for a Level II PASARR referral for 1 of 5 residents (Resident 58), reviewed for unnecessary medications. This failure placed the resident at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the facility's policy titled, Resident Assessment - Coordination with PASARR Program, revised on 02/21/2025, showed the Social Services Director (SSD) or designee was responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. Resident 58 admitted to the facility on [DATE]. Review of Resident 58's face sheet printed on 02/26/2025 showed a diagnosis that included depression (mood disorder that causes a persistent feeling of sadness). Review of Resident 58's PASARR, dated 12/30/2024 showed Section I was marked No for SMI indicators, and that the box for mood disorders (depression) was marked. Further review showed that No Level II evaluation indicated was checked off, and under additional comments resident, Continued Mirtazapine [antidepressant medication] for depression. On 02/21/2025 at 1:20 PM, Staff X, Social Worker, stated that when a resident admitted to the facility, they had to make sure their PASARR was filled out correctly. Staff X further stated that if the resident had any SMI or mental health diagnosis a Level II referral would be required. Staff X stated that Level II PASARRs were important because residents would receive the mental health services they needed. A joint record review and interview on 02/21/2025 at 1:45 PM with Staff X showed Resident 58's PASARR dated 12/30/2024 was marked for no SMI and the box for mood disorders (depression) was marked and no Level II referral required. Staff X stated that the PASARR was not accurate, had not been corrected, had no Level II referral in place, and that there should have been one. On 02/25/2025 at 12:20 PM, Staff G, SSD, stated that if a resident had a medical diagnosis for depression, they would expect a Level II referral to be in place and it was their expectation that PASARRs would be reviewed. On 02/26/2025 at 11:31 AM, Staff A, Administrator, stated that they expected staff to ensure PASARRs were filled out accurately, and if not, staff should contact the hospital to ensure they were corrected upon resident admission. Staff A further stated that if a resident had SMI of depression, they would expect a Level II referral to be in place. Reference: (WAC) 388-97-1915 (2) (a-b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48298 Based on observation, interview, and record review, the facility failed to develop and/or implement care plans for 7 of 8 residents (Residents 43, 78, 1, 9, 80, 3 & 85), reviewed for care planning. The failure to develop person-centered care plans for use of bed rails placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Comprehensive Care Plans, revised on 02/17/2025, showed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objectives and timeframes to meet a resident's medical, nursing .and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The policy further showed that comprehensive care plan will be developed within seven days after the completion of the comprehensive Minimum Data Set (MDS-an assessment tool) assessment. Review of the facility's policy titled, Proper Use of Bed Rails, revised on 02/24/2025, showed, The facility will continue to provide necessary treatment and care to the resident who has bed rails .This should be evidenced in the resident's records, including their care plan .Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars [enabler]. RESIDENT 43 Review of the February 2025 physician order summary report, showed Resident 43 had an order for a left bed enabler bars for transfer and activities of daily living (ADLs), dated 01/15/2025. Review of Resident 43's comprehensive care plan printed on 02/21/2025 did not show a person-centered care plan for use of left bed rail/enabler. Observation and interview on 02/21/2025 at 9:05 AM, showed Resident 43 had a left side rail attached to their bed frame in the raised position. Resident 43 stated that they used the left side rail to reposition and transfer themselves out of their bed. In an interview on 02/24/2025 at 12:15 PM, Staff V, Certified Nursing Assistant (CNA), stated that Resident 43 had a left side rail that they used to reposition in bed and helped [Resident 43] to stand up. In an interview on 02/24/2025 at 12:37 PM, Staff E, Resident Care Manager (RCM), stated that Resident 43 had a left bed enabler or side rail that they used for transfer or repositioning. Staff E stated that Resident 43 did not have a care plan related to the use of bed rails. Staff E stated they did an audit of all residents in their unit that used bed rails and that they added the left bed enabler on 2/20 [02/20/2025] in one of [Resident 43's] care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 78 Review of the February 2025 physician order summary report, showed Resident 78 had an order for both half side rails, dated 10/13/2023, Review of Resident 78's comprehensive care plans printed on 02/21/2025 did not show a person-centered care plan for the use of half side rails. Observation and interview on 02/21/2025 at 8:58 AM, showed Resident 78 had a left side rail attached to their bed frame in the raised position. Resident 78 stated that they used the left side rail to reposition and transfer themselves out of their bed. In an interview on 02/24/2025 at 12:18 PM, Staff V stated that Resident 78 had a left side rail that they used to reposition in bed and helped [Resident 78] to get up from bed. In an interview on 02/24/2025 at 12:51 PM, Staff E stated that Resident 78 did not have bed rails on both sides of their bed. Staff E stated that Resident 78 had a left side bed rail to help with transfer and repositioning. Staff E stated that Resident 78 did not have a care plan for bed rail use. Staff E stated they did an audit of all residents in their unit that used bed rails and that they added the left side enabler bar on 2/20 [02/20/2025] in one of [Resident 78's] care plans. In an interview on 02/25/2025 at 1:04 PM, Staff B, Director of Nursing, stated that they expected for Resident 43 and Resident 78 to have a person-centered care plan related to their use of bed rails. 45146 RESIDENT 1 Observations on 02/19/2025 at 10:41 AM, on 02/20/2025 at 1:51 PM, on 02/21/2025 at 7:55 AM, and on 02/24/2025 at 8:05 AM, showed Resident 1's bed had a bed rail/enabler attached to both sides of their bed. Review of the February 2025 physician order summary report, active as of 02/18/2025, showed Resident 1 had an order for Both 1/2 [half] side rails up for enabler, with an order date of 05/07/2021. Review of the comprehensive care plan printed on 02/20/2025 showed there was no comprehensive person-centered care plan initiated for Resident 1's bed rail/enabler use. A joint observation and record review on 02/24/2025 at 1:08 PM with Staff E, showed Resident 1 had a bed rail attached to both sides of their bed. A joint record review of Resident 1's comprehensive care plan showed there was no care plan for bed rail use. Staff E stated Resident 1 had bed enabler and there was no care plan for it. RESIDENT 9 Review of the quarterly MDS dated [DATE], showed Resident 9 was moderately impaired with cognition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 02/19/2025 at 10:22 AM, on 02/20/2025 at 9:57 AM and at 1:47 PM, on 02/21/2025 at 7:45 AM, and on 02/25/2025 at 9:09 AM, showed Resident 9 was lying in bed with half bed rails attached to both sides of their bed in the raised position. Review of the February 2025 physician order summary report, active as of 02/19/2025, showed Resident 9 had an order for Both 1/2 side rails up for enabler, with an order date of 09/20/2023. Review of the comprehensive care plan printed on 02/20/2025 showed there was no comprehensive person-centered care plan initiated for Resident 9's bed rails use. A joint observation and record review on 02/24/2025 at 12:59 PM with Staff E, showed Resident 9 was lying in bed with half bed rails attached to both sides of their bed in the raised position. A joint record review of Resident 9's comprehensive care plan showed there was no care plan for bed rail use. Staff E stated that Resident 9 had half bed rail on both sides of their bed and there was no care plan initiated for it. RESIDENT 80 Review of the quarterly MDS dated [DATE], showed Resident 80 was severely impaired with cognition. Observations on 02/19/2025 at 10:33 AM, on 02/20/2025 at 9:54 AM and at 1:49 PM, and on 02/24/2025 at 9:31 AM, showed Resident 80 was lying in bed with quarter bed rails attached to both sides of their bed in the raised position. Review of the February 2025 physician order summary report, active as of 02/19/2025, showed Resident 80 had an order for Bilateral [both sides] bed enabler bars for enabler/promote transfer and ADLs [activities of daily living], with an order date of 08/18/2024. Review of the comprehensive care plan printed on 02/20/2025 showed there was no comprehensive person-centered care plan initiated for Resident 80's bed rails use. A joint observation and record review on 02/24/2025 at 1:06 PM with Staff E, showed Resident 80 was lying in bed with quarter bed rails attached to both sides of their bed in the raised position. A joint record review of Resident 80's comprehensive care plan showed there was no care plan for bed rail use. Staff E stated that Resident 80 had bed enabler on both sides of their bed and there was no care plan initiated for it. In an interview on 02/25/2025 at 12:25 PM, Staff B stated that bed enablers were considered as grab bar, or an assist bar and it was their expectation that a care plan was initiated prior to using it. 47680 RESIDENT 3 Review of the quarterly MDS dated [DATE] showed that Resident 3 admitted to the facility on [DATE] and was cognitively intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's February 2025 physician order summary report showed, Left bed enabler bars to promote transfers and ADLs dated 09/23/2024. Review of the comprehensive care plan printed on 02/19/2025 did not show a comprehensive person-centered care plan to address Resident 3's bed rail use. Observation and interview on 02/18/2025 at 10:45 AM, showed Resident 3 lying in bed with a bed rail on the left side of their bed in the raised position. Resident 3 stated that they used their bed rail to get up from bed. Observations on 02/20/2025 at 1:20 PM and on 02/24/2025 at 10:15 AM, showed Resident 3's left bed rail in the raised position. In an interview on 02/24/2025 at 2:17 PM, Staff P, CNA, stated that Resident 3 used the bed rail during transfers and that they would look at the care plan on how to care for Resident 3. In an interview and joint record review on 02/24/2025 at 2:26 PM, Staff D, RCM, stated that they care planned use of bed rails. Joint record review of Resident 3's care plan did not show a care plan for bed rails. Staff D stated that it should have been care planned. In an interview on 02/25/2025 at 12:50 PM, Staff B stated that they expected Resident 3's bed rails/enablers to have been care planned. 52133 RESIDENT 85 Review of the quarterly MDS dated on 12/19/2024, showed Resident 85 was moderately impaired with cognition. Review of Resident 85's February 2025 physician order summary report showed, right bed enabler bar for enabler/promote transfer and ADLs, with an order date on 10/03/2024. Review of Resident 85's comprehensive care plan printed on 02/19/2025 did not show a person-centered care plan for use of right bed rail. Observations on 02/18/2025 at 9:56 AM and on 02/19/2025 at 9:20 AM, showed Resident 85 had a bed rail attached to the right side of their bed in the raised position. Observation on 02/20/2025 at 1:40 PM, showed Resident 85 used the bed rail to turn while in bed. Observation and interview on 02/24/2025 at 7:30 AM, Staff Q, CNA, stated that Resident 85 had one enabler bar on the right side of the bed and that it helped Resident 85 to get up and move in bed. Staff Q further stated that if a resident had a bed rail/enabler bar on their bed, it would be in the care plan in the electronic health record. In an interview on 02/25/2025 at 10:55 AM, Staff D stated that for the enabler bars we do [obtain] an order, inform family, and care plan it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/25/2025 at 12:25 PM, Staff B, stated that the bed enablers were considered as grab bar, or an assist bar and it was their expectation that a care plan was initiated prior to using it. Reference: (WAC) 388-97-1020 (1)(2)(a)

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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** 47680 Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 4 of 18 residents (Residents 76, 1, 492 & 58), reviewed for care plan revision. The failure to revise care plans for residents with diagnosis of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), missing/broken denture and discharge planning placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Comprehensive Care Plans, revised on 02/17/2025, showed, The comprehensive care plan will be reviewed and revised by the interdisciplinary team [IDT-therapy, nursing, social services] after each comprehensive and quarterly MDS [Minimum Data Set- an assessment tool] assessment. Review of the facility's policy titled, Discharge Planning Process, revised on 02/17/2025, showed that subsequent assessment information and discharge goals would be included in the resident's comprehensive plan of care. The policy further showed, The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications. RESIDENT 76 Review of the annual MDS dated [DATE] showed Resident 76 admitted to the facility on [DATE] and was severely impaired with daily decision making. It further showed that Resident 76 was marked in Section I (Active Diagnosis) for non-alzheimer's dementia (cognitive disorders that cause memory loss, confusion, and other cognitive impairments). Review of Resident 76's comprehensive care plan printed on 02/25/2025 showed a care plan for Alt. [alteration] in thought process/psychosocial [aspects relating to social and emotional state] wellbeing r/t [related to] strokes [damage to the brain from interruption of blood supply], encephalopathy [disturbance of brain function], low energy and weakness, adjusting new environment. Further review of the comprehensive care plan did not show a care plan to address Resident 76's dementia. Review of Resident 76's Diagnosis Report printed on 02/25/2025, showed a diagnosis of encephalopathy with an onset date of 07/17/2023 and classified as history. In an interview on 02/25/2025 at 10:28 AM, Staff Q, Certified Nursing Assistant, stated that they would review the care plan when caring for Resident 76. Staff Q further stated that Resident 76 had dementia and required total assist with their care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 02/25/2025 at 10:46 AM, Staff D, Resident Care Manager (RCM), stated that dementia should be care planned. Joint record review of Resident 76's diagnosis list showed a diagnosis of dementia. Staff D stated Resident 76 had dementia. Joint record review of Resident 76's comprehensive care plan showed a care plan for altered thought process related to encephalopathy and did not show that it was related to dementia. Joint record review of Resident 76's diagnosis list showed that encephalopathy was classified as a history. Staff D stated that Resident 76's care plan should have been revised to address Resident 76's dementia. In an interview on 02/25/2025 at 12:57 PM, Staff B, Director of Nursing, stated that they expected residents' who had a diagnosis of dementia to have had a care plan, and that Staff D could have revised it [Resident 76's care plan]. 45146 RESIDENT 1 Review of the quarterly MDS dated [DATE], showed Resident 1 was cognitively intact. Observations on 02/18/2025 at 2:00 PM, on 02/21/2025 at 7:58 PM, and on 02/24/2025 at 8:08 AM, showed Resident 1 was wearing their broken upper denture with two teeth missing. Resident 1 stated that their bottom denture was missing at the facility a year ago and that they did not have replacement yet. Review of the dental consult note dated 06/21/2024 showed that the resident had a loose or ill-fitting upper denture with teeth that were worn down. Review of the dental care plan, revised on 07/06/2021 showed that Resident 1, .has upper and lower full dentures. During an interview and a joint record review on 02/24/2025 at 1:16 PM, Staff E, RCM, stated that Resident 1's lower denture was missing a couple months ago. Joint record review of the dental care plan last revised on 07/06/2021 showed that Resident 1 had full upper and lower dentures. Staff E stated that Resident 1's dental care plan should have been updated. In an interview on 02/25/2025 at 12:30 PM, Staff B stated that they expected Resident 1's dental care plan was reviewed and revised with changes in the resident's dental status. 48298 RESIDENT 492 Review of the Resident 492's admission MDS dated [DATE], showed a Section Q0310 (Resident's Overall Goal) was coded 1 [one], indicating a discharge plan to the community (home). Review of Resident 492's Medicare (national health insurance program) weekly management reviews by the IDT dated 02/04/2025, 02/11/2025 and 02/18/2025 showed Resident 492's discharge goal was to return home after completion of their rehabilitation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 492's discharge planning care plan printed on 02/19/2025 showed that it was initiated on 01/31/2025. Further review of the discharge planning care plan did not show Resident 492's discharge goal to return home and did not show goals or interventions were revised or updated. In an interview and a joint record review on 02/25/2025 at 10:10 AM, Staff Z, Social Worker (SW), stated that Resident 492's discharge goal was to return home after their rehabilitation. Joint record review of discharge planning care plan with Staff Z did not show Resident 492's goal to return home. Staff Z stated that Resident 492's care plan had not been revised or updated to reflect their discharge goal. In an interview on 02/25/2025 at 12:20 PM, Staff G, Social Services Director, stated that Resident 492's discharge goal to return home had been determined at the IDT meeting and should have had been reflected in Resident 492's discharge planning care plan. In an interview on 02/26/2025 at 10:37 AM, Staff B stated that it was their expectation that residents' care plans were reviewed, revised or updated with any change on focus, goals, [and] interventions. Staff B further stated that Resident 492's discharge planning care plan was updated yesterday [02/25/2025] as they had discussed the concerns of not revising the care plan. In an interview on 02/26/2025 at 11:38 AM, Staff A, Administrator, stated that they expected social services staff to have updated or revised the discharge care plans to reflect residents' specific goals and interventions. 49619 RESIDENT 58 Resident 58 admitted to the facility on [DATE]. Review of the admission MDS dated [DATE], showed under Section Q0310. Resident 58's Overall Goal would like to discharge to the community per representative interview. Review of Resident 58's care plan initiated on 01/01/2025, showed a discharge care plan goal of STG [short term goal]: Discharge determination in 3 [three] months, and an intervention for Multidisciplinary evaluation in 3 months. The discharge care plan did not reflect the resident and/or representative's goals for discharge. On 02/18/2025 at 11:34 AM, Collateral Contact 1 stated that Resident 65's goal was to discharge back home. On 02/25/2025 at 10:30 AM, Staff X, SW, stated they determined the resident's goals for discharge upon their admission and in care plan meetings. Staff X stated they would document the resident's goals under Section Q of the MDS. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint record review and interview on 02/25/2025 at 10:43 AM with Staff X, did not show that Resident 58's care plan as to where the resident would like to be discharged to. Staff X stated that Resident 58's representative would like them to go back to the community where they originally lived. Staff X stated that there was no specific goal for the resident in their care plan that reflected this. Staff X further stated that the care plan was a framework for how they cared for the residents and that the social services department was responsible for the discharge planning part of the care plan. On 02/25/2025 at 12:22 PM, Staff G stated that their expectation would be to see the resident's goal coded in section Q of the MDS reflected in the resident's care plan. On 02/26/2025 at 10:37 AM, Staff B stated their expectation was for the care plan to include the resident's goals and they had 21 days to complete the care plan after admission. Staff B further stated if a resident's goals had changed, they would expect staff to update/revise the care plan to reflect the changes. On 02/26/2025 at 11:29 AM, Staff A stated that they would expect the resident's discharge goal to be in their care plan. Reference: (WAC) 388-97-1020 (2)(f) (4)(b) (5)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility failed to ensure adequate staff supervision and/or assistance was provided during meals for 1 of 2 residents (Resident 65) and failed to ensure bed rails/enablers were secured for 1 of 5 residents (Residents 3), reviewed for accident hazards. These failures placed the residents at risk for choking episodes, aspiration (when food or liquid enters the airways or lungs), accidents, injury, and other negative outcomes. Findings included . RESIDENT 65 Review of Resident 65's nutrition care plan, initiated on 11/23/2023, showed an intervention for one to one [1 on 1] supervision assist for aspiration precautions. Review of Resident 65's February 2025 physician order summary report, printed on 02/24/2025, showed a physician order for regular diet with 1 to 1 supervision assist. Further review showed another physician order for aspiration precaution: strict 1 to 1 feeding assist, check for pocketing. Sit fully upright for all PO [by mouth]. Remain fully alert for all PO. Stop PO if decreased LOA [level of alertness] or excessive coughing noted and notify [medical provider]. Observation on 02/20/2025 at 12:44 PM, showed Resident 65 was unsupervised, sitting up in bed with their lunch tray in front of them. Resident 65 was drinking from a cup in front of them. Another observation on 02/24/2025 at 12:42 PM, showed Resident 65 was unsupervised sitting up in bed with their lunch tray in front of them. Resident 65 was using their left hand to grab rice and proceeded to eat it and drank from a cup provided on their tray. Staff R, Licensed Practical Nurse, entered the room and brought a drink to Resident 65 during their lunch time. Staff R did not stay to assist or supervise Resident 65 for the entirety of their meal. After Staff R exited the room, Resident 65 continued to finish their drinks. Joint observation on 02/24/2025 at 1:03 PM with Staff R, showed Resident 65 sitting in bed with their lunch tray in front of them. Staff R stated that the resident did not need supervision assist, and that sometimes they were able to eat better by themselves. Staff R further stated that sometimes the resident refused to be assisted with their meals, and staff would offer gentle reminders to cue with eating. Joint record review and interview on 02/24/2025 at 1:10 PM with Staff R, showed Resident 65's nutrition care plan had an intervention initiated on 11/23/2023, revised on 10/12/2024 for Diet as ordered-Regular diet with thin liquids as tolerated and 1 to 1 supervision for aspiration precaution. Staff R stated that Resident 65 should have been on 1 to 1 supervision assist, and that the staff were expected to follow the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/2025 at 9:17 AM, Collateral Contact 2 stated that Resident 65 needed assistance with their meals as they had a history of a stroke (medical emergency where the blood flow to the brain is interrupted). On 02/25/2025 at 1:13 PM, Staff D, Resident Care Manager, stated staff were expected to follow the resident's care plan. Staff D stated Resident 65 needed 1 to 1 assistance since they had a stroke and needed help. A joint record review of Resident 65's physician diet orders showed orders for 1 to 1 assist. Staff D stated that these orders were in place for Resident 65's safety, aspiration precautions, and that even if the resident refused to be assisted with their meals and staff should still supervise the resident to ensure their safety. On 02/26/2025 at 11:03 AM, Staff B, Director of Nursing, stated that staff should have stayed with Resident 65 during their meals for 1 to 1 supervision assist. Staff B further stated it was their expectation that whoever was assigned to the resident should stay and assist or standby for safety. 47680 Review of the facility's policy titled, Proper Use of Bed Rails, revised on 02/24/2025, showed, The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes .checking bed rails regularly to make sure they are still installed correctly and have not shifted or loosened over time. It further showed under Ongoing Monitoring and Supervision, The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. This should be evidenced in the resident's records including their care plan . RESIDENT 3 Review of the quarterly Minimum Data Set (an assessment tool) dated 02/19/2025 showed Resident 3 admitted to the facility on [DATE] and was cognitively intact. Review of Resident 3's February 2025 physician's order summary report showed, Left bed enabler bars [bed rail] to promote transfers and Activities of Daily Living dated 09/23/2024. Review of the comprehensive care plan printed on 02/19/2025 did not show a care plan to address Resident 3's use of an enabler. Observation and interview on 02/18/2025 at 10:45 AM, showed Resident 3 lying in bed with an enabler on the left side of their bed in the raised position. Resident 3's enabler moved when pushed side to side and left to right. Resident 3 stated that they used the enabler to get up from bed. When asked if their enabler felt loose, Resident 3 stated, maybe a little bit loose. Observations on 02/20/2025 at 1:20 PM and on 02/24/2025 at 10:15 AM, showed Resident 3's left enabler in the raised position. Resident 3's enabler moved when pushed side to side and left to right. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint observation on 02/24/2025 at 2:17 PM, Staff P, Certified Nursing Assistant (CNA), stated that Resident 3 needed limited assistance with transfers and that they used the enabler during transfers. When asked what they would do if a residents' equipment was not working appropriately like a loose enabler, Staff P stated they would notify the nurse and that the nurse would complete a maintenance request form. A joint observation of Resident 3's left enabler showed that it moved when Staff P pushed it side to side. Staff P stated it was a little loose. Staff P tighten the screw of the enabler that was connected to the bed and when they were done, the left enabler was no longer loose. Staff P stated that even though they had tightened the screw, they would let the nurse know to have maintenance check the enabler. In an interview on 02/24/2025 at 2:26 PM, Staff D stated that they expected staff to report to maintenance if enablers were loose. Staff D stated that if the CNA were to find it, they would report it to the nurse and the nurse would fill out a maintenance request form. In an interview on 02/24/2025 at 2:53 PM, Staff H, Environmental Services Director, stated they expected staff to let them know if enablers were loose and to communicate to them through the maintenance request log or to give them a call if it needed to be taken care of right away. In an interview on 02/25/2025 at 12:50 PM, Staff B stated that they expected staff to report loose enablers to maintenance and complete a maintenance request form. Staff B further stated that they expected Staff P to inform maintenance that they had tighten Resident 3's enabler and to check their work. Reference: (WAC) 388-97-1060 (3)(g)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, interview, and record review the facility failed to comprehensively assess residents for the use of bed rails for 7 of 8 residents (Residents 1, 9, 80, 3, 43, 78 & 85) reviewed for bed rails. This failure placed residents at risk for potential injury, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Proper Use of Bed Rails, revised on 02/24/2025, showed, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails .Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars [enabler] . The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternativeness failed to meet the resident's assessed needs . The resident assessment must also assess the resident's risk from using bed rails . the medical record should include evidence of the following .risks and benefits were reviewed with resident or resident representative .was given before installation or use. RESIDENT 1 Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 01/08/2025, showed Resident 1 was cognitively intact. Observations on 02/19/2025 at 10:41 AM, on 02/20/2025 at 1:51 PM, on 02/21/2025 at 7:55 AM, and on 02/24/2025 at 8:05 AM, showed Resident 1's bed had a bed rail attached on both sides of their bed. Review of the order February 2025 physician order summary report, active as of 02/18/2025, showed Resident 1 had an order for both 1/2 [half] side rails [or bed rails] up for enabler, with an order date of 05/07/2021. Review of Resident 1's Electronic Health Record (EHR) showed no assessment completed for Resident 1's bed rail use. A joint observation and record review on 02/24/2025 at 1:08 PM with Staff E, Resident Care Manager (RCM), showed Resident 1 had bed rails attached on both sides of their bed. A joint record review of Resident 1's EHR showed no assessment completed for the use of bed rails. Staff E stated that Resident 1 had bed enablers and there was no assessment completed. RESIDENT 9 Review of the quarterly MDS dated [DATE] showed Resident 9 was moderately impaired with cognition. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 02/19/2025 at 10:22 AM, on 02/20/2025 at 9:57 AM and at 1:47 PM, on 02/21/2025 at 7:45 AM, and on 02/25/2025 at 9:09 AM, showed Resident 9 was lying in bed with half bed rails attached to both sides of their bed in the raised position. Review of the February 2025 physician order summary report, active as of 02/19/2025, showed Resident 9 had an order for both 1/2 side rails up for enabler, with an order date of 09/20/2023. Review of Resident 9's EHR showed no assessment was completed for Resident 9's half bed rail use. A joint observation and record review on 02/24/2025 at 12:59 PM with Staff E, showed Resident 9 was lying in bed with half bed rails attached to both sides of their bed in the raised position. A joint record review of Resident 9's EHR showed no assessment was completed for Resident 9's half bed rails use. Staff E stated that Resident 9 had half bed rails on both sides of their bed and there was no assessment completed for it. RESIDENT 80 Review of the quarterly MDS dated [DATE] showed Resident 80 was severely impaired with cognition. Observations on 02/19/2025 at 10:33 AM, on 02/20/2025 at 9:54 AM and at 1:49 PM, and on 02/24/2025 at 9:31 AM, showed Resident 80 was lying in bed with quarter bed rails attached to both sides of their bed in the raised position. Review of the February 2025 physician order summary report, active as of 02/19/2025 showed that Resident 80 had an order for bilateral [both] bed enabler bars for enabler/promote transfer and ADLs [activities of daily living], with order date of 08/18/2024. Review of Resident 80's EHR showed no assessment was completed for Resident 80's half bed rail use. A joint observation and record review on 02/24/2025 at 1:06 PM with Staff E, showed Resident 80 was lying in bed with quarter bed rails attached to both sides of their bed in the raised position. A joint record review of Resident 80's EHR showed no assessment was completed bed rail use. Staff E stated that Resident 80 had bed enabler on both sides of their bed and there was no assessment completed for it. In an interview on 02/25/2025 at 12:25 PM, Staff B, Director of Nursing, stated that bed enablers were considered as grab bars or an assist bar and that it was the facility's policy to complete an assessment prior to using it. 47680 RESIDENT 3 Review of the quarterly MDS dated [DATE] showed Resident 3 was cognitively intact. Review of Resident 3's February 2025 physician order summary report showed a Left bed enabler bars to promote transfers and ADLs, with an order date of 09/23/2024. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's EHR did not show that an assessment was completed explaining risk and benefits for left bed rail use. Observation and interview on 02/18/2025 at 10:45 AM, showed Resident 3 lying in bed with a bed rail on the left side of their bed in the raised position. Resident 3 stated that they used their bed rail to get up from bed. Observations on 02/20/2025 at 1:20 PM and on 02/24/2025 at 10:15 AM, showed Resident 3's bed rail was in the raised position. In an interview on 02/25/2025 at 10:55 AM, Staff D, RCM, stated that they considered a bed rail/enabler a grab bar and that residents' use it to assist with repositioning and bed mobility. When asked if they completed an assessment prior to use of bed rail explaining risk and benefits of use, Staff D stated that they would complete an assessment, talk to the residents/representative verbally explaining the risk and benefits and that it would be documented in the nursing progress note. A joint record review of Resident 3's nursing progress notes did not show documentation about the risk and benefits of a bed rail use. Staff D stated, I think they [nurses] just forgot to put it in the progress notes. In an interview on 02/25/2025 at 12:50 PM, Staff B stated that they considered an enabler a grab bar and that they were used for mobility. Staff B further stated that they expected that an assessment was completed explaining the risk and benefits to the resident and/or their representative, documented in the progress note, and care planned. 48298 RESIDENT 43 Review of Resident 43's February 2025 physician order summary report, initiated on 01/15/2025, showed an order for left bed rail/enabler bar. Review of the EHR did not show risk assessment or evaluation for left bed rail use was completed for Resident 43. Further review of the EHR did not show Resident 43 and/or their representative were notified related to risk and benefits for the use of left bed rail. Observation and interview on 02/21/2025 at 9:05 AM, showed Resident 43 had left bed rail attached to their bed frame in the raised position. Resident 43 stated that they used the left bed rail to reposition and transfer themselves out of bed. In an interview on 02/24/2025 at 12:15 PM with Staff V, Certified Nursing Assistant, stated that Resident 43 had a left bed rail that they used to reposition in bed and helped [Resident 43] to stand up. In an interview on 02/24/2025 at 12:37 PM, Staff E stated that Resident 43 had a left bed rail that they used for transfer or repositioning. Staff E stated that Resident 43 had not been assessed or evaluated related to the use of the bed rail. Staff E stated, We have no requirement to do an evaluation [for bed rail use]. Staff E further stated that they had not provided education to Resident 43 and/or their representative about the risks/benefits of using bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 78 Review of Resident 78's February 2025 physician order summary report, initiated on 10/13/2023, showed an order for both 1/2 side rails up for enabler. Review of Resident 78's EHR did not show risk assessment or evaluation were completed for bed rails use. Further review of the EHR did not show Resident 78 and/or their representative were informed related to risk and benefits of side rails use. Observation and interview on 02/21/2025 at 8:58 AM, showed Resident 78 had a left side rail attached to their bed frame in the raised position. Resident 78 stated that they used the left side rail to reposition and transfer themselves out of bed. In an interview on 02/24/2025 at 12:18 PM, Staff V stated that Resident 78 had a left side rail that they used to reposition in bed and helped [Resident 78] to get up from bed. In an interview on 02/24/2025 at 12:51 PM, Staff E stated that Resident 78 did not have rails on both sides of their bed. Staff E stated that Resident 78 had a left side rail to help with transfer and repositioning. Staff E stated that Resident 78 had not been assessed or evaluated related to their use of side rails. Staff E stated, We have no requirement to do an evaluation [for bed rail use]. Staff E further stated that they had not provided education to Resident 78 and/or their representative about the risks/benefits of using side rails. In an interview on 02/25/2025 at 1:04 PM, Staff B stated, I would expect everybody [residents] to be assessed for the risk [related to use of bed rails/enablers]. Staff B further stated that they expected residents and/or their representatives to have been educated regarding the risks and benefits of using side rails. 52133 RESIDENT 85 Review of the quarterly MDS dated on 12/19/2024 showed was moderately impaired with cognition. Review of Resident 85's February 2025 physician order summary report showed, right bed enabler bar for enabler/promote transfer and ADLs, dated 10/03/2024. Review of Resident 85's EHR showed no assessment was completed for Resident 85's right bed rail use. Observations on 02/18/2025 at 9:56 AM and on 02/19/2025 at 9:20 AM, showed Resident 85 had a bed rail/enabler bar on the right side of their bed in the raised position. Observation on 02/20/2025 at 1:40 PM, showed Resident 85 used the bed rail to turn while in bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 02/24/2025 at 12:54 PM, Staff D stated that Resident 85 had a right enabler bar. When asked if an assessment would be completed prior to using the bed rail/enabler bar, Staff D stated they [nurses] would do an assessment to see if the resident needs them. Staff D stated there was no assessment completed in the EHR. Staff D further stated that they would expect there to be an assessment documented in a nursing progress note. In an interview on 02/25/2025 at 12:25 PM, Staff B stated the bed enablers were considered as grab bars or assist bar and that it was the facility's policy to complete an assessment prior to using it. Reference: (WAC) 388-97-1060 (3)(g)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 51090 Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed with actual hours worked after the start of each shift for 5 of 7 days (02/19/2025, 02/20/25, 02/21/2025, 02/24/2025 & 02/26/2025), reviewed for sufficient and competent staffing. This failure placed the residents and residents' representatives at risk of not being fully informed of the current staffing levels. Findings included . Review of the facility's policy titled, Nurse Staffing Posting Information, revised on 02/25/2025, showed that the nurse staffing form will be posted daily and will include the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. It further showed that, The information shall reflect staff absences on that shift due to call-outs and illness. After the start of each shift, actual hours will be updated to reflect such. An observation on 02/18/2025 at 10:01 AM, showed posted signage at Nursing Station 2 that listed nursing staff shift hours as follows: -Day shift - 7:00 AM - 3:00 PM -Evening shift - 3:00 PM - 11:30 PM -Night shift - 11:00 PM - 7:30 AM Observations on 02/19/2025 at 8:08 AM, on 02/20/2025 at 8:20 AM, on 02/20/2025 at 2:54 PM, on 02/21/2025 at 8:51 AM and at 2:43 PM, on 02/24/2025 at 1:45 PM, and on 02/26/2025 at 8:35 AM, showed that the facility's daily nursing staffing form posted did not show the actual hours worked for each shift that had started. In an interview on 02/26/2025 at 9:06 AM, Staff C, Staff Development Coordinator, stated that Staff J, Personnel Coordinator, was responsible for updating the daily nurse staffing form posting. Staff C further stated that the facility's scheduler was off from work on Tuesdays and Wednesdays. In an interview on 02/26/2025 at 9:09 AM, Staff B, Director of Nursing, stated that they were responsible for updating the daily nursing staffing posting on the days that Staff J was not scheduled to work. A joint record review and interview on 02/26/2025 at 9:08 AM with Staff B, showed that the facility's daily nursing staffing posting, dated 02/26/2025, did not show the actual hours worked. When asked if any nursing staff callouts for the day shift were known, Staff B answered that there were no call outs from staff for 02/26/2025 day shift. When asked if the actual working hours were known for the shift that had started, Staff B answered, No, because they're working a lot of overtime. Staff B further stated, We don't do the actual working hours until the end of the shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kin on Health Care Center	4416 South Brandon Street Seattle, WA 98118

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview on 02/26/2025 at 9:18 AM, Staff B stated that the facility's daily nursing staff form posted for 02/26/2025 should have had the total actual hours worked completed at the beginning each shift. A joint record review and interview on 02/26/2025 at 9:21 AM, with Staff A, Administrator, showed that the facility's daily nursing staffing posting, dated 02/26/2025, did not show the actual hours worked after the start of the day shift. When asked if the total actual hours worked should have been posted after the start of the shift, Staff A answered, Yes. No Associated WAC

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on observation, interview, and record review, the facility failed to ensure pharmacy services were provided per professional standards of practice for 4 of 9 residents (Residents 39, 14, 49 & 6), reviewed for medication management. The failure to clarify physician's order, document medication, and properly identify residents prior to medication administration placed the residents at risk for medication errors, negative outcomes, and a diminished quality of life. Findings included . Review of the facility's policy titled, Medication Administration, revised on 02/24/2025, showed that Medications are administered .as ordered by the physician and in accordance with professional standards of practice .identify resident by photo in the MAR (medication administration record). The policy further showed to ensure that the six rights of medication administration were followed: right resident, right drug, right dosage, right route, right time, right documentation and to sign the MAR after administration of medication. RESIDENT 39 Resident 39 admitted to the facility on [DATE] with multiple diagnoses that included rheumatoid arthritis (RA-a disease that causes inflammation and damage in the joints and other body parts). Review of the February 2025 MAR printed on 02/21/2025, showed Resident 39 had the following physician orders: -Methotrexate (medication to treat RA), give eight tablets by mouth one time a day every Thursday. -Rocephin (an antibiotic medication to treat infection), inject one gram (unit of measurement) intramuscularly (within the muscle) every twenty-four hours for five days. Further review of the February 2025 MAR showed, INFO [information]: Methotrexate-OK [okay] to continue as long as NOT on any active ANTIBIOTICS for active infections per Rheumatologist [a doctor specializes in RA] recommendation-ok'd [approved] by . ARNP [Advanced Registered Nurse Practitioner]. Further review of the February 2025 MAR showed Resident 39 was administered with rocephin on 02/19/2025 and with methotrexate on 02/20/2025. In an interview and joint record review on 02/21/2025 at 1:33 PM, Staff U, Registered Nurse (RN), stated that they reviewed and followed physician's orders. A joint record review of Resident 39's February 2025 MAR with Staff U, showed Resident 39 had received rocephin on 02/19/2025 and received methotrexate on 02/20/2025. Staff U then read back the physician's order and information about methotrexate. Staff U stated that they had administered methotrexate to Resident 39 on 02/20/2025 and that they should have clarified with the physician prior to administration of methotrexate to Resident 39. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/26/2025 at 8:25 AM, Staff E, Resident Care Manager (RCM), stated that they expected nurses to review and to clarify physician's orders prior to transcribing (writing physician's order) and administration of medications. Staff E stated that Staff U should have held the methotrexate and clarified with the physician before they administered it. RESIDENT 14 Resident 14 admitted to the facility on [DATE] with multiple diagnoses that included chronic obstructive pulmonary disease (COPD-a condition in which airflow to the lungs are limited). Review of the February 2025 MAR showed Resident 14 had an order for fluticasone inhaler (a medication to treat COPD) to be administered two times a day via inhalation (a process of drawing air into the lungs). Observation and interview on 02/24/2025 at 7:37 AM, showed Staff T, RN, was preparing medications for Resident 14. Staff T stated that Resident 14 had a lot of medications in the morning and that they would give the rest at 8:15 AM. Staff T stated that Resident 14 preferred their medications not to be administered all at the same time. In an interview and joint record review on 02/24/2025 at 7:46 AM, Staff T stated that they administered Resident 14's fluticasone inhaler earlier at the time when they checked Resident 14's blood sugar level around 7:12 [AM]. Joint record review of Resident 14's electronic MAR (e-MAR) did not show that the fluticasone inhaler was administered to Resident 14. When asked about their medication administration process, Staff T stated that they were expected to sign the e-MAR after they administered the medication. Staff T stated, I should mark that I have administered the medication. I forgot to mark it. But I gave it when I did the blood glucose [sugar] check. In an interview on 02/25/2025 at 1:32 PM, Staff E stated that staff were expected to document that the medication was administered to the resident. Staff E stated, If you give something [medication] you must mark it as given. An interview on 02/26/2025 at 10:07 AM with Staff B, Director of Nursing, stated that they expected nurses to have had reviewed Resident 39's physician's orders and clarified with the physician prior to administration of both the rocephin and methotrexate to Resident 39. Staff B further stated they expected staff to document in the e-MAR right after they had administered medication to the residents. 51090 RESIDENT 49 Resident 49 readmitted to the facility on [DATE] with diagnosis that included dementia (a progressive condition that affects the brain). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 02/24/2025 at 7:25 AM, showed Staff I, RN, prepared medications at the medication cart before they walked down the hallway to approach an unnamed resident in a wheelchair. Staff I stated, It's not the correct resident, then proceeded to enter Resident 49's room to administer medication. Further observation showed Staff I stated, Good morning, Mama, my name is [staff I], I'm going to give you medication, okay? Staff I then administered medication to Resident 49. It did not show that Staff I identified the resident by photo, interview or other form of identification prior to administration of Resident 49's medication. RESIDENT 6 Resident 6 admitted to the facility on [DATE] with diagnoses that included dementia. An observation and interview on 02/24/2025 at 07:25 AM, showed Staff I prepared medications at the medication cart before they walked down the hallway to enter Resident 6's room. Further observation showed Staff I stated, Your medicine, which prompted Resident 6 to accept their medication. It did not show Staff I identified Resident 6 by photo, interview or other form of identification prior to administration of their medication. Staff I was asked how they identified residents during medication administration, Staff I stated, Most of them have a [identification] band on their hand. Joint observation showed Resident 6 did not have an identification band on their wrist. Staff I stated [Resident 6] doesn't have one. When asked if residents could be identified by asking for their name, Staff I stated, No, [Resident 6] wouldn't' tell me. Staff I further stated that to identify residents without an identification band, I have to ask for date of birth. In a follow-up interview on 02/24/2025 at 8:03 AM, Staff I stated that to identify a resident before medication administration, they referred to the resident's picture outside the resident's room. Staff I further stated that medication carts had updated pictures of residents used to identify residents. When asked how staff ensured accurate medication administration, Staff I answered that they check right resident name, medication, dose, time, route, and any parameters. A joint observation on 02/24/2025 at 7:53 AM with Staff I and Staff B, showed a picture of Resident 6 at the room door entrance. When asked if the picture could be used to identify Resident 6, Staff B stated, [Resident 6] doesn't have glasses on [compared to the picture] and [Resident 6] looks very similar. In an interview on 02/24/2025 at 9:17 AM, Staff D, RCM, stated that the facility's process for identifying the resident during medication administration included identification of the resident by their picture in the MAR, their picture outside of the room, as well as their identification band. Staff D stated that in the absence of an identification band, they expected staff to confirm with other staff when identifying a resident. Staff D further stated that they expected nurses to correctly identify residents before administering medication and that, They need to know the resident rights when passing medication, including identifying the resident. In another interview on 02/24/2025 at 10:55 AM, Staff B stated that the facility's process for identifying a resident was that nurses had pictures of residents in their medication cart that could be taken into the resident's room to identify the resident. When asked if Staff I utilized the pictures available in the medication cart to identify Resident 6, Staff B answered, No, he didn't. Staff B further stated that they expected staff to correctly identify residents before giving medications and that Yes, you have to know who the resident is. I would expect that. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97- 1300 (1)(b)(i)(ii)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure monthly pharmacy recommendations were followed up on for 1 of 5 residents (Resident 76), reviewed for unnecessary medications. This failure placed the resident at risk for receiving unnecessary medications and a diminished quality of life. Findings included . Review of the facility's policy titled, Medication Regimen Review, revised on 02/24/2025, showed, Facility Staff shall act upon all recommendations according to procedures for addressing medication Regimen Review irregularities. Review of Resident 76's admission record printed on 02/25/2025 showed that they readmitted to the facility on [DATE]. Review of the facility provided Pharmacy Drug Medication Review binder showed a document titled, Current Resident listing for [facility's name] with Medication Regimen Review activity between 01/01/2025 and 01/13/2025 had Resident 76 listed on the document. Further review showed no documentation of a pharmacy recommendation for Resident 76. In an interview on 02/24/2025 at 9:29 AM, Staff B, Director of Nursing, stated that Staff B and medical records oversaw the pharmacy drug regimen review documents. Staff B stated that medical records printed the pharmacy recommendations and requested the provider to review and sign it. When the documents were returned, they would be uploaded to Point Click Care (computer software for resident and/or facility records). Staff B stated that they would be given a copy but that it did not always happen. Staff B stated that they placed pharmacy recommendations for the provider in a binder for them to review and when it was completed, they would scan it. When Staff B was informed of the missing pharmacy recommendation for Resident 76, Staff B stated that they would check the binder and that it might still be in there. Review of the facility provided pharmacy recommendation document titled, Note to Attending Physician/Prescriber, printed on 01/13/2025, showed Resident 76 had a psychotropic [mind-altering] gradual dose reduction for Trazadone (medication to treat depression) and Olanzapine (medication to treat mood disorders). It further showed that the Physician/Prescriber Response was not completed. In a follow up joint record review and interview on 02/24/2025 at 12:30 PM with Staff B, showed a document titled, Note to Attending Physician/Prescriber printed on 01/13/2025, showed that the Physician/Prescriber Response was not completed. Staff B stated that they would have expected that the provider read and sign off on it. Staff B further stated that they expected pharmacy recommendations to be reviewed the next time that the provider was in the facility and that if the recommendation had medications on them, they would expect it to be completed within two days and if the provider did not come to the facility, they would fax it to them. Reference: (WAC) 388-98-1300 (4)(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on observation, interview, and record review, the facility failed to ensure refrigerator temperatures were monitored for safe storage of vaccines (biological preparation that provides immunity to a particular disease) were followed for 1 of 1 medication room refrigerator (Station 2 Medication Room Refrigerator), and failed to ensure expired medical supplies and/or biologicals (diverse group of medicines made from natural sources) were removed or discarded in accordance with current accepted professional standards for 1 of 1 clean utility room (Station 2 Clean Utility Room), reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised and ineffective medications and medical supplies. Findings included . According to the Centers for Disease Control and Prevention (CDC) website titled, Vaccine Storage and Handling, dated [DATE], showed, To ensure the safety of vaccines, the storage unit minimum and maximum temperatures should be checked and recorded at the start of each workday. If using a TMD [Temperature Monitoring Devices] that does not display minimum and maximum temperatures, then the current temperature should be checked and recorded a minimum of two times (at the start and end of the workday). Review of the facility's policy titled, Storage of Medication Requiring Refrigeration, revised on [DATE], showed, Temperature to be monitored daily to ensure proper temperature control and documented on the temperature log with date, time, and signature of person performing the check clearly written. Review of the facility's policy titled, Medication Storage, revised on [DATE], showed the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible or missing labels. STATION 2 MEDICATION ROOM REFRIGERATOR During a joint observation and interview on [DATE] at 8:45 AM with Staff E, Resident Care Manager, showed there were three vaccines for Influenza (an infection of the nose, throat and lungs caused by a virus) and three vaccines for COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases can cause difficulty breathing and could result in impairment or death) stored in Station 2 medication room refrigerator. Review of the Station 2 Medication Room Refrigerator Temperature Log for [DATE], [DATE] and February 2025 showed that the refrigerator's temperature check was scheduled two times (once during the day and once at night) for each day of the month. Further review of the refrigerator temperature log showed there were missing refrigerator temperature checks on the following dates: -[DATE] missing daily checks during the day: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] missing daily checks at night: [DATE]. -[DATE] missing daily checks during the day: [DATE] to [DATE], [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE] and [DATE]. -February 2025 missing daily checks during the day: [DATE], [DATE], [DATE], [DATE], [DATE]. -February 2025 missing daily checks at night: [DATE] and [DATE]. In an interview and joint record review on [DATE] at 9:42 AM, Staff E stated that they monitored the medication room refrigerator temperature twice-during the day and at night for each day of the month. A joint record review of the Station 2 medication room refrigerator temperature log for [DATE], [DATE] and February 2025 showed the refrigerator's temperature log had missing temperature checks. Staff E stated that they expected the staff to monitor the temperature and complete the [temperature] log as directed. STATION 2 CLEAN UTILITY ROOM During a joint observation and interview on [DATE] at 9:04 AM with Staff E showed the Station 2 clean utility room had the following expired laboratory and medical supplies: -Two Central Line Trays with ChloraPrep (sterile dressing change trays with an antiseptic that fights bacteria) with an expiration date of [DATE]. -Two BD Culture Swabs (brand of specimen collection tubes) with an expiration date of [DATE]. -Three Intermittent Urinary Catheters (thin, flexible tubes used to drain urine from the bladder) with an expiration date of [DATE]. Staff E stated that they checked the Station 2 clean utility room monthly and made sure that all expired items were removed or discarded. Staff E further stated that the expired sterile dressings, culture swabs and urinary catheters should have been discarded. On [DATE] at 1:13 PM, Staff B, Director of Nursing, stated that they expected the staff to check the refrigerator temperature twice a day [day shift and night shift] for each day of the month and to completely document the refrigerator temperature in the log sheet. Staff B further stated that it was their expectation for the staff to check the expiration date and that laboratory and/or medical supplies with expired dates had to be discarded or thrown away. Reference: (WAC) [DATE](2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 52133 Based on observation, interview, and record review, the facility failed to ensure the sanitizing solution/agent was at the correct concentration used to ensure proper sanitation of food preparation surfaces in accordance with professional standards for 1 of 1 kitchen, reviewed for food safety. This failure placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages) and a diminished quality of life. Findings included . Review of the facility's policy titled, Food Safety Requirements, revised on 01/24/2025, showed that all equipment used in the handling of food shall be cleaned and sanitized, and handle in a manner to prevent contamination. The policy further showed, staff shall follow facility procedures for dishwashing and cleaning fixed cooking equipment. The facility procedure showed that staff clean/wipe with detergent solution, rinsed with hot water, wipe with sanitizing solution, and air dry. Review of the undated online document titled, Washington State Food Worker Manual, showed, Sanitizer solution stops working overtime. Make fresh sanitizer solution every two hours or when it becomes dirty or cloudy. Observation and interview on 02/21/2025 at 11:30 AM showed Staff N, Dietary Aid, tested two sanitizing solution red buckets in the kitchen with test results below the 50 Parts Per Million (ppm - unit of measure for concentration) range. The facility used Auto-Chlor system [Brand name] precision chlorine test paper strips, which had columns with colors and numbers that showed the following: 10 ppm, 50 ppm, 100 ppm, and 200 ppm. Staff N stated that the test strip results should be between 50 ppm to 100 ppm. Staff N stated that when it was closer to two hours, the color got lighter (the test strip color showed below 50 ppm range). Staff N stated that they changed the sanitizing buckets every two hours. Staff N further stated that the result was probably low because it was about time to change [the sanitizing solution], and it got diluted after use. Staff N stated that they did not have a record or log of when it was last changed, but it was done by the dietary aides. Staff N further stated they knew to change them every two hours. In an interview on 02/21/2025 at 2:15 PM, Staff O, Dietary Manager, stated that the sanitizing solution red buckets in the kitchen were used for sanitizing the work surfaces. Staff O further stated that they had to clean their work surface after each task. Staff O stated that sanitizing solution should be changed every two hours and had to be within the 50 ppm to 100 ppm range. Staff O further stated that they did not have a record or a log of when it was last changed and tested . In an interview on 02/24/2025 at 3:08 PM, Staff A, Administrator, stated that they expected the facility to follow what their policy and procedure for the sanitizing solution. Staff A further stated that they would expect the facility to have logged when the sanitizing solution was changed and tested . Reference: (WAC)388-97-1100(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49619 Based on observation, interview, and record review, the facility failed to report a communicable disease (infectious disease that can spread through direct or indirect contact) outbreak (two or more cases of a highly contagious disease) for 1 of 1 outbreak, and failed to ensure proper infection control practices were followed during resident care and medication administration for 2 of 12 residents (Resident 65 & 6), reviewed for infection control. In addition, the facility failed to ensure Transmission Based Precautions (TBP- additional infection control measures used when standard precautions are not enough to prevent the spread of an infection) practices were followed for 2 of 7 residents (Residents 11 & 57). These failures placed the residents, staff, and visitors at an increased risk of infection and related complications. Findings included . Review of the facility's policy titled, Communicable Disease (Infection Control Reporting) Policy, revised on 02/25/2025, showed it was the facility policy to timely report possible incidents of communicable disease or infections to the appropriate personnel or authorities. Review of the facility's policy titled, Hand Hygiene, reviewed/revised on 02/25/2025, showed all staff would perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy further showed that gloves did not replace hand hygiene, if the task required gloves, hand hygiene was to be performed prior to donning (putting on) gloves, and immediately after removing (doffing) them. Review of the Nursing Home Guidelines The Purple Book, dated October 2015, showed communicable diseases should be reported into the department hotline and logged within five days. COMMUNICABLE DISEASE OUTBREAK Review of the facility document titled, Resident Line Listing, updated on 02/06/2025, showed a resident tested positive for Influenza A (type of flu that is a highly contagious viral respiratory infection) on 01/18/2025. Further review showed an additional six residents tested positive for the flu in January 2025. Review of the facility document titled, Resident Line Listing, updated on 02/20/2025, showed four residents tested positive for the flu, and one for respiratory syncytial virus (is a common respiratory virus that infects the nose, throat, and lungs) in February 2025. On 02/24/2025 at 10:32 AM, Staff C, Infection Preventionist, stated that a disease outbreak was considered two or more cases, and that there was currently a flu outbreak in the facility. Staff C further stated that the facility followed the purple book guidelines. Joint record review of the purple book on 02/24/2025 at 10:43 AM with Staff C, showed communicable diseases should be reported to the department/hotline. Staff C stated that they had not reported the flu outbreak and that they should have based it on the purple book. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/26/2025 at 11:30 AM, Staff A, Administrator, stated it was their expectation that communicable diseases would be reported by Staff C to the hotline. On 02/26/2025 at 11:37 AM, Staff B, Director of Nursing, stated that the flu was a communicable disease and that their expectation was for staff to follow the reporting guidelines according to the purple book. Staff B further stated they should have reported the flu outbreak when it initially occurred according to the purple book. HAND HYGIENE RESIDENT 65 Record review of Resident 65's February 2025 physician order summary report, printed on 02/24/2025 showed an order for Enhanced Barrier Precautions (use of Personal Protective Equipment [PPE- gowns and gloves] during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs-bacteria that resists treatment with more than one antibiotic [medication to treat infection]), every shift for MDRO in urine. Observation on 02/20/2025 at 9:26 AM, showed Staff Y, Certified Nursing Assistant (CNA), wore PPE including gloves, gown, mask, and a face shield when performing peri-care (cleaning of private areas) on Resident 65. Staff Y doffed their soiled gloves after cleaning and removing Resident 65's soiled brief and donned new gloves to apply the new brief. Staff Y did not perform hand hygiene after doffing their dirty gloves and donning the new ones. On 02/20/2025 at 10:01 AM, Staff Y stated that after they removed their soiled gloves, they should do hand hygiene before applying new gloves and that they should have washed their hands after removing their soiled gloves when doing care for Resident 65. On 02/25/2025 at 12:11 PM, Staff R, Licensed Practical Nurse, stated staff should do hand hygiene before applying and after removing their gloves. Staff R stated that Staff Y should have done hand hygiene in between glove use. On 02/25/2025 at 1:35 PM, Staff C stated it was their expectation for staff to do hand hygiene before and after a task, between a dirty and clean task, and/or before donning and doffing gloves. On 02/26/2025 at 11:01 AM, Staff B stated it was their expectation for staff to take their gloves off, do hand hygiene and apply a new pair of gloves if needed. 51090 PROPER USE OF BARRIER DURING MEDICATION ADMINISTRATION Review of the facility's policy titled, Medication Administration, revised on 02/24/2025, showed that Medications are administered .in a manner to prevent contamination or infection. RESIDENT 6 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505453	A. Building B. Wing	02/26/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/24/2025 at 8:06 AM, showed Staff I, Registered Nurse, prepared a bottle of over-the-counter eye drops and two Kleenex [a brand of facial tissue] tissues and brought them into Resident 6's room. Observation showed Staff I placed a pair of disposable gloves, the bottle of eye drops and two Kleenex tissues onto the bedside table. Staff I then administered Resident 6's eye drops and used the Kleenex tissues placed onto the bedside table to wipe each of Resident 6's eyes. It did not show that Staff I provided a barrier between the bottle of eye drops and Kleenex tissues to the surface of the bedside table. Further observation showed that Staff I did not clean the eye drops prior to storing in the medication cart. A joint observation and interview on 02/24/2025 at 8:07 AM, showed Staff I had an empty blue container on their medication cart. Staff I stated that the facility's process for handling prepared medications was that they would keep medication in a carrier to keep safe from spilling on the floor. Staff I stated they considered the blue container to be clean. When asked if surfaces in a resident's room were considered clean, Staff I stated, No. Staff I further stated that the Kleenex tissues used to wipe Resident 6's eyes were not supposed to touch it [bedside table surface]. In an interview on 02/24/2025 at 9:29 AM, Staff D, Resident Care Manager (RCM), stated that staff used the blue containers to carry multiple items to include medication. Staff D stated that they expected eye drops and Kleenex tissues to be placed on a clean surface. When asked if they expected staff to use Kleenex tissues placed onto a bedside table, during medication administration, Staff D answered, That's considered contamination .they can use the blue container [for a barrier between surfaces]. In an interview on 02/24/2025 at 10:23 AM, Staff C stated that they expected staff to use the blue containers as carriers during medication administration in areas away from the medication cart. When asked if they expected staff to use Kleenex tissues placed onto a bedside table, during medication administration, Staff C stated, I would expect staff would hand the tissues directly to the resident, and that they would not expect medication administration items to be placed directly on surfaces in a resident's room. In an interview on 02/24/2025 at 10:55 AM, Staff B stated they expected staff would use the blue plastic containers as clean barriers between surfaces during medication administration. Staff B further stated that Resident 6's eye drops bottle and two Kleenex facial tissues should have been in the container. 48298 PROPER USE OF PPE Review of the facility's policy titled, Infection Prevention and Control Program, revised on 02/25/2025, showed, All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. RESIDENT 11 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing progress note dated 02/13/2025, showed Resident 11 was tested for Influenza. Further review of the nursing progress note showed Resident 11 was placed on droplet/contact isolation (a type of TBP used to prevent the spread of respiratory infections through droplets [small particle of moisture produced by coughing or sneezing]) per facility protocol. Review of the laboratory results report dated 02/17/2025, showed Resident 11 tested positive for Influenza A. An observation on 02/19/2025 at 8:59 AM, showed Staff S, CNA, donned gown and gloves, and went in Resident 11's room (a TBP room) without their face shield or goggles (eye protector). Further observation at 9:18 AM, showed Staff S went out of Resident 11's room and headed to the hallway without changing their mask. In an interview and joint record review on 02/19/2025 at 9:22 AM, Staff S stated that they were expected to follow PPE guidelines for residents on droplet/contact isolation precaution. A joint record review of PPE signage posted outside Resident 11's room showed that staff would need to wear mask, gown, gloves and face shield or goggles before entering the room. Staff S stated that they did not wear their face shield or goggles and that they should have had worn them when they entered Resident 11's room. Staff S further stated that they did not change their mask and that they should have after exiting Resident 11's room. Observation on 02/21/2025 at 8:25 AM, showed Staff E, RCM, donned PPE and went in Resident 11's room. Further observation at 8:31 AM, showed Staff E went out of Resident 11's room and walked towards Nursing Station 2 without changing their mask. In an interview on 02/21/2025 at 8:36 AM, Staff E stated that Resident 11 remained on droplet/contact isolation precaution due to influenza. When asked if they were expected to change their mask after they exited Resident 11's room, Staff E stated, I should have changed my mask and I did not [change my mask]. In an interview on 02/24/2025 at 3:04 PM, Staff C stated that it was expected for staff to read infection control signage and to follow proper use (donning and doffing) of PPE for residents on droplet/contact isolation precaution. Staff C stated that staff were expected to have worn their face shield or googles upon entering Resident 11's room and that staff should have changed their masks upon exiting Resident 11's room. In an interview on 02/25/2025 at 1:09 PM, Staff B stated that they expected staff to use proper PPE and to follow infection control practices, which included changing their masks upon exiting a resident's room on TBP. 52331 Review of the facility's policy titled, Infection Prevention and Control Program, revised on 02/25/2025 showed, All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. RESIDENT 57 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the February 2025 physician order summary report, showed Resident 57 was placed on contact and droplet precautions due to Influenza A, dated 02/19/2025. Review of the laboratory results report dated 02/19/2025, showed Resident 57 had tested positive for Influenza A. Observation on 02/18/2025 at 9:27 AM, showed signage outside of Resident 57's room (TBP room) for donning and doffing of PPE. Observation on 02/19/2025 at 9:04 AM, showed Staff L, CNA, came out of Resident 57's room without their face shield or goggles. In an interview and joint record review on 02/19/2025 at 9:04 AM, Staff L stated that they followed the precautions signage before they entered Resident 57's room. A joint record review with Staff L showed the precaution signage outside of Resident 57's room included the use of face shield or goggle prior to entering the room. Staff L stated they did not follow the signage precautions and that they should have donned a face shield or goggles before entering Resident 57's room. Observation on 02/19/2025 at 9:20 AM, showed Staff M, Laundry Aide, went in Resident 57's room wearing their goggles. At 9:22 AM Staff M came out of the room wearing their goggles and carrying soiled linens. Staff M walked toward the hallway and had not changed or sanitized their goggles. In an interview on 02/19/2025 at 2:20 PM, Staff M stated that they followed the PPE signage outside of Resident 57's room. Staff M stated that they forgot to clean (sanitize) their goggles after they exited Resident 57's room. In an interview on 02/24/2025 at 3:04 PM, Staff C stated that it was expected for staff to read infection control signage and to follow proper use (donning and doffing) of PPE for residents on droplet/contact isolation. Staff C stated that staff were expected to have worn their face shield or googles upon entering Resident 57's room and that staff should have sanitized their goggle upon exiting Resident 57's room. In an interview on 02/25/2025 at 1:20 PM, Staff B stated they expected staff to follow infection control practices which included proper use of PPE. Reference: (WAC) 388-97-1320 (1)(a)(c)(2)(c)(5)(c)