STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505478	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corwin Center at Emerald Heights	10901 - 176th Circle Northeast Redmond, WA 98052

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43392 Based on observation, interview, and record review, the facility failed to provide care and services in a manner that maintained and promoted dignity while assisting with meals for 1 of 6 residents (Resident 16), reviewed for dining observations. This failure placed the resident at risk for a diminished self-worth and over-all well-being. Findings included . Resident 16 admitted to the facility on [DATE] with diagnosis that included Alzheimer's (a brain disorder that slowly destroys memory and thinking skills, and eventually affects the ability to carry out the simplest tasks). Review of Resident 16's annual Minimum Data Set (an assessment tool) dated 02/22/2024, showed the resident had memory loss and was dependent on staff for eating. Observation on 04/01/2024 at 12:02 PM, showed Resident 16 was seated upright in their wheelchair with a food tray in front of them and was observed attempting to eat their lunch using a spoon without success. On 04/01/2024 at 12:05 PM, Staff R, Registered Nurse, was observed standing over Resident 16 while assisting them with their meal. On 04/01/2024 at 12:18 PM, Staff R stated they were standing while assisting Resident 16 with their meal. Staff R stated there was no chair in the room and that they were busy on the floor. Staff R further stated that their practice was to either sit and/or stand whichever was comfortable for them. Review of Resident 16's care plan initiated on 05/22/2023, showed Resident 16 was to be provided with 1 on 1 (one resident to one staff) eating assistance at every meal. On 04/05/2024 at 2:15 PM, Staff B, Director of Nursing, stated that they expected their staff to be seated and ensure they were at eye level with the resident when assisting the resident with their meal. Reference: (WAC) 388-97-0180(4)(ii)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure missing item was logged and investigated for 1 of 2 residents (Resident 23), reviewed for personal property. This failure placed the resident at risk for decreased sense of security and a diminished quality of life. Findings included . Review of the facility's policy titled, Filing Grievances/Complaints, revised in November 2010, showed, Any resident, his or her representative (sponsor), family member, appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members, missing items etc. , without fear of threat or reprisal in any form. It further showed that the social services department representative will log the reported concern and the appropriate department manager will respond to the concerned party. Resident 23 admitted to the facility on [DATE]. On 04/01/2024 at 10:29 AM, Resident 23 stated they were missing an electric toothbrush and that their representative had informed the facility about it. On 04/03/2024 at 9:15 AM, Resident 23 stated that their representative told Staff S, Resident Care Manager, about the missing electric toothbrush and that the facility staff tried to look for it and were unable to find it. On 04/03/2024 at 3:10 PM, Resident 23's representative stated that they were aware of Resident 23's missing electric toothbrush and that it went missing three to four months ago. Resident 23's representative stated that Staff S and Staff T, Social Services Director, were aware and were unable to find it. Resident 23's representative further stated that they were not reimbursed for the missing item. Review of Resident 23's inventory list dated 07/31/2023, showed Sonic care [Brand-electric] toothbrush. Review of the December 2023 through April 2024 grievance log did not show that a grievance report was logged for Resident 23. In an interview on 04/03/2024 at 3:13 PM, Staff F, Social Services Associate, stated that if a resident reported missing an item, the staff would fill out a grievance form and would be given to Staff T, who would complete the investigation. Staff F stated that the Director of Nursing (DON) and/or Administrator would review the investigation and give the final report to the resident. Staff F reviewed the grievance log and stated that they did not see a log for Resident 23's missing electric toothbrush. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2024 at 3:28 PM, Staff A, Administrator, stated they were not aware Resident 23 was missing an electric toothbrush. Staff A stated that if Resident 23 had an electric toothbrush listed on their inventory list, they expected a grievance form to be filled out. Joint record review on 04/03/2024 at 3:37 PM with Staff B, DON, showed, Sonic Care toothbrush listed in Resident 23's inventory list dated 07/31/2023. On 04/03/2024 at 4:27 PM, Staff B stated that Staff S reported Resident 23's electric toothbrush might have been on their tray and thrown away. Staff B stated that Staff S reported there was an email thread that occurred between them and Resident 23's representative and that they did not file a grievance report because the person who placed the toothbrush on the tray was a privately hired caregiver. Staff B further stated that Staff S should have filled out a grievance report. Reference: (WAC) 388-97-0560 (2)(b)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 3 of 4 residents (Residents 37, 33 & 4), reviewed for abuse investigations. This failure placed the residents at risk for further physical abuse, injury, and diminished quality of life. Findings included . According to the Washington State Reporting Guidelines for Nursing Homes (Purple Book) dated October 2015, Abuse is the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. The term 'willful' describes the deliberate or non-accidental action or inaction that resulted in the abuse of the resident. Review of the facility's policy titled, Freedom from Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised in September 2019, showed, It is the policy of the facility that each resident has the right to, and will be free from Abuse. The policy showed, the residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. It further showed definition of abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. RESIDENT 37 Resident 37 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 02/08/2024 showed Resident 37 had severe cognitive impairment (confusion and/or memory loss). On 04/01/2024 at 11:13 AM, Resident 37 stated they did not remember any confrontation or altercation with other residents. RESIDENT 33 Resident 33 admitted to the facility on [DATE]. Review of the quarterly MDS dated [DATE] showed Resident 33 had moderate cognitive impairment. On 04/01/2024 at 11:29 AM, Resident 33's representative stated they were aware that Resident 33 was punched by another resident and that they have not noticed any change in Resident 33's behavior or demeanor after the incident. RESIDENT 4 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 4 admitted to the facility on [DATE]. Review of the annual MDS dated [DATE] showed Resident 4 had severe cognitive impairment. On 04/03/2024 at 1:15 PM, Resident 4 stated they did not remember any confrontation or altercation with other residents. Review of the facility's March 2024 Incident Log, showed Resident 37 had a resident-to-resident altercation with Resident 4 on 03/09/2024 and with Resident 33 on 03/17/2024, which occurred in the Great Room (an open space/room in the facility where residents and/or visitors meet, watched TV and/or performed activities). Review of the facility's incident investigation report dated 03/09/2024, showed Resident 4 dumped cold water on Resident 37's back. Resident 37 screamed and threw a paper cup at Resident 4. Resident 4 then kicked Resident 37 who reacted by lightly punching Resident 4's arm. Resident 37 and Resident 4 were in their wheelchair when the incident happened. Further review of the incident investigation showed Resident 37 and Resident 4 had no issue in the past or any known animosity between them and that they did not sustain any physical injuries. Review of the written statement by Staff V, Weekend Receptionist, dated 03/11/2024, showed Staff V observed Resident 37 screamed and threw a paper cup at Resident 4. Staff V then saw Resident 4 kicked Resident 37. The statement further showed that Staff V saw Resident 37 punched Resident 4's arm. Staff J, Nursing Assistant Certified (NAC), was running right behind Staff V, and they separated Resident 37 and Resident 4. On 04/03/2024 at 2:12 PM, Staff J stated they were in the hallway and heard a commotion in the Great Room. Staff J stated they heard Resident 37 screamed why did you throw water? at Resident 4. Staff J separated both residents. Staff J stated that Resident 37 told them that Resident 4 poured water on their back and when they placed their hand over Resident 37's back, they noticed that their shirt was wet. Review of the facility's incident investigation report dated 03/17/2024, showed Resident 37 was yelling play with your own stuff at Resident 33. Staff P, Licensed Practical Nurse, heard the yelling and as Staff P walked into the Great Room, they witnessed Resident 37 raised their right arm and brought down onto Resident 33's left arm, slapping him with an open hand. The investigation report showed Staff P intervened and told Resident 37 to stop. Staff P immediately assessed Resident 33 for injury, and no injury was observed. Further record review of the investigation report showed Resident 37 had a recent resident-to-resident altercation prior to this incident dated 03/09/2024. Review of Resident 33's nursing progress note dated 03/17/2024, showed that a skin assessment was completed with no new skin issues noted. On 04/04/2024 at 10:18 AM, Staff P stated they were charting (writing nurse's notes) and heard Resident 37 yelling with escalating voice. Staff P stated, I saw [Resident 37] wheeling towards [Resident 33] and raised his arm and hit [Resident 33's] left upper arm with an open hand. Staff P stated they separated Resident 37 and Resident 33. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/05/2024 at 10:10 AM with Staff A, Administrator and Staff B, Director of Nursing, stated that they acknowledged that Resident 37, Resident 33, and Resident 4 had been involved in a resident-to-resident incident resulting to physical altercations. Staff A and Staff B stated that they could not have known and prevented the incidents from happening as they could not predict the events before they occurred. Reference: (WAC) 388-97-0640 (1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure allegations of abuse was reported to the State Agency as required for 1 of 3 residents (Resident 30), reviewed for abuse allegations. This failure placed the resident at risk for potential unidentified abuse and lack of protection from abuse. Findings included . Review of the facility's policy titled, Freedom from Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revised in September 2019, showed, if an incident is considered reportable, there shall be an initial (immediate or within 24 hours) report to the department. Resident 30 admitted to the facility on [DATE]. Review of the nursing progress note dated 03/18/2024, showed Staff P, Licensed Practical Nurse, documented that Resident 30 was placed on alert r/t [related to] increasing verbal abuse from roommate. It further showed that Resident 30 made numerous statements to the Nursing Assistant Certified (NAC) to stop roommate from yelling at them and that Resident also stated to NAC, I don't want to do anything more, I'm tired of her yelling at me. I'm just going to sit here. Review of the facility's March 2024 incident log did not show that the incident dated 03/18/2024 was logged for Resident 30 or that the incident was reported to the State Agency. On 04/05/2024 at 9:11 AM, Staff P stated that if they observed abuse, they would protect the resident, assess for injury, and report it to the Director of Nursing (DON), Administrator, and State Agency. Staff P further stated they spoke to Staff S, Resident Care Manager, regarding their concern of verbal abuse and that it was discussed what to do as far as, putting Resident 30 and their roommate on alert and monitoring. Staff P stated that they were educated that it should have been brought to the Administrator's attention immediately. In an interview and joint record review on 04/05/2024 at 9:31 AM, Staff B, DON, stated if an abuse allegation was reported, they would report to the State Agency within two hours if actual abuse happened, if not, they would report it within 24 hours. Staff B stated they would investigate and log it in the incident log within five days. Joint record review of Resident 30's nursing progress note dated 03/18/2024 showed, verbal abuse. Staff B stated, I see it. Staff B stated that they spoke to Staff P about Resident 30 and their roommate yelling and being hard of hearing. Staff B stated that there was a conversation about how they were together and that it didn't have any abuse connotation. Staff B further stated that Staff P should have reported the verbal abuse and that it should have been investigated. On 04/05/2024 at 9:56 AM, Staff A, Administrator, stated that the abuse allegation should have been reported to the State Agency and investigated. Reference: (WAC) 388-97-0640 (5)(a)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to transmit resident assessment data to the Centers for Medicare & Medicaid Services (federal agency that provides health coverage) within the required timeframe for 1 of 3 residents (Resident 5), reviewed for timeliness in transmitting discharge Minimum Data Set (MDS-an assessment tool). This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1. 18.11, revised in October 2023, showed discharge (non-comprehensive) MDS must be completed no later than 14 days after the Assessment Reference Date (ARD) (A2300), and it must be submitted/transmitted within 14 days of the MDS completion date (Z0500+14 days) to the database as required. Resident 5 admitted to the facility on [DATE]. Review of the MDS look up assessment showed that a discharge MDS with an ARD of 12/29/2023 was not completed/submitted and was 83 days late. In an interview and joint record review on 04/03/2024 at 11:14 AM, Staff D, MDS Nurse, stated they used the RAI manual for MDS completion. Staff D stated they would complete the discharge MDS within 14 days from the ARD. Joint record review of Resident 5's MDS look up assessment showed the discharge MDS dated [DATE], was not completed. Staff D stated, I don't know how I missed that. Staff D further stated that Resident 5's MDS should have been completed and submitted. On 04/03/2024 at 1:24 PM, Staff B, Director of Nursing, stated that they expected the MDS to be completed and transmitted in a timely manner. Reference: (WAC) 388-97-1000 (5)(e)(iii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to accurately assess 1 of 6 residents (Resident 29), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate medication coding placed the resident at risk for unidentified or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed, coding instructions to code all high risk drug class medications according to their pharmacological (drug's uses, effects, and modes of actions) classification and not how they are being used. It further showed to check if the resident is taking any medication by pharmacological classification during the 7-day observation period. 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 29 admitted to the facility on [DATE]. Review of the significant change of status MDS with an ARD of 02/08/2024 showed Resident 29 was marked for anticoagulant (blood thinner) medication and not for antiplatelet (helps keep blood flowing in the body) medication. Review of the February 2024 Medication Administration Record (MAR) showed Resident 29 received Brillanta (an antiplatelet medication used to prevent cardiovascular events [conditions affecting the heart or blood vessels] and blood clots) twice a day for hemiplegia (muscle weakness on one side of the body) during the look back period. Further review of the February 2024 MAR did not show Resident 29 had an order for an anticoagulant medication. In an interview and joint record review on 04/03/2024 at 11:14 AM, Staff D, MDS Nurse, stated they used the RAI manual for MDS completion. Joint record review of Resident 29's February 2024 MAR showed Resident 29 did not have an order for an anticoagulant medication. Staff D stated Resident 29's MDS should have been marked for antiplatelet and that they would modify the assessment. On 04/03/2024 at 1:24 PM, Staff B, Director of Nursing, stated they expected the MDS to be completed accurately. Reference: (WAC) 388-97-1000 (1)(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** 47680 Based on observation, interview, and record review, the facility failed to revise comprehensive care plans for 3 of 14 residents (Resident 11, 9 & 20), reviewed for care plan revision. The failure to revise care plans for oxygen use and refusal with care placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Planning- Interdisciplinary Team, revised in November 2011, showed that care plans would be individualized to support the resident's medical concerns with intervention and that each care plan would be updated at least quarterly and as needed. Review of the facility's undated policy titled, Oxygen Administration, showed the resident's care plan shall identify the interventions for oxygen therapy, based upon the resident assessment and orders, such as, but not limited to the type of oxygen delivery system, when to administer, equipment setting for the prescribed flow rates, monitoring of oxygen saturation levels and/or vital signs as ordered and monitoring for complications associated with the use of oxygen. RESIDENT 11 Resident 11 admitted to the facility on [DATE]. On 04/01/2024 at 12:17 PM, Resident 11 stated they used oxygen at night. Review of the April 2024 Treatment Administration Record (TAR) showed the following orders: -Continuous oxygen therapy during the night one liter (a unit of measurement) via nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) with a start date of 03/27/2023. -Change oxygen tubing weekly every week on Friday night shift with a start date of 03/27/2023. Review of Resident 11's medical condition care plan dated 3/26/2024, did not include oxygen use. On 04/04/2024 at 11:15 AM, Staff M, Licensed Practical Nurse (LPN), stated that if a resident was on oxygen, it would be included in their care plan and in the medication administration record. During a joint record review and interview on 04/04/2024 at 11:32 AM with Staff D, Minimum Data Set (MDS) Coordinator, showed Resident 11's care plan did not include oxygen use. Staff D stated that Resident 11's oxygen use should have been part of their care plan and that their care plan needed to be revised. On 04/04/2024 at 2:40 PM, Staff B, Director of Nursing, stated Resident 11's care plan should have been revised to include oxygen use. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47130 RESIDENT 9 Resident 9 admitted to the facility on [DATE]. Review of Resident 9's annual MDS (an assessment tool) dated 02/16/2024, showed one unhealed stage three pressure ulcer (localized damage to the skin/underlying tissue over a bony prominence) and a pressure ulcer treatment. Review of Resident 9's April 2024 TAR showed a wound care/treatment every three days for chronic sacrum (tail bone) wound dated 05/18/2023. Review of Resident 9's TAR for December 2023 through March 2024, showed that the sacrum wound treatment was refused for the following: - Six times in December 2023 - 15 times in January 2024 - Two times in February 2024 - Three times in March 2024 On 04/03/2024 at 9:27 AM, Staff H, LPN, stated that Resident 9 had been refusing sacrum wound treatment and would want dressing change during bathing and/or when the dressing was soiled. On 04/03/2024 at 9:37 AM, Resident 9 stated they did not need frequent wound (sacrum) treatments and that they prefer wound treatments after bathing and/or when soiled. On 04/04/2024 at 10:29 AM, Staff I, LPN, stated that Resident 9 had been refusing their sacrum wound treatment for a while now. Staff I further stated that refusals of treatment were documented on the TAR. Review of the Resident 9's skin care plan revised on 08/11/2015 showed chronic pressure injury to sacrum with a goal to reduce wound size. Further review of Resident 9's skin care plan did not show alternatives or interventions to address refusal with wound care treatments. On 04/04/2024 at 10:55 AM, Staff D stated they reviewed and updated care plans after completion of the MDS and that any other nurse could revise the care plan when a resident consistently refuse care and/or services. Staff D stated that they were not aware of Resident 9's refusal with sacrum wound treatment. Staff D further stated that Resident 9's refusals with pressure ulcer treatment should have been included in the skin care plan. On 04/04/2024 at 1:29 PM, Staff B stated that the expectation was to care plan refusals with care and services including wound treatments. Staff B further stated that Resident 9's care plan should have been updated to show refusal of sacrum wound treatment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	43392 RESIDENT 20 Resident 20 was admitted to the facility on [DATE]. Observations on 04/01/2024 at 3:17 PM, on 04/02/2024 at 2:00 PM, on 04/03/2024 at 11:27 AM, on 04/04/2024 at 3:57 PM, and on 04/05/2024 at 11:11 AM, showed Resident 20 was in bed and was not observed out of bed. On 04/04/2024 at 2:44 PM, Staff P, LPN, stated that Resident 20 had been offered to get out of bed multiple times but continued to refuse. Staff P further stated that refusal of care was documented in Resident 20's progress notes. On 04/04/2024 at 3:57 PM, Resident 20 stated they would like to get out of bed, but they had fainted and had a fall. Resident 20 further stated that after the fall, they were scared and refused to get out of bed. Review of the March 2024 TAR showed that Resident 20 refused to get out of bed seven times. Review of Resident 20's comprehensive care plan dated 02/02/2024, did not show Residents 20's refusals to get out of bed. Joint record review and interview on 04/05/2024 at 2:20 PM with Staff B, showed Resident 20's comprehensive care plan did not include refusals to get out of bed. Staff B further stated their expectation was to revise the care plan to reflect Resident 20's refusal to get out of bed. Reference: (WAC) 388-97-1020 (2)(a)(4)(b)

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	505478	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corwin Center at Emerald Heights	10901 - 176th Circle Northeast Redmond, WA 98052

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to follow insulin (medication to lower blood sugar) orders and clarify medication orders to ensure parameters were in place in accordance with professional standards for 2 of 5 residents (Residents 11 & 1), reviewed for unnecessary medications. This failure placed the residents at risk for medication errors and negative outcomes. Findings included . Review of the facility's policy titled, Medication Administration, revised in April 2024, showed, Obtain and record vital signs [a measurement of the body's most basic functions (blood pressure [amount of force your blood uses to get through blood vessels], pulse rate and temperature)], when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters and to correct any discrepancies and report to the nurse manager. The policy showed that medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The policy further showed to ensure the six rights of medication administration are followed: Right resident, Right drug, Right dosage, Right route, Right time, Right documentation. Review of the facility's policy titled, Insulin Pen Policy, reviewed in April 2024, showed to use insulin pens to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. RESIDENT 11 Resident 11 admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis that included atrial fibrillation (irregular heart rhythm). Review of Resident 11's March 2024 and April 2024 Medication Administration Record (MAR) showed the following orders: -Digoxin (medication to treat abnormal heart rhythms) 125 micrograms (a unit of measurement) tablet by mouth every day for atrial fibrillation with a start date of 03/27/2024. -Metoprolol Succinate (medication to treat high blood pressure) 12.5 milligrams (a unit of measurement) tablet by mouth every day for atrial fibrillation with a start date of 03/27/2024. Review of the pharmacy consultation report dated 11/09/2023, showed Resident 11 was receiving Digoxin and pulse (heart rate) was being monitored but no hold parameter was identified. It further showed that the physician's response was to hold Digoxin if heart rate was less than 55. Review of the Vital Stats [status] report showed Resident 11's pulse was 53 on 03/28/2024, and a pulse of 49 on 03/30/2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2024 MAR showed Resident 11 received Digoxin and Metoprolol Succinate on 03/28/2024 and 03/30/2024. During an interview and joint record review on 04/04/2024 at 3:37 PM with Staff Q, Registered Nurse, stated they checked residents' vital signs prior to giving Digoxin and Metoprolol medication and would hold the medication according to the parameters. Joint record review of Resident 11's April 2024 MAR showed Digoxin and Metoprolol did not have a parameter in place. Staff Q stated that if the medications did not have parameters in place, they would clarify the order with the doctor. In an interview and joint record review on 04/04/2024 at 3:55 PM with Staff B, Director of Nursing, stated that if there were no parameters in place for Digoxin and Metoprolol, they expected staff to call the doctor and clarify the order. Joint record review of Resident 11's April 2024 MAR showed no parameters for Digoxin and Metoprolol. Staff B stated that the parameters should have been in place. In another interview on 04/05/2024 at 3:52 PM, Staff B acknowledged that Resident 11 received Digoxin and Metoprolol Succinate on 03/28/2024 and 03/30/2024 when their pulse was below 55 (pulse were 53 & 49). 48298 RESIDENT 1 Resident 1 admitted to the facility on [DATE]. Review of Resident 1's physician's order showed Insulin Aspart (fast-acting insulin) subcutaneous pen three times a day using the following blood sugar sliding scale in mg/dL (milligram per deciliter - a unit of measurement): 140 thru 180 give three units, 181 thru 240 give four units, 241 thru 300 give six units, 301 thru 350 give eight units, 351-999 give 10 units. If blood sugar is > (more than) 400, call MD (Medical Doctor) immediately, start date of 08/24/2023. Review of Resident 1's March 2024 MAR showed Resident 1 had a blood sugar level of 134, Staff X, Former Director of Nursing Services, administered three units of Insulin Aspart before supper on 03/31/2024. During a joint record review and interview on 04/03/2024 at 3:45 PM with Staff B, showed Resident 1 had a blood sugar level of 134 and received three units of Insulin Aspart. Staff B stated that Resident 1's blood sugar level was below the sliding scale range and that Staff X should have not administered three units of Insulin Aspart. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43392 Based on observation, interview, and record review, the facility failed to monitor for signs and symptoms of bruises or bleeding on a resident receiving anticoagulant therapy (medication that decreases blood's ability to clot) for 1 of 2 residents (Resident 41) and failed to follow physician's order related to insulin (medication to lower blood sugar) sliding scale (a method where the insulin dosage is adjusted based on blood sugar level) for 1 of 1 resident (Resident 1), reviewed for quality of care. These failures placed the residents at risk for adverse consequences and other related complications. Findings included . Review of the facility's policy titled, Medication Administration, reviewed in April 2024, showed to refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects. The policy further showed to report and document any adverse effects or refusals. Review of the facility's policy titled, Insulin Pen Policy, reviewed in April 2024, showed to use insulin pens to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge. Review of the facility's policy titled, Medication Administration, reviewed in April 2024, showed that medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The policy further showed to ensure the six rights of medication administration are followed: Right resident, Right drug, Right dosage, Right route, Right time, Right documentation. RESIDENT 41 Resident 41 admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (irregular heartbeat), falls with multiple fractures (broken bones), generalized muscle weakness and pain. Review of the admission Minimum Data Set (MDS - an assessment tool) dated 02/14/2024, showed Resident 41's cognition was intact. Review of Resident 41's physician's order dated 02/06/2024, showed Enoxaparin (medication to prevent blood clot) 40 milligrams (mg - unit of measurement) per 0.4 milliliters (ml - unit of measurement) subcutaneously (applied under the skin) every day for Deep Vein Thrombosis (blood clot in a deep vein) prophylaxis (measures taken to stop the disease/condition from occurring). It further showed to monitor for signs and symptoms of bruises or bleeding. Review of the February 2024 and March 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed Resident 41 received Enoxaparin. Further review of the MAR and TAR showed there was no documentation for monitoring of bruising and/or bleeding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2024 at 1:15 PM, Resident 41 stated they had bruises on their abdomen and that the bruises were caused by injections given in their abdomen. Review of Resident 41's February 2024 and March 2024 nursing progress notes and weekly skin assessments did not show documentation of the bruises in their abdomen. On 04/03/2024 at 2:26 PM, Staff P, Licensed Practical Nurse, stated there was no documentation showing that the resident was being monitored for anticoagulation therapy. Staff P further stated they should monitor and document for signs and symptoms of bruising and bleeding every shift. During a joint observation and interview on 04/03/2024 at 4:11 PM with Staff Y, Registered Nurse, showed Resident 41 had a large purple bruise on their right and left mid-abdomen. Staff Y stated they were not aware of the bruise. Review of Resident 41's nursing progress notes dated 04/04/2024, showed Staff BB, Registered Nurse, documented, Placed on alert for resident [Resident 41] has large bruises on right mid-abdominal measuring 12x2.5cm [12.0 centimeters (cm - unit of measurement) by 2.5 cm] and other more left side mid abdominal measuring 7x202cm [7.0 cm by 2.0 cm]. The nursing progress notes further showed Resident 41 was asked by Staff BB if they knew how they got the bruises, Resident 41 stated, 'From the blood clotting medicine Enoxaparin] I get in the morning. On 04/04/2024 at 12:00 PM, Staff B, Director of Nursing, stated they should monitor for bruises and bleeding for a resident on anticoagulant therapy. When asked if bruising or bleeding was monitored for Resident 41, Staff B stated, No, but it should have been monitored. 48298 RESIDENT 1 Resident 1 admitted to the facility on [DATE]. Review of Resident 1's physician's order showed Insulin Aspart (fast-acting insulin) subcutaneous pen three times a day using the following blood sugar sliding scale in mg/dL (milligram per deciliter - a unit of measurement): 140 thru 180 give three units, 181 thru 240 give four units, 241 thru 300 give six units, 301 thru 350 give eight units, 351-999 give 10 units. If blood sugar is > (more than) 400, call MD (Medical Doctor) immediately, start date of 08/24/2023. Review of Resident 1's March 2024 MAR showed Resident 1 had a blood sugar level of 134, Staff X, Former Director of Nursing Services, administered three units of Insulin Aspart before supper on 03/31/2024. During a joint record review and interview on 04/03/2024 at 3:45 PM with Staff B, showed Resident 1 had a blood sugar level of 134 and received three units of Insulin Aspart. Staff B stated that Resident 1's blood sugar level was below the sliding scale range and that Staff X should have not administered three units of Insulin Aspart. Reference: WAC 388-97-1060 (3)(i)(4)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on observation, interview, and record review, the facility failed to maintain, label/date, and properly store oxygen nasal cannula/tubing (flexible tubing that sits inside the nose and delivers oxygen) for 2 of 2 residents (Residents 11 & 2), reviewed for respiratory care. This failure placed the residents at risk for unmet care needs, respiratory infections, and related complications. Findings included . Review of the facility's undated policy titled, Oxygen Administration, showed to change the oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. It further showed, Keep delivery services [oxygen mask/tubing and nasal cannula] covered in a plastic bag when not in use. RESIDENT 11 Resident 11 admitted to the facility on [DATE]. Review of the April 2024 Treatment Administration Record showed the following orders: - Continuous oxygen therapy during the night, one liter (a unit of measurement) via nasal cannula with a start date of 03/27/2023. - Change oxygen tubing weekly every week on Friday night shift with a start date of 03/27/2023. During an observation and interview on 04/01/2024 at 7:35 AM, showed Resident 11's oxygen tubing/nasal cannula was laying on top of their bed with the oxygen tubing unlabeled and was not stored in a bag. In another observation at 12:17 PM, showed Resident 11's oxygen tubing was hanging over the left side rail that was in the raised position. Resident 11's oxygen tubing was unlabeled and was not stored in a bag when not in use. Resident 11 stated that they used oxygen at night. In another observation and interview on 04/02/2024 at 2:48 PM, showed Resident 11's oxygen tubing was hanging over the left side rail that was in the raised position with the nasal cannula laying on the ground. The oxygen tubing was not labeled or stored in a bag when not in use. Resident 11 was sitting in their wheelchair by the left side of their bed and while moving themselves back, Resident 11 stepped on the oxygen tubing/ nasal cannula that was laying on the ground. Resident 11 stated they did not want to put the nasal cannula in their nose after stepping on it. Joint observation and interview on 04/02/2024 at 3:06 PM with Staff L, Licensed Practical Nurse, showed Resident 11's oxygen tubing/nasal cannula was not labeled or stored in a bag when not in use. Staff L stated that the oxygen tubing should have been dated and placed in a bag when not in use. RESIDENT 2 Resident 2 admitted to the facility on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's physician order dated 03/25/2024 showed to administer oxygen via nasal cannula two to four liters per minute as needed for comfort. Observation on 04/02/2024 at 2:49 PM, showed Resident 11 was using oxygen via nasal cannula, and the oxygen tubing was unlabeled. During a joint observation and interview on 04/02/2024 at 3:13 PM with Staff L, showed Resident 2's oxygen tubing was unlabeled. Staff L stated that Resident 2's oxygen tubing/nasal cannula should have been labeled/dated. On 04/03/2024 at 1:22 PM, Staff B, Director of Nursing, stated residents who used oxygen should have an order, document the oxygen liter flow, take vital signs, and change oxygen tubing/nasal cannula weekly. Staff B further stated that they expected the oxygen tubing to be labeled/dated and stored in bag when not in use. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure monthly pharmacy recommendations were followed up on by the physician for 1 of 5 residents (Resident 40), reviewed for unnecessary medications. This failure placed the resident at risk of receiving unnecessary medications, medication-related adverse consequences, and a diminished quality of life. Findings included . Review of the facility's policy titled, Medication Regimen Review, revised in August 2017, showed the facility will encourage physician/prescriber or other responsible parties receiving the Medication Regimen Review (MRR) and the Director of Nursing (DON) Services to act upon the recommendations contained in the MRR. For those issues that require physician/prescriber intervention, facility should encourage to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected. Resident 40 admitted to the facility on [DATE]. Review of Resident 40's pharmacy Consultation Report, dated 03/06/2024 did not show a response from the physician and it was not signed by the physician. During a joint record review and interview on 04/04/2024 at 5:09 PM with Staff B, DON, showed the pharmacy consultation report dated 03/06/2024 for Resident 40 had no response from the physician and it was not signed by the physician. Staff B stated they expected the pharmacy recommendation report to be given to the physician and the physician to sign it. Reference: WAC 388-97-1300(4)(c)

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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. 43392 Based on observation, interview and record review, the facility failed to discard expired medication for 1 of 3 medication carts (Cedar Medication Cart) and failed to label/date an open vial of Tubersol (testing solution to diagnose Tuberculosis [infectious bacterial disease that affects the lungs]) for 1 of 1 medication storage room (Cedar Medication Room), reviewed for medication administration and storage. This failure placed the residents at risk to receive expired or compromised medications. Findings included . Review of the facility's policy titled, Storage of Medication, reviewed in August 2012, showed the facility should store all drugs and biologicals in a safe, secure, and orderly manner. It further showed that the facility should not use discontinued, outdated, or deteriorated drugs or biologicals (medicines that are made from natural sources) and that such drugs should be returned to the dispensing pharmacy or destroyed. CEDAR MEDICATION CART During a joint observation and interview on 04/04/2024 at 8:22 AM with Staff M, Licensed Practical Nurse (LPN), showed the Cedar Medication Cart had one bottle of Levothyroxine (medication used to treat an underactive thyroid gland [an organ that produces a substance which controls energy level and growth in the body]) 50 micrograms (mcg - a weight-based measurement) with an expiration date of 12/16/2023. Staff M stated that the Levothyroxine medication was expired and should have been properly disposed. MEDICATION STORAGE ROOM REFRIGERATOR Joint observation and interview on 04/04/2024 at 9:57 AM with Staff B, Director of Nursing, showed the Cedar Medication Storage Refrigerator had one opened and undated multi dose vial of Tubersol. Staff B stated that the vial was opened/undated and that the vial should have had an open date. Staff B further stated that all expired medications should be discarded properly per policy. Reference: (WAC) 388-97-1300(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48298 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 1 kitchen (Fireside Grill Skilled Kitchen). The failure to perform hand hygiene before and after glove change before and/or after serving food placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in November 2017, showed that all staff, residents, and visitors shall use proper hand hygiene/handwashing practices to prevent the spread of infection or contamination. It further showed that, Hand hygiene-a general term that applies to hand washing, antiseptic hand wash, and alcohol based hand rub. The use of gloves does not replace handwashing/hand hygiene. Review of the facility's undated training materials titled, Hand hygiene: Important Information for all Associates, showed that Good handwashing is necessary to remove dirt and germs from your hands and arms that could get into food. It further showed that hands and exposed portions of the arms must be wash before putting on gloves, and then again when changing them. Observation on 04/04/2024 at 12:08 PM, showed Staff W, Cook, was on the tray line and was putting food items on a plate using ladles and tongs. Staff W removed their used gloves and put on a clean pair of gloves without performing hand hygiene in between glove change. Another observation on 04/04/2024 at 12:12 PM, Staff W removed their used glove from their left hand and used a flat ladle to place a burger bun on a plate. Staff W put on a clean glove to their left hand and continued with placing burger buns on a plate using a flat ladle. Staff W then removed their gloves from both hands and put on a clean pair of gloves without performing hand hygiene between glove change. On 04/04/2024 at 12:14 PM, Staff U, Modified Diet (a type of diet tailored to individuals with special nutritional needs) Cook, stated that they were training Staff W to become a modified diet cook to cover staffing needs. Staff U stated, based on our food training, we should wash our hands before putting on gloves and after removing gloves. Staff U further stated they expected Staff W to follow correct hand hygiene practice. During an interview on 04/04/2024 at 1:12 PM with Staff N, Director of Food and Beverage, and Staff O, Registered Dietician, stated they expected the staff (kitchen/dietary) to perform hand hygiene before and after glove use. 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** 48298 Based on observation, interview, and record review, the facility failed to ensure hand hygiene practices and/or proper use of gloves were followed during soiled linen collection by 1 of 1 staff (Staff Z) and failed to properly disinfect medical equipment for 3 of 5 staff (Staff AA, Staff J & Staff K). In addition, the facility failed to ensure the facility's water management program included a flow diagram that assessed the potential growth of Legionella (a water-borne bacteria that can cause pneumonia [a lung infection]) or other waterborne pathogens (an organism that can cause disease) reviewed for infection control. These failures placed the residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in November 2017, showed that all staff, residents, and visitors shall use proper hand hygiene/handwashing practices to prevent the spread of infection or contamination. Hand hygiene means to apply handwashing, antiseptic handwash, and alcohol-based hand rub. Hand hygiene practices should be applied after glove removal. The use of gloves does not replace hand washing/hand hygiene. HAND HYGIENE AND GLOVE USE On 04/01/2024 at 8:41 AM, Staff Z, Janitor, was observed collecting soiled linens from laundry bins placed outside of room [ROOM NUMBER] and room [ROOM NUMBER] and placed them on a covered laundry cart. Staff Z then removed their used gloves and threw them in the garbage. Staff Z continued to push the covered laundry cart up the hallway towards room [ROOM NUMBER] and room [ROOM NUMBER]. Staff Z was observed pulling a pair of gloves from their clothes' pocket and put them on. Staff Z proceeded to remove soiled linens from the laundry bin and placed them on the laundry cart. Staff Z then removed their used gloves and threw them in the garbage bin. Staff Z started to push the laundry cart towards the adjacent hallway. Staff Z did all of these without performing hand hygiene in between glove change. On 04/01/2024 at 8:55 AM, Staff Z stated that one of their responsibilities was to gather soiled linens from the laundry bins located along the hallways. Staff Z stated that they did not perform hand hygiene after removing their used gloves because there was no hand sanitizer in the hallway. Staff Z was shown a hand sanitizer in the entry way in room [ROOM NUMBER] from where Staff Z was standing after removing their used gloves. Staff Z stated they did not do hand hygiene between glove change and that they were not told to perform hand hygiene in between glove change. 43392 DISINFECTION OF VITAL SIGN EQUIPMENT (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's policy titled, Cleaning and Disinfection of Resident Care items and Equipment, revised in November 2017, showed that resident-care equipment, including reusable items, and durable medical equipment (DME) would be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection. Reusable resident equipment will be sterilized between residents according to manufacturer's instructions. For non-soiled equipment between resident use, disinfecting equipment wipes are available. Observation on 04/02/2024 at 2:59 PM, showed Staff AA, Certified Nursing Assistant (CNA), entered room [ROOM NUMBER] with vital sign (a measurement of the body's most basic functions [blood pressure (amount of force your blood uses to get through blood vessels), pulse rate and temperature]) equipment. Staff AA took Resident 6's vital signs and proceeded to take Resident 296's vital signs without sanitizing the vital sign equipment between resident use. On 04/02/2024 at 3:10 PM, Staff AA stated they did not sanitize the vital sign equipment between Resident 6 and Resident 296. 47130 DISINFECTION/SANITIZING OF SIT TO STAND (MECHANICAL/TRANSFER LIFT) Observations on 04/02/2024 at 1:55 PM, showed Staff J, CNA, was bringing a sit to stand transfer lift (medical device used to transfer residents with limited mobility) to Resident 17's room without disinfecting the equipment prior to using it. At 1:56 PM, Staff J transferred Resident 17 from their bed using the sit to stand transfer lift to assist Resident 17 with toileting. At 2:08 PM, Staff J, was observed pushing the sit to stand transfer lift out of Resident 17's room and placed it in the hallway without disinfection after resident use. Further observations on 04/02/2024 at 2:43 PM, showed Staff K, CNA, was taking the sit to stand transfer lift from the hallway without sanitizing it prior to Resident 23's use. Staff M, Licensed Practical Nurse, came to assist with Resident 23's transfer from bed to wheelchair. At 2:53 PM, Staff K was observed pushing the sit to stand transfer lift out of the room and placed it in the hallway without sanitizing it. On 04/02/2024 at 2:56 PM, Staff K stated that their practice was to sanitize the sit to stand transfer lift before and after use. Staff K stated they took the sit to stand transfer lift from the hallway and did not sanitize it before and after use with Resident 23. On 04/02/2024 at 2:58 PM, Staff J stated that their practice was to use the blue tab disposable wipes (Micro-Kill bleach wipes [kills germs]) before and after each use of the sit to stand transfer lift. Staff J stated they should have sanitized the sit to stand lift before and after use with Resident 17. On 04/04/2024 at 1:22 PM, Staff B, Director of Nursing, stated that staff were trained with proper hand hygiene, hand hygiene after glove use, and disinfecting medical equipment. Staff B stated that staff should have washed or sanitized their hands after removal of used gloves. Staff B further stated that staff should have sanitized the sit to stand transfer lift and the vital signs equipment in between resident use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505478	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corwin Center at Emerald Heights	10901 - 176th Circle Northeast Redmond, WA 98052

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47680 WATER MANAGEMENT PROGRAM Review of the facility's policy titled, Water Management Program Policy, revised in October 2022, showed that it is the policy of the facility to establish water management plans for reducing the risk of Legionellosis (a disease caused by Legionella bacteria) and other opportunistic pathogens in the facility's water systems based on nationally accepted standards (for example ASHRAE [American Society of Heating and Air-Conditioning Engineers], CDC, and EPA [Environmental Protection Agency, responsible for the protection of human health and the environment]). Review of the CDC online toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, Version 1.1, dated 06/24/2021, showed that there are seven elements of a Water Management Program, which includes to describe the building water systems using text and flow diagrams. It further showed, In addition to developing a written description of your building water systems, you should develop a process flow diagram and Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in your building water systems. Review of the facility's Water Management Plan, dated November 2023, did not show a flow diagram of their building water systems. On 04/04/2024 at 12:43 PM, Staff E, Facilities Director, stated that the water management plan did not include a flow diagram and that the documents given was what they had. On 04/04/2024 at 2:51 PM, Staff A, Administrator, stated they expected the water management program to be updated/current to the regulation and expected the water management program to have a flow diagram. Reference: (WAC) 388-97-1320 (1)(a)(c)(5)(c)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 47680 Based on interview and record review, the facility failed to maintain an Antibiotic (medications to treat infection) Stewardship Program when the facility failed to implement antibiotic use protocols for 2 of 2 residents (Residents 43 & 38), and failed to ensure standardized tools and criteria were utilized for Antibiotic Stewardship Program (such as Loeb Minimum Criteria [minimum set of signs/symptoms used to determine whether to treat an infection with antibiotics] and/or SBAR [Situation, Background, Assessment, and Recommendation - a toolkit that helps staff/prescribing clinicians communicate about suspected UTIs [Urinary Tract Infections-bladder infection] and facilitates appropriate antibiotic prescribing) to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use, and decrease the development of adverse side effects and antibiotic resistance. These failures placed the residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics. Findings included . Review of the facility policy titled, Antibiotic Stewardship, revised in November 2017, showed that they utilize the Electronic Medical Record Infection Tracker McGreer Criteria protocol to determine if it is necessary to treat with antibiotics or if adjustments in therapy need to be made. It further showed that the Infection Preventionist shall track and review antibiotic utilization and monitor adherence to evidence-based criteria, including documentation related to antibiotic selection and use, tracking antibiotics to review patterns of use and determination of the impact of the antibiotic stewardship interventions, monitoring for clinical outcomes such as rates for antibiotic-resistant organisms, or adverse drug events, assist in prescribing practitioners in choosing the right antibiotic using antibiograms (a tool that summarizes antibiotic resistance based on laboratory data), provide reports related to monitoring antibiotic usage and resistance data and outcome surveillance. Review of the facility's undated antibiotic stewardship resident line listing (infection surveillance log-system to monitor antibiotic use) document showed the following: -Resident 43 had a urine analysis (laboratory test of the urine) completed on 03/14/2024 and the column that would show organism was blank. It further showed that Resident 43 received Macrobid (an antibiotic to treat an infection) 100 milligrams (mg-a unit of measurement) twice a day with resolved date of 03/25/2024. -Resident 38 had a urine analysis completed on 12/28/2023 and the column that would show organism was results to follow. It further showed Resident 43 received Levofloxacin (an antibiotic to treat an infection) 500 mg for five days with no resolved date. Review of Resident 43's electronic health record did not show an updated urine culture. Review of Resident 38's urine analysis report dated 12/31/2023, showed a result of Proteus Mirabilis [a type of bacteria]. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/05/2024 at 11:32 AM, Staff I, Licensed Practical Nurse, stated that when a resident shows signs of UTI, they would contact the doctor, describe the symptoms, and the doctor would order a urine test. Staff I stated that they did not use the SBAR tool or Loebs Minimum Criteria. Staff I stated they used the McGeer Criteria if a resident was on antibiotics and when they put an order for antibiotics in their computer system, they had to fill out a form (McGeer Criteria). During an interview and joint record review on 04/05/2024 at 12:22 PM, Staff B, Director of Nursing/Infection Preventionist, stated that their expectation was that all infections and potential infections were appropriately listed in the antibiotic stewardship line listing, a urine analysis/culture results and residents on antibiotics were followed up on. Joint record review of the antibiotic stewardship line listing showed, Resident 38 and Resident 43 did not have an organism documented. Staff B stated they expected the antibiotic stewardship line listing to be updated and corrected. Staff B stated that they used the McGeer criteria and did not use the Loebs Minimum Criteria. Staff B stated they might use the SBAR tool but was not sure and to confirm with Staff D, MDS (Minimum Data Set) Coordinator. Staff B further stated that the antibiotic stewardship resident line listing mapping (is the process of creating a structured representation of infections) for January 2024 to March 2024 was not completed and that they expected it to be completed. On 04/05/2024 at 12:34 PM, Staff D stated that they did not use the SBAR tool and that they used the McGeer Criteria for UTI. No Associated WAC