STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505465	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Josephine Caring Community	9901 272nd Place Northwest Stanwood, WA 98292

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47104 Based on interview and record review, the facility failed to develop and implement comprehensive, person-centered care plans to meet the needs and preferences for 1 (Resident 92) of 6 sampled residents reviewed for nutrition, 1 (Resident 7) of 5 sampled residents reviewed for unnecessary medications, 2 (Resident 87 and 92) of 2 sampled residents reviewed for restraints, and 1 (Resident 73) of 1 sampled resident reviewed for bowel and bladder. This failure placed residents at risk for not receiving needed, preferred care and services and a diminished quality of life. Findings included . <RESIDENT 7> Resident 7 admitted to the facility with diagnoses to include congestive heart failure (a condition of the heart not pumping blood efficiently which can cause extra fluid in the body), and hypertension (high blood pressure). A review of Resident 7's current care plan printed on 07/14/2024 showed no care plan problem or interventions related to the resident's congestive heart failure or hypertension. In an interview on 07/15/2024 at 10:15 AM, Staff F, Licensed Practical Nurse (LPN)/Case Manager, stated they were responsible for creating Resident 7's care plan. Staff F stated there was not a care plan created for diagnoses of congestive heart failure or hypertension. <RESIDENT 87> Resident 87 admitted to the facility with diagnoses to include stroke and hemiplegia (loss of strength) and hemiparesis (muscle weakness or partial paralysis on one side of the body). A review of Resident 7's current care plan printed on 07/10/2024 showed Resident 87 used a tilt n space wheelchair (a wheelchair that can recline). The care plan did not include information for how to position the resident in the wheelchair. In an interview on 07/12/2024 at 10:15 AM, Staff U, Certified Nursing Assistant (CNA), stated Resident 87 used a tilt n space wheelchair. Staff U stated there was no specific way to position the resident in the wheelchair. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/12/2024 at 10:30 AM, Staff M, LPN/Case Manager, Restorative Program Manager, stated that Resident 87 used a tilt n space wheelchair and they were responsible for updating the resident's care plan. Staff M stated there was no care plan for wheelchair positioning. <RESIDENT 92> Resident 92 admitted to the facility on [DATE] with diagnoses to include dementia (loss of memory), dysphagia (difficulty swallowing), and muscle weakness. A review of Resident 92's current care plan printed on 07/10/2024 showed the resident used a tilt n space wheelchair and was at risk for weight loss. The care plan did not include information for how to position the resident in the wheelchair or monitoring and who to notify wf the resident experienced weight loss. In an interview on 07/12/2024 at 10:03 AM, Staff Q, CNA, stated resident specific information for care or resident preferences would be listed on the care plan. Staff Q stated Resident 92 sits straight up in their wheelchair when eating and when they were not eating the wheelchair was tilted slightly back with legs elevated. In an interview on 07/12/2024 at 10:20 AM, Staff M, LPN/Case Manager, Restorative Program Manager, stated Resident 92 used a tilt n space wheelchair and they were responsible for updating the resident's care plan. Staff M stated if Resident 92 had specific guidelines for wheelchair positioning it should be on the care plan so staff would know how to position the resident. Staff M stated the care plan did not include interventions and/or how to position the resident in the wheelchair. Staff M stated the resident's nutrition care plan did not show interventions, monitoring or who to notify if the resident experienced weight loss 37890 <RESIDENT 73> Resident 73 was a long-term care resident with diagnoses that included diabetes. In an interview on 07/08/2024 at 10:58 AM, Resident 73 stated they had been experiencing diarrhea for approximately 17 weeks. Resident 73 stated they didn't know what the cause was but they had seen a doctor, had testing, and they were now taking a probiotic (a supplement to improve digestion and treat stomach issues such as diarrhea). The resident stated they were often worried they would not make it to the bathroom in time or they would have irritated skin from the diarrhea. Review of the resident record on 07/10/2024 showed that Functional diarrhea was added to the resident's diagnosis list on 03/04/2024 and a referral to a Gastrointestinal (GI) physician was also ordered. Review of the GI visit summary for Resident 73, dated 06/06/2024 showed medication orders to firm stool had been increased. Review of Resident 73's current care plan on 07/17/2024 showed there was no care plan problem or interventions related to the resident's chronic diarrhea. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/15/2024 at 11:30 AM, Staff B, Director of Nursing, stated the case managers were responsible for initiating and updating resident care plans. Refer to WAC 388-97-1020 (1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observation, interview, and record review the facility failed to provide the assistance with activities of daily living (ADL's) for 2 of 7 sampled dependent residents (10 and 33) reviewed for ADL's. The facility failed to provide showers/bathing assistance to a resident (Resident 10), who was dependent on staff for bathing, and failed to ensure a resident that was dependent for assistance with meals was provided the necessary assistance. These failures placed the residents at risk for embarrassment, poor hygiene, unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Shower/Bed-Bath, revised 12/28/2023 stated the facility was to provide bathing assistance by the shower team to ensure and maintain the resident's dignity. Review of the facility policy titled, Standards of Care, revised 03/29/2024 stated care was provided based on the residents physical and mental capabilities. Staff are to offer assistance for dining, feeding assistance, nail care every week, and bathing. <RESIDENT 10> Resident 10 admitted to the facility on [DATE] with diagnoses including depression, and instability of the right knee. The quarterly Minimum Data Set (MDS, an assessment tool) assessment dated [DATE] showed the resident had intact cognition and required partial to moderate assistance with bathing and transfers. In a review of Resident 10's care plan on 07/10/2024 showed a focus point that Resident 10 had ADL self-care performance deficits related to dementia, and weakness (Initiated 05/27/2021). Interventions dated 03/06/2024 showed the resident required substantial assistance for both transfers into the shower, and bathing tasks. The resident preferred to shower twice a week. In a review of Resident 10's documentation report, dated 06/01/2024 - 07/15/2024 for showers twice a week showed the following: - June 2024: offered three times (06/04, 06/11, and 06/25) out of eight opportunities, - July 2024: offered twice (7/2, and 7/9) out of four opportunities. There were no refusals documented. In an observation and interview on 07/08/2024 at 1:09 PM, Resident 10 was observed to have disheveled, greasy hair, and unkempt facial hair. The resident could not recall the last time they had a shower and stated they hoped it was soon. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/12/2024 at 8:53 AM, Staff I, Nursing Assistant Certified (NAC) stated that the facility usually had a shower aide that would do the showers. Staff I stated they will try to assist with showers if there was a call in, and the shower aide was pulled to the floor. Staff I stated they will assist residents to be bathed and shaved based on their preferences. Staff I stated they were familiar with Resident 10 and they did not refuse care very often. Staff I was not aware that the resident required a shower twice a week, or that they needed to be shaved. In an interview on 07/12/2024 at 9:20 AM, Staff E, NAC/shower aide stated they were the primary shower aide for the unit where Resident 10 resided. Staff E stated recently they had been pulled to work as an NAC on the floor due to call offs. Staff E stated Resident 10 will always take a shower when offered, and they preferred to use their electric razor in their room for shaving. In an interview on 07/12/2024 at 10:35 AM, Staff J, License Practical Nurse (LPN) stated they usually had a shower aide on the unit to assist with showers, however if there was a call off's, they would divide the showers among the NACs on the floor to get done. Staff J stated if a resident was refusing a shower or to be shaved the NACs were to report to the nurse, and they would attempt to reapproach. Staff J stated Resident 10 does not refuse, however liked to do things on their time, so your approach really matters with them. In an interview on 07/12/2024 at 10:50 AM, Staff K, Registered Nurse (RN)/Case Manager stated that lately the shower aide had been pulled from showers to assist on the floor. Staff K stated that if a resident was refusing care frequently the staff should notify them so they can try and get to the root of the refusal. Staff K stated that Resident 10 was easy going and was not aware that they were refusing any care. Staff K stated the resident was probably not getting their preferred showers twice a week due to the staffing call offs. In an interview on 07/12/2024 at 1:46 PM, Staff B, Director of Nursing, stated the shower aides and the NACs on the floor were responsible to ensure the residents were getting the showers and shaving done per the resident's preferences. Staff B stated when a resident preferred a shower twice a week, the medical record should show that the facility was at least offering the shower twice a week. Staff B was not aware that Resident 10 was not receiving their preferred number of showers a week. 37890 <RESIDENT 33> Resident 33 admitted to the facility on [DATE] with diagnoses which included protein calorie malnutrition, fractured hip, fractured left arm and advanced dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Review of the Admission MDS assessment dated [DATE] showed Resident 33 required supervision and setup assistance with eating during the prior assessment period. Review of Resident 33's care plan dated 06/06/2024, showed the following interventions: Needs cueing and cleanup with meals/fluids, Assist with meals as (they) allows. Needs to eat where (they) can be monitored by nursing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's documentation survey report for 05/25/2024 through 07/09/2024 showed there were 137 total meals: 45 breakfast meals- only 11 total breakfast meals showed the resident consumed 50% or greater of the meal. 46 lunch meals- only 9 total meals showed the resident consumed 50% or greater of the meal. 46 dinner meals- only 11 total meals showed the resident consumed 50% or greater of the meal. There were only 31 meals that the resident was documented as having consumed 50% or greater of the meal. The other 106 meals were all documented as refused, blank (no documentation of the meal), 0%, or 25%. The documentation survey report also showed the level of assistance documented for each meal. The report documentation showed only eight total documentations that the resident received partial or extensive assistance with eating. In an observation on 07/09/2024 at 9:12 AM, Resident 33 was observed lying in bed with their breakfast tray in front of them. Their eyes were closed. Their breakfast tray was on the overbed table, untouched. There were no staff in the room at the time of this observation. In an observation on 07/09/2024 at 12:12 PM, Resident 33 was sitting in their wheelchair. Their left arm was in a sling, and they were fidgeting with the strap. The resident's lunch tray arrived and was placed in front of the resident who was sitting alone at a round table in the small common area of the unit. There was one full glass of a nutrition shake and one full glass of water. At 12:25 PM, the resident picked up a spoon and attempted to pick up a piece of fruit. After several attempts, they were able to pick up one grape and eat it. At 12:30 PM the resident was able to pick up a piece of pineapple with the spoon and it dropped. After a few attempts, they were able to pick it up and eat it. At 12:35 PM they were able to cut into the corner of the scalloped potatoes and get a small piece; they were having difficulty as it was rather stuck together and had not been cut up for the resident. At 12:38 PM the resident picked up the nutrition shake and took a drink, then another drink. No staff were observed to cue, assist or encourage the resident during this meal. In an observation on 07/11/2024 at 12:42 PM, Resident 33 had their lunch tray in front of them which was untouched. The resident was noted again to be preoccupied with the arm sling, the strap had slid down over their other arm, and they were pulling on the Velcro. Their hands were underneath the clothing protector and lap blanket they had on. The resident then reached for the cup of nutrition shake and took a drink of it. The resident then began hitting their armrest with the closed fist of their right hand and stated Please, please, then sighed, and began to push their wheelchair away from the table. Staff S, NAC, walked by and whispered in the resident's ear, then wheeled the resident into their room. Staff S exited the room and stated they took the resident to the restroom and the resident stated they were done eating. The tray was observed to have one cracker missing from a saltine cracker package and the cup of nutrition shake was almost gone. No staff were observed to cue, assist or encourage the resident during the meal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/11/2024 at 9:16 AM, Staff D, LPN/Care Manager, stated Resident 33 was able to feed themselves and had spurts where they would eat well. The staff were supposed to check in and offer assistance as needed. Staff D was made aware of observations of the resident's poor intakes, distracted fidgeting and the lack of observations of the staff providing any cueing, encouragement or assistance to the resident according to the care plan. In an interview on 07/12/2024 at 12:09 PM, with Staff B, DNS and Staff C (Assistant DNS), the observations and documentation findings were discussed regarding Resident 33. Staff B and Staff C did not have further information regarding Resident 33's lack of assistance with meals. Staff C and Staff B stated that staff were expected to offer assistance as needed to residents. Refer to WAC 388-97-1060(2)(a)(i)(iv)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review, the facility failed to offer appropriate services and assistance to maintain or improve mobility and range of motion for 1 of 1 sampled resident (Resident 107) reviewed for restorative nursing program. This failed practice placed the resident at risk for losing strength and range of motion they gained while receiving therapy services. Findings included Review of the facility policy titled Restorative Nursing Program, dated 12/27/2023, showed the facility would provide maintenance and restorative services designed to maintain and improve residents' abilities to the highest practicable level. It also stated residents may receive restorative nursing services upon discharge from skilled therapy. Resident 107 admitted to the facility on [DATE] with diagnoses to include multiple facial fractures from a fall, iron deficiency anemia (low red blood cells in the blood), and essential tremors. According to the admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], showed the resident had severe cognitive impairment and required assistance with self-care, mobility/ambulation, dressing, standing and transfers. Review of a form titled Physical Therapy Discharge Summary, dated 06/11/2024, showed Resident 107 was discharged from physical therapy services and Collateral Contact 1 (CC1)/ Physical Therapy Assistant (PTA) recommended Resident 107 receive restorative nursing services to maintain their abilities they had attained during therapy. In the review of Resident 107's clinical record for 06/10/2024 through 07/11/2024, showed no documentation that they received or refused restorative nursing care and services. In an interview on 07/10/2024 at 1:55 PM, Staff R, Certified Nursing Assistant (CNA), stated that resident needed more care than what is seems. Staff assist Resident 107 in his dressing and grooming. In an interview on 07/11/2024 at 1:19 PM, Staff M, Licensed Practical Nurse (LPN)/Restorative Program Manager, stated physical therapy staff usually notified them when they recommended restorative nursing care for a resident, but they had not received a recommendation for Resident 107. Staff M stated they were unsure why they had not received a restorative nursing care referral for this resident. In an interview on 07/12/2024 at 11:09 AM, CC1/PTA stated they recommended restorative nursing services for Resident 107 on 06/11/2024 but currently resident is not receiving restorative nursing program. They stated they should have addended their note if they have changed their recommendation. In an interview on 07/12/2024 at 1:02 PM, Resident 107 stated they wouldn't mind doing some exercises and walking with staff. Refer to WAC 388-97- 1060(3)(d)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview, and record review the facility failed to consistently and accurately obtain weights, recognize significant weight loss, and provide consistent assistance with eating and cueing for 1 of 4 sampled residents (Resident 33) reviewed for nutrition. Resident 33 experienced a significant 14.6% weight loss from 05/27/2024 to 07/10/2024. This failure placed the resident at risk for further decline in their weight, unintended consequences of poor nutrition, and decreased quality of life. Findings included . Review of the facility policy titled Nutritional Management, dated 12/27/2023, showed that weekly weights would be obtained on new admissions for 4 weeks. After assessing the weight accuracy, the Licensed Nurse or Nursing Assistant would record the weight in the resident's electronic medical record under vital signs. Re-weighs were required for any unplanned 3-pound (lb) variance from week to week. Resident 33 admitted on [DATE] with diagnoses which included protein calorie malnutrition, fractured hip, fractured left arm and advanced dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Review of the hospital records showed a weight of 110 lbs. on 05/22/2024 and 114 lbs. on 05/24/2024. The resident's height was documented as 66 inches. The resident's Body Mass Index (BMI) was 18.4 which was underweight (below 18.5) for their height. Review of the facility's Registered Dietician (RD) admission assessment dated [DATE] used the hospital admission weight of 110 lbs. and goals were identified as: 1. Maintain current weight of 110 lbs. +/- 3% with no significant weight changes through the next review date. 2. Gradual weight gain is permissible due to low BMI. 3. Provide support, encouragement for resident to comfortably consume as much foods, and beverages as possible The RD assessment further stated Resident 33's average daily intake was likely not meeting the requirements for calories and protein and an appetite stimulant may be appropriate if the resident's weight continued to trend down and appetite was poor. Review of the care plan dated 06/06/2024 showed the RD goals were included with the following interventions: Monitor, record, report to Provider as needed signs and symptoms of malnutrition: Needs cueing and cleanup with meals/fluids, (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Assist with meals as (they) allow. Needs to Eat where (they) can be monitored by nursing. Provide and serve supplements as ordered: Ensure (nutritional supplement) with all meals. RD to evaluate and make diet change recommendations as needed. Resident eats in dining area. Resident eats in room. Review of Resident 33's POLST (Physician's Orders for Life Sustaining Treatment) form dated 05/25/2024 showed a check mark in the box next to preference is to discuss medically assisted nutrition options, as indicated. The POLST was signed by the resident's Power of Attorney and provider on 05/25/2024. Review of facility's nutrition at risk assessment dated [DATE] showed Resident 33 was identified as being at risk for malnutrition due to age, impaired cognition, need for assistance with activities of daily living, low BMI, intake less than 50%, three or more medications, inflammation and current diagnosis impacting the resident's ability to eat. In an observation on 07/09/2024 at 9:12 AM, Resident 33 was observed lying in bed with their breakfast tray in front of them. Their eyes were closed. A bowl of hot cereal and hard cooked egg were on the tray, both untouched. The utensils were still lined up neatly on a clean folded napkin. There were three full lidded cups on the tray. One contained a chocolate shake and the other two contained water. There were no staff present in the room at the time of this observation. An observation on 07/09/2024 at 12:12 PM, showed Resident 33 was in their wheelchair. The resident appeared thin and frail. The resident was wearing a loose fitting t-shirt. Their left arm was in a sling (a bandage that supports and protects an injured arm, wrist, or hand) and they were fidgeting with the strap. The resident's lunch tray arrived and was placed in front of the resident who was sitting alone at a round table in the small common TV area of the unit. The meal was meatloaf, bread, scalloped potatoes, zucchini and a bowl of fruit. There was one full glass of a nutrition shake and one full glass of water. At 12:25 PM, the resident picked up a spoon and attempted to pick up a piece of fruit. After several attempts, they were able to pick up one grape and eat it. At 12:30 PM the resident was able to pick up a piece of pineapple with the spoon and it dropped, but after a few attempts, they were able to pick it up and eat it. At 12:35 PM they were able to cut into the corner of the scalloped potatoes and get a small piece; they were having difficulty as it was sticky and had not been cut up for the resident. At 12:38 PM the resident picked up the nutrition shake and took a few drinks. No staff were observed to cue, encourage or assist the resident with eating their meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an observation on 07/11/2024 at 12:42 PM, Resident 33 had their lunch tray in front of them which was untouched. The resident was looking at the TV and noted to be preoccupied with the sling on their left arm, the strap had slid down over their other arm, and they were pulling on the Velcro. Their hands were underneath the clothing protector and lap blanket they had on. The resident reached for the cup of nutrition shake and took a drink of it. The resident began hitting their armrest with the closed fist of their right hand and stated Please, please, then sighed, and began to push their wheelchair away from the table. Staff S, Certified Nursing Assistant (CNA), walked by and whispered in the resident's ear, then wheeled the resident into their room. Staff S exited the room and stated they took the resident to the restroom and the resident had stated they were done eating. The tray was observed to have one cracker missing from a saltine cracker package and the cup of nutrition shake was almost gone. No staff were observed to cue, encourage or offer to assist the resident during this meal. Record review of Resident 33's meal intake records for 05/25/2024 through 07/09/2024 showed there were 137 total meals: 45 breakfast meals- only 11 total breakfast meals showed the resident consumed 50% or greater of the meal. 46 lunch meals- only nine total meals showed the resident consumed 50% or greater of the meal. 46 dinner meals- only 11 total meals showed the resident consumed 50% or greater of the meal. There were 31 meals during this period that the resident was documented as having consumed 50% or greater of the meals. The other 106 meals were all documented as refused, blank (no documentation of the meal), 0%, or 25%. Review of Resident 33's clinical record on 07/09/2024 showed the vital signs section had one weight of 140 lbs. documented on 05/27/2024. No progress notes or other documentation of the discrepancy (26 lbs.) between the hospital's most recent weight and the facility's admission weight were found. Review of Resident 33's clinical record showed a pre-admission hospital weight of 114 on 05/24/2024 and a facility weight on 05/27/2024 of 140 lbs., which showed a 26 lb. weight gain which had not been reviewed by the facility. The facility had no other weights documented in the resident's record. In an interview on 07/10/24 at 11:24 AM, Staff B, Director of Nursing (DNS), stated there were worksheets filled out by the shower aids that included weights and they kept those in their office. The worksheets were not considered part of the medical record. Staff B stated that the showers and weights were supposed to be entered into the system after they were reviewed by the nurse. On 07/10/2024 at 11: 45 AM, Staff C, Assistant DNS (ADON) provided copies of worksheets titled (Staff E's) showers, or (Staff O's) showers and the dates. The worksheets contained a list of all the showers and weights that were assigned to be done by that shower aid (CNA) on a given day. The following dates showed handwritten weights for Resident 33: 05/27/2024= 140 lbs. (Staff O's showers) 06/05/2024= 140.2 lbs. (Staff E's showers) (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	06/12/2024= 141.2 lbs. (Staff E's showers) 06/18/2024= 141.2 lbs. (Staff O's showers) 06/26/2024= 143 lbs. (Staff E's showers) 06/27/2024= 141.6 lbs. (Staff E's showers) 07/03/2024= 142.5 lbs. (Staff E's showers) There were no signatures to indicate who had obtained the weights, only the name of the assigned shower aid printed at the top of the sheet. There were observed to be different styles of handwriting on the sheets. There was no documentation showing what type of scale was used for each weight. There was a space for nurse's initials on the far right but none of the entries for Resident 33 included a nurse's initials. In an interview on 07/11/2024 at 9:14 AM, Staff D, Registered Nurse (RN)/Case Manager, stated (Staff O, CNA) was no longer employed at the facility. Staff D stated that Staff E, CNA assisted with showers on their unit and the process was for the shower aids to weigh residents on their shower day and when they entered the weights in the computer there was a place to document what type of scale was used. The nurses were responsible to obtain weights for residents who had a daily weight or other weights that needed to be done at a specific time or more often than with their shower. Staff D was asked to review the weight documentation in the computer for Resident 33 which showed only the one weight which was 26 lbs. greater than the most recent hospital weight. Staff D stated they reviewed the weights for the unit weekly and was not aware of the weight discrepancy and missing weight documentation for Resident 33. In an interview on 07/11/2024 at 09:47 AM, Staff D (accompanied by Staff C) stated they had reviewed the weights for Resident 33 and stated the weight (140 lbs.) was entered into the system incorrectly. Staff D stated the weight for Resident 33 was entered as 140 lbs. and it should have been 114 lbs. The incorrect weight had been struck out and a weight of 114 lbs. was now in the system. Staff D was shown the shower worksheets which contained weights that were never entered into the computer system and were showing as consistent with the (now) struck out weight, and discussed observations of the resident's poor intakes and observation of the general thin appearance of the resident which did not match what the shower worksheet weights documented. Staff D stated they were not sure what the resident's correct weight was. In an observation with Staff D on 07/11/2024 at 10:05 AM, Resident 33 was weighed in the shower room on the wheelchair scale. Staff D was observed to zero the scale and the resident was in their chair with the footrests on. The resident was wheeled onto the scale and the combined weight was observed to be 169 lbs. and was verified several times. The wheelchair was weighed separately with the footrests and weighed 71.7 lbs. After subtracting the wheelchair weight, the resident's actual weight was 97.3 lbs., which was a 16.7 lb. (14.6%) weight loss since admission based on the baseline hospital weight of 114 lbs. The resident's BMI was now 15. Review of the medical record, care plans through 07/10/2024 showed no documentation of notification to the provider, POA or additional interventions related to the inaccurate weights. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview and observation on 07/12/2024 9:22 AM, Staff E, CNA, Shower Aide, reviewed the process for weights and weight documentation during shower assignments. Staff E stated they assisted with showers on Resident 33's unit sometimes and the weights were done using the shower chairs. Staff E demonstrated obtaining the weight of a shower chair, zeroing the scale and noted the weight of the shower chair was 17 lbs. which Staff E stated was close to what all the shower chairs weighed. Staff E stated if a resident received a bed bath, they used the Hoyer (mechanical) lift to get their weight. Staff E stated they would enter the weights into the computer at the end of their shift. Staff E was asked about weights for Resident 33 and said they did not remember being the one to obtain any of Resident 33's weights. Staff E stated that sometimes the nurses or the CNAs on the floor would get the weights and write them on the shower worksheets and suggested that was what may have occurred. In an interview on 07/12/2024 at 10:11 AM, Staff N, LPN, stated the nurses or CNAs did not get the weights on their unit. Staff N stated there would have been no reason for them to get (Resident 33's weight) as they were not on a daily weight (or other specifically ordered weight) so the shower aids would have been the ones to get weights for Resident 33. Staff N stated all residents should be getting weighed once a week but there was nothing in the system that notified them if someone did not have a weight. Staff N stated the unit managers reviewed the weights. In an interview on 07/12/2024 at 12:09 PM, with Staff B, DNS and Staff C ADON, Staff B stated the goal was for residents to be weighed weekly and those weights documented in the computer system along with the type of scale used. Staff B stated residents should be re-weighed if there was a discrepancy. The Unit Managers reviewed weights weekly and if there was a change of three lbs. up or down, or if they triggered for weight loss of 5%, or 10%, they would be discussed in the facility team meeting, they would assess the resident and notify the provider, the RD, and the family. Staff B and C stated they had not been aware of Resident 33's weight loss and did not know why the weight documentation was consistently inaccurate for the resident on the worksheets, or how their weights had not been entered into the system or reviewed by any licensed nurses or the Unit Manager according to the policy. Refer to WAC 388-97-1060 (3)(h) This is a recurring deficiency previously cited on the Statement of Deficiencies dated April 25, 2023.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (Resident 15) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure a medical provider assessed and documented a rationale for extended use of an as necessary (PRN) anti-psychotic (medication that treats symptoms that affect the mind, and reality) medication for use over 14 days and provided no duration of use of the anti-psychotic medication. These failures placed the residents at risk for medication-related complications and for receiving unnecessary psychotropic medication. Finding included . Review of the facility policy titled, Psychoactive Medications, revised 12/27/2023 stated any psychotropic medication prescribed as a PRN will be for 14 days and will be re-evaluated for discontinuance or justification from the provider. Resident 15 admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, and dementia. The quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 06/22/2024 showed they had severe cognitive impairment. Review of Resident 15's physician orders showed an order for Quetiapine Fumarate 25 milligrams (mg) every four hours as needed for agitation, started 03/27/2024. Review of Resident 15's electronic medication administration record (EMAR), dated 05/01/2024 - 07/10/2024 showed the following: - May 2024: was not administered, - June 2024: was administered twice, - July 2024: was administered eight times (resident passed away on 07/10/2024). Review of Resident 15's medical record showed no assessment, rationale or review for the use of a PRN anti-psychotic medication, the medical record showed no duration or stop date. In an interview on 07/12/2024 at 1:22 PM, Staff P, Registered Nurse (RN)/Case Manager stated Resident 15 had the order for the Quetiapine which was originally prescribed by hospice for agitation. Staff P confirmed that all PRN psychotropic medications required review every 14 days for rationale, and continued usage. Staff P was unable to provide documentation that the PRN medication had been reviewed every 14 days. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint interview on 07/12/2024 at 1:46 PM, Staff B, Director of Nursing Services (DNS) stated Resident 15 was receiving the PRN Quetiapine for agitation and it was a part of the hospice orders. Staff B was not aware that the PRN medication had not been assessed or reviewed by a provider for rationale or duration since the start date. Further documentation was requested, Staff B was unable to provide any further information. Refer to WAC 388-97-1060(3)(k)

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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. 33954 Based on observation and interview, the facility failed to transport and serve food in a sanitary manner in 3 of 3 units (East, West, North) reviewed for food service. The failure to cover cold foods like fruit cups and desserts placed residents at risk for receiving contaminated foods and for diminished quality of life. Findings included . In an observation on 07/08/2024 at 12:05 PM, the East unit hall tray cart had trays with uncovered mandarin oranges that were served to residents. In an observation on 07/08/2024 at 12:08 PM, the North unit hall tray cart had trays with uncovered mandarin oranges that were served to residents. In an observation on 07/09/2024 at 12:00 PM, the East unit hall tray cart had trays with uncovered fruit that were served to residents. In an observation on 07/09/2024 at 12:09 PM, the East unit had uncovered fruit cups with melon and mandarin oranges that were served to residents. In an observation on 07/10/2024 at 12:15 PM, the East unit hall tray cart had trays with uncovered cups of apricots that were uncovered and were served to residents. In an observation on 07/15/2024 at 11:17 AM, the [NAME] unit hall tray cart had trays with uncovered cake and whipped cream that were served to residents. In an interview on 07/12/2024 at 1:05 PM, Staff T, Dietary Manager, stated they didn't cover their dessert bowls or small cups of condiments. 47104 Refer to WAC 388-97-1100 (2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview, and record review, the facility failed to ensure a system was in place in which residents' records were complete, accurate, accessible, and systematically organized for 6 of twelve residents (33, 49, 78, 92, 103, and 107) reviewed for accurate and complete medical records. The facility failed to ensure the medical records reflected the accurate, and complete weights and bathing documentation for 2 residents (33, and 49), failed to contain the consents for use of restraints for 1 resident (92), failed to include consultant provider notes for podiatry and wound clinic documentation for 2 residents (78, and 103), failed to ensure accurate documentation for meal tray monitoring for 1 resident (92), and failed to ensure accurate documentation for a urinary catheter for one resident (107). This failure to not maintain complete and accurate medical records placed residents at risk for medical complications, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Medical Records, revised 12/27/2023 stated the medical records department will maintain the records on each resident as complete, accurately documented, readily accessible and systematically organized. <WEIGHTS AND SHOWERS> <RESIDENT 33> Resident 33 admitted to the facility on [DATE] with diagnoses which included protein calorie malnutrition, fractured hip, fractured left arm and advanced dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Review of Resident 33's electronic medical record on 07/09/2024 showed one weight had been documented in the resident's clinical record on 05/27/2024. No other weights were documented in the record. <RESIDENT 49> Review of the resident's electronic medical records on 07/11/2024 showed Resident 49 received three showers in the past 2 months. In an interview on 07/10/2024 at 11:24 AM, Staff C, Assistant Director of Nursing (DNS), stated there were worksheets filled out by the shower aides that included weights and they kept those in their office. Staff C stated the worksheets were not considered part of the medical record. The showers and weights were supposed to be entered into the system after they were reviewed by the nurse. At 11:45 AM, Staff C provided copies of handwritten worksheets with names and dates of seven additional showers and weights for Resident 33 and eight additional showers for Resident 49, these were not easily accessible or part of the medical record. 47104 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 92> Resident 92 admitted to the facility on [DATE] with diagnoses to include dementia, dysphagia (difficulty swallowing), and muscle weakness. Review of the Quarterly Minimum Data Set (MDS, an assessment tool) assessment, dated 07/11/2024 showed the resident had severe cognitive impairment. A review of Resident 92's care plan on 07/11/2024 showed Resident 92 used a tilt n space wheelchair (a wheelchair that can recline and is classified as a restraint), initiated on 04/29/2024 and was at risk for weight loss. A review of Resident 92's electronic health record on 07/11/2024 showed no documentation of a Physical Restraint Informed Consent form for Resident 92's tilt n space wheelchair. A review of Resident 92's electronic health record on 07/11/2024 showed Resident 92's tray monitoring (documentation of percentage of meal consumed) dated 06/12/2024 through 07/10/2024 (for 30 days) showed seven missing entries for breakfast, seven missing entries for lunch, and five missing entries for dinner. In an interview on 07/12/2024 at 10:03 AM, Staff Q, Certified Nursing Assistant (CNA) stated the resident used a tilt n space wheelchair. Staff Q stated resident meals were documented by the CNA in point of care (PCC) charting. Staff Q stated each meal is documented individually by the percentage eaten. In an interview on 07/12/2024 at 10:20 AM, Staff M, Licensed Practical Nurse (LPN), Case Manager, Restorative Program Manager, stated the resident used a tilt n space wheelchair and they were responsible for obtaining the consent for that device. Staff M stated they were unable to find the consent form for Resident 92's wheelchair in the electronic medical record or paper chart and would check medical records. Staff M stated CNAs chart resident meal intake in PCC. Staff M stated there was missing documentation in Resident 92's medical record for tray monitoring. On 07/12/2024 at 11:00 AM, Staff M provided a copy of the consent form for Resident 92's tilt n space wheelchair dated 05/13/2024, fourteen days after the restraint was initiated. In an interview on 07/12/2024 at 12:20 PM, Staff G, Medical Records, stated consents were scanned into the medical record. In an interview of 07/15/2024 at 9:50 AM, Staff B, DNS stated the CNAs were responsible for documenting the percentage of meal consumed for each meal in PCC. Staff B stated tray monitoring should be audited for missing documentation. 50725 <RESIDENT 107> Resident 107 admitted to the facility on [DATE]. According to the end of Medicare Part A stay MDS assessment, dated 06/12/2024, the resident had severe cognitive impairment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 07/10/2024 at 10:00 AM Resident 107 did not have a urinary catheter (a tube used to empty the bladder). Review of the progress note, dated 06/10/2024, showed Resident 107's urinary catheter had been discontinued. Review of Resident 107's current care plan, dated 05/28/2024, showed the resident was care planned that they had a urinary catheter. Review of Resident 107's Treatment Administration Records, dated 07/11/2024, showed a licensed nurse had annotated they had changed their urinary catheter and drainage bag on 07/10/2024. In an interview on 07/12/2024 at 9:08 AM, Staff L, Registered Nurse, stated they had signed the treatment administration records in error, documenting that they had changed the urinary catheter and drainage bag, and that the catheter had been discontinued in June 2024. In an interview on 07/11/2024 at 1:19 PM, Staff M, LPN/Resident Care Manager, stated Resident 107's care plan and treatment administration records should have been updated when the urinary catheter was discontinued. 44110 <CONSULTANTS> <RESIDENT 78> Resident 78 admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (slow and progressive disorder of the blood vessels), diabetes, and multiple wounds to right foot. The quarterly MDS assessment dated [DATE] showed the resident had intact cognition and open foot wounds to bilateral feet. In an interview on 07/09/2024 at 12:00 PM, Resident 78 stated they had a couple wounds to both of their feet. Resident 78 stated that they went out to see an outside wound provider for management of their wounds. Review of Resident 78's progress notes on 07/10/2024, showed a communication note dated 05/21/2024, documenting that an outside wound clinic provider was contacted regarding updated orders for the resident's wound care management. Review of Resident 78's medical record showed no record or documentation from an outside wound clinic and/or wound care provider. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/11/2024 at 11:36 AM, Staff F, LPN/Case Manager stated Resident 78 was out of the facility at that time at their wound clinic appointment. Staff F stated that when the resident returned from the wound clinic, they would review the documentation from the wound provider, update any orders, and then place in the medical records box for filing. Staff F stated they were not aware there was no wound clinic documentation in the resident's medical records. In an interview on 07/11/2024 at 1:01 PM, Staff C stated Resident 78 was attending the wound clinic weekly, and they are not going every other week. Staff C provided wound clinic documentation for visits on 06/27/2024, 06/13/2024, 05/30/2024 and 05/16/2024. None of the documentation provided was included in the medical record for Resident 78. <RESIDENT 103> Resident 103 admitted to the facility on [DATE] with diagnoses including muscle weakness, depression, and heart failure. The quarterly MDS assessment dated [DATE] showed that the resident had intact cognition and required substantial to maximum assistance for all personal hygiene care. In an observation and interview on 07/08/2024 at 1:47 PM, Resident 103 was lying in their bed, their feet were exposed from under the sheet. The resident's toenails were observed to be long, and some were curling over the skin of the toe. Resident 103 stated that their toenails needed to be trimmed, and that the toenail on their right big toe had recently fallen off. The right great toenail bed was observed to be pink, and there was no nail present. Review of Resident 103's progress notes on 07/09/2024 showed a progress note dated 05/17/2024, documenting that the resident had been seen by a podiatrist. The note stated the resident had an infection to their right great toe. In a review of Resident 103's medical record showed no record or documentation from a podiatrist, or the infection to the resident's right great toe. On 07/11/2024 at 1:01 PM, Staff C provided the podiatry documentation for Resident 103. Staff C was not sure why it was not in the medical record and was unable to provide any additional information. In an interview on 07/12/2024 at 12:20 PM, Staff G, Medical Records, stated that all documentation placed in the medical records box at the nurse's stations were scanned into the medical record. Staff G stated all consults with providers, such as wound clinic or podiatry notes should be scanned into the medical record. Staff G stated they were instructed not to scan anything into the medical record until the case managers had signed off on it. Staff G stated the wound clinic documentation for Resident 78 and Resident 103's podiatry notes were probably still on the case manager's desk, and therefore had not been signed off or released to them to scan into the record. In an interview on 07/12/2024 at 1:46 PM, Staff B, DNS stated the process was that all documentation should be scanned into the electronic medical record timely. Staff B stated there could be a delay of a week or two at times. Staff B confirmed that consults from May, included Resident 78's wound clinic visits, and Resident 103's podiatry visits should have been in the resident's medical record. Staff B was not aware that the case managers were holding onto documentation and not getting things scanned into the medical record timely. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to WAC 388-97-1720 (1)(a)(i)(ii)(iii)(2)(d)(e)(f)(j)(m)