STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505476	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bailey-Boushay House	2720 East Madison Seattle, WA 98112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an informed consent for psychotropic medication (a drug that affects behavior, mood, thoughts, or perception) was completed prior to medication administration for 1 of 5 residents (Residents 17), reviewed for unnecessary medications. This failure placed the resident and/or their representative at risk of not being fully informed of the risks and benefits before making decisions about medications prior to administration. Findings included . Review of the facility policy titled, Psychotropic Drug Use: Implementation, Monitoring and Reduction, updated in June 2024, showed that An informed consent must be obtained first from the resident or their representative before starting with the medication regimen .An informed consent includes the discussion of the medication's risks and benefits. It further showed that psychotropic drugs included antidepressants (medication to treat depression [A feeling of loneliness and sadness]). Resident 17 admitted to the facility on [DATE] with diagnosis that included depression. Review of physician orders printed on 05/01/2025 showed that Resident 17 was prescribed an antidepressant medication on 11/25/2024. Review of a Medication Administration Record for April 2025, printed on 05/01/2025, showed that Resident 17 received an antidepressant medication daily and that medication administration was started on 11/26/2024. Review of Resident 17's informed consent for an antidepressant medication, printed on 05/05/2025, showed that it was obtained from Resident 17 on 03/25/2025. It showed that Completion of this form is voluntary. If not completed, the medication cannot be administered unless in an emergency. It further showed that Resident 17 was/will be admitted on [DATE] with the above medication [antidepressant medication], as prescribed. (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	In an interview and joint record review on 05/05/2025 at 9:48 AM, Staff F, Charge Registered Nurse, stated that they expected informed consents for psychotropic drug use would be available in the resident's Electronic Health Record (EHR). Joint record review of Resident 17's EHR showed an informed consent for an antidepressant obtained from Resident 17 on 03/25/2025. Staff F stated that they would look further into Resident 17's EHR for presence of an earlier informed consent for antidepressant medication. In a follow up interview at 11:12 AM, Staff F stated Resident 17 did not have an informed consent for antidepressant medication at the start of the medication [administration]. Staff F further stated that they expected informed consent would have been obtained prior to Resident 17 receiving the first dose of antidepressant medication. In an interview on 05/05/2025 at 4:19 PM, Staff B, Director of Nursing, stated that they expected informed consents for psychotropic drug use would be obtained before a resident was started on psychotropic medication. Reference: (WAC) 388-97-0260 (2) (a-d) .

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and record review, the facility failed to ensure resident's fund was transferred to the resident or resident's representative/estate within 30 days of discharge for 1 of 1 discharged resident (Resident 136), reviewed for personal funds. This failure placed the resident and/or their representative/estate at risk for loss of funds and the interest accumulated. Findings included . Review of an undated facility provided document titled, Resident Trust Account, showed that Resident Trust Procedures included that the resident's balance in their personal fund shall be returned to the individual within one week of discharge. Review of Resident 136's discharge Minimum Data Set (an assessment tool), dated 04/14/2024, showed that the resident was discharged from the facility on 04/14/2024. Review of Resident 136's trust account ledger showed that they had a trust balance of $622.23 on 12/31/2024. Review of a copy of the check sent to the resident's representative/estate showed it was sent to them on 01/23/2025, 283 days after the resident's discharge. A joint record review and interview on 05/05/2025 at 8:47 AM with Staff N, Finance Manager, showed that Resident 136 had a trust balance of $622.23 on 12/31/2025 in their trust account ledger. A review of the check sent to Resident 136's representative showed it was dated 01/23/2025. Staff N stated that their process required transferring residents' trust balances within a week after discharge. Staff N further stated that Resident 136's balance was transferred late, and it should have been done within a week after their discharge. In an interview on 05/05/2025 at 11:15 AM, Staff A, Administrator, stated that they expected the residents' funds to be transferred to the resident's representative or estate, as required by the regulations and the facility's policy. Staff A stated that Resident 136's fund was transferred late. Staff A further stated that it was their expectation that Resident 136's balance would be transferred within one week following their discharge. Reference: (WAC) 388-97-0340(5) .

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure the survey result binder included the recent recertification survey results that led to citations and plan of corrections for 2 of 3 years (2023 & 2024), reviewed for availability of survey reports. This failure prevented the residents, residents' representatives, and visitors from exercising their right to review past survey results and the facility's plan of corrections. Findings included . Review of the facility policy titled, Availability of Survey Results, updated in April 2025, showed, Survey reports, certifications, complaint investigations and plans of correction for the preceding three years are available for any individual to review upon request. The policy further showed that A copy of the most recent survey report and any plans of correction are kept in a binder in the residents' day room. Review of the Past Survey Results binder on 05/01/2025 at 2:01 PM, showed that the binder did not contain recertification surveys that resulted in citations for the years 2023 and 2024. Further review of the contents of the binder showed the recertification survey results and associated plan of corrections dated 03/24/2023 and 06/13/2024 were not included. In an interview and joint record review on 05/01/2025 at 2:13 PM with Staff B, Director of Nursing, stated that they were responsible for maintaining and updating the Past Survey Results binder. A joint record review of the Past Survey Results binder did not show recertification survey results for the years 2023 and 2024 and associated plan of corrections dated 03/24/2023 and 06/13/2024. Staff B stated that survey results and the associated plan of corrections were accessible online. Staff B further stated the recertification survey results, and associated plan of corrections could be printed for residents upon request. In an interview on 05/05/2025 at 11:15 AM, Staff A, Administrator, stated that their process involved placing the survey results in the binder upon receipt. Staff A stated that the recertification survey results and associated plan of corrections for years 2023 and 2024 should have been included in the binder. Reference: (WAC) 388-97-0480(1)(a)(c)(4) (5)(a) .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate monitoring was in place for psychotropic (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) medication management for 2 of 5 residents (Resident 13 & 17), reviewed for unnecessary medications. This failure placed the residents at risk for unmet care needs, adverse side effects, and a diminished quality of life. Findings included . Review of the facility policy titled, High-Alert Medication Monitoring Policy, updated in November 2022, showed, Residents prescribed medications falling under the definition of high-risk will be monitored for adverse side effects [or unexpected and harmful reactions from the use of medication] and the observations documented in the clinical record. Residents who use high-risk medications will be routinely assessed for side effects. RESIDENT 13 Resident 13 was admitted to the facility on [DATE] with a diagnosis of anxiety disorder (mental health condition characterized by intense, persistent worry and fear). Review of the physician's order summary report printed on 05/05/2025 at 7:32 AM showed Resident 13 had an order for clonazepam (an antianxiety [a type of psychotropic] medication) 1.5 milligram (unit of measurement) per day. Further review of the physician's order summary report did not show monitoring for adverse side effects of clonazepam. In an interview and joint record review on 05/02/2025 at 2:49 PM, Staff I, Registered Nurse (RN) stated that Resident 13 was taking an antianxiety medication. Staff I stated that residents taking antianxiety medications were monitored for adverse side effects. A joint record review of Resident 13's physician's order printed on 05/05/2025, and the May 2025 electronic medication administration record (e-MAR) showed no monitoring for adverse side effects related to use of antianxiety medication. Staff I stated there was no documentation that Resident 13 was monitored for adverse side effects related to the use of antianxiety medication and that there should have been one. In an interview and joint record review on 05/05/2025 at 3:26 PM, Staff D, Charge RN, stated that psychotropics such as antianxiety medications were considered high-risk medications. A joint record review of the May 2025 physician's order showed Resident 13 had an order for antianxiety medication and it further showed no monitoring for adverse side effects related to use of antianxiety medication. Staff D stated that there was no order for monitoring of adverse side effects related to the use of antianxiety medication and there should have been one. In an interview on 05/05/2025 at 4:29 PM, Staff B, Director of Nursing, stated that they expected Resident 13 to have had a physician order to monitor adverse side effects of antianxiety medication and that Resident 13 should have been adequately monitored for adverse side effects related to antianxiety medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 17 Review of a face sheet printed on 05/01/2025 showed Resident 17 admitted to the facility on [DATE] with diagnosis that included depression (feeling loneliness and sadness). Review of physician's order printed 05/01/2025, showed Resident 17 was prescribed an antidepressant (a psychotropic used to treat depression) on 11/25/2024. Review of Resident 17's April 2025 MAR, printed on 05/01/2025, showed Resident 17 received an antidepressant daily and that medication administration started on 11/26/2024. It further showed that Resident 17 was not monitored for adverse side effects related to antidepressant use. In an interview and joint record review on 05/05/2025 at 9:48 AM, Staff F, Charge RN, stated that they expected monitoring of adverse side effects related to antidepressant use would be included in Resident 17's physician's orders and MAR. Joint record review of Resident 17's physician's orders and April 2025 e-MAR did not show that Resident 17 had an order for staff to monitor for adverse side effects related to antidepressant use. It further showed that daily monitoring for adverse side effects related to antidepressant use was not included in Resident 17's April 2025 e-MAR. Staff F stated that they expected monitoring for adverse side effects related to antidepressant use to start after Resident 17's initial dose. In an interview on 05/05/2025 at 4:19 PM, Staff B stated that they expected adverse side effects monitoring to start when they obtain the informed consent, and before the resident starts [the medication]. Reference: (WAC) 388-97-1060 (3)(k)(i)(4) .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed for 1 of 2 residents (Resident 23), reviewed for SCSA. The failure to complete an SCSA for a decline in eating and transfer placed the resident at risk for delayed care planning, unmet care needs, and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed that a SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team has determined that a resident meets the significant change guidelines for either major improvement or decline. It showed that a significant change is a major decline or improvement in a resident's status that impacts more than one area of a resident's health status. It further showed that a SCSA is appropriate when there is determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's status to the most recent comprehensive assessment and any subsequent quarterly assessments and the resident's condition is not expected to return to baseline within two weeks. Review of a face sheet printed on 05/01/2025 showed that Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's admission MDS dated [DATE], showed Section GG0130 (Self Care) was coded as 02 which indicated that Resident 23's usual performance at the start of the stay (02/09/2024) for eating task was that staff provided substantial/maximal assistance. It showed that Section GG0170 (Mobility) was coded as 03 and that this indicated that Resident 23 received partial/moderate assistance for sit to stand task (the ability to come to standing position from sitting in a chair, wheelchair, or on the side of the bed.) It further showed that coding in Section K0520 (Nutritional Approaches) indicated that Resident 23 did not receive a mechanically altered diet (a required change in texture of food or liquids) or feeding tube (a flexible tube used to deliver liquid nutrition directly into the stomach or intestine when a person cannot eat or swallow normally). Review of a hospital inpatient discharge summary, printed on 05/05/2025, showed that Resident 23 was admitted to an acute hospital on [DATE]. It showed that Resident 23 presented to the Emergency Department for a witnessed aspiration (inhalation of food or fluid into the lungs) event at the facility where Resident 23 was a resident. It showed that Resident 23 was seen by speech therapy but had failed the swallow evaluation and was recommended to continue NPO (nothing by mouth). It further showed that Resident 23 had a feeding tube placed on 03/20/2024 while at the acute hospital. Review of Resident 23's quarterly MDS, dated [DATE], showed Section GG0130 was marked with a dash (-). This mark indicated that Resident 23's usual performance for eating activity was not assessed. It showed that in Section K0520, Resident 23 was marked to have received feeding tube nutritional approach while a resident at the facility. It further showed that Section K0710 (Percent by Artificial Route) was coded a 3, which indicated that Resident 23 received 51% or more proportion of total calories through tube feeding. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's most current quarterly MDS dated [DATE], showed Section GG0130 was coded as 88, which indicated that Resident 23's eating task was not attempted during the assessment period due to medical condition or safety concerns. It showed that Section GG0170 was coded as 1 and that this indicated that Resident 23 was dependent on staff assistance for sit to stand activity. It further showed that Section K0710 was coded as 3, which indicated Resident 23 received 51% or more proportion of total calories through tube feeding. Review of Resident 23's Electronic Health Record (EHR) did not show that a SCSA was completed after Resident 23 had a decline in their status that impacted more than one area of their health status, and that Resident 23's condition was not expected to return to baseline within two weeks. In a joint record review and interview on 05/05/2025 at 1:15 PM with Staff K, MDS Coordinator, the following MDS were reviewed: -admission MDS, dated [DATE], showed Resident 23 was coded to have received substantial/maximal assistance with eating task, partial/moderate assistance for sit to stand task and that Resident 23 did not receive nutritional approach via feeding tube. -Quarterly MDS dated [DATE], showed Resident 23's eating task was not attempted during the assessment period due to medical condition or safety concerns. It further showed that Resident 23 was dependent on staff assistance for sit to stand task and that Resident 23 received 51% or more proportion of total calories through feeding tube. Staff K stated Resident 23 did not admit to the facility with a feeding tube and that Resident 23 transitioned to NPO when their feeding tube was placed during an acute hospital stay on 03/20/2024. Staff K stated that they expected a SCSA would have been completed for Resident 23's decline in condition. In an interview on 05/05/2025 at 4:22 PM, Staff B, Director of Nursing, stated that they followed the RAI Manual for coding accuracy. When asked if they expected an SCSA would have been completed for Resident 23, Staff B stated, Yes. Reference: (WAC) 388-97-1000 (3)(b) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess 4 of 13 residents (Residents 13, 5, 23 & 17), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding opioid (medication to treat pain) use, presence of delusion (false belief), activity interview and insulin (medication/hormone that regulates blood sugar levels) injections placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. It further showed, .The intent of items in this section (Section F-Preferences for Customary Routine and Activities) is to obtain information regarding the residents' preferences for their daily routine and activities .If a resident cannot communicate, then family or significant other who knows the resident well may be able to provide useful information about preferences .If the resident is unable to complete the interview, attempt to conduct the interview with a family member or significant other .Preferences may change over time and extend beyond those included here. Therefore, the assessment of activity preferences is intended as a first step in an ongoing dialogue between the care provider and the resident. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 13 Review of the April 2025 Medication Administration Record (MAR) showed Resident 13 received opioid medication on 04/04/2025. Review of Resident 13's annual MDS dated [DATE] showed opioid use was not marked in Section N (Medications). In an interview and joint record review on 05/02/2025 at 3:21 PM, Staff K, MDS Coordinator, stated they followed the RAI Manual for completion of MDSs. Joint record review of Resident 13's annual MDS dated [DATE] with Staff K showed use of opioid was not marked in Section N. Joint record review of the April 2025 MAR showed Resident 13 received opioid on 04/04/2025 which was within the look-back period (04/03/2025 to 04/09/2025). Staff K stated that they had inaccurate MDS coding, and that Resident 13's opioid use should have been marked in Section N. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 5 Review of Resident 5's quarterly MDS dated [DATE] showed delusion was marked in Section E (behavior). Review of Resident 5's Electronic Health Record (EHR) did not show documentation for the presence of delusion during the look-back period (02/13/2025 to 02/19/2025). A joint record review and interview on 05/02/2025 at 3:21 PM with Staff K, showed Resident 5's quarterly MDS dated [DATE] revealed that delusion was marked in Section E. A joint record review of Resident 5's EHR did not show documentation for the presence of delusion during the look-back period. Staff K stated that they would look for Resident 5's documentation related to presence of delusion. In a follow-up interview on 05/05/2025 at 1:56 PM, Staff K stated, I cannot find any supporting documentation for coding [Resident 5's] delusion in Section E. Staff K further stated that delusion should not have been coded in Resident 5's quarterly MDS. In an interview on 05/05/2025 at 4:29 PM, Staff B, Director of Nursing, stated that they expected residents' MDS assessments to be coded accurately. RESIDENT 23 Review of Resident 23's annual MDS dated [DATE] showed Section C0100 (Should Brief Interview for Mental Status be Conducted?) was coded as 0, which indicated that Resident 23 was rarely/never understood. It further showed that Section F0400 (Interview for Daily Preferences) was not completed with Resident 23's family/significant other. In an interview and joint record review on 05/02/2025 at 2:25 PM, Staff K stated that they completed Section F of Resident 23's annual MDS dated [DATE]. Staff K further stated that they followed the RAI Manual for MDS coding accuracy. Joint record review of Resident 23's annual MDS showed Section F0400 was not completed with Resident 23's family/significant other. Staff K stated that they did not complete the interview with Resident 23's family/ significant other because they were not present at the facility at the time. When asked if they attempted to call Resident 23's family or significant other to complete the interview, Staff K stated, No, I did not, and that they should have attempted to interview the family/significant other for Resident 23. In an interview on 05/05/2025 at 4:21 PM, Staff B stated that they expected MDS resident interviews to be completed with the resident's representative if the resident was unable to be interviewed. RESIDENT 17 Review of Resident 17's quarterly MDS dated [DATE], showed Section N0350 (Insulin) was coded as 1 which indicated that Resident 17 received one insulin injection during the observation period (02/24/2025 through 03/03/2025). Review of Resident 17's physician's orders, printed on 05/01/2025, did not show that Resident 17 had an order for Insulin. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 05/02/2025 at 9:32 AM, Staff K stated that they completed Section N0350 of Resident 17's quarterly MDS dated [DATE]. Joint record review of Resident 17's quarterly MDS, showed Section N0350 was coded as 1 which indicated that Resident 17 received one insulin injection during the observation period. Staff K stated that Resident 17 was not prescribed insulin and that it should not have been coded. In an interview on 05/05/2025 at 4:15 PM, Staff B stated they followed the RAI Manual for MDS coding accuracy and that they expected MDS to be completed accurately. Reference: (WAC) 388-97-1000 (1)(b) .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 5 Review of Resident 5's Level I PASARR completed on 04/10/2017 showed the diagnosis of psychotic and anxiety disorders were marked in Section I and no referral for Level II evaluation was indicated. Review of Resident 5's Electronic Health Record (EHR) did not show a Level I PASARR was updated and no referral for Level II evaluation was completed. In a joint record review and interview on 05/05/2025 at 10:09 AM with Staff G showed Resident 5's Level I PASARR was completed on 04/10/2017 and SMI indicators were checked. Further joint review of Resident 5's Level I PASARR did not show a referral for Level II evaluation was indicated. Staff G stated that Resident 5 had SMI and referral for a Level II evaluation was not completed. Staff G stated that Resident 5 should have had an updated Level I PASARR and should have had a referral for a Level II evaluation. RESIDENT 13 Review of Resident 13's Level I PASARR completed on 09/21/2020 showed the diagnosis of anxiety disorders was marked in Section I and no referral for Level II evaluation was indicated. Review of Resident 13's EHR did not show a Level I PASARR was updated and no referral for Level II evaluation was completed. In a joint record review and interview on 05/05/2025 at 10:09 AM with Staff G showed Resident 13's Level I PASARR was completed on 09/21/2020 and a SMI indicator was checked. Further joint review of Resident 13's Level I PASARR did not show a referral for Level II evaluation was indicated. Staff G stated that Resident 13 had SMI and a referral for a Level II evaluation was not completed. Staff G stated that Resident 13 should have had an updated Level I PASARR and should have had a referral for a Level II evaluation. In an interview on 05/05/2025 at 2:15 PM, Staff A stated that they expected Resident 5 and Resident 13 to have had updated Level I PASARR and referral for Level II evaluation completed. Based on interview and record review, the facility failed to ensure accurate completion and update of Level 1 Pre-admission Screening and Resident Review (PASARR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID], or Related Conditions [RC] are not inappropriately placed in nursing homes for long term care) were conducted for 5 of 6 residents (Residents 2, 5,13,17 & 22), and failed to ensure Level II PASARR referral were made for 4 of 6 residents (Residents 2, 5, 13 & 22), reviewed for PASARR screening. These failures placed the residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet mental health care needs. Findings included . (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Pre-admission Screening and Resident Review [PASARR], updated in February 2025, showed PASARR Level I screening looks for indicators that a person may have an intellectual disability or related condition, or a serious mental illness. If indicators are found, the individual will be referred to the Developmental Disabilities Administration for PASARR Level II assessment. RESIDENT 2 Review of the face sheet printed on 05/05/2025 showed Resident 2 was admitted to the facility on [DATE] with diagnosis that included depression (feeling of loneliness and sadness). Review of Resident 2's Level I PASARR dated 01/11/2022, showed the diagnosis of anxiety (overwhelming feelings of worry, fear or nervousness) and psychotic disorders (a condition where a person loses touch with reality) were marked in Section I (SMI/ID/RC). A joint record review and interview on 05/05/2025 at 10:19 AM with Staff G, Social Worker, showed that Resident 2's Level I PASARR in Section I had diagnosis of anxiety and psychotic disorders marked. A joint record review of the face sheet showed that Resident 2 had a diagnosis of depression as of 10/02/2024. Staff G stated that they did not know that Resident 2 needed Level II PASARR. Staff G further stated that Resident 2's Level I PASARR should have been updated to reflect the new diagnosis of depression. In an interview on 05/05/2025 at 11:15 AM, Staff A, Administrator, stated they expected the PASARR forms to be accurate and reflect residents' diagnosis of SMI. Staff A stated that Resident 2 had anxiety and psychotic disorders checked in Section I that PASARR level II evaluation referral should have been made. Staff A further stated that Resident 2's Level I PASARR form should have been updated to reflect their current medical diagnosis of SMI. RESIDENT 17 A Review of a face sheet printed on 05/01/2025 showed Resident 17 admitted to the facility on [DATE] with diagnosis that included panic disorder with anxiety (having sudden, intense waves of fear that hit out of nowhere, even when there's no real danger). Review of Resident 17's physician's orders, printed on 05/01/2025, showed that Resident 17 was prescribed an anxiolytic (medication used to treat anxiety). In an interview on 04/29/2025 at 1:59 PM, Resident 17 stated, I have anxiety, I'm on medication for it and I see a therapist. Review of Resident 17's Level I PASARR dated 12/25/2024 did not show that anxiety disorders were marked in Section I. It further showed that Resident 17's Level I PASARR was completed by Staff G. In an interview and joint record review on 05/05/2025 at 10:22 AM, Staff G stated that they were responsible for ensuring Level I PASARR was completed accurately. Joint record review of Resident 17's Level I PASARR dated 12/25/2024 did not show that anxiety disorders were marked in Section I. Staff G stated that they expected Level I PASARR to be completed accurately and that Resident 17's anxiety disorder should have been marked. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 22 Review of Resident 22's Level I PASARR completed on 12/11/2023 showed that mood disorders and other psychotic disorder were marked in Section I. It further showed that no referral for Level II evaluation was indicated in Section IV (Service Needs and Assessor Data). Review of Resident 22's EHR did not show that a Level I PASARR was updated and a referral for Level II evaluation was completed. A joint record review and interview on 05/05/2025 at 10:28 AM with Staff G, showed Resident 22's Level I PASARR dated 12/11/2023 required a Level II evaluation due to SMIs were indicated. Staff G stated that Resident 22's Level I PASARR was inaccurate and that a Level II referral should have been made. In an interview on 05/05/2025 at 3:46 PM, Staff A stated that they expected Level I PASARR would be completed accurately and referrals for Level II evaluations would be made timely. Reference: (WAC) 388-97-1975 (1)(4) .

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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** RESIDENT 13 Review of the February 2025 Medication Administration Record (MAR) printed on 05/02/2025 showed Resident 13 had a physician order for apixaban (an anticoagulant) tablet five milligrams (a unit of measurement) to give every 12 hours. Further review of the February 2025 MAR showed Resident 13 had started taking anticoagulant on 02/03/2025. Review of Resident 13's comprehensive care plan printed on 05/02/2025 did not show a care plan for use of anticoagulant and/or monitoring of its adverse side effects. In an interview and joint record review on 05/02/2025 at 2:49 PM, Staff I, Registered Nurse, stated that Resident 13 was on an anticoagulant medication. A joint record review of Resident 13's comprehensive care plan with Staff I did not show an anticoagulant care plan and/or monitoring of its side effects. Staff I stated that they monitored residents on anticoagulant for its side effects and that it should be part of their care plan. In an interview and joint record review on 05/02/2025 at 3:21 PM with Staff K, Minimum Data Set (an assessment tool) Coordinator, stated that Resident 13 was taking an anticoagulant. A joint record review of Resident 13's comprehensive care plan with Staff K did not show an anticoagulant care plan or monitoring of its side effects. Staff K stated that the use of anticoagulant and monitoring of its side effects should have been included in Resident 13's comprehensive care plan. In an interview on 05/05/2025 at 4:29 PM, Staff B stated they expected the use of anticoagulant and monitoring of its side effects should have been included in Resident 13's comprehensive care plan. Reference: (WAC) 388-97-1020 (1)(2)(a) Based on interview and record review, the facility failed to develop care plans for 2 of 12 residents (Residents 17 & 13), reviewed for comprehensive care plan. The failure to develop care plans for Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event that was either experienced or witnessed) and use of an anticoagulant (medication to prevent blood clot) placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Trauma-Informed and Culturally Competent Care, updated in March 2024, showed that the purpose of the facility policy was to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice .to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. It further showed, Work with residents and families to create a plan that embraces strengths. Review of the facility policy titled, Care Planning - Interdisciplinary Team, updated in April 2025, showed, The interdisciplinary team is responsible for the development of resident care plans .and implementation of the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 17 Review of a face sheet printed on 05/01/2025, showed Resident 17 admitted to the facility on [DATE] with diagnosis that included PTSD. In an interview on 04/29/2025 at 1:59 PM, Resident 17 stated that they had a diagnosis of PTSD after experiencing two separate traumatic events in the past. Resident 17 stated that, There are certain things I don't feel comfortable with. Review of the comprehensive care plan printed on 05/01/2025, showed no documentation that Resident 17 had a history of trauma and/or identified triggers. A joint record review and interview on 05/01/2025 at 1:41 PM with Staff V, Social Worker, showed that the comprehensive care plan did not address Resident 17's diagnosis of PTSD and associated triggers with specific interventions. Staff V stated, It doesn't look like triggers are referenced. When asked if Staff V expected Resident 17's care plan would include PTSD and triggers, Staff V stated, I think it would be a relevant addition to [Resident 17's] care plan. In an interview on 05/05/2025 at 4:15 PM, Staff B, Director of Nursing, stated that they expected residents who have a known diagnosis of PTSD to receive trauma-informed care. Staff B further stated that they expected PTSD triggers would be included in the residents' comprehensive care plan.

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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** Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 2 of 12 residents (Resident 19 & 23), reviewed for care plan revision. The failure to revise the care plan to include refusal to wear safety apron for smoking and identified activity preferences placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Discharge Planning, Discharge Summary and Post-discharge Plan of Care-Inpatient, updated in October 2022, showed, A comprehensive care plan will be developed by the interdisciplinary team within 21 days of admission and updated at minimum every three (3) months or more often if needed . Review of the facility's document titled, Resident Recreation and Activities Policy, updated in November 2022, showed [Facility will] Offer activities tailored to each individual resident's interest, abilities, and preferences, as identified through assessments and care planning. RESIDENT 19 An observation on 05/01/2025 at 9:58 AM, showed Resident 19 was smoking in the designated area accompanied by Staff E, Registered Nurse (RN). Further observation showed Resident 19 had no safety apron for smoking. An observation and interview on 05/01/2025 at 1:35 PM, showed Resident 19 self-propelled toward the second floor nursing station and informed Staff E that they wanted to go out and smoke. Staff E informed Resident 19 about wearing a safety apron to which Resident 19 responded, No. Staff E stated that Resident 19 had been refusing to wear a safety vest for smoking. Review of Resident 19's comprehensive care plan printed on 04/30/2025 did not show Resident 19's refusal behavior to wear a safety apron for smoking. In an interview and joint record review on 05/01/2025 at 3:08 PM, Staff C, Charge RN, stated that they would always ask Resident 19 about wearing a safety apron but [Resident 19] always refuses. A joint record review of residents' sign-out sheets for April 2025 with Staff C showed Resident 19 had been refusing to wear a safety apron for smoking. When asked if they had updated Resident 19's care plan to include their refusal to wear a safety apron for smoking, Staff C stated, No. Staff C further stated, I would expect it to have been included in the care plan. In an interview on 05/01/2025 at 4:29 PM, Staff B, Director of Nursing, stated that they expected Resident 19's comprehensive care plan to have been revised and/or updated to include their refusal to wear a safety apron for smoking. RESIDENT 23 (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 Resident 23's quarterly Minimum Data Set (MDS - an assessment tool) dated 11/17/2024 showed Section F0400 (Interview for Daily Preferences) was completed with Resident 23's Collateral Contact 1 (CC1). It further showed the following activity preferences were marked as very important to Resident 23: -To be around animals such as pets -To do your favorite activities -To go outside to get fresh air when the weather is good The activity To do things with groups of people, was marked as somewhat important, for Resident 23. Review of Resident 23's activities care plan printed on 05/05/2025, did not show Resident 23's activity preferences that were marked on Resident 23's quarterly MDS. A joint record review and interview on 05/02/2025 at 3:32 PM with Staff X, Activities Assistant, showed Resident 23's quarterly MDS dated [DATE] showed Section F0400 was completed with Resident 23's CC1. Staff X stated that they contributed to the development of Resident 23's activity care plan. A joint record review of the activity care plan did not show Resident 23's activity preferences were included. When asked if identified preferences in an MDS should be included in the care plan, Staff X stated, I think it should be. Staff X further stated that Resident 23's activity care plan did not list [Resident 23's] preferred activities and that, It should, but I don't [do not] see anything that would say that at this time. In an interview on 05/05/2025 at 3:45 PM, Staff A, Administrator, stated that they expected residents' activity care plans and program would be inclusive of interest and preferences for daily activities that were identified by the resident's family/representative. Reference: (WAC) 388-97-1020(2)(f)(4)(b) .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an activity program met the need of 1 of 1 resident (Resident 23), reviewed for activities. The failure to implement an individualized ongoing program to support the resident in their choice of activities based on the comprehensive assessment and care plan placed the resident at risk for unmet activity pursuit, social isolation, and a diminished quality of life. Findings included . Review of the facility policy titled, Resident Recreation and Activities, updated in November 2022, showed [Facility will] Offer activities tailored to each individual resident's interest, abilities, and preferences, as identified through assessments and care planning. Review of a face sheet printed on 05/01/2025, showed Resident 23 was admitted to the facility on [DATE]. In a phone interview on 04/29/2025 at 11:07 AM, Resident 23's Collateral Contact 1 [CC1] stated that Resident 23 was in their room 24/7 [24 hours, 7 days a week]. Review of Resident 23's admission Minimum Data Set (MDS - an assessment tool) dated 02/16/2024 showed Section F0400 (Interview for Daily Preferences) was completed with Resident 23. It further showed that the following daily preferences were marked as very important to Resident 23: -To listen to music [that Resident 23] liked -To keep up with the news -To go outside to get fresh air when the weather is good Additionally, the daily preference to be around animals such as pets, was marked to be somewhat important for Resident 23. Review of Resident 23's quarterly MDS dated [DATE] showed Section F0400, was completed with CC1 and that the following daily preferences were marked as very important to Resident 23: -To be around animals such as pets, -To do [Resident 23's] favorite activities, -To go outside to get fresh air when the weather is good. Additionally, the daily preference to do things with groups of people, was marked to be somewhat important for Resident 23 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 23's activity care plan printed on 05/05/2025, showed that Resident 23 needed assistance to be escorted to activity functions. Further review did not show that the identified daily preferences from Resident 23's admission MDS and quarterly MDS were included in Resident 23's activity care plan. Multiple observations showed Resident 23 remained in their room at the following times: - On 04/30/2025 at 2:10 PM and at 2:46 PM, Resident 23 was lying in bed, and their TV had a paused screen with the message, Are you still watching? - On 05/01/2025 at 8:16 AM, Resident 23 was lying in bed, and their TV was playing media. - On 05/02/2025 at 2:22 PM, Resident 23 was lying in bed, and their TV was playing media. It did not show that Resident 23 was offered activities outside of their room. In an interview and joint observation on 05/02/2025 at 10:03 AM, Staff Y, Registered Nurse, was asked what activities were offered to Resident 23, Staff Y answered, TV and [Resident 23's CC1] visiting with their dog. Staff Y further stated that the activity person comes in [Resident 23's room] once in a while and therapy work with them [in the room]. I don't think there's anything [activities] else. A joint observation showed Resident 23 had a Geri-chair (specialized medical recliner) in their room. When asked if Resident 23 was safe to use their Geri-chair outside of their room, Staff Y stated Yes, I would say it would be safe, if [Resident 23] can be reclined. Staff Y further stated that Resident 23's Geri-chair could be used to take them out to the patio somewhere, it would be nice. A joint record review and interview on 05/02/2025 at 3:32 PM with Staff X, Activities Assistant, showed Resident 23's quarterly MDS dated [DATE], indicated an interview for daily preferences was completed. Staff X stated that they completed the daily preferences interview with Resident 23's CC1. Staff X stated that they contributed to the development of Resident 23's activity care plan. A joint record review of Resident 23's activity care plan did not show that the identified daily preferences from Resident 23's quarterly MDS were included. Staff X stated that the identified daily preferences should have been included in Resident 23's care plan. Further joint record review showed, The resident needs assistance/escort to activity functions. Staff X stated that Resident 23 has not been going to group activities. Staff X stated that Resident 23 could have been transported outside of their room with their Geri-chair. When asked if they kept a log of activities that Resident 23 was offered or that Resident 23 participated outside of their room, Staff X stated that they documented monthly in the progress notes and that Resident 23 had not been provided any activities outside their room, for the month of April 2025. When asked if Resident 23's activity care plan was personalized to allow staff to offer activities tailored to Resident 23's interest and preferences, as identified from Resident 23's admission and quarterly MDS, Staff X stated No, it's not personalized. In an interview on 05/05/2025 at 3:45 PM, Staff A, Administrator, stated that they expected residents' activity program would be inclusive of interest and preferences for daily activities that were identified through assessments, such as MDS. Reference: (WAC) 388-97-0940(1)(2) .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident who was a trauma survivor and diagnosed with Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event that was either experienced or witnessed) was adequately assessed for trauma-informed care and associated triggers in accordance with professional standards of practice for 1 of 2 residents (Resident 17), reviewed for mood/behavior. This failure placed the resident at risk for unidentified triggers, re-traumatization, and a decreased quality of life. Findings included . Review of the facility policy titled, Trauma-Informed and Culturally Competent Care, updated in March 2024, showed that the purpose of the facility policy was to guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice .to address the needs of trauma survivors by minimizing triggers and/or re-traumatization. It further showed Work with residents and families to create a plan that embraces strengths. Review of a face sheet printed on 05/01/2025, showed Resident 17 admitted to the facility on [DATE] with diagnosis that included PTSD. In an interview on 04/29/2025 at 1:59 PM, Resident 17 stated that they had a diagnosis of PTSD after experiencing two separate traumatic events. Resident 17 stated that, there are certain things I don't feel comfortable with. Review of the comprehensive care plan printed on 05/01/2025, did not show documentation that Resident 17 had a history of trauma and/or identified triggers. In an interview and joint record review on 05/01/2025 at 1:41 PM, Staff V, Social Worker, was asked about the facility's process for identifying resident-specific triggers for those diagnosed with PTSD and Staff V stated that their facility did not have a specific assessment to identify PTSD triggers. Staff V stated that they reviewed a resident's mental health history and assessed residents upon admission through their initial social services assessment. A joint record review of Resident 17's progress note, dated 11/28/2024, showed that the initial social services assessment was completed with Resident 17 by Staff V. Staff V stated, We didn't specifically talk about triggers or PTSD related concerns. A joint record review of Resident 17's comprehensive care plan did not show PTSD and/or associated triggers were identified or addressed with specific interventions. Staff V stated, It doesn't look like triggers are referenced. When asked if they expected Resident 17's care plan would include PTSD and associated triggers, Staff V stated, I think it would be a relevant addition to [Resident 17's] care plan. In an interview on 05/05/2025 at 4:15 PM, Staff B, Director of Nursing, stated that they expected residents who have a known diagnosis of PTSD to receive trauma-informed care. Staff B further stated that they expected an assessment would be completed to identify resident-specific trauma, associated triggers and that PTSD triggers would be included in the residents' comprehensive care plan. Reference: WAC 388-97-1060(3)(e) (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing form was accurately completed to reflect the facility's name for 5 of 5 days (04/29/2025, 04/30/2025, 05/01/2025, 05/02/2025 & 05/05/2025), reviewed for sufficient and competent staffing. This failure placed the residents and residents' representatives at risk of not being fully informed of the current staffing levels. Findings included . Review of the facility policy titled, Posting Direct Care Daily Staffing Numbers, updated in November 2022, showed that the information recorded on the form shall include the name of the facility. Observations of the facility document titled, Licensed and Unlicensed Staff in our Nursing Home Today [dated accordingly], showed that the facility name was not reflected on the document posting at the following times: - Day one on 04/29/2025 at 8:33 AM - Day two on 04/30/2025 at 9:03 AM - Day three on 05/01/2025 at 11:36 AM - Day four on 05/02/2025 at 11:05 AM - Day five on 05/05/2025 at 1:32 PM In an interview and joint record review on 05/05/2025 at 1:44 PM, Staff F, Charge Registered Nurse, stated that they were responsible for managing the posting of direct care daily staffing numbers. A joint record review of the postings dated 04/29/2025, 04/30/2025, 05/01/2025, 05/02/2025, and 05/05/2025 with Staff F, showed that the facility name was not reflected on the documents. When asked if the documents posted reflected the name of the facility, Staff F stated, No. In an interview and joint record review on 05/05/2025 at 4:12 PM, Staff B, Director of Nursing, stated that their posted direct care daily staffing numbers facility form did not include the facility name and that I don't see it. No Associated WAC .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bailey-Boushay House	2720 East Madison Seattle, WA 98112

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure adequate monitoring was conducted for use of anticoagulant (medication that prevents blood clot) for 1 of 5 residents (Resident 13), reviewed for unnecessary medications. This failure placed the resident at risk of receiving unnecessary medications, adverse side effects, and related complications. Findings included . Review of the facility policy titled, High-Alert Medication Monitoring Policy, updated in November 2022, showed, Residents prescribed medications falling under the definition of high-risk will be monitored for adverse side effects and the observations documented in the clinical record. Residents who use high-risk medications will be routinely assessed for side effects. Review of the physician's order summary report printed on 05/05/2025 at 7:32 AM, showed Resident 13 had an order for apixaban (an anticoagulant medication) five milligrams (mg-a unit of measurement) to be given every 12 hours for pulmonary embolism (blood clot in the lungs) and deep vein thrombosis (blood clot in the deep vein). Further review of the physician's order summary report did not include monitoring for adverse side effects related to anticoagulant use. Review of the April 2025 and May 2025 Medication Administration Records (MARs) showed Resident 13 had been receiving an anticoagulant medication since 02/03/2025. Further review of April 2025 and May 2025 MAR indicated that Resident 13 was not monitored for adverse side effects from anticoagulant use. In an interview and joint record review on 05/02/2025 at 2:49 PM, Staff I, Registered Nurse (RN), stated that they monitored residents on anticoagulant for its adverse side effects. A joint record review of the physician's order with Staff I showed Resident 13 had an order for apixaban five mg to be given every 12 hours. Further review of the physician's order summary report did not include monitoring for adverse side effects related to anticoagulant use. A joint record review of May 2025 MAR did not show Resident 13 had monitoring for adverse side effects from anticoagulant use. Staff I stated that Resident 13 had no adequate monitoring for adverse side effects related to anticoagulant use. In an interview and joint record review on 05/02/2025 at 3:21 PM, Staff K, Minimum Data Set (an assessment tool) Coordinator, stated that Resident 13 was taking an anticoagulant. A joint record review of the physician's order and the May 2025 MAR showed Resident 13 was not monitored for adverse side effects from anticoagulant use. Staff K stated that Resident 13 did not have adequate monitoring for anticoagulant use. In an interview on 05/05/2025 at 3:51 PM, Staff F, Charge RN, stated that Resident 13 did not have physician's order for monitoring adverse side effects from anticoagulant use. In a follow-up interview at 4:35 PM, Staff F stated that they just added the adverse side effects monitoring in the physician's order for Resident 13. In an interview on 05/05/2025 at 4:29 PM, Staff B, Director of Nursing, stated that they expected Resident 13 to have had a physician order to monitor adverse side effects of anticoagulant and that it should have been adequately monitored for adverse side effects. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-1060 (3)(k)(i)(4) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to appropriately store biologicals (medicines made from living things like proteins that help treat and/or prevent diseases) to maintain the appropriate temperature range for 1 of 1 medication refrigerator (2nd floor Medication Refrigerator), and failed to ensure medical supplies were labeled with expiration dates for 1 of 2 medication carts (West 3 Medication Cart), reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised and/or ineffective biological and medical supplies. Findings included . Review of the facility policy titled, Medication Storage in the Facility, updated in May 2017, showed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. 2ND FLOOR MEDICATION REFRIGERATOR A joint observation and interview on 04/30/2025 at 12:45 PM with Staff H, Registered Nurse (RN), showed COVID-19 (disease caused by a virus called SARS-CoV-2) and influenza (disease caused by a virus causing the flu) vaccines (biological injections) were stored in the medication refrigerator. When asked if the internal refrigerator temperatures were monitored, Staff H stated, Yes and provided a copy of the facility document titled, Refrigerator/Freezer Log, 2nd Floor Medication Room Refrigerator, dated April 2025. Review of the facility's document titled, Refrigerator/Freezer Log, 2nd Floor Medication Room Refrigerator, dated April 2025, showed, Acceptable temperature ranges: Medication Fridge 36-46 degrees Fahrenheit [F - unit of measurement]. It further showed that recorded internal refrigerator temperatures for the following dates fell below the acceptable temperature range: - On 04/04/2025 it was recorded at 35 degrees F - On 04/18/2025 it was recorded at 33 degrees F - On 04/25/2025 it was recorded at 35 degrees F It further showed that the refrigerator log directed staff to notify the Facilities Manager [Staff U] and write a work-order. It did not show that work orders were filed for 04/04/2025, 04/18/2025 and 04/25/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint record review and interview on 05/02/2025 at 11:24 AM, with Staff F, Charge RN, showed the facility's document titled, Refrigerator/Freezer Log, 2nd Floor Medication Room Refrigerator, dated April 2025 had temperature readings recorded on 04/04/2025, on 04/18/2025, and on 04/25/2025 that fell below the acceptable temperature range. It further showed that no work orders were completed for the temperature readings recorded on 04/04/2025, 04/18/2025 and on 04/25/2025. Staff F stated that they expected work orders to have been completed. When asked if biologicals were stored in the 2nd floor medication fridge, Staff F stated, yes and that COVID-19 and influenza vaccines were stored in the 2nd floor medication refrigerator. A joint record review of the manufacturer packaging instructions for storage for COVID-19 and influenza vaccines showed recommended to be stored within 36-46 degrees F. Staff F stated that they expected vaccines would have been stored according to the manufacturer's instructions. A joint record review and interview on 05/02/2025 at 1:01 PM with Staff U, showed the facility document titled, Refrigerator/Freezer Log, 2nd Floor Medication Room Refrigerator, dated April 2025 had temperature readings recorded on 04/04/2025, on 04/18/2025 and on 04/25/2025 that fell below the acceptable temperature range and that no work orders were completed. When asked if Staff U was notified of the temperatures that fell below the acceptable temperature range in the month of April 2025, Staff U stated they would check their records. In a follow up interview at 1:33 PM, Staff U stated that there was no work orders received or completed for the 2nd floor medication fridge temperature readings on 04/04/2025, on 04/18/2025, and on 04/25/2025. Staff U stated that they believed they were supposed to receive work orders for temperature readings that fell below the acceptable range. WEST 3 MEDICATION CART Review of an undated online manufacturer documented titled, 3M [brand name] Disposable Respirator 1860, 1860s, N95 [type of respirator (type of filtering mask)] Technical Data Sheet, showed, Shelf life of the unopened product is five (5) years from date of manufacture when stored within temperature range .End of shelf-life date is marked on the product packaging. Before initial use, always check that the product is within the stated shelf life. When storing or transporting this product use original packaging provided. A joint observation and interview on 05/01/2025 at 8:48 AM with Staff Z, RN, showed unbagged teal-colored masks labeled 3M 1860 N95 were stored in the bottom drawer of the medication cart. Staff Z stated that the stored N95 masks were used by staff. When asked if the shelf life or expiration dates of the stored N95s were known, Staff Z stated that the expiration date was labeled on the box (manufacturer's packaging). When asked to refer to the box, Staff Z stated that the box can't [cannot] be located. Staff Z further stated that they expected to reference the expiration date for N95's stored in the medication cart and that It should have an expiration date. In an interview on 05/05/2025 at 4:12 PM, Staff B, Director of Nursing, stated that they expected biologicals would be stored at the recommended temperature range to ensure efficacy. Staff B stated that they expected work orders to have been completed when medication refrigerator temperatures fell below the acceptable range. Staff B further stated that they expected all stored supplies in the medication carts would have an expiration date for staff to reference. Reference: (WAC) 388-97-1300 (2) .

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** STAFF O Review of the face sheet printed on 05/05/2025 showed that Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's self-care deficit care plan, printed on 04/30/2025, showed that Resident 15 required one-person total assistance with eating. During the entrance conference meeting on 04/29/2025 at 9:00 AM, Staff A, Administrator, and Staff B, stated that they had a paid feeding assistance program in the facility. Observation on 04/30/2025 at 12:02 PM, showed Resident 15 was sitting in the dining room and was assisted by Staff O, Recreation Therapists. In an interview on 04/30/2025 at 12:29 PM, Staff O stated that they assisted Resident 15 with their lunch meals. Staff O stated that they received paid feeding assistant training in the year 2017. When asked to provide their training certificate, Staff O provided a digital presentation document about texturizing and feeding basics, dated 2015. Further review of the document did not indicate that Staff O received the training. When asked if Staff O had a certificate, Staff O stated, Let me look for it. Staff O did not provide the requested training certificate. In an interview on 05/05/2025 at 9:08 AM, Staff F stated that Resident 15 received paid feeding assistance. Staff F stated that they would expect Resident 15 to be assisted by a trained paid feeding assistant. In an interview on 05/05/2025 at 1:06 PM, Staff B stated that they would expect Resident 15 to be assisted by trained staff with their meals. Staff B stated that Staff O had reported to them that they had received paid feeding assistant training. Staff B stated that Staff O did not receive a certificate of training completion, and that the facility was unable to locate it in their records. Reference: WAC 388-97-1060 (3)(h)(i) Based on observation, interview, and record review, the facility failed to ensure a resident in the paid feeding assistance program was adequately assessed for appropriateness to receive paid feeding assistance for 1 of 4 residents (Resident 24), and failed to ensure staff providing the paid feeding assistance was properly trained for 1 of 10 staff (Staff O), reviewed for dining observations. These failures placed the residents at risk for choking and aspiration (inhalation of food or fluid into the lungs) and a diminished quality of life. Findings included . (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Using Paid Feeding Assistants, updated in March 2024, showed that residents would be assessed for appropriateness for the program. The policy showed that the Charge Nurse or MDS (Minimum Data Set-an assessment tool) Coordinator will determine if a resident is safe to be fed by a Paid Feeding Assistant. The policy showed that no residents with complicated feeding problems will be deemed appropriate to be fed by the Paid Feeding Assistant and that Complicated feeding problems can include, but not limited to difficulty swallowing, etc. The policy further showed that paid feeding assistance would be provided by only recreation therapist and other clinical staff with appropriate training. RESIDENT 24 Review of Resident 24's physician's orders, printed on 05/01/2025, showed, regular diet, regular texture, nectar/mildly thick consistency, which indicated that Resident 24 required liquids to be thickened. Review of Resident 24's speech therapy progress note dated 01/23/2025, showed that Resident 24 was assessed during a meal and that they reported a little trouble chewing and swallowing food textures and difficulty swallowing thin liquid. It showed that Resident 24 showed overt [something obvious] signs of aspiration with thin liquid by straw. It further showed that the speech therapist recommended Resident 24 to continue with nectar thick liquids and one on one feeding assistance. Review of Resident 24's electronic health records did not show documentation of an assessment for Resident 24's appropriateness to receive assistance from paid feeding assistants. In an interview on 05/01/2025 at 4:07 PM, Staff F, Charge Registered Nurse, stated that Resident 24 received paid feeding assistance provided by patient [resident] care assistants. Staff F stated that Resident 24 had been deemed to have swallowing issues with thin liquids. When asked if an assessment was completed to ensure Resident 24 was appropriate to receive assistance from paid feeding assistants, Staff F stated, I have consulted with the team, and that there was no documentation of an assessment that was completed. In an interview on 05/01/2025 at 4:37 PM, Staff K, MDS Coordinator, was asked if they were responsible for completing assessments for determining residents were safe to receive paid feeding assistance, Staff K stated, I did not know I was supposed to do that. Observation on 05/02/2025 at 8:50 AM showed Resident 24 was assisted with their meal by Staff Q, Patient Care Assistant. It further showed that Resident 24's meal tray had a bowl of hot cereal, a plate of banana slices and two bottles filled with thickened liquids. In an interview and joint record review on 05/02/2025 at 11:11 AM, Staff B, Director of Nursing, stated that Resident 24 had difficulty swallowing. When asked if Resident 24 was assessed for appropriateness to receive feeding assistance, Staff B stated, let me find out. A joint record review of the facility's policy titled Using Paid Feeding Assistants, updated in March 2024, showed that no resident with complicated feeding problems will be deemed appropriate to receive paid feeding assistance and that complicated feeding problems included difficulty swallowing. Staff B stated that Resident 24 did not meet the criteria for the paid feeding assistance program. In a follow-up interview at 12:38 PM, Staff B stated there was no documentation for an assessment completed to determine if Resident 24 was safe to receive paid feeding assistance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 1 of 3 Refrigerators (Reach-in Cooler), reviewed for food services. The failure to label and date food items placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages) and a diminished quality of life. Findings included . Review of the facility policy titled, Food Receiving and Storage, revised in November 2022, showed that foods shall be stored in a manner that complied with safe food handling practices. The policy further showed that all foods stored in the refrigerator were covered, labeled and dated. Joint observation of the reach-in cooler and interview on 04/29/2025 at 8:34 AM with Staff M, Nutrition Assistant, showed the following food items: -One opened container of Ultra [brand name] Milk with no open date -One opened container of Thick & Easy [brand name] dairy beverage with no open date -One unlabeled and undated, brownish-colored sliced food items inside a resealable plastic bag -One unlabeled and undated food item wrapped in aluminum foil Staff M stated that the brownish-colored sliced food items inside the resealable plastic bag were cooked roast beef slices, and the item wrapped in aluminum foil was Kielbasa [brand name] sausage. Staff M stated that they should have dated the container of Ultra Milk and the Thick & Easy dairy beverage when they opened them. Staff M further stated that they should have labeled and dated the cooked roast beef slices and Kielbasa sausage before storing them inside the reach-in cooler. In an interview on 04/29/2025 at 8:46 AM with Staff J, Executive Chef, stated that they expected that the open container of Ultra milk and the open container of Thick & Easy dairy beverage should have had open dates. Staff J further stated that the cooked roast beef slices and kielbasa sausage should have been properly labeled and dated. In an interview on 05/05/2025 at 2:15 PM, Staff A, Administrator, stated that they expected staff to have properly labeled and dated food items. Reference: (WAC) 388-97-1100 (3) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** PROPER REMOVAL OF PPE STAFF R An observation of room [ROOM NUMBER] at 04/29/2025 at 10:48 AM showed a contact isolation [use of gown and gloves to prevent the spread of germs] sign was posted at the entrance. It further showed a PPE cart, and a black covered trash bin placed outside of room [ROOM NUMBER]. An observation on 04/30/2025 at 12:19 PM showed Staff R, CNA, wore PPE prior to entering room [ROOM NUMBER] to deliver a lunch tray. It further showed Staff R exited room [ROOM NUMBER] without removing their used gown and gloves. In an interview on 04/30/2025 at 12:31 PM, Staff R was asked what the facility's process was for entering rooms when contact isolation was indicated and Staff R stated, I wear PPE and that to protect ourselves and so we don't spread the illness out of their room. Staff R further stated, Everything in the room stays in the room, including PPE, we don't [do not] bring outside. When asked if they removed their used PPE outside of the room, Staff R stated, It just became my habit and that room [ROOM NUMBER] did not have a trash bin dedicated for removing PPE inside the room. In an interview and joint observation on 05/05/2025 at 8:28 AM, Staff D stated they followed CDC guidelines for infection prevention and control. Joint observation showed room [ROOM NUMBER] had a PPE cart and a black covered trash bin outside of the room. When asked if they considered used PPE to be contaminated, Staff D stated, Yes. Staff D further stated that they expected used PPE to be removed inside the room when contact isolation was indicated. In an interview on 05/05/2025 at 4:12 PM, Staff B stated they followed CDC guidelines for infection prevention and control. Staff B further stated that they expected used PPE would be removed inside the rooms. STAFF H An observation on 04/30/2025 at 9:36 AM, showed Staff H, RN, administered medications to Resident 9 (on EBP-precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections). Staff H removed their used reusable gown and placed it inside the laundry bin outside Resident 9's room. In an interview on 04/30/2025 at 2:01 PM, Staff H stated that they placed their used reusable gown inside the laundry bin outside Resident 9's room. When asked if they were following proper infection control practices, Staff H stated that it was their practice (to dispose used reusable gown outside the residents' room) in the facility. In an interview on 05/05/2025 at 2:06 PM, Staff D stated that they expected staff to remove their used PPE before they leave the resident's room. In an interview on 05/05/2025 at 4:22 PM, Staff B stated that they expected staff to remove their used PPE before exiting an EBP room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1320 (1)(a)(c) Based on observation, interview and record review, the facility failed to ensure infection prevention and control practices were followed related to hand hygiene between glove change and/or proper removal of used Personal Protective Equipment (PPE-gown and gloves) for 4 of 6 staff (Staff T, L, R & H), reviewed for infection control. These failures placed the residents, staff, and visitors at risk for facility acquired or healthcare-associated infections and related complications. Review of the facility policy titled, Infection Prevention and Control Program, updated in June 2024, showed Employees and volunteers at [facility name] follow the CDC [The Centers of Disease Control and Prevention] Hand Hygiene guidelines. It further showed that employees followed guidelines produced by CDC. Review of the CDC's online document titled, Guideline for Isolation Precautions [steps used in healthcare settings to prevent the spread of infections]: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), dated 11/27/2023, showed Before leaving the patient's room or cubicle, remove and discard PPE .remove gloves after contact with a patient and/or the surrounding environment .remove gown and perform hand hygiene before leaving the patient's environment. HAND HYGIENE STAFF T An observation on 04/30/2025 at 2:19 PM showed Staff T, Housekeeper, parked a housekeeping cart in front of room [ROOM NUMBER]. It showed Staff T entered room [ROOM NUMBER] while holding wet cleaning-wipes with gloves on. It further showed Staff T exited room [ROOM NUMBER] and replaced their used gloves with new gloves from their housekeeping cart, without performing hand hygiene. Additional observations showed the following: - At 2:25 PM Staff T exited room [ROOM NUMBER] while holding a filled clear bag that they placed in the housekeeping cart. Staff T then removed their used gloves and put on a new pair of gloves. It did not show Staff T performed hand hygiene between glove change. -At 2:29 PM Staff T exited room [ROOM NUMBER] while wearing gloves and opened a door labeled 3F. Staff T then removed their used gloves at the housekeeping cart and put on a new pair of gloves without performing hand hygiene between glove change. In an interview on 04/30/2025 at 2:37 PM, Staff T stated they wore gloves to clean surfaces in the rooms to include the sink counters, the bathrooms and the floors. When asked if they cleaned their hands before wearing new gloves, Staff T stated, Yes, when I finish cleaning the room. When asked if they would perform hand hygiene when removing used gloves and before wearing new gloves, Staff T stated, I don't know. In an interview on 05/05/2025 at 10:51 AM, Staff D, Infection Preventionist, stated that they expected housekeeping staff would perform hand hygiene between glove use and that it was standard practice. Staff D further stated that they did not expect used gloves to be worn in the hallways and that they expected used gloves to be removed inside the rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/05/2025 at 4:12 PM, Staff B, Director of Nursing, stated that they followed CDC guidelines for infection prevention and control and that they expected all staff would follow hand hygiene practices to prevent the spread of infection. STAFF L An observation on 04/29/2025 at 12:13 PM showed Staff L, Certified Nursing Assistant (CNA), had their gloves on and was setting up Resident 10's lunch meal. Staff L then removed their used gloves and put on a new pair of gloves that was handed to them by Staff C, Charge Registered Nurse (RN). Staff L did not perform hand hygiene prior to wearing their new pair of gloves. In an interview on 04/29/2025 at 12:30 PM, Staff C stated that they expected staff to perform hand hygiene in between glove change. In an interview on 04/29/2025 at 12:35 PM, Staff L stated that they did not perform hand hygiene after they removed their used gloves. Staff L stated that they were expected to perform hand hygiene between glove change. In an interview on 05/05/2025 at 2:08 PM, Staff D stated that they expected staff to perform hand hygiene before and after glove change.