STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505475	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Homes Health Center	826 South 218th Street Des Moines, WA 98198

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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. 45941 Based on interview and record review the facility failed to ensure informed consent (a process explaining the risks and benefits of a treatment prior to use) was obtained prior to administration of psychotropic (affecting mental state) medications for 3 of 5 residents (Resident 53, 212, & 213) reviewed for unnecessary medications. This placed residents at risk for unwanted treatment. Findings included . <Facility Policy> According to a facility policy titled, Use of Psychotropic Medication, revised 07/02/2024, the facility would develop psychotropic medication regimens in collaboration with residents/resident representatives. The policy showed residents/resident representatives would be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/nonpharmacological interventions. According to a facility policy titled Promoting/Maintaining Resident Self-Determination, revised 07/29/2024, the facility would ensure each resident had the opportunity to exercise their autonomy. The policy showed the residents rights to determine what, if anything, they would prefer to do or not to do each day would be honored in accordance with physician orders. <Resident 53> Review of Resident 53's records showed a 10/06/2021 Durable Power of Attorney (DPOA) paperwork that designated a Resident Representative (RR) to make decisions for them regarding their healthcare. According to a 09/13/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 53 was severely cognitively impaired. The MDS showed the primary information source was provided by Resident 53's RR. The assessment showed Resident 53 had diagnoses of, but not limited to, anxiety disorder, depression, and age-related cognitive decline. Review of Resident 53's records showed a physician order for an antianxiety medication started on 09/17/2024 and stopped on 10/25/2024. These physician orders showed Resident 53 was ordered another antianxiety medication on 10/28/2024 to be administered twice daily for seven days then double the dose starting on 11/05/2024. Resident 53's records showed no consent was obtained for either medication prior to administration. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 212> Review of Resident 212's physician orders showed a 10/07/2024 antidepressant medication prescribed for sleep, two 10/08/2024 antidepressant medications prescribed for depression and anxiety, and a 10/08/2024 antipsychotic medication prescribed for Parkinson's psychosis. Review of Resident 212's records showed consent forms with no signatures from Resident 212. Resident 212's records had consent forms with verbal consent typed in resident signature area on two separate 10/10/2024 consent forms for the two antidepressants prescribed for depression. Resident 212's records had consent forms with verbal order typed in resident signature area on a 10/10/2024 consent form for an antidepressant prescribed for sleep and an antipsychotic medication prescribed for psychosis. <Resident 213> According to a 09/13/2024 Admission MDS, Resident 213 was moderately cognitively impaired. The assessment showed Resident 213 had diagnoses of, but not limited to, anxiety disorder and depression. The MDS showed Resident 213 was receiving antidepressant medications during the assessment period. Review of Resident 213's records showed a 10/02/2024 physician order for a hypnotic medication and a 10/23/2024 antidepressant medication. Review of Resident 213's records showed three consent forms, a 10/03/2024 for an antianxiety medication with resident signature box left blank and a first name with RR, DPOA typed in authorized persons name & relationship box, a 10/03/2024 for a hypnotic medication with verbal consent from RR typed in under the resident signature box, and a 10/03/2024 consent form for an antidepressant medication with the first name and RR, DPOA typed under the RR or DPOA box. The 3 consent forms for Resident 213 were all signed by Staff E without a witness signature for the verbal consents. In an interview on 10/29/2024 at 12:14 PM Staff E (Registered Nurse, Resident Care Manager) stated consent was not obtained for either antianxiety medication for Resident 53 prior to administration but should have been. Staff E stated they were expected to print the consent forms and obtain a signature, then scan the signed consent forms into the resident's records. Staff E stated when they obtained a verbal consent, they were expected to have two staff/witness sign the consent form. REFERENCE: WAC 388-97-0260.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on interview and record review, the facility failed to thoroughly investigate and rule out abuse/neglect for 1 of 1 sampled resident (Resident 31) reviewed for abuse investigations. Facility's failure to complete a thorough investigation and provide feedback regarding the resident's concerns placed residents at risk for potential abuse and other negative health outcomes. Findings included . <Facility Policy> Review of the facility policy titled, Abuse, Neglect and Exploitation, revised June 10 2024, showed the facility would implement processes to prevent and prohibit all types of abuse or neglect and establish a safe environment. The facility would rule out abuse and neglect by use of identification, assessments, and care planning for appropriate interventions. The policy showed the facility would monitor residents with needs and behaviors which might lead to conflict, and the facility would provide information to staff and residents on how and to whom concerns would be reported. The policy also showed the facility would provide feedback regarding the concerns that were expressed by the resident. <Resident 31> According to the 09/23/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 31 admitted to the facility on [DATE] with multiple complex conditions that included kidney insufficiency, high blood pressure and heart failure. The MDS showed Resident 31 could communicate needs, be understood by others, had weakness and was dependent on the staff to move and transfer. In an interview on 10/22/2024 at 12:37 PM Resident 31 stated the resident from the room next door opened their door and came into their room at 3:30 am the other morning. Resident 31 stated they told staff, but nothing happened, and no one came and talked to them regarding their concern. In an interview on 10/24/2024 at 9:49 AM Resident 31 stated at 3:30 am yesterday, the other resident came into their room again. The other resident had on underwear and t-shirt, came into their room, turned their room light on and asked for a garbage can. Resident 31 stated they called downstairs at 3:30 to let the facility know that a resident came into their room. Resident 31 stated they left a message for the Administrator, and they still have not come to talk to them about this. Resident 31 stated they heard the staff yelling with each other in the hallway about the other resident wandering into rooms. Resident 31 stated on the first occurrence the same resident went to their room and turned the light on and went through their drawers. Resident 31 stated they were a victim of domestic violence, and this was very scary for them. The staff told Resident 31 the other resident roamed around at night and does not sleep. Resident 31 stated nobody had ever talked to them about either of these events and they feel they don't matter to the staff at all. In an interview on 10/24/2024 at 11:13 AM Staff B (Director of Nursing) and Staff C (Social Services Director) stated all staff should fill out a grievance report when an incident was reported by a resident. Staff B and Staff C stated they did not have any grievance reports for Resident 31. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/2024 at 1:38 PM Staff A (Administrator) stated they did not hear about a previous occurrence happening and said staff are now working on a grievance report for the most recent event. Staff A stated the staff should have started the grievance report when the resident first notified staff of the event but did not. REFERENCE: WAC 388-97-0640(6)(a)(b).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45941 Based on interview and record review, the facility failed to ensure a system by which residents/representatives received required written notices at the time of transfer/discharge, or as soon as practicable for 3 of 4 residents (Residents 16, 35, & 46) reviewed for hospitalization s. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> A facility policy titled, Transfer, and Discharge (including AMA) revised on 08/08/2024, showed a notice of transfer/discharge must be provided to the resident/representative when an emergency transfer to an acute care facility is ordered. The policy showed the notice would include the specific reason and basis for transfer, date of transfer, and name of the hospital to which the resident was transferred or discharged . <Resident 16> Review of Resident 16's 03/31/2024 Discharge Return Anticipated Minimum Data Set (MDS- an assessment tool) showed the resident was transferred to an acute care hospital on 03/31/2024. Record review on 10/23/2024 showed no documentation staff provided the required written notification to Resident 16 and/or their representative regarding their transfer to the hospital. <Resident 35> Review of Resident 35's 02/12/2024 Discharge Return Anticipated MDS showed Resident 35 discharged to an acute care hospital on 02/12/2024. Record review on 10/23/2024 showed no documentation staff provided the required written notification to Resident 35 and/or their representative regarding their discharge. In an interview on 10/28/2024 at 12:55 PM, Staff F (Resident Care Manager) stated they did not know about the process for written notification, and they were not being provided to any of the residents transferred to the hospital In an interview on 10/29/2024 at 12:34 PM, Staff B (Director of Nursing) stated it was important to provide a written transfer notification to ensure the resident or resident representative was informed of the reason for transfer and to ensure the transfer was in alignment with the resident's stated goals for care and preferences, but the facility did not follow the facility policy. 50511 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 46> Review of Resident 46's 08/31/2024 Discharge Return Anticipated MDS showed the resident was transferred to an acute care hospital on 08/31/2024. Record review showed an unedited, unsigned, and blank Nursing Home Transfer or Discharge Notice form dated 8/31/2024 in Resident 46's record. No documentation in record that staff provided the required written notification to Resident 46 and/or their representative regarding their transfer to the hospital. In an interview on 10/29/2024 at 12:34 PM, Staff B stated it was important to provide a written transfer notification to ensure the resident or resident representative was informed of the reason for transfer and to ensure the transfer was in alignment with the resident's stated goals for care and preferences, but the facility did not follow the facility policy. REFERENCE: WAC 388-97-0120 (2)(a-d).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) process (a federal requirement to help ensure that individuals who had a mental disorder or intellectual disabilities were offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and received the services they need in those settings), was followed for 1 of 4 residents (Resident 213) sampled for PASRR review. This failure placed residents at risk for not receiving specialized mental health services, unidentified mental health needs and a decreased quality of life. Findings included . <Resident 213> According to the 10/05/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 213 admitted to the facility on [DATE] with multiple complex conditions that included psychiatric mood disorder and confusion. Review of Care Area assessment dated [DATE] showed resident had confusion, behavior and mood disorder. Review of physician orders dated 10/4/2024 showed resident had a diagnosis of depression and anxiety. Review of 10/04/2024 Cognitive Care Plan (CP) showed Resident 213 had impaired cognitive function, and impaired thought processes. Goals listed on the CP was the resident would be free of delirium. Interventions listed on the CP was staff was to report new onset of delirium symptoms such as disorientation, restlessness, agitation and altered sleep cycle and to redirect and reorient to person, place and time as required. Review of the Pre-Admission Screening and Resident Review (PASRR) CP dated 10/4/2024 showed Level 1, Level 2 referral not indicated. Goals were to monitor for significant change and update the PASRR as needed, interventions listed was for staff to monitor for significant changes and to update the PASSR. Review of the clinical record on 10/24/2024 showed the admission PASRR was signed by hospital staff on 09/28/2024. Section 1 of the PASRR form did not have any Serious Mental Illness Indicators checked off for mood or anxiety disorders. Section IV of the form was left blank with no boxes marked to designate if a Level II evaluation was needed or not. No updated PASSR was found since. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/29/2024 at 9:59 AM, Staff C (Social Services Director) verified the PASRR I form was not fully completed by the hospital. Staff C stated the resident did have an increase in antidepressant medication and the resident did wander at night, therefore may need a PASRR II. Staff C stated a PASRR I should have been fully completed as PASRR was important for the resident to be properly assessed and to determine if there were any additional services or interventions needed for the resident. REFERENCE: WAC 388-97-1915 (1)(2).

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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** 45941 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the resident's mental health condition for 1 of 3 (Resident's 14) residents reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and /or not receiving timely and necessary services to meet their mental health needs. Findings included . <Resident 14> According to a 09/19/2024 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 14 admitted to the facility on [DATE]. The assessment showed Resident 14 had diagnoses of, but not limited to, non-Alzheimer's dementia, Seizure disorder, Psychotic disorder, delusional disorders, and unspecified mental disorder due to unknown physiological condition. The MDS showed Resident 14 received antipsychotic medications during the assessment period. Review of Resident 14's records showed a 01/28/2024 physician order for an antipsychotic medication to be administered every morning and a 09/05/2024 antipsychotic medication to be administered in the evening. Records review showed an 08/06/2021 Level I PASRR for Resident 14. This PASRR listed psychotic disorder and delusional disorder as Serious Mental Illness (SMI) indicators. The PASRR I was marked no level II evaluation indicated. In an interview on 10/29/2024 at 9:38 AM Staff C (Social Service Director) stated Resident 14 should have been referred for a Level II PASRR but was not. 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** 45941 Based on observation, interview, and record review, the facility failed to develop and/or implement a comprehensive Care Plan (CP) for 2 of 18 sampled residents (Residents 53, 2) whose comprehensive CPs were reviewed. The failure to develop comprehensive, individualized CPs with resident-specific goals and/or interventions placed residents at risk for unmet care needs and a decreased quality of life. Findings included . <Resident 53> According to a 09/13/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 53 admitted to the facility on [DATE]. The assessment showed Resident 53 was severely cognitively impaired and had a diagnosis of, but not limited to, pain in right hip and other chronic pain. The MDS showed Resident 53 received scheduled and as needed pain medication and was observed to express symptoms of pain three to four days during the seven-day assessment period. Review of Resident 53's records showed a physician order for scheduled pain medication to be administered routinely In an interview on at Staff F (Registered Nurse - Resident Care manager) stated Resident 53 did not have a pain CP but should. Staff F stated it was important to have individualized CPs to provide necessary cares for each resident. <Resident 2> According to the 07/30/2024 Quarterly MDS, Resident 2 had weakness on right side of the body related to a stroke (when part of the brain does not have enough blood flow). Observations on 10/21/2024 at 11:02 AM, 10/22/2024 at 10:56 AM and 2:50 PM, on 10/23/2024 at 11:23 AM, and on 10/24/2024 at 11:07 AM showed Resident 2 was up in their wheelchair, right hand was contracted and had long fingernails. In an interview on 10/24/2024 at 11:12 AM, Staff O (Registered Nurse) stated Resident 2's right hand was contracted and had long fingernails. Staff O stated to provide nail care on the contracted hand was hard for the nursing assistant staff. In an interview on 10/24/2024 at 11:27 AM, Staff H (Certified Nursing Assistant) stated Resident 2's right hand was very contracted, and they were not sure how to provide care to clip fingernails. In an interview on 10/29/2024 at 9:24 AM, Staff F reviewed Resident 2's record and stated there were no instructions for staff to provide care for Resident 2's right contracted hand. Staff F stated there should be a care plan to instruct staff how to provide care for Resident 2's contracted hand, but there was none. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review, the facility failed to ensure Care Plans (CPs) were accurately reviewed and revised to reflect current resident status and needs as required for 3 (Residents 24, 213, & 212) of 17 residents reviewed for CP's. This failure left residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident 24> According to the 09/23/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 24 had a Pressure Ulcer (PU) on their sacrum (triangular bone at base of spine, upper buttocks). The MDS showed Resident 24 required maximal assistance with bed mobility and toileting needs. Review of the 08/09/2024 Skin CP showed Resident 24 had a sacrum PU and was at risk for new PU development. Nursing interventions included Resident 24 needed to be repositioned at least every two hours and more often with two staff members. Observations on 10/22/2024 at 8:33 AM and 11:12 AM, on 10/23/2024 at 8:24 AM and 12:33 PM, and on 10/24/2024 at 8:55 AM and 11:07 AM showed Resident 24 was sitting in the dining room for breakfast and after meals, staff moved Resident 24 to the common area in their wheelchair. All these observations showed Resident 24 was sitting in their wheelchair on their buttocks. In an interview on 10/28/2024 at 1:27 PM, Staff F (Resident Care Manager) stated Resident 24 had PU on their sacrum and they expected staff to reposition the resident in their wheelchair every two hours and as needed. Staff F stated they noticed Resident 24 sitting in their wheelchair in the dining room and then in the common area for activities on their buttocks. Staff F stated staff was supposed to lay Resident 24 back in bed after meals. Staff F reviewed Resident 24's CP and stated staff did not revise the CP to instruct staff to transfer Resident 24 to bed after meals to keep pressure off of their buttocks/sacrum. In an interview on 10/29/2024 at 10:02 AM. Staff B (Director of Nursing) stated they knew the facility had a CP issue. Staff B stated staff should have revised to CPs according to resident's current skin issues but they did not. 50511 <Wandering> <Resident 213> According to the 09/23/2024 Admission MDS, Resident 213 admitted to the facility on [DATE] with medically complex conditions that included high blood pressure, history of urinary tract infections, and muscle weakness. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Functional CP dated 10/03/2024 showed Resident 213 had self-care performance deficit related to memory impairment, confusion, and dementia. Resident 213's CP did not show Resident 213 wandered. Review of the October 2024 care staff task sheet showed the number of times per shift staff were to observe Resident 213 had demonstrated behaviors that caused stress or anxiety to self or other residents. The evening shift staff (2 PM to 10 PM) documented 20 times behavior issues were noted, the night shift (10 PM to 6 AM) documented 43 times behavior was noted. In an interview on 10/24/2024 at 11:24 AM Staff E (Registered Nurse-Resident Care Manager) stated they were aware that Resident 213 was at risk for wandering as they had pictures of the resident in a wander/elopement binder that they kept at the nurse's station. Staff E stated they were only aware that Resident 213 had knocked on another resident's door and was not aware of Resident 213 going into other resident's rooms. In an interview on 10/29/2024 at 1:00 PM, Staff B stated that Resident 213's CP needed to be updated and completed in a timely manner as the CP reflected the care services that were needed for Resident 213. <Transfer Pole> <Resident 212> According to the 10/10/2024 Admission MDS, Resident 212 admitted to the facility on [DATE] with medically complex conditions that included muscle weakness, unsteadiness on feet, and a need for assistance with personal care. Review of the Fall CP dated 10/8/2024 showed Resident 212 was at risk for falls. Interventions listed on the CP showed Resident 212 needed to be evaluated and supplied with appropriate adaptive equipment and devices as needed and that Resident 212 needed a safe environment. The CP did not show a transfer pole listed on the CP. Observation on 10/22/2024 at 9:29 AM showed Resident 212 had a transfer pole installed by the right side of the resident's bed. In an interview on 10/28/2024 at 2:13 PM, Staff E stated they could not find a transfer pole assessment for Resident 212 in the medical record or in the CP. In an interview on 10/29/2024 at 1:12 PM Staff B stated a transfer pole assessment and consent was needed and should have been listed in Resident 212's CP but was not. Staff B stated there was a risk of potential harm if the transfer bar was not used properly. Refer to F689 Free of Accident Hazards Reference WAC 388-97-1020(2)(a)(b).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Homes Health Center	826 South 218th Street Des Moines, WA 98198

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 45941 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL), related to cleanliness and grooming for 5 (Residents 2, 3, 24, 35, & 37) of 17 sample residents reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with showers, shaving, and nail care, placed the residents at risk for poor hygiene, long facial hair, embarrassment, and diminished quality of life. Findings included . <Facility Policy> According to the facility policy titled, Activities of Daily Living, revised 07/26/2024, the facility would provide ADLs in accordance with resident's comprehensive assessment, Care Plan (CP), and resident's needs and choices to ensure a resident's ADL abilities would not deteriorate unless deterioration in function was unavoidable. <Resident 2> According to the 07/30/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 2 had weakness on right side of the body related to a stroke and required maximal assistance with personal hygiene including showers. The MDS showed Resident 2 had no behavior of refusing care during the assessment period. Observations on 10/21/2024 at 11:02 AM, 10/22/2024 at 2:48 PM, and 10/24/2024 at 10:57 AM showed Resident 2 had long facial hair on chin area and long fingernails on right contracted hand. According to the 12/19/2022 ADL self-care performance deficit CP, Resident 2 was dependent on staff for personal hygiene including showers. In an interview on 10/24/2024 at 11:17 AM, Staff O (Registered Nurse) stated they expected staff to check all resident's preferences related to ADLs and provide assistance as needed every morning. Staff O stated staff should have shaved Resident 2's facial hair and clipped fingernails. <Resident 3> Observations on 10/21/2024 at 9:02 AM, 10/22/2024 at 12:25 PM, and 10/25/2024 at 10:01 AM showed Resident 3 was lying in bed, had long fingernails and greasy hair. According to the revised 11/12/2023 ADL self-care performance deficit CP, Resident 3 was dependent on staff for personal hygiene including shower related to poor balance and left side vision blind. The CP included the interventions for the staff showed Resident 3 preferred a shower twice a week and required maximal to total assistance with shower, and one person assistance with nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/29/2024 at 1:00 PM, Staff F (Resident Care Manager) stated Resident 3 refused the care at times. Staff F reviewed Resident 3's record and confirmed no shower was provided and documented for the last 30 days. Staff F Stated staff should have provided showers and nail care on scheduled shower days but they did not. <Resident 24> According to the 09/23/2024 Quarterly MDS, Resident 24 was required total assistance with personal hygiene and showers. The MDS showed Resident 24 had no behavior of refusing care during the assessment period. Observations on 10/22/2024 at 1:20 PM, 10/24/2024 at 11:07 AM, and 10/25/2024 at 9:52 AM showed Resident 24 was up in their wheelchair and had long fingernails and greasy hair. According to the revised 10/30/2023 ADL self-care performance deficit CP showed Resident 24 was dependent on staff for showers and personal hygiene including nailcare. In an interview on 10/28/2024 at 1:18 PM, Staff F stated Resident 24 was scheduled to have a shower once every week. Staff F reviewed Resident 24's record and confirmed no shower was documented for the last 30 days. Staff F stated staff should provide showers and nail care as scheduled, but they did not. <Resident 35> According to the 09/28/2024 Quarterly MDS, Resident 35 had intact memory, weakness on one side of the body, and required one person assistance with showers and personal hygiene. The MDS showed Resident 35 had no behavior of refusing care during the assessment period. In an interview on 10/22/2024 at 10:37 AM, Resident 35 stated they had not received a shower for a month. According to a 12/01/2023 ADL self-care performance deficit CP, Resident 35 needed one person assistance with shower and personal hygiene. In an interview on 10/28/2024 at 12:37 PM, Staff F reviewed Resident 35's record and stated staff should provide showers to Resident 35 as scheduled, but they did not. <Resident 37> According to the 09/17/2024 Admission MDS, Resident 37 had an intact memory, and required total assistance with showers and personal hygiene from staff. The MDS showed Resident 37 had no behavior of refusing care during the assessment period. Observations on 10/22/2024 at 12:30 PM, 10/24/2024 at 9:21 AM, and 10/25/2024 at 10:10 AM showed Resident 37 was lying in bed and had greasy hair. According to the 09/16/2024 ADL self-care performance deficit CP, Resident 37 was totally dependent on staff for showers and personal hygiene care needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/28/2024 at 1:37 PM, Staff F reviewed Resident 37's record and stated staff should have provided showers to Resident 37 as scheduled, but they did not. In an interview on 10/29/2024 at 12:34 PM, Staff B stated they expected staff to check all resident's preferences related to ADLs and provide assistance as needed every morning including oral care, shaving facial hair, and nail care. Staff B stated they expected staff to provide showers to residents as scheduled. REFERENCE: WAC 388-97-1060(2)(C).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review the facility failed to ensure the resident environment was free of accident hazards for 2 of 2 residents sampled for accidents (Resident 213, & 212). The failure to ensure supervision of wandering residents and safety of transfer pole device was accurately assessed for safety placed residents at risk for accidents, injury, and negative health outcomes. Findings included . <Facility Policy> According to a facility policy titled, Elopements and Wandering Residents, revised 07/26/2024, the facility would ensure that residents who exhibit wandering behavior or were at risk for elopement received adequate supervision to prevent accidents in accordance with their person-centered plan of care to address the factors contributing to wandering. The policy showed staff would develop interventions to increase staff awareness of resident's risk, all risks would be added to the resident's Care Plan (CP) and communicated to the staff. The effectiveness of interventions would be evaluated, and changes would be made as needed. <Wandering> <Resident 213> According to the 09/23/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 213 admitted to the facility on [DATE] with medically complex conditions that included high blood pressure, history of urinary tract infections and muscle weakness. Review of a Functional CP, dated 10/03/2024, showed Resident 213 had self-care performance deficit related to memory impairment, confusion, and dementia. The CP for Resident 213 showed they had confusion. Resident 213's CP did not show Resident 213 wandered. Review of the October 2024 care task sheet showed the number of times per shift Resident 213 demonstrated behaviors that caused stress or anxiety to self or other residents. The evening shift staff documented behavior issues were noted 20 times for Resident 213. The night shift documented Resident 213 had behavior issues 43 times. In an interview on 10/22/2024 at 10:13 AM Resident 213 stated they went out of their room and the staff got mad at them. Review of Resident 213's progress notes dated 10/23/2024 showed documentation by Staff Y (Licensed Practical Nurse-Team Leader). Progress notes showed another resident (Resident 31) called to the front desk to report Resident 213 had wandered into their room. Staff Y noted that they had to remind the care staff to watch Resident 213's location every 15 minutes. Resident 213's progress notes showed care staff did not know that the resident was going into other resident's rooms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/2024 at 11:24 AM Staff E (Registered Nurse-Resident Care Manager) stated they were aware that Resident 213 was at risk for wandering as they had pictures of the resident in a wander/elopement binder that they kept at the nurse's station. Staff E stated they were only aware that Resident 213 had knocked on another resident's door and was not aware of Resident 213 going into other resident's rooms. In an interview and observation on 10/25/2024 at 5:01 AM Staff N (Certified Nursing Assistant) stated Resident 213 often gets up during the night. Staff N stated Resident 213 was confused and would try to go to the bathroom on their own without asking for assistance. Staff N stated they had to check Resident 213's location every 15 minutes. Staff N stated they thought Resident 213 was asleep, then went into resident's room and observed Resident 213 standing up without pants on and in need of assistance. In an interview on 10/25/2024 at 5:03 AM with Staff Y stated Resident 213 sometimes doesn't sleep, stands up on their own and sometimes does not have pants on. Staff Y stated the staff had to check Resident 213's location every 15 minutes. In an interview on 10/29/2024 at 1:00 PM, Staff B (Director of Nursing) stated that Resident 213's CP needed to be updated and completed in a timely manner as the CP reflected the care services that were needed. Staff B stated this was important so every person caring for the resident had access to how to care for Resident 213's care needs. <Transfer Pole> <Resident 212> According to the 10/10/2024 Admission MDS, Resident 212 admitted to the facility on [DATE] with medically complex conditions that included muscle weakness, unsteadiness on feet, and a need for assistance with personal care. Review of a Fall CP, dated 10/08/2024, showed Resident 212 was at risk for falls. Interventions listed on Resident 212's CP showed the resident needed to be evaluated and supplied with appropriate adaptive equipment and devices as needed and needed a safe environment. The CP did not show a transfer pole was installed in Resident 212's room. Record review of Resident 212's medical record showed a consent for a partial side rail was obtained from resident on 10/10/2024 and did not show a transfer pole consent was obtained. Observations on 10/22/2024 at 9:29 AM showed Resident 212 had a transfer pole by the right side of their bed. In an interview on 10/28/2024 at 2:13 PM, Staff E stated they could not find a transfer pole assessment for Resident 212 in the medical record. Staff E stated an assessment and consent form was very important for Resident 212's safety to make sure there was a safe enough distance between the transfer pole and the bed so resident would not get wedged in between the pole and the bed. Staff E stated, they had a side rails consent form but the order was switched to a transfer pole and the facility did not obtain a consent or assessment at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/29/2024 at 1:12 PM Staff B stated a transfer pole assessment and consent was needed and should have been listed in the CP but was not. Staff B stated there was a risk with potential harm if the transfer bar was not used properly. REFERENCE: WAC 388-97-1060(3)(g).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review the facility failed to ensure 1 of 3 sampled residents (Residents 212) with urinary catheters (a flexible tube inserted into the bladder to drain urine) received care and services consistent with professional standards of care. The failure of the facility to ensure physician orders with a supporting diagnosis, routine catheter care and monitoring was provided, placed the residents at risk for infections, skin breakdown, and diminished quality of care. Findings included . <Facility Policy> Review of the facility policy titled, Catheter Care, dated 07/26/2024, showed the purpose of the policy was to ensure that residents with indwelling catheters received appropriate catheter care when indwelling catheters was in use. <Resident 212> Review of the Admission Minimum Data Set (an assessment tool) dated 10/10/2024 showed that Resident 212 was admitted to the facility on [DATE] with muscle weakness, Parkinson's disease (movement disorder), lack of coordination,and had a urinary catheter during the assessment period. Review of Resident 212's Care Plan (CP) initiated on 10/18/2024 did not show an indwelling catheter on Resident 212's CP. No interventions or goals were shown to monitor the indwelling catheter or to provide instructions on how to care for the indwelling catheter for Resident 212. CP incorrectly showed the resident had urge and functional bladder incontinence related to activity intolerance and physical limitations. Review of Resident 212's Kardex (task list for care staff) on 10/23/2024 did not show instructions for catheter care for resident. In an interview on 10/28/2024 at 2:05 PM, Staff E (Registered Nurse - Resident Care Manager) stated they were not aware that Resident 212 had a catheter and it was not on the residents CP, but it should have been. In an interview on 10/29/2024 at 1:00 PM, Staff B (Director of Nursing) stated it was important to address an indwelling catheter on Resident 212's CP and to do so in a timely manner. Staff B stated the CP is a reflection of care services to be provided to the resident and instructions on CP was provided so everyone taking care of the resident had access to the instructions for care. REFERENCE: WAC 388-97-1060 (3)(c).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 33) reviewed for pain management received the necessary treatment, services, and follow-up care to manage their pain during wound care. This failure placed residents at risk for avoidable pain, refusal of wound treatments and a diminished quality of life. Findings included . <Facility Policy> Review of the facility policy titled, Pressure Injury Prevention and Management, revised 08/09/2024, showed the facility would utilize a systematic approach for pressure injury prevention and management, including using evidence-based treatments with current standards of process for treatment decisions based on condition of the wound, including the presence of pain. Modifications of interventions would be considered for resident's non-compliance to treatment. <Resident 33> According to the 07/26/2024 Admission Minimum Data Set (an assessment tool), Resident 33 admitted to the facility on [DATE] with loss of movement to one side of the body, multiple sclerosis (progressive neurological condition), and pressure ulcers to right heel and right and left hip areas. Review of a 08/09/2024 Pain Care Plan (CP) showed Resident 33 had acute/chronic pain related to hip and right heel wounds and contractures. Interventions listed on Resident 33's pain CP was to evaluate pain, evaluate effectiveness of pain-relieving interventions, and administer pain medication per order. Review of Resident 33's physicians orders showed an 08/10/2024 pain medication order to give pain medications one hour prior to wound therapy treatment as needed for pain. Review of the 09/05/2024 skin CP showed Resident 33 had pressure ulcers to the left and right hip areas and to their right heel that was present on admission to the facility. Interventions listed on Resident 33's skin CP was staff would administer pain medications and treatments as ordered and monitor effectiveness. Interventions were provided if Resident 33 refused treatments, staff was to confer with the resident, interdisciplinary team and the family to determine why. The skin CP showed staff would use and document alternative methods to gain compliance for refusals. Review of Resident 33's October 2024 Medication Administration Records showed pain medications were not provided on 10/22/2024, 10/24/2024, 10/25/2024 or 10/26/2024. Review of Resident 33's October 2024 Treatment Administration Record showed they refused wound care on 10/22/2024, 10/25/2024, and 10/26/2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/2024 at 10:16 AM Resident 33 stated they always had pain during wound treatments. Resident 33 stated the other night when the nurse came to do wound treatment it was so painful. Resident 33 stated that maybe if they came earlier in the day to provide treatment, rather than at night, they could tolerate the pain better. Resident 33 stated no one had talked to them about changing the time of wound care. In an interview on 10/28/2024 at 12:41 PM, Resident 33 stated they refused wound care for only one day this past weekend because it was too late and wound care was so painful and they told the nurse the reason why. In an observation and interview on 10/29/2024 at 10:31 AM Resident 33 complained of pain when Staff W (Registered Nurse -Team Lead) assessed Resident 33's pressure wounds. Resident 33 told Staff W that their pain medication did not always help with the pain. In an interview on 10/28/2024 at 2:33 PM Staff E (Registered Nurse-Resident Care Manager) stated that it was important for the nurses providing wound care to pre-medicate resident prior to providing wound care for resident's comfort. Staff E stated staff should discuss risks and benefits with resident and document reason for refusals for wound care. Staff E stated that it was important to assess for pain for resident's comfort and to assess the effects of pain medications. In an interview on 10/29/2024 at 1:24 PM Staff B (Director of Nursing) stated they would expect treatments and medications to be provided as ordered. Staff B stated they expected staff to document the condition of the wound and if treatment orders were or were not effective,or why treatments were not completed. REFERENCE: WAC 388-97-1060(1).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44296 Based on interview and record review the facility failed to ensure nurse and nurse aide staff had the appropriate competencies and skill sets to provide nursing and related services, to assure resident safety, and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident according to the facility assessment, resident-specific assessments and resident plans of care for 7 of 7 staff (Staff H, I, J & K - Nurse Aids and Staff E, G, & R - Licensed Nurses) reviewed for competency. The failure to develop and implement a process to evaluate staff's competency and skills to perform job expectations, including medication pass evaluation of competency, placed residents at risk for medication errors, accidents, injuries, infections, diminished quality of life, and diminished quality of care. Findings included . The 2024 Facility Assessment review date 09/08/2024 showed training/education and competencies of nurses and nurse aides that were necessary to provide support and care to the residents of the facility. Registered Nurse (RN) training and education needs for competency: training in assessments, medication management, emergency response, change in condition, identify medical interventions, care planning, care coordination, supervising and mentoring licensed nurses and nurse aids, regulatory compliance, communication skills, cultural competency, and emergency protocols. Licensed Practical Nurse (LPN) training and education needs for competency: basic clinical skills, nursing tasks, medication administration, vital sign monitoring, care documentation, emergency response, communication, compassionate care, regulatory knowledge, cultural competency, and emergency protocols. Nurse Aide (NA) training and education needs for competency: personal care skills, vital sign monitoring, safety and mobility, communication and empathy, infection control, emergency protocols, and cultural competency. In an interview and record review on 10/28/2024 at 1:09 PM with Staff M (Human Resources Director) and Staff A (Administrator) training and education documents were requested for Staff G, H, I, J, and K. Documents were not found in the staff's records. Staff A was asked how staff is evaluated for competency in the required skills to provide care to residents. Staff A stated the Administrator, Director of Nursing and the Staff Development Specialist were all new in their positions. Staff A stated a system needed to be developed and implemented to evaluate RN, LPN and NA staff competency in the areas identified on the Facility Assessment. Refer to F759 Free of Medication Error Rate 5 Percent or More Refer to F947 Required Inservice Training for Nurse Aides REFERENCE: WAC 388-97-1080(1).

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 44296 Based on interview and record review, the facility failed to ensure staff with a Nursing Assistant Registered (NAR) certificate completed a Certified Nursing Assistant (CNA) class and passed the state license exam within four months of hire for 2 of 2 NAR staff (Staff J & L) reviewed for CNA licensure. This failure placed residents at risk to receive care from unlicensed staff. Findings included . The facility staff list provided on 10/21/2024 showed Staff J & L were both hired as NARs on 04/09/2024. Review of the 10/28/2024 the Washington State Provider Credential Search website showed Staff L was currently a NAR, not a CNA. The verification showed Staff L was first credentialed as a NAR on 08/05/2021 with renewal on 01/02/2024. Review of the 10/28/2024 the Washington State Provider Credential Search website showed Staff J was currently a NAR, not a CNA. The website showed Staff J was first credentialed on 08/07/2023 and last renewal was on 01/10/2024. Review of the daily schedules for 10/2024 showed Staff J and Staff L both were scheduled and worked with residents as NARs. In an interview on 10/28/2024 at 1:09 PM, Staff A (Administrator) stated both Staff J and Staff L had worked at the facility for longer than four months as a NAR. Staff A stated neither Staff J or Staff L had a current CNA license. Staff A stated both Staff J and Staff L were scheduled and worked as an NAR since 04/09/2024. REFERENCE: WAC 388-97-1660 (2)(b), (3)(a)(i).

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	505475	A. Building B. Wing	10/29/2024

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Wesley Homes Health Center	826 South 218th Street Des Moines, WA 98198

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to ensure 3 (Residents 3, 35, & 53) of 5 residents reviewed for unnecessary medications, were free from unnecessary psychotropic (medication that affected behavior, mood, thoughts, or perception) medications. This failure left residents at risk for unnecessary medications, adverse side effects, and other negative health outcomes. Findings included . <Facility Policy> Review of the facility's Use of Psychotropic Medication policy revised 07/08/2024, showed the facility would not give psychotropic medications to their residents unless the medication was necessary to treat a specific condition and the indications for use would be documented in resident's medical record. The policy showed supportive documentation included non-pharmacological interventions addressed prior to initiating a psychotropic medication. <Resident 3> According to the 07/11/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 3 had diagnoses of Schizophrenia (disorder affecting a person's ability to think, feel, and behave) and depression. Resident 3 received antidepressant and antipsychotic medications during the assessment period and was assessed with behaviors and daily rejection of care during the assessment period. Review of Resident 3's Medication Administration Record (MAR) showed Resident 3 received antidepressant and antipsychotic medications every day as ordered. Review of Resident 3's record on 10/25/2024 showed no documentation of non-pharmacological interventions attempted prior to initiating and administering psychotropic medications. In an interview on 10/28/2024 at 1:57 PM, Staff F (Resident Care Manager - RCM) reviewed Resident 3's record and stated there was no non-pharmacological interventions attempted. Staff F stated there should be non-pharmacological interventions attempted and documented in resident's record, but it was not done. <Resident 35> According to the 09/28/2024 Quarterly MDS, Resident 35 received antidepressant medication during the assessment period and was assessed with no behavior or rejection of care during the assessment period. Review of Resident 35's MAR showed Resident 35 received antidepressant medications every day as ordered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 35's record on 10/25/2024 showed no documentation of non-pharmacological interventions attempted prior to initiating and administering psychotropic medications. In an interview on 10/28/2024 at 1:57 PM, Staff F reviewed Resident 35's record and stated there was no non-pharmacological interventions attempted. Staff F stated there should be non-pharmacological interventions attempted and documented in Resident 35's record, but it was not done. In an interview on 10/29/2024 at 8:36 AM, Staff C (Social Services Director) stated they reviewed psychotropic medications for all residents every month as a team. Staff C stated they did not attempt non-pharmacological interventions prior to initiating psychotropic medications, but they should have. In an interview on 10/29/2024 at 12:34 PM, Staff B (Director of Nursing) stated non-pharmacological interventions are important to reduce the risk of unnecessary medications for residents. Staff B stated staff should have attempted and documented non-pharmacological interventions prior to initiating and administering psychotropic medications to residents, but they did not. <Resident 53> According to a 09/13/2024 Admission MDS Resident 53 admitted [DATE] with diagnoses of, but not limited to, depression and anxiety. The MDS showed Resident 53 received antidepressant medications during the assessment period. Review of Resident 53's records showed physician orders for narcotic pain medication. Resident 53's records showed no non-pharmacological pain interventions ordered. In an interview on 10/29/2024 at 12:14 PM Staff E (Registered Nurse, RCM) stated Resident 53 does not have non-pharmacological pain interventions but should. Staff E stated non-pharmacological pain interventions were important, so they were not administering unnecessary medications. REFERENCE: WAC 388-97-1060(3)(k)(i).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50511 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 Percent (%). Failure to properly administer 28 of 35 medications for 4 of 6 residents (Resident 54, 6, 44 and 163) observed during medication pass resulted in a medication error rate of 68 %. This failure placed residents at risk for not receiving the correct dose at the correct time or receiving less than the intended therapeutic effects of physician ordered medication. Findings included . <Facility Policy> Review of the 01/2024 facility, Medication Administration policy showed medications should be administered in accordance with written orders of the prescriber. The six rights of medication administration were to be followed that included the right time and right documentation. Staff were to administer medication within 60 minutes prior to or after scheduled time unless otherwise ordered by the physician. Staff were to report and document discrepancies and report to the nurse manager. Observations of medication pass on 10/23/2024 at 1:37 PM, showed Staff G (Registered Nurse) was administering morning medications for residents instead of in the AM as shown on the resident's Medication Administration Record (MAR). <Resident 54> Review of October 2024 MAR showed an order for probiotic (antidiarrhea medication) to be given at 9 AM and 2 PM. An antibiotic was to be given at 8:00 AM, 12:00 PM and 5:00 PM. A blood pressure medication was to be given at 8:00 AM and at 5:00 PM. Observation on 10/23/2024 at 1:37 PM showed Staff G gave Resident 54 the 8:00 AM dose of antidiarrhea medication, blood pressure medication, and antibiotic medication at 1:37 PM. Staff G did not check with the resident's provider before administering medications 4 hours later than the ordered time as shown on the MAR MAR. <Resident 6> Review of October 2024 MAR showed Resident 6 was to be given antidepressant medication, anti-inflammatory/blood thinning medication, dementia medication, allergy medication, and rash cream at 8:00 AM, a vitamin supplement was to be given in the morning. Observation on 10/23/2024 at 1:55 PM Staff G gave Resident 6 the AM dose of antidepressant, anti-inflammatory/blood thinning medication, dementia medication, allergy medication, vitamin supplement and rash cream at 1:55 PM and did not check with the provider before administering medications 4 hours later than the ordered time as shown on the MAR. <Resident 44> (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of October 2024 MAR showed Resident 44 was to be given narcotic pain medication at 9:00 AM. Resident 44's antidepressant medication, nerve pain medication, diabetes medication, and oil mineral supplement were to be given at 8:00 AM. Observation on 10/23/2024 at 2:10 PM, Staff G administered Resident 44's AM narcotic pain medication, antidepressant medication, nerve pain medication, diabetes medication and oil mineral supplement at 2:10 PM. Staff G did not check with the provider before administering medications 4 hours later than medication times listed on the MAR. <Resident 163> Review of October 2024 MAR showed Resident 163 was to be given blood pressure medication, anti-inflammatory medication, antidepressant medication, allergy medication, laxative medication, fiber powder supplement, stool softener and vitamin supplement at 8:00 AM. Narcotic pain medication was to be given at 9:00 AM. Observation on 10/23/2024 at 2:30 PM, Staff G administered Resident 163's AM narcotic pain medication, antidepressant medication, nerve pain medication, diabetes medication, and oil mineral supplement after 2:00 PM. Staff G did not check with the provider before administering medications four hours later than medication times listed on the MAR. In an interview on 10/23/2024 at 2:10 PM, Staff G stated we couldn't get everybody's medication out in time this morning. Staff G stated they just give out the medication as was not sure what the policy was in giving medications past the time shown on the MAR as ordered. In an interview on 10/28/2024 at 02:25 PM, Staff E (RN-Resident Care Manager) stated morning medication pass time was from 7 to 10 AM. Staff E stated they were not sure of the policy on medication management and pass times but that the nurse would need to be counseled. Staff E stated it was important for medications to be administered as ordered and on the MAR so residents could achieve the desired effect of the medication especially for blood pressure, pain, and antibiotic medications. Staff E stated to follow the provider's order was important, so the patient does not have undesired effects. In an interview on 10/29/2024 at 1:08 PM, Staff B (Director of Nursing) stated if a nurse was running late with medications, they should report to management to let them know if the medication administration window time had passed. Staff E stated the nurse needed to call the provider to notify them the resident did not get their medications within the medication administration window of time and then monitor the residents for adverse side effects. Refer to F726 - Competent Nursing Staff REFERENCE: WAC 388-97-1060 (3)(k)(ii).

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50511 Based on observation, interview, and record review, the facility failed to ensure dietary orders pertaining to the consistency of foods were implemented for 3 of 6 (Residents 34, 37, & 45) residents whose dietary intake was reviewed. This failure placed residents at risk for choking, poor nutritional intake, and weight loss. Findings included . <Facility Policy> According to a facility policy titled, Resident Food Services - Special Food Needs, Swallowing/Chewing Difficulties, and Food Allergies, revised 01/2024, showed all foods and beverages would be assessed and determined safe for residents with special dietary needs, including those with food allergies, cultural and religious dietary preferences, and/or swallowing/chewing difficulty. The policy showed nursing would communicate diet orders, dietary staff would ensure diet information was transferred to meal ticket identifying residents diet order, food allergies, and special instructions. The policy showed dining staff would follow diet orders, allergies, special instructions, and modified textures per meal tickets/diet orders. According to a facility policy titled, Resident Food Services - Resident Dining Profile and Food Preferences, revised 01/2024, residents on a modified/therapeutic diet were offered similar choices as the main meal in compliance with their diet restrictions. The policy showed a nutrition file was used to maintain accurate records of resident's diets, intolerance's, allergies, assistive devices, and preferences as well as necessary information pertaining to the contents of the meal served. <Resident 34> Review of Resident 34's records showed a 12/02/2023 diagnosis of Oral Phase Dysphagia (a swallowing disorder). According to a 09/29/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 34 admitted on [DATE] with a diagnosis of, but not limited to, oral phase dysphagia. The MDS showed Resident 34 was on a therapeutic diet with a mechanically altered diet (change in texture of foods) during the assessment period. The assessment showed Resident 34 was dependent on staff for eating. Review of Resident 34's records showed a 10/09/2024 Social Service progress note stating the family requested to not include bread in Resident 34's diet due to their difficulty swallowing. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation, interview, and record review on 10/21/2024 at 12:19 PM Staff U (Certified nursing Assistant) was observed to be feeding Resident 34. Resident 34's lunch tray had a sandwich and a dinner roll. Staff U was observed to feed Resident 34 a bite of their sandwich. Review of Resident 34's lunch tray meal ticket showed no bread products such as sandwich or dinner rolls. In an interview at this time Staff U reviewed Resident 34's meal tray ticket and stated they were not to receive any bread products and should not have had a sandwich or a dinner roll served to them. Staff U stated they should have reviewed the meal ticket and meal tray before giving it to Resident 34, but they did not. In an interview on 10/22/2024 at 1:42 PM Staff V (Registered Dietician) stated they had a dietary expediter supervisor that read the meal tray ticket to the dietary server and the server then dished what was allowed for the resident according to their diet orders and preferences. Staff V stated they were unsure of how Resident 34 was served the sandwich and dinner roll but should not have received any bread products and it was a mistake. 45941 <Resident 37> Review of the 09/30/2024 Dietary communication form in Resident 37's record showed Resident 37 had regular textures, no bread due to difficulty chewing. Review of the October 2024 physician orders showed Resident 37 had a general diet, regular texture, thin liquid, and no bread per speech therapist ordered on 09/30/2024. Observation on 10/21/2024 at 12:28 PM showed Resident 37 received a lunch tray with two sandwiches. Meal ticket on Resident 37's meal tray showed the instructions for no bread. In an interview on 10/21/2024 at 12:41 PM, Resident 37's representative stated Resident 37 had a hard time with chewing and swallowing the bread. Resident 37 should not have bread on their tray. In an interview on 10/22/2024 at 1:42 PM Staff V stated they had a dietary expediter supervisor that read the meal tray ticket to the dietary server and the server then dished what was allowed for the resident according to their diet orders and preferences. Staff V stated they were unsure of how Resident 37 was served the sandwich but should not have received any bread products and it was a mistake. <Resident 45> According to a 09/06/2024 Quarterly MDS, Resident 45 was on a therapeutic diet with a mechanically altered diet during the assessment period. The assessment showed Resident 45 needed assistance from staff for eating. Observation on 10/21/2024 at 12:45 PM showed Resident 45 received their lunch tray in the dining room, had half a sandwich with chopped meat and lettuce. Review of Resident 45's October 2024 physician order directed staff to provide mechanical soft diet with thin liquids and small portions. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the meal ticket on Resident 45's lunch tray showed to provide mechanical soft diet and ground meat on Resident 45's sandwich. In an interview on 10/21/2024 at 12:49 PM in the dining room, Staff X (Registered Nurse) stated Resident 45 should have ground meat in the sandwich, but the kitchen staff did not read the meal ticket. In an interview on 10/22/2024 at 1:42 PM Staff V stated they had a dietary expediter supervisor that read the meal tray ticket to the dietary server and the server then dished what was allowed for the resident according to their diet orders and preferences. Staff V stated it was a mistake. REFERENCE: WAC 388-97-1100(1), -1220. 44296

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation interview and record review the facility failed to store, prepare and serve food in accordance with food service safety standards. The failure to cover, label and date stored foods, maintain clean ceiling vents, and perform standard hand hygiene and glove use to prevent cross-contamination placed residents at risk of foodborne illness and diminished quality of life. Findings included . <Food Preparation> Observation on [DATE] at 9:31 AM showed Staff AA (Cook) wearing plastic gloves over knitted safety gloves and washing raw chicken at the prep sink. Staff AA left the sink, did not remove the contaminated gloves or wash their hands, then touched a large spoon to stir the soup on the stovetop, left the spoon in the soup, turned and touched the three soup warming pans on a cart by the stove, picked up a plastic bag of frozen corn and placed it in a pan on the prep table, walked to the other side of the kitchen and returned to the sink, still wearing the same contaminated gloves. In an interview on [DATE] at 9:36 AM, Staff AA was still wearing the plastic gloves over the cut gloves and was asked, When washing raw chicken when should gloves be removed? Staff AA stated, I will remove them right now. Staff AA stated they should be removed and hands washed after touching the raw chicken. In an interview on [DATE] at 9:48 AM, Staff S (Executive Chef) stated gloves should be removed and hands should be washed after touching raw chicken and before touching anything in the kitchen. Staff S was informed about the observation of Staff AA and stated Staff AA should not have touched all the other areas of the kitchen with the contaminated gloves. <Food Storage> The facility policy for Food and Supply Storage, revised ,d+[DATE], showed foods must be covered, labeled and dated for unused portions and open packages. Kitchen observations on [DATE] at 8:39 AM showed expired foods in the walk in refrigerator including beef dated to use by [DATE], egg salad dated to use by [DATE], ham dated to use by [DATE]. Dry storage observations showed opened chicken seasoning received [DATE] with no open date or use by date, two bottles of unopened salad dressing showed a manufacturer expiration date of [DATE], and two boxes of powdered cake/pie mix showed an expiration date of [DATE]. Walk-in freezer observations showed opened, undated boxes of frozen beef, Beyond meat, and turkey patties. A small refrigerator contained strawberries that were not dated. Another small refrigerator showed two types of cut melons that were not dated. A small freezer showed containers of beef, frozen onions, and carrots that were open and not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on [DATE] at 9:29 AM in the lower level walk in freezer showed open containers of frozen waffles, a pan of single hot dogs in a bag, one bag of frozen bread bowls with a use by date [DATE], two other bags of bread bowls were undated, two bags of cake rounds were not dated, butchers block of beef was undated, blueberry bakers were not labeled or dated. In an interview on [DATE] at 8:52 AM, Staff Q (Lead Cook) stated expired food should be thrown out and removed the beef, egg salad, and ham from the walk in refrigerator during the interview. Staff Q stated boxes of food are labeled when received then when box is opened, the label is filled out with open date and use by date and put on the opened box. Staff Q stated if there is no date on the item the facility used the manufacturer dates. Observation on [DATE] at 9:59 AM inside the walk in refrigerator showed uncovered and undated raw sliced mushrooms in a cardboard box on a middle shelf and uncovered, undated raw green onion stalks on the top shelf. In an interview on [DATE] at 10:02 AM, Staff Q (Cook) observed the uncovered and undated sliced mushrooms and the green onions and stated they were supposed to be covered and dated. <Kitchen Sanitation> Kitchen observations on [DATE] at 8:39 and [DATE] at 9:59 AM showed two overhead vents, one above the clean dish area, the other above the food prep and serve area. The vents were observed with thick grey debris stuck to and hanging from the crossed vent cover with air moving through the grey debris. In an interview on [DATE] at 8:45 AM, Staff T (Hospitality Manager) stated the vents in the kitchen should be clean. Staff T stated kitchen staff should identify areas that need cleaning and notify maintenance to have work completed. REFERENCE: WAC [DATE](3), -2980.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 44296 Based on observation and interview the facility failed to ensure 2 of 3 garbage dumpsters and 1 of 2 recycling dumpsters were properly covered, the surrounding areas were kept clean, and free of trash/debris and food scraps. These failures placed the facility at risk of attracting bugs, rodents, birds, and other disease-carrying germs/bacteria that could reproduce, grow, and place the residents at risk for acquiring these diseases. Findings included . Observations on 10/21/2024, 10/22/2024, 10/23/2024, 10/24/2024, 10/25/2024, 10/28/2024 and 10/29/2024 showed the outside refuse area with uncovered garbage dumpsters and uncovered recycle dumpsters. Observations on these dates showed sea gulls (birds) flying over the dumpsters, opening the garbage bags for food scraps. These observations showed trash such as plastic, paper, gloves, food scraps, and other debris on the concrete surrounding the dumpsters. In an observation and interview on 10/29/2024 at 11:18 AM, Staff P (Director of Environmental Services) observed the refuse area and stated the dumpsters should be covered, the ground around the refuse area should not have debris, food scraps or other items to attract pests. Staff P stated the area needed to be cleaned up right away. REFERENCE: WAC 388-97-1320(4).

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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** 44296 Based on observation, interview, and record review the facility failed to implement an infection prevention and control program to prevent, identify, report, investigate, and control infections and communicable diseases according to national standards. The failure to implement a system of surveillance designed to identify possible communicable diseases and infections before they could spread to other persons in the facility, implement Enhanced Barrier Precautions (EBP) to prevent the spread of infections for 2 of 5 residents (Residents 33 & 212), and ensure staff used Personal Protective Equipment (PPE) as required placed all residents at risk for facility-acquired or healthcare-associated infections and related complications. Findings included . <Infection Prevention and Control Program (IPCP)> Review of the Facility Assessment, revised 09/08/2024, showed the facility infection prevention and control (IPC) program would effectively prevent, identify, report, investigate, and control infections and communicable diseases. The FA showed the facility used a surveillance system that included tracking infections, monitoring infection rates and trends to detect potential outbreaks and identify the effectiveness of the current IPC measures. Review of the facility policy titled Infection Surveillance dated 07/26/2024 showed a system of infection surveillance served as a core activity of the facility's IPC. The policy showed the facility would maintain documentation of incidents, findings, and corrective actions made by the facility. The policy showed the facility adhered to a nationally recognized surveillance criteria to identify infections. The policy showed all infections for residents, staff, and volunteers would be tracked and outbreaks would be investigated. The policy showed the facility would monitor surveillance activities, collect identified data on infections, staff observations and identify outcomes, trends and patterns. The policy showed data would be captured and reported monthly using charts and data comparisons over time using formulas for calculating infection rates. In an interview on 10/28/2024 at 2:02 PM with Staff B (Director of Nursing) and Staff D (Infection Control Preventionist) records of the facility infection surveillance was requested. Staff B and Staff D were asked to provide the data for infection tracking infections, monitoring infection rates, and any other data analysis or summaries used in the facility IPCP for the months of 07/2024, 08/2024, and 09/2024. Staff B and Staff D stated they would need assistance and time to gather the information requested. In an interview on 10/29/2024 at 9:25 AM, Staff D stated all the information the facility had for infection surveillance was in the antibiotic stewardship binder and no other data was available. Staff D stated the data for the months of 07/2024, 08/2024 and 09/2024 could not be located or provided for review. Staff D reviewed the binder and was not able to find the information requested in the binder. (continued on next page)

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	505475	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Homes Health Center	826 South 218th Street Des Moines, WA 98198

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/29/2024 at 11:02 AM, Staff A (Administrator) stated the requested information for the infection surveillance for 07/2024, 08/2024 and 09/2024 was not completed. Staff A stated the infection control systems were not intact and needed improvement. 50511 <Enhanced Barrier Precautions (EBP)> Review of the facility policy Enhanced Barrier Precautions dated 07/26/2024 showed the facility implemented EBP to prevent the transmission of multi-drug resistant organisms (MDRO). The policy showed staff would recognize the need for EBP thorough training of EBP precautions, high risk activities, common organisms that require EBP and staff were expected to comply with all designated EBP signage posted outside the resident room, use designated Personal Protective Equipment (PPE) for direct care, and hand hygiene. The policy showed nurses would implement EBP for residents with certain conditions or devices, obtain physician orders for EBP for residents that have wounds, indwelling medical devices or has a MDRO infection or colonization. <Resident 33> According to the 07/26/2024 Admission Minimum Data Set (MDS-an assessment tool), Resident 33 admitted to the facility on [DATE] with open pressure ulcers on their right heel, right hip, and left hip areas and had an indwelling catheter to drain urine. Observations on 10/25/2024 at 9:50 AM showed Resident 33's room did not have a EBP sign posted outside their room or supplies easily available outside the room for staff use. <Resident 212> Review of Resident 212's 10/07/2024 Baseline Care Plan, Resident 212 was admitted to the facility on [DATE] and had an indwelling urinary catheter. Observations on 10/22/2024 at 11:01 AM showed Resident 212 room did not have a EBP sign posted outside their room or supplies easily available outside the room for staff use. In an interview on 10/23/2024 at 10:11 AM, Staff D stated any resident with wounds, indwelling catheter, tube feeding, or an ostomy (opening in abdomen for bowel elimination) should be on EBP precautions. 45941 <Personal Protective Equipment (PPE)> Reveiw of the facility policy titled Personal Protective Equipment dated 07/26/204 showed the facility promoted the use of PPE to prevent the transmission of pathrogents to residents, visitors and staff. The policy showed staff would receive traning on why, what, how to use PPE on hire, annually, when new products are introduced and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Transmission Based Precautions (TBP) dated 07/26/2024 showed there facility would use standard approaches as defined by the CDC (Center for Disease Control) for TBP. Staff would follow CDC guidance for the use of a fit-tested N-95 respirator. Observation on 10/21/2024 at 8:30 AM showed Staff Z (Certified Nursing Assistant) was wearing two masks (an N-95 respirator on top of a surgical mask) over their nose and mouth. Staff Z had gown, gloves, hair cover, and face shield on and went into a room with droplet precaution isolation sign on the door to deliver a breakfast tray. Staff Z came out of the room, removed gloves and gown and sanitized their hands. Staff Z was not observed to clean their face shield. In an interview on 10/21/2024 at 8:38 AM, Staff Z stated they had to wear a surgical mask under the N-95 respirator because they were allergic to N-95 respirator. Staff Z stated they were supposed to clean their face shield when they came out of the isolation room, but they forgot and did not clean the face shield. Observation on 10/22/2024 at 8:31 AM showed Staff Z was delivering the breakfast trays in resident's rooms and was wearing N-95 respirator only. In an interview on 10/22/2024 at 8:40 AM, Staff Z stated they were not wearing two masks, like they were on the day before, because Staff D provided Staff Z with a different N-95 respirator to try. Staff Z stated they did not get any rashes on their face with the new N-95 respirator. Staff Z stated they were not fit tested for the new N-95 respirator. In an interview on 10/29/2024 at 1:45 PM, Staff D stated Staff Z should not wear two masks at the same time. Staff D stated the facility expectation was all staff should be fit tested before using a N-95 respirator. Staff D stated Staff Z should have, but did not, have fit testing done before using the new N-95 respirator. REFERENCE: WAC 388-97-1320(1)(a)(2)(a-c)(5).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 44296 Based on interview and record review, the facility failed to implement a facility-wide system for Antibiotic (ABO) Stewardship (a program to improve how ABO medications are prescribed, treating bacterial infections, and reduce the inappropriate use of ABO medications). The facility failed to implement an accurate surveillance method to track all resident infections, identify the source of infections, collect diagnostic data for organisms and ensure correct ABO treatment, identify residents' symptoms and use nationally recognized assessment criteria for prescribing ABO medications, monitor isolation precaution timelines, identifying trends in types infections or similar organisms, analyze data collected to provide ABO and infection reports to the prescribers of antibiotics. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate/unnecessary use of ABOs and an increased risk for ABO resistant organisms. Findings included . Review of the facility policy Antibiotic Stewardship Program dated 07/10/2024 showed the facility implemented an ABO Stewardship program to optimize the treatment of infection and reduce the adverse events associated with ABO use. The policy showed nurses assess residents, notify the physician for laboratory testing if indicated, nurses would conduct an ABO time out to determine continued ABO use or need for adjustments, the facility used national standard surveillance tools and published criteria to meet the criteria for ABO treatment. The policy showed ABOs would be monitored for indications for use according to lab reports, response to treatment, and review of prescribed ABO outside of the facility for appropriateness. The policy showed monthly antibiotic review would be completed by the pharmacist and monthly measurements of ABO prevalence, tracking infections and ABO use with outcome measures, and ABO resistance. The policy showed the facility would maintain documentation for assessments, ABO use protocols, data collection for ABO use, process and outcome measures, ABO Stewardship meeting minutes, feed back reports, records related to education of physicians, staff, and residents, and annual reports. The policy showed the ABO stewardship monitoring activities were discussed in the Quality Assurance and Process Improvement (QAPI) meetings. In an interview on 10/28/2024 at 2:32 PM, with Staff B (Director of Nursing) and Staff D (Infection Control Preventionist), Staff D stated they were new to the position starting in 08/2024. Staff D provided a binder labeled ABO Stewardship with printed materials for 08/2024, 09/2024, and 10/2024. Staff D stated they did not have a data collection analysis or summary for the resident infections in 08/2024 or 09/2024. Staff D showed where the ABO cases are loaded in an online tracking program. Staff D was not able to print or provide data reports according to the ABO stewardship policy. Staff D stated they did not know how to gather the reports and needed to ask for assistance to obtain the documents. Staff B and Staff D were asked to provide surveillance logs showing the data collection for infections, tracking and trending documentation for infections, documentation of analysis of resident ABO use, and any data reports or summary for the prior four months of infections and ABO use. Review of the facility ABO Stewardship binder for the months of 09/2024 and 10/2024 showed printed physician orders for individual resident's antibiotic use, a copy of the medication administration record for the ABO, and some had laboratory reports. The documents listed in the facility policy were not provided in the binder. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/29/2024 at 9:25 AM, Staff D stated they were told there was a printed surveillance spreadsheet in the ABO stewardship binder provided on 10/28/2024. A review of the spreadsheet for 09/2024 and 10/2024 with Staff D showed incomplete with many blanks in the columns for infection etiology, evaluation of infection, laboratory results, infection type and location, organism, resident symptoms, and whether the infection met the criteria for ABO treatment. In an interview on 10/29/2024 at 11:02 AM, Staff A (Administrator) reviewed the facility infection surveillance spreadsheet. Staff A stated they saw much of the data was not documented. Staff A stated the ABO stewardship program should not have blank areas on the spreadsheet. Staff A stated the spreadsheet should be completed and accurate to include resident's symptoms, identifed organisms causing infection, confirmation of lab cultures, and analysis of the infection to ensure it met the criteria for ABO treatment. Staff A stated the ABO stewardship program was not intact and did not meet the ABO stewardship program policy requirements. REFERENCE: WAC 388-97-1320(1)(a)(2)(a-c).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 44296 Based on interview and record review, the facility failed to develop, implement and maintain an in-service training program that ensured 4 of 4 Nursing Aides (Staff H, I, J & K) completed the required training, including dementia care management and training for special needs of residents, to ensure continued competency when providing resident care. The failure to provide nurse aides the required training on hire, provide no less than 12 hours of continuing education annually, and perform annual performance evaluations to address weak areas for additional training placed residents at risk for less than competent care and services from nurse aide staff. Findings included . The 2024 Facility Assessment (FA), review date 09/08/2024, showed Nurse Aides (NA) would require training/education and competency to provide support and care needed to the resident population. The FA listed the following training/ education needs: basic personal care skills, vital signs monitoring, safety and mobility, communication and empathy, infection control, emergency protocols, and cultural competency. The FA stated required in-service training for NAs must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year, must include dementia management training and resident abuse prevention training, must address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff, and for NAs providing services to individuals with cognitive impairments, training must address the care of the cognitively impaired. In an interview and record review on 10/28/2024 at 1:09 PM with Staff M (Human Resources Director) and Staff A (Administrator), Staff A stated NA training was completed in an on-line program and through staff meetings for all staff. Staff A stated there was a checklist NAs completed during orientation and on the floor training with an experienced staff person to verify competency. Staff A stated the checklist was completed by the experienced staff person and returned to the supervisor for the staff records. A request was made for the training checklists, online training and all staff meeting documentation for NA Staff H, I, J and K. In an interview on 10/28/2024 at 2:16 PM, Staff B (Director of Nursing) stated there was not a system in place for annual evaluations of NA skills for competency verification. In an interview on 10/29/2024 at 9:25 AM, Staff D (SDS, Staff Development Specialist) stated NA staff completed a training checklist while training with an experienced NA staff. Staff D did not have any of the completed NA checklists and stated they did not track the completion of the checklists. Staff D was not able to provide any information about the required training for NAs on hire or 12 hours annually. Staff D stated they were new to the SDS role and to check with the Administrator about NA training. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/29/2024 at 11:09 AM, Staff A stated there were no training checklists for NA Staff H, I or J. Staff A stated training documentation requested for Staff H, I, J and K were not able to be located. Staff A stated the NA training program was not developed or implemented and needed work to meet the requirement of required training on hire, 12 hours of continuing education annually, and annual performance evaluations to address weak areas for additional training. Refer to F726 Competent Nursing Staff REFERENCE: WAC 388-97-1680 (2)(a)(b)(i-ii)(c).