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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Columbia Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 4700 Phinney Avenue North Seattle, WA 98103	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to ensure residents were evaluated, assessed, and obtained a physician order for safe administration of medications for 1 of 2 residents (Resident 285), reviewed for self-medication administration. This failure placed the resident at risk for medication errors, adverse medication interactions, and complications. Findings included . Review of the facility's undated policy titled, Resident Self-Administration of Medication, showed, A resident may only self-administer medications after the facility's interdisciplinary [Team] (IDT) has determined which medications may be self-administered safely .the results of the [IDT] assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. It further showed that All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Resident 285 admitted to the facility on [DATE] with diagnosis that included left humerus (a bone in the upper arm) fracture (broken bone). Review of Resident 285's Electronic Health Records (EHR) did not show completed documentation of an IDT assessment to determine if any medications could be self-administered and stored safely by Resident 285. Review of Resident 285's physician orders, printed on 03/14/2025, did not show an order for self-administration or independent storage of medication. Review of Resident 285's comprehensive care plan printed on 03/14/2025, did not show documentation that Resident 285 could safely self-administer or independently store medication. Observation and interview on 03/14/2025 at 9:36 AM and at 3:15 PM, showed Resident 285 seated in their wheelchair with their bedside table in front of them. It further showed Resident 285 had a teal-colored eye drop bottle on their bedside table. Resident 285 stated that they self-administered their eye drops. When asked if the staff were aware of them self-administering their eye drops, Resident 285 stated I think so, it's always there [on Resident 285's bedside table] to be seen. Resident 285 further stated that staff did not worry about it [eye drops] and that it had been hiding in plain sight. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another observation and interview on 03/17/2025 at 10:00 AM, showed Resident 285 seated with their bedside table in front of them. It showed Resident 285 had a teal-colored bottle of eye drops labeled Refresh [a brand name] Tears, on their bedside table. Resident 285 stated that they like to use them myself. When asked if they were assessed by the facility to safely self-administer their eye drops, Resident 285 stated I don't think so, I've always done it myself. Observation and interview on 03/18/2025 at 8:30 AM, showed Staff M, Registered Nurse, prepared medication at the medication cart that was parked in front of Resident 285's room. Staff M stated they had already given Resident 285 their morning medications in their room. Staff M further stated that they did not observe medication on Resident 285's bedside table. A joint observation and interview on 03/18/2025 at 8:33 AM, showed Resident 285 had a bottle of Refresh Tears on their bedside table. Staff M stated they observed Resident 285 with a bottle of Refresh Tears on their bedside table and that medication should not be at the bedside. Staff M further stated that Resident 285 did not have a physician's order for the Refresh Tears and that Resident 285's EHR did not indicate that Resident 285 could self-administer eye drops. In an interview and joint record review on 03/18/2025 at 9:47 AM, Staff F, Unit Manager, stated they expected staff would collect medication observed at residents' bedside for safe storage. Staff F further stated that they did not expect Resident 285 to have a bottle of eye drops at their bedside without being assessed to be able to safely self-administer medication. Staff F stated that they expected a physician's order for Resident 285 to self-administer medication. In an interview on 03/20/2025 at 1:32 PM, Staff B, Director of Nursing, stated they expected staff to remove medications observed at residents' bedside for safe storage. Staff B further stated they expected Resident 285 to have been assessed to be able to safely administer their eye drops. Reference: (WAC) 388-97-1060(3)(l), 0440

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	505470	A. Building B. Wing	03/20/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 51090 Based on observation, interview, and record review, the facility failed to develop a comprehensive system for ensuring residents and representatives could anonymously report their concerns for 2 of 2 facility floors (First Floor & Second Floor), reviewed for grievances. This failure placed residents and representatives at risk for unresolved concerns, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Grievance and Concerns, showed, At admission, the Admissions department designee informs the Resident/Resident's Authorized Representative about their right to voice grievances orally, in writing, and anonymously regarding the care and treatment/lack of treatment, lost/misplaced personal items, behavior of staff and of the other residents, and other concerns during their stay. Review of the facility's undated document titled, Resident Handbook, did not show documentation of a system to file grievances anonymously. Review of the facility's undated form titled, Grievance/Concern Form, did not show documentation of a system to file grievances anonymously. FIRST FLOOR In an interview and joint observation on 03/20/2025 at 9:07 AM Staff E, Unit Manager, stated that they oriented residents to the facility's grievance form upon admission to the facility. Staff E further stated that grievances can be filed in writing by submitting a completed grievance form to a staff member. When asked how grievances could be filed anonymously, Staff E stated that there is a box at the front desk. Joint observation of the first-floor front desk area did not show a box that was accessible to persons submitting a completed grievance form. Staff E stated that completed grievance forms would be collected by staff and filed in the social worker's mailbox, located in a locked office on the first floor. Staff E stated that the process for collection of completed grievance forms was not anonymous. SECOND FLOOR In an interview on 03/20/2025 at 9:18 AM, Staff H, Social Services, stated they were the appointed grievance officer. When asked how completed grievance forms were collected, Staff H stated that completed grievance forms would be collected by staff and filed in the social worker's mailbox, located in a locked office on the second floor. Staff H further stated that they did not recall the facility having a box to drop [grievances] into and that We don't have an anonymous process. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another joint record review and interview on 03/20/2025 at 9:50 AM with Staff E, showed the facility's undated document titled, Resident Handbook, did not show documentation of a system to file grievances anonymously. Staff E stated that the information provided in the Resident Handbook did not include information on how to file a grievance anonymously. Staff E further stated, I don't see it. In an interview on 03/20/2025 at 1:59 PM, Staff A, Administrator, stated We don't have an anonymous box identified as a grievance collection site. Staff A stated they expected residents/representatives would have access to a system to file a grievance anonymously. Staff A further stated, There will be a process to have grievances collected anonymously. Reference: (WAC) 388-97-0460 (1)

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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** 51090 Based on interview and record review, the facility failed to accurately assess 1 of 17 residents (Resident 39), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments in capturing appropriate diagnosis placed the resident at risk for unidentified 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 .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). Most MDS items themselves require an observation period, such as seven or 14 days, depending on the item. The RAI manual's Section I (Active Diagnoses) coding instruction directed to code active diagnoses in the last 60 days that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring or risk of death during the seven-day look-back. It further instructed that a medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. Review of Resident 39's face sheet showed they admitted to the facility on [DATE] with diagnosis that included depression (mood disorder). Review of Resident 39's physician orders dated 02/21/2025 showed Resident 39 was prescribed an antidepressant (medication to treat depression). Review of Resident 39's Admission MDS dated [DATE], did not show Section I was marked for any mood disorders, including depression. It further showed that Section N (Medications-under N0415C) was marked, indicating Resident 39 received an antidepressant. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 03/18/2025 at 3:59 PM, Staff S, MDS Coordinator, stated they followed the RAI Manual for MDS coding accuracy. Joint record review of Resident 39's face sheet showed they admitted to the facility on [DATE] with diagnosis that included depression. Staff S stated that Resident 39 admitted to the facility with a diagnosis of depression. Joint record review of Resident 39's admission MDS dated [DATE], did not show Section I was marked for any mood disorders, including depression. It further showed that Section N was marked for Resident 39 receiving an antidepressant. Staff S stated Resident 39 received medication for depression at the time of admission to the facility and that [Diagnosis of depression] was not coded, we can modify it. In an interview on 03/18/2025 at 4:07 PM, Staff B, Director of Nursing, stated they expected MDS to be completed accurately. Reference: (WAC) 388-97-1000 (1)(j)

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F 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

PASARR screening for Mental disorders or Intellectual Disabilities

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45146

Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness (SMI), intellectual disabilities (ID); or related conditions are not inappropriately placed in nursing homes for long term care) forms were accurate and/or sent out timely for a Level II PASARR referral for 5 of 7 residents (Residents 2, 22, 34, 63 & 39), reviewed for PASARRs. This failure placed the resident at risk for not receiving the care and services appropriate for their needs.

Findings included .

Review of the facility's undated policy titled, PASRR Program Policy, showed, This facility coordinates assessments with the preadmission screening and resident review (PASRR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to this facility will be screened by Social Services for serious mental disorders or intellectual disabilities and related conditions in accordance with the State Medicaid rules for screening .Social Services shall be responsible for keeping track of each resident's PASRR screening status and referring to the appropriate authority.

RESIDENT 2

Resident 2 admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Post-Traumatic Stress Disorder (PTSD - a mental health condition that's caused by an extremely stressful or terrifying event either being part of it or witnessing it), and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions).

Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated 12/19/2024, showed Resident 2 had active diagnoses of depression, psychotic disorder and PTSD.

Review of Resident 2's Level I PASARR dated 07/03/2024, showed diagnosis of personality disorder (long-term patterns of behavior and inner experiences that differ significantly from what is expected) was marked. Resident 2's Level 1 PASARR did not reflect Resident 2's diagnoses of mood disorder, PTSD and psychotic disorder. Further review of the PASARR showed Level II evaluation referral was required for SMI.

Review of the Electronic Health Record (EHR) showed no documentation that Resident 2's PASARR Level I was corrected to include the correct diagnoses of the resident.

Review of the social service note dated 01/14/2025 showed that Resident 2's PASARR Level II referral was sent (six months after Level II evaluation referral was required).

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F 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview and joint record review on 03/18/2025 at 1:43 PM, Staff G, Social Services, stated that when a resident admitted from the hospital, they would review PASARR for accuracy and make corrections as needed. Staff G further stated that if Level II evaluation was required, they would send the referral. A joint record review of Resident 2's Level I PASARR dated 07/03/2024, showed mood disorder, PTSD and psychotic disorder were not documented on the PASARR. Staff G stated that Resident 2's PASARR Level I, Could be more accurate. When asked why Resident 2's PASARR referral was not sent in July 2024, Staff G stated that they found Resident 2's PASARR Level I during a PASARR audit.

On 03/20/2025 at 8:59 AM, Staff B, Director of Nursing/Director of Social Services, stated that they would expect Social Services review and correct PASARR forms. Staff B further stated they expected Resident 2's PASARR to be accurate, and Level II referral was made timely.

47680

RESIDENT 22

Review of the face sheet printed on 03/17/2025 showed that Resident 22 admitted to the facility on [DATE] with diagnoses that included schizophrenia (serious mental health condition that affect how they think, feel and behave), anxiety (intense and excessive feelings of worry, nervousness, or fear) and other recurrent depressive disorders.

Review of Resident 22's Level 1 PASARR dated 11/08/2024, showed that Section IA (SMI) was marked for schizophrenia. It did not show that it was marked for anxiety and recurrent depressive disorder. Further review showed that Section IV (4- Service Needs and Assessor Data) was marked for No level II evaluation indicated.

RESIDENT 34

Review of the face sheet printed on 03/18/2025 showed that Resident 34 admitted to the facility on [DATE] with diagnoses that included major depressive disorder and PTSD.

Review of Resident 34's Level I PASARR dated 09/09/2024, showed that Section IA was marked for depressive disorder. It did not show that it was marked for PTSD. Further review showed that Section IV was marked for No level II evaluation indicated.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 03/18/2025 at 11:16 AM, Staff H, Social Services, stated that they reviewed Level I PASARRs on admission for accuracy and if the Level I PASARRs were not accurate, they would fill out a new Level I PASARR and send it to the PASSAR evaluator for review if needed. Joint record review of Resident 22's diagnosis list showed a diagnosis for anxiety and other recurrent depressive disorders. Review of Resident 22's Level I PASARR dated 11/08/2024 showed that anxiety and depressive disorder were not marked in Section IA. When asked if it was accurate, Staff H stated, I guess not. Further review of Resident 22's Level I PASARR showed in Section IV, it was marked for No level II evaluation indicated. When asked if it was accurate, Staff H stated, it can be and that Resident 22 was very stable. Staff H stated they were trained to only mark No level II evaluation required when making changes to Level I PASARR on admission in the most recent training they had. Joint record review for Resident 34's diagnosis list showed that they had a diagnosis of PTSD. Joint record review of Resident 34's Level I PASARR dated 09/09/2024, showed that PTSD was not marked on Section IA. When asked if it was accurate, Staff H stated, Not totally accurate. When asked if Section IV was accurate, Staff H stated that based on when Resident 34 was admitted to the facility, their Level I PASARR was accurate because Resident 34 was very functional. Staff H further stated from their understanding, even if a resident had an SMI diagnosis, they do not mark level II evaluation indicated if the resident's condition was stable and that they were able to manage it. In an interview and joint record review on 03/20/2025 at 12:11 PM, Staff B stated that they expected PASARRs to be completed accurately when completed by their staff and when they are completed by the hospital. Staff B stated that if PASARRs were inaccurate, I expect them [staff] to make it accurate, do a correction and to send it in as soon as they are aware. Joint record review of Resident 22's Level I PASARR dated 11/08/2024, showed that Section IA was not marked for anxiety and recurrent depressive disorder and Section IV was marked for No level II evaluation indicated. Staff B stated that they would have expected Resident 22's Level I PASARR to be accurate. Joint record review of Resident 34's Level I PASARR dated 09/09/2024, showed Section IA was not marked for PTSD and Section IV was marked for No level II evaluation indicated. Staff B further stated that they would have expected Resident 34's Level I PASARR to be completed accurately. 52331 RESIDENT 63 Review of the face sheet printed on 03/18/2025 showed that Resident 63 admitted to the facility on [DATE] with diagnoses that included PTSD. Review of the Level I PASARR dated 12/11/2024 completed by the hospital, showed Section IA was marked No for SMI indicators. Further review showed Section IV was marked No Level II evaluation indicated. Review of another Level I PASARR dated 12/11/2024 completed by Staff G, showed Section IA was marked Yes for SMI indicators and the box for anxiety disorder (mental health condition with excessive worry and feeling of fear) was marked and written PTSD inside the box. Further review showed Section IV was marked No Level II evaluation indicated. A joint record review and interview on 03/18/2025 at 12:00 PM with Staff G, showed Resident 63's Level I PASARR completed by Staff G dated 12/11/2024 was marked Yes for SMI indicators and no Level II referral required. Staff G stated, Based on this form, I should send out PASARR Level II. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 03/20/2025 at 12:39 PM, Staff B, stated We should send out Level II PASARR for Resident 63. 51090 RESIDENT 39 Resident 39 admitted to the facility on [DATE] with a diagnosis of mood disorder. Review of Resident 39's Level I PASARR completed by the hospital, dated 02/20/2025, showed Section IA was marked No, which indicated that Resident 39 did not have SMI identified. It further showed that Section IV was not completed. In an interview on 03/18/2025 at 10:55 AM, Staff G stated that they were responsible for ensuring Level I PASARR forms were reviewed for accuracy when residents admitted to the facility. Staff G stated that during their review of Level I PASARRs, they would make a referral for Level II PASARR evaluation If the resident will be [at the facility] longer than 30 days. A joint record review and interview on 03/18/2025 at 11:06 AM, showed Resident 39's Level I PASARR completed by Staff G dated 02/20/2025, showed that Section IA was marked Yes, to indicate Resident 39 had a SMI identified. It further showed that Section IV was marked No Level II evaluation indicated, which showed Resident 39 did not show indicators of SMI. When asked if Section IV was accurately completed, Staff G stated, I can't choose any other box, and that they believed it was completed accurately. A joint record review and interview on 03/20/2025 at 1:31 PM with Staff B, showed Resident 39's Level I PASARR completed by Staff G dated 02/20/2025, showed that Section IA was marked Yes, and Section IV was marked No Level II evaluation indicated. Staff B stated that they expected PASARR evaluations to be completed accurately. Staff B further stated that Resident 39's Level 1 PASARR dated 02/20/2025 should have been marked Level II evaluation referral required for SMI, in Section IV. Reference: (WAC) 388-97-1915 (2)

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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** 49619 Based on observation, interview, and record review, the facility failed to implement and develop care plans for 2 of 17 residents (Residents 49 & 1), reviewed for comprehensive care planning. The failure to implement and/or develop care plans for nutrition, nail care and weight monitoring placed the residents at risk for malnutrition, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Comprehensive Care Plans, showed it was the facility policy to develop and implement a comprehensive person-centered care plan for each resident. RESIDENT 49 Resident 49 admitted to the facility on [DATE]. Review of Resident 49's nutrition care plan printed on 03/17/2025, showed an intervention to Provide oral nutritional supplements as ordered. Review of Resident 49's Nutrition/Registered Dietitian assessment dated [DATE] showed, the facility would provide a strawberry Ensure [nutritional drink/supplement designed to provide balanced nutrition, including protein, vitamins, and minerals] with each breakfast. Review of Resident 49's breakfast meal ticket dated 03/19/2025 and 03/20/2025 showed a standing order for an eight fluid ounce Ensure (strawberry flavor). In an interview on 03/13/2025 at 3:29 PM, Collateral Contact 1 (CC1), stated that they had requested Resident 49 to receive an Ensure, but did not get it as far as they knew. CC1 further stated that they asked the staff on multiple visits to report what the resident had for breakfast, and they did not report that Resident 49 had an Ensure with their breakfast meal. Observation on 03/14/2025 at 9:23 AM, showed Resident 49 was being assisted during the breakfast meal. No Ensure was observed with Resident 49's breakfast meal. Another observation on 03/20/2025 at 8:40 AM, showed Resident 49 received their breakfast tray. No Ensure was observed with Resident 49's breakfast meal. In a joint observation and interview on 03/20/2025 at 9:18 AM with Staff FF, Nursing Assistant Certified, showed no Ensure was provided with Resident 49's breakfast. Staff FF stated no Ensure was provided for Resident 49's breakfast tray. Staff FF further stated that Ensure supplements came from the kitchen and that they delivered what was on the tray. (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 03/20/2025 at 11:54 AM, Staff Q, Registered Dietitian, stated they would expect the resident to receive what was listed as Standing Orders on their meal ticket. Staff Q stated they had not been following what we said we would do. Staff Q further stated, they would expect the care plan to match what we are doing. In a joint record review and interview on 03/20/2025 at 1:21 PM with Staff AA, Licensed Practical Nurse, showed Resident 49's nutrition care plan printed on 03/17/2025 had an intervention to provide oral nutritional supplements as ordered. Staff AA stated Resident 49 was getting fluids but, I think we missed the Ensure. Staff AA stated that nursing staff was expected to follow Resident 49's care plan. Staff AA further stated that staff should check Resident 49's tray to make sure they received the Ensure, and if it was not, they should inform the kitchen to supply it. In an interview on 03/20/2025 at 1:29 PM, Staff E, Unit Manager, stated they would expect nursing staff to follow the care plan. Staff E further stated that they would expect staff to provide oral nutritional supplements like Ensure if it was care planned. In an interview on 03/20/2025 at 1:37 PM, Staff B, Director of Nursing, stated they would expect staff to follow the resident's care plan. 45146 RESIDENT 1 Resident 1 admitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus (a disorder in which the body does not produce enough or respond normally to insulin [a hormone that lowers the level of glucose (a type of sugar) in the blood], causing blood sugar levels to be abnormally high) and End Stage Renal Disease (ESRD- where kidney function has declined to the point that the kidneys can no longer function on their own). Review of the quarterly Minimum Data Set (an assessment tool) dated 02/21/2025, showed Resident 1 was cognitively intact. Observations on 03/13/2025 at 2:44 PM and on 03/17/2025 at 7:54 AM, showed the resident's fingernails were long and untrimmed. Review of Resident 1's comprehensive care plan printed on 03/14/2025 showed no person-centered care plan for diabetic nail care. Further review of the care plan showed Resident 1 had a care plan intervention to be weighed daily due their diagnoses of ESRD. Review of the January 2025, February 2025, and March 2025 Medication Administration Record (MAR) showed that Resident 1 had an order to be weighed daily. Further review of the MAR showed that Resident 1's weight was recorded for seven days in January 2025, for six days in February 2025, and for three days from 03/01/2025 to 03/16/2025. In an interview on 03/19/2025 at 9:03 AM, Resident 1 stated that they were waiting for the nurses to trim their fingernails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Lutheran Home	4700 Phinney Avenue North Seattle, WA 98103

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/2025 at 11:46 AM, Staff V, Registered Nurse, stated that nurses were responsible for trimming the resident' fingernails due to their diagnosis. In an interview and a joint record review on 03/19/2025 at 1:48 PM, Staff E stated that diabetic nail care would be ordered, and care planned. Staff E stated if there was a care plan for daily weight, they would expect the daily weight was taken according to the order. Joint record review of the care plan printed on 03/14/2025 showed that Resident 1 had no care plan for diabetic nail care. The care plan further showed that Resident 1 had a care plan for daily weight. Joint record review of Resident 1's January 2025, February 2025 and March 2025 MAR showed that Resident 1's daily weight was not consistently recorded as ordered and care planned. Staff E stated that there should have been a care plan for Resident 1's diabetic nail care and the care plan for their daily weights should have been completed daily as it was ordered and care planned. In an interview on 03/20/2025 at 8:32 AM, Staff B stated that they expected Resident 1's diabetic nail care was care planned, and the nail care was provided by nurses weekly. At 8:45 AM, Staff B stated that they expected Resident 1's daily weight order was followed and implemented. Reference: (WAC) 388-97-1020 (1)(2)(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to conduct timely care plan meetings with residents and/or their representatives for 2 of 3 residents (Residents 2 & 22), reviewed for care planning. This failure placed the residents and/or their representatives at risk for not having input regarding care goals, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Care Planning-Resident Participation, showed, The facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation) .The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. If the participation of the resident and/or resident representative is determined not practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record. RESIDENT 2 Resident 2 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated 12/19/2024, showed Resident 2 was cognitively intact. In an interview on 03/14/2025 at 10:07 AM, Resident 2 stated that they had not had a care conference recently. Review of the progress note dated 09/23/2024 showed a care conference was held with Resident 2 on that day. Further review of Resident 2's progress notes from 09/24/2024 through 03/17/2025 did not show further documentation of care conferences being offered or held. Review of the facility's undated document titled, Care Plan Review Signature Record 2024, showed no documentation that Resident 2 was offered or participated in the care plan review. In an interview on 03/19/2025 at 1:00 PM, Staff H, Social Services, stated that care conferences would be held every three months with MDS schedule. Staff H stated that the facility used to document care conferences in the residents' progress note but now it would be documented in the Care Plan Review Signature Record. In an interview on 03/20/2025 at 8:50 AM, Staff B, Director of Nursing/Director of Social Services, stated that care conferences would be held in conjunction with MDS schedule, and residents would be invited to participate. Staff B further stated that if a resident refused to participate in the care plan review, there should be a note in the resident's medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47680 RESIDENT 22 Review of the face sheet printed on 03/17/2025, showed that Resident 22 admitted to the facility on [DATE]. In an interview on 03/13/2025 at 3:13 PM, Resident 22 stated that they did not know of any care conferences. Review of Resident 22's progress notes from 11/13/2024 through 03/19/2025, did not show documentation that a care conference and/or care plan review was held with Resident 22 and/or their representative. Review of the document titled, Care plan Review Signature Record 2024, dated 12/11/2024, showed that it was signed by Social Services and the Dietician. There were no signatures from Resident 22 or their representative. Review of the Care plan Review Signature Record 2025, dated 03/12/2025, showed that it was signed by Social Services and the Dietician. There were no signatures from Resident 22 or their representative. In an interview on 03/18/2025 at 11:56 AM, Staff H stated that care conferences were usually scheduled within seven days and at least enough time to be evaluated by therapy and nursing assessments were completed. When asked if a care conference was held with Resident 22 and/or their representative, Staff H stated, I imagined we did in the beginning, but we didn't document it. Staff H further stated that it would be documented in the progress notes. In a follow up interview and joint record review on 03/20/2025 at 10:46 AM, Staff H stated that care plans were reviewed based on the MDS. When asked if the resident's representatives were involved, Staff H stated, Usually, yes, it depends on each person's situation. Joint record review of the Care plan Review Signature Record 2024 showed no signatures from Resident 22 or their representative. Staff H stated that they cannot verify if Resident 22 or their representative attended the care plan review because it was not documented. Staff H stated that Resident 22 should have been involved in their care plan review. Staff H further stated that they did not have documentation to prove that a care conference was held, or that Resident 22 and their representatives were involved in the care plan review. In an interview and joint record review on 03/20/2025 at 12:27 PM, Staff B stated that they expected care plan meetings to be completed on admission, quarterly, annually, or with a significant change. Staff B stated that they expected care conference to be held within the first week. Staff B stated that residents were invited to the care plan review meeting if they choose to come. Joint record review of the Care plan Review Signature Record 2024 showed that it was signed by Social Services and the Dietician. When asked what the signatures indicated, Staff B stated that those who attended the meeting will sign the care plan review signature record form. When asked if Resident 22 and/or their representative attended, Staff B stated they did not attend the meeting because it was not signed. Staff B stated, The form shows who attended. Staff B further stated that they expected Resident 22 to have been invited and would have expected Staff H to document that Resident 22 was invited and chose not to come. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-1020 (2)(f)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 52331 Based on observation, interview, and record review, the facility failed to ensure staff documented medications in accordance with professional standards for 1 of 7 residents (Resident 388), reviewed for medication administration. This failure placed the resident at risk for medication errors and negative outcomes. Findings included . Review of the facility's undated policy titled, Medication Administration, showed Medications are administered by license nurses, as ordered by the physician and in accordance with professional standards of practice. It also showed to ensure Medication Administration Record (MAR) was signed after medication administration. Observation on 03/18/2025 at 4:31 PM, showed Staff U, Registered Nurse, prepared and signed off medications in the MAR prior to medication administration for Resident 388. In an interview on 03/18/2025 at 4:36 PM, Staff U stated that they should have signed the MAR after administering Resident 388's medications. In an interview on 03/19/2025 at 9:37 AM, Staff F, Unit Manager, stated They are not supposed to sign [the MAR] before giving the medications. In an interview on 03/19/2025 at 3:00 PM, Staff B, Director of Nursing, stated it was their expectation that medications were signed off after medication administration. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted professional standards of practice for 2 of 2 residents (Residents 22 & 9), reviewed for respiratory care. The failure to follow physician orders for oxygen therapy and properly store nebulizer (medical device that turns liquid medication into a fine mist that can be inhaled through a mouthpiece or mask) equipment placed the residents at risk for respiratory infections, and related complications. Findings included . Review of the facility's undated policy titled, Oxygen Administration, showed, Oxygen is administered under orders of the physician .Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. It further showed, Keep delivery devices covered in a bag when not in use. RESIDENT 22 Review of the face sheet printed on 03/17/2025 showed that Resident 22 admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- a condition that blocks air flow and make it difficult to breathe) with acute exacerbation (worsening of symptoms) and acute and chronic respiratory failure with hypoxia (occurs when the lungs struggle to deliver adequate oxygen to the blood, leading to low oxygen levels). Review of Resident 22's March 2024 Medication Administration Record (MAR) printed on 03/17/2025, showed an order for Ipratropium-Albuterol Inhalation Solution (medication used to treat COPD) orally four times a day for wheezing, shortness of breath, or increased work of breathing with a start date of 11/15/2024. It further showed that Resident 22 received it four times a day from 03/01/2025 through 03/16/2025. Observations on 03/13/2025 at 3:19 PM and on 03/14/2025 at 11:50 AM, showed Resident 22's nebulizer mouthpiece was laying on top of the bedside table and was not properly stored. Observation and interview on 03/17/2025 at 11:29 AM, showed Resident 22's nebulizer mouthpiece was laying on top of the bedside table and was not properly stored. Resident 22 stated that they used it every day and that staff did not store it in a bag after use. Observations on 03/18/2025 at 12:16 PM and on 03/19/2025 at 10:36 AM, showed Resident 22's nebulizer mouthpiece was laying on top of the bedside table and was not properly stored. In an interview and joint observation on 03/19/2025 at 10:39 AM, Staff I, Licensed Practical Nurse, stated that nebulizer equipment was changed every Friday and that they would store it in a bag when not in use. Joint observation of Resident 22's nebulizer equipment showed that the mouthpiece was laying on top of the bedside table and was not properly stored. Staff I stated that it should have been stored in a bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/2025 at 12:52 PM, Staff E, Unit Manager, stated that nebulizer equipment was changed every seven days and stored in a bag when not in use. Staff E further stated that they expected Resident 22's nebulizer equipment to be stored in a bag when not in use. In an interview on 03/19/2025 at 2:33 PM, Staff B, Director of Nursing, stated that nebulizer equipment should be stored in a bag when not in use and ensure the equipment was cleaned. When asked if they expected Resident 22's nebulizer equipment to be stored in a bag when not in use, Staff B stated, I would. RESIDENT 9 Review of the face sheet printed on 03/14/2025 showed Resident 9 admitted to the facility on [DATE] with diagnoses that included moderate persistent asthma (chronic lung condition that causes the airways to become inflamed and narrow, making it difficult to breathe) with acute exacerbation. Review of Resident 9's March 2025 MAR showed an order for oxygen two liters per minute via nasal cannula (flexible tubing that sits inside the nose and delivers oxygen) continuously every shift with a start date of 01/31/2025. Observation on 03/13/2025 at 1:59 PM, showed Resident 9 in their room sitting in their wheelchair and was not using oxygen. Observation and interview on 03/14/2025 at 12:04 PM, showed Resident 9 in their room sitting in their wheelchair brushing their teeth. No oxygen supplies observed in their room. Resident 9 stated that they did not use oxygen. Observation and interview on 03/17/2025 at 8:52 AM, showed Resident 9 was lying in bed and was not using oxygen. Resident 9 stated that they no longer used oxygen because their oxygen levels were normal and that they did not have any difficulty breathing. Observation on 03/19/2025 at 10:32 AM, showed Resident 9 was lying in bed and was not using oxygen. In an interview and joint record review on 03/19/2025 at 10:43 AM, Staff I stated that they followed physician oxygen orders and that if a resident refused oxygen, they would notify the physician. Joint record review of Resident 9's March 2024 MAR showed an order for oxygen two liters per minute via nasal cannula continuously. Staff I stated that Resident 9 did not use oxygen since they were transferred to their current room on 03/13/2025. Staff I stated that they should have clarified the order with the physician. Staff I further stated that Resident 9 did not need oxygen and that their oxygen saturations (amount of oxygen in the blood) were good. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/19/2025 at 12:54 PM, Staff E stated that they expected staff to administer oxygen per physician's order. Staff E stated that if a resident refused oxygen or no longer needed oxygen, they expected staff to assess the resident, notify the physician and document. Staff E further stated that they assessed Resident 9, and that Resident 9 reported that they did not need oxygen. Staff E stated that Resident 9 did not use oxygen since they transferred to their current room and even longer than that. Staff E further stated that they expected staff to clarify the oxygen order with the physician if oxygen was still needed. In an interview on 03/19/2025 at 2:33 PM, Staff B stated that they expected staff to follow physician orders and that if a resident declined to use oxygen or no longer needed oxygen, they expected staff to talk to the physician for clarification of the order. Staff B further stated that staff should have informed the Unit Manager or called the physician. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52133 Based on interview and record review, the facility failed to ensure required qualifications were up to date for 1 of 18 staff (Staff EE), reviewed for qualified dietary staff. This failure placed residents at risk of receiving unsafe dietary services from staff that did not have a current food handler's permit. Findings included . Review of the facility's undated policy titled, Dietary Services-Staff, showed, The facility employs sufficient staff with the appropriate competencies and skill sets to carry out the functions of the Food and Nutrition Services. Review of the facility's Dietary Aide job description, revised on [DATE], showed Required Education and Experience: Ability to obtain and maintain a [NAME] Food Handler's license. In an interview and joint observation on [DATE] at 8:20 AM with Staff D, Food Service Manager, stated they would expect dietary staff to have a current [NAME] Food Handler's permit. Joint observation showed Staff EE, Dietary Aide, had a [NAME] Food Handler's permit that expired on [DATE]. Staff D stated that Staff EE worked in the kitchen after the expiration date on [DATE], [DATE], [DATE], [DATE] and [DATE] and that they should not have. In an interview on [DATE] at 2:30 PM, Staff A, Administrator, stated they expected the dietary staff to be current and up to date with their food handler's permits. Reference: (WAC) [DATE]

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to ensure residents received weekly menus consistently for 1 of 2 residents (Resident 33) and to provide an ordered nutritional supplement for 1 of 1 resident (Resident 49), reviewed for dining services. This failure placed the residents at risk for not having their food choices honored, dissatisfaction with meals, unmet nutritional needs, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Standardized Menus, showed The facility will make reasonable efforts to provide food that is appetizing and culturally appropriate for residents. Menus will be planned to meet basic nutritional needs by providing meals based on individual nutritional assessment and individualized plan of care .All menus used by the facility should be dated and posted. Menus should be kept on file for at least 30 days .The weekly menus are available by [Facility's] first and second floor elevators and delivered to each resident weekly. Daily menus are posted at the entrance of each dining room .The facility will support the resident's right to make personal dietary choices. RESIDENT 33 Resident 33 admitted to the facility on [DATE]. Review of Resident 33's Admission Minimum Data Set (MDS - an assessment tool), dated 02/26/2025 showed Section K (Swallowing/Nutritional Status) was completed by Staff Q, Registered Dietitian, on 02/24/2025. It further showed that Resident 33 was assessed to have reported dislike of food. Review of Resident 33's Nutrition Assessment, dated 02/24/2025, showed that Staff Q met with Resident 33 to discuss food preferences. It further showed that [Resident 33] states [they] know how to use the menu. In an interview and observation on 03/13/2025 at 10:10 AM, Resident 33 stated they received a weekly menu from Staff Q one time in the week that they admitted to the facility. Resident 33 stated, The other weeks, I have not seen any menu anymore and that Everything I eat is a surprise for me. When asked if Resident 33 was provided their menu/dietary choices, they stated, Not sure, because I don't have a copy [of the weekly menu] for myself. Observation of Resident 33's room did not show a weekly menu was available to them. In a follow up interview on 03/14/2025 at 3:22 PM, Resident 33 was asked if they knew where menus were posted and they stated, I don't understand the meaning of the [daily] menu, it's in the dining room but it's nothing you can choose at the moment and that I don't understand because the tray is already prepared for you. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Joint record review and interview with Resident 33 on 03/17/2025 at 10:10 AM, showed a weekly menu was dropped off to their room. It further showed that the weekly menu was for the dates 03/15/2025 through 03/21/2025. Resident 33 stated, Yesterday, they were giving everyone the menu, but no one has come back to take it. Resident 33 further stated that they have not seen that version of the weekly menu before and that It was different, before I did not see alternatives. In an interview and joint record review on 03/18/2025 at 9:09 AM, showed a weekly menu, dated 03/15/2025, posted in the hallway of the Cedar unit. Staff N, Nursing Assistant Certified (NAC), stated that they did not routinely pass out the weekly menu to residents. In an interview on 03/18/2025 at 1:23 PM, Staff O, Activities Aide/Dietary Aide, stated the weekly menu came from the Dietary Manager on Wednesdays. Staff O stated they assisted residents who were listed to need assistance with their menu selections. Staff O further stated that they worked in the kitchen on Wednesdays as a Dietary Aide. In an interview on 03/19/2025 at 10:15 AM, Staff D, Food Service Manager, stated that the Activities Department met with identified residents to go over the weekly menus to assist them with menu selections for the upcoming week. Staff D stated, the Kitchen receives the completed menus by Thursday, latest is Friday. When asked to show past menu selections collected from Resident 33, Staff D stated, We don't usually keep them, and that once [residents] make selections and [completed weekly menus] comes back to us, I don't think they make a copy. In an interview on 03/19/2025 at 1:06 PM, Staff P, Activities Aide, stated that they collected the weekly menus from downstairs and visited the rooms of select residents. Staff P stated they referred to a list of residents who needed assistance with menu selections and that this list was from Staff Q. When asked if Resident 33 received assistance with menu selections, Staff P stated I did not [provide assistance to Resident 33]. I think she was very independent and that I never thought to bring a menu to [Resident 33]. When asked if Staff P oriented Resident 33 to where weekly menus were located, Staff P stated, I did not. In an interview on 03/19/2025 at 1:28 PM, Staff Q stated that they visited Resident 33 on 02/24/2025 to complete their Nutrition Assessment and to introduce the weekly menu. Staff Q stated that after the initial visit with a resident, in subsequent weeks, the activity staff do the menu selections [with residents]. Staff Q further stated that they referred residents who needed assistance with menu selections to a list used by Activities Department and that Resident 33 was not listed. When asked if Resident 33 was oriented to where to find the weekly menus, Staff Q stated, I don't recall, but Activities drop it off [to the residents]. In an interview on 03/19/2025 at 3:07 PM, Staff R, Activities Director, stated weekly menus are distributed to residents by Activities staff on Wednesdays. Staff R further stated, We don't distribute them to everybody, and that on Wednesdays, It's just me and [Staff P]. When asked if residents were oriented to where to find the weekly menus, Staff R stated, The [Nursing] Aides know where they are at, the residents don't know unless they ask for it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Lutheran Home	4700 Phinney Avenue North Seattle, WA 98103

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

In a joint interview on 03/20/2025 at 10:28 AM, with Staff D and Staff L, Dietary Aide, Staff D stated that Staff L managed the completed weekly menus received by the kitchen. When asked if a completed weekly menu was received from Resident 33 in past weeks, Staff L stated, I don't think I ever got one from them. When asked if they expected residents to be able to select their menu options in advance, Staff D stated, Sure, and I think somebody up there determines that either Nursing or the Registered Dietitian.

In an interview on 03/20/2025 at 1:44 PM, Staff A, Administrator, stated residents were able to select food/menu preferences beyond what was offered on the fixed menu in advance by completing the weekly menus. When asked if they expected the weekly menu would be available for all residents, Staff A stated, My expectation is that they're delivered weekly.

49619

RESIDENT 49

Resident 49 admitted to the facility on [DATE].

Review of Resident 49's Nutrition/Registered Dietitian assessment dated [DATE] showed, Per discussion with [Collateral Contact 1 (CC1)], will provide applesauce/canned fruit/gelatin each meal, and strawberry Ensure [nutritional drink/supplement designed to provide balanced nutrition, including protein, vitamins, and minerals] each breakfast. It further showed, Kitchen providing strawberry Ensure [nutritional supplement] each breakfast.

Review of Resident 49's Nutrition/Registered Dietitian assessment dated [DATE] showed the facility would, honor res [resident] requests/refusals to the greatest extent possible. It also showed under Nourishments, a Strawberry Ensure with breakfast.

Review of Resident 49's breakfast meal ticket dated 03/19/2025 and 03/20/2025 showed a standing order for an eight fluid ounce Ensure (strawberry).

In an interview on 03/13/2025 at 3:29 PM, CC1, stated that they had requested Resident 49 receive an Ensure, but did not get it as far as they knew. CC1 further stated they asked the staff on multiple visits to report what the resident had for breakfast, and they did not report that Resident 49 had an Ensure with their breakfast meal.

Observation on 03/14/2025 at 9:23 AM, showed Resident 49 being assisted during the breakfast meal. No Ensure was observed with Resident 49's breakfast meal.

Another observation on 03/20/2025 at 8:40 AM, showed Resident 49 received their breakfast tray. No Ensure was observed with Resident 49's breakfast meal.

In a joint observation and interview on 03/20/2025 at 9:18 AM with Staff FF, NAC, showed no Ensure was provided with Resident 49's breakfast. Staff FF stated there was no Ensure on Resident 49's breakfast tray. Staff FF further stated that Ensure supplements came from the kitchen, and that they delivered what was on the tray.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/20/2025 at 11:39 AM, Staff D, stated their process for the supplements including Ensure would be for the kitchen to supply them daily if there was a label for the order. In an interview on 03/20/2025 at 11:54 AM, Staff Q, stated that if an Ensure was requested they would add it in their nutritional assessment, and that they would add the order into the tray card system. Staff Q stated a label would get generated for the kitchen to provide the supplements including Ensure and nursing staff would be responsible for delivering it to the resident. Staff Q stated they would expect the resident to receive what was listed as Standing Orders on their meal ticket. Staff Q stated that Resident 49 had a strawberry Ensure as a standing order for breakfast, but that a meal label box wasn't checked in their system, so a label was not generated and the ensure was not being sent. Staff Q stated this box should have been checked initially. Staff Q stated that Resident 49 clearly liked the strawberry Ensure. In an interview on 03/20/2025 at 1:42 PM, Staff A, stated that staff would collect resident food preferences during the admission assessment typically by the dietitian. Staff A stated that they expected the facility to accommodate the resident's preferences and that they would expect a resident to receive the standing orders on their meal tickets. Staff A further stated this was important, so they get what they want. Reference: (WAC)388-97-1180 (2) -1200 (2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52133 Based on observation, interview, and record review, the facility failed to ensure foods were stored and handled appropriately in accordance with professional standards of food safety for 2 of 2 kitchen refrigerators (Kitchen Reach-In refrigerator and Kitchen Walk In refrigerator), 1 of 1 kitchen dry storage room, 2 of 7 unit refrigerators ([NAME] dining room pantry white refrigerator and [NAME] pantry silver refrigerator), 1 of 3 dining rooms ([NAME] dining room), and 2 of 4 halls (Dogwood and [NAME]), reviewed for food services. The failure to date and discard food items past the use by/expire date, cover food items during meal tray delivery, and use appropriate food handling when assisting residents placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Food Safety Product Labeling and Dating Guidelines, revised on [DATE] showed, Once a product does have a documented use by date, the FDA [Food and Drug Administration] Food Code and Sodexo Policy requires the product to be consumed or discarded by that date. Review of the facility's policy titled, Food Safety Policies and Standards, revised on [DATE] showed, Manufacture's expiration dates must be adhered to. Further review showed, Employees may not contact exposed ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. Review of the facility's undated policy titled, Room Service Policy, showed, Staff will transport patient food and beverage in covered carts or cover individual food and beverage items. EXPIRED FOOD ITEMS IN THE KITCHEN'S REACH-IN REFRIGERATOR In an interview and joint observation on [DATE] at 8:05 AM, Staff D, Food Service Manager, stated they expected dietary staff to label and date open food items. Staff D further stated they expected dietary staff to check food items for use by date and to discard items passed the use by date. Joint observation with Staff D showed one gallon of fat free milk with used by date of [DATE] in the kitchen reach-in refrigerator. Staff D stated that the fat free milk should have been discarded. In an interview on [DATE] at 2:30 PM, Staff A, Administrator, stated they expected food items in the kitchen refrigerators to not be expired or passed the use by date. Staff A further stated that the dietary staff should have discarded expired or passed the use by date items. SPOILED FOOD ITEMS IN THE KITCHEN'S WALK-IN REFRIGERATOR In an interview and joint observation [DATE] at 8:10 AM, Staff D stated they expected dietary staff to check for any rotten or mold food items and to discard if found. Joint observation with Staff D showed reddish-purple grapes with white fuzzy substance in the kitchen walk-in refrigerator. Staff D stated that the white fuzzy substance on the grapes was mold and that it should have been discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 2:30 PM, Staff A stated they expected the dietary staff to check the food items in the kitchen refrigerators and discard if there was mold. FOOD LABELING IN THE KITCHEN DRY STORAGE ROOM In an interview and joint observation on [DATE] at 8:13 AM, Staff D stated they expected food items to be labeled and dated. Joint observation with Staff D showed two unopened and unlabeled bags of cereal in the kitchen dry storage room. Staff D stated the two unopened and unlabeled bags looked like Cheerios [brand of cereal]. Staff D stated the bags of cereal should have been labeled/dated. In an interview on [DATE] at 2:30 PM, Staff A stated they expected the dietary staff to label and date the food items in the dry storage room. EXPIRED FOOD ITEMS IN THE [NAME] DINING ROOM PANTRY REFRIGERATORS In an interview and joint observation on [DATE] at 2:20 PM, Staff Q, Registered Dietitian, stated they expected food items in the refrigerator to be labeled and dated. Joint observation with Staff Q showed two unopened yogurts with an expiration date of [DATE] in the white refrigerator and one carton of Med Plus 2.0 (nutritional supplement) vanilla flavored with an expiration date of [DATE] in the silver refrigerator in the [NAME] dining room pantry. Staff Q stated they expected staff to check items and discard them if expired. In an interview on [DATE] at 9:00 AM, Staff D stated they expected both dietary and nursing staff to have discarded expired items on the unit refrigerators. Staff D stated Dietary staff will maintain and throw away expired or use by date items or if resident/family brings items we will follow policy of three days then throw away. Nursing will assist as well. We check daily. Ultimately it's us [dietary staff] who are responsible. In an interview on [DATE] at 2:30 PM, Staff A stated they expected the dietary staff to check and discard expired food items in the unit refrigerators. FOOD HANDLING IN THE [NAME] DINING ROOM Observation on [DATE] at 11:57 AM showed Staff X, Nursing Assistant Certified (NAC), was assisting Resident 21 with her lunch tray. Staff X peeled the banana and then moved the unpeeled banana with their bare hands to another part of the plate. In an interview on [DATE] at 12:49 PM, Staff X stated they would take off the cover and cut their food if they need help. Staff X further stated they would use a knife or gloves to peel food and cut it. In an interview on [DATE] at 11:25 AM, Staff I, Licensed Practical Nurse, stated nursing staff would have to wear gloves if peeling bananas or use dining utensils. Staff I further stated that nursing staff would not touch an unpeeled banana with their hands. In an interview on [DATE] at 11:35 AM, Staff E, Unit Manager, stated they would expect nursing staff to use the utensils on the tray for cutting food and to use gloves to peel bananas. Staff E further stated nursing staff should not touch the banana or food with their bare hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 1:00 PM, Staff B, Director of Nursing, stated they would expect the nursing staff to not touch food items with their bare hands when they assist residents with their food tray. UNCOVERED FOOD ITEMS DURING MEAL TRAY DELIVERY [NAME] DINING ROOM Observations on [DATE] at 12:20 PM showed three unknown staff carried three uncovered cheesecakes on the meal trays out of the [NAME] dining room into the hall. In an interview on [DATE] at 12:49 PM, Staff X stated the food was usually covered by the kitchen whom they get the trays from. In an interview on [DATE] at 12:56 PM, Staff L, Dietary Aide, stated the cheesecake was not covered at first until they got some plastic wrap brought up to them. Staff L further stated the cheesecake should have been covered. In an interview on [DATE] at 11:25 AM, Staff I stated the trays being delivered in hall to resident rooms should have items covered. In an interview on [DATE] at 11:40 AM, Staff D stated anytime food was going down the hall it should be covered. Staff D further stated, We don't go down the hall with uncovered food. In an interview on [DATE] at 2:30 PM, Staff A stated they would expect food items to be covered when traveling in the halls to resident rooms. 45146 DOGWOOD HALLWAY TRAY Observation on [DATE] at 12:16 PM, showed Staff DD, NAC, was carrying an uncovered cheesecake on a meal tray from Dogwood Hall dining room to room [ROOM NUMBER]. At 12:23 PM, Staff DD was observed carrying another meal tray with uncovered cheesecake from the dining room to room [ROOM NUMBER]. Observation on [DATE] at 12:18 PM, showed Staff T, Infection Control Nurse, was carrying an uncovered cheesecake on a meal tray from Dogwood Hall dining room, entered room [ROOM NUMBER] and placed it on Resident 3's bedside table. Further observation showed Staff T was carrying another uncovered cheesecake on a meal tray from the dining room down the hallway to the second floor nurse station and entered room [ROOM NUMBER]. In an interview on [DATE] at 12:24 PM, Staff DD stated that the cheesecake on the meal tray was not covered when they were delivered. In an interview on [DATE] at 12:28 PM, Staff T stated that the cheesecake on the meal tray was not covered when it was delivered to room [ROOM NUMBER] and stated they would make sure all food items were covered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observations on [DATE] at 12:39 PM, at 12:55 PM, and at 2:01 PM, showed Resident 3 was sleeping and did not eat their lunch. Observations showed their lunch tray with uncovered cheesecake was sitting on their bedside table. In an interview on [DATE] at 8:46 AM, Staff D stated that meal trays should be placed in a covered meal cart and delivered to rooms. Staff D stated that when a single tray delivered from the dining room to a residents' room, they expected all food items on the tray to be covered. 47680 [NAME] HALLWAY TRAY Observation on [DATE] at 12:19 PM, showed Staff J, NAC, left the [NAME] dining room with a meal tray and walked down the hallway and delivered the meal tray to room [ROOM NUMBER]-B with the cheesecake uncovered. Staff Z, Nursing Assistant Registered, walked down the hallway with a meal tray and delivered it to room [ROOM NUMBER]-D with the cheesecake uncovered. At 12:23 PM, Staff Z took another meal tray from the [NAME] dining room and delivered it to room [ROOM NUMBER]-D with the cheesecake uncovered. In an interview on [DATE] at 12:44 PM, Staff J stated their process was to take the meal tray from the dining room and deliver it to the residents' room. When asked if the food was covered, Staff J stated, It's always covered, but not sure what happened today and that they were not sure if the dietary aide did not have any supplies. In an interview on [DATE] at 12:52 PM, Staff L was asked about the uncovered cheesecake, Staff L stated that they were not covered because they were out of plastic wrap and that their supervisor had brought some in. Staff L further stated that the first few trays that were delivered to resident rooms had uncovered cheesecake and when the plastic wrap was brought up to them, they started to cover the cheesecake. In an interview on [DATE] at 1:30 PM, Staff D stated that they expected food items on the meal tray to be placed in a covered cart and delivered room by room. Staff D stated that they expected that anything that went down the hallway was covered. In an interview on [DATE] at 10:25 AM, Staff A stated that they expected meal trays to be delivered down the hallway in a covered cart or the food on the tray to be individually covered. Reference: (WAC) [DATE] (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on observation, interview, and record review, the facility failed to ensure hand hygiene and proper use of gloves were followed during resident care and housekeeping for 3 of 7 staff (Staff Y, Z & K), failed to ensure hand hygiene and/or sanitation of medication trays during medication administration were performed for 2 of 3 staff (Staff U & V), and failed to ensure Enhanced Barrier Precautions (EBP- additional infection control measures focusing on gown and glove use during high-contact resident care) practices were followed for 1 of 3 staff (Staff W), reviewed for infection control. In addition, the facility failed to ensure proper sanitization of medical equipment were conducted for 2 of 3 staff (Staff W & CC) and failed to properly handle a urinary catheter (a semi-flexible tube inserted into the bladder to drain urine) bag for 1 of 4 residents (Resident 41). These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . Review of the facility's undated policy titled, Hand Hygiene, showed All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy further showed, The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning [applying] gloves, and immediately after removing gloves. HAND HYGIENE & GLOVE USE STAFF Y & STAFF Z Observation on 03/17/2025 at 1:57 PM, showed Staff Y, Nursing Assistant Certified (NAC), and Staff Z, Nursing Assistant Registered, were providing peri-care (cleaning of private areas) for Resident 49. Staff Y and Staff Z both uncovered Resident 49 and assisted with removing the resident's pants. Staff Y unfastened Resident 49's soiled brief. Staff Y and Staff Z both began to clean Resident 49's peri-area in a downward motion. Staff Y began to tuck in the dirty brief (soiled with bowel movement [BM]) and cleaned Resident 49's bottom. Staff Z had a treatment cream for Resident 49's bottom and applied it. Staff Z did not change their gloves and do hand hygiene prior to applying the treatment cream to Resident 49's bottom. Staff Y continued to assist Resident 49 with applying a new brief and putting the resident's pants and covers back on. Staff Y did not change their gloves and perform hand hygiene after they assisted with cleaning Resident 49's BM. On 03/17/2025 at 2:19 PM, Staff Z stated that they should have removed their gloves after doing peri-care on Resident 49, performed hand hygiene, applied new gloves, and then applied the treatment cream to Resident 49's bottom. Staff Z further stated that hand hygiene was important for infection control and sanitary for the resident and themselves. On 03/17/2025 at 2:30 PM, Staff Y stated that hand hygiene should be performed before starting a task, after completing a task, and after glove removal. Staff Y further stated that after assisting with peri-care of Resident 49, they should have changed their gloves and perform hand hygiene before moving on to the next task. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/17/2025 at 2:50 PM, Staff AA, Licensed Practical Nurse, stated hand hygiene should be performed before applying gloves, and after removing them prior to the next task. Staff AA further stated hand hygiene was important to prevent cross contamination and protection to the resident and themselves. On 03/19/2025 at 2:49 PM, Staff T, Infection Control Nurse, stated they expected staff to perform hand hygiene before and after glove use. Staff T stated they would have expected Staff Z to remove their dirty gloves after assisting Resident 49 with peri-care, perform hand hygiene, and apply new gloves to apply the treatment cream to Resident 49's bottom. Staff T further stated that Staff Y should have removed their dirty gloves after assisting Resident 49 with peri-care and performed hand hygiene and applied new gloves prior to touching clean items. On 03/19/2025 at 3:00 PM, Staff B, Director of Nursing, stated that they expected staff to perform hand hygiene before care, before touching a resident, upon entering a room, if their hands became contaminated/soiled, and after removing their gloves. Staff B further stated, gloves do not replace hand hygiene. 47680 STAFF K Observation and interview on 03/13/2025 at 10:58 AM, showed Staff K, Housekeeper, left room [ROOM NUMBER] with gloves on, walked to the housekeeping cart and removed their gloves. Staff K pushed the housekeeping cart down the hallway and parked it by room [ROOM NUMBER]. Staff K applied clean gloves without performing hand hygiene and brought a yellow bucket into room [ROOM NUMBER]. Staff K wiped the sink counter, took the trash bag from the trash bin, and cleaned the room. When Staff K was done, they took the trash bag with their gloved hands, left the room and placed the trash bag inside a larger trash bag that was on the cart. Staff K removed their gloves and pushed their housekeeping cart by room [ROOM NUMBER]. Staff K applied clean gloves without performing hand hygiene and took a yellow bucket to room [ROOM NUMBER]. Staff K cleaned the sink and the bathroom. When asked what they were doing, Staff K stated they were cleaning the resident's room. Staff K continued to wipe the sink and swept the floor of room [ROOM NUMBER]. Staff K then took the trash in the room and placed the trash bag inside a larger trash bag that was on their cart. Staff K took the mop that was in their cart, went back to room [ROOM NUMBER] and mopped the floor. When they were done, Staff K removed their gloves and took the big trash bag that was on their cart to the linen chute room. Staff K then pushed the housekeeping cart down the hallway, parked their cart by room [ROOM NUMBER], and applied clean gloves without performing hand hygiene. Staff K did not perform hand hygiene between glove use. In an interview on 03/14/2025 at 8:17 AM, Staff K stated that they used gloves when cleaning resident rooms and when they were done cleaning one room, they would change their gloves. When asked if they cleaned their hands after glove use, Staff K stated, Yes, but I didn't wash. When Staff K was informed of observation of not performing hand hygiene between glove use, Staff K stated, I didn't wash my hands before I put a new one. In an interview on 03/19/2025 at 1:51 PM, Staff C, Housekeeping Supervisor, stated that they expected staff to use gloves before they entered the rooms and to perform hand hygiene between glove use. Staff C further that Staff K should have performed hand hygiene between glove use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/19/2025 at 2:41 PM, Staff B stated that they expected staff to perform hand hygiene before and after glove use. Staff B further stated that they expected Staff K to perform hand hygiene between glove use. 51090 Observation on 03/14/2025 at 7:55 AM, showed Staff K was in the hallway of Cedar Unit with their housekeeping cart. Staff K was observed exiting room [ROOM NUMBER] wearing gloves, holding a filled plastic bag that they placed in their housekeeping cart. With the same gloves, Staff K placed a wet floor sign in front of room [ROOM NUMBER] before they re-entered room [ROOM NUMBER] with a flat broom. At 7:58 AM, Staff K exited room [ROOM NUMBER] and returned cleaning supplies to their cart before they removed used gloves and applied new gloves. Staff K did not perform hand hygiene between glove use. Further observation showed Staff K entered room [ROOM NUMBER]. At 8:02 AM Staff K wearing gloves, exited room [ROOM NUMBER] and rolled their cart down the hallway to the linen chute room where they placed filled plastic bags down the chute. At 8:03 AM, Staff K exited the linen chute room while wearing gloves. Staff K then handled their clothing to put away keys before they handled supplies on their cart including paper towels. Staff K did not change gloves and/or performed hand hygiene between tasks. In an interview on 03/14/2025 at 8:17 AM, Staff K stated they wore gloves when cleaning surfaces in resident rooms that included the sink, toilet and floors. Staff K stated they replaced used gloves every time I finish the one room. When asked if they expected to clean their hands between glove use, Staff K stated Yes and that I didn't wash my hands. In an interview on 03/19/2025 at 2:48 PM, Staff T stated they expected all staff to follow proper hand hygiene procedures to prevent the spread of infection. Staff T stated they expected Staff K would have performed hand hygiene between glove use. Staff T further stated that they did not expect used gloves to be worn outside of resident rooms and that [Staff K] should have removed the dirty gloves, while in the room, and performed hand hygiene. In an interview on 03/19/2025 at 3:00 PM, Staff B stated they expected everyone to perform hand hygiene after removing used gloves and before putting on new gloves. Staff B further stated they did not expect used gloves to be worn outside in the hallways. 52331 Observation on 03/13/2025 at 11:46 AM, showed Staff K had gloves on and mopped the floor in room [ROOM NUMBER]. Then they went to their housekeeping cart outside room [ROOM NUMBER] and removed the mopping pad from the bottom of the mop and placed it in the bucket on the cart. Staff K removed their gloves and took a new roll of paper towels with their bare hands from their housekeeping cart and refilled the paper towel dispenser in room [ROOM NUMBER]. Staff K did not perform hand hygiene after they removed their soiled gloves or prior to refilling room [ROOM NUMBER]'s paper towel dispenser. Staff K applied a new pair of gloves and went to room [ROOM NUMBER] and started cleaning the sink and bathroom. Staff K did not perform hand hygiene before they donned new gloves and went into room [ROOM NUMBER]. In an interview on 03/14/2025 at 8:16 AM, Staff K stated they did not wash their hands in between glove use and they should have. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Columbia Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 Phinney Avenue North Seattle, WA 98103	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MEDICATION ADMINISTRATION Review of the facility's undated policy titled, Medication Administration, showed, Perform hand hygiene prior to administering medication per facility protocol and product. STAFF U Observation on 03/18/2025 at 4:08 PM, showed Staff U, Registered Nurse (RN), was preparing Resident 39's medications on their medication cart. Staff U used the mouse and keyboard to document [the medications]. Staff U then entered the resident's room and administered their medications. Staff U did not perform hand hygiene prior to preparing the resident's medications, before entering their room and/or prior to administering their medications. Observation on 03/18/2025 at 4:13 PM, showed Staff U returned to the medication cart and prepared Resident 67's medications. Staff U used the mouse and keyboard to document. During medication preparation, Staff U touched the vital sign (measurements of the body's most basic functions) equipment and then dispensed the medications into a medication cup. Staff U then locked the medication cart and entered Resident 67's room. Staff U did not perform hand hygiene prior to administering Resident 67's medications. Observation on 03/18/2025 at 4:31 PM, showed Staff U returned to the medication cart and unlocked the medication drawer. Staff U used the mouse and keyboard to document. Staff U touched the vital sign equipment and dispensed the medications into the medication cup for Resident 388. Staff U entered Resident 388's room and applied gloves without performing hand hygiene. Staff U administered medications to Resident 388 and then removed their gloves. In an interview on 03/18/2025 at 4:38 PM, Staff U stated that they should have done hand hygiene before entering, after leaving the resident's room and/or between glove use. In an interview on 03/19/2025 at 9:37 AM, Staff F, Unit Manager, stated that Staff U should have performed hand hygiene before entering [the resident's room] and/or before glove use. In an interview on 03/19/2025 at 2:48 PM, Staff T stated they expected hand hygiene all the time, hand hygiene before entering, in between care, and also hand hygiene before they come out of the room. In an interview on 03/19/2025 at 3:00 PM, Staff B stated they expected everyone to perform hand hygiene before entering and/or leaving the resident's room and between glove use. Staff B further stated, gloves do not replace hand hygiene. Staff V Observation on 03/17/2025 at 7:30 AM, showed Staff V, RN, entered Resident 53's room. Staff V had Resident 53's medication cup on a medication tray and placed the medication tray on top of Resident 53's bedside table. After the medications were administered, Staff V returned to the medication cart and placed the medication tray on top of the cart. Staff V did not sanitize the medication tray after use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/17/2025 at 7:50 AM, showed Staff V dispensed the medications in the medication cup and placed it on the medication tray. Staff V entered Resident 389's room and placed the medication tray on Resident 389's bedside table. After the medications were administered, Staff V returned to the medication cart and placed the medication tray on top of the cart. Staff V did not sanitize the medication tray before and after use. Observation on 03/17/2025 at 8:12 AM, showed Staff V dispensed the medications for Resident 4. Staff V then entered Resident 4's room and placed the medication tray on Resident 4's bedside table. Staff V then took the medication tray back to the medication cart. Staff V did not sanitize the medication tray before and after use. In an interview on 03/17/2025 at 8:42 AM, Staff V stated they should sanitize the medication tray before and after use. In an interview on 03/20/2025 at 3:48 PM, Staff T stated Staff V should have sanitized the medication tray between residents. In an interview on 03/20/2025 at 3:48 PM, Staff B stated they expected nurses to sanitize the medication tray before and after use. ENHANCED BARRIER PRECAUTIONS Review of the facility's undated policy titled, Enhanced Barrier Precautions, showed, EBP refer to an infection control intervention designed to reduce transmission of the multidrug-resistant organisms that employs targeted gown, and gloves use during high contact resident care activities .High-contact resident care activities include changing briefs or assisting with toileting. STAFF W Review of Resident 385's March 2025 Medication Administration Record showed an order to Monitor incision [surgical] site on: Right hip incision covered w[with]/silver dressing 40 cm [centimeter-unit of measurement], with a start date of 03/04/2025. Observation on 03/13/2025 at 9:30 AM, showed an EBP signage on Resident 385's closet door for donning and removing Personal Protective Equipment (PPE- use of gown and gloves to minimize exposure to hazards that could cause illness). Observation on 03/13/2025 at 2:37 PM, showed Staff W, NAC, was in Resident 385's room assisting them with their meal. Further observation showed a garbage bag containing a soiled brief and hospital gown behind Resident 385's wheelchair. A joint record review and interview on 03/13/2025 at 2:46 PM with Staff W, showed an EBP signage on Resident 385's closet door that indicated to gown and glove for high-contact resident care activities. Staff W stated, I did not put the gown on this time when I changed her, dressed her up, and fed her. Staff W further stated they should have worn proper PPE before changing the resident's brief and clothes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/19/2025 at 9:37 AM, Staff F stated that they expected staff to follow the PPE signage inside the room on the closet. Staff F further stated that they expected them to wear proper PPE when caring for residents on EBP. In an interview on 03/19/2025 at 2:48 PM, Staff T stated they expected staff to wear PPE when taking care of a resident on EBP and performing high-contact care. In an interview on 03/19/2025 at 2:48 PM, Staff B stated that they expected staff to wear proper PPE for brief change. 45146 RESIDENT CARE EQUIPMENT Review of the facility's undated policy titled, Cleaning and Disinfection of Resident-Care Equipment, showed, Resident-care equipment can be a source of indirect transmission of pathogens [disease causing bacteria or viruses]. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC [Centers for Disease Control and Prevention] recommendations in order to break the chain of infection . Multiple-resident use equipment shall be cleaned and disinfected after each use. Observation on 03/13/2025 at 9:51 AM, showed Staff BB, NAC, was exiting room [ROOM NUMBER] while pushing a sit to stand lift (mechanical transfer lift device) after transferring the resident in room [ROOM NUMBER]. Further observation showed Staff BB stored the sit to stand lift in the storage room. No cleaning/disinfecting of the sit to stand lift was observed after it was used in room [ROOM NUMBER]. Observation on 03/13/2025 at 11:28 AM, showed Staff W was removing the same sit to stand lift from the storage room and entering room [ROOM NUMBER] to assist Resident 385 with transfer. Further observation showed after assisting Resident 385 with transfer, Staff W stored the lift in the storage room without cleaning/disinfecting it. In an interview on 03/13/2025 at 11:36 AM, Staff W stated they did not clean/disinfect the sit to stand lift before or after using it for Resident 385. Staff W further stated that they were new staff and were not sure when to clean/disinfect the sit to stand lift and stated they would check with their supervisor. At 11:40 AM, Staff W stated that they did not know the requirement to clean/disinfect the sit to stand lift and they should have cleaned/disinfected it before and after using it for Resident 385. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/13/2025 at 3:04 PM, showed Staff CC, NAC, was checking Resident 41's vital signs using a vital sign equipment. After completing the vital sign check of Resident 41, Staff CC left the resident's room and rolled the vital sign equipment to room [ROOM NUMBER] and started checking Resident 5's vital signs. No cleaning/disinfecting of the vital sign equipment observed between residents use. After completing vital sign checks of Resident 5, Staff CC was observed continuing checking the vital sign of Resident 16 in room [ROOM NUMBER]. Staff CC left room [ROOM NUMBER] with the vital sign equipment and entered room [ROOM NUMBER] without cleaning/disinfecting the equipment. Staff CC checked the vital signs of Resident 46 in room [ROOM NUMBER] and left the room and plugged-in the vital sign equipment to an outlet located in the unit's hallway. Staff CC did not clean/disinfect the vital sign equipment between resident use or after completing each task. In an interview on 03/13/2025 at 3:12 PM, Staff CC stated that they would clean the vital sign equipment, After we [were] done with everyone. Staff further stated, We do not clean [the vital sign equipment] in between the residents use unless the resident's arm is visibly dirty. In an interview on 03/19/2025 at 9:13 AM, Staff T stated that they expected staff to clean/disinfect resident care equipment before and after each resident use. In an interview on 03/20/2025 at 8:28 AM, Staff B stated that they expected staff to clean/disinfect resident care equipment between resident use. INDWELLING URINARY CATHETER Resident 41 admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia (an enlargement of the prostate gland) and urinary tract infection (bladder infection). Observations on 03/13/2025 at 8:41 AM, on 03/17/2025 at 8:09 AM and at 10:57 AM, and on 03/18/2025 at 8:43 AM, showed Resident 41 was sitting in a wheelchair in their room. Further observation showed their indwelling urinary catheter drainage bag was hanging on the side of their wheelchair and was touching the floor. There was no barrier placed between the drainage bag and the floor. Observations on 03/14/2025 at 2:59 PM and on 03/18/2025 at 8:43 AM, showed Resident 41's indwelling urinary catheter drainage bag was hanging under their bed. Further observation showed the resident's bed was placed in low position and the drainage bag was touching the floor. A joint observation and an interview on 03/19/2025 at 10:33 AM with Staff V, showed Resident 41 was sitting in a wheelchair and their catheter drainage bag was hanging from the right side of their wheelchair and touching the floor. Staff V stated the drainage bag should not have touched the floor. In an interview on 03/20/2025 at 8:46 AM, Staff B stated that their expectation was that the catheter drainage bag should not have touched the floor. Staff B further stated when the resident's bed was placed in the lowest position, there should have been some kind of barrier placed between the drainage bag and the floor. Reference: (WAC) 388-97-1320 (1)(a)(c)(5)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49619 Based on interview and record review, the facility failed to ensure residents and/or their representative were provided information about COVID-19 (an infectious disease-causing respiratory illness) vaccinations, including risks, benefits, potential side effects, documented if the vaccine was accepted and/or refused in the medical record for 2 of 5 residents (Residents 22 & 63), reviewed for COVID-19 immunizations. This failure placed the residents at risk for COVID-19 infection and denied the residents and/or their representative of the right to make informed decisions. Findings included . Review of the Centers for Disease Control and Prevention online document titled, Staying Up to Date with COVID-19 Vaccines, dated 01/07/2025, showed that everyone ages 6 months and older should get a 2024-2025 COVID-19 vaccine. It showed that for people ages 12-[AGE] years are up to date when they have received one dose of the 2024-2025 COVID-19 vaccine. It further showed that for people ages [AGE] years and older are up to date when they have received two doses of any 2024-2025 COVID-19 vaccine 6 months apart. Review of the facility's undated policy titled, COVID-19 Vaccination, showed, It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine. It showed COVID-19 vaccinations would be offered to residents when supplies were available, as per CDC and/or FDA guidelines, unless medically contraindicated, the individual had already been immunized or refused the vaccine. The policy showed the facility would educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such. The policy further showed in case of lack of availability of the COVID-19 vaccine, the facility would demonstrate the vaccine had been ordered, plans were developed on how the vaccines would be administered, residents would be screened and determined those who wished to receive the vaccine, and education regarding the immunization was implemented. RESIDENT 22 Resident 22 admitted to the facility on [DATE]. Review of the Electronic Health Record (EHR) showed no documentation that Resident 22 had been offered, accepted or refused, and/or provided education about the 2024-2025 COVID-19 vaccine. On 03/18/2025 at 1:00 PM, Resident 22 stated they would like the COVID-19 vaccination. RESIDENT 63 Resident 63 admitted to the facility on [DATE]. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 63's EHR showed no documentation that Resident 63 had been offered, accepted or refused, and/or provided education about the 2024-2025 COVID-19 vaccine. In an interview on 03/18/2025 at 1:33 PM, Staff B, Director of Nursing, stated that their process in the year 2024 was to offer COVID-19 immunizations during their vaccine clinic that occurred in October 2024. Staff B stated they had a limited number of vaccines and would prioritize long term residents first, staff, and then short-term residents if any were remaining. Staff B stated that they would expect to administer the vaccines depending on the availability and soon, and if not available, let the resident know that is out of our control. Staff B stated that consents for immunizations served as documentation to show that the resident and/or representative were educated on the risks and benefits of the vaccine. In a phone interview on 03/19/2025 at 1:54 PM, Staff GG, Pharmacist, stated that they did a vaccine clinic on 10/15/2024 with the facility and would be informed approximately how many vaccines would be needed, and would try to bring extra. Staff GG stated that vaccine availability was not a huge problem and would offer to come back if a lot of people were missed and do a follow-up clinic. In a follow up interview on 03/19/2025 at 2:21 PM, Staff B stated that Resident 22 was not offered a COVID-19 vaccine because they admitted in November 2024 after their vaccine clinic in October 2024. Staff B stated that they were going to have another clinic in April 2025, and it would be offered then. Staff B stated that Resident 63 was not offered a COVID-19 vaccine and did not want one when they recently offered it on 03/18/2025. Staff B further stated that Resident 22 and Resident 63 were not offered COVID-19 vaccines because they were short term residents at the time of the vaccine clinic in October 2024. No reference WAC