| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505478 | A. Building<br>B. Wing | 04/23/2025 |

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| Corwin Center at Emerald Heights | 10901 - 176th Circle Northeast<br>Redmond, WA 98052 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on interview and record review, the facility failed to accurately assess 3 of 19 residents (Residents 24, 48 & 10), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding weights and constipation (passing fewer than three stools a week or having a difficult time passing stool) placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life.<br><br>Findings included .<br><br>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. The MDS manual further showed to mark/code medications given to the resident by any route.<br><br>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).<br><br>RESIDENT 24<br><br>Review of a quarterly MDS dated [DATE] showed Resident 24's admitted to the facility on [DATE]. Further review of the MDS showed a weight of 168 pounds (lbs. - unit of mass/weight measurement) was entered in Section K (Swallowing/Nutritional Status) under K0200B (resident's weight).<br><br>Review of the weight record printed on 04/17/2025 showed that Resident 24 weighed 165.8 lbs. on 01/17/2025.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and joint record review on 04/22/2025 at 2:17 PM with Staff F, Registered Dietician, stated they follow the RAI manual for completion of MDSs. Staff F stated they used the most current resident's weight during the look back period to code for it in Section K. A joint record review of Resident 24's quarterly MDS dated [DATE] showed a weight of 168 lbs. A joint record review of Resident 24's weight record showed a weight of 165.8 lbs. on 01/17/2025. Staff F stated that the most current weight of 165.8 [rounded to 166] lbs. on 01/17/2025 should have been entered in Resident 24's MDS and that the MDS was coded inaccurately.<br><br>In an interview on 04/23/2025 at 3:10 PM, Staff B, Director of Nursing Services, stated they expected MDSs to be completed fully, on time, submitted on time, and be accurate. Staff B further stated they expected Resident 24's MDS to be accurate.<br><br>52331<br><br>RESIDENT 10<br><br>Review of Resident 10's quarterly MDS dated [DATE] showed 123 lbs. was entered in Section K0200B.<br><br>Review of the February 2025 weight record printed on 04/21/2025, showed Resident 10's weight was 122 lbs. on 02/03/2025.<br><br>A joint record review and interview on 04/22/2025 at 1:06 PM with Staff E, MDS Coordinator, showed Resident 10's quarterly MDS dated [DATE] was coded 123 lbs. in Section K0200B. A joint record review of February 2025 weight record showed Resident 10's weight was 122 lbs. on 02/03/2025. Staff E stated that Staff F was responsible for Section K0200B and that Resident 10's MDS was inaccurate.<br><br>In an interview on 04/22/2025 at 2:16 PM, Staff F stated Resident 10's MDS dated [DATE] was inaccurate and that the weight of 122 lbs. should have been entered in Resident 10's quarterly MDS.<br><br>In an interview on 04/23/2025 at 4:19 PM, Staff B stated they expected MDSs to be completed accurately.<br><br>46912<br><br>RESIDENT 48<br><br>Review of the RAI Version 3.0 manual, dated October 2024, showed that constipation was defined as If the resident has two or fewer bowel movements during the 7-day look-back period.<br><br>Review of the significant change in status MDS assessment dated [DATE], did not show constipation was marked for Resident 48 in Section H (Bladder and Bowel) under H0600 (constipation).<br><br>Review of the undated daily charting [bowel functions] from 03/29/2025 through 04/04/2025 showed Resident 48 had two bowel movements in the 7-day look-back period.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and joint record review on 04/22/2025 at 1:06 PM, Staff E stated their process for coding for constipation was to look at bowel records and only code for hard stools. A joint record review of the RAI manual showed that constipation was defined as, If the resident has two or fewer bowel movements during the 7-day look-back period. And a joint record review of the daily charting from 03/29/2025 through 04/04/2025, showed Resident 48 had two bowel movements in the 7-day look-back period. Staff E stated, it should have been coded for constipation, and it was not.<br><br>In an interview on 04/23/2025 at 12:12 PM, Staff B stated they expected the MDS assessment to be completed accurately.<br><br>Reference: (WAC) 388-97-1000 (1)(b) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52331<br><br>Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR- an assessment used to identify residents referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or related conditions are not inappropriately placed in nursing homes for long term care) forms were accurate and/or sent out timely for a Level II PASARR referral for 3 of 6 residents (Residents 10, 53 & 32), reviewed for PASARRs. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.<br><br>Findings included .<br><br>Review of the facility's policy titled, Preadmission Screening and Resident Review, revised in October 2017, showed, Social Services or Designee shall review all Level I screening forms for accuracy. If at any time the Facility finds that the previous Level I screening was incomplete, erroneous, or no longer accurate, the facility shall immediately complete a new screening using Level I form. If the corrected Level I screening identifies a possible serious mental illness or intellectual disability or related condition, Social Services or designee shall notify Developmental Disability Administration (DDA) and/or the mental health PASRR evaluator so that a Level II evaluation can be conducted.<br><br>RESIDENT 10<br><br>Review of the face sheet printed on 04/17/2025 showed Resident 10 admitted to the facility on [DATE] with diagnoses that included major depressive disorder (depression - a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (intense and excessive feelings of worry, nervousness, or fear).<br><br>Review of Resident 10's Level I PASARR dated 04/29/2024, showed Section IA (SMI) was marked for mood disorder depression and anxiety disorder. Further review showed that Section IV (4- Service Needs and Assessor Data) was marked for No level II evaluation indicated.<br><br>RESIDENT 53<br><br>Review of the face sheet printed on 04/17/2025 showed Resident 53 admitted to the facility on [DATE] with diagnosis that included depression.<br><br>Review of Resident 53's Level I PASARR dated 02/17/2025, showed Section IA (SMI) was marked for no SMI. Further review showed that Section IV was marked for No level II evaluation indicated.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and joint record review on 04/23/2025 at 11:33 AM, Staff I, Social Services Associate, stated they reviewed Level I PASARRs for accuracy, and that if any diagnoses listed in the SMI section of the PASARR were marked, PASARRs needed to be sent to the PASARR office for a Level II evaluation. A joint record review of Resident 10's Level I PASARR dated 04/29/2024 showed that Section IA was marked for depression and anxiety disorder. Further review of Resident 10's Level I PASARR showed in Section IV, it was marked for No level II evaluation indicated. When asked if it was accurate, Staff I stated it was not accurate and that they should have sent a Level II referral to the PASARR coordinator for Resident 10. A joint record review of Resident 53's face sheet printed on 04/17/2025 showed a diagnosis for depression. Review of Resident 53's Level I PASARR dated 02/17/2025 showed that depression was not marked in Section IA, and No level II evaluation indicated. Staff I stated Resident 53's Level I PASARR was not accurate, depression should have been marked, and they should have sent a Level II referral to the PASARR coordinator.<br><br>In an interview on 04/23/2025 at 4:19 PM, Staff B, Director of Nursing Services, stated that they expected PASARR forms to be completed accurately and that Level II PASARR referral would be sent to the PASARR coordinator if residents had a SMI diagnosis.<br><br>In an interview on 04/23/2025 at 5:15 PM, Staff A, Administrator, stated that they expected Social Services would follow the PASARR policy and send out Level II PASARR referrals if required.<br><br>47218<br><br>RESIDENT 32<br><br>Review of the face sheet printed on 04/17/2025 showed Resident 32 had a diagnosis of anxiety.<br><br>Review of Resident 32's Level I PASARR dated 03/19/2025 showed anxiety was marked in Section IA. Further review of the Level I PASARR showed that referral for Level II evaluation was not marked.<br><br>A joint record review and interview on 04/23/2025 at 11:33 AM with Staff I, showed that Resident 32's PASARR dated 03/19/2025 had anxiety marked in the SMI section and no referral for Level II was marked. Staff I stated that Resident 32 had diagnosis of anxiety and that their PASARR should have been marked for Level II evaluation referral. Staff I further stated that Resident 32's Level I PASARR should have been sent to the PASARR coordinator for a Level II evaluation.<br><br>In an interview on 04/23/2025 at 4:06 PM, Staff A, Administrator, stated they expected staff to follow the facility's PASARR policy.<br><br>Reference: (WAC) 388-97-1975(1) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>46912<br><br>Based on interview and record review, the facility failed to ensure resident-centered care and treatment were provided in accordance with professional standards of practice when facility staff failed to do skin care evaluations for 1 of 4 residents (Resident 12), reviewed for skin conditions. This failure placed the resident at risk for unmet care needs and a diminished quality of care.<br><br>Findings included .<br><br>Review of the facility's undated policy titled, Skin Observation, showed, Early recognition of skin break down is key to the overall management and resolving of the skin issue. It is imperative and stressed that skin assessments be completed as scheduled. It further showed that The Licensed Nurse is expected to perform a full body skin audit weekly per facility protocol.<br><br>Review of the facility's undated policy titled, Comprehensive Care Plan, showed, The comprehensive care plan will describe, at a minimum .the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>Review of Resident 12's Skin Conditions care plan, revised on 11/13/2024, showed that Resident 12 has fragile skin, prone to bruising and/or skin tears. It further showed the intervention for weekly skin checks, document results.<br><br>Review of the March 2025 Treatment Administration Record (TAR) showed Resident 12 had an order for Weekly skin check that started on 01/26/2023. It further showed on 03/29/2025 that a skin check was not done because Resident 12 was sleeping.<br><br>Review of the April 2025 TAR showed Resident 12 had an order for Weekly skin check that started on 01/26/2023. It further showed on 04/12/2025 that a skin check was not done because Resident 12 was sleeping.<br><br>In an interview and joint record review on 04/18/2025 at 10:15 AM, Staff V, Registered Nurse, stated that they follow the care plan when caring for residents. Joint record review of Resident 12's Skin Conditions care plan, showed to perform weekly skin checks. Further joint record review of Resident 12's March 2025 and April 2025 TARs showed no documentation that skin checks were performed on 03/29/2025 and on 04/12/2025. Staff V stated that there should have been weekly skin checks.<br><br>In an interview and joint record review on 04/18/2025 at 11:32 AM, Staff D, Resident Care Manager, stated that every resident was on weekly skin checks. A joint record review of the March 2025 and April 2025 TARs showed Resident 12 had no documentation that skin checks were performed on 03/29/2025 and 04/12/2025. Staff D stated that the nurse stated that the resident was sleeping and that the nurse needs education. They need to be choosing the appropriate options. Staff D stated that the expectation was that skin checks should be done weekly. In a follow up interview on 04/23/2025 at 11:04 AM, Staff D stated that they expected the care plan to be followed as guidance.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and joint record review on 04/23/2025 at 12:12 PM, Staff B, Director of Nursing, stated that they expected care plans to be followed and if it says to do weekly skin checks, I expect weekly skin checks. A joint record review of the March 2025 and April 2025 TARs showed Resident 12 had no documentation that skin checks were performed on 03/29/2025 and 04/12/2025. Staff B stated it had been documented that the resident was sleeping and they [the nurse] should have come and tried again or should have told the next shift.<br><br>Reference: (WAC) 388-97-1060 (1)(3)(b) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52133<br><br>Based on observation, interview and record review, the facility failed to monitor significant weight loss for 1 of 2 residents (Resident 53), reviewed for nutrition/hydration. This failure placed the residents at risks for nutrition-related complications, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Weight Loss/Gain, Unintentional, revised in February 2024, showed, The Registered Dietitian [RD] will be notified of any weight change equal to or greater than 4% over 1 month or 8% over 6 [six] months. The policy further showed, the resident's attending provider [medical doctor or physician assistant], family/DPOA [Durable Power of Attorney] as well as any other appropriate clinicians will be notified with unanticipated significant weight changes.<br><br>Resident 53 was admitted to the facility on [DATE] with diagnosis that included dementia (a progressive condition that affects the brain).<br><br>Review of nutrition care plan dated 02/17/2025, showed Resident 53 was at risk for altered nutritional status and/or weight loss. The nutrition care plan further showed that staff would offer a nutritional supplement if Resident 53 ate less than 50% of a meal. Review of the nutrition care plan dated 02/19/2025 showed that Resident 53 was at Risk for inadequate nutritional intake related to poor appetite, often about 25% of meals, with a goal of no unplanned and unpreventable weight loss, through the next quarterly review. The care plan interventions showed that the RD would monitor weights, oral intake and would initiate trial oral nutrition supplements as needed.<br><br>Review of the nursing progress note dated 02/25/2025, showed Staff F, RD, documented that Resident 53 was seen/reviewed for nutrition and new onset of poor oral intake. The progress notes further showed Resident 53 weighed 133.3 pounds (lbs. - unit of mass/weight measurement). Staff F noted nutrition interventions/recommendations to add Boost (brand name) High Protein supplement 120 milliliters (ml - unit of volume measurement), assistance at mealtimes and encourage oral intake, and weighed weekly as able. The progress notes further showed the nutritional goal was for oral intake to meet or exceed 50% of meals, to not have unintentional/unpreventable weight loss, and that Staff F would monitor monthly or as needed.<br><br>Review of the admission Minimum Data Set (an assessment tool) dated 02/24/2025, showed Resident 53 required partial/moderate assistance with eating and had a weight of 133 lbs.<br><br>Review of Resident 53's weight report printed on 04/17/2025, showed the following:<br><br>-On 02/18/2025 - 133.4 lbs.<br><br>-On 03/24/2025 - 118.8 lbs.<br><br>-On 04/14/2025 -115.8 lbs.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 53 had a significant weight loss of 12.93 % from 02/18/2025 to 04/14/2025, in less than two months.<br><br>During multiple observations on 04/17/2025 at 9:05 AM, on 04/18/2025 at 9:17 AM, and on 04/22/2025 at 12:54 PM, Resident 53's food tray had less than 25% of meal consumed.<br><br>In an interview and joint record review on 04/22/2025 at 2:46 PM, Staff H, Registered Nurse, stated they checked the weight tracker in Matrix (the program for electronic health record) for weight loss. Staff H further stated that they would reweigh to make sure the weight was accurate, checked if the resident was eating, and then would notify the provider, Staff F, and/or speech therapy [or Speech Language Pathologist-experts in communication and treats various swallowing problems]. Staff H stated then they would make a progress note. A joint record review of the weight record showed Resident 53 had a significant weight loss on 03/24/2025 and 04/14/2025 with no documentation that the provider, Staff F, and/or SLP were notified.<br><br>In an interview and joint record review on 04/22/2025 at 2:55 PM, Staff F stated that they assessed all residents upon admit, quarterly, monthly for high-risk residents, and as needed. Staff F further stated the facility would notify them of residents' weight loss either in person, by email, or during the monthly nutrition at risk meeting. Staff F stated they would communicate with the provider either in person or by email if there was significant weight loss. A joint record review of the weight records and progress notes showed that Resident 53 had a significant weight loss on 03/24/2025 and 04/14/2025 and there was no documentation that the provider and/or Staff F were notified. Staff F stated they were not notified and were unaware of Resident 53's weight loss and that they missed Resident 53's weight loss on 03/24/2025.<br><br>In an interview and joint record review on 04/24/2025 at 3:16 PM, Staff D, Resident Care Manager, stated that if a resident had a significant weight loss, the nursing staff would reweigh and weigh again the next day to ensure accuracy of weight. Staff D stated that if the weight was accurate, they would notify the provider and Staff F of the weight loss. A joint record review showed that Resident 53 had significant weight loss on 03/24/2025 and 04/14/2025 with no documentation that the provider or Staff F were notified. Staff D stated there should be communication to Staff F and the provider if there was weight loss.<br><br>In an interview on 04/24/2025 at 4:19 PM, Staff B, Director of Nursing Services, stated they expected the nursing staff to notify the provider and Staff F if weight loss was discovered.<br><br>Reference: (WAC) 388-97-1060(3)(h) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on interview and record review, the facility failed to ensure adequate monitoring of adverse side effects and parameters (when to notify the provider or hold the medication) for insulin (medication/hormone that regulates blood sugar levels) were conducted for 1 of 5 residents (Resident 36), reviewed for unnecessary medications. This failure placed the resident at risk for unmet care needs, related complications, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, High Risk Medications, revised in 2025, showed that the facility recognized that some medications were associated with greater risks of adverse consequences than other medications and that high-risk medications included medications that treat diabetes (high levels of sugar in the blood). The policy further showed that the facility would obtain and document specific parameters for administration or withholding certain high-risk medications such as insulin as per the physician's or practitioner's orders.<br><br>MONITORING FOR ADVERSE SIDE EFFECTS<br><br>Review of Resident 36's April 2025 Medication Administration Record (MAR) printed on 04/17/2025, showed orders for insulin Glargine (brand name insulin) to administer 20 units (unit of measurement) subcutaneously (under the skin) once a day at 7:00 AM and another order for Humalog (brand name insulin) to administer 10 units subcutaneously twice a day at 11:00 AM and 5:00 PM. Further review of the MAR did not show Resident 36 was being monitored for hypoglycemia (blood sugar level is lower than the standard range) and/or hyperglycemia (blood sugar level is higher than the standard range).<br><br>Review of the April 2025 Treatment Administration Record (TAR) printed on 04/17/2025, did not show Resident 36 was being monitored for hypoglycemia and/or hyperglycemia.<br><br>Review of Resident 36's care plan dated 12/24/2024 showed interventions to Monitor for sx [symptoms] of hypoglycemia: Rapid onset- Skin pale, cold, clammy, sweaty, confusion, anxious [state of worry, unease, or nervousness] or nervous behavior, personality changes, weak fine tremors, hunger, headaches, dizziness, vision changes, shallow breathing, rapid strong pulse, seizures [abnormal electrical activity in the brain]/coma [prolonged loss of consciousness], low blood sugar, staggering gait. Treat per orders and notify MD [medical doctor or provider] for continued care after stabilization . Monitor for s/sx [signs/symptoms] of hyperglycemia slow onset - Skin hot, dry, face flushed, fruity odor to breath, dehydration [when there is not enough fluid in the body], weak rapid pulse, deep labored breathing, drowsiness, lethargy, nausea, vomiting, thirst, irritable, polyuria [urinating more than normal], low blood pressure, high blood sugar. Treat per orders and notify MD for continued care after stabilization.<br><br>(continued on next page) |

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| | 505478 | A. Building<br>B. Wing | 04/23/2025 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview and joint record review on 04/23/2025 at 11:11 AM, Staff G, Licensed Practical Nurse, stated that residents who got medications for diabetes or insulin should have had an order for monitoring for hypoglycemia and hyperglycemia that would show up in the MAR or TAR for the nurses to document. A joint record review of Resident 36's April 2025 MAR and TAR did not show an order for monitoring signs and symptoms of hypoglycemia and hyperglycemia. Staff G stated that they did not see an order in Resident 36's MAR and TAR to monitor hyperglycemia and hypoglycemia, and that there should have been.<br><br>In another interview on 04/23/2025 at 11:20 AM, Staff G stated that Resident 36 had a care plan that indicated monitoring for signs and symptoms of hypoglycemia and hyperglycemia. When asked staff if there was adequate ongoing documentation to show that Resident 36's was being monitored for hypoglycemia and hyperglycemia, Staff G stated, No, there is none.<br><br>In an interview and joint record review on 04/23/2025 at 2:32 PM, Staff D, Resident Care Manager, stated they expected residents receiving insulin to be monitored for hypoglycemia and hyperglycemia. A joint record review of April 2025 MAR and TAR did not show Resident 36 was being monitored for insulin use. Staff D stated they did not see Resident 36 was monitored for hyperglycemia/hypoglycemia and that they should have been.<br><br>PARAMETERS FOR INSULIN USE<br><br>Review of Resident 36's April 2025 MAR printed on 04/17/2025, showed orders for insulin Glargine to administer 20 units subcutaneously every morning at 7:00 AM. Further review of the insulin order did not show parameters for when to hold the medication and/or to notify the provider.<br><br>In an interview and joint record review on 04/23/2025 at 2:39 PM, Staff D stated they expected to see parameters for residents receiving insulin for when to hold the medication and/or to notify the provider. A joint record review showed Resident 36's April 2025 MAR had orders for insulin Glargine without parameters. Staff D stated that Resident 36's insulin Glargine order did not have parameters to hold it and/or to notify the provider if the blood sugar showed certain numbers [too low and too high blood sugar levels]. Staff D further stated that Resident 36's insulin order for Glargine should have had parameters for when to hold it and/or notify the provider.<br><br>In an interview on 04/23/2025 at 3:19 PM, Staff B, Director of Nursing Services, stated they expected residents who were getting insulin to be monitored for signs and symptoms of hypoglycemia and hyperglycemia. Staff B stated Resident 36's orders to monitor signs and symptoms for hypoglycemia and hyperglycemia and should have started it when Resident 36 readmitted to the facility on [DATE], Staff B further stated they should have had parameters for insulin use.<br><br>Reference: (WAC) 388-97-1060 (3)(k)(i)(4) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912<br><br>Based on observation, interview, and record review, the facility failed to ensure medications were properly stored for (Resident 2) and failed to dispose of expired medical supplies for 1 of 1 medication room (Cedar Hallway Medication Room), reviewed for medication storage and labeling. These failures placed the residents at risk of medication errors, receiving compromised medical supplies, possible infections, and adverse consequences.<br><br>Findings included .<br><br>Review of the facility's policy titled, Storage of Medications, revised in August 2012, showed that the facility would store all drugs (medications) and biologicals (medical supplies) in a safe, secure, and orderly manner. The policy further showed, the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.<br><br>RESIDENT 2<br><br>Resident 2 admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease (a progressive brain disorder that affects memory, thinking, and behavioral skills).<br><br>Observation on 04/16/2025 at 12:29 PM, showed Resident 2 in their wheelchair self-propelling themselves through the hallway and picked up something off the ground. Further observation showed that it was a pill, and that Resident 2 handed it to Staff U, Nursing Assistant Certified.<br><br>In an interview on 04/16/2025 at 12:38 PM, Staff U stated that Resident 12 had handed them a tiny pill and I took it to my supervisor.<br><br>In an interview on 04/23/2025 at 9:00 AM, Staff G, Licensed Practical Nurse, stated that medications should be stored in the medication cart, and they would not expect there to be loose pills. When asked about medications found on the ground, Staff G stated that there should be no loose pills on the ground or the cart.<br><br>In an interview on 04/23/2025 at 12:12 PM, Staff B, Director of Nursing Services, stated they expected medications to be stored securely, in bubble packs or containers. Staff B further stated that there should be no loose pills in the medication cart or on the ground.<br><br>52133<br><br>MEDICATION STORAGE ROOM<br><br>In a joint observation and interview on 04/21/2025 at 3:00 PM with Staff D, Resident Care Manager, showed that the Medication storage room had the following expired medical supplies:<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - One box of 100 syringes of Medline (brand name) 3 milliliters (ml- unit of capacity) 25-gauge (G- unit of thickness) x 1 inch (in- unit of length) safety syringes with an expiration date of 08/16/2024.<br><br>- Three boxes of 40 syringes totaling to 120 syringes of BD (brand name) 60 ml syringe Luer-lock (style of syringe tip) tip with an expiration date of 04/30/2024.<br><br>Staff D stated, the night shift nurses checked the medication room daily and conducted random audits from nursing and the pharmacy. Staff D stated that expired medications and supplies would then be discarded if found. Staff D further stated that the Medline syringes and BD syringes were expired and should have been discarded.<br><br>In an interview on 04/23/2025 at 4:19 PM, Staff B stated that they would expect staff to not use expired supplies and discard expired supplies if found.<br><br>Reference: (WAC) 388-97-1300(2) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52331<br><br>Based on observation, interview, and record review, the facility failed to discard expired sanitizing solution test strips for 2 of 2 kitchens (Fire Side Grill Kitchen and Main Kitchen) and failed to ensure food items were stored and handled appropriately in accordance with professional standards of food safety for 1 of 1 dry storage room (Main Kitchen Dry Storage Room) and for 1 of 1 resident refrigerator (Resident Use Only Refrigerator), reviewed for food services. In addition, the facility failed to cover food items during meal tray delivery. These failures placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages) and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, Food Services: Food Storage and Safe Handling, revised in [DATE], showed the facility would provide safe and sanitary storage, preparations, distribution, serving, and disposal of food in accordance with professional standards for food service safety.<br><br>Review of the facility's policy titled, Use and Storage of Food Brought in by Family or Visitors, revised in [DATE], showed that all the food items that were already prepared by the family or visitor brought in would be labeled with content and would be dated. The policy further showed that food items not consumed within three days, would be discarded by facility staff.<br><br>EXPIRED SANITIZING SOLUTION TEST STRIPS<br><br>A joint observation and interview on [DATE] at 8:13 AM with Staff N, Executive Chef, showed they used the [NAME] (brand name) test strips to check the sanitizing solution ppm (parts per million-unit of measurement). Further observation showed that the [NAME] test strips had an expiration date of [DATE]. Staff N then got another bottle of [NAME] test strips that had an expiration date of [DATE]. Staff N stated, I need to order new bottle of test strips, I cannot find one that [was] not expired, but it [[NAME] test strips] still works.<br><br>MAIN KITCHEN DRY STORAGE ROOM<br><br>In an interview and joint observation on [DATE] at 9:04 AM, Staff N stated they expected staff to follow the use by date from manufacturer to discard the food items. Joint observation with Staff N showed five unopened bottles of coconut aminos (salty, savory seasoning sauce made from the fermented sap of coconut palm and sea salt) with used by date of [DATE], four unopened bottles of Balsamic vinegar with used by date of [DATE], and two unopened bottles of Sriracha hot honey with used by date of [DATE]. Staff N stated that the expired food items should have been discarded.<br><br>RESIDENTS USE ONLY REFRIGERATOR<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In a joint observation and interview on [DATE] at 12:32 PM with Staff C, Infection Preventionist, showed a half loaf of bread in a clear plastic bag with use by date of [DATE] for Resident 258, and a small container of soup dated [DATE] for Resident 27. Staff C stated that the facility kept food items brought in by family for three days and food items then would be discarded by facility staff. Staff C further stated that Resident 258's half loaf of bread and Resident 27's soup should have been thrown away.<br><br>In an interview on [DATE] at 3:38 PM, Staff O, Director of Food and Beverage/Executive Chef, stated that staff should not have used expired test strips and that they expected expired food items to be discarded even if they were unopened.<br><br>In an interview on [DATE] at 12:36 PM, Staff A, Administrator, stated they expected staff to follow the food policy. Staff A further stated that they expected staff to discard expired test strips and food items.<br><br>46912<br><br>UNCOVERED FOOD ITEMS<br><br>Review of the facility's policy titled, The Dining Experience, dated 2017, showed that In the event of a hall tray, all food items and beverages shall be wrapped individually when leaving the dining area. In the event food needs to be transported from the main kitchen to the Skilled kitchen all food items shall be wrapped until they reach their destinations.<br><br>Observation on [DATE] at 11:56 AM, showed unidentified staff carrying uncovered mandarin oranges [canned] from the meal cart down the hallway to the dining room. At 12:00 PM, Staff U, Nursing Assistant Certified (NAC), carried uncovered cake from the meal cart to room [ROOM NUMBER]. At 12:03 PM, Staff U carried uncovered cake from the meal cart to room [ROOM NUMBER] and Staff P, NAC, carried uncovered mandarin oranges from the meal cart to room [ROOM NUMBER]. Additional observation at 12:07 PM showed unidentified staff were carrying uncovered mandarin oranges and cake to room [ROOM NUMBER].<br><br>In an interview and joint observation on [DATE] at 12:21 PM, Staff P stated that normally they [food items] were covered in clear wrap. Joint observation showed that the mandarin oranges were not covered. Staff P stated that food items should be covered when being transported through the hallways.<br><br>In an interview on [DATE] at 3:39 PM, Staff O stated that they expected anything [food items] travelling outside the kitchen has to be covered all the way to the resident's rooms. Staff O stated that cake and mandarin oranges, should be covered when being transported to resident rooms.<br><br>In an interview on [DATE] at 3:48 PM, Staff A stated they expected staff to follow the food policy for covering food items.<br><br>Reference: (WAC) [DATE] (3) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218<br><br>Based on observation, interview, and record review, the facility failed to ensure resident records were complete and accurate for 4 of 6 residents (Residents 42, 36, 53 & 3), reviewed for resident records. The failure to accurately write medications orders, fill out resident forms properly, and complete/check routine bed positioning device placed the residents at risk for unmet care needs, inaccurate monitoring, potential for injury, and a diminished quality of life.<br><br>Findings included .<br><br>Review of the facility's policy titled, High Risk Medications, revised in 2025, showed that the facility recognized that some medications were associated with greater risks of adverse consequences than other medications and that high-risk medications included medications that treat diabetes-high levels of sugar in the blood). The policy further showed that the facility would obtain and document specific parameters for administration or withholding certain high-risk medications such as insulin (medication/hormone that regulates the body's blood sugar level) as per the physician's or practitioner's orders.<br><br>Review of the facility's policy titled, Medication Orders, revised in 2025, showed that the elements of medications orders were .date and time the order is written . resident's full name .name of medication . dosage-strength of medication is included . time or frequency of administration . duration or stop date if applicable . route of administration . Type/Formulation (if applicable) . hour of administration (if applicable) . diagnosis or indication for use.<br><br>RESIDENT 42<br><br>Review of Resident 42's physician orders printed on 04/17/2025 showed an order dated 06/27/2024 for Multiple Vitamin-Minerals (multivitamin with minerals- a supplement) to give one tablet by mouth every day. The multivitamin order further showed to monitor for BEHAVIOR: Combative: 1) Approach in a calm manner, 2) Discourage behavior, 3) Offer food/drink, 4) Offer choices, S) Assess for pain or discomfort, hot or cold, 6) provide guidelines for behavior, 7) Reproach in a short time, 8) Remove from the situation.<br><br>Review of the April 2025 Medication Administration Record (MAR) showed Resident 42 was administered their multivitamin every day from 04/01/2025 to 04/23/2025 with exception of 04/21/2025.<br><br>In an interview and joint record review on 04/23/2025 at 10:57 AM, Staff H, Registered Nurse, stated that medication orders had the resident's name, the name of the medication, dose, route, frequency, and reason why the medication was given. A joint record review showed Resident 42's April 2025 MAR had an order for multivitamin with minerals with instructions to monitor for combative behavior within the body of the order. Staff H stated that Resident 42's multivitamin order was started on 06/27/2024. Staff D further stated that Resident 42 was not monitored for behaviors and that the behavior order should not have been part of Resident 42's multivitamin order, it was entered by mistake, it should not be there.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A joint record review and interview on 04/23/2025 at 2:14 PM with Staff D, Resident Care Manager, showed Resident 42's April 2025 MAR had an order of multivitamin that included orders to monitor for combative behaviors and interventions listed within the body of the order. Staff D stated that the order for monitoring combative behaviors should not have been part of Resident 42's multivitamin order.<br><br>A joint record review and interview on 04/23/2025 at 3:24 PM with Staff B, Director of Nursing Services, showed Resident 42's April 2025 MAR had an order for monitoring combative behavior within the body of their multivitamin order. Staff B stated that the order for monitoring behaviors should not have been part of Resident 42's multivitamin order and that Resident 42, did not have any behaviors to monitor for.<br><br>RESIDENT 36<br><br>Review of Resident 36's April 2025 MAR printed on 04/17/2025, showed orders for insulin glargine (type of insulin) to administer 20 units (unit of measurement) subcutaneously (under the skin) every morning at 7:00 AM. Further review of the insulin order did not show parameters for when to hold the medication and/or when to notify the provider [medical doctor or physician assistant).<br><br>In an interview and joint record review on 04/23/2025 at 2:39 PM, Staff D stated they expected to see parameters for residents receiving insulin for when to hold the medication and/or to notify the provider. A joint record review of the April 2025 MAR showed Resident 36 had orders for insulin glargine without parameters. Staff D stated that Resident 36's insulin glargine order did not have parameters to hold the medication and/or to notify the provider if the blood sugar showed certain numbers [too low and too high blood sugar levels]. Staff D further stated that Resident 36's insulin order for glargine should have had parameters.<br><br>In an interview and joint record review on 04/23/2025 at 3:19 PM, Staff B stated that Resident 36's order for insulin glargine should have had parameters for when to hold the medication and/or notifying the provider.<br><br>52331<br><br>RESIDENT 53<br><br>Review of the facility's policy titled, Preadmission Screening and Resident Review (PASRR or PASARR- an assessment used to identify residents referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities [ID]; or related conditions are not inappropriately placed in nursing homes for long term care), revised in October 2017, showed, Social Services or Designee shall review all Level I screening forms for accuracy. If at any time the Facility finds that the previous Level I screening was incomplete, erroneous, or no longer accurate, the facility shall immediately complete a new screening using Level I form.<br><br>Review of the face sheet printed on 04/17/2025 showed Resident 53 admitted to the facility on [DATE] with diagnosis that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 53's Level I PASARR dated 02/17/2025, did not show depression was documented in Section IA (SMI).<br><br>A joint record review on 04/23/2025 at 11:33 AM with Staff I, Social Services Associate, showed Resident 53's face sheet listed a diagnosis of depression. A joint record review of Resident 53's Level I PASARR dated 02/17/2025 showed that depression was not marked in Section IA. Staff I stated that Resident 53 had a diagnosis of depression. When asked if Resident 53's Level II PASARR was accurate, Staff I stated that it was not and that they should have updated Section IA to include the diagnosis of depression.<br><br>In an interview on 04/23/2025 at 4:19 PM, Staff B stated that they expected all the information on PASARR forms to be completed accurately.<br><br>In an interview on 04/23/2025 at 5:15 PM, Staff A, Administrator, stated that they expected Social Services would follow the PASARR policy and complete the form accurately.<br><br>52133<br><br>RESIDENT 3<br><br>Review of the facility's policy titled, Proper Use of Positioning Devices, revised in January 2014, showed Positioning Devices can be considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed) . Positioning Devices are only permissible if they are used to treat a resident's medical symptoms or to assist the resident with mobility and transfer . An assessment will be made to determine [whether] the resident will benefit from the use of a positioning device and that the resident can physically and safely use one.<br><br>Multiple observations on 04/16/2025 at 9:21 AM, on 04/17/2025 at 9:21 AM, and on 04/18/2025 at 2:30 PM showed Resident 3's left side bed positioning device was loose and able to wiggle when moved from side to side.<br><br>Review of Resident 3's facility room rounds form, dated 04/18/2025 did not show bed positioning devices were listed and/or that it was regularly inspected.<br><br>In an interview and joint record review on 04/23/2025 at 1:23 PM, Staff A stated that staff (managers doing room rounds) would check for bed positioning devices and document on the facility room rounds form sections under, Is the room in good repair? and/or Furniture in good repair. Staff A stated, the bed positioning devices are attached to the bed, so when they check the bed those are included in the bed. The bed is considered furniture. A joint record review of the room rounds form for Resident 3 dated 04/18/2025 showed check marks were documented under sections, Is the room in good repair? and Furniture in good repair. Staff A stated check marks documented on room rounds form meant that there were no issues found. Staff A stated that they were made aware of Resident 3's left bed positioning device was loose and wiggly that day [04/18/2025] when the work order was made. Staff A further stated that they expected the managers to check the bed positioning devices as a bed is furniture. So, they will check the positioning devices with the bed and if there are any issues with them to notify [Staff A] and make a work order. When asked if Resident 3's room rounds form was accurately documented that bed positioning devices were monitored, Staff A stated that the bed positioning devices were checked under the sections for room in good repair and furniture in good repair.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reference: (WAC) 388-97-1720 (1)(a)(ii) |

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|---|---|---|---|
| | 505478 | A. Building<br>B. Wing | 04/23/2025 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912<br><br>Based on observation, interview, and record review, the facility failed to appropriately use Personal Protective Equipment (PPE-use of face mask, gown, and gloves) for 1 of 4 staff (Staff T) and failed to perform hand hygiene during meal tray pass for 3 of 8 residents (Residents 52, 39 & 257), reviewed for infection control. In addition, the facility failed to handle a urinary catheter (a semi-flexible tube inserted into the bladder to drain urine) bag appropriately for 1 of 1 resident (Resident 23), reviewed for urinary catheter care. These failures placed the residents, staff, and visitors at an increased risk of infection and related complications.<br><br>Findings included .<br><br>Review of the facility's undated policy titled, Transmission-Based (Isolation) Precautions, showed that Transmission-based precautions .refer to actions (precautions) implemented in addition to standard precautions that are based upon the means of transmission .in order to prevent or control infections. It showed that Droplet Precautions is Intended to prevent transmission of pathogens spread through . respiratory droplets that are generated by a resident who is coughing, sneezing, or talking. It further showed that the recommendations for PPE for Droplet Precautions included, [NAME] [put on] a mask upon entry into the patient room.<br><br>Review of the facility's policy titled, Infection Prevention and Control Program, revised in 2025, showed, Standard Precautions: All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.<br><br>PPE USE<br><br>Observation on 04/16/2025 at 8:52 AM, showed Staff T, Nursing Assistant Certified (NAC), wearing a N95 (a device designed to protect the wearer against particles and help prevent the spread of germs) mask and helping the resident in room [ROOM NUMBER]D (Droplet Precautions room). Staff T left the room and did not take off their soiled mask and did not put on a new one. Further observation showed a PPE cart outside the room.<br><br>Additional observation on 04/16/2025 at 12:08 PM, showed Staff T came out room [ROOM NUMBER]W (Droplet Precautions room) and did not change their soiled N95 mask. Staff T then went into room [ROOM NUMBER] wearing the same N95 mask. Staff T then went into room [ROOM NUMBER]D (Droplet Precautions room). Staff T did not change masks between resident rooms. Further observation showed a PPE cart outside the room.<br><br>In an interview on 04/16/2025 at 2:15 PM, Staff T stated that we wear masks when we go in [to Droplet Precautions rooms] and then take off everything and put on a new mask. Staff T further stated that their process was to take off their old [soiled] mask in the resident's room, sanitize their hands and put a new mask on inside the room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 04/22/2025 at 10:24 AM, Staff C, Infection Preventionist, stated that they expected staff to wear PPE when going into a Droplet Precautions room, provide care, take off PPE inside of the room, perform hand hygiene and put on a new mask. When asked where staff should put on their new mask, Staff C stated, outside the room.<br><br>In an interview on 04/23/2025 at 12:12 PM, Staff B, Director of Nursing, stated that for staff taking care of a resident on Droplet Precautions, they expected staff to wear PPE when entering the room, provide care, take off PPE and perform hand hygiene. Staff B further stated that they expected staff to change their soiled masks after leaving the Droplet Precautions room.<br><br>52331<br><br>HAND HYGIENE<br><br>RESIDENT 52<br><br>Observation on 04/18/2025 at 8:16 AM, showed Staff P, NAC, delivered Resident 52's meal tray to their bedside table, moved the bedside table closer to Resident 52, and moved their walker away. Staff P did not perform hand hygiene in between tasks and/or after leaving Resident 52's room.<br><br>RESIDENT 39<br><br>Observation on 04/18/2025 at 8:18 AM showed Staff P delivered Resident 39's meal tray to their room without performing hand hygiene. Staff P placed Resident 39's meal tray on their bedside table and moved the bedside table in front of Resident 39. Staff P did not perform hand hygiene in between tasks and/or after leaving Resident 39's room.<br><br>RESIDENT 257<br><br>Observation on 04/18/2025 at 8:20 AM, showed Staff P delivered Resident 257's meal tray to their room without performing hand hygiene. Staff P moved the bedside table closer to Resident 257 and moved their walker away.<br><br>In an interview on 04/18/2025 at 8:36 AM, Staff P stated that they should have done hand hygiene before entering and after leaving the rooms of Residents 52, 39 and 257.<br><br>In an interview on 04/22/2025 at 11:29 AM, Staff D, Resident Care Manager, stated that Staff P should have performed hand hygiene after they touched anything in the residents' rooms and/or after leaving the resident's room.<br><br>In an interview on 04/22/2025 at 12:57 PM, Staff C stated they expected all staff to do hand hygiene before entering and after leaving the residents' room.<br><br>In an interview on 04/23/2025 at 4:19 PM, Staff B stated that they expected staff to perform hand hygiene before entering and after leaving the residents' room.<br><br>INDWELLING URINARY CATHETER<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | RESIDENT 23<br><br>Resident 23 admitted to the facility on [DATE] with diagnoses that included urinary retention (inability to completely empty the bladder [body organ that collects urine]), benign prostatic hyperplasia (an enlargement of the prostate gland [male reproductive gland]).<br><br>Multiple observations on 04/16/2025 at 10:51 AM, at 1:22 PM, and at 2:04 PM, showed Resident 23's indwelling urinary catheter drainage bag was hanging under their bed and touching the floor.<br><br>A joint observation and interview on 04/16/2025 at 2:13 PM, Staff Q, Registered Nurse, showed Resident 23's catheter drainage bag hanging from the right side of bed and touching the floor. Staff Q stated that Resident 23's drainage bag should not have touched the floor.<br><br>In an interview on 04/22/2025 at 11:29 AM, Staff D stated that Resident 23's drainage bag should not have touched the floor, and that there should have been a barrier between the floor and the drainage bag.<br><br>In an interview on 04/22/2025 at 12:57 PM, Staff C stated that they expected the resident's drainage bag should not have touched the floor.<br><br>In an interview on 04/23/2025 at 4:19 PM, Staff B stated that the indwelling urinary catheter drainage bag should not be on the floor.<br><br>Reference: (WAC) 388-97-1320 (1)(a)(c)(2)(c) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>46912<br><br>Based on interview and record review, the facility failed to ensure a resident received education regarding the potential risks and benefits when offering influenza vaccine (used to prevent influenza [an infection of the nose, throat, and lungs]) for 1 of 5 residents (Resident 10), reviewed for immunizations. 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 their influenza immunization.<br><br>Findings included .<br><br>Review of the facility's policy titled, IC [Infection Control]-Influenza Vaccine, revised in January 2023, showed that Prior to the vaccination [influenza vaccine], the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. It further showed, Provision of such education shall be documented in the resident's .medical record, as applicable.<br><br>Review of a nursing progress note dated 11/04/2024, showed Resident [Resident 10] received her flu [Influenza] shot per resident's direction on 11/04/2024.<br><br>Review of Resident 10's clinical record (electronic health record and paper record) showed no documentation that Resident 10 and/or their representative was provided risks and benefits of the influenza vaccine.<br><br>In an interview on 04/22/2024 at 10:24 AM, Staff C, Infection Preventionist, stated that they provided risks and benefits for vaccinations prior to giving vaccinations to residents. Staff C stated that we have a VIS [Vaccine Information Statement] that we give them. When asked if Resident 10 was provided risks and benefits for their influenza vaccination given on 11/04/2024, Staff C stated I can't find it. It must have been lost.<br><br>In an interview on 04/23/2024 at 12:12 PM, Staff B, Director of Nursing, stated that they expected the influenza vaccine to be offered to all residents, annually during flu season. Staff B further stated that they expected risks and benefits to be provided to residents prior to receiving the influenza vaccine and it should be documented either on paper or in a note.<br><br>Reference: (WAC) 388-97-1340 (2) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52133<br><br>Based on observation, interview, and record review, the facility failed to ensure bed rails (bed positioning devices) were properly secured and maintained/checked for safety for 1 of 5 residents (Resident 3), reviewed for accident hazards. This failure placed the residents at risk for injury and/or entrapment.<br><br>Findings included .<br><br>Review of the facility's policy titled, Proper Use of Positioning Devices, revised in January 2014, showed Positioning Devices can be considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed) . Positioning Devices are only permissible if they are used to treat a resident's medical symptoms or to assist the resident with mobility and transfer . An assessment will be made to determine the resident will benefit from the use of a positioning device and that the resident can physically and safely use one.<br><br>Resident 3 was admitted on [DATE] with multiple diagnoses that included Parkinsons disease (a progressive neurodegenerative disorder that primarily affects movement, causing symptoms like tremors, slowness of movement, rigidity, and postural instability), hemiplegia (a condition characterized by paralysis on one side of the body) to right dominant side, and dementia (a progressive condition that affects the brain with decline in mental ability).<br><br>Review of the Activities of Daily Living (ADL) care plan dated on 04/18/2025 showed an intervention that Resident 3 required one to two staff maximum assist to roll side-to-side in bed and to cue/assist Resident 3 to use bilateral (both sides) positioning devices to participate in turning.<br><br>Multiple observations on 04/16/2025 at 9:21 AM and on 04/17/2025 at 9:21 AM, showed Resident 3's left side positioning device was loose and able to wiggle.<br><br>In a joint observation and interview on 04/18/2025 at 11:40 AM with Resident 3 showed, their left side positioning device was loose and able to wiggle back and forth. Resident 3 stated that they used their bed positioning devices when they turned in bed by holding on to them. Resident 3 stated that their left side positioning device was loose.<br><br>In an interview and joint observation on 04/18/2025 at 2:09 PM with Staff R, Nursing Assistant Certified, stated if a resident's bed positioning device is loose or is not secure, they would do a work order for maintenance and let management know. In a joint observation, Staff R stated Resident 3's left side positioning device was not secure and that it should have been.<br><br>In an interview on 04/18/2025 at 2:30 PM, Staff B, Director of Nursing Services, stated that after therapy evaluated the residents and nursing assessed the residents, staff get consent, a provider's order, and then care plan the positioning devices. Additionally, Staff B stated then they would install the positioning devices on the residents' bed. Staff B further stated if there were any issues with the residents' positioning devices, they would expect staff to do a work order.<br><br>(continued on next page) |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 04/22/2025 at 10:28 AM, Staff S, Director of Facilities, stated the bed positioning devices were not included in their (maintenance staff) routine checks. Staff S further stated bed positioning devices were checked during the facility room round checks.<br><br>In an interview on 04/22/2025 at 10:40 AM, Staff A, Administrator, stated that bed positioning devices were checked once a week during room rounds and that each manager was assigned rooms to check.<br><br>Review of Resident 3's facility room rounds form dated 04/18/2025 did not show bed positioning devices were listed and/or that it was regularly inspected.<br><br>In an interview and joint record review on 04/23/2025 at 1:23 PM, Staff A stated that staff (managers doing room rounds) would check for bed positioning devices and document on the facility room rounds form sections Is the room in good repair and/or Furniture in good repair. Staff A stated, the bed positioning devices are attached to the bed, so when they check the bed those are included in the bed. The bed is considered a furniture. Joint record review of the room rounds form for Resident 3 dated 04/18/2025 showed check marks were documented for sections Is the room in good repair and Furniture in good repair. Staff A stated check marks documented on room rounds form meant that there were no issues found. Staff A stated that they were made aware of Resident 3's left bed positioning device was loose and wiggly that day [04/18/2025] when the work order was made. Staff A further stated that they expected the managers to check the bed positioning devices as a bed is furniture. So, they will check the positioning devices with the bed and if there are any issues with them to notify [Staff A] and make a work order.<br><br>Reference: (WAC) 388-97-2100 (1)(2) |