STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505469	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at Skyline	715 9th Avenue Seattle, WA 98104

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interview and record review, the facility failed to establish a grievance policy that designated a Grievance Official (an individual responsible for overseeing the grievance process) for 2 of 2 floors (Seventh & Eighth Floor), reviewed for grievances. This failure placed residents and their representatives at risk of not having access to the required information regarding the Grievance Official, potentially hindering the facility's ability to investigate and resolve concerns effectively.Findings included .Review of the facility's policy titled, Grievances, revised on 01/01/2025, showed that Residents are welcome to approach staff members to express their complaints or recommendations.The social worker will meet residents as needed, and as requested by the nursing department, to discuss and address any complaints or recommendations residents may have.When a problem(s) occurs or becomes known, the person responsible for responding and correcting it should be notified.When grievances cannot be resolved or the person making a complaint does not feel comfortable speaking with the person(s) responsible for its resolution, it can be referred to the facility Administrator for necessary action and response. Further review did not show that a Grievance Official was designated to oversee the grievance process.Review of an undated grievance forms posted next to elevators on the seventh and eighth floors did not show documentation of information regarding the Grievance Official, including contact information.In a group interview on 08/06/2025 at 10:30 AM, Residents 31, 16, and 23 were asked if the facility Grievance Official responded to the resident or family group concerns, Residents 31, 16, and 23 stated that the [previous Administrator] did. Residents 31, 16, and 23 could not identify who the grievance official was currently.In an interview and joint record review on 08/07/2025 at 4:01 PM, Staff A, Administrator, stated that the Social Services Director was the facility's Grievance Official. A joint record review of the facility's grievance policy did not show documentation that a Grievance Official and their contact information was designated. Staff A stated that, The previous Administrator changed it to be him, but it should be the Social Services Director and that the facility's policy did not reflect that.Reference: (WAC) 388-97-0460.

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

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide the required Registered Nurse (RN) coverage for 1 out of 30 days (08/03/2025), reviewed for staffing. This failure placed the residents at risk for inadequate assessments, delay in care services by an RN, unmet care needs, and a diminished quality of life.Findings included .Review of the facility's document titled, Daily Clinical Staff Posting, dated 08/03/2025 did not show documentation of RN coverage on 08/03/2025 for at least eight consecutive hours a day.In an interview and joint record review on 08/07/2025 at 11:43 AM, Staff E, Staffing Coordinator, stated they were responsible for the daily clinical staff posting. Staff E further stated they would schedule 16 hours of RN coverage a day. A joint record review of the clinical staff posting dated 08/03/2025 showed no RN coverage for 08/03/2025. Staff E further stated there was no RN coverage on 08/03/2025 and that there should have been.In an interview on 08/07/2025 at 12:30 PM, Staff A, Administrator, stated there should be at least eight consecutive hours a day of RN coverage. Staff A further stated that they expected there to be at least eight consecutive hours a day of RN coverage on 08/03/2025.Reference: (WAC) 388-97-1080 (8).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure sanitizing solution test strips were not used after expiration date and failed to keep records of the sanitizing solution test log forms for 1 of 1 kitchen (Fourth Floor Main Kitchen), and failed to ensure food items were discarded after the use-by-date in accordance with professional standards for food safety for 1 of 3 storage rooms (Seventh Floor Storage Area), reviewed for food services. These failures 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, Test Strips for Sanitizing Solution, revised on 01/01/2025, showed that sanitizing solutions used in the facility would be tested daily and would use approved testing strips to verify correct concentration levels. The results would be documented and maintained for compliance with federal, state, and local regulations. The policy further showed that salinizing solution test logs would be retained for a minimum of three months or per facility policy.Review of the facility's policy titled, Food Storage, revised on 04/11/2025, showed that the facility would ensure all food was stored appropriately according to state and federal food code to prevent foodborne illness in the community.SANITIZING TEST STRIPS/TEST LOG RECORDS-FOURTH FLOOR MAIN KITCHENA joint observation and interview on 08/04/2025 at 10:59 AM with Staff F, Sous Chef, showed they were using the sanitizing test strip to check the level of Parts Per Million (PPM - unit of measure for concentration) of the sanitizing solution. Further joint observation of the sanitizing solution test strips with Staff F showed that the test strips read Hydrion QT-40 (brand name - used to check the level of sanitizing solution) had an expiration date of 08/15/2024. Staff F stated that the sanitizing solution test strip was expired. Staff F found an unopened Hydrion QT-40 sanitizing solution test strip with an expiration date of 08/15/2024. Staff F stated that the additional sanitizing solution test strip was also expired. Staff F stated that the kitchen staff had been using the expired test strips and that the sanitizing test strips should have been discarded.In an interview on 08/07/2025 at 9:02 AM, Staff G, Sous Chef, stated that they expected staff to use sanitizing test strips that were not expired. Staff G further stated that they did not know the sanitizing solution test strips had expired. When asked Staff G for the sanitizing solution test log for the last six months, Staff G stated that the facility did not keep records of previous months' sanitizing solution test logs and that they were discarded at the end of the month. Staff G further stated that they did not know that sanitizing solution test logs records needed to be maintained.FOOD ITEMS BEYOND USE BY DATE-SEVENTH FLOOR STORAGE AREAA joint observation and interview on 08/06/2025 at 12:28 PM with Staff T, Cook, showed the Seventh-Floor Kitchen storage area had a bottle of tabasco [brand of hot spicy] sauce had a use-by-date of 08/03/2025 and a bottle of chocolate sauce that had a use-by-date of 07/25/2025. Staff T stated that the bottles of chocolate sauce and tabasco sauce should have been discarded by their use-by-date.In an interview on 08/06/2025 at 4:02 PM, Staff H, Executive Chef, stated they expected food items to be discarded by their use-by-date. Staff H further stated that the food items from the Seventh-Floor Kitchen storage should have been discarded.In an interview on 08/07/2025 at 5:29 PM, Staff A, Administrator, stated they expected staff to discard expired sanitizing solution test strips and that records for the logs should have been kept. Staff A further stated that they expected foods items to be discarded by their use-by-date.Reference: (WAC) 388-97-1100 (3).

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to ensure infections related to initiation of antibiotic (medicine that prevents or treats infections) practices were based on the Center for Disease Control and Prevention (CDC) approved criteria for 6 of 6 months (February 2025, March 2025, April 2025, May 2025, June 2025 & July 2025), reviewed for antibiotic stewardship program. This failure placed the residents at risk of receiving or not receiving necessary antibiotics, and a diminished quality of care.Findings included .Review of the facility's policy titled, Antibiotic Stewardship Program, revised on 01/22/2024, showed that the antibiotic stewardship program was to optimize the treatment of infections while reducing adverse events associated with antibiotic use. It showed that the facility used Loeb Minimum Criteria [a set of clinical guidelines designed to help determine if a resident in long term care likely has an infection, even if the infection has not been confirmed by diagnostic testing - these criteria include specific signs and symptoms that, when present, suggest the need for antibiotic therapy] to determine whether to treat an infection with antibiotics. The policy further showed that nursing would monitor the initiation of antibiotics on residents and conduct an antibiotic timeout within 48-72 hours of antibiotic therapy to monitor response to the antibiotic and review laboratory results and consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings. Review of the Infection Control Log, from February 2025 to July 2025 did not show documentation that the Loeb's criteria was used to indicate if residents' signs and symptoms met the minimum criteria prior to their prescribed antibiotics. A joint record review and interview on 08/07/2025 at 4:52 PM with Staff B, Director of Nursing, showed the infection control log from February 2025 to July 2025 did not have documentation that the signs and symptoms of residents met the minimum criteria for antibiotic use. Staff B stated that they believe the facility had not been using the Loeb Minimum Criteria to check if the residents' signs and symptoms met the criteria prior to antibiotic use. No Associated WAC.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper storage, dating and labeling of respiratory equipment for 3 of 4 residents (Residents 1, 2 & 3), reviewed for respiratory care. These failures placed the residents at risk for respiratory infection, related complications, and a diminished quality of life.Findings Included . Review of the facility's policy titled, Oxygen Administration,” revised on 02/07/2024 showed, it is the policy of the facility to administer oxygen to the residents when insufficient oxygen is being carried by the blood to the tissues. Place nasal cannula (a flexible tubing that delivers oxygen through the nose) or mask in place with date written on label attached to tubing. The oxygen tubing should be changed every week with a new cannula or mask. RESIDENT 1Review of a face sheet printed on 08/07/2025 showed Resident 1 was admitted to the facility on [DATE] with diagnosis that included parainfluenza (a group of viruses that cause different types of lung infections) and acute and chronic respiratory failure with hypoxia (a condition characterized by low levels of oxygen in the blood). Review of Resident 1's April 2025 physician's orders showed an order for one to four liters (unit of measurement) per minute of oxygen as needed and a use of Continuous Positive Airway Pressure (CPAP- a device that helps people with breathing difficulties) at night. Further review of the orders showed instruction for staff to change oxygen tubing weekly in the evening every Tuesday for oxygen use. Observation of Resident 1's oxygen equipment on the following dates showed:-On 08/04/2025 at 2:42 PM, the oxygen nasal cannula was not labelled/dated, laying on the resident's recliner, and not properly stored. The CPAP tubing nose piece (inserted through the nose for delivery of air) was observed laying on the nightstand table and was not properly stored. -On 08/05/2025 at 11:52 AM, the oxygen nasal cannula was not labelled/dated. The CPAP tubing nose piece was observed laying on the nightstand table and was not properly stored. A joint observation and interview on 08/05/2025 at 12:19 PM with Staff M, Registered Nurse, showed Resident 1's nasal cannula tubing was not labelled or dated. The CPAP tubing nose piece was observed laying on the nightstand table and was not properly stored. Staff M stated that the nasal cannula tubing should be dated and initialed when it was changed, and the CPAP nose piece should be properly stored when not in use. In an interview on 08/07/2025 at 11:12 AM, Staff B, Director of Nursing, stated that it was their expectation that oxygen nasal cannula tubing be changed once a week with date and staff initial. Staff B further stated that oxygen nasal cannula tubing and CPAP nose piece should be properly stored in a clear plastic bag when not in use. RESIDENT 2Review of a face sheet printed on 08/04/2025 showed Resident 2 readmitted to the facility on [DATE] with diagnosis that included pneumonia (lung infection that makes it hard to breathe). Review of Resident 2's physician orders printed on 08/05/2025 did not show an order for nebulizer (a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	small machine that turns liquid medicine into a mist for inhaling) treatment. An observation on 08/07/2025 at 12:35 PM showed Resident 2 had a nebulizer machine attached with respiratory equipment and was placed on the bedside drawer. Further observation showed the respiratory equipment was unlabeled/undated. In an interview on 08/07/2025 at 3:19 PM Staff D, Resident Care Manager, stated that it was the facility's process to label respiratory equipment with the date of first use and to be “bagged” for clean storage. A joint observation of Resident 2's room on 08/07/2025 at 3:48 PM showed a nebulizer machine attached with respiratory equipment placed on the bedside drawer that was unlabeled. Staff D stated they would remove the nebulizer machine from Resident 2's room because Resident 2 did not have an “order for it.” RESIDENT 3Review of a face sheet printed on 08/04/2025 showed Resident 3 admitted to the facility on [DATE] with diagnosis that included obstructive sleep apnea (a condition where breathing repeatedly stops and starts during sleep) and human parainfluenza virus pneumonia (a lung infection caused by a virus) with an onset date of 07/30/2025. Review of the physician orders printed on 08/05/2025, showed Resident 3 had an order for CPAP at bedtime. It further showed that Resident 3 had an order for nebulizer treatment three times a day for dyspnea (shortness of breath). An observation on 08/07/2025 at 12:22 PM in Resident 3's room showed nebulizer parts to include a mouthpiece were uncovered and placed on a paper towel on top of a stack of cardboard boxes near the bedside. Further observation showed the nebulizer parts were unlabeled. In an interview on 08/07/2025 at 3:19 PM, Staff D stated that respiratory equipment included nebulizer equipment as well as CPAP equipment. A joint observation and interview on 08/07/2025 at 3:58 PM with Staff D, showed Resident 3's room nebulizer parts were unlabeled/uncovered and were placed on a paper towel on top of a stack of cardboard boxes near the bedside. Further observation showed Resident 3's CPAP equipment including a nose piece was uncovered and placed on top of Resident 3's bedside drawer. Staff D stated that they expected Resident 3's respiratory equipment would be labeled and/or stored in a “clean bag.” In an interview on 08/07/2025 at 6:21 PM, Staff B stated that it was the facility's policy to label respiratory equipment and to properly store them. Reference: (WAC) 388-97-1060(3)(j)(vi) .

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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** Based on observation, interview, and record review, the facility failed to dispose expired medication in accordance with current accepted professional standards for 1 of 1 medication refrigerator (8th Floor Medication Room Refrigerator), reviewed for medication storage and labeling. This failure placed the residents at risk for receiving compromised or ineffective medications, potential unsafe medication administration, and potential adverse side effects. Findings included .Review of the facility's policy titled, Medication Label, revised on [DATE], showed that nursing staff would ensure resident's medication was appropriately labeled according to pharmacy recommendation. Multi-dose vials that have been opened or accessed (e.g., needle punctured) were dated and discarded within 30 days unless the manufacturer specified a shorter or longer date for the open vial.A joint observation and interview on [DATE] at 2:08 PM with Staff M, Registered Nurse, showed the Eighth Floor Medication Room Refrigerator had one multi-dose vial of tuberculin (purified protein derivative, is a combination of proteins that are used in the diagnosis of tuberculosis [a serious illness caused by a type of bacteria that mainly affects the lungs]) with an open date of [DATE]. Staff M stated that tuberculin was good for 30 days from the date it was opened. Staff M stated that the tuberculin vial was two days past the expiration date and should have been discarded.In an interview on [DATE] at 11:40 AM, Staff B, Director of Nursing, stated that they referred to a pharmacy sheet with names of medication and when medication would expire. Staff B further stated that it was their expectation that staff would identify and properly dispose of expired medication.Reference: (WAC) 388-97-1300 (2).

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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. Based on observation, interview, and record review, the facility failed to ensure a detailed written description of the facility's water system was included in their water management program and/or appropriate personnel were included in the water management team that assessed the potential growth of Legionella (a family of micro-organisms which are naturally found in water bodies), failed to ensure an outbreak (a sudden rise in the incidence of a disease or infection) was reported for 4 of 4 residents (Residents 6, 3, 1 & 22), and failed to ensure appropriate Personal Protective Equipment (PPE- equipment wore to minimize exposure to hazards that can cause serious illnesses) was used for 2 of 7 residents (Residents 7 & 3), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included… Review of the facility's policy titled, “Legionella Water Management Program,” reviewed on 04/11/2024, showed that “as part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team.” The document further showed that the water management team consisted of at least the following personnel: the infection preventionist, administrator, medical director (or designee), director of maintenance and the director of environmental services. The policy further showed that the facility's water management program included a detailed description and diagram of the water system in the facility. Review of the facility's policy titled, “Enhanced Barrier Precautions [EBP- precautions to protect the spread of infectious organisms],” revised on 01/01/2025, showed that the facility would implement EBP for the prevention of transmission of multidrug-resistant organisms (bacteria that is resistant to one or more classes of antibiotics (medicine that prevents or treats infections) using gown and gloves during high-contact resident care activities that included dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, and urinary catheter (or foley urinary catheter - a semi-flexible tube inserted into the bladder [a hollow muscular sac that stores urine] to drain urine) care. WATER MANAGEMENTReview of the “Water Management and Legionella Prevention Plan,” revised on 07/20/2025, did not show that infection preventionist and/or medical director were part of the water management team members. Further review of the document did not show a detailed description of the facility's water system. A joint record review and interview on 08/07/2025 at 2:13 PM with Staff P, Director of Facilities, showed the facility's water management program had a schematic diagram of the facility's water system and did not show a detailed written description of the facility's water system. Staff P stated that the water management schematic diagram was the facility's water system. In an interview on 08/07/2025 at 4:48 PM, Staff D, Infection Preventionist (IP), stated they were not part of the water management program/plan team. A joint record review and interview on 08/07/2025 at 5:29 PM with Staff A, Administrator, did not show the facility's water management plan included a detailed description of the facility's water system. Staff A stated that the water management plan should have included a detailed description of the facility's water system. A joint record review of the water management program did not show that the IP and/or the medical director were included in the water management team. A joint record review (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the facility's water management policy indicated that the IP and medical director were part of the water management team. Staff A stated that the IP and medical director should have been part of the water management team. OUTBREAK REPORTINGReview of the facility's policy titled, “Infection Outbreak Response and Investigation,” revised on 01/01/2025, showed that two or more residents or staff with similar symptoms were considered an outbreak. Further review of the policy showed that the outbreak would be notified to the “Local/State Health Department.” Observations on 08/04/2025 at 2:55 PM showed Residents 6, 3, 1 & 22 were placed on droplet precautions (steps used to stop the spread of germs that travel through the air in tiny droplets when someone talks, coughs, or sneezes) and/or contact precautions (measures to prevent the spread of germs from one person to another by touching the infected person or their environment). Review of a nursing progress note dated 07/28/2025 showed Resident 6 had possible Human Parainfluenza (HPIVs-commonly cause upper and lower respiratory infections) and was placed on droplet precautions. Review of a nursing progress notes dated 07/31/2025 showed Resident 3 had a diagnosis of parainfluenza and was placed on droplet precautions. Review of a nursing progress notes dated 07/29/2025 showed Resident 1 had a diagnosis of parainfluenza and was placed on droplet precautions. Review of nursing progress notes dated 07/25/2025 showed Resident 22 had respiratory symptoms and was placed on droplet precautions. In an interview on 08/07/2025 at 4:37 PM, Staff D stated they did not know if the respiratory symptoms for Residents 6, 3, 1 and 22 were an outbreak and/or should have been reported to the state and/or local health department. In an interview on 08/07/2025 at 4:58 PM, Staff B, Director of Nursing, stated they did not know if the respiratory symptoms for Residents 6, 3, 1 and 22 were considered an outbreak and that their respiratory symptoms were not reported to the State and/or local health department. USE OF PPE-EBP PRECAUTIONSRESIDENT 7Review of Resident 7's physician orders printed on 08/04/2025 showed an order dated 06/03/2024 for “Enhanced Barrier for device care: PEG tube (Percutaneous Endoscopic Gastrostomy or feeding tube - a special type of flexible tubing that allows a person to receive nutrition, hydration, and medication through the tube instead of by mouth) and Foley Catheter Placement.” Observation on 08/04/2025 at 4:12 PM showed Staff I, Certified Nursing Assistant (CNA) and Staff J, CNA, were entering Resident 7's room with a Hoyer (mechanical lifting device) lift without wearing their gown. Further observation showed Resident 7 had an EBP signage outside their room that instructed staff to wear gowns and gloves for high-contact resident care activities that included transferring and urinary catheter care. In an interview and joint record review on 08/04/2025 at 4:21 PM, Staff I and Staff J, stated that they transferred Resident 7 from bed to wheelchair using the Hoyer lift, and emptied Resident 7's urinary (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	catheter bag. A joint record review with Staff I and Staff J showed an EBP signage outside Resident 7's room that instructed staff to wear gowns and gloves for high-contact resident care activities that included transferring and assisting with catheter care. Staff I and Staff J stated that they should have worn a gown when assisting Resident 7 with catheter care and transfers. In an interview on 08/06/2025 at 4:15 PM, Staff K, Registered Nurse (RN), stated staff [Staff I and Staff J] should have worn their gown when assisting Resident 7 with high-contact care activities. In an interview on 08/07/2025 at 4:23 PM, Staff D stated that staff [Staff I and Staff J] should have worn a gown when assisting Resident 7 with catheter care and transfers. In an interview on 08/07/2025 at 5:10 PM, Staff B stated they expected staff to wear a gown when providing high-contact care activities to residents on EBP precautions. Staff B further stated that Staff I and Staff J should have worn their gown when assisting Resident 7 with catheter care and transfers. USE OF PPE-DROPLET PRECAUTIONSRESIDENT 3Review of the facility's policy titled “Infection Control Prevention and Control Program,” revised on 04/01/2025, showed that the facility established and maintained an infection prevention and control program that prevented, identified and controlled the spread of infections and communicable disease in the facility. It further showed that the facility provided PPE to support compliance with transmission-based precautions (steps used to stop the spread of germs) and ensured that it was readily available for staff use. Review of a face sheet printed on 08/05/2025, showed Resident 3 had a diagnosis of Human Parainfluenza Virus (HPIV) pneumonia (a lung infection caused by a virus called HPIV) with an onset date of 07/30/2025. Review of Resident 3's physician orders showed an order for droplet precautions for HPIV dated 08/04/2025. An observation and record review on 08/04/2025 at 9:21 AM showed that signage indicated droplet precautions and a PPE isolation cart were placed at the entrance of Resident 3's room. Review of the droplet precautions sign showed that everyone must “make sure their eyes, nose and mouth are fully covered before room entry.” An observation on 08/06/2025 at 9:03 AM showed Staff L, CNA, wore a gown, gloves, face mask and eye protection that was secured across Staff L's forehead via a strip of adhesive. Staff L wore their personal eyeglasses in addition to eye protection. Further observation did not show Staff L's eyes were fully covered on the sides prior to entering Resident 3's room. In an interview and joint observation on 08/07/2025 at 9:23 AM, Staff M, RN, stated that to properly wear the eye protection with the adhesive strip, personal eyeglasses had to be removed to allow for the adhesive strip to “stick” and protection to the sides of the eyes was provided. Staff M stated that they used a face shield as eye protection because it allowed them to wear their personal eyeglasses with eye protection. A joint observation of Resident 3's PPE isolation cart did not show alternative forms of eye protection were available for staff use. Staff M stated that face shields were “gone,” but that they expected face shields would be stocked in the PPE cart. An observation on 08/07/2025 at 8:41 AM showed Staff N, Lifestyles Assistant, wearing a gown, (continued on next page)

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	505469	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves and a face mask prior to entering Resident 3's room. Further observation did not show Staff N's eyes were fully covered prior to room entry. In an interview and joint record review on 08/07/2025 at 8:44 AM, Staff N stated that they wore a gown, gloves, and a face mask prior to entry of rooms indicated for droplet precautions. Joint record review of Resident 3's droplet precautions sign showed an indication to wear eye protection prior to room entry. Staff N stated that they should have worn the “shield” and that they should have worn eye protection prior to room entry. In an interview on 08/07/2025 at 3:19 PM, Staff D stated that they expected staff would follow isolation precautions indicated by “signs” posted prior to room entry. Staff D stated that they expected staff with personal eyeglasses to wear eye protection that fully covered their eyes. Staff D further stated that they expected PPE isolation carts would be stocked with PPE for staff use. In an interview on 08/07/2025 at 6:21 PM, Staff B stated that the facility followed the Centers for Disease Control and Prevention guidelines for infection prevention and control. Staff B further stated that they expected staff would follow isolation precautions when indicated and that PPE for staff use would be “always available and replenished.” Reference: (WAC) 388-97-1320 (1)(a)(5) .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a copy of the advance directive (a written document describing a resident's wishes for care if they became incapacitated such as a living will or Durable Power of Attorney [DPOA- a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so]) for health care was obtained from the resident/representatives who had an advance directive for 1 of 1 resident (Resident 11), reviewed for advance directive. This failure placed the resident and/or their representative at risk for losing their right to have their preferences honored regarding care Findings included .Review of the facility's policy titled, Advanced Directives, revised on 01/01/2025, showed that the facility will provide residents with information about advanced directives and will take necessary steps to follow resident's directive. The policy further showed that during the initial resident assessment, the Registered Nurse will offer the resident information about the advance directive and a copy of resident valid advance directive, and the most recent advance directive will be kept in the residents' record. Review of a face sheet printed on 08/05/2025 showed that Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Electronic Health Record (EHR- miscellaneous tab) printed on 08/05/2025 showed there was no copy of an advance directive or documentation that the resident was asked to provide a copy or offered assistance in completing one.In an interview on 08/05/2025 at 11:22 AM, Resident 11 stated that they had a copy of their advance directive at home and that they could not remember if they were asked by the facility to provide a copy. A joint record review and interview on 08/05/2025 at 3:04 PM with Staff C, Social Worker, showed that there was no documentation in the EHR that an advance directive was requested, offered, or obtained. Staff C stated that a copy of an advance directive should have been requested during admission. Staff C further stated that if a resident did not have one then Staff C would help them to formulate or guide them to resources in the community. In an interview and joint record review on 08/07/2025 at 12:02 PM, Staff B, Director of Nursing, stated that social services staff were responsible for requesting a copy of advance directive during admission or offering to formulate one. If one existed, a copy should be in their EHR. A joint record review of Resident 11's EHR showed no copy or documentation of an advance directive. Staff B stated Resident 11 should have had a copy of their advance directive in their EHR. Reference: (WAC) 388-97-0280 (1)(3)(a) .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure non-pharmacological (treating a health problem without using medications) interventions were in place for an antidepressant (medication used to treat depression -feeling loneliness and sadness) for 1 of 5 residents (Resident 3), reviewed for unnecessary medications. This failure placed the resident at risk for unidentified non-pharmacological interventions, unmet care needs, adverse side effects, and a diminished quality of life.Findings included .Review of Resident 3's physician orders showed an order for an antidepressant to treat depression that started on 07/24/2025.Review of Resident 3's health records (physician orders and care plan) printed on 08/05/2025 did not show documentation of non-pharmacological interventions associated with the use of an antidepressant. Review of the August 2025 Medication Administration Record (MAR) did not show Resident 3 had documentation of non-pharmacological interventions associated with the use of an antidepressant.In an interview on 08/07/2025 at 2:36 PM with Staff M, Registered Nurse, stated that Resident 3 was not included in the list of residents that received mental health services (services that include behavioral interventions -individualized, non-pharmacological approaches to treat a health problem).In an interview and a joint record review on 08/07/2025 at 3:01 PM with Staff D, Resident Care Manager, stated that a mental health consultation was not indicated for Resident 3. A joint record review of Resident 3's Electronic Health Records (EHR) including the August 2025 MAR and care plan did not show documentation of non-pharmacological interventions associated with the use of antidepressants. When asked if they expected non-pharmacological interventions associated with antidepressant use would be identified and documented, Staff D stated, I am not sure.In an interview and joint record review on 08/07/2025 at 6:21 PM, Staff B, Director of Nursing, stated that the facility's Interdisciplinary Team (a working group of staff with different kinds of expertise) discussed and identified non-pharmacological interventions for residents receiving medications such as antidepressants. A joint record review of Resident 3's August 2025 MAR did not show documentation of non-pharmacological interventions associated with the use of an antidepressant. Staff B stated that they expected staff would chart non-pharmacological interventions related to antidepressant use in the MAR.Reference: (WAC) 388-97-1060 (3)(k)(i).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed for 1 of 2 residents (Resident 2), reviewed for significant change of condition. The failure to complete an SCSA within 14 days of a significant change of condition placed the resident at risk for delayed care planning, unmet care needs, and a diminished quality of life.Findings included .Review of 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 that an SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team determined that a resident meets the significant change guidelines for either major improvement or decline. The RAI manual showed, A significant change is a major decline or improvement in a resident's status that:Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; Impacts more than one area of the resident's health status; and Requires interdisciplinary review and/or revision of the care plan.Review of an admission MDS dated [DATE] showed that Resident 2 did not have weight loss. It further showed that Resident 2 did not have functional limitation in range of motion (limitation that interfered with daily functions or placed the resident at risk of injury in the last seven days) to their upper extremity (shoulder, elbow, wrist, hand).Review of a quarterly MDS dated [DATE], showed that Resident 2 had a significant weight loss (5% [five percent] or more in the last month or loss of 10% or more in the last six months) and that Resident 2 was not on a physician-prescribed weight-loss regimen. It further showed that Resident 2 had functional limitation in range of motion to both upper extremities.Review of a document titled, Weights and Vitals Summary, printed on 08/05/2025 showed Resident 2 weighed 160 pounds on 04/14/2025 and 129.4 pounds on 07/14/2024, which indicated a significant weight loss of 19% in three months.In an interview on 08/06/2025 at 8:56 AM, Staff R, Occupational Therapy Assistant, stated that Resident 2 had functional limitation in range of motion to both arms due to their inability to raise or bring up their arms.In a phone interview on 08/07/2025 at 4:36 PM, Staff Q, MDS Coordinator, stated that they followed the RAI Manual for coding accuracy and that they completed MDS assessments for Resident 2. A virtual joint record review of Resident 2's quarterly MDS dated [DATE] showed that Resident 2 was marked to have had a significant weight loss and that Resident 2 was not [NAME] physician-prescribed weight-loss regimen. It further showed that Resident 2 was marked to have had functional limitation in range of motion to both upper extremities. Staff Q stated that the significant weight loss and limited range of motion met two areas of decline and that Resident 2 should have had a SCSA completed.In an interview on 08/07/2025 at 6:21 PM, Staff B, Director of Nursing, stated that they expected MDS assessments would capture the full picture of the resident. Staff B further stated that a SCSA should have been completed for Resident 2 related to their significant weight loss and a decline in range of motion.Reference: (WAC) 388-97-1000 (3)(b).

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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** Based on interview and record review, the facility failed to accurately assess 1 of 15 residents (Resident 28), reviewed for resident assessment. The failure to ensure resident assessment was completed accurately on the Minimum Data Set (MDS-an assessment tool) regarding discharge status placed the resident at risk for unidentified and/or unmet care needs, and a diminished quality of life.Findings included .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 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).Review of the discharge MDS dated [DATE] showed Resident 28 was discharged from the facility on 06/07/2025. Further review of the MDS showed Section A0310G (Type of Discharge) was marked unplanned. Review of Resident's 28 care conference note dated 06/06/2025 showed that the discharge was planned for Resident 28 to discharge to the community (home) on 06/07/2025 and all the transport and care services outside the facility had been coordinated and scheduled.In an interview and joint record review on 08/07/2025 at 9:10 AM, Staff Q, MDS Coordinator, stated that they followed the RAI manual when completing the MDS. A joint record review of the care conference note dated 06/06/2025 showed that Resident 28 had a planned discharge to the community. Further review of the discharge MDS under Section A0310G showed, it was marked as unplanned discharge. Staff Q stated that Resident 28 had a planned discharge to the community and that their MDS was inaccurate. Staff Q further stated that Resident 28's type of discharge should have been marked as a planned discharge.In an interview on 08/07/2025 at 11:34 AM, Staff B, Director of Nursing, stated that they expected the MDS to be completed accurately. Reference: (WAC) 388-97-1000(1)(b).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or implement a discharge care plan for 1 of 12 residents (Resident 15), reviewed for comprehensive care plan. This failure placed the resident at risk for unmet care needs and a diminished quality of life.Findings included .The facility's policy titled, Policy and Procedure - Resident Comprehensive Assessment and Care Plan, dated 10/25/2017, showed the care plan is person centered and involves the interdisciplinary team. The policy further showed that the care plan will identify all the residents' needs according to the comprehensive assessment, care plan decisions will be documented, and it would be completed within seven days of completion of the comprehensive assessment.Review of a face sheet printed on 08/07/2025 showed Resident 15 was admitted to the facility on [DATE].Review of a comprehensive care plan printed on 08/04/2025, showed Resident 15 had no care plan for discharge planning.In an interview on 08/07/2025 at 12:26 PM, Resident 15 stated that they were feeling frustrated and did not understand why no one had discussed their return to assisted living facility. Resident 15 stated they had spoken with several staff, could not recall their names, and they did not appear to know what the plan was regarding their discharge.In an interview and joint record review on 08/05/2025 at 2:58 PM, Staff C, Social Worker, stated that discharge planning was initiated during admission to ensure a smooth and safe transition back to their homes or other care settings after completion of therapy at the facility. A joint record review of Resident's 15's comprehensive care plan did not show a care plan for discharge. Staff C stated that there should have been a discharge plan completed during admission for Resident 15.A joint record review and interview on 08/07/2025 at 11:30 AM with Staff B, Director of Nursing, showed that Resident 15 did not have a discharge care plan. Staff B stated it was their expectation that discharge care planning would be completed during admission.Reference: (WAC) 388-97-1020(1), (2)(a)(b)(c).

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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** Based on observation, interview, and record review, the facility failed to ensure Activities of Daily Living (ADL) assistance were consistently provided for 1 of 2 residents (Resident 2), reviewed for ADLs. The failure to provide a resident who was dependent on staff for assistance with personal hygiene and nourishment placed the resident at risk for aspiration (food and/or liquid enters the lungs instead of the stomach) and associated complications, poor hygiene, decreased self-esteem, and a diminished quality of life.Findings included .Review of the facility's policy titled, ADLs Policy, revised on 01/01/2025, showed that the purpose of the policy was to assist resident in achieving maximum function and to improve quality of life.PERSONAL HYGIENEReview of a face sheet printed on 08/05/2025, showed Resident 2 readmitted to the facility on [DATE] with diagnosis that included pneumonitis (lung infection) due to inhalation of food and vomit, dysphagia (difficulty swallowing) and rheumatoid arthritis (disease affecting joints).Review of a care plan printed on 08/05/2025, showed that Resident 2 required extensive assistance (hands-on help from others to complete a task) by one to two staff with personal hygiene.An observation on 08/07/2025 at 8:50 AM showed Staff X, Physical Therapist and Staff R, Occupational Therapy Assistant, entered Resident 2's room.An observation on 08/07/2025 at 9:34 AM showed Resident 2 was seated in their wheelchair that was parked in front of their room. Resident 2's hair was worn down and unkempt. Further observation showed Staff U, Certified Nursing Assistant (CNA), assisted Resident 2 into their room and Staff U stated that they should brush [Resident 2's] hair.In an interview on 08/07/2025 at 9:37 AM, Staff U stated Resident 2's hair doesn't [does not] looked brushed to me. Staff U further stated that Resident 2 enjoyed having their hair fixed and that Resident 2 would ask staff to take pics [picture] of it and send it to [Resident 2's representative].In an interview on 08/07/2025 at 9:44 AM, Staff R stated that they provided grooming and personal hygiene assistance for residents. When asked if they assisted Resident 2 with personal hygiene, Staff R stated that they didn't [did not] focus on grooming this morning.In an interview on 08/07/2025 at 9:54 AM with Staff X and Staff R, Staff X stated that they would usually ask residents about their preference for personal hygiene prior to assisting residents outof their rooms. Staff X further stated that they did not offer Resident 2 the opportunity to brush their hair prior to assisting them out of their room and that they should have. Staff R stated that Resident 2's hair looked like it needed brushing while we were at the [parallel] bars (exercise equipment).NOURISHMENTReview of the August 2025 physician orders showed Resident 2 had an order for 1:1 (one on one) feeding related to aspiration precautions dated 07/22/2025.An observation on 08/07/2025 at 12:01 PM showed Resident 2 was seated in the Eight-Floor dining room for lunch. It further showed Staff L, CNA, placed a beverage on the dining table that was within easy reach of Resident 2 before Staff L left the dining table to attend to other residents in the dining room. Resident 2 then brought the beverage up to their mouth and took a sip. It did not show Resident 2 was provided 1:1 assistance with their beverage.In an interview on 08/07/2025 at 12:25 PM, Staff M, Registered Nurse, stated that Resident 2 required 1:1 assistance with meals related to aspiration precautions and poor appetite. Staff M further stated that Resident 2 could drink [fluids] on their own.In an interview and joint record review on 08/06/2025 at 2:49 PM, Staff D, Resident Care Manager, stated that Resident 2 required 1:1 feeding assist as of 07/25/2025. A joint record review of a document titled, Point of Care (POC-care plan for CNA), printed on 08/07/2025, showed Resident 2 had two instructions for level of assistance with meals that included supervision for all meals and provide 1:1 feeding assistance. Staff D stated that the POC needed to be updated and that they expected that staff would sit down with [Resident 2] to provide 1:1 assistance with their meals including drinks.In an interview on 08/07/2025 at 6:21 PM, Staff B, Director of Nursing, stated that ADL assistance was provided by different disciplines including the therapy department. Staff B stated that they expected staff would make sure the resident's dignity is preserved and that Resident 2's hair should have been (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	combed prior to leaving their room. Staff B further stated that they expected Resident 2's POC would be updated to reflect the care needs.Reference: (WAC) 388-97-1060(1)(2)(c)(3)(i).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow a therapeutic diet and to provide education to the resident's representative regarding the risks of not following the therapeutic diet for 1 of 1 resident (Resident 2), reviewed for nutrition. This failure placed the resident at risk of unmet care needs, medical complications, and a diminished quality of life.Findings included .Review of a face sheet printed on 08/05/2025, showed Resident 2 readmitted to the facility on [DATE] with diagnosis that included pneumonitis (lung infection) due to aspiration (food or liquid enter the lungs instead of the stomach) of food and vomit, and dysphagia (difficulty swallowing).Record review of a physician order dated 07/25/2025 showed Resident 2 was prescribed a diet of minced and moist texture (a diet that consists of foods that are finely chopped and are moist enough to hold together easily) and mildly thick consistency (liquids that are slightly thicker than regular liquids).Review of a document titled, Speech Therapy Treatment Encounter, dated 08/05/2025 showed, It was noted that [Resident 2] had thin [non-thickened] liquids at bedside provided to [Resident 2] by her CNA [Certified Nursing Assistant] staff, the therapist educated nursing and CNA staff of [Resident 2's] thickened liquid precautions.An observation on 08/05/2025 at 3:36 PM showed Resident 2 was lying in bed and had three non-thickened drinks placed on their bedside table within easy reach of Resident 2. Further observation showed Resident 2 had a box of Triscuit (brand name of snack crackers) and a can of Cheetos (brand name of firm and crispy snacks) stored on top of their room furniture.An observation on 08/05/2025 at 12:18 PM showed Resident 2 was assisted by Staff L, CNA, with their snack and drink in the eight-floor dining room. It further showed that Resident 2 was given a small bag of Ritz (brand name) crackers with cheese.In an interview on 08/06/2025 at 11:46 AM, Staff L stated that Resident 2 received soft foods and a lot of thick fluids. When asked if Resident 2 could eat Ritz crackers as part of their ordered diet, Staff L stated, I typically give those as a snack because I noticed [Resident 2] doesn't [does not] have difficulty with it [Ritz crackers]. Staff L further stated that they supplied the Ritz crackers to Resident 2 from the pantry in the dining room.An observation on 08/06/2025 at 2:09 PM, showed Resident 2's representative was standing in Resident 2's room when Resident 22 stopped ambulating in the hallway to greetResident 2's representative. Resident 2's representative stepped out to meet Resident 22 at the doorway and stated, I have homemade cookies, I brought [Resident 2] some, before offering cookies to Resident 22.Additional observation and interview on 08/06/2025 at 2:09 PM showed Resident 2 was accompanied by their representative and that they had a sandwich given to them. Resident 2's representative stated it was a soft sandwich. Resident 2's representative stated that they were aware of Resident 2's prescribed texture diet and that Resident 2 had aspirated twice. Resident 2's representative further stated that Resident 2 could eat the Triscuit and Cheetos stored in their room because they dissolved pretty fast. When asked if the facility had provided education regarding Resident 2's prescribed diet texture, Resident 2's representative stated that they met with the Speech therapist back in June, but that it was prior to Resident 2's change in diet texture.In an interview on 08/06/2025 at 2:17 PM, Staff M, Registered Nurse, stated crackers were not included in Resident 2's prescribed diet texture and that Not dry crackers, it's supposed to be moist, that's [that is] why [Resident 2] is on aspiration precautions.In an interview on 08/06/2025 at 2:49 PM, Staff D, Resident Care Manager, stated that Staff L should not have provided Resident 2 the Ritz crackers and that No, it should be minced and moist. When asked if Resident 2's representative was given education on the risks of not following Resident 2's prescribed diet texture, Staff D stated that they would review Resident 2's health records for documentation.In a follow-up interview and joint record review on 08/06/2025 at 4:09 PM, Staff D stated that it was facility protocol that when staff were aware of risks to a resident that We would provide a risks and benefits education. Staff D further stated that a risks and benefit education had not been provided to Resident 2's representative associated with not following the prescribed diet (continued on next page)

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	505469	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at Skyline	715 9th Avenue Seattle, WA 98104

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	texture. A joint record review of Resident 2's speech therapy and treatment encounter note dated 08/05/2025 showed Resident 2 was provided with regular liquids by CNA staff. Staff D stated that they expected staff would follow the prescribed diet texture for Resident 2.In an interview and joint record review on 08/07/2025 at 6:21 PM, Staff B, Director of Nursing, stated that a diet prescribed for aspiration precautions was a therapeutic diet. Staff B stated that they expected a discussion with Resident 2's representative would have occurred to explain the risks of not following the prescribed diet texture. A joint record review of Resident 2's Electronic Health Records did not show documentation of risks and benefits education provided to Resident 2's representative. Staff B stated, [Resident 2] doesn't [does not] have one of those.Reference: (WAC) 388-97-1060 (1)(3)(h)(i).

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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** Based on observation, interview, and record review, the facility failed to ensure disinfectants (cleaning products containing chemicals that kill germs) were stored properly for 1 of 1 room (room [ROOM NUMBER]), reviewed for accident hazards. This failure placed the residents at risk for potential ingestion and/or exposure to cleaning chemicals and potential negative outcomes.Findings included .Review of the facility's policy titled, Storage of Chemicals, revised on 01/01/2025, showed All chemicals, including cleaning supplies, disinfectants, and hazardous substances, must be stored in a secure, labeled, and well-ventilated area to prevent unauthorized access by residents, staff or visitors.The purpose of this policy is to ensure the safe and compliant storage of chemicals within the nursing facility to prevent accidental poisoning, exposure.Review of a face sheet showed Resident 3 readmitted to the facility to room [ROOM NUMBER] on 04/29/2025.An observation on 08/04/2025 at 10:46 AM showed a metal canister with liquid disinfectant and compressed gas (Lysol - brand name of disinfectant) and a plastic canister with pre-moistened disinfecting wipes (Clorox - brand name of disinfectant) was stored on the bathroom sink counter of room [ROOM NUMBER]. Further observation showed an un-covered used toothbrush, an un-covered water floss pick (dental hygiene device), and un-covered towels were stored on the bathroom sink along with the disinfectants. It did not show disinfectants were stored in a secure manner to prevent unauthorized access by residents, staff or visitors.Another observation on 08/05/2025 at 8:27 AM showed a canister of Lysol spray and a canister of Clorox wipes were stored on the bathroom sink of room [ROOM NUMBER] along with personal hygiene products.In an interview on 08/05/2025 at 11:36 AM, Staff W, Private Caregiver, stated that they used the disinfectant supplies that were stored in the bathroom sink of room [ROOM NUMBER] and that Resident 3 used the personal hygiene supplies stored on the bathroom sink in their room.In an interview on 08/05/2025 at 11:42 AM, Staff M, Registered Nurse, stated that it was the facility's process to store disinfecting supplies with housekeeping staff and that, they keep [disinfectants] in their [cleaning] cart, and they lock when not in use. Staff M further stated that chemicals would not be stored in a resident's room.A joint observation on 08/05/2025 at 11:52 AM with Staff M showed a canister of Lysol spray and a canister of Clorox wipes were stored on the bathroom sink of room [ROOM NUMBER] along with personal hygiene products. Staff M stated that they considered Lysol and Clorox as disinfectants and that they expected disinfectants would not be stored on the bathroom sink of Resident 3's room.In an interview on 08/05/2025 at 3:14 PM, Staff D, Resident Care Manager, stated that housekeeping staff were responsible for daily cleaning of resident rooms to include the bathroom. Staff D further stated that the Lysol spray and Clorox wipes should not be there [room [ROOM NUMBER]]. Staff D further stated that they expected cleaning supplies with chemicals would be safely stored with the housekeeper.In an interview on 08/07/2025 at 6:21 PM, Staff B, Director of Nursing, stated that they expected disinfectants would not be stored in resident rooms because it [disinfectants] can still be accessible by other residents and that chemicals should be stored with housekeeping for safe keeping and for use.Reference: (WAC) 388-97-1060(3)(g).

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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. Based on interview and record review, the facility failed to ensure a Medication Regimen Review (MRR - a comprehensive assessment of resident's medications, performed by a pharmacist [a qualified professional to provide expert advice on medication management, safety, and regulatory compliance] to identify and address potential problems) was completed for 1 of 5 residents (Resident 20), reviewed for unnecessary medications. This failure placed the resident at risk of receiving unnecessary medications and a diminished quality of life.Review of the facility's policy titled, Medication Regimen Review, revised on 07/01/2024, showed, Recommendations are acted upon and documented by the facility staff and or the prescriber.Review of the facility provided MRR showed Resident 20 had recommendations dated on 04/11/2025 to change administration times for gabapentin (medication to treat restless leg syndrome [a condition that causes irresistible urge to move the legs]) and magnesium (supplement) to be spaced two hours apart due to the efficacy of gabapentin may be decreased resulting in breakthrough symptoms. Further review showed the pharmacy recommendation was completed on 05/26/2025, 45 days later.In an interview and joint record review on 08/07/2025 at 6:02 PM, Staff B, Director of Nursing, stated that they oversaw the MRR documents. Staff B stated the pharmacist would send/email them the monthly review, the Resident Care Managers (RCMs) would give the recommendations to the provider, after the provider completes them then the RCMs carried out the recommendations. A joint record review of the April 2025 MRR and the April 2025 and May 2025 Medication Administration Records, showed Resident 20 had recommendations that were not implemented until 05/26/2025. Staff B stated that they expected Resident 20's 04/11/2025 MRR recommendations to have been implemented within 24-48 hours of receiving them and not a month [and a half later].Reference: (WAC) 388-97-1300 (4)(c).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure staff was provided education about COVID-19 (a viral illness that causes fever, difficulty breathing or possibly death) vaccination, including risks, benefits, potential side effects, document if the vaccine was accepted and/or refused in employee record for 1 of 1 staff (Staff O), reviewed for COVID-19 immunizations. This failure placed staff and residents at risk of and exposure to illness from COVID-19.Findings included .Review of the facility's policy titled, COVID-19 Prevention, Response and Reporting, reviewed on 02/07/2025, showed that the facility would offer resources and counseling to healthcare personnel, residents and visitors on the importance of receiving the COVID-19 vaccine and staying up to date with all recommended COVID-19 vaccine doses.Review of the staff list showed Staff O, Certified Nursing Assistant, was hired on 06/11/2010.In an interview on 08/06/2025 at 2:43 PM, Staff O stated they refused the COVID-19 vaccine booster and was informed of the risks and benefits last year and signed a paper.In an interview on 08/07/2025 at 6:24 PM, Staff E, Staffing Coordinator, stated that staff were provided information regarding COVID-19 vaccine risk and benefits. When asked for a copy of the risk and benefits, Staff E did not provide documentation regarding COVID-19 vaccination education and/or risk and benefits for Staff O.In an interview on 08/07/2025 at 7:32 PM, Staff B, Director of Nursing, stated they were going to look for documentation for Staff O's COVID-19 vaccine education and/or risks and benefits.On 08/07/2025 at 8:30 PM Staff A, Administrator, stated that they were not able to find documentation to show that Staff O was provided risks and benefits related to COVID-19 vaccination.Reference: (WAC) 388-97-1320(1)(a).

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bed rails (bed enablers) were properly secured and maintained for safety for 2 of 2 residents (Residents 9 & 29), reviewed for accident hazards. This failure placed the residents at risk for injury and/or entrapment.Findings included .Review of the facility's policy titled, Bed Rail, revised on 01/01/2025, showed that the facility would ensure the safe and appropriate use of bed rails in compliance with federal and state regulations, minimize risk of injury, and protect resident rights. It further showed that nursing staff would inspect rails each shift for secure attachment and defects, check resident's positioning and skin integrity, and monitor for signs of distress, agitation, or injury.RESIDENT 9Review of the activities of daily living care plan initiated on 11/30/2020, showed Resident 9 used bilateral (both) grab bars/enablers to maximize independence with turning and repositioning in bed dated 07/23/2024.Observations on 08/04/2025 at 9:47 AM and on 08/07/2025 at 11:47 AM, showed Resident 9's right bed rail was not tightly secured and was easily moved from side to side when manually checked.In an interview and joint observation on 08/07/2025 at 1:17 PM, Staff S, Licensed Practical Nurse, stated they did not expect residents' bed rails to be loose. A joint observation with Staff S showed Resident 9's right bed rail was not tightly secured to their bed. Staff S stated that Resident 9's right bed rail was more loose than the left bed rail, and that they should not have been loose.In an interview and joint observation on 08/07/2025 at 1:56 PM, Staff P, Director of Facilities, stated that maintenance staff would check residents' rooms including beds and bed rails monthly. Staff P stated that if there were issues with bed rails, maintenance staff would fix them. A joint observation of Resident 9's right bed rail showed it was not tightly secured and was easily moved from side to side. Staff P stated that they were going to replace Resident 9's bed rails.RESIDENT 29Review of a face sheet printed on 08/04/2025 showed Resident 29 was admitted to the facility on [DATE].An observation and interview on 08/04/2025 at 11:01 AM, showed that Resident 29's right bed rail was not tightly secured, it was loose. Resident 29 stated that their right bed rail was wobbly. Another observation and interview on 08/07/2025 at 12:47 PM, showed Resident 29's right bed side rail was not tightly secured. Resident 29 stated, it worries me that it [bed rail] is wobbly because I am a strong and I use it all the time.A joint observation and interview on 08/07/2025 at 1:19 PM with Staff S, showed Resident 29's right bed rail was not tightly secured. Staff S stated, the bed rail is loose and it should not have been.A joint observation and interview on 08/07/2025 at 1:59 PM with Staff P, showed Resident 29's right bed rail was not tightly secured and was easily moved from side to side. Resident 29 stated, it worries me that it is wobbly, I use it all the time. Staff P stated that they would replace Resident 29's right bed rail.In an interview on 08/07/2025 at 5:32 PM, Staff A, Administrator, stated that they expected residents' bed rails to be secured.Reference: (WAC) 388-97-2100.