STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505474	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha and Mary Health Service	19160 Front Street Northeast Poulsbo, WA 98370

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure residents and/or their representatives were provided accurate information regarding the risks and benefits associated with proposed drug therapies for 2 of 5 sampled residents (Residents 11 & 73) reviewed for unnecessary medications. The failure to accurately identify medication/drug class and associated adverse side effects (ASEs) detracted from residents' ability to make informed decisions about proposed drug therapies, and placed them at risk for making treatment decisions based on inaccurate information. Findings included . Review of the facility's Psychotropic Drug Utilization policy, dated 12/2024, showed a psychotropic drug was defined as any drug that affects brain activities associated with mental process and behavior. In the event a psychoactive medication was ordered, licensed staff would obtain informed consent for the use of the medication prior to initiating therapy. 1) Review of the Electronic Health Record (EHR) showed Resident 11 was admitted on [DATE]. Resident 11 had diagnoses of depression (decreased pleasure or interest) and post-traumatic stress disorder (PTSD, traumatic event that triggers thoughts/distress/anxiety). Review of the EHR showed Resident 11 was receiving Abilify (anti-psychotic medication, decreases symptoms of disconnect with reality) for depression and post traumatic stress disorder (PTSD). The Significant Change Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 11 was able to make needs known and was cognitively intact. Review of Resident 11's consent form for Abilify on 04/04/2024 listed Abilify as an antidepressant. During an interview on 12/11/2024 at 11:32 AM, Staff E, Unit Manager/Licensed Practical Nurse, said the purpose of reviewing risk and benefits during consent for psychotropic medications was so residents would know what the side effects were, what the medication did, and how the medication could help them. For informed consent, Staff E said the residents needed to know the class the drug was and what medication they were to receiving. Staff E said that antipsychotic medication consent should go over antipsychotic risks and benefits, and for Resident 11, the Abilify consent was incorrectly done under antidepressant but should have been redone to be an antipsychotic medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/2024 at 2:16 PM, Staff B, Director of Nursing Services, said the resident or their power of attorney needs to be informed about the risk and benefits of psychotropic medications, for informed consent. When asked if the risks and benefits were the same for an antidepressant and an antipsychotic, Staff B said they were not exactly the same. Staff B said Resident 11 should have had their Abilify consent done as an antipsychotic, and it was an error that it was completed as an antidepressant. 37044 2) Resident 73 admitted to the facility on [DATE]. The Annual MDS, dated [DATE], showed the resident was cognitively impaired, had diagnoses of anxiety, depression and agitation, and received antianxiety, antidepressant and antipsychotic medication during the assessment period. On 10/11/2024 a new order was obtained for Nuedexta (a central nervous system agent) daily for pseudobulbar affect (PBA, causes episodes of uncontrollable laughing, crying, or anger that were unrelated to mood). An Authorization for Psychoactive Medication consent form, dated 12/11/2023, showed staff presented Nuedexta to the resident as an antipsychotic medication and a mood stabilizer. The indications for use were documented as calling out, yelling, and dementia with behaviors (agitation). On 12/12/2024 at 12:38 PM, when asked if Nuedexta was accurately identified as an antipsychotic medication and mood stabilizer Staff L, Unit Manager, stated, No. When asked if calling out, yelling, and dementia with agitation were appropriate indications for use of Nuedexta, Staff L said no and acknowledged Resident 73 was provided inaccurate drug information for Nuedex, to include the drug class, indications for use and potential adverse side effects. Reference WAC 388-97-0300(3)(a), -0260, -1020(4)(a-b)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50392 Based on observations, interview, and record review the facility failed to obtain an assessment, orders, consent, and develop a care plan for the use of potential restraints for 1 of 4 residents (Resident 91) reviewed for physical restraints. This failure placed residents at risk for potential injury, potential restraint, unmet care needs, and a diminished quality of life. Findings included . Resident 91 readmitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set, an assessment tool, dated 09/19/2024, showed Resident 91 was dependent with mobility abilities, was rarely/never understood, and was moderately impaired for daily decision making. On 12/10/2024 at 2:49 PM, Resident 91 was observed in bed with body pillows (longer than standard pillows) on both sides of their bed positioned under the fitted sheet. Review of Resident 91's Electronic Health Record showed no assessment, consent, orders, or care plan documentation for the body pillows. On 12/11/2024 at 8:45 AM, Resident 91 was observed eating breakfast in bed with body pillows on both sides of the bed positioned under the fitted sheet. On 12/12/2024 at 6:23 AM, Resident 91 was observed to have one standard pillow on the left side of their bed, positioned under the fitted sheet. On 12/12/2024 at 6:52 AM, Staff J, Certified Nursing Assistant, when asked why body/standard pillows had been placed for Resident 91, Staff J said staff put pillows there because Resident 91 moved back and forth, could turn themselves, and sometimes their feet would slide off the bed. Staff J said they knew the pillow should not be under the fitted sheet and they were placed there to keep Resident 91 from falling out of bed. On 12/12/2024 at 12:12 PM, Staff L, Unit Manager, said they were conducting an audit for the use of body pillows due to there not being orders, care plan, or consent and those things should have been done, especially if the resident could not remove the pillows themselves. When asked about an assessment for bed pillows, Staff L said she would have to follow up with the Director of Nursing (DNS), and she believed a policy discussion was on the horizon. On 12/13/2024 at 2:03 PM, Staff B, Director of Nursing Services, said for the use of body/bed pillows his expectation was that an assessment, consent, orders, and a care plan would be done, and these had not been done. Reference WAC 388-97-0620(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** 50945 Based on interview and record review, the facility failed to ensure Minimum Data Set Assessments (MDS), assessment tool, were accurate for 2 of 25 sampled residents (Residents 54 and 11). This failure placed residents at risk for unidentified and unmet care needs and a diminished quality of life. Findings included . 1) Review of the Electronic Health Record (EHR) showed Resident 54 was admitted on [DATE]. Resident 54 had diagnoses of retention of urine and neuromuscular dysfunction of the bladder (problem with bladder control). Resident 54 had a suprapubic catheter (small tube that drains urine from bladder by an incision through the abdomen). Resident 54's Annual MDS, dated [DATE], documented they had an indwelling catheter (including suprapubic catheter and nephrostomy tube) and for urinary continence that they were always incontinent (no episodes of continent voiding). Further review of the MDS showed that for urinary continence another option that was available but was not selected was, Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days). During an interview on 12/13/2024 at 10:10 AM, Staff B, Director of Nursing Services (DNS), said they had spoken to the MDS nurse and clarified that Resident 54 had a catheter and should not have been coded as incontinent, and this did not meet expectations. Review of an email communication on 12/13/2024 at 10:37 AM, showed Staff G, MDS Nurse/Registered Nurse (RN) stated, Continence is coded 'not rated in the MDS anytime a resident has a urinary catheter for all 7 days regardless of catheter changes or leaking. 2) Review of the EHR showed Resident 11 was admitted on [DATE]. Resident 11 had diagnoses of depression (decreased pleasure or interest), anxiety (increased stress), and post-traumatic stress disorder (traumatic event that triggers thoughts/distress/anxiety). Review of Resident 11's Level 2 Preadmission Screening and Resident Review (PASRR, a screening form for mental illness and/or intellectual disability), dated 10/07/2023, provided the facility with information on interventions to help care for Resident 11. Review of the Significant Change MDS, dated [DATE], showed that Resident 11 did not have a Level 2 PASRR selected. For the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition, the form had No selected. This left the rest of the questions related to the Level 2 PASRR conditions blank. During an interview on 12/12/2024 at 10:30 AM, Staff H, MDS Manager/RN, said Resident 11's 10/15/2024 MDS was documented incorrectly, the Level 2 PASRR should have been documented, and that they needed to modify it. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/13/2024 at 11:53 AM, Staff B, DNS, said it did not meet expectations that the Level 2 PASRR was not documented in the MDS for Resident 11. Reference WAC 388-97 -1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) assessment accurately reflected the resident's mental health diagnoses and Level II PASRR evaluations were timely referred and completed for 1 of 5 residents (Resident 73) reviewed for PASRRs. The failure to ensure Level I PASRRs were accurately completed, and residents were timely referred for Level II PASRR evaluations, placed residents at risk for inappropriate placement, and not receiving timely and necessary mental health services to meet their mental health needs. Findings included . Resident 73 admitted to the facility on [DATE]. The Annual Minimum Data Set Assessment, dated 09/25/2024, showed the resident was severely cognitively impaired, and had diagnoses of non-Alzheimer's dementia (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform basic tasks) with agitation, and anxiety (a common reaction to stress that can cause physical, mental, and behavioral symptoms) and depressive (a serious mental illness that can affect how you feel, think, and act) disorders. A Mental Health Evaluation, dated 03/06/2023, documented Resident 73 had active diagnoses of major depressive disorder, anxiety disorder and dementia with agitation. A Level I PASRR dated 01/24/2023, documented Resident 73 had a diagnosis of anxiety disorder and determined a Level II PASRR evaluation referral was required for serious mental illness. The assessment did not include the resident's depressive disorder or dementia with behaviors/agitation diagnoses. Review of Resident 73's Electronic Health Record revealed no documentation for a Level II PASRR evaluation. On 12/16/2023 at 9:09 AM, Staff M, Social Services Clinician, said Resident 73's Level I PASRR was inaccurate and needed to be redone. Documentation was requested to show the resident's level II PASRR evaluation referral was made and/or the evaluation had been completed. No further documentation was provided. Reference: WAC 388-97-1915 (1)(2) (a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to review, revise and implement a comprehensive plan of care to included resident specific information for 5 of 25 sampled residents (Residents 59, 78, 91, 11 & 51) reviewed for care plans. The failure to establish care plans that were individualized, accurately reflected assessed care needs and provided direction to staff, placed residents at risk to receive inappropriate and inadequate care to meet their individualized needs. Findings included . 1) Resident 59 was admitted to the facility on [DATE] with diagnosis of sleep apnea (a sleep disorder characterized by repeated pauses in breathing during sleep). The Quarterly Minimum Data Set (MDS), an assessment tool, dated 11/06/2024, showed the resident required supervision to substantial assistance with activities of daily living (ADL) and was cognitively intact. Resident 59's altered respiratory status/difficulty breathing care plan, dated 05/16/2022, listed the resident had a continuous positive airway pressure (CPAP, a treatment for sleep apnea and other breathing disorders that involves wearing a mask that delivers a constant stream of pressurized air through the nose during sleep). On 12/12/2024 at 11:01 AM, Staff B, Director of Nursing (DNS), said Resident 59's care plan should include information on how to contact the vendor/pulmonologist if there was a concern or problem with the CPAP and he said they would update the care plan. 2) Resident 78 was admitted to the facility on [DATE] with a diagnosis of chronic pain. The Quarterly MDS, dated [DATE], showed the resident required partial to setup assistance with ADLs and was cognitively intact. A review of Resident 78's care plan, dated 04/11/2024, listed a problem of acute and chronic pain. On 12/11/2024 at 12:57 PM, Staff E, Unit Manager (UM)/Licensed Practical Nurse (LPN), said non-pharmacological interventions (NPIs) should be on Resident 78's care plan and the expectation was that the NPIs would be tailored specifically to the resident. 50392 3) Resident 91 readmitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 91 had diagnoses including dysphagia (difficulty swallowing foods or liquids), and Moderate Protein-Calorie Malnutrition (not consuming enough protein and calories to meet nutritional needs), was rarely/never understood, and it was very important to Resident 91 to do their favorite activities. Review of Resident 91's physicians orders showed the following order for diet, General Diet, diet Dysphagia Ground texture, thin consistency, EBC/fort [Every Bite Counts, fortified] foods to encourage consumption related to unspecified severe protein-calorie malnutrition. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 91's ADL care plan documented interventions for eating and diet as: Independent with eating with set-up. General, regular texture thin fluids. On 12/16/2024 at 11:56 AM, Staff L, UM, said it did not meet expectations that Resident 91's care plan did not reflect the correct diet, and it was incorrect. <Failure to have person centered Care Plan> Review of Resident 91's care plan showed the following under interventions/tasks: when the resident choose not to participate in organized activities, the resident prefers to (SPECIFY) for social and sensory stimulation, initiated 07/01/2024. On 12/11/2024 at 12:05 PM, Staff L, UM said the care plan indicating SPECIFY without including specific information for Resident 91 did not meet expectations for a resident specific care plan. 50945 4) Review of the Electronic Health Record (EHR) showed Resident 11 was admitted on [DATE]. Resident 11 had diagnoses of depression (decreased pleasure or interest) and post-traumatic stress disorder (traumatic event that triggers thoughts/distress/anxiety). The Significant Change MDS, dated [DATE], showed Resident 11 was able to make needs known, was cognitively intact, and had documented delusions. <Pain Management Care Plan> Review of the EHR showed Resident 11 currently received an as needed narcotic (strong pain medication) for pain management, as well as scheduled doses of acetaminophen (mild pain medication). Review of Resident 11's care plans showed a care plan for pain that did not include narcotic usage or non-pharmacological (non-medication) interventions. During an interview on 12/11/2024 at 11:32 AM, Staff E, UM/LPN, said their expectation for the pain care plan was that it would be tailored to the resident, such as how the resident liked to be comfortable and how they wanted their pain managed. For Resident 11, Staff E said they did not see any non-pharmacological interventions for pain management in the care plan, and their expectation was for the narcotic and non-pharmacological interventions to have been included. During an interview on 12/11/2024 at 2:16 PM, Staff B, DNS, said their expectation for a pain management care plan was it should have interventions, it should include non-pharmacological interventions, and it should mention narcotics if they were on any. For Resident 11, Staff B said the care plan missing non-pharmacological interventions for pain management and not mentioning the narcotic Resident 11 was on, should have been addressed. <Psychotropic Non-Pharmacological Intervention Care Plan> Review of Resident 11's EHR showed they were receiving daily psychotropic medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's psychotropic medication care plans showed there were no non-pharmacological interventions listed. During an interview on 12/12/2024 at 11:23 AM, UM/LPN, said they were unable to find non-pharmacological interventions for Resident 11's psychotropic medication in the care plan. <Infection Control Precautions> 5) Resident 59 was admitted on [DATE]. An observation of Resident 59's door from the hallway, on 12/12/2024 at 8:18 AM, showed that they were on a precaution for Aerosol Generating Procedure (AGP, procedure that produce very small particles in the air) overnight. Review of Resident 59's care plans showed that they were receiving CPAP (an aerosol generating procedure) but did not include anything about AGP. During an interview on 12/16/2024 at 9:33 AM, Staff F, Infection Preventionist (IP)/LPN, said the care plan should include if a resident was on an AGP, and for Resident 59 it was not in the care plan and should have been. During an interview on 12/16/2024 at 3:09 PM, Staff B, DNS, said Resident 59 should have had their care plan updated to have shown the interventions being done. 6) Resident 51 was admitted on [DATE]. Review of Resident 51's care plans showed that they were receiving CPAP and did not have a care plan for an AGP. During an interview on 12/16/2024 at 9:33 AM, Staff F, IP/LPN, said Resident 51 also needed to have an AGP care plan. Reference WAC 388-97-1020(1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 6 of 25 sampled residents (Residents 73, 99, 81, 8, 11 and 91) whose care plans were reviewed. These failures placed residents at risk for unmet care needs and diminished quality of life. Findings included . 1) Resident 73 admitted to the facility on [DATE]. Review of the Annual Minimum Data Set (MDS, an assessment tool) showed the resident had severe cognitive impairment, diagnoses of dementia with agitation, and anxiety and depressive disorders. Resident 73 required treatment with antidepressant, antianxiety, and antipsychotic medications during the assessment period. A psychotropic drug use CP, revised 10/25/2024, showed the resident received clonazepam (an anxiolytic medication) and Seroquel (an antipsychotic medication) for anxiety. Staff were directed to monitor behaviors and document them on the behavior flowsheet. The CP did not indicate what behaviors the resident's anxiety manifested, no target behaviors (TBs) were identified that each medication was initiated to treat. On 12/12/2024 at 12:38 PM, Staff L, Unit Manager (UM), said the CP inaccurately identified the diagnosis for the use of Seroquel as anxiety, rather than dementia with severe agitation. Staff L, also said that the specific TB(s) a medication was initiated to treat should be included in the CP. Resident 73 started on mirtazapine (an antidepressant medication) daily on 04/03/2024. The indication for use was depression with a decreased appetite. Loss of interest in food was the identified TB. Review of the psychotropic drug use CP, revised 10/25/2024, showed Resident 73's mirtazapine use was not identified or addressed on the CP. On 12/12/2024 at 12:43 PM, Staff L, UM, said, Resident 73's mirtazapine should have been included on the psychotropic drug CP, but was missed. An order for Nuedexta (a central nervous system agent), dated 03/12/2023, showed it was initiated to treat pseudobulbar affect (PBA, a neurological disorder that causes uncontrollable bouts of emotion such as laughing and crying). Review of the Behavior Monitors CP, revised 10/25/2024, showed the resident was started on Nuedexta for involuntary crying/laughter related to Major Depressive Disorder (MDD), rather than PBA as stated in the order. On 12/16/2024 at 10:47 AM, Staff L, UM, said the CP was inaccurate and needed to be updated/revised to reflect a diagnosis of PBA. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident 99 admitted to the facility on [DATE]. Review of a Behavior Monitors CP, revised 10/29/2024, showed direction to staff to monitor the number of times the target behavior (SPECIFY) related to (SPECIFY Dx), (SPECIFY medication) occurred during the shift. On 12/16/2024 at 10:27 AM, Staff L, UM, said Resident 99's behavior CP was incomplete and needed to be updated to include what psychotropic medication was in use, the supporting diagnosis and the resident specific target behaviors. 50488 3) Resident 81 was admitted to the facility on [DATE] with diagnosis of Guillain-Barre Syndrome (a condition in which the immune system attacks the nerves) and malnutrition (lack of sufficient nutrients in the body). The Quarterly MDS, dated [DATE], showed Resident 81 was moderately cognitively impaired and did not receive nutrition via a feeding tube. On 12/10/2024 at 2:24 PM, review of Resident 81's care plan, revised 09/23/2024, showed a PEG (Percutaneous Gastrostomy) tube (used when someone is unable to eat or drink enough food or liquids to meet their nutritional needs) had been placed on 01/31/2024 and was pending discontinuation. On 12/10/2024 at 2:30 PM, a note from a medical provider, dated 09/27/2024, said the PEG tube was removed on 09/27/2024. On 12/11/2024 at 4:05 PM, Staff C, Assistant Director of Nursing Services, said care plans should be updated quarterly and/or with significant changes, by either the Unit Manager or the MDS nurse. The expectation was that care plans were updated as changes took place. 50945 4) Resident 11 was admitted on [DATE]. Resident 11 had diagnoses of depression (decreased pleasure or interest) and anxiety (increased stress). Review of the Significant Change MDS, dated [DATE], showed that Resident 11 was no longer on hospice (end of life care with limited interventions). Review of Resident 11's care plans, showed that a care plan for psychotropic drug (medication that affects the mental state) use still mentioned that Resident 11 was on comfort care (hospice), and was last revised 10/06/2024, before Resident 11 was discharged from hospice. The same care plan had an intervention, last revised 10/06/2024, for lorazepam (anti-anxiety medication) as needed every two hours for anxiety and/or restlessness. Review of the Electronic Health Record (EHR) showed Resident 11's lorazepam dose was discontinued on 11/7/2024. During an interview on 12/11/2024 at 11:32 AM, Staff E, UM/ Licensed Practical Nurse (LPN), said Resident 11's care plan was not updated since it still mentioned hospice and their care plan should have been revised when they were discharged from hospice. Staff E reported Resident 11 was not receiving lorazepam, that it had been discontinued. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/2024 at 2:16 PM, Staff B, Director of Nursing Services (DNS), said their expectation for revising care plans was for any significant change, change of condition, or any new orders or recommendations from the provider. Regarding Resident 11's care plan mentioning hospice, Staff B said their expectation was that it would have been completed timely and been up to date. 5) Resident 91 was admitted on [DATE]. On 12/11/2024 at 10:20 AM, an observation of Resident 91's door from the hallway showed no signage was posted that indicated the resident required any transmission based precautions. Review of Resident 91's care plan showed an intervention, initiated 12/30/2023, for enhanced barrier precautions (EBP, infection control precaution of wearing gown and gloves during high contact activities during resident care). During an interview on 12/13/2024 at 1:08 PM, Staff F, Infection Preventionist/LPN, said Resident 91 was not on EBP, did not need to be on EBP currently, the care plan needed to be updated, and this did not meet expectations. During an interview on 12/16/2024 at 2:59 PM, Staff B, DNS, said the care plan for Resident 91 should have been updated. 6) Resident 8 was admitted on [DATE]. Review of Resident 8's care plans showed on 07/31/2024, a care plan for aerosol contact isolation had been initiated. Resident 8 was no longer on this precaution on 12/09/2024. During an interview on 12/13/2024 at 1:08 PM, Staff F, Infection Preventionist/LPN said Resident 8's care plan needed to be updated, and their care plan did not meet expectations. During an interview on 12/16/2024 at 3:07 PM, Staff B, DNS, said this did not meet expectations. Reference WAC 388-97-1020(2)(c)(d)

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	505474	A. Building B. Wing	12/16/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 3 of 25 sampled residents (Residents 73, 51 and 40) reviewed for professional standards. Facility staff failed to timely transcribe and timely carry out physician orders, and/or clarify confusing or incomplete orders. Additionally, staff failed to ensure medications were secure, as nurses left the medication cart unlocked when unattended and/or left medication at a residents' bedside without an order to do so, or a self-medication assessment being completed. These failures placed residents at risk for medication errors, complications of treatments, and other potential negative health outcomes. Findings included . <Failure to Clarify Incomplete Orders> 1) Resident 73 admitted to the facility on [DATE]. Review of the Annual Minimum Data Set (MDS, an assessment tool) showed the resident had severe cognitive impairment, a diagnosis of heart failure and required the use of supplemental oxygen (O2) during the assessment period. Resident 73 had a 03/06/2024 order for oxygen one to five liters per minute (1-5L/min) via nasal cannula, to maintain oxygen saturation greater than 92 percent. Review of the November and December 2024 Medication Administration Records (MARs) showed the spaces provided for nurses to document the flow rate of oxygen that was administered had all been struck out (boxes contained Xs). This resulted in nurses failing to document on the MAR, for a six-week period, the amount of oxygen that had been administered. On 12/12/2024 at 12:54 PM, Staff L, Unit Manager (UM), said it was the expectation nurses document the dose of medication they administered on the MAR but acknowledged facility nurses failed to do so. Staff L said nursing should have identified the order was incomplete and/or input into the computer incorrectly, and clarified/corrected the order, but failed to do so. 2) Resident 51 admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident had severe cognitive impairment, a diagnosis of obstructive sleep apnea, and required the use of a non-invasive mechanical ventilator (continuous positive airway pressure/CPAP). Review of Resident 51's physicians' orders showed the following CPAP orders: a) Apply CPAP at bedtime and remove in the AM. b) Wipe down mask (including areas that contact skin) using a damp towel with mild detergent and warm water. Allow mask to air dry out of direct sunlight. Ensure mask is dry before use. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 51's CPAP orders did not include what the ordered CPAP pressure settings were, provide direction to staff to check and refill the humidifier chamber weekly and as needed, or identify that the humidifier chamber should only be filled with distilled water. On 12/16/2024 at 4:25 PM, Staff C, Assistant Director of Nursing Services (ADNS), said facility nurses should have identified Resident 51's CPAP orders were incomplete and called and clarified the orders, but failed to do so. 50392 <Failure to timely transcribe and/or timely carry out laboratory orders> 3) Resident 51 admitted to the facility 07/31/2024. Review of the Significant Change MDS, dated [DATE], showed Resident 51 had diagnoses including heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively) and generalized edema (fluid accumulation that affects the whole body) and was severely cognitively impaired. An order request, dated 11/29/2024, sent by facility staff to Resident 51's physician, documented Resident 51 had significant edema to both lower extremities and was taking Lasix and spironolactone (medications that promotes removal of excess fluid from the body) with little improvement to edema. Further review of the order request showed Resident 51's physician had responded on 12/02/2024 with new orders to draw laboratory tests for basic metabolic panel (BMP) and magnesium, as well as to increase the dose of the medications Lasix and spironolactone. A progress note, dated 12/02/2024, documented Resident 51's physician was in to see the resident and received a orders to increase Lasix to 160 mg [milligram] and increase spironolactone to 50 mg. Labs to be drawn 12/3 BMP and magnesium. A review of the laboratory test results showed labs for BMP and magnesium were not drawn until 12/11/2024. On 12/16/2024 at 3:05 PM, Staff C, ADNS, regarding laboratory tests being ordered for Resident 51 on 12/02/2024 and not being drawn until 12/11/2024, said normally it would be drawn in the next couple of days, especially with a change of medication, it may have gotten missed or wasn't done right away. At 3:18 PM, Staff L, Unit Manager/Licensed Practical Nurse (LPN), said if laboratory tests were ordered she would expect them to be done the next business day. At 3:27 PM, Staff L reviewed the order requisition for Resident 51's labs. Staff L said staff had requested the date of service for Resident 51's labs to be drawn on 12/11/2024, it should have been requested for 12/03/2024. <Failure to lock medication cart> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) On 12/11/2024 at 2:54 PM, a medication cart located on the Bay Unit, outside of room [ROOM NUMBER] was observed with the latch not flush with the cart indicating it was unlocked. The medication drawers were easily opened. At 2:55 PM, a facility guest walked past the unlocked cart. At 3:00 PM, staff walked by the unlocked cart. At 3:01 PM, staff walked past the unlocked cart. At 3:03 PM, staff walked past the unlocked cart. At 3:07 PM, Staff N, Registered Nurse, walked up to the unlocked medication cart, 13 minutes after the initial observation that the cart was unlocked. Staff N said this was their assigned cart and it should have been locked. On 12/12/2024 at 9:24 AM, Staff L, Unit Manager, said her expectation was for the medication carts to be locked when staff were away from them. 5) Resident 40 readmitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed Resident 40 had diagnoses including hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (weakness or paralysis on one side of the body) affecting their left non dominant side, dizziness, repeated falls and was cognitively intact. <Failure to ensure self-administration assessment> On 12/09/2024 observation of Resident 40's bedside table showed a bottle of [NAME] anti-itch lotion with a prescription label on the back. Resident 40 had a physician's order for [NAME] External Lotion 0.5-0.5% (Camphor & Menthol), apply to affected areas topically every 6 hours as needed for skin .resident may self-administer. Review of the Resident 40's care plans showed no documentation that an assessment for the self-administration of [NAME] External Lotion had been completed. At 12:09 PM, Staff L, UM, when asked for documentation for Resident 40 that a self-administration form for [NAME] lotion had been done and documented, Staff L reviewed the Electronic Health Record (EHR) and said they would follow up. At 1:02 PM, Staff L, UM, said they were unable to locate a Self-Administration of Medication assessment tool for Resident 40. On 12/12/2024 at 12:44 PM, Staff B, DNS, said before a resident can self-administer medication a self-administration assessment should be done. <Failure to secure medication observed at bedside> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/2024 at 12:01 PM, Staff O, LPN when shown the medication bottle of [NAME] Lotion on Resident 40's bedside table said medications should not be left at the bedside. Staff O said the [NAME] lotion had been stored at Resident 40's bedside, and it would be best practice for it to be stored at the nurses' station. On 12/12/2024 at 12:44 PM, Staff B, DNS, in regards to Resident 40's [NAME] lotion having been stored at bedside, Staff B said it should have been in the nurses' cart and it should not have been stored at the bedside. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review the facility failed to provide assistance with bathing for 1 of 5 residents (Resident 90) reviewed for activities of daily living (ADLs). The failed practice placed residents at risk for a decline in care and quality of life. Findings included . Resident 90 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 09/04/2024, documented the resident had severe cognitive impairment and required supervision for ADLs. A review of the Point of Care (nursing assistant task documentation) response history for 30 days, the 'Shower Book' and the 'Marina Daily Shower' sheets documented Resident 90 only received a shower on 11/17/2024, 12/02/2024, and 12/08/2024. A review of Resident 90's care plan, dated 11/29/202,3 listed a problem of ADL self-care performance deficit . and an intervention of if unable to perform shower, offer bed bath. On 12/12/2024 at 2:26 PM, Staff E, Unit Manager/Licensed Practical Nurse, said Resident 90 did not receive a shower during the week of November 24th because the shower aide was pulled to the floor. Staff E said the expectation would be that the resident should have been offered a bed bath if they did not have a shower aide that day. At 2:57 PM, Staff B, Director of Nursing Services, said Resident 90 did not get a shower that week because there were staff call outs, and said a bed bath should have been offered. Reference WAC 388-97-1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on interview and record review, the facility failed to implement care and services in accordance with accepted professional standards for 3 of 6 residents (Residents 82, 11, and 99) reviewed for quality of care related to bowel management and hospice services. This failure placed the residents at risk for discomfort and complications related to constipation and risk for substandard care related to lack of coordination with hospice (provides end of life orders/interventions). Findings included . <Bowel management> Facility Bowel Management Policy, dated 2024, said the licensed nurse was to check the bowel record each day. If there was no BM (bowel movement) or small BM, the nurse would implement non-pharmacological interventions. If no BM for three days or more, pharmocological interventions would also be offered. It was the responsibility of the nurse to complete documentation and to notify the medical provider if interventions were ineffective. 1) Resident 82 admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], showed Resident 82 was cognitively intact, needed extensive assistance with activities of daily living, and had a diagnosis of constipation. Review of the Electronic Health Record (EHR) for November and December showed Resident 82 did not have a BM between [DATE] and [DATE] nor between [DATE] and [DATE]. Resident 82 received daily scheduled Miralax (stimulates a bowel movement) 17 grams and Senna Plus two tablets in the AM and two tablets in the PM. PRN (as needed) bisacodyl 5 milligrams was administered on [DATE] and [DATE]. No other PRN bowel meds were documented to have been given. No non-pharmacological interventions were documented. On [DATE] at 12:41 PM, Staff D, Assistant Director of Nursing Services (ADNS), said the expectation was for aides to tell the nurse if a resident did not have a BM for two days. The nurses were expected to look at the dashboard every shift which would show no BM for two days. The nurses would document non-pharmacologic BM interventions. The nurses would document pharmacological interventions, results and/or refusal of BM meds to show attempts were made. On [DATE] at 2:12 PM, Staff C, ADNS, said the expectation was pharmacological and non-pharmacological interventions were implemented no later than day three. when a resident did not have a BM and everything should have been documented. 50945 2) Review of the EHR showed Resident 11 was admitted on [DATE]. Resident 11 had a diagnosis of reduced mobility and was receiving an as needed opioid (strong pain medication, has a potential side effect of constipation) pain medication. Review of the Significant Change MDS, dated [DATE], showed Resident 11 was dependent on staff for cares. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's orders showed an order for MiraLAX powder for no bowel movement for two days. The order also included non-pharmacological interventions to be done before administering MiraLAX, which included: 1. Offered prune juice 2. Encouraged to drink more fluids 3. Increase fiber intake 4. Exercise Further review of the orders showed three more medications ordered to stimulate a bowel movement: a bisacodyl tablet for every 24 hours as needed for constipation if no bowel movement in two days with non-pharmacological interventions to be done before giving, a bisacodyl suppository with non-pharmacological interventions to be done before giving, and for failure of oral bowel medication or suppository, a fleet oil enema could be given once every 24 hours. During a past 30-day look back period on [DATE], Resident 11's bowel elimination record showed that they did not have a bowel movement on: [DATE]-[DATE] (3 days) [DATE]-[DATE] (4 days) During a review of the EHR on [DATE], there were no progress notes found, and no as needed medications provided for the dates listed above. During an interview on [DATE] at 11:32 AM, Staff E, Unit Manager (UM)/Licensed Practical Nurse (LPN), said Resident 11 should have received MiraLAX after the second day of no bowel movement. Staff E confirmed Resident 11 did not have bowel movements on the dates above, and that there was no documentation of the administration of as needed medications or non-pharmacological interventions having been done. Staff E said their expectation for staff was to review the bowel movement record every morning, to have monitored, to have reviewed as needed orders, to have passed the information on in report, and to have administered accordingly and documented. During an interview on [DATE] at 2:16 PM, Staff B, Director of Nursing Services (DNS), said their expectation was for non-pharmacological interventions to be attempted before giving a medication to stimulate a bowel movement. For Resident 11, Staff B said their expectation was for the bowel protocol to have been followed unless refused, and if the bowel protocol was not followed, then there should have been documentation of an attempt at non-pharmacological intervention. 37044 <Hospice> 3) Resident 99 admitted to the facility on [DATE]. Review of the Admission MDS showed the resident had a diagnosis of malignant breast cancer and received hospice services. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospice coordinated plan of care showed it was expired, as it was for the certification period [DATE] - [DATE]. On [DATE] at 2:03 PM, Staff L, UM, confirmed there was not a current hospice plan of care in Resident 99's EHR. When asked how they knew what disciplines and at what frequency the resident was to receive from hospice, Staff L said they were unsure. On [DATE] at 2:11 PM, Staff T, Administrative Assistant, confirmed no current hospice plan of care was present in the hospice binder and indicated they would contact hospice to obtain one. Reference WAC [DATE](1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on observation, interview, and record review, the facility failed to ensure the pressure relieving device was working correctly for 1 of 3 sampled residents (Resident 81) reviewed for pressure ulcers. This failure placed residents at risk for delayed healing and further skin impairment. Findings included . Resident 81 was admitted to the facility on [DATE] with diagnoses of Guillain-Barre Syndrome (a condition in which the immune system attacks the nerves) and malnutrition (lack of sufficient nutrients in the body). The Quarterly Minimum Data Set, an assessment tool, dated 09/23/2024 showed Resident 81 was moderately cognitively impaired, needed extensive assist for activities of daily living, and had one or more unhealed pressure ulcers. On 12/09/2024 at 10:18 AM and 3:30 PM, Resident 81 was observed lying in bed. A pressure relieving mattress was in place with a setting of 5 (1-softest setting through 5-firmest setting). On 12/10/2024 at 10:30AM, on 12/11/2024 at 9:27 AM and 10:57AM, and on 12/12/2024 at 10:26AM and 2:32 PM, Resident 81 was lying in bed. The pressure setting for the mattress was at 5. The 'New Air Mattress Guidelines,' revised 11/2024, under the section 'settings,' stated, Comfort level (on pump): To patient comfort, start at level 3 when placed, heavier patients may need firmer, and lighter patients may need softer (these setting should be included in the Care Guide/Care Plan). Resident 81's care plan, revised on 10/24/2023, indicated an air mattress was in place. Directions were to ensure air mattress was functioning properly each shift. Air mattress was to be set at level 3 due to Resident 81's weight of 107 pounds. On 12/12/2024 at 2:30 PM, Staff S, Wound Management Registered Nurse, said Resident 81 had chronic pressure areas that developed quickly and were hard to heal. When asked if Resident 81 had an air matress, Staff S said the resident did and reviewed the care plan. Staff S said the air mattress was set at level 3 for the last recorded weight of 107 pounds on 11/29/2024. On 12/12/2024 at 12:54 PM, Staff I, Licensed Practical Nurse, said residents on the [NAME] Unit were weighed weekly or more often, if needed. Staff I said air mattress settings were based on weight and nurses should be monitoring the air mattress settings for accuracy each shift. On 12/13/2024 at 12:56 PM, Staff D, Assistant Director of Nursing Services, said pressure reducing mattresses were set per manufacturer guidelines and weight. Staff D observed Resident 81's mattress was at the level 5 setting and said it should have been on level 3 for maximum effectiveness. The setting should be on the Treatment Administration Record, a monitoring tool for nurses, to be signed off on each shift. Staff D did not know why a weight had not been obtained for Resident 81 since 11/29/2024. WAC -388-97-1060 (3)(a)

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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** 37044 Based on observation, interview and record review, the facility failed to ensure oxygen (O2), continuous positive airway pressure services (CPAP, an external device that provides a fixed pressure to keep breathing airways open while you sleep), and breathing treatments via nebulizer (a machine that turns liquid medicine into a mist that can be inhaled) were provided in accordance with accepted professional standards of practice for 3 of 5 residents (Residents 73, 51 and 81) reviewed for respiratory care. The failure of staff to document the amount of O2 administered, to ensure O2 orders included checking and replacing of humidifier bottles, and CPAP orders included the prescribed pressure settings, type of mask to be used (e.g. nasal pillows, nasal mask, full face mask), direction to check and refill the humidifier reservoir, and identification of the solution to be used (e.g. distilled water), placed residents at risk for ineffective assisted ventilation and unmet respiratory needs. Findings included . Review of the facility's Oxygen Administration policy, dated 12/2024, showed oxygen tubing, nasal cannulas, humidifier bottles, and the O2 external filter on O2 concentrators, should be changed weekly. Review of the facility's CPAP/BIPAP Support policy, dated 2024, showed it directed staff to: a) Set the settings on the CPAP machine as prescribed. b) Wipe the machine down with warm soapy water and rinse at least once a week. c) Refill humidifier chamber with clean distilled water only. d) Clean the humidifier chamber weekly and dry. e) to disinfect the humidifier chamber, place vinegar-water solution (1:3 ratio) into humidifier. Soak for 30 minutes and rinse thoroughly. Review of the facility's Departmental (Respiratory Therapy) Prevention of Infection Policy, dated 2024, under subtitle Infection Control Related to Medication Nebulizers/Continuous Aerosol showed it directed staff to: 1. Obtain equipment (i.e., administration set-up, plastic bag, gauze sponges). 2. Wash hands. After completion of therapy: 1. Remove the nebulizer container; 2. Rinse the container with fresh tap water; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Dry on a clean paper towel or gauze sponge. 4. Take care not to contaminate internal nebulizer tubes. 5. Wipe the mouthpiece with damp paper towel or gauze sponge. 6. Store the circuit in plastic bag, marked with date and resident's name, between uses. 7. Wash hands. 8. Discard the administration set-up every seven (7) days. <Oxygen Services> 1) Resident 73 admitted to the facility on [DATE]. Review of the Annual Minimum Data Set (MDS, an assessment tool) showed the resident had severe cognitive impairment, a diagnosis of heart failure and required the use of supplemental O2 during the assessment period. On 12/10/2024 at 9:14 AM, Resident 73 was observed lying in bed receiving O2 via nasal cannula (NC) at 2 liter per minute (L/min). Observation of the O2 concentrator showed there was a humidifier bottle attached, dated 12/03/2024 that had approximately 1/4 inch of fluid remaining and only bubbled sporadically. Resident 73's physicians' orders showed the following 03/06/2024 O2 orders: a) O2 at 1-5 L/min via NC, titrate to keep O2 saturation (O2 sat) above 92 percent. b) Change oxygen tubing once a week on Tuesdays. The orders did not include instruction to staff to check and replace the humidifier bottle as needed or direct staff to clean the O2 concentrator external filter weekly. Review of the November and December 2024 Medication Administration Records (MARs) showed for the O2 at 1-5 L/min via NC, titrate to keep oxygen saturation (SpO2) above 92 percent, order, staff were provided a place each shift to document the resident's O2 sat and the number of hours the O2 was in use. No place was provided to document how many L/min of O2 the resident was administered. Additionally, there was no direction to staff to change the resident's humidifier bottle or to replace the external filter on the O2 concentrator weekly, as directed in the facility policy. On 12/12/2024 at 12:54 PM, when asked if they could determine how many L/min of O2 the resident received each shift from 11/01/2024 - 12/12/2024 Staff L, Unit Manager, stated, No. Staff L said it was the expectation that each nurse document on the MAR how many L/min of O2 the resident was administered to maintain their O2 sat greater than 92 percent, but acknowledged they failed to do so. Staff L then explained that direction to staff to change the O2 concentrators external filter and humidifier bottle weekly, should have been included in Resident 51's O2 maintenance orders, but was not. <CPAP Services> (continued on next page)

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	505474	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha and Mary Health Service	19160 Front Street Northeast Poulsbo, WA 98370

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident 51 admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident had severe cognitive impairment, a diagnosis of obstructive sleep apnea, and required the use of a non-invasive mechanical ventilator (CPAP). Review of Resident 51's physician's orders showed the following CPAP orders: a) Apply CPAP at bedtime and remove in the AM. b) Wipe down mask (including areas that contact skin) using a damp towel with mild detergent and warm water. Allow mask to air dry out of direct sunlight. Ensure mask is dry before use. The orders did not include what the ordered CPAP pressure settings were, direction to staff to check and refill the humidifier chamber with clean distilled water only, and to clean the humidifier chamber weekly or to disinfect the humidifier chamber utilizing a 1:3 ration of vinegar and water. On 12/16/2024 at 4:25 PM, Staff C, Assistant Director of Nursing Services (ADNS), said Resident 51's CPAP orders should have included the ordered CPAP pressure settings, direction to staff to check and refill the humidifier chamber weekly and to disinfect the humidifier chamber to use a 1:3 ratio of water and vinegar and let soak for 30 minutes before thoroughly rinsing the chamber out. 50488 <Nebulizer Services> 3) Resident 81 admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 81 was moderately cognitively impaired and had diagnoses of respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body) and chronic (continuing over a long period of time) cough. On 12/09/2024 at 10:18 AM, Resident 81 was observed lying in bed. A nebulizer machine was noted to be on the right side table. The tubing was labeled 12/04 and the mouth piece was attached to the nebulizer container. The set was in a unlabeled plastic bag. Resident 81's care plan, revised 06/14/2024, noted Resident 81 had an altered respiratory status and was at high risk for developing pneumonia (an infection that inflames the air sacs in the lungs) and/or acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions). Treatments via the nebulizer and the care of associated equipment were not on the care plan. The MARs showed a start date of 02/05/2024 for Ipratropium-Albuterol Solutuion 0.5-2.5 (3)mg (milligram)/3ml (millileter) two times a day for wheezing/SOB (shortness of breath). Document lung sounds prior to treatment and post treatment. Document time to set up, administer, assess, and clean equipment and inhale three milliliters orally every four hours as needed for wheezing/SOB. Document lung sounds prior to treatment and post treatment. Document time to set up, administer, assess and clean equipment. There was no documentation for lung sounds or for cleaning of the equipment. There were no directions on how to clean, replace, or store the equipment. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/2024 at 12:00 PM, Staff D, ADNS, said the nurses should be following the policy on how to care for the nebulizer equipment. Staff D said the instructions should have been on the Treatment Administration Record (TAR) so nurses could sign off when it was completed. On 12/13/2024 at 1:57 PM, Staff C, ADNS, said the expectation was that the cleaning and care of the nebulizer equiment needed to be on the TAR and that nurses would sign off once completed. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview, and record review the facility failed to comprehensively assess residents for the use of bed rails/mobility bars for 4 of 5 residents (Residents 11, 51, 40,and 91) reviewed for physical restraints. This failure placed residents at risk for potential injury, potential restraint, unmet care needs, and a diminished quality of life. Findings included . Review of the facility policy, titled Proper Use of Side Rails, revised 09/2024, documented side rails will not be offered to residents on admission. A full assessment will be completed and informed consent obtained prior to authorizing the use of side rails. 1) Review of the Electronic Health Record (EHR) showed Resident 11 was admitted on [DATE]. Resident 11 had diagnoses of depression (decreased pleasure or interest), anxiety (increased stress), and post-traumatic stress disorder (traumatic event that triggers thoughts/distress/anxiety). The Significant Change Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 11 was able to make needs known and was cognitively intact, but had documented delusions. The MDS showed that Resident 11 was dependent (helper does all the effort) for positioning for: 1. rolling left to right 2. sit to lying 3. lying to sitting on side of bed 4. sit to stand 5. chair to bed transfer Review of Resident 11's document, titled Assessment and Consent for Safety Enabling Device-V2, dated 04/04/2024, showed that Resident 11 had bilateral side rails 1/2 size for bed mobility. The form had a section that said Explain Why it is not a restraint and filled in is the answer enhanced bed mobility. Review of the document showed that it was missing: 1. Any attempt to use an alternative 2. Assessment of the resident for risk of entrapment prior to installation Review of Resident 11's orders showed the side rails, ordered 04/04/2024, were for enhanced mobility and were not to be used for patients with confusion or altered mental status unless recommended by therapy. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 11 had a fall on 07/23/2024. A progress note from later that day described Resident 11 as having hallucinations, and telling staff they wanted to get into bed despite already being in bed. During an observation and interview on 12/12/2024 at 8:25 AM, Resident 11 had upper bilateral bed rails/mobility bars in an up position. Resident 11 said they were never instructed on how to lower them, did not use the mobility bars to independently position in bed, and only used the mobility bars when being repositioned by staff. During an interview on 12/13/2024 at 9:15 AM, Staff E, Unit Manager (UM)/LPN, said normally Physical Therapy/Occupation Therapy (PT/OT) was responsible for an evaluation within the first 24 hours of admission, to assess whether mobility bars were appropriate for the resident. Staff E said consent was required because they could be considered a restraint, and then the resident would need an order and care plan. When asked when mobility bars were contraindicated, Staff E said for residents that no longer need them, such as from a change of condition. In this situation, then a reevaluation would be needed to determine if they were appropriate or if it was unsafe. Documentation was requested to show if Resident 11 had any assessment completed, related to mobility bar safety, continued necessity and re-assessments after the 07/23/2024 fall. During a follow up interview on 12/13/2024 at 1:53 PM, Staff E, UM/LPN, said the requested documentation did not exist. Staff E said their expectation was for better assessments for mobility bars in resident rooms, and that the lack of documentation did not meet expectations. During an interview on 12/16/2024 at 3:25 PM, Staff B, Director of Nursing Services (DNS), when provided the list of documentation requested for Resident 11 that did not exist, said it did not meet expectations. When asked about Resident 11's fall in July, said it did not meet expectations that it was not reevaluated. 50392 2) Resident 91 readmitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 91 had diagnoses including slurred speech and aphasia (a language disorder that affects a person's ability to communicate), and was rarely/never understood. Review of Resident 91's document titled, Assessment and Consent for Safety Enabling Device, showed no area indicating an evaluation/assessment was done. The form did not identify what less restrictive options were attempted, did not evaluate for safety or entrapment concerns or propose ways to reduce risks to the resident. Observation on 12/09/2024 at 9:08 AM, showed Resident 91 had two bed rails/mobility bars by the head of the bed, positioned up. On 12/11/2024 at 12:08 PM, Staff L, UM, said Resident 91 had bed rails and they used them. On 12/12/2024 at 6:52 AM, Staff J, Certified Nursing Assistant (CNA), said Resident 91 could not independently release the bed rails/mobility bars. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident 40 readmitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed Resident 40 had diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting their left non dominant side, dizziness, and repeated falls and was cognitively intact. Review of Resident 40's document titled, Assessment and Consent for Safety Enabling Device, showed no area indicating an evaluation/assessment was done. The form did not identify what less restrictive options were attempted, did not evaluate for safety or entrapment concerns or propose ways to reduce risks to the resident. Observation and interview on 12/12/2024 at 7:41 AM, showed Resident 40 had two bed rails/mobility bars by the head of the bed, positioned up. Resident 40 said she could not release the bed rails by herself. 4) Resident 51 admitted to the facility 07/31/2023. Review of the Significant Change MDS dated [DATE] showed Resident 51 had diagnoses that included hemiplegia and hemiparesis affecting their right dominant side and was severely cognitively impaired. Review of Resident 51's document titled, Assessment and Consent for Safety Enabling Device, showed no area indicating an evaluation/assessment was done. The form did not identify what less restrictive options were attempted, did not evaluate for safety or entrapment concerns or propose ways to reduce risks to the resident. Observation on 12/12/2024 at 8:22 AM, showed Resident 51 had two bed rails/mobility bars by the head of the bed, positioned up. On 12/12/2024 at 6:56 AM, Staff J, CNA, said Resident 51 could not independently release the side rails to the downward position. On 12/11/2024 at 2:19 PM, Staff L, UM/LPN, said only the form titled Assessment and Consent for Safety Enabling Device was being done and there was no additional document of a safety assessment done prior to placement of bed rails/mobility bars. On 12/13/2024 at 10:53 AM, Staff B, DNS, said there should be an evaluation/assessment done prior to placement of side rails/mobility bars, and a periodic reevaluation to see if they are still beneficial, safe, and appropriate for the resident. When asked for documentation for Resident's 51, 40, and 91 that an evaluation or assessment had been done for bed rails/mobility bars, Staff B said they would follow up on that. Additional documentation was provided on 12/13/2024 at 1:11 PM, by Staff B, DNS, for Resident 51 and 91. Review of the documentation showed no assessments for side rails/mobility bars. No additional documentation was received for Resident 40. During a follow up interview on 12/13/2024 at 2:03 PM, when specifically asked for bedrail assessments, Staff B, DNS, was unable to provide any documentation that bedrail assessments had been completed. Reference WAC 388-97-1060 (3)(g)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to use nonpharmacological interventions (NPI, nonmedicated methods of achieving an outcome) prior to the use of as needed (PRN) pain medications for 4 of 8 sampled residents (Residents 11, 24, 78 and 355) when reviewed for unnecessary medications and pain. This failure placed residents at risk of avoidable side effects, taking unneeded medications, and a diminished quality of life. Findings included . 1) Resident 78 was admitted to the facility on [DATE] with diagnoses including dementia and chronic pain. The Quarterly Minimum Data Set (MDS), an assessment tool, dated 10/17/2024, showed the resident required partial to setup assistance with activities of daily living (ADLs) and was cognitively intact. A review of Resident 78's Electronic Health Record (EHR) showed an order for oxycodone 5 milligram (mg, a unit of measurement for weight in the metric system) every 4 hours as needed for chronic pain and an order for acetaminophen 325 mg tablet, to give two tablets for mild pain/fever every six hours. A review of Resident 78's Pain Tool, dated 12/10/2024, listed Repositioning Warm blanket/towel Distraction on Phone/Tv Coloring pages as What non-pharmacological interventions reduce pain/discomfort. A review of the Medication Administration Record (MAR) for November 2024 showed Resident 78's PRN oxycodone was given 29 times and the acetaminophen was given 21 times and no NPIs were documented as provided in Resident 78's progress notes. A review of the MAR for December 2024 showed Resident 78's PRN oxycodone was given ten times and the acetaminophen was given five times and no NPIs were documented as provided in Resident 78's progress notes. On 12/11/2024 at 1:36 PM Staff B, Director of Nursing Services (DNS), said he did not see NPIs being documented for Resdient 78 in a progress note and his expectation was that the nursing staff document NPIs more when a resident complains of pain. 50488 2) Resident 355 admitted to the facility on [DATE] with a diagnosis of age-related osteoporosis (a condition where the bones become weak and brittle) with current pathological fracture (bone fracture caused by weakness of the bone structure). The Medicare 5-Day MDS showed Resident 355 was moderately cognitively impaired and was able make needs known. Review of the MAR showed an order for Tramadol (a narcotic used to treat moderate to severe pain). The order was for 100 mg every six hours as needed for pain. Resident 355 received 12 doses from December 1st through December 9th. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 355's care plan, dated 11/21/2024, said to monitor/document the side effects of the pain medication. There was no documentation on the side effects of the pain medication or of NPIs. On 12/10/2024 at 3:21PM, Staff D, Assistant Director of Nursing Services, said the expectation was that pain medications would have side effect monitoring and non-pharmocological interventions on the Treatment Administration Record (TAR). 50945 3) Review of the EHR showed Resident 11 was admitted on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 11 was able to make needs known and was cognitively intact. Review of Resident 11's orders showed that they were being given acetaminophen three times a day for pain and had an order for morphine (narcotic pain medication) as needed for every two hours. Review of the MAR on 12/10/2024, for November 2024 and 12/01/2024 to 12/09/2024, showed Resident 11 received morphine 12 times total in November and only once thus far in December. Pain scores were not found with scheduled acetaminophen administration. Review of the EHR showed no documentation of NPIs used for November and December 2024. Review of the previous five weekly pain assessments showed pain score out of 10 where 1 is mild pain and 10 is worst pain possible: 12/05/2024 no pain location listed, current pain 1, worst pain 1 11/28/2024 no pain location listed, current pain 1, worst pain 1 11/21/2024 no pain location listed, current pain 1, worst pain 1 11/14/2024 no pain location listed, current pain 1, worst pain 1 11/07/2024 no pain location for medications (does mention Orajel for tooth ache); No pain scores provided During an interview on 12/11/2024 at 8:29 AM, Resident 11 said they would be interested in switching to a longer acting medication for pain, had not had any discussion with the facility on changing the morphine order, and was not asked for a pain score every time acetaminophen was given. During an interview on 12/11/2024 at 3:48 PM, Resident 11 said once a week someone came and asked if they were having pain or not, but they did not remember being asked to give a specific number. Resident 11 said they did not know if they needed scheduled acetaminophen three times a day. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/2024 at 11:32 AM, Staff E, UM/LPN, said pain management was reviewed when there was a change of status such as discharging from hospice. When asked for documentation that Resident 11's narcotic pain medication, morphine, was reevaluated after Resident 11 was discharged from hospice, Staff E was unable to provide documentation. Staff E said their expectation was that staff would follow up with the provider on the necessity for pain management, or that a discussion was had on if there was an alternative option. Staff E said there was not a discussion on longer acting pain medication for Resident 11. Staff E reviewed the MAR and reported Resident 11 only received morphine three times thus far in December. Staff E said their expectation for pain management was that staff would use a pain scale, have documented the location of the pain, followed up on if the pain medication was effective, and documented a progress note of the NPIs implemented. During this interview, Staff E confirmed that there was no documentation in the EHR under progress notes of NPIs for pain, for Resident 11. Staff E said there were no pain scores connected to the scheduled acetaminophen dose, that the order needed to be updated to include scores, and that staff would not know if the acetaminophen was effective without the scores. During an interview on 12/11/2024 at 2:16 PM, Staff B, DNS, said their expectation when a resident was discharged from hospice was that medications would have been reviewed for appropriateness and staff should have referred to provider to re-evaluate medications. Staff B said Resident 11 used morphine only 12 times in November 2024, and that number did not reflect that they had persistent chronic pain. When asked if Resident 11 needed every two-hour PRN narcotic pain medication, Staff B said no because Resident 11 was not receiving medication every day. When asked about Resident 11 not having NPIs documented, Staff B said nurses had the opportunity to document in progress notes or the administration record. During this interview, Staff B said for scheduled pain medication, staff always gave the medication even when there was no pain. Staff B said Resident 11 was being monitored weekly with pain assessments for the continued need for acetaminophen. Staff B said the weekly assessments let staff know if the acetaminophen was needed. Staff B stated the resident reported the acetaminophen relieved pain during the last assessment, so the medication was still needed. When asked their expectation if a general resident that received scheduled acetaminophen was having pain scores obtained with each administration and the resident reported no pain each time for a week, Staff B said they would expect staff to review if the medication was needed. 50392 4) Resident 24 was admitted to the facility 04/09/2024. Review of the Quarterly MDS, dated [DATE], showed Resident 24 had a diagnosis of chronic pain and was moderately cognitively impaired. Review of the MARs, dated November 2024 and December 2024, showed Resident 24 had an order for oxycodone every every hours PRN, with no NPIs documented. On 12/16/2024 at 12:16 PM, Staff L, UM said NPIs should be part of the pain medication orders and documented on the MAR. When asked to provide documentation that NPIs had been attempted for Resident 24, Staff L said there was no documentation this had been done. Reference WAC 388-97-1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 AMENDED 01/02/2024 Based on interview and record review, the facility failed to ensure 7 of 7 sampled residents (Residents 11, 73, 78, 27, 62, 22, and 82) reviewed for unnecessary medications were free from unnecessary psychotropic (affect mind, emotions and/or behaviors) medications. Facility staff failed to fully complete the Abnormal Involuntary Movement Scale (AIMS, an assessment used to determine the severity of abnormal movements in a patient's body) for residents using antipsychotic (a class of drugs used to treat mental health conditions characterized by psychosis) medication. The facility also failed to identify, monitor, and document observed target behaviors and non-pharmacological interventions. These failures placed residents at an increased risk for experiencing medication-related adverse side effects, unmet needs, and a diminished quality of life. Findings included . Review of the facility policy titled, Psychotropic Drugs Utilization, dated 12/2024, documented, A. Movement disorder evaluation will be completed (AIMS, DISCUS [Dyskinesia Identification System: Condensed User Scale (DISCUS), assessment tool], etc). This record will remain in the resident's chart. D. Targeted unacceptable behavior will be defined. Acceptable levels of this activity will be indicated in the care plan. (see Target Behavior Reference Guide) E. Specified behaviors to be modified will be defined if applicable. IV. The specific behavior or manifestation of the disordered thought process and the medication side effects to be monitored will be identified for each resident in their Care Plan. V. Data collection will be done on the medication administration record. VII. Documentation of observed adverse reactions will be on the medication administration record and will be summarized monthly. VIII. Staff will continue to document significant behaviors or unusual behaviors or levels of behavior in the progress notes, as they are observed on a daily and shift-to-shift basis . XI. Each psychotropic medication will be monitored separately and documented independently. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Review of the Electronic Health Record (EHR) showed Resident 11 was admitted on [DATE]. Resident 11 had diagnoses of depression (decreased pleasure or interest) and post-traumatic stress disorder (PTSD, traumatic event that triggers thoughts/distress/anxiety). The Significant Change Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 11 was able to make needs known, was cognitively intact, and had documented delusions. Review of Resident 11's orders showed they were receiving two psychotropic medications: 1. Duloxetine (an antidepressant) once a day for major depressive disorder 2. Abilify (an antipsychotic) once a day for PTSD and depression <AIMS Assessment Form> Review of Resident 11's care plan showed they were supposed to have AIMS assessments done every six months and as needed, initiated 02/17/2023, due to being on psychotropic medications. Resident 11's AIMS forms completed on 03/27/2024, 05/01/2024, and 11/01/2024 were reviewed, and all were missing the top section on the form (the part that asks the resident to perform certain tasks). During an interview on 12/11/2024 at 8:29 AM, Resident 11, after reviewing some of the questions from the top of the AIMS form that was blank, said the facility has not asked them to do them. Question seven was reviewed, Ask resident to tap thumb, with each finger, as rapidly as possible for 10-15 seconds: separately with right hand, then with left hand, and Resident 11 said they had not been asked to do that. During an interview on 12/11/2024 at 11:32 AM, Staff E, Unit Manager (UM)/Licensed Practical Nurse (LPN), said Resident 11's last AIMS form was not filled out completely as Resident 11 could complete some of tasks in the section left blank. Staff E said their expectation was to redo the AIMS assessment with all the tasks Resident 11 was capable of completing, with every box filled out with what Resident 11 could and could not complete. During an interview on 12/11/2024 at 2:16 PM, Staff B, Director of Nursing Services (DNS), said the whole form for the AIMS should be attempted. For Resident 11, Staff B said it did not meet expectations that the last AIMS form had the top section blank, and their expectation was that staff would have attempted and documented an attempt to fill out the top of the form, with a reason documented if a question was not performed. <Psychotropic Medication Behavior Monitoring> Review of Resident 11's EHR showed documentation that Certified Nursing Assistant's (CNAs) were documenting that behaviors occurred, with behaviors noted in the past 30 days on: 11/18/2024 at 5:59 AM 11/19/2024 at 8:39 PM (continued on next page)

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	505474	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha and Mary Health Service	19160 Front Street Northeast Poulsbo, WA 98370

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/25/2024 at 9:59 PM Review of Resident 11's EHR, showed no further documentation of follow up to those behaviors being noted. No progress notes were found on those dates. No descriptions of the behaviors were found. During an interview on 12/11/2024 at 11:32 AM, Staff E, UM/LPN, when asked what the process was for behavior monitoring, said the CNA should chart and mark if a behavior happens, but cannot be descriptive. Staff E said some nurses charted on behavior monitoring also, which allowed them to write a progress note. Staff E said that behaviors needed to be monitored to investigate them, in order to know what correct interventions were needed, to determine if social services needed to be involved, if there needed to be a care conference, and if the resident needed to be put on an alert. When asked what behaviors Resident 11 had on 11/18/2024, 11/19/2024, 11/25/2024, Staff E said they were unable to find a progress note for those dates, and their expectation was for nurses to write a progress note if Resident 11 was having behaviors. During an interview on 12/11/2024 at 2:16 PM, Staff B, DNS, said when a behavior was witnessed, the CNAs were to tell the nurses, then the nurses were to provide interventions. Regarding Resident 11's behaviors, Staff B said their expectation was for Resident 11 to have been placed on alert and have monitored behaviors. <Psychotropic Medications Without Non-pharmacological Interventions> Review of Resident 11's EHR showed no documentation of non-pharmacological interventions being implemented, despite Resident 11 receiving psychotropic medication and having documented behaviors. During an interview on 12/11/2024 at 2:16 PM, Staff B, DNS, said for psychotropic medications, CNAs were able to provide non-pharmacological interventions if there were behaviors noted. Staff B said nurses had the opportunity to chart on non-pharmacological interventions when they administered psychotropic medications, and that nurses should chart in the progress notes. During an interview on 12/12/2024 at 11:23 AM, Staff E, UM/LPN, said they were unable to find any documentation that Resident 11 had non-pharmacological interventions done for psychotropic medications. 37044 2) Resident 73 admitted to the facility on [DATE]. Review of the Annual MDS showed the resident had severe cognitive impairment, diagnoses of dementia with agitation, and anxiety and depressive disorders. Resident 73 required treatment with antidepressant, antianxiety, and antipsychotic medications during the assessment period. A psychotropic drug use care plan (CP), revised 10/25/2024, showed the resident received clonazepam (an antianxiety medication) and Seroquel (an antipsychotic medication) for anxiety. Staff were directed to monitor behaviors and document them on the behavior flowsheet. The CP did not indicate what behaviors the resident's anxiety manifested; no specific target behaviors (TBs) were identified that each medication was initiated to treat. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Behavior Monitor CP, revised 10/25/2024, identified the TBs for each psychotropic medications as follows: a) clonazepam- anxiousness as evidenced by calling out. b) Seroquel- agitation related to dementia with inability to self-soothe. c) mirtazapine- diminished appetite or lack of interest in food. d) Nuedexta (not a psychotropic medication)- involuntary crying/laughter, related to Major Depression Disorder. On 12/12/2024 at 12:38 PM, Staff L, UM, said the CP inaccurately identified the diagnosis for the use of Seroquel as anxiety, rather than dementia with severe agitation. Staff L, also said that the specific TB(s) a medication was initiated to treat should be included in the CP. A 09/30/2024, Pharmacist's Recommendation to Prescriber note, showed a recommendation to perform a gradual dose reduction (GDR) of the residents Seroquel to 25 milligrams (mg) three times daily. The recommendation was approved by the physician on 10/02/2024 and implemented. A 11/16/2024, Order Request, documented Resident 73 was calling out multiple times throughout the evening shift. A copy of 09/30/2024 GDR recommendation was attached. The provider responded on 11/18/2024 with an order to return the resident's Seroquel order to 25mg twice daily and 50 mg at bedtime. Review of the EHR showed Resident 73 had not demonstrated any increase in behaviors to include agitation, which had been identified as the target behavior for the use of Seroquel, since the 10/02/2024 GDR was initiated. The 11/16/2024 nurses note and order request was the first time a nurse had documented increased calling out, or any other behavior issues. No documentation was present to support the determination of a failed GDR. Additionally, calling out was the identified TB for the use of clonazepam, not Seroquel. On 12/12/2024 at 1:14 PM, Staff L, UM, confirmed calling out was the identified TB for the use of clonazepam not Seroquel. When asked if there was any documentation to support Resident 73 had demonstrated increased agitation since the Seroquel GDR was performed Staff L stated, not that I see. No further information or documentation was provided to support the determination that the resident had a failed GDR of their Seroquel. 42960 3) Resident 78 was admitted to the facility on [DATE] with diagnoses including depression and anxiety. The Quarterly MDS, dated [DATE], showed the resident required setup to partial assistance with activities of daily living (ADLs) and was cognitively intact. A review of the EHR showed an order for Lexapro (a drug used to treat depression and certain anxiety disorders) 5 milligrams (mg) to be given in the morning for depression and an order for buspirone (an antianxiety medication) 5 mg to be given in the morning for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the EHR showed Behavior Tracking #2 Did monitored behavior, tearfulness, statements of sadness, related to Depression DX r/t use of Lexapro occur during shift? If so, then notify LN.and yes was documented on 11/26/2024 and 12/5/2024. A review of the progress notes revealed no corresponding notes from the nurse. A review of the EHR showed Behavior Tracking #3 Did monitored behavior, break through anxiety AEB panic attacks, related to anxiety dx r/t use of Buspar occur during shift? If so, then notify LN. and yes was documented on 11/21/2024 and 12/3/2024. A review of the progress notes revealed no corresponding notes from the nurse. On 12/11/2024 at 12:57 PM, Staff E, UM/LPN said we don't have behavior monitors and her expectation was that monitors be ordered so that if there were increased depression or anxiety symptoms, an adjustment could be made. On 12/11/2024 at 1:36 PM, Staff B, DNS said the CNAs documented behavior monitoring in Point of Care (POC) and if there were behaviors, the CNAs would report them to the nurse. The nursing staff would charted by exception when Resident 78 has those behaviors. When the DNS was asked if the nursing staff were documenting the behaviors the CNAs were charting for Lexapro and Buspirone, he said I don't see any documentation in the progress notes for Resident 78 . 46793 4) Resident 27 was admitted to the facility on [DATE], with diagnoses including cognitive communication deficit (communication difficulty caused by cognitive impairment), major depressive disorder, anxiety disorder and unspecified dementia (decline in mental abilities that affect daily life), with other behavioral disturbances. The Quarterly MDS, dated [DATE], documented Resident 27 was severely cognitively delayed with limited communication abilities. Resident 27's orders showed they were receiving four psychotropic medications: 1. venlafaxine (an antidepressant) once a day for depression. 2. buspirone (an antianxiety) two times a day for anxiety. 3. lorazepam (an antianxiety) three times a day and PRN for anxiety. 4. mirtazapine (an antianxiety) one time a day for appetite stimulant. Review of Resident 27's EHR showed no documentation or implementation of target behavior monitoring for any of the psychotropic medications. 5) Resident 62 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's Disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks), major depressive disorder, anxiety disorder, unspecified psychosis (a mental health condition characterized by a loss of contact with reality), and unspecified dementia, severe with agitation. The Quarterly MDS, dated [DATE], documented Resident 62 was severely cognitively delayed, with limited communication abilities. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 62's orders showed they were receiving three psychotropic medications: 1. Lexapro (an antidepressant) once a day for depression/anxiety. 2. Seroquel (an antipsychotic) two times a day for agitation. 3. buspirone (an antianxiety) twice a day for anxiety. Review of Resident 62's EHR showed no documentation or implementation of target behavior monitoring for any of the psychotropic medications. On 12/12/2024 at 10:48 AM, Staff B, DNS, said target behaviors and monitoring should have been implemented and documented in the EHR. 50488 6) Resident 82 admitted to the facility on [DATE] and was diagnosed with major depressive disorder on 05/30/2024 and anxiety disorder on 12/02/2024. The Quarterly MDS, dated [DATE], showed Resident 82 was cognitively intact and was able to make needs known. A review of the EHR showed a PRN order for lorazepam (a psychotropic medication that produces a calming effect on the brain and nerves) 0.5mg. Give 0.25mgs every six hours as needed for anxiety until 11/11/2025. The medication start date was 11/11/2024. Directions to staff were: Document behaviors exhibited and non-pharmacological interventions used before giving PRN Ativan: 1. Yelling 2. Inability to self-soothe 3. Temper outburst 4. Inconsolable crying 5 refusing care. Interventions were: 1. Redirection 2. Food/beverage 3. Reassurance 4. Offered activities/exercise 5. Offer warm blanket 6. Manage pain. A review of the December MAR showed Resident 82 had received the PRN dose on the 3rd, the 6th, and the 10th. There was no documentation of behaviors exhibited or of non-pharmacological interventions. On 12/11/2024 at 4:08 PM, Staff C, Assistant Director of Nursing Services (ADNS), said lorazepam should not be ordered as a PRN for longer than two weeks as there was not sufficient documentation by the ordering provider. Behaviors exhibited should have been documented. Non-pharmacological interventions should have been implemented and documented before lorazepam was given. 7) Resident 22 admitted to the facility on [DATE]. The Quarterly MDS dated [DATE], showed Resident 22 was moderately cognitively impaired, was dependent on staff for most ADLs, and had diagoses of depression and dementia. A review of the MAR showed Resident 22 recieved two psychotropic medications: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	buproprion HCl ER (an anti-depressant) oral tablet extended release 100 mg every morning for major depressive disorder. Start date of 12/07/2023. duloxetine HCl (an anti-depressant) oral capsule delayed release 60 mg daily for depression/pain. Start date of 01/30/2024. A review of the CNA November task list showed Resident 22 exibited behaviors on 11/13/2024, 11/14/2024, 11/15/2024, 11/17/2024 and on 11/19/2024. The CNAs charted non-med interventions did not alter behaviors. The charting did not specify what those interventions were. There was no documentation completed by the nurse. On 12/11/24 at 04:08 PM, Staff C, ADNS, said the expectation was that the nurses monitored for side effects and the aides monitored for behaviors. They made a check mark and then were expected to tell the nurse. The nurse was expected to assess, chart, and put the resident on alert. Staff C noted these behaviors were not addressed and that there was a breakdown in the system. Non-pharmacologic interventions and behavior monitoring should have been on the Treatment Administration Record to be signed off by the nurse, for both psychoactives and narcotics. Reference WAC 388-97-1060 (3)(k)(i)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to promptly notify the ordering provider of laboratory results that fell outside of clinical reference ranges for 1 of 5 sample residents (Resident 73) reviewed for unnecessary medications. This failure placed residents at risk for delayed treatment and potential negative outcomes. Findings included . Review of the facility's, Provider Notification - Labs policy, dated 12/2024, showed the facility must promptly notify the attending provider of lab results that fall outside of clinical reference ranges. Delayed notification may contribute to delayed changes to the treatment plan. Promptly meant that results would be relayed with little or no delay to the ordering physician, or in accordance with facility policy regarding which labs require immediate versus non- immediate notification. Lab results requiring non-immediate provider notification could be placed in the providers folder for review upon next visit. 1) Resident 73 was admitted to the facility on [DATE]. The Annual Minimum Data Set, an assessment, dated 09/25/2024, showed the resident had severe cognitive impairment, diagnoses of diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high) and heart failure. Resident 73 received diuretic medication (medications that help reduce fluid buildup in the body) and hypoglycemic medication (medication to maintan blood sugar levels) during the assessment period. Resident 73 had a 03/17/2023 order for metformin (a diabetic medication) daily and a 03/06/2023 order for spironolactone (a diuretic medication, for heart failure) daily. A provider note, dated 05/22/2024, documented Resident 73 had elevated blood glucose levels and had their three-month blood draw scheduled for 05/24/2024. The provider ordered an A1C (a blood test that reflects your average blood glucose levels over the past 3 months) be added to the three month blood draw which also included: a complete blood count (CBC, a blood test used to look at overall health and find a wide range of conditions, including anemia, infection and leukemia); thyroid stimulating hormone (TSH, blood test that measures this hormone); complete metabolic panel (CMP, a routine blood test that measures 14 different substances in a sample of your blood); B-type natriuretic peptide (BNP, high BNP level means you may have heart failure or that your heart failure is getting worse); and vitamin D and B12 levels. Review of Resident 73's electronic health record showed an A1C was not drawn until 07/02/2024, 41 days later. The resident had an elevated A1C of 6.1, outside of the clinical reference range. Review of the lab showed the provider was not notified of the A1C result until 08/05/2024, 34 days after the lab results were available. Additionally, the labs that were to be drawn every three-months (TSH, B12, vitamin D, BNP, CBC, CMP and BNP), as of 12/16/2024, still had not been drawn as ordered. On 12/12/2024 at 1:14 PM Staff L, Unit Manager, confirmed Resident 73's A1C results were outside of the clinical reference range and were not reported to the provider for greater than a month. Staff L acknowledged the labs ordered to be drawn every three-months still had not been drawn. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/2024 at 3:43 PM, Staff C, Assistant Director of Nursing Services, said the labs were to be drawn every three-months and should have already been drawn as ordered. Staff C also said a 34-day delay between receiving lab results that were outside of clinical reference ranges, and notification of the provider, did not meet the expectation of prompt notification of the provider. Reference WAC 388-97-1260(3)(a), (4)(b), -0320(1)(b)

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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** 50945 Based on observation, interview, and record review the facility failed to ensure residents on enhanced barrier precautions (EBP, infection control precaution of wearing gown and gloves during high contact activities during resident care) had precaution signage implemented correctly for 5 out of 14 residents (Residents 19, 576, 59, 24, and 155) reviewed for EBP, that infection control precautions were followed for 2 of 3 residents (Residents 54 and 91) sampled for observation of infection control practices, the antibiotic surveillance was accurate and complete, the Legionella Water Management Program identified and monitored internal areas of risk, and to store and clean continuous positive airway pressure machines (CPAP, device that uses mild air pressure to keep breathing airways open while you sleep) for 1 of 3 residents (Resident 51) reviewed for CPAP. This failure placed residents at risk for spread of infection, health complications, unidentified care needs, and a diminished quality of life. Findings included . Review of the facility policy titled Enhanced Barrier Precautions, reviewed 10/2024, defines enhanced barrier precautions as, the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multidrug-resistant organisms] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The policy showed clear signage will be posted by the door outside of the room and the wall above the resident bed indicating EBP precautions. The policy also showed a True Blue magnet would be used as signage outside of resident rooms on the door frame. Review of the facility policy titled, Influenza, Prevention and Seasonal Control, dated 09/2024, showed under Standard Precautions hand hygiene should be performed by staff frequently, including before and after resident contact, after any contact with potentially infectious material, and before/after removal of PPE such as gloves. < EBP Isolation Precaution Signage> 1) Review of Resident 19's Electronic Health Record (EHR) showed they admitted to the facility on [DATE], were on dialysis and had a wound. Review of the document titled [NAME] Isolation Precautions, provided on 12/13/2024, listed Resident 19 as being on EBP. Observation on 12/10/2024 at 9:34 AM, showed there was no EBP signage for Resident 19's room. 2) Review of Resident 576's EHR showed they admitted to the facility on [DATE] and had a urinary catheter. Observation on 12/13/2024 at 12:47 PM, showed Resident 576 did not have EBP signage posted on the door or in their room. 3) Review of Resident 159's EHR showed they admitted to the facility on [DATE]. Review of the document titled Bay Isolation Precautions, provided on 12/13/2024, listed Resident 159 as being on EBP for a slow healing wound. (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 12/13/2024 at 12:41 PM, showed Resident 159 had no EBP signage outside of their room. 4) Review of Resident 24's EHR showed that they admitted to the facility on [DATE]. Review of the document titled Bay Isolation Precautions, provided on 12/13/2024, did not have Resident 24 listed as being on an isolation precaution such as EBP. During an interview on 12/12/2024 at 8:58 AM, Staff L, Unit Manager (UM)/Licensed Practical Nurse (LPN), said residents with wounds or urinary catheters would need to be on EBP. Staff L said that Resident 24 was no longer on EBP. During an observation and interview on 12/12/2024 at 9:07 AM, Resident 24 was observed to have a True Blue EBP sticker on their side of the room on their wall. Staff L, UM/LPN looked at wall, removed the sign from the wall, and said that the signage was put up for the wrong resident, as Resident 24's roommate, Resident 155, was missing signage. Staff L said Resident 24 no longer needed to be on EBP as they no longer had a wound, but it was possible the signage was left up in error. 5) Review of Resident 155's EHR showed that they admitted to the facility on [DATE] and had a urinary catheter. During an observation and interview on 12/12/2024 at 9:07 AM, Resident 155 was observed to be missing signage for EBP. Staff L, UM/LPN said Resident 155 needed to be on EBP for a urinary catheter. During an interview on 12/13/2024 at 1:08 PM, Staff F, Infection Preventionist/LPN, said it did not meet expectations that Resident 19 did not have EBP signage, Resident 576 should have been placed on EBP, and it did not meet expectations that Resident 159 only had EBP signage inside the room and nonvisible from outside the room. During an interview on 12/16/2024 at 3:07 PM, Staff B, Director of Nursing Services (DNS), said it did not meet expectations that Resident 19 and Resident 576 did not have EBP signage, and there should have been an EBP sticker (sign) outside of Resident 159's room to let staff know there was a precaution. Staff B said it did not meet expectations Resident 24 was on EBP when it was no longer needed or that Resident 155 was not on EBP for a catheter. <Observations of Infection Control Practices> 6) Review of the EHR showed Resident 54 was admitted to the facility on [DATE] and was on EBP for having a suprapubic catheter (small tube that drains urine from bladder by an incision through the abdomen). An observation on 12/12/2024 at 10:17 AM, showed Staff I, LPN, did not wear a gown during catheter care. Further observation showed Staff I only used hand sanitizer/washed hands when entering and exiting the room and missed multiple opportunities for hand hygiene. Staff I hand sanitized, entered room, touched blinds, put on gloves, then provided suprapubic catheter care (involving removal of a soiled gauze), took gloves off, opened blinds, and then washed hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/2024 at 11:15 AM, Staff I, LPN, said for EBP rooms, staff should wear a gown and that they should have worn a gown when caring for Resident 54. Staff I said hand hygiene should be performed after catheter care, going in or out of the room, and if staff touched anything that was 'soiled.' During an interview on 12/13/2024 at 1:19 PM, Staff F, Infection Preventionist/LPN, said it did not meet expectations that staff did not wear a gown in Resident 54's room for suprapubic catheter care and there were multiple opportunities for hand hygiene including after touching blinds or other items in the room. During an interview on 12/16/2024 at 2:58 PM, Staff B, DNS, said it did not meet expectations that staff did not wear a gown during patient care for Resident 54. 7) Review of the EHR showed Resident 91 was admitted to the facility on [DATE] and was not on a special isolation precaution. Observation on 12/12/2024 at 10:13 AM, showed Staff K and Staff J, Certified Nursing Assistants (CNA), provided care to Resident 91 using a Hoyer (assistive equipment for moving a resident). Staff K was observed to wear gloves, then touched multiple surfaces in the residents' room including Resident 91, the resident's wheelchair and the Hoyer lift. The Hoyer was moved out of the room to a storage area. Staff K was observed to not clean the Hoyer and proceeded to go down the hall. During an interview at 12/12/2024 at 10:20 AM, Staff J, CNA, said since the pandemic was no longer a factor, that the Hoyer could be cleaned any time and as needed. Staff J said it was not cleaned before and after use anymore, unless the resident was on an isolation. During an interview on 12/12/2024 at 10:26 AM, Staff K, CNA, said they do not wipe the Hoyer down after every use, only if the resident is on precautions or if it is soiled. During an interview on 12/13/2024 at 1:19 PM, Staff F, Infection Preventionist/LPN, said CNAs should clean the Hoyer between use, the observation and interviews did not meet expectations, and staff would need more education. When asked about the residents that should be on EBP and have no signage, Staff F said that was why staff should clean after each resident. During an interview on 12/16/2024 at 2:59 PM, Staff B, DNS, in response to the observation and interviews regarding the Hoyer, said standard precautions should be followed and staff needed more training on this. <Infection Surveillance> Review of a document provided on 12/10/2024 for October, November, and December 2024 antibiotic line listing (a document that facilities use to monitor residents for infection, to list symptoms of the infection, to show what organism was present in any cultures, what treatment the resident was on, if they met criteria for antibiotics, etc.), showed: 1. Multiple residents had no dates listed for when symptoms started 2. Multiple residents only had one or two symptoms listed (continued on next page)

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	505474	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martha and Mary Health Service	19160 Front Street Northeast Poulsbo, WA 98370

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Multiple residents being treated for urinary tract infection did not have cultures listed 4. Multiple residents were missing outside records for cultures During an interview on 12/12/2024 at 3:03 PM, Staff F, Infection Preventionist/LPN, said the antibiotic line listing should be fully filled out, that not all signs and symptoms were listed on the sheet, and they had missed the onset date for symptoms. Regarding labs, Staff F said the facility had switched labs, they were unable to scan any of the labs into the records, and they were not receiving an end of the month microbiology report from pharmacy, with the last report being given in September 2024. During an interview on 12/16/2024 at 1:06 PM, Staff F, Infection Preventionist/LPN, when asked about Resident 156 having a negative urine sample, said the resident had an additional urine test done by the urologist that was positive for yeast, and the urologist had wanted the resident to stay on the antibiotic and added an additional medication to treat the yeast. Staff F said they did not document the result from the urologist. During an interview on 12/16/2024 at 1:06 PM, Staff F, Infection Preventionist/LPN, when asked about Resident 79 and why the line listing did not include any information on the blood cultures ran at the hospital, due to sepsis (infection of the blood) and urinary tract infection being listed, Staff F said they were unaware the hospital ran blood cultures and did not have a copy of the results. At 1:54 PM, Staff F followed up on what symptoms Resident 79 had (only low blood pressure/hypotension was listed) and said that Resident 79 had pelvic discomfort, hematuria (blood in urine), hypotension, and elevated troponin (test used to measure heart damage). During an interview on 12/16/2024 at 2:44 PM, Staff F, Infection Preventionist/LPN, when asked about Resident 66 and how facial swelling met antibiotic criteria, said Resident 66 had facial swelling, redness, and pain. Resident 66 had a CT/computed tomography scan (a machine that takes a series of X-rays and a computer for images of bones and soft tissue) that showed the resident had parotitis (inflammation of the major salivary gland). Staff F said they did not put this information on the line listing and there should have been more information on the form. During an interview on 12/16/2024 at 2:44 PM, Staff F, Infection Preventionist/LPN, when asked about Resident 82 having the same symptoms listed in both October and December 2024 but not listed as meeting criteria for antibiotics in December, said there were more symptoms that were left off of the antibiotic line list for October, and in December there were less symptoms and those symptoms were now baseline. When asked about Resident 82 being on antibiotics despite the resident not meeting criteria to be on one, Staff F said they did not have documentation of any conversation with the provider. Review of the surveillance documents of residents currently on transmission-based precautions titled Bay Isolation Precautions and [NAME] Isolation Precautions, provided on 12/13/2024, showed the list: 1. Was missing a resident with EBP signage outside their room 2. Had residents on the list, with no EBP signage outside their room (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Had incorrect room numbers for multiple residents During an interview on 12/13/2024 at 1:08 PM, Staff F, Infection Preventionist/LPN, said this form was updated the previous day on 12/12/2024 due to a new admission requiring isolation precaution. When asked about that admission not having signage up on 12/13/2024 for EBP, Staff F said the staff that admitted the resident should have placed the resident on EBP or notified nursing, and they would follow up with admissions. When asked about the room numbers not being updated, Staff F said they could be updating the room numbers. During an interview on 12/16/2024 at 3:07 PM, Staff B, DNS, said the antibiotic line listing should have been more detailed and should have included all of the resident symptoms, and that they will give the infection preventionist more tools to track laboratory values. <Legionella Water Management Program> Review of the facility's document titled, [NAME] & [NAME] Health Services Legionella Water Management Program, revised 08/2024, defined Legionellosis as a condition caused by the bacterium Legionella that can reside in facility water distribution systems. The document had sections for: Areas of Risk, Control Measures and Monitoring Plan and Review Process Review of Areas of Risk showed the facility had not identified any possible internal areas of risk. The document then included ice machines and eye wash stations and explained why there were not considered areas of risk. Review of Control Measures and Monitoring Plan showed the facility was to regularly test hot water temperatures to ensure they were within acceptable limits. No ranges were listed in this section of what temperatures they were monitoring for. During an interview on 12/16/2024 at 1:56 PM, Staff F, Infection Preventionist/LPN, said temperature logs were done daily, that Legionella grew best from 77 to 113 degrees Fahrenheit (F), and then showed documentation of temperature logs. When asked what happens when the temperature was within 77 to 113 degrees F, as was noted frequently on the temperature log shown, Staff F said they continued to monitor for changes, prevented stagnation, and checked on the hot water heater/boiler. When asked if these temperature logs had identified potential areas for Legionella to grow, Staff F said no because water flows through it. Staff F said to prevent Legionella, nothing should stay in the pipes. During an interview on 12/16/2024 at 2:07 PM, Staff R, Project Manager, when asked about the provided documentation of temperature logs provided above, being mostly within the range of temperature Legionella grows best in, said the facility had never identified that area as high risk to test, and that hot water heater/boilers were left at 112 to 113 degrees F to prevent burning residents. When asked about what was done in rooms not being used, Staff R said the empty rooms were cleaned but the faucets did not need to be flushed. When asked if the area from the valve to the faucet had stagnant water in that section of the pipe, Staff R said yes that section had stagnant water, and they should develop a log to track and record flushing the sinks not being used. Review of Review Process showed the Legionella Water Management Program was approved annually by the Quality Assurance and Performance Improvement (QAPI) Team. Documentation was requested on 12/16/2024 at 11:18 AM from Staff F that the program was reviewed by QAPI, and none was provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Legionella Water Management Program included a document titled, Developing a Water Management Program to Reduce Legionella Growth & Spead in Buildings, dated 06/24/2021, a toolkit from the Centers for Disease Control and Prevention (CDC). The toolkit had information for facilities on where Legionella could grow or spread which included: Hot and cold-water storage tanks Water heaters Water filters Faucets Shower heads and hoses Pipes, valves, and fittings Eyewash stations Ice machines CPAP machines During an interview on 12/16/2024 at 1:56 PM, Staff F, Infection Preventionist/LPN, when asked about the CDC list for where Legionella could grow, said the CPAPs would be an area of concern and this would need to be addressed in the policy. When asked how the facility was monitoring the program if there were no identified areas of concern, Staff F said that was a valid concern and they would need to address that in QAPI. During an interview on 12/16/2024 at 3:31 PM, Staff A, Administrator, said their expectation for recognizing risk for Legionella was the facility should explore more avenues than they had been. Staff A said they had not gotten any Legionella test kits because they had not identified any areas of risk. 50392 <Failure to clean CPAP humidifier reservoir> Review of the facility policy titled CPAP/BIPAP SUPPORT dated 2024, documented general guidelines for cleaning: 1. Humidifier (if used): a. use clean, distilled water only in the humidifier chamber. b. clean humidifier weekly and air dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. To disinfect, place vinegar-water solution (1:3) in clean humidifier. Soak for 30 minutes and rinse thoroughly. Resident 51 admitted to the facility 07/31/2024. Review of the Significant Change Minimum Data Set Assessment showed Resident 51 had a diagnosis of obstructive sleep apnea (intermittent airflow blockage during sleep) and was severely cognitively impaired. On 12/10/2024 at 9:48 AM, Resident 51 had a CPAP machine on their bedside table with a humidifier reservoir visible. Review of physician's orders showed Resident 51 used a CPAP machine. No orders were located regarding cleaning of humidifier reservoir. On 12/13/2024 at 2:24 PM, Staff P, LPN, said Resident 51 had a humidifier with a reservoir tank for water placement. On 12/16/2024 at 10:39 AM, Staff Q, Registered Nurse, said the CPAP reservoirs for the humidifier should be cleaned periodically, there should be physician's orders to clean the reservoir, and it should be on the Treatment Administration Record (TAR) to make sure it was getting done. Staff Q could not locate physician's orders or anything on the TAR for the cleaning of the humidifier reservoir for Resident 51. On 12/16/2024 at 12:08 PM, Staff L, Unit Manager said for Resident 51 said they could not locate orders or directions on the TAR for cleaning the CPAP reservoir, there should be orders, and it should be on the TAR. <Failure to store CPAP to prevent contamination/infection> On 12/09/2024 at 4:13 PM and 12/10/2024 at 8:42 AM, observed CPAP machine and mask on Resident 51's bedside table, mask was not in plastic bag and was resting on the tabletop. On 12/11/2024 at 12:33 PM, observed CPAP machine and mask on Resident 51's bedside table, mask was not in plastic bag and was resting on top of a radio that was on tabletop. On 12/12/2024 at 12:23 PM, Staff F, Infection Preventionist/LPN, said her expectation was for CPAP masks be wiped down daily and stored in a plastic bag at bedside after cleaning. Staff F said it did not meet expectations that Resident 51's mask was stored uncovered on the tabletop. On 12/12/2024 at 12:40 PM, Staff B, DNS, said CPAP masks should be stored in a sealed bag or container to prevent infection. Reference WAC 388-97-1320 (1)(a)(c),(2)(a)(b)