STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505483	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaska Gardens Health and Rehabilitation	6220 South Alaska Street Tacoma, WA 98408

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to ensure incidents, accidents, and alleged violations were thoroughly investigated for 3 of 3 sample residents (Residents 1, 8, & 38) reviewed for investigations. These failures placed residents at risk for abuse, neglect, adverse events, significant injuries, rehospitalization s, and diminished quality of care/quality of life. Findings included . POLICY Review of the facility's Abuse and Neglect Policy and Procedure revised [DATE] showed all resident events would be thoroughly investigated to determine if abuse had occurred. The thorough investigation would conclude with the answers to the who, what when, where, how, and why the incident happened. Each phase of a thorough investigation would include two stages: data collection (who, when, where) including written, signed and dated witness statements collected as soon as possible after the event with as much detail as possible. Other documents included in a thorough investigation (if they pertained) included lab test results, progress notes, care plans, staff attendance records, names of emergency service responders, and data analysis (the how and why). The resident's clinical record would include enough information about the incident to enable staff to identify, plan for, and meet the residents' needs. Evidence of the investigation would be readily available for State Agency (SA). According to the Washington State Department of Social & Health Services Nursing Home Guidelines -The Purple Book, revised [DATE] defined an Accident as any unexpected or unintended incident, which may result in injury or illness to a resident. Repeated accidents without facility intervention or if the prior risk of an event was identified and no action was taken to prevent the occurrence, could be considered neglect. An Incident was an occurrence involving a resident in which mistreatment, neglect, abuse, misappropriation of resident property or financial exploitation are alleged or suspected, or a substantial injury of unknown source/cause/circumstance. All incidents required thorough investigation to rule out abuse/neglect, including (but not limited to) any occurrence that was not consistent with standards of care and practice, substantial injuries of unknown source, and any alleged violations. Review of the facility's Accidents and Incidents - Investigating and Reporting policy, revised [DATE] showed the facility would investigate and report all accidents and incidents involving residents, employees, and visitors that occurred on the premises. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 1> Review of the [DATE] Admission Minimum Data Set (MDS-an assessment tool) showed Resident 1 admitted on [DATE], had moderate cognition problems, hallucinations, and behaviors. Resident 1 diagnoses included a heart rhythm problem that increased fall risk, a fracture of the spine, Parkinson's disease (a progressive neurological disorder that can cause hallucinations and increase fall risk), urinary problems, and hallucinations. Resident 1 required staff assistance for all activities of daily living (ADLs) and had occasional incontinence. Resident 1 had frequent pain that effected their sleep and day-to-day routine. Resident 1 had falls that resulted in fractures prior to admission, one non-injury fall since admission, and medications associated with high fall risk that included antipsychotics and antidepressants. FALLS: Review of Resident 1's Fall care plan (CP), dated [DATE], showed to monitor for side effects of any medications that could cause gait disturbances, sudden drop in blood pressure and pulse, weakness, dizziness, sedation, fatigue, seizures, fainting, or vertigo. Review of Resident 1's Kardex (quick reference CP interventions and alerts for CNAs), dated [DATE], showed no fall interventions or behavior interventions for the CNAs to implement. Review of Resident 1's progress notes showed they had a fall on [DATE] at 3:30 PM. The documentation showed no injuries were identified and the immediate intervention was to encourage Resident 1 to be in highly visualized areas while in the wheelchair, which they were in when they fell (in the wheelchair at the nurse's station). Further review of the progress notes did provide documentation to show consistent post-fall monitoring occurred, or any further falls sustained by Resident 1. In an interview on [DATE] at 2:30 PM, Staff C, Registered Nurse-Resident Care Manager (RCM), stated Resident 1 had three falls while a resident at the facility according to the electronic risk management system: a fall on [DATE] at 3:30 PM, a fall on [DATE] at 4:12 PM, and a fall on [DATE] at 2:15 PM. Staff C stated Resident 1 did not have a fall report entered in risk management for [DATE]. Staff C was unable to locate documentation in the clinical record to show the fall events on [DATE] and [DATE] were documented and had post fall alert monitoring documentation. Review of the facility's mandatory reporting log for [DATE] and [DATE] showed Resident 1 had one fall on [DATE] at 3:30 PM and an allegation of abuse/neglect dated [DATE]. The falls on [DATE] and [DATE] were not logged. Review of the three facility Fall Investigations dated: [DATE] at 3:30 PM, [DATE] at 4:12 PM, and [DATE] at 2:15 PM showed thorough investigations were not conducted to identify root cause, determine any unmet care needs, investigate other potential medical concerns or changes in condition, medication reviews, or review and revision of the CP. ALLEGED VIOLATION: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nurse progress note dated [DATE] at 2:22 PM showed Resident 1's Collateral Contact (CC-immediate family member) arrived to visit, called [DATE], and had Resident 1 transferred to the hospital. CC alleged that the facility had not provided the care Resident 1 needed, and was not getting better. Review of the facility's investigation dated [DATE] at 3:07 PM did not provide documentation to show a thorough and complete investigation was conducted. The documentation did not provide: an interview with Resident 1's Responsible Party (or attempts made), written/signed/dated witness statements from the staff who cared for Resident 1, interviews from other residents, validation of a thorough clinical chart review, or analysis to conclude abuse/neglect had not occurred. A request for more information or documentation of the investigation was requested but no further information was provided. In an interview on [DATE] at 10:27 AM, Resident 1's Responsible Party (R1-RP) stated after resident 1 fell , the facility did nothing about it. They were notified of one fall, on [DATE], they assumed occurred that day. Resident 1 was left to sit up in the wheelchair all day, in the halls or at the nurse station, and was not allowed to lay down for naps. The facility staff told R1-RP Resident 1 required more supervision, so they were kept at the nurse station for increased supervision. R1-RP stated [they] visited almost every day and there were many instances where Resident 1 was found in the hall/nurse station unsupervised. They were at the facility [DATE] just before dinner time and noticed Resident 1 was not doing well. Resident 1 was so groggy they just mumbled words and appeared out-of-it. R1-RP stated they were out of town on [DATE] so CC went to check on Resident 1. R1-RP stated CC found Resident 1 in the wheelchair at the nurse station, slumped over the side of the wheelchair arm, and thought Resident 1 had died . CC had to go find help because there were no staff at the nurse station. After CC found staff who said they would lay Resident 1 down, CC called R1-RP to report what occurred. R1-RP directed CC to call 911 and then call [them] back. R1-RP was on speaker phone and could hear the paramedics repeatedly calling out Resident 1's name to get them awake but Resident 1 could not respond. R1-RP stated at the hospital they found Resident 1 was over-sedated from the medications, had a urine infection, and a hip fracture. In an interview on [DATE] at 2:30 PM, Staff C, stated the nurses on shift of the accident/incident were responsible to initiate fall investigations, report to the physician and responsible party, and implement immediate interventions. They were expected to gather witness statements from the staff and detail the scene of the event in their incident report they imitated in Risk Management. Staff C stated the RCMs, or Staff B, Director of Nursing (DNS), reviewed the documentation to ensure the pos- fall steps were completed and all investigations were thorough and complete. In an interview on [DATE] at 4:45 PM, Staff A, Administrator stated the Director of Nursing, DNS, was responsible to ensure the investigations were thorough and complete. The DNS logged all incidents and accidents on the mandatory reporting log. Staff A stated in the absence of the DNS; [they] maintained the reporting log. Staff A was not aware the falls on [DATE] and [DATE] were not logged on the reporting log. Staff A was not aware Resident 1's hip fracture found after discharge. <RESIDENT 8> Review of the [DATE] Admission MDS showed Resident 8 admitted to the facility [DATE], had moderate cognition problems, required assistance for ADLs, had frequent bowel incontinence, and diagnoses included stroke, dysphagia (difficulty swallowing), diabetes, obstructive sleep apnea, and a newly placed feeding tube. Resident 8 had falls prior to admission but no falls since they admitted . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8's fall CP, initiated [DATE], showed non-person-centered CP interventions that directed staff to assist with ADLs, give medications as ordered, do a fall assessment, and the standard call light within reach and answer promptly. Review of the facility's mandatory reporting log for [DATE] showed: two falls on [DATE], one at 8:21 PM and the other at 10:30 PM; and a report to the SA of an allegation of neglect regarding Resident 8 on [DATE] at 9:00 AM. Review of the facility incident reports dated [DATE] at 8:21 PM and [DATE] at 10:30 PM showed they were not complete or thoroughly investigated. Review of the facility's abuse/neglect investigation dated [DATE] at 9:00 AM showed the facility received a phone survey (date not specified) from Resident 8's Responsible Party that the facility neglected Resident 8 by not taking care of their needs, including medical equipment, and they died . The investigation did not provide supporting documentation to show a thorough and complete investigation was conducted to rule out neglect related to failure to provide care and services they required and the chain of events that occurred prior to Resident 8's unexpected death. In an interview on [DATE] at 4:41 PM, Resident 8's responsible party (R8-RP) stated after Resident 8's roommate discharged ; Resident 8 started falling because there was no one in the room to call for help for Resident 8. R8-RP stated Resident 8 told them their call light was often out of their reach. They also experienced long call wait times and by the time staff arrived they were already incontinent. R8-RP stated on [DATE], they were contacted by someone at the facility and told Resident 8 fell and asked if they could put side rails on the bed, but nothing was done. R8-RP stated Resident 8 fell again and hit their head. Resident 8 lost weight even though they were on a feeding tube to prevent weight loss. Resident 8 called R8-RP because the facility had not dealt with their urinary problems including blood in their urine and inability to urinate. R8-RP was not contacted when Resident 8 was sent to the emergency roiagnom on [DATE]. Resident 8 asked R8-RP to bring them food because they were hungry and their oral care supplies because the facility did not provide them. Resident 8 wanted a shave and after multiple times asking, R8-RP emailed the Social Services Director and finally something was done about it. They only received three calls from the facility, two were about Resident 8's falls and the third was that Resident 8 was dead. Review of the [DATE] Death in facility MDS showed Resident 8 passed away. <RESIDENT 38> Review of the [DATE] Admission MDS showed Resident 38 admitted to the facility on [DATE]. They had severe cognition problems, required maximum assistant with ADLs, and was incontinent. Resident 38 diagnoses included surgical repair of a hip fracture, dementia, difficulty swallowing, and knee pain. They admitted with no pressure ulcer/pressure injury (PU/PI), were assessed to be at risk for the development of PU/PI and had surgical incisions. Resident 38 did not have a pressure reducing device for the chair or bed, a turning/repositioning program, nutrition or hydration interventions to manage skin problems, surgical wound care, or application of ointments used to prevent skin breakdown. Resident 38 received antipsychotic, antidepressant, and opioid medications. Review of the [DATE] mandatory reporting log showed the facility reported an allegation of neglect on [DATE]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation dated [DATE] showed Resident 38's Collateral Contact, R38-CC, a caregiver at the Adult Family Home (AFH), contacted the facility on [DATE] after they discharged from the facility. R38-CC identified on their admission skin evaluation Resident 38 had two wounds [they] were not aware of. R38-CC was unable to provide clinical characteristics because they were not a nurse, they did not have wound care orders/treatment supplies. The investigation showed it was not thorough or complete. In an interview on [DATE] at 1:15 PM, R38-CC stated they conducted their admission skin evaluation as soon as Resident 38 arrived at their facility. They found Resident 38 had a wound on their buttock, a wound on their heel, and something on their toe. They contacted the facility right away to notify them of the wounds and requested wound care orders, but the facility stated R38-CC did not have any wounds. R38-CC stated they contacted a mobile healthcare provider service, and an Advanced Registered Nurse Practitioner, ARNP, came to their facility later that same day to evaluate Resident 38's wounds. The ARNP informed R38-CC Resident 38 had a Stage II pressure injury (partial-thickness skin loss) on the buttock (they were concerned was infected) and ordered Resident 38 a topical antibiotic ointment and an oral antibiotic for seven days. Resident 38 also had a DTI (deep tissue injury- area of tissue injury of unknown stage/depth) on the right heel, a DTI on the back of the ankle along the Achilles tendon (the tendon that attaches the heel bone to the back calf muscle), a suspected DTI on the base of the right big toe, and a skin tear on the right side of the right lower leg. Refer to F689, F697, F758 REFERENCE WAC [DATE] (6)(a).

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 . Based on observation, interview and record review, the facility failed to ensure baseline care plans (CP) were developed/implemented and provided in written summary to the resident/responsible party, in a language they understood, within 48 hours of admission for 5 of 5 sample residents (Residents 1, 2, 8, 19, & 13) reviewed for baseline CPs. The failure to ensure completion of the baseline or comprehensive CP timely after admission, that addressed the resident's immediate health/safety needs and provided the instructions necessary to properly provide effective, person-centered care that met professional standards of quality placed the residents at risk for unidentified and/or unmet care needs, rehospitalization , adverse events, substandard quality of care, and diminished quality of life. Findings included . POLICY Review of the facility's Baseline Care Plans policy, revised [DATE], showed the facility would develop a baseline CP (or comprehensive CP) to meet the immediate health and safety needs for each resident within 48 hours of admission. The baseline CP would be implemented and updated as needed until completion of the comprehensive assessment and CP. If the facility used the comprehensive CP in place of the baseline CP, they would ensure the comprehensive CP met all the requirements of the baseline CP and was completed within 48 hours of admission. The facility would provide the resident and/or representative a written summary of the baseline CP, in a language they understood that included their stated goals and objectives, a summary of their medications, dietary instructions, any services and treatments they required by the facility or contracted staff. There would be documentation in the clinical record to validate all the components of the written summary were provided to the resident/responsible party. <RESIDENT 2> Review of Resident 2's clinical census showed they admitted to the facility on [DATE] and transferred back to the hospital 11 days later, on [DATE]. Review of Resident 2's Interfacility Transfer Discharge Orders and pertinent hospital records, dated [DATE], showed Resident 2 discharged from the hospital with recent worsening of their chronic heart failure and a major heart surgery. Resident 2 had orders for weight bearing restrictions-Sternal Precautions (temporary restriction after open-heart surgery to protect the healing bones of the chest), wound care needs, heart failure care, diabetic care, labs, and oxygen. Review of the Baseline CP Evaluation, dated [DATE], showed the evaluation was incomplete and did not provide instructions for direct care staff to implement important healthcare and safety instructions ordered in the Transfer Discharge orders. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 2's baseline comprehensive CP, dated [DATE], showed the facility did not include person-centered instructions for diet, Cardio-Respiratory/Heart failure focus problems and care instructions, pain managements, diabetes management, or the Therapy plan with schedule and recommendations based on their initial evaluations for safe mobility and activities of daily living (ADL) care. Review of the clinical record did not provide documentation to show Resident 2 was provided a written summary of their baseline CP evaluation or comprehensive CP. In an interview on [DATE] at 1:10 PM, Staff C, Registered Nurse-RN, Resident Care Manager-RCM, stated they were unable to locate documentation in the clinical record to show a baseline CP evaluation (or comprehensive CP) was completed and provided to Resident 2 within 48 hours of their admission. In an interview on [DATE] at 3:25 PM, Resident 2 stated they did not recall receiving a written summary of their CP or medication list. Resident 2 stated they did not receive the care they expected to receive after they discharged from the hospital and felt No one knew what they were supposed to do. Resident 2 stated the Certified Nursing Assistants (CNAs) did not know their weight bearing restrictions with Sternal Precautions and did not know they required their head of bed to be always elevated so they could breathe. Resident 2 stated the facility did not change their leg surgical wound dressing for several days after admission, it re-opened, and got infected. Resident 2 stated their blood sugars were not taken at the correct times in correlation with their meals, their blood sugars ran high and low, and staff would bring their meal and tell them Go ahead and start eating the nurse will be in to check your sugar. In an interview on [DATE] at 1:25 PM, Staff Z, Registered Nurse, [NAME] President of Clinicals, stated the Baseline CP evaluation, once completed, did not transfer information over to the comprehensive CP or the Kardex (the direct care staff care plan) in Point Click Care (PCC - the electronic medical record software). The staff were expected to complete the Baseline CP evaluation in addition to initiating the comprehensive CP for the direct care staff to have access to the care instructions through the Kardex. <RESIDENT 8> Review of Resident 8's clinical census showed they admitted to the facility on [DATE] and died in the facility 14 days later, on [DATE]. Review of Resident 8's hospital Provider Orders-Nursing Home Transfer, Continuum of Care, and Discharge Summary dated [DATE]; and Comprehensive CP on [DATE] showed the minimum healthcare, safety, and physician ordered instructions related to their stroke, tube feeding, nutrition/hydration, respiratory care, and urinary problems were not addressed with their specific needs on the Comprehensive CP. Review of the clinical record did not show a baseline CP evaluation was completed or that the resident/responsible party received written summary of the baseline CP. In an interview on [DATE] at 4:31 PM, Resident 8's Responsible Party stated they were never provided a baseline CP. <RESIDENT 19> (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 19's clinical census showed they admitted to the facility on [DATE] and died in the facility 12 days later, on [DATE]. Review of Resident 19's hospital Provider Orders-Nursing Home Transfer, Continuum of Care, and Discharge Summary dated [DATE], After Visit Summary's dated [DATE] and [DATE]; and Comprehensive CP on [DATE], showed the CP did not address or provide instructions to staff to meet their personalized immediate healthcare and safety needs. Review of a Baseline CP evaluation dated [DATE] showed the evaluation was not completed; the evaluation was blank and unsigned. In an interview on [DATE] at 1:31 PM, Staff C, Registered Nurse-RN, Resident Care Manager-RCM, stated they were unable to locate a completed baseline CP or show a summary of the baseline CP and medication list were provided to Resident 19 within 48 hours of admission. Staff C stated the Baseline CP evaluation should have been completed the day of admission but was not. <RESIDENT 1> Review of Resident 1's clinical census showed they admitted on [DATE] and transferred back to the hospital 12 days later, on [DATE]. Review of Resident 1's hospital Provider Orders-Nursing Home Transfer and Continuum of Care, dated [DATE]; and Comprehensive CP on [DATE] showed the minimum health, safety, and physician ordered instructions related to their medical conditions, monitoring of behaviors and adverse effect of psychotropic medications, personalized relevant fall interventions, swallowing problems, and urinary problems were not addressed on the comprehensive CP. Review of the clinical record did not show a baseline CP evaluation was completed or that the resident/responsible party received written summary of the baseline CP. In an interview on [DATE] at 10:27 AM, Resident 1's Responsible Party stated they were never provided a baseline CP. <RESIDENT 13> Review of Resident 13's clinical census showed they admitted on [DATE]. Review of Resident 13's Hospital After Visit Summary, Provider Orders-Nursing Home Transfer, and Discharge Summary dated [DATE] showed they admitted to the facility with a serious heart infection, received intravenous antibiotics, oxygen use, had chronic and acute pain needs, diabetes management with blood sugar checks and relevant medications, a swallow problem that required a modified texture diet, and wound care for pressure ulcers. Review of Resident 13's Baseline CP evaluation dated [DATE] showed Resident 13 could not easily communicate with staff and their primary language was Spanish (of Castilian dialect). The documentation did not show how staff would communicate with Resident 13 or provide care instructions to staff for their identified care needs. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 13's comprehensive CP on [DATE] did not show important care interventions needed to meet their identified health/safety needs including how the facility would communicate with Resident 13. Review of the clinical record did not show a written summary of the baseline CP and medication list were provided to Resident 13 or their responsible party, in a language they understood. In an observation on [DATE] at 8:30 AM of Resident 13's environment, no posted signage of their interpreter line phone number w/ specific language and dialect was observed. There were no other acceptable communications tools available in the room to communicate with Resident 13 (like a picture book or pain scale with faces for instance). In an interview on [DATE] at 1:45 PM, Staff C stated they spoke fluent Spanish and conducted interviews or translated with other IDT (Interdisciplinary Team) members who needed to interview Resident 13. Staff C stated the facility used an interpreter line that staff could call to communicate with Resident 13. Staff C stated the direct care staff should have tools available for immediate use to communicate basic needs with Resident 13 but did not. REFERENCE [DATE] (3).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 46472 Based on observation, interview and record review, the facility failed to ensure care and services provided met professional standards of practice for 8 of 12 sample residents reviewed for professional standards. The failure to: hold anti-hypertensive blood pressure (bp) medications when vital signs were outside ordered parameters (Residents 2, 38, & 40), ensure labs specimens were collected and results reported to the physician timely (Residents 22, 8, 1, & 26), and ensure residents were consistently monitored (and documented) regarding alert charting (events and changes of condition) and daily skilled nursing documentation (for residents who were admitted under their skilled Medicare A benefit) (Residents 8, 2, 14, & 38) was timely, thorough, and complete with the required relevant information to show they continued to require skilled nursing care. These failures placed residents at risk for adverse events, rehospitalization , diminished quality of care/quality of life. Findings included . NURSING DOCUMENTATION Skilled Nursing Documentation Requirements Review of the Center for Medicare and Medicaid (CMS) Chapter 8 Medicare Benefit Policy Manual Coverage of Extended Care (SNF) Services, revised issue 10-05-2023, showed the requirements for participation for a skilled Medicare A SNF (Skilled Nursing Facility) stay must have daily documentation that reflects the need for the continuation of the skilled care and additional documentation more often if the resident's conditions warrant the need, such as a change of condition or more frequent monitoring. The residents medical record is expected to provide important communication among all members of the care team regarding the development, course, and outcomes of the skilled observations, assessments, treatments, and resident training performed. The documentation must be timely, clear, concise and readily available. It should include the resident's vital signs and description of their condition at the time, the reason they are receiving the skilled services, the skilled services delivered, and their response to the service. CMS outlined four principle skilled nursing services that required timely and thorough documentation for Medicare A coverage: 1) Management and evaluation of a care plan- the development, management, and evaluation of the care plan based on the physician's orders in addition to any supporting documentation constituting skilled nursing services. Nurses need to document the services that require skilled personnel to meet the resident's needs to achieve their stated goals, promote recovery, and ensure medical safety. 2) Observation and assessment of the resident's condition- additionally, the documentation must reflect the likelihood of change in a resident's condition. For example, if skilled personnel identified the possible need to modify the treatment to help stabilize the condition. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alaska Gardens Health and Rehabilitation	6220 South Alaska Street Tacoma, WA 98408

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Teaching and Training - the documentation must thoroughly describe all efforts made to educate the resident/caregiver and their responses to the training. If applicable, the medical record should also describe the reason for the failure of any educational attempts. Topics of teaching could include colostomy care, insulin administration, prosthesis management, catheter care, G-tube feedings, IV access sites, and wound care. 4) Direct skilled nursing services provided - Nursing services are inherently complex. Because of this, these services can only be performed by or under the supervision of a registered nurse or a licensed practical (vocational) nurse. Some examples of direct skilled nursing services are IV feeding (must meet criteria), IV meds, suctioning, tracheostomy care, rehabilitation nursing procedures, ulcer care, tube feedings, care for surgical wounds, and diabetes management with injections. Review of the facility's Alert Charting/Skilled Charting Guidelines revised March 2017, only pages 5 and 6 of 19 total pages were provided. The guidelines showed monitoring for patient education, tube feeding, Events other than falls, Falls with injury, Falls without injury, and exacerbation of chronic heart/lung conditions, and edema (new/abnormal). The guidelines showed a quick reference to staff on how often to chart for Alert Charting and key skilled factors for the nurses to observe, monitor and document for skilled care services. <RESIDENT 8> Review of Resident 8's Provider Orders-Nursing Home Transfer signed 12/24/2024 showed the physician certified their post hospital skilled nursing care was medically necessary on a continuing basis for the conditions Resident 8 received care for in the hospital. Resident 8 had a new feeding tube placed during the hospital stay and was treated for a new stroke with difficulty swallowing and poorly controlled diabetes. Review of the progress notes from 12/25/2024 to 01/08/2025 did not provide documentation to show the facility consistently monitored their medical conditions (and reasons for admission) that met their need for daily skilled nursing care. The documentation also showed the facility did not consistently provide monitoring/documentation for events that occurred or their changes of condition. Resident 8 was at the facility for 14 days. The progress notes showed daily skilled nursing documentation occurred on eight of 14 days and the eight skilled nursing notes did not meet the Medicare requirement for skilled nursing documentation. <RESIDENT 2> Review of Resident 2's Interfacility Discharge Orders dated 12/02/2024 showed the physician certified that post hospital skilled nursing care was medically necessary on a continuing basis for the conditions Resident 2 was treated for in the hospital. Resident 2 was treated for heart failure exacerbation (worsening) and had open heart surgery bypass grafting (a surgical procedure that creates pathways around obstructions in blood flow of the heart to prevent muscle death). Review of Resident 2's nurse progress notes between 12/02/2024 and 12/13/2024 did not provide documentation to show the facility provided consistent daily skilled nursing services that met the Medicare requirement or consistently monitored Resident 2 more frequently (every shift) during their changes of condition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 14> Review of Resident 14's Skilled Nursing Facility Transfer Orders dated 12/30/2024 certified post-hospital skilled nursing care was medically necessary on a continuing basis for the conditions Resident 14 was treated for in the hospital. Review of Resident 14's hospital Discharge Summary dated 12/30/2024 showed they were treated for neurological changes due to a brain tumor. Review of Resident 14's nurse progress notes between 12/20/2024 and 01/13/2025 did not provide documentation to show the facility provided consistent daily skilled nursing services that met the Medicare requirements. The documentation did not show they were consistently monitored more frequently during their change of condition. <RESIDENT 38> Review of Resident 38's Provider Orders-Nursing Home Transfer dated 01/23/2025 showed they certified post-hospital skilled nursing care was medically necessary on a continuing basis for the conditions Resident 38 was treated for in the hospital. Resident 38's transfer diagnosis was surgical aftercare following repair of a hip fracture. Review of Resident 38's nurse progress notes between 01/23/2025 and 02/13/2025 did not provide documentation to show the facility provided consistent daily skilled nursing services that met the Medicare requirements. The documentation did not show the facility planned or monitored for complications related to their care needs. LAB RESULTS <RESIDENT 22> Review of physician order dated 02/10/2025 at 11:44 AM showed order for a STAT (as soon as possible-without delay) set of labs and a UA (urinalysis - a test to check for urinary tract infection) for a change of condition. An update to the order was done at 3:30 PM for a straight catheterization to obtain the urine for the UA. Review of the lab report dated 02/12/2025 at 1:07 PM showed the blood sample was collected at 7:41 PM (almost eight hours after the order was written for STAT lab draw). The lab report showed the Lab Company called the facility to report a Critical Result on 02/10/2025 at 11:47 PM. Review of the clinical record did not show documentation the physician was called regarding the critical lab. The record showed that no new orders related to the critical lab were written until 02/12/2025 at 6:00 AM, when the physician reviewed the labs in the electronic record. Review of the UA Lab Report dated 02/13/2025 at 1:07 PM showed the urine specimen was not obtained until 02/11/2025 at 6:30 AM, 15 hours after the STAT UA order was updated to collect via catheter to obtain the specimen. The lab results were flagged abnormal but Resident 22 had already been transferred to the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 02/17/2025 Post Acute & Transition of Care Orders showed orders for blood sugar checks every six hours with sliding scale insulin and to recheck their electrolytes (a lab) in 2-3 days after readmission. Review of the 02/17/2025 facility readmission orders showed the orders for the blood sugar checks every six hours, sliding scale insulin, and lab order were not transcribed or implemented. Review of the clinical record did not show a complete medication reconciliation and verification of orders was conducted on admission. In an interview on 03/19/2025 at 4:30 PM Resident 22's Physician, stated the after-hours provider would have taken the call if it was reported. The Physician stated they would investigate it. <RESIDENT 8> Review of a physician order dated 12/30/2024 at 11:49 AM showed a STAT order for blood work and UA due to a change in condition. Review of the Lab Report dated 12/30/2024 at 10:48 PM showed the blood specimen was collected at 5:04 PM and received at the lab at 9:06 PM. Lab report did not show a UA specimen was collected. Review of the clinical record did not show results of a UA. <RESIDENT 1> Review of physician's order dated 01/02/2025 showed an order for a UA to investigate the cause of their painful urination. Review of the clinical record did not provide documentation to show a UA was collected or sent to the Lab. A request for the UA was made but no further information was provided. <RESIDENT 26> Review of Resident 26's physician orders showed: -A physician order dated 01/15/2025 at 3:19 PM for STAT UA w/ C&S. -A physician order dated 01/20/2025 at 9:00 AM for UA. -A physician order dated 01/21/2025 at 3:08 PM for STAT UA to rule out UTI. Review of the Lab Result section of Resident 26's electronic record showed no lab reports for a UA. ANTI-HYPERTENSIVE MEDICATION PARAMETERS (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Standing Physician Orders, dated 09/01/2022, showed for patients who took blood pressure (bp) medications, the facility protocol was to hold all blood pressure medications if the systolic blood pressure (SBP - the top number of the blood pressure reading) was 110 or less. If the blood pressure medication was a beta blocker or a calcium channel blocker (selected classes of anti-hypertensive medications to treat high blood pressure) the hold parameters were to include holding for a heart rate (HR) of 60 or less. The appropriate parameters would be included in the physician order. <RESIDENT 2> Review of Resident 2's December 2024 MAR showed: -A PO dated 12/02/2024 for a beta blocker anti-hypertensive medication to administer every AM and PM with parameters and to hold the medication if the SBP was less than 110 or the HR was less than 60. The documentation showed vital signs outside the ordered parameters, but the medication was still administered on: 12/05/2024 PM, 12/08/2024 PM, 12/09/2024 AM, and 12/11/2024 PM. <RESIDENT 38> Review of Resident 38's January and February 2025 MARs showed: -A physician order dated 01/23/2025 for amlodipine (blood pressure medication) -to hold for SBP less than 110 or HR less than 60. The documentation showed the medication was administered when their vital signs were outside parameters (and it should have been held) on the 01/24/2025 morning dose, 02/12/2025 morning dose and 02/13/2025 morning dose. -A physician order dated 01/23/2025 for carvedilol (blood pressure medication) -to hold for SBP less than 110 or HR less than 60. The documentation showed the medication was administered when their vital signs were outside parameters (and it should have been held) on 01/24/2025 morning dose, 02/01/2025 evening dose, 02/12/2025 morning and evening dose, and 02/13/2025 morning dose. <RESIDENT 40> Review of Resident 40's February 2025 MAR showed: -A physician order dated 12/16/2024 for amlodipine (blood pressure medication) -to hold for SBP less than 110 or HR less than 60. The documentation showed the medication was administered when their vital signs were outside parameters (and it should have been held) on the 02/10/2025, 02/16/2025, 02/17/2025. REFERENCE WAC: 388-97-1620 (2)(b)(i)(ii),(6)(b)(i).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to provide care and services in accordance with professional standards of practice and quality care to meet their physical, mental, and psychosocial needs for 5 of 6 residents (Residents 38, 2, 13, 5, & 10) reviewed. The failure to conduct weekly skin checks, follow physician orders for dressing changes, and monitor residents with wounds (Residents 38, 2, 13, & 5) and failure to develop/implement heart failure/respiratory care plans that aligned with professional standards, follow physician ordered heart failure care interventions, and provide consistent monitoring of their chronic/acute/change of conditions (Residents 2 & 10) placed the residents at risk for adverse events, rehospitalization s, worsening skin conditions, infections, pain, and diminished quality of care/quality of life. Findings included . Review of the facility's Skin Integrity policy, revised January 2025, showed the facility had a systematic monitoring process for evaluating and documenting skin integrity. Resident's skin was observed daily during the provision of activities of daily living and changes identified would be reported to the nurse. The nurses conducted weekly full body skin checks that were documented on the Treatment Administration Record (TAR) with their initials and either a NO or a YES (NO indicated no new skin impairment and YES indicated new skin impairment present). If a skin impairment was identified on admission, the nurse would document the skin problems with measurements, color, and other required characteristics on the Weekly Wound Evaluation (for surgical, pressure, burns, and vascular ulcers). Bruises, skin tears, and abrasions were monitored on the TAR weekly until resolved. The physician would be notified and a treatment order obtained. The responsible party/resident would be notified of the new orders and treatment plan, and the CP would be updated. If the skin impairment occurred after admission, all the previous steps would be followed plus: initiation of alert charting, notification (and documentation) to the physician and responsible party, update the CP, notify the Registered Dietician, notify the Director of Nursing (DNS). If the skin impairment indicated a potential change of condition, and the DNS would complete a comprehensive review of the resident's medical record to evaluate if the impairment was avoidable or unavoidable. All wounds were evaluated weekly and documented in the clinical record. <RESIDENT 38> Review of the 01/29/2025 Admission Minimum Data Set (MDS-assessment tool) showed Resident 38 admitted to the facility on [DATE]. They had severe cognition problems, required maximum assistance with activities of daily living (ADLs), and was incontinent. Resident 38 diagnoses included surgical repair of a hip fracture, dementia, difficulty swallowing, and knee pain. They admitted with no pressure ulcer/pressure injury (PU/PI), were assessed to be at risk for the development of PU/PI, and had surgical incisions. The assessment showed Resident 38 did not have: a pressure reducing device for the chair or bed, a turning/repositioning program, nutrition or hydration interventions to manage skin problems, surgical wound care, or application of ointments used to prevent skin breakdown. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 38's Skin CP dated 01/23/2025 showed Resident 38 was at risk for skin breakdown due to weakness and left hip fracture surgical wound. The interventions included: after each turn assure heels were not touching (did not indicate what), assist to move up in bed, avoid skin to skin contact, barrier ointment or lotion as needed, weekly skin checks, and turn every two hours. The CP did not address offloading of boney prominences (tailbone, elbows, heels off the bed), contracture management and positioning, or surgical wound monitoring. Review of the Kardex (quick reference care directives for Certified Nursing Assistants-CNAs) dated 01/13/2025 directed CNAs to avoid skin to skin contact whenever possible and turn every two hours. The Kardex did not provide CNAs instructions to address Resident 38's risk factors for PU/PI development including management of incontinence, barrier ointment for skin protection, contracture management/positioning, or offloading instructions. Review of the January and February 2025 MAR/TARs showed a physician's order dated 01/23/2025 for weekly skin checks. The TARs documentation showed the skin checks due on 01/29/2025 and 02/12/2025 were not done. The skin check due on 02/05/2025 was signed as completed, indicated Resident 38 had a new skin impairment, and to referred to the Weekly skin check evaluation. Review of the clinical record did not show a Weekly Skin Check evaluation completed for the skin check for 02/05/2025. Review of the nurse progress note dated 02/13/2025 at 1:44 PM showed Resident 38 discharged home (to their Adult Family Home-AFH) with all their medications and personal belongings. They were transported in a wheelchair accompanied by their spouse. The documentation did not show a skin check was completed on discharge. In an interview on 03/19/2025 at 12:35 PM Staff C, Registered Nurse-RN, Resident Care Manager-RCM, stated they were unable to locate documentation to show weekly skin checks were conducted after 02/02/2025 or at discharge. Staff C stated the medication nurses were responsible for the weekly skin checks and the skin checks should have been done when scheduled but were not. In an interview on 03/20/2025 at 1:15 PM, R38-CC (CAN-AFH staff) stated they conducted Resident 38's skin evaluation just after the arrived back home. They found Resident 38 had wounds [they] were not notified of prior to discharge. They contacted the facility right away to notify them of the wounds that were not reported on discharge. R38-CC stated they contacted a mobile healthcare provider service, and an Advanced Registered Nurse Practitioner, ARNP, came to the AFH later that day and evaluated Resident 38's wounds. The ARNP reported Resident 38 had a Stage II PU/PI (partial-thickness skin loss) on their sacrum (lower back/upper buttock area), dermatitis between the buttocks from incontinence, a DTI (deep tissue injury of unknown stage/depth) on the right heel, and a linear DTI along their right Achilles tendon (the tendon at the back of the ankle), a suspected DTI at the base of their right great toe, and a skin tear on the right lower leg. The ARNP wrote wound care instructions for the AFH and ordered an oral and topical antibiotic for the dermatitis and suspected wound infection. <RESIDENT 2> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 12/08/2024 Admission MDS showed Resident 2 admitted to the facility on [DATE], had no problems with cognition, required assistance with ADLs, and diagnoses included surgical aftercare following heart surgery, heart failure, and diabetes. Resident 2 had surgical wounds and required surgical wound care. Review of Resident 2's Skin CP showed they had a surgical wound with staples on the left leg but directives to staff regarding the care and monitoring of the surgical wound. Review of the Resident 2's signed admission orders dated 12/02/2024 showed no wound care treatment orders or monitoring for the left leg surgical wound. Review of the December 2024 MAR showed no daily monitoring of the left leg surgical wound on 12/02/2024, 12/03/2024, and 12/04/2024. Review of a physician progress note dated 12/04/2024 showed Resident 2 complained of pain and reported drainage from their left leg surgical incision. They removed a dressing from the incision and found drainage and other symptoms of infection. The physician obtained a wound culture of the drainage. Review of progress notes between 12/05/2024-12/09/2024 did not provide documentation to show the facility consistently monitored their left leg wound. Review of a physician progress note dated 12/09/2024 showed they received the wound culture results and ordered antibiotics for left leg surgical wound infection. Review of an infection preventionist note dated 12/10/2024 at 10:22 AM showed Resident 2 was started on an antibiotic for ten days for surgical site infection. The documentation showed Resident 2 had severe pain to the site, redness, warmth to touch, and heavy drainage. Review of the December 2024 MAR physician's order dated 12/05/2024 directed nurses to cleanse the left leg wound and apply a clean dressing daily and monitor for infection. The MAR documentation showed the dressing was not changed on 12/09/2024 or 12/12/2024. Review of Resident 2's progress notes did not provide documentation to show the facility consistently monitored on alert status: their surgical incision, wound care, and antibiotic treatment for complications and/or response to the treatment. In an interview on 02/19/2025 at 2:30 PM, Resident 2 stated they asked the nurse every day after their admission when someone was going to change the dressing on their leg because they had pain to the site and were concerned for infection because they could see drainage. They reported it to their nurse, but the dressing was not changed. Resident 2 stated the nurse replied to their request with, The wound nurse will change the dressing. Resident 2 stated the wound nurse never came and they had the same dressing on for several days. Resident 2 stated when the physician saw them on 12/04/2024, they asked the physician when someone was going to look at their left leg surgical incision and change the dressing. The physician removed the dressing from the leg and there were two areas on the incision that had opened and had a lot of stinky drainage. Resident 2 stated they ended up with an infection of the leg wound that has delayed healing and continued to require weekly wound care center visits for care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 13> Review of the 02/24/2025 Admission MDS showed Resident 13 admitted [DATE] with Pressure Ulcer/Pressure Injuries (PU/PIs) on both heels. Review of the Skin at Risk CP dated 02/18/2025 directed staff to provide treatment and monitoring as ordered. Review of the Nurse Clinical Admission evaluation dated 02/18/2025 showed Resident 13 had a Stage II PU/PI on the left heel and a Stage I PU/PI on the Right heel. The evaluation did not include measurements of the wounds or descriptions. Review of the February 2025 MAR/TARs did not show treatment orders for both heel PU/PIs. An observation on 02/20/2025 at 12:04 PM showed Resident 13 lying on their bed, with their heels on the mattress, and not elevated off the bed. They had a gauze dressing that appeared to be loose and falling off under yellow slip-socks. In an interview on 02/20/2025 at 12:15 PM, Staff FF, LPN, stated the wound nurse would change Resident 13's dressings. Staff FF stated the wound nurse would know to change the dressing because the wound care orders would alert them. Staff FF was not aware there were no wound care orders. In an interview on 02/20/2025 at 3:30 PM, Staff A, Administrator, stated the wound nurse evaluated the wounds on 02/19/2025 but had forgot to enter wound care orders and their documentation into the electronic record. <RESIDENT 5 > Review of the 12/25/2024 Admission MDS showed Resident 5 admitted to the facility on [DATE] and had skin tears but no application of dressings for wound care. Review of Resident 5's hospital Nursing Home Transfer Form dated 12/19/2024 showed they had skin tears on both elbows that were covered with a dressing. Review of the Nursing Clinical Admission note, dated 12/19/2024 at 11:15 PM showed Resident 5 had: a left elbow skin tear and a right elbow skin tear. Review of Resident 5's facility Admission orders dated 12/19/2024 did not show wound care treatment orders for the elbows. Review of the Non-Pressure Skin Weekly Review dated 12/24/2024 and 12/27/2024 did not show the elbows were evaluated. The weekly skin evaluation scheduled for 12/26/2024 was not completed. In an interview on 02/04/2024 at 2:30 PM, Resident 5's Collateral Contact (R5-CC) stated Resident 5 was discharged from the hospital on 12/19/2024 and transferred to the facility for care. Resident 5 discharged from the facility on 01/02/2025 and was found with dressings on both their elbows that were dated 12/19/2024-the day they admitted to the facility and Resident 5 reported the facility had not changed their dressings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 12/08/2024 Admission MDS showed Resident 2 admitted [DATE], had no problems with cognition, required assistance with ADLs, and diagnoses included surgical aftercare following heart surgery, heart failure, a heart rhythm problem, high blood pressure in the lungs, kidney problems. Resident 2 had shortness of breath during activity, at rest, and when lying flat. Resident 2 received diuretic (water pill) medication and oxygen. Review of the comprehensive CP showed no focus problems for heart of lung problems. The CP did not provide staff with person-centered care instructions to meet their immediate identified care needs related to their heart failure, heart surgery, or lung problems. Review of Resident 2's hospital Interfacility Discharge Orders dated 12/02/2024 showed their last heart failure exacerbation (worsening of a chronic condition) that required hospitalization was 11/12/2024. Their discharge orders included: Sternal Precautions (a set of weight bearing and mobility instructions used after heart surgery to protect the healing chest wall), incentive spirometry (important lung exercises to perform after surgery to help prevent complications like pneumonia), a cardiac diet (low salt, low fat), intake and output monitoring, and daily weights. Review of Resident 2's facility admission orders dated 12/02/2024 did not show orders for a cardiac diet, daily weights, Sternal Precautions, or incentive spirometry. Review of the Nursing Clinical Admission progress note dated 12/02/2024 showed they had 3+ pitting edema to both feet, reported shortness of breath lying flat, shortness of breath with activity, and required their head of bed to be elevated while in bed. Review of the physician History & Physical, dated 12/03/2024 showed Resident 2 had an extensive history of heart problems, congestive heart failure, and had an open-heart surgery two weeks prior to admission. The documentation showed Resident 2's weight measured 249 pounds, reported shortness of breath, severe chest pain 10/10 at the chest surgical wound site, excessive fatigue, dizziness, and pain of the left leg and thigh surgical sites. The physician's Assessment & Plan included: to monitor for worsening shortness of breath, edema, monitor weight, and urine output. Review of the Physical Medicine Rehabilitation Initial Evaluation dated 12/04/2024 showed Resident 2 reported fatigue with activity, chest incisional site pain, and could not lay flat or else they went into a panic state due to inability to breathe. The providers plan for cardiac care included daily weights, use of the incentive spirometer, and following sternal precautions. Review of the physician progress note dated 12/04/2024 showed Resident 2 continued to have intermittent SOB and severe surgical site pain. Review of a physician progress note dated 12/06/2024 showed nursing reported Resident 2 was complaining about chest pain, chest tightness, and shortness of breath. A new order was written for breathing treatments. Review of the clinical record did not provide documentation to show breathing treatments were administered. Review of a nursing skilled evaluation note dated 12/06/2024 at 9:58 PM showed Resident 2 had shortness of breath and chest pain 5/10, sharp, constant. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's weight record for 12/07/2024 showed they weighed 254 pounds (an increase of five pounds in four days). The weight record showed that was the last weight measured. Review of a nursing skilled evaluation note dated 12/07/2024 at 8:21 PM showed Resident 2 had shortness of breath and chest pain 5/10, sharp, constant. Review of a nursing skilled evaluation note dated 12/08/2024 at 8:10 PM showed Resident 2 had shortness of breath and chest pain 5/10, sharp, constant. Review of the nurse skilled evaluation dated 12/11/2024 at 8:34 PM showed Resident 2 had constant chest pain (not rated), sharp and aching. Review of the physician progress note dated 12/13/2024 showed Resident 2 suddenly became confused with low oxygen saturation and respiratory distress. Resident 2 was transferred to the hospital. The documentation still showed Resident 2's weight measured 249 pounds. In an interview on 02/13/2024 at 1:00 PM, Resident 2's Physician stated they were not notified of Resident 2's weight increase of four pounds in five days. Resident 2 should have been weighed daily as ordered by the hospital physician. Resident 2's Physician stated their expectation for heart failure care included low salt diet, fluid restriction, monitoring edema routinely, and daily weights (dependent on their risk for exacerbation) with notification of weight increases of three to five pounds over two to five days, then re-evaluate. In an interview on 02/19/2024 at 2:30 PM, Resident 2 stated they were not weighed daily, their edema was not monitored consistently and received foods on their tray not in line with their diet restrictions. Resident 2 stated they did not feel the facility staff knew how to handle their medical conditions. Resident 2 stated the staff did not follow their requests for the head of bed to stay elevated or follow their sternal precautions. <RESIDENT 10> Review of Resident 10's clinical record showed they admitted to the facility on [DATE] after a four-day hospital stay for respiratory failure, congestive heart failure, severe pulmonary hypertension (high blood pressure of the arteries of the lung), right sided heart failure, and COPD (chronic obstructive pulmonary disease- a chronic lung condition) exacerbation. Since admission they were re-hospitalized five more times for respiratory failure/volume overload/heart failure/COPD exacerbation. Each hospital discharge included orders for low sodium/cardiac diet, daily weights (and to notify the physician of weight gain of two pounds in one day or five or more pounds in five days), fluid restrictions, and intake/output monitoring. Review of the 01/16/2025 Quarterly MDS showed Resident 10 had no cognition problems, required maximum assistance for ADLs, and diagnoses included respiratory failure, heart failure, pneumonia, and chronic lung disease. Their weight measured 247 pounds. Resident 10 had shortness of breath at rest, during activities, and when lying flat. Resident 10 received oxygen services and required the use of a BIPAP (non-invasive mechanical ventilation device used during sleeping hours) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Comprehensive CP on 02/12/2025 showed no CP focus problems or person-centered care instructions for their multiple chronic heart conditions including heart failure, their chronic lung conditions, or risk for rehospitalization . Review of Resident 10's Kardex on 02/12/2025 did not show heart or respiratory care instructions to the CNAs regarding use of oxygen, shortness of breath lying flat, weight monitoring, or fluid restriction allowance. The Kardex did not provide symptoms to monitor and report to help with early identification of a lung/heart exacerbation. <Last hospitalization > Review of the 12/06/2024 hospital discharge summary showed Resident 10 weighed 239 pounds and was treated for electrolyte imbalance and respiratory failure. Review of Resident 10's Post Acute & Transition of Care Orders dated 12/06/2024 showed a referral to the Heart Failure Clinic (cardiology), orders for labs in 2-3 days after readmission to the facility, and a low salt/low fat diet. Review of Resident 10's facility Admission orders dated 12/06/2024 showed the orders for low salt diet, daily weights, edema monitoring, and referral to the Heart Failure Clinic were not transcribed. Review of Resident 10's 12/09/2024 physician history and physical -Assessment and Plan showed their heart failure plan included low-sodium diet, monitor weekly weights, continue with the diuretics as ordered, and follow up with cardiology. No CP was initiated, and no orders were entered. Review of the progress notes from 12/06/2024 to 12/13/2024 did not provide documentation to show the facility consistently monitored their heart/lung conditions every shift after readmission and during administration of intravenous antibiotics. Review of Resident 10's weight record showed no weigh measurement between 12/06/2024 and 12/12/2024. The 12/12/2024 weight measured 247.5 pounds (8.5 pounds more than their weight measured at the hospital on 12/06/2024-five days prior). Review of the December 2024 MAR showed a physician's order dated 12/19/2024 for monitoring weights weekly for four weeks then evaluate. The documentation showed the weights for 12/20/2024 and 12/27/2024 both measured 247.5 pounds (the same weight as the 12/12/2024 measurement). Review of the physician note dated 01/28/2025 showed their plan for heart failure still included weekly weights and another request to follow up with cardiology. Review of Resident 10's weight record showed two weights for January: on 01/03/2025 and 01/10/2025 their weight measured 247.0 both days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's clinical record showed their last visit with the Heart Failure Clinic was May of 2024. At that visit the provider scheduled an appointment with hematology/oncology (blood/cancer) doctor. The record did not provide documentation to show they have been back to the cardiologist since their 12/06/2024 readmission and no record of attending their scheduled hematology/oncology appointment. In an interview on 02/13/2024 at 1:00 PM, Resident 10's Physician stated their expectation was the facility followed all orders from the hospital discharging physician, including daily weights, intake, and output, and if they had questions to contact the hospital for clarification or [them] to clarify. Resident 10's Physician stated they would alter the orders as necessary. Resident 10's Physician stated they would need to review the clinical record but expected that if the resident had an increase in weight or any change of condition, they be notified timely. Resident 10's Physician was not aware the facility was not weighing Resident 10 weekly. The facility was cited F684 on 01/22/2025 and remains out of compliance. This is a repeated citation. REFERENCE WAC 388-97-1060 (1).

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to develop and implement a resident-centered fall prevention care plan (CP) to reduce their specific risk factors for falls, consistently provide adequate supervision, and ensure residents were consistently monitored for post-fall injuries for 3 of 6 Residents (Residents 1, 8, & 11) reviewed for falls. Resident 1 experienced harm when they fell out of their wheelchair at the nurse's station and sustained a hip fracture. These failures placed all residents at risk for avoidable future falls, adverse events, physical injuries, pain, functional decline, and diminished quality of care/quality of life. Findings included . <POLICY> Review of the facility's Managing Falls and Fall Risk policy, revised [DATE], showed the facility would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. The facility, physician, and consultant pharmacist would identify and adjust medications known to increase the risk of falls or indicate rationale why the medications could not be adjusted, even for a trial period. Review of the facility's Assessing Falls and Their Causes policy, revised [DATE], showed the facility would timely notify the physician and family when a fall occurred. They would monitor for delayed complications and document their findings in the clinical record. The facility would initiate an incident report with details defining the fall including the preceding chain of events to identify potential causes for the fall. The physician would examine the resident after a fall. A Post-Fall Evaluation would be conducted. After the fall, the facility would document in the clinical record: the condition in which they were found, assessment data, medical interventions implemented, notifications of physician and family, completion of a fall risk assessment, appropriate interventions taken to prevent future falls, and their response to the interventions. Review of a The Fall Prevention Program (undated, one page document) showed the facility would place blue tags on the doors that said FALL PROGRAM, blue arm bands on the residents that say Resident on the fall program, non-skid socks were available for residents on the fall program, a blue information sheet above the patient's bed that would list their specific fall intervention codes (D=Dysum, T=Tipper bars, L=low bed, FW=Footwear, FM=Floor mat, and assistive device they needed), and a fall binder would be kept each nurse's station. The nurses would also enter orders for the specific fall interventions and add the tasks into the POC (Point-of-Care -electronic documentation system for the Certified Nursing Assistants, CNAs). Review of the facility's Alert Charting/Skilled Charting Guidelines, updated [DATE], showed when a resident fell , nurses were required to monitor and document their status by placing them on Alert Charting with vital signs every shift for 72 hours to monitor for: pain, injury, change in level of consciousness or mentation, problems with balance or functional abilities, and implement nursing interventions to prevent falls. If there was an injury with the fall, they would also do routine neurological checks (for head injury or unwitnessed fall) and skin evaluations. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<RESIDENT 1> Review of the [DATE] Admission Minimum Data Set (MDS-an assessment tool) showed Resident 1 admitted to the facility on [DATE] and was assessed to have moderate cognition problems, hallucinations, and behaviors. Resident 1 diagnoses included atrial fibrillation (a cardiac-rhythm problem known to increase fall risk), a fracture of the spine, Parkinson's disease (a progressive neurological disorder that can cause hallucinations and increase fall risk), and hallucinations. Resident 1 required staff assistance for all activities of daily living (ADLs) and had occasional incontinence. Resident 1 had frequent pain that effected their sleep and day-to-day routine, their highest level of pain was ,d+[DATE] (per pain scale 0=no pain and 10=extreme pain), and no routine scheduled pain medication. Resident 1 had falls that resulted in fractures prior to admission, one non-injury fall since admission, and medications associated with high fall risk included antipsychotics and antidepressants. Review of Resident 1's Fall CP dated [DATE] showed non-personalized interventions dated [DATE] to: announce themselves when approaching resident, ensure nonskid footwear were on, ensure the call light was within reach and answered promptly, encourage call light use, explain all procedures and purpose prior to starting tasks, and monitor for side effects of any medications that could cause gait disturbances, sudden drop in blood pressure and pulse, weakness, dizziness, sedation, fatigue, seizures, fainting, or vertigo. Review of Resident 1's Kardex (quick reference CP interventions and alerts for CNAs) dated [DATE] showed none of the [DATE] Fall CP interventions were present on the Kardex for the CNAs to implement. FALL #1: Review of a nurse progress note dated [DATE] at 5:04 PM showed Resident 1 had a fall at the nurse's station after trying to stand up from their wheelchair without assistance. The documentation showed they would encourage Resident 1 to remain in highly supervised area when in their wheelchair. Review of the progress notes did not provide documentation to show Resident 1 was consistently monitored on alert charting every shift for 72 hours after the fall on [DATE]. Review of the facility's Fall (Witnessed) Risk Management Report dated [DATE] at 3:30 PM showed their investigation was not thorough or complete. The investigation did not include the preceding chain of events/circumstances regarding the fall and no root cause analysis to identify the unmet care need or reason Resident 1 tried to stand without assistance. The investigation did not provide documentation to show a fall risk assessment was conducted, the CP was updated to prevent future falls, or they monitored Resident 1's response to the interventions. Review of the Kardex dated [DATE], [DATE], and [DATE] did not show any fall interventions for CNAs to implement. FALL #2: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility 's Fall (Witnessed) Risk Management Report dated [DATE] at 4:12 PM showed Resident 1 was attempting to stand without assistance in their room, the CNA saw Resident 1 attempt to stand and tried to assist but Resident 1 scratched them and they were not able to stop them from falling. Their plan was to have Resident 1 seen by mental health services, place them on the Fall Prevention Program to increase supervision, alert charting for behaviors, monitoring for a change in condition or latent injuries, and update the CP. Review of the progress notes did not provide documentation to show a fall event occurred on [DATE] at 4:12 PM, notification to the physician and responsible party of a fall, new interventions implemented, or consistent post-fall alert charting every shift for 72 hours after the fall. Review of the physician progress note on [DATE] showed Resident 1 was confused, agitated, and made multiple attempts to walk independently despite redirection to sit back in the wheelchair. Resident 1 was seated in the wheelchair at the nurse's station during the encounter and was uncomfortable due to back pain. The documentation did not show they evaluated Resident 1 for a fall and there were no changes made to their plan. Review of a Physical Medicine Rehabilitation Physiatry (a medical specialty that focuses on the diagnosis, prevention, and treatment of disabilities related to the brain, nerves, bones, muscles, and joints to restore function, reduce pain, and improve quality of life) Initial evaluation dated [DATE] at 3:38 PM showed Resident 1 reported pain ,d+[DATE] and described their back pain as bothersome, their right knee as sore, and had pain when they urinated. Resident 1 reported they fell (date not specified) but were not injured. The provider planned to schedule acetaminophen (pain medication) routinely throughout the day and would order a pain medication cream to apply to the skin. A UA (urinalysis- a test used to diagnose urinary tract infection) was ordered on [DATE]. Review of the Fall CP showed an update on [DATE] to keep resident in a highly visualized area when in the wheelchair (four days after the Fall #1 and two days after Fall #2); mental health referral and Fall Prevention Program (two days after Fall #2). The CP showed the updates were not timely. Review of the Kardex dated [DATE] showed the updates: on the Fall Prevention Program (from the intervention for the fall on [DATE]) and to keep them in highly visible areas when up in the wheelchair (the intervention from the fall on [DATE]) Review of a physician progress note dated [DATE] showed Resident 1 was very confused, a very high fall risk, and continued to try to self-ambulate. Review of a therapy progress note dated [DATE] at 5:17 PM showed Resident 1 ambulated 35-feet with minimal assistance for balance and safety. Resident 1 ambulated a total of 60 feet. FALL #3: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Fall (Witnessed) Risk management report, dated [DATE] at 2:15 PM showed Resident 1 was at the nurse's station in their wheelchair, stood up, fell , and landed on their buttocks. The documentation showed one staff member (coming on shift) reported they saw the resident stand and fall but could not get to them in time. A typed interview statement with Staff R, CNA, showed they tried to change Resident 1 before the end of their shift but Resident 1 refused so they left them in the wheelchair at the nurse station for safety. The interventions and conclusion, dated [DATE], showed they would place auto-lock brakes on the wheelchair, place Resident 1 on alert charting, and update the CP. Review of the clinical record did not show physician orders were obtained for their specific Fall Prevention Program interventions or auto-lock brakes for the wheelchair. Review of the nurse progress notes for [DATE] did not provide documentation to show a fall occurred, that the physician and responsible party were notified, that new interventions were implemented, or that consistent post-fall alert charting was done every shift for 72 hours after the fall. Review of the physical therapy progress note dated [DATE] at 4:27 PM showed therapy attempted to work with Resident 1 but they were unable to get Resident 1 to stand (using maximum assist of two staff), they resisted standing and kept sitting back down. The documentation did not show the therapy staff notified nursing or the physician of their new onset of inability or unwillingness to stand. Review of the physician note dated [DATE] showed Resident 1 had worsening confusion and agitation. The nursing staff reported to the provider they needed one-to-one care; they were still a fall risk and tried to leave the wheelchair on multiple occasions. The provider documented Resident 1 is staying by the nurse station most of the time. Review of a nurse progress note dated [DATE] at 2:22 PM showed Resident 1's Collateral Contact (CC) arrived to visit, called [DATE], and Resident 1 was transferred to the hospital. In an interview on [DATE] at 10:27 AM, Resident 1's Responsible Party (R1-RP) stated after resident 1 fell , the facility did nothing about it. They only received one notification of a fall, on [DATE] but were not notified of the falls on [DATE] and [DATE]. Resident 1 was left to sit up in the wheelchair all day, in the halls or at the nurse station, and was not allowed to lay down for naps. R1-RP stated they visited every day and sometimes twice a day and there were many occasions they arrived to find Resident 1 in the wheelchair either at the nurse's station or down the hall towards their room and there were no staff around. On one visit a staff member put a blue wrist band on Resident 1's wrist and when we asked why, they said 'so the staff knew they were a high fall risk'. The next day when we were in to visit the blue band was gone and we never saw it again. They were at the facility [DATE] just before dinner time and noticed Resident 1 was not doing well; they were so groggy they could barely talk and looked out-of-it. R1-RP stated they were out of town on [DATE] so their Collateral Contact (CC) went to check on Resident 1. R1-RP stated CC found Resident 1 in the wheelchair at the nurse's station, slumped over to the side, and thought Resident 1 had died . CC had to go find help because there were no staff at the nurse's station. After CC found staff who said they would lay Resident 1 down, CC went outside and called R1-RP to report what occurred. R1-RP directed CC to call 911 and then call R1-RP back. R1-RP was on speaker phone and could hear the paramedics repeatedly calling out Resident 1's name to get them awake. R1-Rp stated at the hospital they found Resident 1 was too sedated from their psychotropic medications and had a hip fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Inpatient Hospitalist History & Physical Note dated [DATE] showed Resident 1 was admitted to the hospital for mental status changes due to psychotropic medications, a fever, an elevated white blood cell count, and an abnormal UA. They held their antipsychotic, antidepressant, and Parkinsons medications on admission to the hospital. On [DATE], after Resident 1 was more alert, the hospital physical therapist attempted to transfer Resident 1 and they were not able to stand, sat back down, had facial grimacing, and guarded their right hip. An x-ray showed Resident 1 had an acute hip fracture which required surgical intervention. In an interview on [DATE] at 2:30 PM, Staff C, Registered Nurse-Resident Care Manager (RCM), stated Resident 1 had three falls while a resident at the facility according to the electronic risk management system: a fall on [DATE] at 3:30 PM, a fall on [DATE] at 4:12 PM, and a fall on [DATE] at 2:15 PM. Staff C was unable to locate documentation to show the fall events on [DATE] and [DATE] were recorded in the medical record and alert charting was completed. Staff C stated the CP updated after the fall were not done timely and there could have been more relevant CP interventions after the first fall since Resident 1 was already at the nurse's station when they fell . Staff C stated nurses were expected to document the event in the nurse progress notes, place the resident on Alert charting (for a minimum of 72 hours), and ensure a relevant intervention was updated in the CP before the end of their shift. Staff C stated the nurses knew how to update the CP and Kardex and it was not done timely. Staff C stated the RCMs, or Staff B, Director of Nursing, DNS, reviewed the documentation to ensure the post fall steps were completed. Staff C was unable to locate the lab result report for the UA ordered [DATE]. Staff C stated they would investigate. No further information was provided. In an interview on [DATE] at 1:00 PM, Staff D, Physician, stated they were unaware of Resident 1's falls but would need to review their documentation. Staff D stated if they were notified of a fall, they would have addressed it in their visit note. Staff D stated it was their expectation the facility notified them of each fall in a timely manner and that the licensed nurses or Resident Care Managers reviewed their provider notes after each visit and followed their recommended plans they documented at the end of their progress notes. In an interview on [DATE] at 8:40 AM, Staff R, CNA, stated they did not know what the facility's Fall Prevention Program was or why some name tags on the name plates were blue and some were white. Staff R stated they knew who a fall risk was by looking at their Kardex every day and notifications during shift change. They stated for every resident that was a high fall risk, they made sure their beds were in the lowest position (most of the time), and they had fall mats on the floor. They also did 15-minute checks, ensured the doors stayed open, and residents could not be alone in their room in their wheelchairs, they needed to be at the nurse's station to be monitored. They had never seen residents wear blue wrist bands. <RESIDENT 8> Review of the [DATE] Admission MDS showed Resident 8 had moderate cognition problems, required assistance for ADLs, had frequent bowel incontinence, and diagnoses included stroke, diabetes, obstructive sleep apnea, and a newly placed feeding tube. Resident 8 had falls prior to admission but no falls since they admitted . Review of the [DATE] Death in facility MDS showed Resident 8 passed away. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Fall CP dated [DATE] showed they were at risk of falls and had non-personalized fall interventions that included: appropriate footwear always, call light within reach and answered promptly, monitor for medication side effects, refer to therapy, and report falls to the provider. In an interview on [DATE] at 4:41 PM, Resident 8's responsible party, R8-RP, stated after Resident 8's roommate discharged ; Resident 8 started falling because there was no one in the room to call for help for Resident 8. R8-RP stated Resident 8 told them their call light was often out of their reach. They also experienced long call wait times and by the time staff arrived they were already incontinent. R8-RP stated Resident 8 fell on [DATE]. R8-RP stated they were contacted by someone at the facility and told Resident 8 fell and asked if they could put side rails on the bed, but nothing was done. R8-RP stated Resident 8 fell again after the first fall and hit their head. The nurse did not know Resident 8 fell until they did their rounds. Review of the facility's mandatory reporting log for [DATE] showed Resident 8 had two falls on [DATE], the first fall was at 8:21 PM and the second fall was at 10:30 PM. Fall#1: Review of the facility's fall investigation dated [DATE] at 8:21 PM showed Resident 8 was found lying on the floor beside their bed. Resident 8 reported they were getting ready for bed and slid off the bed. They were evaluated for injuries and assisted back into bed. The new intervention was to get them a wider bed. Fall#2: Review of the facility's fall investigation dated [DATE] at 10:30 PM (two hours after the first fall) showed Resident 8 was found lying on the floor beside their bed, again. Resident 8 stated they were trying to go to the bathroom and fell . They placed a fall mat on the side of the bed. Review of the typed-in resident statement showed Resident 8 stated they were trying to go the bathroom and fell to their right side. The one staff typed-in statement showed 'they found them on the floor, they said they rolled out of bed'. The investigation did not show written, signed/dated witness statements were obtained, details of the scene including whether the call light was on or not, analysis of the prior chain of events, identification of Resident 8's unmet care need, or a plan on how to better provide more prompt toileting assistance. The investigation did not include completed neurological checks or post-fall monitoring. The new intervention was to get them a wider bed, the same intervention from the first fall, add them to The Fall Prevention Program, and placed a fall mat on the floor next to the bed. Review of a SBAR notification to the provider, dated [DATE], showed Resident 8 fell . There was no description or time of the fall indicated on the notification. They requested to put side rails on the bed and floor mats on the floor on the side of the bed. The physician signed the response on [DATE]. Review of a Fall CP update, dated [DATE], showed Resident 8 was on the Fall Prevention Program. The CP did not show updates that included: fall mats, side rails, low bed, or a wider mattress. Review of the Kardex, dated [DATE], [DATE], [DATE], and [DATE] showed no fall care plan interventions for CNAs to implement. (continued on next page)

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	505483	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 8's physician orders showed an order, dated [DATE] for a larger mattress to allow more room for bed mobility and care to help reduce the risk of falls. The physician orders did not show orders for side rails, low bed, or fall mats were transcribed and implemented. Review of a Fall CP update, dated [DATE], showed Resident 8 was provided a wider mattress (four days after the falls). Review of the Resident 8's progress notes did not provide documentation to show fall events occurred on [DATE] or: notification to the physician and responsible party of the falls, new interventions implemented, or consistent post-fall alert charting every shift for 72 hours after the falls. <RESIDENT 11> Review of the [DATE] Quarterly MDS showed Resident 11 had cognition problems, required assistance with ADLs, and diagnoses included diabetes, depression, chronic lung disorders, and muscle weakness. Resident 11 had two or more non injury falls since their prior assessment. Review of the Fall CP dated [DATE] showed Resident 11 was at risk for falls or injury due to impaired balance and mobility. The CP showed they fell on [DATE]. The Fall CP interventions included: an intervention dated [DATE] to keep call light within reach; an intervention dated [DATE] to keep the right side of the bed against the wall; [DATE] to ensure the bed was in the lowest position before leaving the room; an intervention on [DATE] for the Fall Prevention Program; [DATE] to place a perimeter mattress to define bed edges; and a fall intervention dated [DATE] for a bariatric alternating pressure mattress. Review of a nurse progress note dated [DATE] at 12:57 AM, showed Resident 11 fell from their bed. Resident 11 reported they were trying to adjust themselves in their bed but leaned too far over to the left, fell , and landed on their left side. After they were assessed for injury, they were assisted back to bed, educated on call light use, lowered the bed to the lowest position, and ensured the bed brakes were in the locked position. The documentation did not show the physician and responsible party were notified. The documentation showed there was not consistent post fall alert charting documented every shift for 72 hours after the fall. Review of Resident 11's Kardex dated [DATE] directed staff to encourage use of the call light for assistance and to ensure they left the bed in the lowest position prior to leaving the room. There were no other interventions for fall prevention on the Kardex. During an interview and observation on [DATE] at 8:10 AM, Resident 11 was in bed. There were no other staff in the room. Their bed was not in the lowest position and not with the right side of the bed against the wall. Between the bed and the wall on the right side was an IV pole and their oxygen concentrator. The mattress was not a perimeter mattress. There was a blue piece of paper with nothing on it-covering another blue piece of paper on the wall at the head of the bed. Resident 11 stated they had not fallen in a while and was doing good at staying off the floor. They did not know they had a blue sign at the head of their bed, so they did not know what it said. The sign was not reachable due to the bed and medical equipment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 8:40 AM, Staff R, CNA, Staff R stated the blue sign on the wall in Resident 11's room was information about their transfers and bed mobility. Staff R was not aware Resident 1's right side of the bed was supposed to be against the wall. <THE FALL PREVENTION PROGRAM> In an interview on [DATE] at 1:15 PM, Staff C, Registered Nurse-RN, stated when residents had a second fall, they were placed on the Fall Prevention Program. Staff C stated they were unsure if there were documented protocol. After a resident had a second fall, they would be placed on the Fall Prevention Program: they would have a blue sign in their room with their fall interventions on them, they would have blue name tags on the outside of their doors. Staff C stated they obtained physician orders for fall interventions that required an order (like side rails, low beds, or beds against the wall). Staff C stated they have never seen a fall binder at the nurse station or blue wrist bands used, and the facility did not have a structured clinical systems meeting for falls (like they did for Nutrition/Skin weekly meetings) or other ongoing monitoring process for residents with repeated falls, but did discuss falls that occurred the prior day (or weekend) during their morning clinical meeting. In an interview on [DATE] at 9:30 AM, Staff JJ, CNA, stated they were unsure why some name plate name tags were blue, and some were white. They did not know the specifics of the Fall Prevention Program but knew that they would look at the Kardex to tell them if the resident had interventions for fall prevention. In an interview on [DATE] at 6:40 AM, Staff KK, LPN, stated they were unsure what the significance was of the blue name tags versus the white name tags on the name plates, but they would find out. No further information was provided. In an interview on [DATE] at 2:45 PM, Staff A stated some of the components on the Fall Prevention Program were not done at the facility including the nurses' putting orders in for fall interventions and tasks into the CNAs POC documentation program, they did not keep a fall binder at the nurse stations, and did not place blue wrist bands on residents. In an interview on [DATE] at 11:50 AM, Staff I, RN, stated they knew which residents were fall risks by looking in their room to see if they had fall mats by their bed. Staff I stated after a resident fell , they were required to document the event, initiate an investigation, report the fall to the physician and responsible party, and implement an intervention to help prevent further falls. Staff I stated they knew how to update the CP but did not know how the interventions transferred over to the Kardex for CNAs to implement. Staff I stated their system to educate the oncoming staff of the CP updates with new interventions was verbally during shift report. Refer to F610, F658, F697, F758. REFERENCE WAC [DATE] (3)(g).

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to ensure residents received care and services to maintain acceptable parameters of nutritional status and there was a safe and accurate system to prevent complications from enteral (feedings administered through a tube) feedings for 12 of 12 residents (Residents 8, 19, 20, 22, 33, 21, 18, 26, 24, 14, 31 & 40) reviewed for nutrition and hydration. The failure to: accurately assess (and re-assess as needed) residents nutritional status and develop/revise/implement person-centered care plans (CP) for residents at risk; reconcile, accurately transcribe, and implement nutrition related physician orders and/or Registered Dietician (RD) recommendations; ensure timely RD evaluations; ensure residents were weighed according to policy/physician orders and monitored routinely; and ensure residents who required downgraded texture diets received the diet they were ordered and speech evaluations (Residents 14 & 24); and ensure residents who required fluid restrictions were monitored/documented accurately (Resident 31). These failures placed residents at risk for weight loss, electrolyte imbalances, dehydration, aspiration, pneumonia, and hospitalization and constituted an Immediate Jeopardy (IJ). Resident 20 experienced harm when they required urgent transfer to the hospital on 02/10/2025 and was admitted with a diagnoses with aspiration pneumonia, sepsis, severe dehydration, severe malnutrition, and acute kidney injury after the facility failed to: accurately assess and develop/revise a CP to ensure aspiration precautions were followed to help prevent aspiration pneumonia; monitor, document, and evaluate their nutritional status and intake to insure they received the nutrition/fluids they required to meet their daily needs to prevent avoidable dehydration and severe malnutrition; ensure licensed staff routinely provided physician ordered oral care to help prevent infection in the event of aspiration. Resident 22 experienced harm when they required repeated transfers to the emergency room and hospitalized for dehydration and uncontrolled blood sugars after the facility failed to: accurately assess their feeding tube status and develop CP interventions to prevent dehydration and fluid volume loss; were not provided the nutrition they were ordered to receive, and delayed implementation of physician orders for interventions to correct their electrolyte imbalance. Resident 40 experienced harm when they had an unplanned significant weight loss of 20 pounds in two weeks. The facility failed to develop and implement a person-centered nutrition CP that addressed their identified risks and care needs, consistently monitor weights, or evaluate oral intake for a resident identified at risk for altered nutrition. An Immediate Jeopardy (IJ) was called on 02/26/2025 at 2:45 PM in CFR 483.25(g)(1)-(3) when the facility failed to have a safe and accurate system in place for residents receiving nutrition enterally to maintain acceptable parameters of nutritional and hydration status. This failure caused harm to three residents and placed residents at risk for severe weight loss, significant dehydration, aspiration, and death. The immediacy was removed on 02/27/2025 after onsite verification by the investigator reviewed the facility's nutrition related documentation, nutrition assessments, staff education, facility audits, and accurate implementation of provider orders. Findings included . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<POLICY> Review of the facility's Enteral Nutrition policy, revised November 2018, showed staff would provide adequate nutritional support via tube feeding as ordered by the physician. The nurse would confirm the tube feeding orders were complete including: the correct formula, the specific enteral access device (gastric tube or jejunostomy tube, etc.), the administration method (continuous, bolus, or intermittent), the volume/rate/time of administration, the volume/rate goals with advancement recommendations, and flushing (solution, volume, frequently, timing, and 24-hour volume). The provider would consider need for lab orders, head of bed elevation, oral care, and checks for gastric residual volume. Risk of aspiration (which was affected by was affected by moderate to severe swallowing difficulties, improper positioning of the resident during feeding, and failure to confirm placement prior to initiating feeding) would be assessed by the nurse and provider and addressed in the residents' care plan. The nursing staff and the provider would monitor the resident for signs or symptoms of inadequate nutrition, altered hydration, high or low blood sugars, altered electrolytes (such as sodium and potassium levels in the blood), and for worsening conditions that placed the resident at risk for nutrition/hydration complications. <RESIDENT 20> Review of the 02/16/2025 Quarterly MDS showed Resident 20 admitted to the facility on [DATE], had severe problems with cognition, and diagnoses included pneumonia, dysphagia, chronic obstructive pulmonary disease (restrictive airway), presence of a feeding tube, and was at risk for malnutrition. Resident 20's weight measured 127 pounds and was not assessed to have significant weight changes. Review of Resident 20's speech evaluation, dated 11/20/2024, showed Resident 20 had severe dysphagia and history of aspiration pneumonia. Resident 20 had asthma and a very weak cough that was not effective to clear aspirated materials when they were cued to cough. They were determined to require nothing passed orally (NPO) status with long-term assisted nutrition (tube feeding) as their new established baseline. The speech pathologist documented they were not able to treat further and placed a sign in their room regarding STRICT NPO status and recommended frequent oral care. Review of Resident 20's Nutrition Hydration risk CP, revised 01/08/2025, showed the CP interventions were not person-centered and did not include timeframes and parameters for monitoring to achieve desired nutritional goals including how often they should be weighed. Review of Resident 20's Feeding Tube CP, initiated 01/08/2025, directed staff to ensure their HOB was elevated at least 30-45 degrees during tube feeding and for 30 minutes after, NPO, and provide good oral care (with no frequency directives or how it was supposed to be provided). The task was assigned to both the NACs and Nurses. Review of Resident 20's February 2025 MAR/TARs showed: -A physician order dated 01/28/2025 for tube feeding formula at 70 ml/hr for 20 hours (total volume 1400 ml/day), on at 2:00 PM and off at 10:00 AM. Based on the order, the facility should have provided 560 ml on the Day shift and 840 ml on the night shift. The documentation showed 24-hour total volumes administered were: 02/01/2025 (560ml), 02/02/2025 (560 ml), 02/03/2025 (560 ml), 02/04/2025 (1120 ml), 1680 ml each day 02/05/2025, 02/06/2025, 02/07/2025, 02/08/2025, and 02/09/2025. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-A physician order dated 01/09/2025 for tube feeding water hydration water flush of 49ml/hour x 20 hours while the tube feeding formula was running (to total 273-410ml/shift). The documentation was set up for three eight-hour shifts per day unlike the formula documentation that was set up for two 12-hour shifts per day. The total volume in the text of the order did not show accurate shift total volume goals. Based on the order, Resident 20 should have been provided: 196 ml of water on the day shift, 392 ml on the evening shift, and 392 ml on the night shift for a total 24-hour volume of 980 ml/day. The documentation showed the 24-hour total water volumes administered were: 450ml (530ml less than they required) on 02/01/2025, 02/02/2025, 02/3/2025, 02/4/2025, 02/05/2025, and 02/08/2025; 300 ml (680ml less than required) on 02/06/2025, 542ml (438ml less than required) on 02/07//2025, and 934 ml (46ml less than required) on 02/09/2025. -A physician order dated 12/11/2024 directed staff to provide oral care with prescribed oral solution and an oral swab and HOB greater than 60 degrees and suction PRN (as needed). The documentation showed that oral care was never provided. CHANGE OF CONDITION: Review of a Medication Administration Note, dated 02/09/2025 at 2:41 PM, showed to keep HOB at least 30 degrees while tube feeding is running. When it is not elevated properly, resident starts a gurgling sound in their throat. Have stressed importance to staff and resident to keep HOB elevated at all times. Review of a Medication Administration Note, dated 02/10/2025 at 4:52 AM, showed they administered Tylenol for a temperature of 99.6 and Resident 20 had shallow respirations. Review of Resident 20's Kardex, dated 02/10/2025, showed under Alerts/Safety: staff to provide local care to feeding tube site as ordered and monitor for signs or symptoms of infection task for licensed nurses only, not CNAs. The Kardex did not show any directions to staff they were STRICT NPO, had HOB requirements for elevation of 30-45 degrees during tube feeding (or at-all-times), who was responsible for oral care and when, complications/symptoms to monitor for and when to notify the nurse, foley catheter care, or documentation of urine output. Review of an eINTERACT Situation/Background/Assessment/Recommendation (SBAR) Summary for Providers change of condition note, dated 02/10/2025 at 6:07 AM, showed Resident 20 experienced a change of condition related to fever. The documentation showed their vital signs (timed for 7:13 AM) were a very low blood pressure (79/56), Heart rate was very high (138), respirations were very high (28), oxygen saturation was very low at 82% with oxygen on a nasal cannula, and temperature was elevated at 99.8 degrees. The physical assessment showed they had labored and rapid breathing with abnormal lung sounds and a resting pulse greater than 100 beats per minute. The Nursing observations, evaluation, and recommendations showed Resident 20 was transferred out to the hospital after they developed fever, shallow breathing and hyperventilation (breathing too fast). The writer contacted the on-call provider who gave an order for oxygen at two liters per minute, a breathing treatment, and to monitor vital signs every 30 minutes until stable then change to every two hours. They administered Tylenol but it was not effective. The documentation did not indicate what time the actual change was identified, what time the provider was contacted, the exact time of the interventions implemented (and resident response), and what time they were transferred out of the facility. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a hospital inpatient progress note, dated 02/11/2025, showed Resident 20 was admitted with septic shock (severe infection) and acute hypoxic respiratory failure due to aspiration pneumonia, hypernatremia (dehydration), acute kidney injury, and severe malnutrition. READMISSION: Review of the Kardex, dated 02/25/2025, showed it had not been updated after readmission. Review of the February 2025 MAR/TARs showed: -A physician order dated 02/13/2025 for tube feeding formula at 70 ml/hour x 20 hours (total volume 1400 ml/day). The documentation for 24-hour shift totals showed: 840 ml on 02/14/2025 and 560ml each day from 02/15/2025 to 02/20/2025. -A physician order dated 02/13/2025 for FWF (free water flush) at 41 ml/hour x 20 hours to provide total volume of 820 ml. The documentation did not show shift volumes administered or total 24-hour volumes. In an observation on 03/03/2025 at 3:55 PM, Resident 20 was in bed, the tube feeding was disconnected as ordered. No suction machine was observed at the bedside. Their HOB was at 15 degrees. There was one oral swab in the top drawer of the nightstand. Resident 20 was not interviewable due to their cognition although they appeared awake and alert. Resident 20 opened their mouth for an observation, their lips and oral cavity appeared dry and unclean. <RESIDENT 22> Review of Resident 22's Quarterly MDS, dated [DATE] showed they had severe problems with cognition, dependent on staff for all ADL cares, and diagnoses included a stroke with hemiplegia (unable to move a side of the body), diabetes, high blood pressure, heart failure, and was not at risk for malnutrition. Resident 22 weighed 149 pounds and did not receive tube feeding. Review of Resident 22's Nutrition Hydration Status risk CP, initiated 01/09/2025 showed Resident 22 had a feeding tube, was NPO, and history of ER visits due to clogged feeding tube. The 01/09/2025 CP interventions included: Aspiration precautions, directions to follow orders for diet and labs, and observe for signs or symptoms of dehydration (i.e., dry mouth, cracked lips, dry skin, and decreased urine output). The CP did not include person-centered goals/interventions for maintaining a patent feeding tube or parameters for monitoring of nutritional status. Review of the Tube Feeding CP, revised 01/09/2025, showed Resident 22's HOB requirement was to be at least 30-45 degrees during tube feeding and for 30 minutes after the tube feeding, provide/maintain good oral hygiene (but did not specify how often and who performed it) and nursing was to record Resident 22's formula intake and water flushes on the MAR/TARs. The CP did not include person-centered interventions to meet all their identified care needs. Review of a nurse progress note, dated 01/17/2025 at 1:48 PM, showed Resident 22 was sent to the emergency room because their feeding tube was clogged, and they were unable to remove the blockage. The resident required ambulance transport to the hospital to have their feeding tube replaced. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	PHYSICIAN ORDERS: Review of Resident 22's January 2025 MAR/TAR showed: -A physician order dated 01/09/2025, for Diabetisource 1.2 at 78 ml/hour for 20 hours, on at 4:00 PM and off at 12:00 PM (total volume 1560 ml). The order set for documentation showed administration times for 12:00 AM and 12:00 PM. Between 01/10/2025 at 12:00 AM and 01/28/2025 at 12:00 AM, there was no documentation the tube feeding was administered, the boxes were blank for 18 days. -A physician's order, dated 01/09/2025 for feeding tube water flushes 28 ml/hour for 20 hours from 4:00 PM to 12:00 PM (total volume 280 ml per shift) but the total volume shift goal in the text of the order was transcribed incorrectly, did not equal what 28ml/hour for 20 hours would provide (560 ml), and the documentation showed they were administered 280 ml each shift (3 shifts). -A physician's order dated 09/29/2023 for weekly weights and the TAR documentation showed no weights were measured for 01/06/2025, 01/13/2025 and 01/20/2025. Resident 22's weight on 01/27/2025 measured 149 pounds. CHANGE OF CONDITION & DELAYED CARE: Review of Resident 22's blood sugar record from 02/01/2025 to 02/13/2025 showed they began having very high blood sugars. Review of providers progress note, dated 02/12/2025, showed Resident 22's blood pressure at 3:51 PM was 116/67 and heart rate was elevated (102). The documentation showed they reviewed Resident 22's abnormal labs including a very high sodium level (dehydration is the most common cause for high sodium levels) and very high blood sugars. On 02/12/2025 at 6:00 AM the physician ordered one liter of intravenous fluids and then repeat the labs. This was the first ordered intervention to correct the critical sodium level, 30 hours after the Lab Company notified the facility of the critical lab value on 02/10/2025 at 11:37 PM. Review of a nurse progress note, dated 02/12/2025 at 11:45 AM, showed the facility did not have the fluids the provider ordered (a special type of solution used to correct this high sodium level) and the pharmacy would not be able to deliver any for four hours. Review of a nurse progress note, dated 02/12/2025 at 3:40 PM, showed they started intravenous administration of the ordered fluids at 3:30 PM, (39 hours after they were notified of the critical lab value). Review of the nurse progress note, dated 02/13/2025 at 3:47 AM, showed the Lab Company called the facility and reported the repeat sodium level was higher than the sodium result sodium result on 02/10/2025. The nurse called the on-call provider who ordered Resident 22 be transferred to the hospital. READMISSION: (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Hospital Post Acute & Transition of Care Orders, dated 02/17/2025, showed n tube feeding orders for Diabetisource AC at 65 ml/hour x 24 hours and water flushes of 150ml every four hours. Resident 22 was diagnosed with a high sodium level, high blood sugar and fluid volume deficet (needed 5.7 liters). Review of the Resident 22's February 2025 MAR of the orders transcribed on readmission showed: -The tube feeding order, dated 02/17/2025, was Diabetisource 1.2 at 78 ml/hour x 20 hours on at 4pm and off at 12:00 PM (total volume 1560ml/day), the same tube feeding order they had before they went to the hospital for dehydration and uncontrolled blood sugars, and no volume totals documented. -The Water flush order, dated 02/17/2025, for 50ml/hour x 20 hours from 4:00 pm to 12:00 PM (total of 1000 ml/day), and no total volumes documented. -The order for the lab to monitor the potassium was not transcribed to the admission orders and was not drawn two to three days after admission. During an observation on 02/24/2025 at 12:00 PM, Resident 22 was awake in bed, their tube feeding was running, and the HOB did not appear to be at least 30 degrees or more. Resident 22's lips were dry, very chapped, with large pieces of dry, dead skin hanging off their lips. Their teeth appeared to have a film of debris covering them. -At 12:02 PM, Staff CC, LPN, entered the room with a small medicine cup of clear liquid and did not appear to notice the HOB was not at 30 degrees. At 12:03 PM, Staff CC was asked what the HOB elevation requirements were for Resident 22. Staff CC stated the HOB was to be at 30-45 degrees during tube feeding and at least 30 minutes after the tube feeding was stopped, which they were there to do. Staff CC was asked if the HOB was at 30 degrees, and they stated yes. Staff CC was asked how they knew it was 30 degrees; they looked at the bed for a few seconds, stated just a minute, then left the room without stopping the tube feeding. -At 12:05 PM, a CNA entered the room with a meal tray for Resident 22's roommate, realized the roommate was not in the room, and then left the room (with the meal tray) but did not recognize Resident 22's HOB was not elevated to 30 degrees while the tube feeding was running. -At 12:08 PM, Staff N, CNA, entered the room with personal care items for Resident 22. Staff N was asked about the HOB requirements for Resident 22 and replied, 30 to 45 degrees at all times. Staff N was asked if they thought Resident 22's HOB was at least 30 degrees, and Staff N stated, definitely not. Staff N stated they last cared for Resident 22 about 10:30 AM and they always double check the HOB level before they left the room. Staff N stated when they needed to provide cares for Resident 22, they notified the nurse so they could put the tube feeding on hold to perform cares safely, and either the nurse was their care partner, and if not, they notified the nurse when their tasks were completed. -At 12:10 PM, Staff CC returned to the room with an angle gauge. When Staff CC applied the angle gauge to the bed, they found the angle gauge that was already on the bed, hidden under the mattress cover. Staff CC confirmed the HOB was not at 30 degrees and stopped the tube feeing. Staff N stated they didn't know about the gauge on the bed but thought it was a good idea. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Observation at 12:10 PM of the angle gauge on Resident 22's bed showed the angle of the HOB was at 20 degrees. Staff CC was unsure how long it had been less than 30 degrees. -At 12:12 PM, Staff CC began providing Resident 22 oral care and stated the nurses provided the oral care every shift. Staff CC stated they were also there to check Resident 22's blood sugar which was ordered for before meals and at bedtime and then they would disconnect his tube feeding and clear the pump. Staff CC stated the total volumes on the pump showed the previous nurses did not clear the pump on their shift. In an interview on 02/25/2025 at 3:30PM, Staff H, LPN-RCM, stated they were not aware the tube feeding orders were changed at the hospital. In an interview on 02/26/2025 at 10:47 AM, Staff O stated they were not aware of the hospital provider ordered Diabetisource AC but if they had, they would have recommended to proceed with that product due to its carbohydrate nutritional properties which show better blood sugar control. <RESIDENT 40> Review of Resident 40's hospital After Visit Summary dated 12/16/2024 showed their weight measured 133 pounds. Review of the 12/22/2024 Admission MDS showed Resident 40 admitted to the facility on [DATE], had severe cognition problems, required assistance with ADLs, and diagnoses included a respiratory infection, diabetes, dementia, hypokalemia (low amount of potassium in the blood). Resident 40 was not at risk for malnutrition and weighed 135 pounds. Resident 40 had no natural teeth. Review of Resident 40's nutrition CP, initiated 12/16/2024, showed they were at risk for nutritional/fluid deficits due to preferences not to eat or drink. The interventions provided were not person-centered and did not address the risk factors identified in the comprehensive assessment. The CP directed staff to monitor/document/report to MD PRN for signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. The CP did not indicate how often Resident 40 should be weighed, monitor intake and record every meal. RD to evaluate and make diet change recommendations as needed. Review of Resident 40's Kardex, dated 12/18/2024, showed CNAs were informed they were able to eat with supervision but did not provide instructions regarding their diet order, dental status, or when to report to the nurse if they did not consume a certain percent of their meal/fluids for each meal. A physician's order, dated 12/18/2024, directed staff to weight Resident 40 on 12/16/2024, 12/17/2024, 12/18/2024 then weekly for three weeks. Review of the weight record showed their weight measured 135 pounds on 12/17/2024, 12/18/2024, and 12/20/2024. Review of the Nutrition Evaluation, dated 12/26/2024, showed Resident 40's weight was stable and their estimated calorie needs were 1230-1500 kcal per day and 1800 ml of fluid/day. The RD recommended to provide one diabetic meal replacement supplement for additional calories and protein and continue weekly weights. The CP was not updated. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 40's weight record showed no weight measurement for 12/27/2024. On 01/03/2025, their weight measured 115 pounds, a 14.8% weight loss in two weeks. Review of Resident 40's progress notes, between 01/02/2025 and 01/10/2025, showed no documented nurse progress notes or skilled charting documentation. There was no documentation to show the facility identified Resident 40's significant weight loss on 01/03/2025, or that the physician and responsible party were notified of the weight loss. The progress notes did not indicate Resident 40 was on alert charting status, did not provide consistent monitoring of their intake, or evaluation for increased need of assistance for eating. In a physician's note, dated 01/10/2025 (untimed), showed Resident 40 had increased confusion and was difficult to arouse. Their physical exam showed Resident 40 had fluid volume deficit. Review of a physician's order, dated 01/10/2025 at 12:28 PM, showed instructions to start intravenous (IV) fluids for rehydration at 75 ml/hour for three days (no number of liters were given) to start at 5:00 PM. The order was confirmed by a nurse at 12:30 PM. Review of the January 2025 MAR showed the 01/10/2025 physician order for IV fluids due at 5:00 PM. The documentation showed 9-other/see nurse notes. Review of the nurse progress showed no nurse progress notes for 1/10/2025 after 2:44 AM when a late entry daily skilled note was entered. The nurse progress notes did not provide documentation to show Resident 40 was ordered IV fluids, why the fluids were not initiated, or Resident 40's change of condition status. Review of a physician's order, dated 01/11/2025 at 12:04 PM, showed to place a peripheral IV for hydration (19 hours after the IV was ordered to start) and a second order to administer IV rehydration at 75 ml/hour for three days. Review of the Peripheral IV Insertion Record, dated 01/11/2025 at 12:30 PM, showed a traveling IV Nurse started an IV access in the left arm. Review of the January 2025 MAR/TAR showed the 01/11/2025 order for IV rehydration. The documentation did not show the volume of fluids administered for each shift to indicate how much fluid Resident 40 received. Review of Resident 40's fluid intake documentation between 01/09/2025 and 01/15/2025 only showed their fluid intake from meals. On 01/10/2025 their fluid intake from all meals was 920 ml and on 01/11/2025 it was 500 ml. Review of Resident 40's Weight Summary Report dated 01/10/2025 showed they had a greater than 10% weight loss in less than 180 days. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Nutrition Hydration Skin Committee Review evaluation dated 01/14/2025 showed Resident 40's weight measured 119 pounds. The documentation showed they only had a 5% unplanned significant weight loss, consumed 25-50% of their meals, and had abnormal labs that showed fluid volume deficit and required IV hydration to correct. They planned to increase Resident 40's diabetic meal replacement supplement to two times a day. The documentation did not show the IDT evaluated Resident 40 to identify why they lost the weight. The CP was not updated. In an interview on 03/19/2025 at 12:45 PM, Resident 40's Responsible Party, RP, stated they not notified of Resident 40's weight loss in the beginning of January but could tell they had lost a lot of weight. RP did not know it was 20 pounds. RP stated on 01/10/2025, the physician said they would start IV fluids because Resident 40 was dehydrated. RP stated [they] came back the next day around lunch time and Resident 40's IV fluids were still sitting at the bedside, and they did not have an IV-line in. They found out the IV had not been started because no one could start IVs. RP stated the facility finally called in a nurse to start the IV on 01/11/2025. RP stated Resident 40 was missing their bottom denture since admission. <RESIDENT 8> Review of the 12/31/2024 Admission Minimum Data Set (MDS), an assessment tool, showed Resident 8 admitted to the facility on [DATE], had mild cognition problems, required assistance with activities of daily living, and diagnoses included a stroke, dysphagia (impaired swallowing), diabetes, and a newly placed feeding tube. Resident 8 was not at risk for malnutrition, weighed 202 pounds, received more than half of their total calorie needs for the week from tube feeding but only received a total of 500 ml's or less for average daily fluid intake for the week. Review of Resident 8's Nutrition Hydration Status CP, dated 12/25/2024, showed they were on aspiration precautions, directed staff to monitor for signs or symptoms of dehydration, and was referred to the RD for evaluation of their nutritional status. The 12/25/2024 intervention for diet order stated, per MD order and was not personalized to show they were NPO (nothing by mouth). The CP did not provide personalized interventions and timeframes/parameters for monitoring. The Comprehensive CP, initiated 12/25/2024, did not show a focus problem for feeding tube status, maintenance, and care. The CP did not show interventions for HOB elevation requirements to prevent aspiration or oral care frequency, who was responsible for oral care, and how it was to be performed. Review of Resident 8's Kardex (care plan directives to the direct care staff- Certified Nursing Assistants -CNAs), dated 12/25/2024, 12/26/2024, and 12/31/2024, showed the same interventions that included bathing preferences, floating heels while in bed, and leisure activities. The Kardex did not show that Resident 8 was NPO status, their tube feeding schedule, HOB elevation requirements, aspiration precautions, oral care responsibilities, or complications/signs/symptoms to monitor for and report. Review of Resident 8's Kardex, dated 01/06/2026 (12 days after admission), showed tasks for feeding tube site care and water flushing per physician orders (duties for licensed staff only). The Kardex did not show interventions for HOB elevation requirements, aspiration precautions, tube feeding complications to monitor for, oral care interventions, or urinary catheter care. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 02/24/2025 at 12:15 PM, Staff M, CNA, stated they knew the residents who were NPO or who had other special care needs through communication during shift report and by reviewing the Kardex in their POC (Point-of-care electronic documentation system). Staff M stated they were expected to review the Kardex daily to identify changes in the resident's CP that were specific to their job duties. Staff M confirmed that if the Kardex did not have the necessary information to meet the resident's basic care need it was difficult to care for the residents and made some cares more time consuming. In an interview on 03/03/2025 at 12:15 PM, Staff C, Registered Nurse-RN/Resident Care Manager-RCM, stated it was the responsibility of the admitting nurse to initiate the baseline care plan and the Kardex for the direct care staff to meet their basic care needs after admission. It was their expectation it was done by the end of the shift they arrived on or at least by the end of the day. Staff C stated the Interdisciplinary Team (IDT) reviewed new admissions during their clinical meeting and the RCMs were responsible to complete the CPs and other tasks that were incomplete or needed correction. PHYSICIAN ORDERS: Review of Resident 8's Hospital Provider Orders-Nursing Home Transfer, dated 12/25/2024, showed Resident 8's diet was NPO and the tube feeding orders showed Glucerna 1.2 (supplemental nutrition) at 25 milliliters (ml)/hr (hour) now and advance by 15 ml every six hours until goal rate of 85ml/hour, x 16 hours per day and additional water flush of 30 ml every four hours, and monitor intake/output. Resident 8's weight measured 225 pounds. Review of the December 2024 Medication and Treatment Administration Records (MAR/TAR) showed: -A physician's order dated 12/25/2024, Glucerna 1.2 @ 70 ml/hr x 16 hours/day and increase the rate to 85ml/hour in six hours. The tube feeding order was not complete with all required components according to their facility policy. The order was never discontinued and a new order transcribed to show they increased the rate to 85ml/hour six hours after admission on 02/25/2024. The MAR/TARs did not provide documentation to show the total volume of formula administered each shift or the 24-hour totals. The documentation showed the rate of administration was at 70ml/hour (15ml/hour less than ordered) from 12/26/2025 until the order was discontinued on 01/06/2025. -A physician's order dated 12/25/2024, for water flushes: 15-30 ml of water before and after medication administrations. The TARs did not show total volume of water provided each shift for all medications administered. -The MAR/TARs did not show the physician's order, dated 12/25/2024, for water hydration flushes of 30ml every four hours (total 180ml/day) was transcribed or implemented by staff. In an interview on 02/24/2025 at 4:00 PM, Staff G, Licensed Practical Nurse-LPN/ RCM, stated the MAR/TAR did not include the 12/25/2024 order for water hydration and could not state if it was implemented. Staff G stated the MAR/TAR did not show they increased the formula rate to 85ml/hour as ordered on 12/25/2024. Staff G stated the orders were unclear and should have been clarified on admission or during the nurse-to-nurse report with the hospi [TRUNCATED]

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on interview and record review the facility failed to ensure residents were assessed and person-centered pain care plans (CPs) were developed/implemented and revised to meet their pain management needs for 3 of 5 sample residents (Residents 1, 2, & 13) reviewed for pain. Resident 2 experienced harm when the facility failed to accurately clarify and transcribe admission orders for pain medications, ensure scheduled pain medications were administered timely, evaluate for the underlying cause of sudden onset of severe chest pain after open heart surgery, monitor for adverse effects of opioid use, was transferred to the hospital in acute respiratory failure, and found to have broken chest wires (internal fixation hardware in place to hold the chest together after open heart surgery) that required surgical intervention to repair. Resident 1 experienced harm when their complaints of pain went unaddressed, their behavioral signs of pain were not evaluated, were not monitored for post-fall injuries, was transferred to the hospital, and found to have a new hip fracture that required surgical intervention. These failures placed all residents at risk for adverse events, uncontrolled pain, diminished quality of care/quality of life. Findings included . <POLICY> Review of the facility's Pain Assessment and Management policy, revised October 2022, showed the pain assessment was used to help staff identify pain in the resident and to develop interventions that were consistent with the resident's goals, care needs, and addressed the underlying causes of the pain. --The facility would anticipate their need for pain interventions based on their clinical conditions know to be risk factors for pain. --To recognize pain the staff would monitor each shift (and more frequently if needed) for pain by observing the resident (during rest and movement) for physiological signs of pain (including increased blood pressure, heart rate, and respirations, or somnolence) and behavioral (non-verbal) signs of pain (including: behaviors such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in physical functioning/activities, appetite changes, and insomnia.) They would ask the resident about their pain and use standardized pain scale tools based on their cognitive status. --The facility would gather information from the resident or representative regarding pain history, characteristics, and non-medication interventions. --When opioids were use for pain management, residents were monitored for effectiveness, adverse effects, and opioid overdose. --Due to the risk of fatal respiratory depression, opioids and benzodiazepines (antianxiety medications) were not administered together unless a clinical indication for the resident was documented, and they were carefully monitored. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	--Acute pain or significant worsening of chronic pain should be assessed every 30-60 minutes after onset and reassessed until relief was obtained. <RESIDENT 2> Review of the 12/08/2024 Admission Minimum Data Set (MDS-assessment tool) showed Resident 2 admitted on [DATE], had no problems with cognition, required assistance with Activities of Daily Living (ADLs), and diagnoses included surgical aftercare following heart surgery, heart failure, diabetes. Resident 2 had shortness of breath with activity, at rest, and when lying flat. Resident 2 had surgical incisions, and they were on a scheduled pain medication regime, received PRN (as needed) medication, opioid medications, and antianxiety medications. Review of the Pain CP, dated 12/02/2024, showed non person-centered interventions to: anticipate need for pain relief and respond immediately to any complaint of pain; evaluate the effectiveness of pain interventions; review for alleviating of symptoms, dosing schedules, resident satisfaction with results, impact on functional ability, and impact on cognition; Monitor/ document for probable cause of each pain episode and remove/limit causes where possible, monitor/record/report to nurse any non-verbal symptoms of pain: changes in breathing, vocalizations. Notify physician if interventions are unsuccessful or if current complaint is a significant change. Review of the Kardex, dated 12/13/2024, showed no directives to the Certified Nursing Assistants (CNAs) regarding sternal precautions, head of bed elevation due to shortness of breath, pain factors, or symptoms to report if observed regarding pain after heart surgery. Review of Resident 2's hospital Interfacility Discharge Orders and Medication Administration Record (MARs) dated 12/02/2024 showed orders for oxycodone (an opioid narcotic) 5mg tablets, take 0.5-1 tablet (2. 5mg-5mg) every six hours as needed for severe pain, lidocaine 4% patch applied topically cut in half and placed on the skin on both sides of the chest surgical incision at bedtime and removed after 12 hours of use, and acetaminophen 1,000mg every six hours for pain. The orders also showed to observe Sternal Precautions. Review of Resident 2's facility Admission physician orders dated 12/02/2024 showed an order for oxycodone 2.5mg every six hours as needed for pain 1-5/10 (mild-moderate pain), an order for oxycodone 5mg every six hours as needed for pain 6-10/10 (moderate-severe), and lidocaine 4 % patch (apply to painful area, apply at bedtime and remove in the morning). The oxycodone and lidocaine patch orders were not accurately transcribed and/or clarified. The Sternal Precautions order was not transcribed to the admission orders. Review of the December 2024 MAR for 12/03/2024 showed Resident 2 was due for their routine acetaminophen at 12:00 AM and the medication was administered at 3:39 AM (three and a half hours late). Review of the nursing note dated 12/03/2024 at 9:39 AM showed Resident 2 was given oxycodone 5mg for pain rated 6/10. The note did not indicate the site of the pain or show non-medication interventions attempted and response. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the physician History & Physical, dated 12/03/2024 (untimed) showed Resident 2 had an extensive history of heart problems, congestive heart failure, and had an open-heart surgery two weeks prior to admission. The documentation showed nursing reported Resident 2 developed shortness of breath (SOB), anxiety, and severe chest pain 10/10 at their chest surgical site. They also had pain in their left leg and thigh surgical sites. The documentation did not show new orders were provided to investigate the underlying cause of their sudden onset of severe chest pain and shortness of breath. Resident 2 was ordered Ativan (a benzodiazepine antianxiety medication) for a panic attack. Review of December 2024 MAR for 12/03/2024 day shift documentation did not show non-pharmacological interventions were implemented, additional pain medication alternatives were ordered, the time and administration of Ativan for the panic attack. Review of the physician progress note, dated 12/04/2024, showed Resident 2 continued to have intermittent SOB and severe surgical site pain. Resident 2 also had pain and drainage from their left leg surgical site. Review of a physician progress note, dated 12/06/2024, showed nursing reported Resident 2 was complaining about chest pain, chest tightness, and shortness of breath. A new order was written for breathing treatments. Review of the December 2024 MAR for 12/06/2024 showed: -Their 12:00 AM scheduled acetaminophen was not administered until 3:15 AM (over three hours late). At 5:04 AM Resident 2's pain was 8/10 and was given oxycodone. -Their 6:00 PM scheduled acetaminophen was not administered until 7:26 PM (over one hour late). At 10:21 PM, Resident 2 was given oxycodone for moderate pain. Review of a nursing skilled evaluation note, dated 12/06/2024 at 9:58 PM, showed Resident 2 had shortness of breath and chest pain 5/10, sharp, and constant. Review of the December 2024 MAR for 12/11/2024 showed their 12:00 AM scheduled acetaminophen was due but was not administered until 1:10 AM at the same time as oxycodone for pain 5/10. Review of the nurse skilled evaluation, dated 12/11/2024 at 8:34 PM, showed Resident 2 had constant chest pain (not rated), sharp and aching. Relaxation techniques and position changes not effective. Resident 2 given oxycodone at 10:00 PM (two hours after they documented pain) for pain 5/10. Review of Resident 2's Medication Administration Report, MARs, and progress notes for December 2024 showed Resident 2 received their scheduled acetaminophen one hour late (or more) 14 doses of 44 total administered. The oxycodone was administered 13 times. Six of the 13 oxycodone doses were administered after late administrations of their scheduled acetaminophen. Additionally, the MARs did not provide documentation to show the facility monitored for adverse effects of opioid medications, or the use of both opioids and benzodiazepines together. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the clinical record did not provide documentation to show the facility evaluated for the underlying cause of Resident 2's acute onset of severe pain at their chest surgical site that started on 12/03/2025, carefully monitored their use of opioids, or identified the potential risks of administering both opioids and benzodiazepines together. Review of the nurse progress note dated 12/13/2025 at 12:17 PM showed Resident 2 was unable to stay awake and their oxygen saturation was low. They were instructed by the physician to call 9-1-1 and Resident 2 was transferred to the hospital. In an interview on 02/19/2025 at 2:30 PM, Resident 2 stated the night shift staff were uncaring and did not listen. Resident 2 stated the staff did not follow or know what sternal precautions were. Resident 2 stated on the first night, they had to use the restroom, so they put on the call light. The staff took so long to answer, they were incontinent in their bed. The staff told Resident 2 they were going to change their bedding. Resident 2 told the CNA they would need assistance to transfer to the wheelchair so they could make the bed, but the staff said No they were going to change the bedding with Resident 2 in the bed. Resident 2 told the staff they could not lay flat and needed to avoid rolling on their side due to their sternal precautions. The staff just started lowering the head of the bed which caused Resident 2 to begin having significant shortness of breath, and then the staff started rolling Resident 2. Before Resident 2 could get their heart pillow (special pillow used after open heart surgery to apply support to the chest when moved) to their chest, the staff began to roll [them] to their right side, they felt and heard a pop in their chest, and then extreme pain in addition to their already worsening shortness of breath. Resident 2 stated they told the staff about their sternal pain and clicking /popping noises from their chest the staff told them That is normal. Resident 2 stated they also had severe pain in their leg due to an infection in a surgery site they got at the facility and now required ongoing wound care every week. They rarely got their Tylenol on time which made it hard for them to get ahead of the pain. Resident 2 stated after they went to the hospital and saw their surgeon, they discovered Resident 2 had fractured sternal wires which made the plate became unstable. Resident 2 had to have another surgery to repair the wires and plate. In an interview on 02/13/2025 at 1:10 PM, Staff D, Physician, stated they did not order diagnostic tests or further investigate Resident 2's continued shortness of breath and chest pain. They ordered Ativan for their panic attack and Resident 2's breathing improved. <RESIDENT 1> Review of Resident 1's hospital History & Physical, dated 12/18/2024, showed Resident 1 had a new fracture of the lower spine with complications that caused pain due to pressure on their spinal cord and spinal stenosis (a condition of the spine that causes pain usually in the back and neck, numbness of the arms/legs/feet, weakness and cramping of the limbs, difficulty walking, loss of balance, and difficulty controlling bladder/bowel function). The documentation showed that Resident 1 had been unable to get out of bed due to uncontrollable lower back pain for the two weeks prior to hospitalization and surgical intervention was not an option. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the 01/05/2025 Admission Minimum Data Set (MDS-assessment tool) showed Resident 1 had moderate cognition problems, had no problems understanding others, and was usually able to make themselves understood. Resident 1's diagnosis included Parkinsons disease (progressive brain disease) and a fracture of the spine. Resident 1 required staff assistance for all activities of daily living (ADLs). Resident 1 had frequent pain that effected their sleep routine and day to day activities, their highest level of pain during the previous five days was 8/10 (0=no pain and 10=severe pain) but had no routine scheduled pain regime and had not received any non-medication interventions or PRN (as needed) pain medications. Review of Resident 1's Pain care plan (CP), dated 12/30/2024, showed non-personalized interventions that directed staff to anticipate need for pain relief and respond immediately to any complaint of pain, monitor/document probable cause of each pain episode and remove/limit causes where possible, notify the physician if interventions were unsuccessful or if there was a change in pain complaints, and observe and report changes in usual routine, sleep patterns, decrease in functional mobility, decrease in range of motion, and withdrawal or resistance to care. The CP did not show person-centered non-medication interventions to help with pain relief or any CP updates after it was initiated. Review of the Kardex (care instructions for direct care staff), dated 01/11/2025, directed the Certified Nursing Assistants (CNAs) to monitor Resident 1 for oral pain and report the nurse. The Kardex did not show Resident 1's pain problem related to their fracture of the spine or chronic neck, knee, and back pain. The Kardex showed no direction for the CNAs to monitor for expressions of distress or non-verbal signs of pain and offered no non-pharmacological pain relief interventions the CNAs could implement. Review of the facility's Fall Risk Management Report, dated 12/31/2024 at 3:30 PM, showed Resident 1 fell after trying to stand from the wheelchair without assistance. The report did not show a post-fall pain evaluation was conducted or consistent alert status monitoring for injuries. Review of Resident 1's physician History & Physical note, dated 12/31/2024, showed Resident 1 reported they were uncomfortable due to back pain. The documentation did not provide the characteristics of the pain. Review of the Occupational Therapy note, dated 12/31/2024 at 10:04 AM, showed Resident 1 reported they had constant pain to their neck and low back that limited their functional abilities. Sitting down, remaining still, change in body position all helped to relieve their pain. Their pain was worsened by prolonged activity. Their pain at rest and with movement was 5/10 and described the pain as aching. Review of the facility 's Fall Risk Management Report, dated 01/02/2025 at 4:12 PM, showed Resident 1 was attempting to stand without assistance and fell . The report did not show a post-fall pain evaluation was conducted or consistent post-fall alert monitoring for injuries. Review of the physician progress note, dated 01/03/2025, showed Resident 1 was confused, agitated, attempting to self-ambulate by getting up from the wheelchair, and uncomfortable due to back pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a Physical Medicine Rehabilitation Physiatry initial evaluation (a medical specialty that focuses on the diagnosis, prevention, and treatment of disabilities to restore function, reduce pain, and improve quality of life), dated 01/03/2025 at 3:38 PM, showed Resident 1 reported pain 7/10, their back was bothering them, their right knee was sore, and they had discomfort with urination. The providers plan showed they would provide orders for routinely scheduled acetaminophen (pain reliever) 1,000 mg (milligrams) twice daily and a topical pain relief cream twice daily. They ordered a urine analysis (UA) on 01/02/2025 to investigate the urination discomfort and if the UA was negative, they would administer a steroid injection in the right knee (due to arthritis-a painful joint disorder) if Resident 1 was agreeable and a candidate. Review of a physician order, dated 01/05/2025, showed routine orders for acetaminophen 1,000 milligrams twice daily and topical pain cream for back pain twice daily. The order was scheduled to administer the first dose on 01/06/2025 at 8:00 AM, (three days after they complained of pain 7/10). Review of the December 2024 and the January 2025 Medication Administration Records (MAR) showed between 12/30/2024 and 01/05/2025, Resident 1 was not provided any non-medication interventions or as needed medications for pain, including when Resident 1 reported: uncomfortable back pain to the physician on 12/31/2024 and 01/03/2025, constant pain and pain rated 5/10 to the occupational therapist on 12/31/2024, and pain 7/10 the physiatrist 01/03/2025. Review of the physician progress note, dated 01/07/2025, showed Resident 1 presented with expressions of distress including confusion, agitation, and hallucinations. Review of a nursing advanced skilled evaluation dated 01/08/2025 at 1:22 PM, (a late entry for unknown date and time) showed Resident 1 displayed expressions of distress that included disorganized thinking, anxiousness, agitation, and behaviors. Review of the facility's Fall Risk management report, dated 01/08/2025 at 2:15 PM, showed Resident 1 had a fall and landed on their buttocks after trying to get up out of the wheelchair. The report did not include a post-fall pain evaluation or evidence of consistent post-fall alert monitoring for injuries. Review of the medication administration note, dated 01/08/2025 at 4:05 PM, showed Resident 1 was provided ibuprofen (pain medication) 600 milligrams. The documentation did not show what non-medication interventions were attempted, their assessed pain level, or the site of their pain. In an interview on 02/05/2025 at 10:30 AM, Resident 1's Responsible Party, R1-RP, stated Resident 1 was seen by a pain specialist on 01/03/2025 who asked Resident 1 for permission to administer a steroid injection in their knee to help with the pain. The specialist said they would return the next week with the injection but never came back. R1-RP stated Resident 1's pain was not managed, and they did not feel most staff took the time to allow Resident 1 to communicate their pain needs. R1-RP stated Resident 1 would complain about not being able to lay down between mealtimes for pain relief and was always stuck in the wheelchair. R1-RP stated they never saw Resident 1 in their bed, and they visited daily. R1-RP stated Resident 1's medication for hallucinations and Parkinson's caused them to become progressively lethargic and barely able to talk at. R1-RP stated on 01/11/2025, after it got so bad, they called 9-1-1 themselves to have Resident 1 transferred to the hospital. R1-RP stated the hospital held the sedating medications, Resident 1 became more clear and able communicate. That was how they found Resident 1 had a hip fracture and had to have surgery. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/13/2025 at 2:30 PM, Staff C, Registered Nurse, Resident Care Manager, stated when residents complained of pain, the nurse should be notified as soon as possible so the resident could be assessed and pain interventions implemented. Residents were assessed for pain after falls during their initial evaluation by the nurse after the fall and a post fall pain evaluation. In an interview on 02/24/2025 at 1:00 PM, Staff II, Physiatrist, stated the orders for the scheduled medications should have been transcribed on 01/03/2025 but were not. Staff II stated they typically stopped by the nurse to notify them if a resident complained of pain but could not recall whether they had and was not able to find documentation of that in their notes. <RESIDENT 13> Review of the 02/24/2025 Admission MDS showed Resident 13 admitted [DATE], was non-English speaking and required an interpreter, had cognition problems, and required assistance with ADLs. Resident 13 diagnoses included a serious heart infection, pneumonia, diabetes. Resident 13 had constant pain rated 8/10 (as the worst pain they experienced in the previous five days) and was on a scheduled pain medication regime. Resident 13 had Pressure Ulcer/Pressure Injuries (PU/PI) on both of their heels on admission. Review of the pain CP, dated 02/18/2025, showed non-personalized directives for staff to monitor/record/report to the nurse complaints of pain or request for pain treatment and encourage the use of non-pharmacological pain relief interventions: repositioning, relaxation, bathing, heat or cold application. Review of the Kardex, dated 02/20/2025, did not show directives regarding Resident 13's pain, location, and non-pharmacological pain interventions. Review of the February 2025 MAR showed: -A physician order, dated 02/18/2025, for a strong routine pain medication. The documentation showed the medication was not administered on 02/18/2025 at 8:00 PM, 02/19/2025 at 8:00 AM and 8:00 PM, and on 02/20/2025 at 8:00 AM. -A physician order, dated 02/18/2025, for a routine medication for nerve pain that also was not administered on 02/18/2025 at 8:00 PM, 02/19/2025 at 8:00 AM and 2:00 PM. -A physician order, dated 02/19/2025, for non-personalized non-medication pain interventions. The documentation showed no interventions were implemented. -A physician order, dated 02/18/2025, for acetaminophen every six hours scheduled routinely. The documentation showed Resident 2 did not get the medication on 02/18/2025 at 6:00 PM, 02/19/2025 at 6:00 AM, 12:00 PM or 6:00 PM. The progress notes documentation showed medication on order. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	In an interview on 02/20/2025 at 9:15 AM, Staff FF, Licensed Practical Nurse (LPN), stated Resident 13 admitted on [DATE] and they had not received their strong routine pain medication from the pharmacy, and it was not available in their emergency medication kit. Staff FF stated they called the pharmacy, and the pharmacy stated they never received a hard copy prescription from the facility and would not be able to fill it until it was received. Staff FF stated they were sending the pharmacy a prescription. Staff FF stated Resident 13 should have received all their medications timely and if they had not arrived from the pharmacy, the nurse should contact the physician to notify them and obtain further orders to hold the medications or administer alternative medications. Staff FF stated acetaminophen was an over-the-counter medication and always on hand and should have been administered. In an observation and interview on 02/20/2025 at 9:20 AM, Resident 13 was lying in bed, appeared restless (moving their knees up and then down every couple of minutes), and showed facial grimacing. Resident 13 stated through verbal and non-verbal communication (in a non-English language understood by the surveyor) they had pain in both their heels, the left heel pain was 8/10 and the right heel pain was a 5/10. Resident 13 had no pillows on their bed to help keep their heels floated and the heels were directly on the bed. Review of the February 2025 MAR for 02/20/2025 at 9:50 AM, showed Staff FF had documented Resident 13 had no pain. In an interview on 02/20/2025 at 9:35 AM, Staff FF stated they had not asked Resident 13 if they had pain because they did not speak their language. Staff FF stated they were not sure what the facility policy was regarding translation services, but Resident 13 did not have translation information in their room. In an interview on 02/20/2025 at 11:20 AM, Staff C (who spoke the non-English language fluently) stated Resident 13 should have information for the staff to communicate basic needs like pain, hunger, and bathroom as well as information for the translation line but did not. Staff C stated Resident 13 should have received all their ordered medications timely but did not. Refer to F655, F684, F689, F758 Reference WAC: 388-97-1060 (1).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to ensure 12 of 12 sampled residents (Residents 26, 2, 22, 13, 10, 38, 14, 8, 17, 34, 23, & 15) were free from significant medication errors. The failure to: conduct a thorough medication reconciliation on admission, verify allergies prior to administration, clarify duplicate or questionable orders, correctly transcribe orders into the electronic Medication Administration Record (MAR), administer medications timely in accordance with professional standards of practice, and report/investigate all identified medication errors placed residents at risk for adverse events, rehospitalization , poorly managed health conditions, and diminished quality of care/quality of life. Findings included . Review of the facility's Adverse Consequences and Medication Errors policy, revised April 2014, showed the Interdisciplinary Team (IDT) would evaluate medication usage to prevent and detect adverse consequences and medication-related problems like adverse drug reactions and side effects. Adverse outcomes would be reported to the appropriate entities. The facility would follow clinical guidelines, manufacturer's instructions, ensure appropriate indications for use, and determine whether the resident has a known allergy to the medication. The IDT would review the resident's medication regimen for efficacy and actual/potential medication-related problems on an ongoing basis. The facility would notify the physician of medication errors promptly and monitor the resident closely for 24-72 hours or as directed, documented in the clinical record, and complete an incident report. The Quality Assurance Performance Improvement (QAPI) committee would conduct a root cause analysis of medication administration errors to determine the source of errors, implement process improvement steps, and compare results over time to determine that system improvements were effective at reducing errors. Review of the facility's Admission Assessment and Follow-Up: Role of the Nurse policy revised September 2012 showed the policy had not been reviewed/revised or updated since 2012. The policy showed the facility would reconcile the list of medications from their medication history, admitting orders, and the discharge summary. They would contact the physician to communicate and review findings of their initial assessment and obtain admission orders based on their assessment and finding. They would contact outside services as necessary and follow professional standards of practice. <RESIDENT 26> Review of Resident 26's hospital Discharge Summary dated 12/16/2024 showed they had a history of a stroke, heart attack, and long-term use of blood thinners. The discharge summary medication list included orders dabigatran 150mg twice daily, an oral blood thinner. Review of Resident 26's 12/22/2024 Admission Minimum Data Set (MDS-assessment tool) showed they admitted [DATE] and were not on blood thinners during the observation period. Review of Resident 26's facility Admission orders dated 12/16/2024 showed the order for dabigatran was not transcribed to the admission orders and implemented. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record showed Resident 26 was transferred to the hospital for neurologic changes on 01/30/2025. Review of Resident 26's hospital Discharge Summary 02/21/2024 showed the hospital identified [they] were not given the blood thinner after admission to the facility (between 12/16/2024 and 01/30/2025). Review of the clinical record did not show a medication reconciliation was conducted on the admission or the readmission. <RESIDENT 2> Insulin Allergy: Review of Resident 2's Interfacility Discharge Orders dated 12/02/2024 showed they were allergic to glargine (Lantus) insulin. They were ordered Degludec (a long-acting insulin) 21 units every day with dinner for diabetes. Review of the December 2024 MARs showed two long-acting insulin orders: 1) a physician's order dated 12/02/2024 for Lantus 21 units at bedtime (the medication listed on the allergy list). The documentation showed the Lantus was administered on 12/02/2024 and 2) a 12/02/2024 physician order for Deglu[DATE] units one time a day at 5:00 PM that showed it was not administered on 12/02/2024. Review of the clinical record did not provide documentation to show a medication reconciliation was conducted or admission insulin orders were clarified. Pain Medications: Review of Resident 2's hospital Interfacility Discharge Orders and Medication Administration Record (MARs) dated 12/02/2024 showed orders for oxycodone (an opioid narcotic) 5mg tablets, take 0.5-1 tablet (2. 5mg-5mg) every six hours as needed for severe pain, lidocaine 4% patch applied topically cut in half and placed on the skin on both sides of the chest surgical incision at bedtime and removed after 12 hours of use, and acetaminophen 1,000mg every six hours for pain. Review of Resident 2's facility Admission physician orders dated 12/02/2024 showed an order for oxycodone 2.5mg every six hours as needed for pain 1-5/10 (mild-moderate pain), an order for oxycodone 5mg every six hours as needed for pain 6-10/10 (moderate-severe), and lidocaine 4 % patch (apply to painful area, apply at bedtime and remove in the morning). The oxycodone and lidocaine patch orders were not accurately transcribed and/or clarified. Review of the December 2024 MAR for 12/03/2024 at 12:00 AM showed scheduled acetaminophen was due but was not administered until 3:39 AM (three and a half hours late). Review of the December 2024 MAR for 12/06/2024 at 12:00 AM showed scheduled acetaminophen was due but was not administered until 3:15 AM (over three hours late). Review of the December 2024 MAR for 12/06/2024 at 6:00 PM showed their scheduled acetaminophen was due but was not administered until 7:26 PM (over an hour late). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's Medication Administration Report, MARs, and progress notes for December 2024 showed Resident 2 received their scheduled acetaminophen one hour late (or more) 14 doses of 44 total administered. <RESIDENT 22> Review of Resident 22's Post Acute & Transition of Care Orders dated 02/17/2025 showed (in RED print) Please control BG (blood glucose-sugar). Use medium dose SSI (sliding scale insulin). The SSI was ordered for every six hours due to their tube feeding/NPO (nothing by mouth) status. Review of the February 2025 MAR showed: -An order dated 02/17/2025 for long-acting insulin 20 units twice daily- was not administered on the 02/17/2025 evening or 02/18/2025 morning doses. -The blood sugar checks every six hours and SSI were not transcribed or initiated on readmission. Review of the clinical record did not show the facility conducted a medication reconciliation at readmission. In an interview on 02/25/2025 at 3:30 PM, Staff H, Licensed Practical Nurse-LPN, Resident Care Manager-RCM, stated insulins should have been transcribed and administered as ordered but were not. <RESIDENT 13> Review of Resident 13's Provider Orders-Nursing Home Transfer dated 02/18/2025 showed they admitted to the facility with a serious heart infection, pneumonia, sepsis, diabetes, and neuropathy (nerve pain). Resident 13's discharge orders included three different intravenous (IV) antibiotics daily, scheduled and sliding scale insulins for diabetes, and several scheduled pain medications. Review of the February 2025 MAR showed Resident 13 was not administered any of their ordered medications on 02/18/2025 or 02/19/2025. Review of Medication Administration Notes dated 02/19/2025 at 3:17 AM and 02/19/2025 at 10:16 AM showed Meds on order as the reason medications were not administered. In an interview on 02/20/2025 at 9:18 AM, Staff FF, LPN, stated Resident 13's narcotic pain medication was not available to administer and they just sent a signed prescription to the pharmacy so it could be delivered. Resident 13 had not received their scheduled pain narcotic pain medication for their morning dose on 02/20/2025. Staff FF stated when medications were not available, the nurses were supposed to call the physician to notify them and obtain further orders to either hold the medication or administer an alternative medication if one was available. Staff FF stated they did not know why Resident 13's medications were not received from the pharmacy. Review of the clinical record did not show the physician was notified their medications were unavailable or that a medication reconciliation on admission was conducted. <RESIDENT 10> (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's Hospital Post Acute Transfer Orders dated 12/06/2024 showed orders for a lidocaine patch (for pain) to be applied to their shoulder every day and a diuretic (water pill) 2.5mg every other day for heart failure. Review of Resident 10's December 2024 and January 2025 MAR diuretic documentation showed 10 of 30 scheduled doses were not administered and the lidocaine patch on 01/27/2025 was not administered. Review of the Medication Administration note dated 01/27/2025 at 10:51 AM showed the pain patch was not available to administer. Review of the Medication Administration note dated 01/27/2025 at 10:54 AM showed the diuretic medication was not available. The documentation did not show they notified the physician. Review of the clinical record did not show a medication reconciliation was conducted on readmission. In an interview on 02/13/2025 at 1:10 PM, Staff D, Physician, stated they were not aware the medications were not available and or that they missed 10 doses of their diuretic medication. In an interview on 02/13/2025 at 1:44 PM, Staff C, Registered Nurse-RN, Resident Care Manger-RCM, stated the nurse should have contacted the physician to notify them the medication was not available. Staff C was not able to locate documentation to show the physician was notified. <RESIDENT 38> Review of the 01/29/2025 Admission MDS showed Resident 38 admitted to the facility on [DATE]. They had severe cognition problems, required maximum assistant with ADLs, and was incontinent. Resident 38 had no behaviors and diagnoses included surgical repair of a hip fracture, dementia, difficulty swallowing, and knee pain. Resident 38 received antipsychotic and antidepressant medications. Review of Resident 38's hospital After Visit Summary (AVS) physician orders dated 01/23/2025 showed instructions to STOP giving five different medications: Seroquel (the antipsychotic medication), bethanechol, loratadine, Miralax, and senna-doss. Review of Resident 38's January 2025 MAR showed orders dated 01/23/2025 for the five medications they were ordered to STOP taking according to the AVS. The documentation showed the medications were administered. Review of the clinical record did not show a medication reconciliation was completed on admission or orders were clarified. In an interview on 03/19/2025 at 12:40 PM Staff C, stated the nurse entering the admission orders should have clarified the Seroquel with the physician. Staff C was unable to locate a medication reconciliation completed on admission. <RESIDENT 14> (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 14's Admission MDS dated [DATE] showed they admitted [DATE] and had diabetes with long-term use of insulin. Review of Resident 14's hospital physician Discharge Summary dated 12/30/2024 showed they started a long-acting insulin 5 units every day at bedtime for diabetes on 12/25/2024 and they required insulin while on steroids. Review of Resident 14's Hospital MAR showed they received the long-acting insulin, and a sliding scale insulin as needed before meals and at bedtime. Review of Resident 14's Skilled Nursing Facility Transfer Orders dated 12/30/2024 showed orders for: -An oral diabetic medication 500mg tablet-two tablets (1000 mg) twice daily for diabetes. -Blood sugar checks before each meal and at bedtime (AC & HS). -A steroid medication daily. -No insulins orders were on the discharge medication list. Review of the Resident 14's December 2024 MAR showed the oral diabetic medication was transcribed incorrectly on admission as 500 mg-one table twice daily and administered on 12/30/2024 at 4:00 PM and 12/31/2024 at 8:00 AM (a transcription error). The MAR also showed the blood sugar checks were transcribed for every six hours, not AC & HS as ordered. Review of Resident 14's clinical record did not show a medication reconciliation was completed on admission including clarification of Resident 14's insulin orders. Review of Resident 14's January 2025 MAR showed a physician's order dated 01/02/2025 to administer sliding scale insulin four times a day and was scheduled for every six hours (12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM), not AC&HS. On 01/09/2025 the order times were changed AC&HS (7:30AM, 11:30AM, 4:30 PM and 9:00 PM). Review of Resident 14's Medication Administration Audit Report and blood sugar record documentation showed: -On 01/09/2025 at 9:00 PM their blood sugar was 281 and four units of insulin were administered on 1/10/2025 at 4:36 AM, over seven hours after the blood sugar. -On 01/10/2025 at 4:30 PM their blood sugar was 288 and four units of insulin were administered at 6:15 PM (almost two hours after the blood sugar was taken and after dinner was served). -On 01/10/2025 at 9:00 PM their blood sugar was 290 and four units of insulin were administered on 01/11/2025 at 12:08 AM, three hours after bedtime. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/13/2025 at 9:35 AM, Resident 14's Responsible Party, R14-RP, stated Resident 14 blood sugars were poorly controlled and they were supposed to be on insulin but were not when they admitted . R14-RP stated they notified the facility of their concerns regarding diabetic management and medications but did not believe they were heard. R14-RP stated family was always present for mealtimes. They observed nurses administer Resident 14 insulin without checking their blood sugar before the insulin administration, especially at breakfast. When they questioned the staff, the staff reported the blood sugar was already checked. Some nurses brought their insulin way after the meal, sometimes over an hour. <RESIDENT 8> Review of Resident 8's Hospital Continuum of Care Orders, dated 12/25/2024, showed orders for tube feeding administration that started at 4:00 PM and stopped at 8:00 AM, orders for a long-acting insulin 10 units daily and to hold if fasting (not eating), and blood sugar checks every six hours with sliding scale insulin coverage. Resident 8 also had orders for continuous oxygen. Review of the Resident 8's December 2025 MAR/TAR documentation showed: -A 12/25/2024 physician order for long-acting insulin 10 units one time a day and hold if blood sugar was less than 100. The long-acting insulin was scheduled for 7:30 AM, 30 minutes before the tube feeding was stopped for eight hours. -A 12/25/2024 physician order for blood sugar checks and sliding scale insulin scheduled for AC& HS, not every six hours as ordered. The MAR documentation showed Resident 8 received insulin at -No orders for continuous oxygen. Review of the clinical record did not provide documentation to show the facility conducted an admission medication reconciliation or clarification of orders. In an interview on 02/13/2025 at 1:35 PM, Staff D stated it was their expectation the nurses conducted a thorough medication reconciliation on admission, called the physician when clarification was needed, when medications were not available, and for medication errors. <RESIDENT 17> Review of a Medication Administration Note dated 01/31/2025 at 9:03 AM showed their Advair inhalant medication (for the treatment of chronic respiratory disease) was not available. The documentation showed they reordered it from the pharmacy and were told it was already filled the week prior on 01/23/2025. The nurse requested the pharmacy to fill another prescription and bill the facility. The documentation did not show the provider was notified. LATE MEDICATION ADMINISTRATION & DOCUMENTATION: <RESIDENT 23> In an interview on 02/13/2025 at 4:00 PM, Resident 23 stated they did not receive their medications on time, and sometimes did not get them. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 23's February 2025 MAR showed they had end-stage kidney disease and went to dialysis three times a week. Review of the physician order dated 02/09/2025 showed orders for a phosphate binder (a medication taken with meals for residents who have end-stage kidney disease) scheduled every day at mealtimes (at 8:00 AM, 12:00 PM, and 5:00 PM). The documentation showed the 12:00 PM doses on 02/10/2025 and 02/12/2025 were not administered-they were out at dialysis. Review of Resident 23's Late Medication Administration Report showed they received the scheduled phosphate binder (due at 5:00 PM) more than two hours after the meal on 02/04/2025, 02/05/2025, 02/13/2025, 02/14/2025, 2/15/2025, 02/16/2025, 02/17/2025, 02/19/2025, 02/21/2025, 02/24/2025, 02/26/2025, 02/27/2025, 02/28/2025. <RESIDENT 34> Review of Resident 34's clinical census showed they admitted to the facility on [DATE] and transferred to the hospital 02/13/2025. Review of Resident 34's January and February 2025 MARs showed orders for sliding scale insulin before meals and bedtime, a routine combination insulin 70/30 (fast acting and medium acting) 10 units in the morning and at bedtime, a diuretic in the morning and early evening hours, and routine acetaminophen (pain reliever) in the morning and early evening hours. Review of Resident 34's Late Medication Administration Report (of greater than one hour) between 01/01/2025 and 02/13/2025 showed Staff RR, LPN, consistently documented [they] administered all Resident 34's medications at the same time on each of two Day shifts and 12 Night shifts they worked in January 2025 and five Night shifts in February 2025. In an interview on 02/20/2025, Staff KK, LPN, stated the professional standards of medication administration included the Right time and Right documentation (along with Right medication, dose/frequency, and route) and nurses were expected to follow a consistent safe process for medication administration to prevent medication errors. Similar findings for . <RESIDENT 10> Review of Resident 10's MAR showed: early evening orders for a diuretic, a muscle relaxer for pain management, an anti-anxiety medication (scheduled three times a day), a routine pain reliever gel; and bedtime scheduled orders for a muscle relaxer, anti-anxiety medication, potassium and magnesium supplements, and a routine pain reliever gel. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's Late Medication Administration Report for February 2025 showed Staff RR documented Resident 10's early evening ordered medications as administered at the same time as their late evening medications or was over an hour late with medication administration on: 02/01/2025, 02/05/2025, 02/06/2025, 02/07/2025, 2/10/2025, 02/11/2025, 02/12/2025, 02/13/2025, 02/16/2025, 02/17/2025, 02/18/2025, 02/19/2025, 02/22/2025, 02/24/2025, 02/25/2025, and 02/28/2025. The report also showed Staff SS, LPN, administered Resident 10's early evening ordered medications as administered at the same time as their late evening medications, or was late with medication administration over two hours on: 02/03/2025, 02/08/2025, 02/09/2025, 2/14/2025, 02/20/2025, 02/21/2025, 02/26/2025, 02/27/2025. <RESIDENT 15> Review of Resident 15's February MAR showed orders for early evening administration of two different seizure medications and bedtime medications that included blood pressure medications. Review of Resident 15's Late Medication Administration Report for February 2025 showed Staff RR documented Resident 15's early evening ordered medications as administered at the same time as their late evening medications or was over an hour late with medication administration on: 02/01/2025, 02/05/2025, 02/06/2025, 02/07/2025, 2/10/2025, 02/11/2025, 02/12/2025, 02/13/2025, 02/16/2025, 02/17/2025, 02/18/2025, 02/19/2025, 02/22/2025, 02/24/2025, 02/25/2025, and 02/28/2025. The facility was cited F760 and remains out of compliance. This is a repeated citation. REFERENCE WAC 388-97-1060 (3)(k)(iii).

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46472 Based on interview and record review, the facility failed to ensure [it] was administered in a manner that used resources effectively and efficiently to attain or maintain the residents highest practical physical, mental, and psychosocial well-being, and the facility maintained substantial compliance with state and federal regulations. The failure to ensure adequate clinical administrative oversight in the absence of both the Director of Nursing (DNS) and Regional [NAME] President of Clinicals and implement an effective Quality Assurance Process Improvement (QAPI) program placed residents at risk for adverse events, substandard quality of care, rehospitalization , and diminished quality of care/quality of life. Findings included . During a review of the facility's historical surveys showed the facility continued out of compliance after they received citations on 01/22/2025 for F684 Quality of Care and F760 Significant Medication Errors. Before the facility achieved compliance, an abbreviated Complaint Investigation (CI) initiated on 01/15/2025 resulted in a citation on 01/31/2025 for F580 Notification of Changes and another abbreviated CI initiated 02/03/2025 resulted in failed practice identified in the care areas of: Abuse, Care Planning, Substandard Quality of Care in Nutrition/Hydration Status Maintenance, other Quality of Care areas, and Pharmacy Services on 03/19/2025 (including repeated citations in F684 Quality of Care and F760 Significant Medication Error). On 02/26/2025 at 2:45 PM, the facility was notified of an Immediate Jeopardy (IJ) at CFR 483.25 (g)(1)(2)(3) F-692, Nutrition/Hydration Status Maintenance, related to the facility's failure ensure 11 of 11 Residents received care and services to maintain acceptable parameters of nutritional status. Refer to F-692. < DELEGATION OF TASKS TO QUALIFIED STAFF> During onsite visits conducted on 02/03/2025, 02/13/2025, 02/20/2025, 02/24/2025, 03/03/2025, and 03/04/2025, Staff B, DNS, was not at the facility. Interviews with staff showed Staff B was on leave for personal reasons. During the onsite visits on 02/03/2025, 02/13/2025, 02/20/2025, 02/24/2025, and 03/03/2025 Staff Z, Regional [NAME] President of Clinicals, was also not available on leave but returned 03/04/2025. Review of the Facility Assessment, dated 02/27/2025, showed in the absence of the DNS the Assistant Director of Nursing (ADNS) would fill in. The facility did not have an ADNS. In the absence of an ADNS, a Resident Care Manager (RCM), with a Registered Nurse (RN) license would act as designated backup. Review of facility staffing showed Staff C, Registered Nurse-RN, RCM was the facility's only RCM with an RN license. In an interview on 02/13/2025 at 1:55 PM, Staff C stated they were not the appointed DNS until their DNS returned to work. In an interview on 03/04/2025 at 2:11 PM, when asked who ensured physician orders were implemented after admission, Staff A, Administrator, stated normally it was the DNS but currently the Administrator was responsible. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administration failed to ensure clinical nursing oversight and supervision was managed by a trained Registered Nurse in the absence of the DNS. The failure to appoint a designee that was trained or knowledgeable in administrative nursing services and regulatory operations of the nursing facility, contributed to the facility's inability to maintain substantial compliance with the Medicare/Medicaid regulatory requirements for participation and provide quality care and services to the residents identified in the cited care areas. <QAPI> The Administration failed to develop, implement, and monitor a QAPI program and educate staff of the QAPI goals of the facility. Refer to F867 QAAPI Activities and F944 QAPI Training. REFERENCE: WAC 388-97-1620.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46472 Based on interview and record review, the facility failed to have an effective Quality Assurance/Performance Improvement (QAPI) Committee that self-identified deficient practices, and/or implemented corrective action for identified deficiencies. The failure to utilize the facility's QAPI procedures to sustain compliance with regulations for the facility, placed residents at risk for adverse events, unsafe conditions, delay in necessary care and services, and a diminished quality of care/quality of life. Findings included . Review of the facility's Quality Assurance and Performance Improvement (QAPI) Program policy, revised March 2020, showed that quality of care deficiencies was identified through feedback and data, and would undergo appropriate corrective action. Corrective actions were monitored against established goals and benchmarks by the QAPI committee. 1. Refer to Code of Federal Regulations (CFR): S483.45(f)(2) F760 Residents are Free of Significant Med Errors: During an interview on 03/04/2025 at 2:11 PM, when asked if the facility had any active Performance Improvement Projects (PIPs) Staff A, Administrator stated they had PIPs for their three citations they received in January 2025 including but not limited to: Significant Medication Errors for not having medications available. Staff A was asked if the QAPI committee had identified any concerns regarding their new resident admission process, Staff A stated they developed a new admission check list. Review of the facility history showed the facility failed to ensure administration of a prescribed respiratory medication (a medication used to treat breathing problems) and received a citation 01/22/2025. The facility alleged compliance on 01/27/2025. The facility did not identify their failure to ensure newly admitted resident's medications were readily available in a timely manner upon admission and the orders were accurate, complete, and reconciled. 2. Refer to CFR: S483.25(g)(1) F692 Nutrition/Hydration Status Maintenance: During an interview on 03/04/2025 at 2:11 PM, Staff A stated in the December 2024 and January 2025 QAPI meetings the residents who triggered for significant weight changes were consistent, monitored, and the variance reports showed improvement. When asked if the committee had identified any tube feeding dependent resident's that experienced weight loss or other hydration/electrolyte problems, Staff A stated No. The facility did not self-identify their failure to ensure residents received the nutrition they required and consistently monitored the residents response to interventions. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Refer to CFR: S483.25(d) F689 Free of Accident Hazards/supervision/devices: During an interview on 03/04/2025 at 2:11 PM, Staff A stated, the facility tracked missed alert charting notes and skilled notes. Staff A stated Medical Records staff conducted the audits. Staff A stated they reviewed the clinical alert list in PCC (the computer charting program), and the 24-hour log to see who was on alert monitoring documentation. The facility did not self-identify their failure to consistently implement fall care plans, initiate incident reports, or consistently document monitoring following resident falls. 4. Refer to CFR: S483.95 F940 Training Requirements: In an interview on 03/04/2025 at 1:21 PM, Staff P, Staff Development Coordinator, shared the tracking tools used by the facility. The hours were not tracked annually and Staff P had to add up the hours for each staff reviewed. During an interview on 03/04/2025 at 2:11 PM, Staff A stated the trainings were logged and they kept track of the hours. Staff A stated they expected the facility to meet the required annual in-service hours for CNAs. The facility did not self-identify they were not in compliance with the training requirements. REFERENCE: WAC 388-97-1760(1)(2).

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 46472 Based on interview and record review, the facility failed to ensure staff were educated on all required topics specified on their Facility Assessment for 4 of 4 sampled staff (Staff Q, R, S & T) reviewed for annual education and training. Failure to ensure staff received required trainings placed residents at risk for unmet care needs, inadequate quality of care, and diminished quality of life. Findings included . Review of the facility assessment, dated 02/27/2025, showed the following trainings were provided to staff annually: -Resident Rights and Facility Responsibilities - ensured staff members were educated on the rights of the resident and the facility's responsibility to provide proper quality care. -Change of Condition - ensured staff were educated on how to identify a resident's change of condition including: including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life. -Person-Centered Care Competencies - the delivery of personalized care that aligned with the residents' goals and professional standards. -Activities of Daily Living Competencies Review of employee files showed Staff Q, Nursing Assistant Certified (NAC) was hired 01/24/2024. In an interview and record review on 03/04/2025 at 1:21 PM, Staff P, Staff Development Coordinator, reviewed the facility's training records and stated Staff Q did not have Resident Rights training. Staff P was unable to find documentation to support Staff Q had been educated on Identification of resident changes in condition, I don't see that. Staff P was unable to find a completed competency for Person-centered care and added, I don't know what that is. Staff P was unable to find documentation that Staff Q completed a competency for Activities of Daily Living. During an interview on 03/04/2025 at 2:11 PM, when asked regarding the trainings listed on the Facility Assessment, Staff A, Administrator stated the training was provided based on a calendar of annual of required trainings. During an interview on 03/04/2025 at 3:30 PM, Staff Z, Regional [NAME] President of Clinicals, stated they created the in-service calendar to ensure mandatory trainings were conducted as planned. The calendar was requested and not provided. In addition, training records were requested for Staff R, NAC, (hired 03/29/2022), Staff S, NAC, (hired 09/21/2023), and Staff T, NAC, (hired 12/01/2023) to show they received the required annual training. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/04/2025 at 4:34 PM, Staff Z, stated that Staff P was not able to find competencies for the requested staff. REFERENCE: WAC 388-97-1680.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 46472 Based on interview and record review, the facility failed to ensure 4 of 4 Certified Nursing Assistants (CNAs) (Staff Q, R, S, & T) were provided mandatory Quality Assurance and Performance Improvement (QAPI) training. Failure to ensure staff received the required QAPI training, which included how to communicate concerns, problems, or opportunities for improvement placed residents at risk for unmet care needs, unsafe environment, and diminished quality of care/quality of life. Findings included . In an interview on 03/04/2025 at 12:15 PM, Staff R, CNA, stated they did not know what the QAPI committee was or what QAPI meant. Staff R stated if they had concerns they told their nurse. In an interview and record review on 03/04/2025 at 1:21 PM, Staff P, Staff Development Coordinator reviewed the facility's training records and stated Staff Q did not have QAPI training. During the interview Staff P was not able to provide a carriculum for QAPI training, but did say the facility trained staff on Stop and Watch, directing staff that if they see something to report it and put a note in the computer. The facility was unable to provide documentation to show Staff R, NAC, (hired 03/29/2022), Staff S, NAC, (hired 09/21/2023), and Staff T, NAC, (hired 12/01/2023) recieved the required annual training. Reference WAC 388-97-1680 (2) (a)(b)(ii).