STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505485	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Grove Health Care Center	400 - 29th Street Northeast Puyallup, WA 98373

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview and record review, the facility failed to have psychotropic medication (medications that affect a person's mental state) consents completed, signed, and in place prior to residents receiving these medications for 3 of 5 sampled residents (Residents 92, 87, and 2) reviewed for unnecessary medication use. This failure placed the resident or their legal representatives at risk for lack of knowledge to make an informed decision regarding the use of the medication, adverse side effects, and a diminished quality of life. Findings included . Resident 92 Review of the electronic health record (EHR) showed Resident 92 admitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set assessment (MDS), an assessment tool, dated 12/19/2024, showed Resident 92 had diagnoses of depression, anxiety disorder, and insomnia (sleeplessness). Review of Resident 92's January 2025 medication administration records (MAR) from 01/01/2025 - 01/23/2025 showed the resident was prescribed and provided Zolpidem Tartrate (a hypnotic medication used to induce sleep) as needed for severe intermittent insomnia and Escitalopram Oxalate (an antidepressant medication) one time a day for depression. Review of Resident 92's psychotropic medication administration disclosure/informed consent dated 09/19/2024 for Zolpidem Tartrate showed an area to document the frequency the medication should be provided; however, the frequency was not documented. Review of Resident 92's EHR showed no consent was completed and in place for the use of Escitalopram Oxalate. During an interview on 01/24/2025 at 12:12 PM, Staff E, Licensed Practical Nurse (LPN), stated an informed consent was to be obtained prior to a resident being provided a psychotropic medication. Staff E stated Resident 92's informed consent for Zolpidem Tartrate should have had the frequency of the medication documented. Staff E stated they were unable to locate an informed consent for the use of Resident 92's provider ordered Escitalopram Oxalate medication and there should have been one obtained. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/24/2025 at 1:30 PM, Staff B, Director of Nursing Services (DNS), stated Resident 92's consent for Zolpidem Tartrate was missing the frequency and it should have been documented on the form. Staff B stated they were unable to locate a consent for Resident 92's Escitalopram Oxalate medication and this did not meet expectations. 46067 Resident 87 Review of EHR showed Resident 87 admitted to the facility on [DATE] with diagnoses to include dementia (a condition affecting memory, thinking and social abilities). Resident 87 required moderate assistance and was able to make needs known. Review of EHR showed Resident 87 had a provider's order dated 01/20/2025 for risperidone (an antipsychotic medication). Review showed no consent was on file for the medication. Review of Resident 87's January 2025 MAR showed the resident was received risperidone per provider's orders. During an interview on 01/27/2025 at 1:56 PM, Staff B, DNS, stated they were unable to locate any documentation related to the consent. Staff B stated the expectation was that a signed consent or verbal acknowledgement should be on file prior to administration of antipsychotic medications. 49926 Resident 2 Review of the EHR showed Resident 2 was admitted to the facility on [DATE] with diagnoses to included diabetes (high sugar in the blood), heart failure, depression and suicidal ideations. Resident 2 was able to communicate needs. During an interview on 01/22/2025 at 12:20 PM, Resident 2 stated, I wish I can talk to someone with sad facial expression and no eye contact. Review of provider's orders showed an order for Trazodone (an antidepressant medication) dated 11/25/2024 to be given for insomnia. Review of the EHR showed no verbal or written consent obtained prior administration of this medication. During an interview on 01/27/2025 at 12:43, Staff R, Resident Care Manager, was not able to find consent for the medication. Reference WAC 388-97-1020(4) (a-b)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to periodically review a resident's advanced directive (AD, a legal document that states your wishes for medical care if you are unable to make decisions for yourself) and obtain and maintain court-appointed guardianship (legal process where a court appoints someone to make decisions for a person who is unable to do so for themselves) documentation for 1 of 2 sampled residents (Resident 77) when reviewed for advanced directive. This failure placed the resident at risk of not having an established decision maker, lack of ability to direct care, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 77 admitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set assessment (MDS), an assessment tool, dated 11/15/2024, showed Resident 77 had diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), depression, and Osteoarthritis (a condition that causes pain, stiffness, and reduced movement in the joints). Review of Resident 77's EHR showed the following three Social Services Assessment and Documentation forms: -Form dated 02/14/2024 showed no AD was in place due to Resident 77 was unable to sign AD documentation at that time related to cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). -Form dated 05/16/2024 showed no AD was in place due to Resident 77 was unable to sign AD documentation at that time related to cognition. -Form dated 01/14/2025 showed there was a court-appointed guardian, and documents were requested for medical records. Review of Resident 77's EHR showed no AD for healthcare or court-appointed guardianship documentation. During an interview on 01/27/2025 at 11:27 AM, Staff F, Social Services (SS), stated Resident 77 should have had an AD review in August 2024 and in November 2024 and that did not happen. Staff F stated Resident 77's family member had stated they were the resident's legal guardian; however, they were unable to locate that documentation in the resident's medical record. During an interview on 01/27/2025 at 11:48 AM, Staff D, Business Office Manager (BOM), stated they should have followed up with Resident 77's family member to obtain guardianship paperwork, documented attempts to obtain them, and this did not meet expectations. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/2025 at 1:25 PM, Staff A, Administrator, stated AD was to be reviewed upon admission, quarterly, and as needed. Staff A stated Social Services were responsible for obtaining AD. Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observations and interview, the facility failed to provide a safe, sanitary, and homelike environment for 1 of 4 sampled residents (Resident 62) reviewed for environment. Failure to ensure a wheelchair was in good repair placed the resident at risk for infections, injuries, and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed that Resident 62 readmitted to the facility on [DATE] with diagnoses to include cancer and depression and was able to make needs known. Observation and interview on 01/23/2025 at 9:30 AM showed both armrests on Resident 62's wheelchair had multiple cracked areas in the vinyl with exposed beige material underneath which created an uncleanable surface. Resident 62 stated it was their personal wheelchair and eventually the material on the armrests just cracked. Follow-up observation and interview on 01/29/2025 at 10:54 AM showed Resident 62's wheelchair armrests continue to be in disrepair. Resident 62 stated both armrests on their wheelchair were rough to the touch. Resident 62 stated staff had seen them on their wheelchair and should have seen that the armrests needed to be fixed or replaced. During an interview and joint observation on 01/29/2025 at 10:59 AM Staff E, Licensed Practical Nurse, stated Resident 62's wheelchair armrests were both torn, cracked, rough to the touch, and not a cleanable surface. Staff E stated the wheelchair needed to be removed and maintenance and physical therapy informed for wheelchair armrests to be fixed/replaced. During an interview on 01/29/2025, Staff B, Director of Nursing Services, stated the condition of Resident 62's wheelchair armrests did not meet expectations. Reference WAC 388-97-0880

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observation, interview and record review the facility failed to ensure a resident was free from neglect when it prevented transfer out of a power wheelchair for three nights, prevented wound care during that time and caused distress related to transfer assistance from staff for 1 of 7 sampled residents (Resident 78) reviewed for abuse/neglect. This failure placed facility residents at risk of not receiving required care and services and a decreased quality of life. Findings included . Review of facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated September 2022, showed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management . All allegations are thoroughly investigated. The administrator initiates investigations. Resident 78 Review of the electronic health record (EHR) showed Resident 78 admitted to the facility on [DATE] with diagnoses of palliative care (end-of-life), osteomyelitis (infection of the bone), and diabetes (too much sugar in the blood). Resident 78 was able to make needs known. Review of the care plan, initiated 08/02/2024, showed Resident 78 was dependent on staff for transfers in/out of bed with a mechanical lift. During an interview and observation on 01/22/2025 at 10:46 AM, Resident 78 stated they were left in their power wheelchair for three nights because the facility could not locate a piece of equipment needed to transfer them into bed. Resident 78 stated they would not be left in the same situation, so they always kept the equipment in bed with them. Observation showed Resident 78 took a piece of metal with pins out from under the covers. During an interview on 01/29/2025 at 11:34 AM, Staff P, Certified Nursing Assistant (CNA), stated Resident 78 had told them the mechanical part was missing, and they were sleeping in their power wheelchair at night. Staff P stated they reported the incident to Staff N, Licensed Practical Nurse (LPN). During an interview on 01/29/2025 at 12:14 PM, Staff N, LPN, stated they were on vacation during the time Resident 78 was sleeping in their wheelchair at night. Staff N stated Resident 78 required a special part to be able to use the mechanical lift because the resident was an amputee. Staff N stated when told of Resident 78's allegation the staff checked on Resident 78's wounds to ensure they had not worsened, located the missing piece of equipment, then transferred Resident 78 into bed. Staff N stated they considered Resident 78's statements to be an allegation of neglect, and they had spoken with Staff B, Director of Nursing Services (DNS), about the allegations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/2025 at 12:18 PM, Staff B, DNS, stated they were aware of an issue of locating the mechanical equipment needed to transfer Resident 78. Staff B stated they were unaware Resident 78 had stated they slept in their wheelchair for three nights. During an interview on 01/29/2025 at 12:31 PM, Staff F, Social Services, stated Resident 78 made an allegation of neglect when they filled out a grievance form and put it in the social services grievance box. Staff F stated they informed Staff B, DNS, of the allegations. During an interview on 01/29/2025, Staff B, DNS, stated allegations of abuse/neglect should be reported to the DNS and the resident should be protected from further abuse/neglect while an investigation was conducted. Staff B stated being left in a wheelchair to sleep for three nights would be considered an allegation of neglect. Refer to F609 for additional information. Reference WAC 388-97-0640 (1).

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to obtain provider's order, assessment and consent for the use of low bed for 3 of 3 sampled residents (Residents 86, 74 and 89) reviewed for use of physical restraints. This failure placed the residents at risk for injury, unmet needs and a diminished quality of life. Findings included . Review of the facility's policy titled Use of Restraints, revised April 2017, showed, (1) Physical Restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body [.] (9) Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. Resident 86 Review of the electronic health record (EHR) showed Resident 86 was admitted to the facility on [DATE] with diagnoses to include intracranial hemorrhage in brain (bleeding in the brain), anxiety, depression, and aphasia (inability to verbally communicate). Resident 86 was not able to communicate their needs. Resident 86 was assessed to be a fall risk and required the assistance of staff for mobility. Observation on 01/22/2025 at 9:15 AM, showed Resident 86 in their room laying on a bed that was lowered to the floor. Review of Resident 86's care plan showed an intervention bed in low position initiated on 08/26/2024. Review of Resident 86's EHR showed no consent, order, or assessment about the low bed. Resident 74 Review of the EHR showed Resident 74 was admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), depression, and osteopenia (a condition that occurs when the body doesn't make new bone as quickly as it reabsorbs old bone). Resident 74 was assessed to be a fall risk and required the assistance of staff for mobility. Observation on 01/24/2025 at 10:22 AM showed Resident 74 in a low bed in their room. Review of the Resident 74's EHR showed no order, assessment, or consent for the use of the low bed. Resident 89 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed Resident 89 was admitted to the facility on [DATE] with diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety, and palliative care (approach aimed at optimizing quality of life). Resident 89 was assessed to be a fall risk and required the assistance of staff for mobility. Observation on 01/24/2025 at 10:15 AM showed Resident 89 in a low bed in their room. Review of the Resident 89's EHR showed no order, assessment, or consent for the use of the low bed. During an interview on 01/28/2025 at 10:19 AM, Staff B, Director of Nursing Services, stated a low bed could be considered a restraint and needed to have consent, assessment, order and care plan. Staff B stated the lack of these on the above-mentioned residents did not meet expectations. This is a recurring deficiency previously cited in the Statement of Deficiencies dated 12/05/2024. Reference WAC 388-97-0620

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to identify and investigate allegations of abuse/neglect for 6 of 7 sampled residents (Residents 78, 48, 77, 360, 2, and 66) when reviewed for abuse/neglect. These failures placed residents at risk of continued abuse/neglect and a diminished quality of life. Findings included . Review of facility policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated September 2022, showed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management . 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediatly to the administrator and other officials according to state law. 2. The administrator or individual making the allegation immediatly reports his or her suspicion to the following persons or agencies: the state licensing/certification agency, local/state ombudsman, resident's representative, adult protective services, law enforcement officals, the resident's attending physician and the facility medical director. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury . All allegations are thoroughly investigated. The administrator initiates investigations. Review of a facility policy titled, Accidents and Incidents - Investigating and Reporting, dated July 2017, showed all accidents or incidents involving residents, employees, visitors, vendors, etc, occurring on premises shall be investigated and reported to the Administrator. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident. Resident 78 Review of the electronic health record (EHR) showed Resident 78 admitted to the facility on [DATE] with diagnoses of palliative care (end-of-life), osteomyelitis (infection of the bone), and diabetes (too much sugar in the blood). Resident 78 was able to make needs known. Review of the care plan, initiated 08/02/2024, showed Resident 78 was dependent on staff for transfers in/out of bed with a mechanical lift. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 01/22/2025 at 10:46 AM, Resident 78 stated they were left in their power wheelchair for three nights because the facility could not locate a piece of equipment needed to transfer them into bed. Resident 78 stated they would not be left in the same situation, so they always kept the equipment in bed with them. Observation showed Resident 78 took a piece of metal with pins out from under the covers. Review of the facility's accident/incident log showed no entry for this event. During an interview on 01/29/2025 at 11:34 AM, Staff P, Certified Nursing Assistant (CNA), stated Resident 78 had told them the mechanical part was missing, and they were sleeping in their power wheelchair at night. Staff P stated they reported the incident to Staff N, Licensed Practical Nurse (LPN). During an interview on 01/29/2025 at 12:14 PM, Staff N, LPN, stated they were on vacation during the time Resident 78 was sleeping in their wheelchair at night. Staff N stated Resident 78 required a special part to be able to use the mechanical lift because the resident was an amputee. Staff N stated when told of Resident 78's allegation the staff checked on Resident 78's wounds to ensure they had not worsened, located the missing piece of equipment, then transferred Resident 78 into bed. Staff N stated they considered Resident 78's statements to be an allegation of neglect, and they had spoken with Staff B, Director of Nursing Services (DNS), about the allegations. During an interview on 01/29/2025 at 12:18 PM, Staff B, DNS, stated they were aware of an issue of locating the mechanical equipment needed to transfer Resident 78. Staff B stated the mechanical piece was located and new ones were ordered. Staff B stated an investigation was not initiated, a grievance was completed for the event, and they were unaware Resident 78 had stated they slept in their wheelchair for three nights. During an interview on 01/29/2025 at 12:31 PM, Staff F, Social Services, stated when the facility received an allegation of abuse/neglect the DNS was informed and an investigation was conducted. Staff F stated Resident 78 made an allegation of neglect when they filled out a grievance form and put it in the social services grievance box. Staff F stated they informed Staff B, DNS, of the allegations and had assumed an investigation was started. Review of the Grievance/Complaint Resolution Report, dated 01/19/2025, showed Resident 78 had completed a grievance form with the nature of the complaint/concern as missing equipment for transfers to bed, three days slept in wheelchair, and no bandage change because of lack of transfer. Department findings showed the concern was received on 01/23/2025 and the resolution was the equipment was located, a review of wound care, and new equipment was ordered. The grievance did not identify the concern being an allegation of neglect and was completed on 01/23/2025. During an interview on 01/29/2025, Staff B, DNS, stated allegations of abuse/neglect should be reported to the DNS and the resident should be protected from further abuse/neglect while an investigation was conducted. Staff B stated being left in a wheelchair to sleep for three nights would be considered an allegation of neglect. Staff B stated Resident 78 wrote the allegation on a grievance on 01/19/2025, but the social services department did not check the box it was placed in until 01/23/2025. Staff B stated staff responded to the allegation by ensuring wound care had been provided and the mechanical equipment had already been located by the time the grievance was reviewed. Staff B stated an investigation should have been more thorough to rule in/out neglect. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 48 Review of the quarterly minimum data set assessment (MDS) dated [DATE], showed Resident 48 readmitted on [DATE] with multiple diagnoses to include heart and lung disease, quadriplegia (paralysis or loss of ability to move all four limbs), anxiety, and depression. The MDS showed Resident 48 was able to make needs known, used an electric power wheelchair for mobilization, and was dependent on staff for activities of daily living. During an interview on 01/22/2025 at 2:35 PM, Resident 48 stated the facility staff had removed them from their electric wheelchair recently and placed them into a manual wheelchair due to a safety issue. Resident 48 stated a staff at the facility saw them in the middle of the road while they used their electric power wheelchair for transportation. The resident further stated they were not in the middle of the road but were driving on the side of the road and wanted their electric wheelchair back because the manual one they currently were in was uncomfortable and it did not fit their body correctly. Review of Resident 48's progress note dated 1/13/2025 showed a nursing note that documented, This morning at appox. 0850 (AM), Resident (48) was observed in a power wheelchair in roadway going toward cul de sac (street) area with bus and another car behind the resident. Reported to DNS (Director of Nursing). Referral to physical therapy for power wheelchair assessment for safety evaluation. Review of a Resident 48's document titled, Resident Agreement: Rules for Safe and Effective Operation of Power Mobility Device (PMD) dated 10/21/2024 showed a signed form that documented the resident understood when operating the PMD, it was only to be operated on sidewalks and special care taken on driveways and car thoroughfares. An additional form dated 10/21/2024 showed Resident 48 had a power-mobility driving assessment / education tool conducted at the facility and displayed adequate skill and safety to utilize a power mobility device inside and outside the facility. Review of the facility's incident log entries for 1/13/2025 to 1/22/2025 showed no incident was documented that was related to Resident 48's recent electric wheelchair safety incident that was used for their transportation on a roadway. During an interview on 01/24/2025 at 8:50 AM, Staff K, Director of Rehabilitation (DOR), stated a facility staff had witnessed Resident 48 operating their electric power wheelchair in an unsafe manner and that it was removed from them and a manual wheelchair was temporarily provided until an evaluation could take place and an interdisciplinary (IDT) meeting held to discuss the electric power wheelchair plan. During an interview on 01/24/2025 at 9:05 AM, Staff C, Assistant Director of Nursing (ADON), stated that they probably should have done an incident report on Resident 48's poor safety judgment (unsafe electric wheel operation in a roadway); however, they just conduct an interdisciplinary meeting note. During an interview on 01/24/2025 at 9:18 AM, Staff B, DNS, stated the unsafe operating of an electric wheelchair incident (operating a power wheelchair by Resident 48 in the middle of a road and in front of a bus) should have had an incident report generated and placed into the state log to address it immediately so that a thorough investigation was conducted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38344 Resident 77 Review of the EHR showed Resident 77 admitted to the facility on [DATE] and was able to make needs known. The quarterly MDS, dated [DATE], showed Resident 77 had diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), depression, and osteoarthritis (a condition that causes pain, stiffness, and reduced movement in the joints). During an interview on 01/22/2025 at 11:50 AM, Resident 77 stated about five months ago a man creeped into their room, the man had a mental problem, and staff were aware. During a follow-up interview on 01/23/2024 at 10:04 AM, Resident 77 stated about six months ago they heard the door to their room shaking, a white man with white hair kicked the door open, they told the man to get out, and they told staff about it. Review of the facility's incident reporting log from August 2024 through January 24, 2025, showed no incident logged for a resident-to-resident altercation for Resident 77. Review of the facility's grievance/concern log from August 2024 through January 20, 2025, showed no grievance/concern logged for a resident-to-resident altercation for Resident 77. Review of Resident 77's provider progress note dated 10/02/2024 showed, On 9/28/2024, [Resident 77] had a verbal altercation with a patient with Alzheimer's who attempted to enter [Resident 77's] room without permission. During an interview on 01/27/2025 at 10:08 AM, Staff E, Licensed Practical Nurse (LPN), stated if a resident-to-resident altercation occurred related to a resident trying to enter another resident's room without their permission then an incident report investigation should be implemented, both residents placed on alert charting, and be monitored for psychological harm related to the intruder. Staff E stated care plans should be updated with interventions to prevent further occurrence. Staff E stated they did not know if Resident 77's incident on 09/28/2024 was investigated; however, Resident 77's care plan showed no new interventions related to that altercation or for an intruder and there should have been some type of interventions after the incident. Staff E stated that Resident 77's 09/28/2024 resident-to-resident altercation should have been investigated. During an interview on 01/27/2025 at 10:31 AM, Staff B, DNS, stated Resident 77's resident-to-resident altercation incident on 09/28/2024 did not appear to have been investigated. Staff B stated it should have been investigated and risk management opened. Staff B stated they would have needed to know if Resident 77 was fearful at the time because they knew the resident had a history of trauma that could play into the situation. Staff B stated they did not see any interventions related to preventing an intruder or related to a resident-to-resident altercation and there should have been. During an interview on 01/27/2025 at 1:57 PM, Staff A, Administrator, stated they did not recall Resident 77's 09/28/2024 incident or that an incident report or grievance was logged for Resident 77's resident-to-resident altercation on 09/28/2024. Resident 360 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed that Resident 360 admitted to the facility on [DATE] with diagnoses to include a broken left upper thigh bone, kidney disease, and Crohn's disease (a bowel disease that affects the lining of the digestive tract and can cause stomach cramping and pain). Resident 360 was able to make needs known. During an interview on 01/29/2025 at 9:36 A, Resident 360 stated when they first arrived at the facility they were upset because they had an issue with getting their as needed pain medication and staff were aware of it. Review of Resident 360's provider telehealth visit progress note dated 01/15/2025 at 6:28 PM showed that Resident 360 had informed the provider that they had not received their pain medication since 7:00 AM this morning. It further showed Resident 360 had admitted to the facility on [DATE] from the hospital and took Dilaudid (a medication used to treat moderate to severe pain) for back and leg pain; however, no script was sent from the hospital. It showed the plan was a prescription for Dilaudid 4 milligrams (mg) orally every three hours as needed Dispense: 4 tablet, Refills: 0. Review of Resident 360's January 2025 medication administration record (MAR) showed an order for Dilaudid oral tablet 4 mg give 1.5 tablet by mouth every three hours as needed for pain with a start date of 01/14/2025 at 4:00 PM and it was discontinued on 01/15/2025 at 7:50 PM. It showed another order for Dilaudid oral tablet 4 mg give one tablet by mouth every three hours as needed for pain with a start date of 01/14/2025 at 4:00 PM and it was discontinued on 01/15/2025 at 7:50 PM; however, documentation showed that the medication Dilaudid was never provided. Review of Resident 360's EHR on 01/28/2025 showed no explanation as to why the resident did not receive the as needed pain medication Dilaudid per provider's orders or documentation to show potential neglect related to not receiving the as needed pain medication had been investigated. During an interview on 01/29/2025 at 11:14 AM, Staff E, LPN, stated they did not see follow-up documentation related to Resident 360's 01/15/2025 provider telehealth visit progress note that showed the allegation of not receiving as needed pain medication had been addressed and it should have been. Staff E stated there should have been an investigation to rule out neglect. During an interview on 01/29/2025 at 11:31 AM, Staff B, DNS, stated they were not aware of the provider telehealth visit progress note dated 01/15/2025 that showed Resident 360 reported not receiving their as needed pain medication. Staff B stated no incident was logged as reported for Resident 360's telehealth visit incident, and this did not meet expectations. Staff B stated that Resident 360's allegation should have been investigated. 49926 Resident 66 Review of the EHR showed Resident 66 was admitted to the facility on [DATE] with diagnosis to include fracture of right tibia (shin bone), diabetes (high blood sugar) and colostomy (surgically created opening in the abdomen through which waste from large intestine can be expelled). Resident 66 was able to communicate needs. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/22/2025 at 9:26 AM, Resident 66 stated they were left uncovered for about 45 minutes the previous day, it was cold, the nurse was snippy, and it took a long time to get pain medication. Resident 66 stated they reported this to the night shift nurse who covered them with a blanket. Review of the incident log and grievance log for January 2025 on 01/27/2025 showed no investigation logged under Resident 66's name. During an interview on 01/27/2025 at 10:28 AM, Staff F, Social Service, stated the night nurse should have reported the allegation and followed the facility protocol for allegations. Resident 2 Review of the EHR showed Resident 2 was admitted to the facility on [DATE] with diagnoses to included diabetes, heart failure, depression, and suicidal ideations. Resident 2 was able to communicate needs. During an interview on 01/22/2025 at 12:13 PM, Resident 2 stated the staff were unkind, they talked loudly, and said nasty things that the resident could hear. When Resident 2 was asked if they reported this to the staff, Resident 2 stated No, because when I did last time, I got people riled up. Resident 2's statements were reported to Staff A, Administrator, on 01/22/2025 at 3:10 PM. Review of the incident log and grievance log for January 2025 on 01/27/2025 showed no investigation logged under Resident 2's name. During an interview on 01/27/2025 at 10:30 AM, Staff F, Social Services, stated when there was an allegation from a resident, other residents were interviewed and an investigation was initiated. During an interview on 01/27/2025 at 12:25 PM, Staff R, Resident Care Manager, stated the process when there was an allegation from a resident was to fill out a grievance and the number one priority was to make sure the resident was safe. During an interview on 01/29/2025 at 8:32 AM, Staff B, DNS, stated they were not aware of the allegations, and it should have been identified and reported. Reference WAC 388-97-0640(5)(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide written notification of the reason for hospital transfer to the resident or responsible party and/or Washington State Long-Term Care Ombudsman program (Ombuds) for 2 of 4 sampled residents (Resident 81 & 13) reviewed for hospitalization . This failure placed the resident at risk for not knowing rights regarding transfer and discharge from the facility, and diminished protection from been inappropriately discharged . Findings included . Review of the electronic health record (EHR) showed Resident 81 admitted to the facility on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain) and diabetes (too much sugar in the blood). Resident 81 was able to make needs known. Review of Resident 81's EHR showed a hospitalization on [DATE], and readmission to the facility on [DATE]. The EHR did not show documentation a notice of transfer was provided to Resident 81 or their representative. During an interview on 01/23/2025 at 12:52 PM, Staff C, Assistant Director of Nursing (ADON), stated the resident/resident representative did not receive a written notice of transfer as they should have. Staff C stated nursing should have provided notice upon transfer or sent certified mail to the resident representative. During an interview on 01/28/2025 at 2:27 PM, Staff A, Administrator, stated the expectation was that residents received written notification at the time of transfer. 38344 Resident 13 Review of Resident 13's EHR showed the resident readmitted to the facility on [DATE] with diagnoses to include heart failure, chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) and was able to make needs known. Review of the discharge minimum data set assessment (MDS), an assessment tool, dated 08/15/2024, and the entry tracking record MDS, dated [DATE], showed Resident 13 was transferred from the facility to the hospital on 08/15/2024 and readmitted to the facility on [DATE]. During an interview on 01/28/2025 at 10:32 AM, Staff E, Licensed Practical Nurse, stated Resident 13 was provided with verbal notification for transfer to the hospital on 08/15/2024. Staff E stated they did not provide written notification for transfers to the hospital to residents and/or responsible party, only verbal notifications. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/28/2025 at 1:59 PM, Staff B, Director of Nursing Services, stated they were unable to tell by the documentation in Resident 13's EHR if a written hospital transfer form notification was sent to the hospital with the resident on 08/15/2024 or provided to the resident and it should have been. Staff B stated to check with Social Services related to the Ombuds program notifications. During an interview on 01/28/2025 at 2:14 PM, Staff F, Social Services (SS), stated the Ombuds program was not provided a written notice of transfer for Resident 13's transfer to the hospital on 08/15/2024 and should have been. Reference WAC 388-97-0120 (2)(a-d), -0140(1)(a)(b)(c)(i-iii)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide written bed hold notice at the time of transfer to the hospital for 2 of 4 sampled residents (Residents 81 and 13) reviewed for hospitalization . This failure placed the residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 81 admitted to the facility on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain) and diabetes (too much sugar in the blood). Resident 81 was able to make needs known. Review of Resident 81's EHR showed a hospitalization on [DATE], and readmission to the facility on [DATE]. The EHR did not show documentation or progress notes related to a bed hold for the hospitalization . During an interview on 01/23/2025 at 12:46 PM, Staff D, Business Office Manager (BOM), stated it was their responsibility to follow up on bed holds; however, this one was not completed due to the weekend. During an interview on 01/23/2025 at 12:52 PM, Staff C, Assistant Director of Nursing (ADON), stated residents should receive a bed hold packet at the time of transfer if they were alert and oriented. Staff C stated a bed hold was not offered but should have been. During an interview on 01/28/2025 at 2:27 PM, Staff A, Administrator, stated the expectation was that bed holds were done at the time of the resident transfer or within 24 hours and documentation scanned into the medical record. 38344 Resident 13 Review of Resident 13's EHR showed the resident readmitted to the facility on [DATE] with diagnoses to include heart failure, chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems) and was able to make needs known. Review of the discharge minimum data set assessment (MDS), an assessment tool, dated 08/15/2024, and the entry tracking record MDS, dated [DATE], showed Resident 13 was transferred from the facility to the hospital on 08/15/2024 and readmitted to the facility on [DATE]. During an interview on 01/28/2025 at 1:15 PM, Staff D, BOM, stated they did not see a bed hold form/documentation in Resident 13's EHR and there should have been. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/28/2025 at 1:59 PM, Staff B, Director of Nursing Services, stated bed holds were to be offered to all residents when transferred to the hospital and there should have been a bed hold located in Resident 13's EHR for the transfer to the hospital on 08/15/2024. Reference WAC 388-97-0120 (4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on interview and record review, the facility failed to accurately assess the status for 1 of 5 sampled residents (Resident 41) reviewed for Pre-Admission Screening and Resident Review (PASARR, a mental health screening tool). This failure had the potential to place the resident at risk for not receiving the care and services required to meet their needs. Findings included . Review of electronic health record (EHR) showed Resident 41 was admitted to the facility on [DATE] with diagnoses to include anxiety, chronic obstructive pulmonary disease (disease that blocks airflow and make it difficult to breath), depression, and personality disorder (mental and behavioral disorder associated with significant distress or disability and have negative impact on the quality of life). Resident 41 was able to communicate needs. Review of the PASARR, dated 05/07/2020, showed Resident 41 had a level 2 evaluation and required special interventions and follow up by a provider. Review of the minimum data set assessment (MDS), an assessment tool, dated 12/02/2024, showed Resident 41 was coded as not having a level 2 PASRR and not having serious mental illness. During an interview on 01/29/2025 at 9:09 AM, Staff S, Social Service Director, stated Resident 41 received a level 2 PASARR and the MDS was coded wrong. During an interview on 01/29/2025 at 9:32 AM, Staff A, Administrator, stated the MDS should have been coded as a level 2 and the MDS needed to be changed. Reference WAC 388-97-1000(1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASARR, a mental health screening tool) assessments were accurately or timely completed for 2 of 7 sampled residents (Residents 92 & 360) reviewed for PASARRs and unnecessary medications. This failure placed the residents at risk for unidentified mental health care needs and a diminished quality of life. Findings included . Resident 92 Review of the electronic health record (EHR) showed that Resident 92 admitted to the facility on [DATE] and was able to make needs known. Review of the admission minimum data set assessment (MDS), an assessment tool, dated 09/26/2024, showed Resident 92 had diagnoses of depression and insomnia. It showed Resident 92 received antianxiety, antidepressant, and hypnotic (used to induce sleep) medications. The quarterly MDS dated [DATE] showed Resident 92 had diagnoses of depression, anxiety disorder, and insomnia (sleeplessness). Review of Resident 92's level 1 PASARR, dated 09/17/2024, completed by the hospital case manager, showed Resident 92 had no serious mental illness (SMI) indicators marked on the form and no level 2 evaluation indicated. Review of Resident 92's level 1 PASRR, dated 12/10/2024, completed by the facility's Social Services Director, showed the resident had SMI indicators marked on the form for depressive and anxiety disorders. The form showed that a level 2 evaluation referral was required. During an interview on 01/24/2025 at 11:37 AM, Staff F, Social Services, stated Resident 92's 12/19/2024 level 1 PASARR was not accurate because the resident had a diagnosis of depression and received a medication for anxiety and that was not reflected on the form. Staff F stated the 12/10/2024 level 1 PASARR for Resident 92's referral for a level 2 PASARR was late and should have been referred upon admission. During an interview on 01/24/2025 at 12:00 PM, Staff B, Director of Nursing Services (DNS), stated PASARRs were to be obtained prior to admission and reviewed by social services for accuracy. Staff B stated if PASARRs were inaccurate then social services would complete another one upon admission. Staff B stated Resident 92's level 1 PASARRs did not meet expectations due to accuracy and timeliness of referral. Resident 360 Review of the EHR showed that Resident 360 admitted to the facility on [DATE] with diagnoses to include a broken left upper thigh bone and kidney disease. Resident 360 was able to make needs known. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 360's level 1 PASARR dated 01/15/2025 showed the resident admitted to the facility on [DATE] and had no SMI indicators marked on the form and no level 2 evaluation indicated. This form was completed one day after admission. Review showed no level 1 PASRR completed prior to admission or upon admission. During an interview on 01/29/2025 at 9:51 AM, Staff S, Social Service Director, stated Resident 360's 01/15/2025 level 1 PASARR did not meet expectations because it was completed late. During an interview on 01/29/2025 at 9:55 AM, Staff B, DNS, stated Resident 360's 01/15/2025 level 1 PASARR should have been completed prior to admission or upon admission and this did not meet expectations. Reference WAC 388-97-1915 (1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to develop and implement comprehensive person-centered care plans for 2 of 24 sampled residents (Residents 39 & 84) whose care plans were reviewed. Failure to develop and implement care plans that were individualized, and accurately reflected resident care needs related to impaired vision and smoking status placed residents at risk of unmet care needs and potential negative outcomes. Findings included . Resident 39 Review of the electronic health record (EHR) showed Resident 39 admitted to the facility on [DATE] with diagnoses to include heart failure, diabetes (too much sugar in the blood), and anxiety disorder. Resident 39 was able to make needs known. Review of the annual minimum data set assessment (MDS), an assessment tool, dated 09/07/2024 showed in Section B that Resident 39 had impaired vision with no corrective lenses. It showed in Section V that Resident 39's care area assessment was triggered to have a care plan for visual function developed. Review of the quarterly MDS dated [DATE] showed Resident 92 had impaired vision with no corrective lenses. Review of Resident 39's current care plan, reviewed on 01/22/2025, did not show a care plan for impaired vison. During an interview on 01/28/2025 at 1:45 PM, Staff O, MDS Nurse, stated Resident 39's care plan did not meet expectations because there should have been a care plan for impaired vision. During an interview on 01/28/2025 at 1:52 PM, Staff B, Director of Nursing Services (DNS) stated Resident 39 should have had a care plan that addressed impaired vision. Resident 84 Review of the EHR showed that Resident 84 admitted to the facility on [DATE] with diagnoses to include anemia and anxiety disorder. Resident 84 was able to make needs known. Review of Resident 84's admission MDS dated [DATE] showed Resident 84 did not use tobacco. Review of the facility's Resident Smoker List, undated, provided on 01/22/2025, showed Resident 84 smoked. Review of Resident 84's smoking evaluation dated 11/21/2024 showed the resident smoked. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 84's current care plan, reviewed on 01/22/2025, did not show a care plan for smoking. During an interview on 01/28/2025 at 10:54 AM, Staff E, Licensed Practical Nurse, stated residents' who smoked should have a smoking care plan to monitor for ashes on resident's clothes or wheelchair and to monitor for burn holes on clothing or burns on the skin. Staff E stated Resident 84 smoked; however, smoking was not addressed on the resident's care plan, and it should have been. During an interview on 01/28/2025 at 2:46 PM, Staff B, Director of Nursing Services, stated Resident 84 should of had a smoking care plan in place prior to 01/28/2025 and this did not meet expectations. Reference WAC 388-97-1020(1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed conduct timely care planning meetings with residents or responsible party for 2 of 4 sampled residents (Residents 48 & 77) reviewed for care planning. These failures placed residents at risk for unmet needs, care not provided as directed, and a diminished quality of life. Findings included . Resident 48 Review of the electronic health record (EHR) showed Resident 48 readmitted on [DATE] with multiple diagnoses to include heart and lung disease, fibromyalgia (a chronic condition characterized by widespread musculoskeletal pain and fatigue), quadriplegia (paralysis or loss of ability to move all four limbs) and depression. Resident 48 was able to make needs known and was dependent on staff for activities of daily living. During an interview at 01/22/2025 at 1:21 PM, Resident 48 stated they did not recall having a recent care conference. During an interview on 01/23/2025 at 12:11 AM, Staff S, Social Service Director, stated Resident 48's last care conference was on 05/10/2023. Staff S stated this did not meet expectations as care conferences should be held quarterly. Resident 77 Review of the EHR showed Resident 77 admitted to the facility on [DATE] and was able to make needs known. Resident 77 had diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), depression, and osteoarthritis (a condition that causes pain, stiffness, and reduced movement in the joints). During an interview on 01/23/2025 at 10:10 AM, Resident 77 stated they did not recall attending a care conference. During an interview on 01/23/2025 at 12:11 AM, Staff S, Social Service Director, stated Resident 77's last care conference was on 02/12/2024. Staff S stated this did not meet expectations as care conferences should be held quarterly. During an interview on 01/28/2025 at 2:25 PM, Staff A, Administrator, stated they were unaware of any missed or late care conferences. Staff A stated the expectation was that care conferences were to be conducted every three months unless there were extenuating circumstances. Reference WAC 388-97-1020(2)(c)(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to meet professional standards of practice for diagnosing residents with mental health disorders 1 of 5 sampled residents (Resident 2) reviewed for use of unnecessary medications. This failure placed the resident at risk for unmet needs, complications, and diminished quality of life. Findings included . Review of electronic health record (EHR) showed Resident 2 was admitted to the facility on [DATE] with diagnoses to included diabetes (high sugar in the blood), heart failure, depression and suicidal ideation. Resident 2 was able to communicate needs. Review of the EHR showed Resident 2 received a level 2 Pre-Admission Screening and Resident Review (PASARR, a mental health screening tool). Review of the PASARR level 2 showed, 2) why is [Resident 2] on quetiapine (psychoactive medication)? Admiting MD (physician) note states this is for 'schizophrenia' (mental disorder that affects a person's ability to think, feel and behave clearly), but there is no indication that [Resident 2] has this dx (diagnosis) anywhere in the records. Review of the History and Physical form, signed 04/17/2022 showed Resident 2 had no diagnosis or history of schizophrenia. Review of Resident 2's order summaries from a previous facility, dated 09/16/2022, showed the medication quetiapine was prescribed for major depressive disorder. Review of pharmacy consultation report dated 07/13/2023 showed Per CMS [Center for Medicare and Medicaid Services], schizophrenia diagnosis must be supported with DSM-5 [Statistical Manual of Mental Disorders - Fifth edition, a manual that provides information on diagnosis of mental health disorders] supportive assessment. SOM [State Operations Manual, guidance to surveyors to regulate nursing homes] states: Schizophrenia must be diagnosed by a qualified practician, using evidence-based criteria and professional standards, such as the diagnostic and Statistical Manual of Mental Disorders-Fifth edition (DSM-5) and documented in the medical record. During an interview on 01/22/2025 at 12:20 PM, Resident 2 stated I wish I can talk to someone with a sad facial expression and no eye contact. During an interview on 01/27/2025 at 12:43 PM, Staff R, Resident Care Manager, stated Resident 2 came from a different facility. When asked about the schizophrenia diagnosis, Staff R was not able to provide additional evidence of why Resident 2 had this diagnosis. During an interview on 01/29/2025 at 11:32 AM, Staff B, Director of Nursing Services, stated they would look for supporting documentation, but was not able to provide any. 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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview and record review, the facility failed to ensure a mobility device was available for 1 of 5 sampled residents (Resident 4) when reviewed for mobility. The facility failed to implement a bowel program for 2 of 5 sampled residents (Residents 24 and 108) reviewed for bowel management. These failures placed the residents at risk for unmet needs, worsening condition, and decreased quality of life. Findings included . <Mobility Device> Resident 4 Review of the electronic health record (EHR) showed Resident 4 was admitted to the facility on [DATE] with diagnoses to include malignant melanoma (skin cells that become cancerous), malnutrition, depression and diabetes (high sugar in blood). Resident 4 was able to make needs known. Observations on 01/22/2025 and 01/24/2025 showed Resident 4 lying in bed, naked. During an interview on 01/23/2025 at 9:40 AM, Resident 4 stated they did not get out of bed because the facility had not provided them a wheelchair which matched their height. Resident 4 stated they would like to be outside of the room and see the other residents. During an interview on 01/24/2025 at 1:14 PM, Staff R, Resident Care Manager, stated Resident 4 required a wheelchair which fit their height, and they did not currently have one. During an interview on 01/29/2025 at 8:30 AM, Staff B, Director of Nursing Services, stated the residents were offered to go out of their rooms and Resident 4's status of no wheelchair to fit their height or way to get out of their room did not meet expectations. 51907 <Bowel Management> Resident 24 Review of the EHR showed Resident 24 admitted to the facility on [DATE] with diagnoses that included chronic pain and other psychoactive (affecting the brain) substance dependence. Review of the quarterly minimum data set assessment (MDS), an assessment tool, dated 12/16/2024, showed Resident 24 was incontinent of bowel and bladder. The MDS showed Resident 24 could voice their needs and preferences. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provider orders showed Resident 24 had orders for the following medications for constipation: Colace two times daily, Senna Plus in the evening, milk of magnesia (MOM) as needed if no bowel movement in three days, Dulcolax suppository as needed if no result from MOM by next shift, Fleet Enema as needed if no result from Dulcolax within 2 hours. Review of the January 2025 bowel monitoring task showed Resident 24 did not have a bowel movement form 01/01/2025 through 01/05/2025. Review of the medication administration record (MAR) for January 2025 showed Resident 24 was administered MOM on 01/05/2025 at 12:25 PM. The next documented bowel movement was 01/06/2025 at 08:04 PM, greater than 24 hours after administration of MOM. Review showed Dulcolax or Fleet Enema were not administered per provider order. Review of the January 2025 bowel monitoring task showed that Resident 24 had no bowel movement from 01/17/2025, through 01/20/2025. Review of the MAR showed no MOM, Dulcolax, or Fleet enema were documented as provided. Resident 108 Review of the EHR showed Resident 108 admitted to the facility on [DATE] with diagnoses that included major depressive disorder and anxiety disorder. Review of the quarterly MDS, dated [DATE], showed Resident 108 was frequently incontinent of bowel and bladder. The MDS showed Resident 108 could voice their needs and preferences. Review of provider orders, dated 02/04/2023, showed Resident 108 had orders for the following constipation medications: Miralax powder daily, MOM as needed if no bowel movement in 3 days, Dulcolax suppository if no result from MOM by next shift, Fleet Enema if no result from Dulcolax within two hours. Review of the January 2025 bowel monitoring task showed Resident 108 did not have a bowel movement from 01/01/2025 through 01/05/2025. Review of the MAR for January 2025 showed MOM was administered on 01/05/2025 at 1:09 PM for constipation. Review of the EHR showed Resident 108 had a large bowel movement on 01/06/2025 at 11:39PM, more than 24 hours after the administration of MOM. Review of the EHR showed Dulcolax or fleet enema were not administered per provider order. During an interview on 01/27/2025 at 12:10 PM, Resident 108 stated they only received bowel medications when they asked for it and it was not offered. Resident 108 stated they were supposed to have a bowel movement at least every three days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/27/2025 at 10:57 AM, Staff E, Licensed Practical Nurse (LPN), stated if a resident did not have a medium or large bowel movement for greater than 72 hours, the facility charting system would alert the staff, who would then follow the bowel protocol per providers orders. Staff E stated if a resident did not have a bowel movement for more than 72 hours, it would show up on the dashboard where all the nurses could see it and they could initiate the protocol. Staff E stated the information on who needed bowel medications was filled out on a paper form that was passed from nurse to nurse until the resident had a bowel movement. Staff E stated the nurses would document what medication was given with the date and time. During an interview on 01/28/2025 at 10:16AM, Staff B, Director of Nursing Services (DNS), stated their expectation was the nurse would assess the resident and initiate the bowel protocol per providers orders if a resident did not have a bowel movement for more than 72 hours. Reference WAC 388-97- 1060 (1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure an ordered intervention (Low Air Loss Mattress - LALM, a mattress used to redistribute pressure evenly and can help prevent pressure ulcers, also known as bedsores) was being monitored and used as directed in the prevention of pressure ulcers for 3 of 7 residents (Residents 73, 83, and 18) when reviewed for pressure wound related interventions. This failure prevented the facility implementing the plan of care that included the needed intervention (LALM) to promote wound healing and prevent decline. Findings included . The National Pressure Ulcer Advisory Panel (NPUAP) dated 02/20/18, described/defined that a suspected deep tissue injury as: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This injury can result from prolonged pressure and may either resolve or develop into further tissue loss. Findings included . Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 12/12/2024 showed Resident 73 admitted on [DATE] with diagnoses to include heart and lung disease, hospice (care provided to sick or terminally ill residents), dementia, and malnutrition. The electronic health record (EHR) showed the resident was able to make needs known, received hospice care, was dependent on staff for all activities of daily living (ADLs) and had pressure ulcers to buttocks area and both heels. Review of Resident 73's provider's order dated 01/17/2025 showed licensed nurses (LNs) were to monitor functioning and setting of LALM every shift. Resident 73's treatment administration record (TAR) showed LNs were documenting they were monitoring functioning and the settings of the LALM every shift. Review of the care plan, dated 11/14/2024, showed Resident 73 had actual skin breakdown to the sacral (buttocks area) related to decreased activity, limited mobility and generalized weakness. Several interventions to assist in healing the resident's wound skin impairment included for the use of an air mattress for pressure reduction. During an interview and observation on 01/24/2025 at 1:24 PM, Staff H, Licensed Practical Nurse (LPN), stated Resident 73 required wound/skin care to both heels. Resident 73 was observed in bed, the head of the bed was slightly raised, and foam soft booties were noted on the resident's lower extremities (heels) and were slightly elevated. Staff H stated the wound care to the resident's buttocks was already conducted in the early AM by an outside wound care provider; however, Staff H stated they still needed to conduct skin care to the resident's lower extremities (heels). An LALM was observed in use and was inflated with the device set at 200 lbs. When asked whether Resident 73 weighed 200 lbs. Staff H stated the resident did not weight that amount and that the LALM setting was incorrect based on the resident's weight. Review of Resident 73's EHR dated 11/01/2024 showed the resident last weight was 126.8 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 01/24/2025 at 1:15 PM, Staff E, Licensed Practical Nurse (LPN), stated the resident's air mattress was set up by the facility's maintenance department personnel and it should be set and locked for the resident's current weight. Staff E stated the licensed nurses were to monitor and check the settings every shift; however, during a review of the resident's EHR no settings were documented per Staff E. During an interview on 01/24/2025 at 1:23 PM, Staff J, Maintenance Assistant (MA), stated they would set up the resident's LALM mattresses whenever they were notified a resident needed one and would view or eyeball the residents to get a range that the mattress needed to be inflated to. Staff J stated they usually set and locked the mattress settings based on the closest to the resident's weight range (i.e. 150-200 lbs.) During an interview and observation on 01/24/2025 at 2:09 PM, Staff E entered two additional facility resident rooms (Resident's 83 and 18), and who both had providers orders for LALM usage, revealed incorrect LALM weight settings based on their current weights. Resident 83's last weight reviewed within the resident's EHR dated 01/03/2025 was documented as 83 lbs.; however, the LALM setting was observed to be set at 200 lbs. Resident 18's EHR documented a weight of 90 lbs.; however, the LALM setting was locked at 400 lbs. Staff E stated both resident's LALM setting were incorrect based on their weights and would need to be changed to the correct setting. During an interview on 01/24/2025 at 1:34 PM, Staff C, Assistant Director of Nursing (ADON), stated their expectation would be once an order was received from the provider for the use of an LALM, the maintenance staff was directed to set up the resident's mattress based on the residents' weights and the LNs were to ensure the LALM were being monitored and set at the correct settings. Reference WAC 388-97--1060(3)(b)(j)(viii)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure risk factors were consistently monitored and addressed to minimize the risk for accident hazards for 2 of 7 residents (Residents 94 and 86) when reviewed for accident hazards. The failures to consistently monitor and ensure a wanderguard devices was functional for Resident 94 and to identify and minimize the risk factors for falls for Resident 86 placed them at risk for potential injury, negative outcomes and decreased quality of life. Findings included . Review of a facility's policy titled, Tab Alarms, Bed Alarms, Wanderguard System, dated 12/12/2024, showed the wanderguard (a wearable device used to monitor and alert caregivers when a resident with dementia or cognitive impairment attempts to leave a safe area) would be used for residents at risk for elopement (when a resident identified as wandering leaves the facility without staff knowledge or authorization). A plan of care must be formulated with the Interdisciplinary Team (Nursing, Physical Therapy, Occupational Therapy, Dietary, Activities, Social Worker and Resident/Family) to determine the need for the device and documented in the resident's care plan. In addition, the wanderguard bracelets were to be checked (monitored) daily. Resident 94 Review of the quarterly Minimum Data Set (MDS, a required assessment tool), dated 01/01/2025, showed Resident 94 admitted on [DATE] with multiple diagnoses to include heart disease, stroke, dementia, anxiety and depression. The MDS showed the resident had significant level of cognition impairment and was dependent on staff for assistance with activities of daily living (ADLs) Review of Resident 94's Elopement Risk, form, dated 11/25/2024, showed they were able to ambulate (walk) or self-propel a wheelchair independently, had a history of actual elopement or attempted elopement, and wandered to places that placed the resident at significant risk of getting to potentially dangerous places (i.e. outside the facility). An additional elopement assessment dated [DATE], conducted by a facility's Licensed Nurse (LN), had checked a box on the document that showed the resident exhibited a behavior that may result in exit -seeking behavior, - hovering near exits. Review of Resident 94's current care plan, multiple dates, showed Resident 94 had impaired / decline in cognitive function impaired thought processes related to the condition, dementia, had short term memory loss, impaired decision making and had a wanderguard placed. Interventions included for staff LNs to ensure the wanderguard was functioning properly every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 94's past incident reports showed on three separate occasions the resident had successfully eloped to outside the facility. On 11/24/2024 the resident had signed themselves out of the facility. Per the incident report the front door receptionist noted it was not a normal occurrence and called the nurse's station whereas a nurse came to assist and brought the resident back in from a sidewalk. A repeat elopement assessment was conducted on 11/25/2024 and the wanderguard was placed. The second elopement occurred on 01/06/2025 whereas the resident was found by a community member at a nearby apartment complex from the facility. The wanderguard was noted to be in place and was tested to be functional upon the resident's return; however, the document indicated the Alarm off. The third elopement incident was dated 01/18/2025 and a description of the event documented that another facility resident had called the nurse's station to inform staff that Resident 92 was walking away from the building. A nurse walked outside to retrieve the resident and brought them back inside. The resident's wanderguard was tested again and found to be functioning; however, the incident documented that the nursing staff had not heard the alarm that was set off from the facility's front door. Review of Resident 94's treatment administration record (TAR) for December 2024 and January 2025 showed a provider's order dated 12/24/2024 for the LNs to check the function of the wanderguard every shift. Review of the December 2024 TAR wanderguard order showed the LN's had not documented they had checked (initialed) off the wanderguard was functional for evening and night shift. A continued review of the January 2025 TAR showed multiple dates throughout January of blank documentation entries that the LNs had checked the function of the resident's wanderguard. The January 2025 missing entries included 01/07/2025- (day shift), 01/08/2025- evening and night shift, 01/20/2025-day shift, 01/26/2025- evening and night shift, and 01/27/2025 evening shift. During an interview and observation on 01/28/2025 at 10:57 AM, Staff N, Licensed Practical Nurse (LPN), was asked whether they had tested Resident 94's wanderguard on their shift yet and what the procedure they used to determine whether the device was functional. Staff N responded they had not tested the device today but stated they would usually place the resident into a wheelchair and wheel them to a nearby hallway exit door that had a wanderguard sensor receiver to test the device. Staff N stated the resident's wrist wanderguard would then be placed by the exit door sensor which would alarm. Staff N was observed to position the resident by the exit door sensor and held the resident's wrist with the wanderguard to and against the wanderguard door sensor; however, no alarm was generated or was audible. Staff N was directed to find a portable hand held wanderguard scanner (tester) and to test the resident's wanderguard. A portable handheld wanderguard scanner was eventually found after several minutes, but again this device also did not appear to generate a positive functionality test. During an interview and observation on 01/28/2025 at 11:14 AM, Staff B, Director of Nursing (DNS), stated they would test a brand new wanderguard at the facility's front door. Staff B was then observed to pass the device by the facility's front of the door wanderguard sensor, however, no audible alarm was generated until Staff B passed the device a short distance pass the sensor toward the front or exterior portion of the door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/28/2025 at 1:21 PM showed Staff B informed Staff N to remove Resident 94's wrist wanderguard. The resident's wanderguard was then re-checked by Staff B at the exit hallway door and an audible alarm was generated when it was passed through or out the door to the exterior (outside). Staff B stated the wanderguards were not to be checked in this manner, but rather with the handheld wanderguard scanner. Staff B directed Staff N to find another wanderguard scanner and one was found in another medication cart which achieved a positive functionality check and produced a green light flash. During an interview on 1/28/2025 at 11:42 AM, Staff B, Director of Nursing Services (DNS), stated the expectation would be for Staff LNs to check and ensure the resident's wanderguard was functional as per the provider's orders every shift and document in the TAR. Staff B stated it was their expectation the LNs were knowledgeable and educated on the correct wanderguard testing procedures. 49926 Resident 86 Review of the EHR showed Resident 86 was admitted to the facility on [DATE] with diagnoses to include intracranial hemorrhage in brain (bleeding in the brain), anxiety, depression and aphasia (inability to verbally communicate). Resident 86 was not able to communicate their needs. Multiple observations on 01/23/2025 and 01/27/2025 showed Resident 86 sat in a tilt in space wheelchair in front of the nurse's station and frequently reached or gestured towards staff and passersby. Review of EHR showed Resident 86 had 3 falls: on 11/13/2024 at 7:20 PM in the dining room, 12/22/2024 at 6:45 PM in the resident's room, and 01/17/2025 at 9:40 PM in the dining room. Review of the fall investigation for the fall on 12/22/2024 showed a new intervention to assist the resident to bed after administration of evening medications. Review of the care plan showed the intervention for the 12/22/2024 fall was not included in the resident's care plan and Resident 86 had a repeat fall in the dining room. During an interview on 01/24/2025 at 1:14 PM, Staff R, Resident Care Manager, stated part of the process after a fall was to update the care plan. Reference WAC 388-97-1060(3)(g)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to ensure the facility's Registered Dietician's (RD) recommendations were administered as ordered to prevent continued weight loss for 1 of 3 sample residents (Resident 73) reviewed for nutrition. This failure placed the residents at risk for unmet nutritional needs and continued weight loss. Findings included . Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 12/12/2024 showed that Resident 73 admitted on [DATE] with diagnoses to include heart and lung disease, hospice (end of life care), dementia (progressive decline in brain functions), and malnutrition. Review of the electronic health record (EHR) showed the resident was able to make needs known, received hospice care (care provided to sick or terminally ill residents), was dependent and required substantial/maximal assistance by staff to assist with meals. Review of a Registered Dietitian (RD) assessment dated [DATE] showed Resident 73 would benefit from increased protein supplementation for increased needs due to newly identified pressure wounds (skin sores that develop due to prolonged pressure due to immobility and exacerbated by lack of essential nutrients like protein, vitamins and minerals). The RD documentation showed the resident had an order for the licensed nurses (LNs) to administer Med Pass 2.0 (a fortified nutritional shake, to supplement calories and protein) as necessary for supplementing the resident's intake when it was less than 50%. The RD assessment notes showed Resident 73 required one-on-one assistance with meals and would need continued assistance and encouragement for intake at meals and supplemental Med Pass 2.0 for better nutritional intake. Review of Resident 73's current care plan, multiple dates, showed the resident was at nutritional risk due to poor food and fluid intake due to poor intake of fluids and food. Several interventions included for staff to provide the house supplement (Med Pass 2.0) as ordered. Review of Resident 73's EHR task section for dietary intake showed the facility staff had documented multiple entries the resident had eaten less than 25-50% of their meals. Review of Resident 73's December 2024 and January 2025 medication administration records (MARs) showed a provider's order dated 6/14/2024 for the LNs to administer Med Pass 2.0 as needed for supplementing intake and optimizing nutrition if oral intake was less than 50% and to offer 240 milliliters (mls). The December 2024 and January 2025 MAR showed no documentation that the Med Pass 2.0 was administered to the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 73's EHR clinical notes dated 12/29/2024, 01/01/2025, and 01/13/2025 showed the resident refused or ate 0% of the last three meals/snacks provided; however, the EHR showed no refusal or offer Med Pass 2.0 being documented as being offered. On 01/22/2025 an additional clinical note was documented by the RD for the order for Med Pass 2.0 for oral intake less than 50% and the resident's dietary intake remained poor, a new recommendation was made to change the med pass from as necessary to routine 120 ml twice a day to provide additional calories and protein to meals. During an interview on 01/22/2025 at 12:55 PM, Resident 73's family member stated the resident had lost weight and had observed the facility staff appeared to be rushed during mealtimes whenever they (facility staff) were to feed the resident. During an interview on 01/23/2025 at 2:42 PM, Staff E, Licensed Practical Nurse (LPN), stated the expectation would be the Certified Nurse Aide (CNA) who assisted with feeding the resident and who had recorded their intake less than 25-50% intake would inform the LN. The expectation then would be for the LN to administer the as necessary (PRN) Med Pass nutritional supplement as ordered. During an interview on 01/23/2025 at 2:45 PM, Staff C, Assistant Director of Nursing (ADON), stated if the resident had a poor intake (less than 25%) and was recorded it would then show up on the resident's EHR dashboard to update the LN who could then provide the needed intervention (Med pass nutritional supplementation) as indicated in the resident's PRN orders. During a telephonic interview on 01/30/2025 at 11:15 AM, Staff G, RD, stated their expectation would be for the LN to administer and document the resident's Med Pass supplement as ordered whenever the resident had less than 50% of their dietary intake. Reference WAC 388-97-1060 (3)(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with provider orders for 1 of 2 sampled residents (Resident 59) reviewed for respiratory care. Failure to follow provider's orders for oxygen (O2) therapy placed residents at risk for unmet needs and potential negative outcomes. Findings included . Review of the electronic health record (EHR) showed Resident 59 admitted to the facility on [DATE] with diagnoses that included dementia (a condition affecting memory, thinking and social abilities) and asthma. Resident 59 used oxygen therapy. Review of current provider orders, dated January 2025, showed Oxygen at 1-2 liters per minute by nasal canula every day and night shift. Observations throughout the day on 01/23/2025 and 01/24/2025 showed an unused O2 concentrator with no oxygen tubing in the corner of the room. Resident 59 was not observed wearing a nasal canula or using oxygen. During an interview on 01/24/2025 at 1:03 PM, Resident 59 stated they had not used oxygen while admitted to the facility. Review of the January 2025 Medication Adminstration Record showed staff signed off daily that Resident 59 was utilizing oxygen as ordered. During an interview on 01/24/2025 at 1:07 PM, Staff U, Registered Nurse (RN), stated they had signed the oxygen was administered on 01/24/2025 and in the past because the Resident 59's O2 saturation levels were always above 92%. During an interview on 01/24/2025 at 1:18 PM, Staff B, Director of Nursing (DNS), stated the expectation was that the provider orders were followed, and staff should not have been signing if the resident was not using the oxygen. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51907 Based on interview and record review, the facility failed to provide pain medication per provider's order to ensure a resident was able to participate in physical therapy services for 1 of 5 sampled residents (Resident 24) reviewed for position and mobility. This failure placed residents at risk of decreased mobility, increased pain, unidentified and unmet care needs, and a diminished quality of life. Findings included . Review of the facility's document Pain Protocol, dated October 2022, showed the nursing staff would assess each individual for pain upon admission to the facility, at the quarterly review, whenever there was a significant change in condition, and when there was onset of new pain or worsening of existing pain. Review of the electronic health record (EHR) showed Resident 24 admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (a chronic neurological disorder), pressure ulcer of right hip (a deep wound that may impact muscle, tendons, ligaments, and bone), chronic pain (pain lasting three months or longer), paraplegia (weakness or paralysis to the lower limbs), muscle weakness, need for assistance with personal care, pain in joints of right hand, and contracture (a permanent tightening of the muscles) of the right hand. Review of the quarterly minimum data set (MDS, an assessment tool), dated 12/16/2024, showed Resident 24 was able to make needs known. Review of the care plan dated 06/08/2017 showed, Evaluate and medicate for pain, as appropriate, prior to activity or rehabilitation program. Review of the provider's orders showed Resident 24 had an order for a fentanyl patch (a pain medication) every 72 hours, dated 05/29/2024, an order for oxycodone (a pian medication) every 6 hours, dated 06/19/2023, and an order for morphine sulfate (a pain medication) every 8 hours as needed for pain, dated 02/21/2024. Review of the EHR showed Resident 24's last pain assessment was completed on 03/26/2024. Review of the restorative flow sheets (tracking of services to exercise joints) showed Resident 24 refused the restorative program multiple times due to pain during October 2024, November 2024, and December 2024. Review showed the resident refused services due to pain on the following dates: 10/22/2024, 10/24/2024, 10/31/2024, 11/06/2024, 11/07/2024, 11/11/2024, 11/12/2024, 11/16/2024, 12/10/2024, 12/11/2024, 12/12/2024, 12/16/2024, 12/19/2024, and 12/24/2024. Review of the October 2024, November 2024, and December 2024 medication administration record (MAR) showed pain medication was not administered to Resident 24 for 12 of the 14 refusals for pain or discomfort. Review showed non-pharmacological interventions (methods to reduce pain without medication) were not offered to Resident 24 for pain for these refusals. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2025 MAR showed out of 19 occurrences of pain rated 6-8 (moderate to severe pain), Resident 24 was not offered pain medication or non-pharmacological interventions for 15 occurrences. During an interview on 01/27/2025 at 10:57 AM, Staff E, Licensed Practical Nurse (LPN), stated if a resident refused care due to pain, they would educate and have conversations with the resident. Staff E stated the staff would offer as needed pain medication or cream. During an interview on 01/27/2025 at 1:38 PM, Staff M, Certified Nursing Assistant (CNA), stated the resident had pain with their care often and they reported it to the nurse when it occurred. During an interview on 01/27/2025 at 2:39 PM, Resident 24 stated if they had pain during care, they would notify staff by using their call light and the nurse would bring their pain medication. Resident 24 stated if they had pain during restorative and therapy sessions, they massaged the painful area and tried to get through the pain. Resident 24 stated they felt their pain medications were not effective enough to control their pain and felt the pain medication was starting to wear off. During an interview on 01/28/2025 at 10:00 AM Staff K, Director of Rehabilitation Services, stated Resident 24 complained of tightness in their joints, and not pain. Staff K stated Resident 24's wound caused discomfort, and the resident refused full range of motion due to their pain. During an interview on 01/28/2025 at 10:14 AM, Staff C, Assistant Director of Nursing (ADON), stated if a resident consistently refused therapy due to pain, the staff would talk with the resident, assess if pain was a potential concern, and inform therapy. During an interview on 01/28/2025 at 10:16 AM Staff B, Director of Nursing, stated staff would perform a pain assessment for a change in condition or a change in pain level. During an interview on 01/28/2025 at 11:38 AM, Staff L, LPN, stated if a resident refused their restorative program due to pain, the nurses would assess pain levels and administer as needed pain medications. During an interview on 01/28/2025 at 2:38 PM, Staff C, ADON, stated Resident 24 should have been offered pain medication before their restorative or therapy sessions. Staff C stated Resident 24 should be offered pain medications when they complained of pain. Reference WAC 388-97-1060 (1)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49926 Based on observation, interview, and record review, the facility failed to ensure there was a registered nurse (RN) working a minimum of eight hours each day for 60 of 92 days when reviewed for staffing. This failure placed the residents at risk for delayed assessments/treatments and a diminished quality of care. Findings included . Review of the working nursing schedule for the month of July 2024 showed no RN scheduled for 23 of 31 days. Review of the working nursing schedule for the month of August 2024 showed no RN scheduled for 19 of 31 days. Review of the working nursing schedule for the month of September 2024 showed no RN scheduled for 18 of 30 days. During an interview on 01/29/2025 at 9:36 AM, Staff Q, Staffing Coordinator, stated they did their best with the RN nurses that were available and were scheduled, and the facility just did not have enough. During an interview on 01/30/2025 at 10:15 AM, via electronic communication, Staff B, Director of Nursing Services, stated the expectation was for the staffing coordinator to prioritize RN coverage. Staff B stated not having the minimum eight hour daily RN coverage did not meet expectation. Reference WAC 388-97-1080(3)(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to act on the consultant pharmacist's medication regimen review (MRR) recommendations and/or to have clearly documented rationale for not following the recommendation for 1 of 5 sampled residents (Resident 92) reviewed for unnecessary medication use. This failure placed the resident at risk for experiencing adverse side effects, medical complications, and a decreased quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 92 admitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set assessment (MDS), an assessment tool, dated 12/19/2024 showed Resident 92 had diagnoses of depression, anxiety disorder, and insomnia (sleeplessness). Review of Resident 92's provider orders showed an order dated 09/19/2024 for Clonazepam (antianxiety medication) 0.5 milligrams (mg) two times a day for anxiety and an order dated 11/15/2024 for Zolpidem Tartrate (a hypnotic medication used to treat sleeplessness/insomnia) 5 mg as needed for severe intermittent insomnia at bedtime for six months. Review of Resident 92's pharmacist consultation report recommendation from 10/09/2024 through 10/10/2024, signed by the provider on 10/18/2024, showed to reduce future risk of falls consider the recommendation to reduce clonazepam to 0.5 mg to once a day in the evening with future discontinuation of the medication, if able. The form showed the provider declined the recommendation and did not wish to implement any changes due to a handwritten note that showed working with mental health has the rest of the sentence was not legible. Review of Resident 92's pharmacist consultation report recommendation from 11/11/2024 through 11/13/2024, signed by the provider but not dated, showed Resident 92 had an order for Zolpidem Tartrate 5 mg one tablet by mouth as needed for sleeplessness/insomnia. It showed to consider discontinuing the as needed (PRN) Zolpidem or if the medication could not be discontinued at that time, document the indication for use, the intended duration of therapy, and the rationale for the extended period. Review showed an example as X [times] 6 months for severe intermittent insomnia. The rationale for the recommendation showed, CMS [Centers for Medicare and Medicaid Services] requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber had required documentation for extended use. It showed the provider accepted the recommendation with the following modifications, See Attachment However, there was no form attached to the report. Review of Resident 92's form tiled, PRN Psychotropic Review, signed by the provider on 11/15/2024, showed the rationale to extend Zolpidem 5 mg six months was due to a Failed GDR. [Gradual dose reduction, a trial to discontinue or reduce medication use] Severe intermittent insomnia. This document did not show directions for the medication (i.e. frequency or route the medication was to be provided). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 92's January 2025 medication administration records (MAR) from 01/01/2025 - 01/23/2025 showed the resident was provided clonazepam 0.5 mg two time a day for anxiety and PRN Zolpidem Tartrate 5 mg by mouth for severe intermittent insomnia at bedtime for 6 months. Documentation showed Resident 92 received Zolpidem 10 out of 23 days. During an interview on 01/24/2025 at 12:12 PM, Staff E, Licensed Practical Nurse (LPN), stated Resident 92 admitted to the facility on [DATE] and they were unable to locate documentation in Resident 92's EHR that a GDR for Zolpidem Tartrate had been conducted. Staff E stated there should have been documentation to clearly show that a GDR was done for Zolpidem; however, the provider scripts (instruction orders for the medication) showed the order had been used continuously. During an interview on 01/24/2025 at 1:30 PM, Staff B, Director of Nursing Services, stated they were unable to locate documentation in the mental health provider note dated 10/12/2024 that showed Resident 92's Clonazepam use was discussed/reviewed for a GDR. Staff B stated Resident 92 was being provided Clonazepam twice a day and the provider note dated 10/19/2024 did not address the pharmacy recommendation for a decrease in Clonazepam. Staff B stated they needed to obtain provider clarification for the rationale of not following pharmacy's October 2024 recommendation and this should have been clarified and addressed sooner. In continued interview on 01/24/2025 at 1:30 PM, Staff B stated Resident 92 received as needed Zolpidem Tartrate regularly in November and December 2024 and continued to receive it in January 2025. Staff B stated they were unable to locate documentation to show a GDR was conducted for Zolpidem Tartrate per Resident 92's November 2024 pharmacy recommendation and this did not meet expectations. Reference WAC 388-97-1300(4)(c)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to provide non-pharmacological (non-medicated) interventions (NPI) prior to as needed (PRN) pain medications for 6 of 8 sampled residents (Residents 78, 48, 94, 92, 360, and 87) when reviewed for unnecessary medications. These failures placed residents at risk for taking unnecessary medications, avoidable side effects, and a diminished quality of life. Findings included . Resident 78 Review of the electronic health record (EHR) showed Resident 78 admitted to the facility on [DATE] with diagnoses of palliative care (end-of-life), osteomyelitis (infection of the bone), and diabetes (too much sugar in the blood). Resident 78 was able to make needs known. Review of current provider's orders showed Resident 78 received a narcotic pain medication PRN and NPI were to be provided prior to the use of the PRN pain medication. Review of the medication administration record (MAR) showed Resident 78 received nearly daily PRN pain medication in December 2024 and January 2025. Review showed no NPI were provided during these months. During an interview on 01/29/2025 at 11:49 AM, Staff B, Director of Nursing Services (DNS), stated the facility would provide NPI prior to the use of PRN pain medications to ensure the PRN pain medications were necessary. Staff B stated Resident 78 had orders for a PRN pain medication and NPI prior to the use of it. Staff B stated Resident 78 used the PRN pain medication nearly daily and NPI were not provided in the months of December 2024 and January 2025, and this did not meet their expectation. 34567 Resident 48 Review of the quarterly minimum data set assessment (MDS), dated [DATE], showed Resident 48 readmitted on [DATE] with multiple diagnoses to include heart and lung disease, fibromyalgia (a chronic condition characterized by widespread musculoskeletal pain and fatigue), quadriplegia (paralysis or loss of ability to move all four limbs), radiculopathy (a condition whereas one or more nerve roots in the spinal column becomes compressed and irritated), anxiety and depression. The electronic health record (EHR) showed Resident 48 was able to make needs known and was dependent on staff for all activities of daily living. Review of Resident 48's current care plan, multiple dates, showed the resident exhibited or was at risk for alterations in comfort related to chronic pain and musculoskeletal disorder. Interventions on the care plan documented licensed nurses (LN) were to monitor for pain and attempt NPI to alleviate pain and document effectiveness. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 48's MAR for January 2025 showed a provider's order dated 09/24/2024 for staff to administer oxycodone (a medication used to treat moderate to severe pain) every four hours as needed for chronic pain and an additional order dated 10/18/2021 for the LN staff to administer acetaminophen (a medication used to treat mild pain) every 4 hours as needed for mild pain. Multiple entries showed that the LNs had administered pain medications as directed; however, the non-pharmacological interventions that were ordered were not being consistently documented within Resident 48's MAR. Review of January 2025 MAR showed an additional provider's order dated 01/13/2025 for the LNs to document nonpharmacological interventions (NPIs) to include, A. Repositioning, B. Relaxation, C. Food/Fluid, D. Massage, E. Exercise, F. Immobilization of joint, G. Other, write in progress note as needed Document results, R. Results non-pharm (-) ineffective (+) effective. The document showed no documentation of any LN initials to indicate NPI were administered on the January 20025 MAR. Resident 94 Review of the quarterly MDS, dated [DATE], showed Resident 94 admitted on [DATE] with multiple diagnoses to include heart disease and stroke, osteomyelitis, dementia (a progressive decline in mental functions), anxiety and depression. The MDS showed the resident with significant level of cognition impairment and was dependent on staff for assistance with activities of daily living (ADLs) Review of the MAR dated January 2025 showed a provider's order dated 10/07/2024 for staff to administer Hydrocodone-Acetaminophen 1 tablet (a medication used to treat moderate pain) every eight hours as needed for moderate pain and an additional order dated 10/07/2024 for the LNs staff to administer Hydrocodone-Acetaminophen 2 tablet every eight hours as needed for moderate to severe pain. Multiple entries showed that the LNs had administered the as necessary pain medications as directed; however, the NPIs that were ordered were not being consistently documented within Resident 48's MAR. Review of January 2025 MAR showed an additional provider's order dated 01/13/2025 for the LNs to document NPI to include, A. Repositioning, B. Relaxation, C. Food/Fluid, D. Massage, E. Exercise, F. Immobilization of joint, G. Other, write in progress note as needed Document results, R. Results non-pharm (-) ineffective (+) effective. The document showed no documentation of any LN initials to indicate NPI were administered on the January 20025 MAR. During an interview on 01/28/2025 at 1:48 PM, Staff C, Assistant Director of Nursing (ADON), stated the expectation would be for the LNs to first attempt NPIs prior to the administration of the PRN pain medications. 38344 Resident 92 Review of the EHR showed Resident 92 admitted to the facility on [DATE] and was able to make needs known. The quarterly MDS, dated [DATE], showed Resident 92 had diagnoses of atrial fibrillation (irregular heart rate), anxiety disorder, and insomnia (sleeplessness). (continued on next page)

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	505485	A. Building B. Wing	01/29/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 92's provider's orders showed an order for a narcotic (used to treat moderate to severe pain) medication to be provided as needed for pain and an order for nonpharmacological interventions to be provided prior to use of as needed pain medication with results to be documented if effective or ineffective. Review of Resident 92's January 2025 MAR from 01/01/2025 - 01/23/2025 showed Resident 92 received as needed narcotic pain medication 77 times and order for nonpharmacological interventions and results were blank and showed no documentation. During an interview on 01/24/2025 at 1:06 PM, Staff T, Licensed Practical Nurse (LPN), stated Resident 92 should have had non-pharmacological interventions documented in the January 2025 MAR prior to use of a narcotic medication being provided and that did not happen for Resident 92. During an interview on 01/24/2025 at 2:13 PM, Staff B, Director of Nursing Services (DNS), stated non-pharmacological interventions were to be offered/provided prior to giving as needed pain medications to residents, and documented in the MAR. Staff B stated Resident 92's January 2025 MAR should have had non-pharmacological interventions documented prior to the resident receiving the narcotic medication and this did not meet expectations. Resident 360 Review of the EHR showed that Resident 360 admitted to the facility on [DATE] with diagnoses to include a broken left upper thigh bone, kidney disease, and Crohn's disease (a bowel disease that affects the lining of the digestive tract and can cause stomach cramping and pain). Resident 360 was able to make needs known. Review of Resident 92's provider's orders showed an order dated 01/14/2025 for acetaminophen (used to treat minor aches and pains) every four hours as needed for pain and an order dated 01/15/2025 for a narcotic medication to be provided every three hours as needed for pain. Review of the MAR dated January 2025 from 01/01/2025 - 01/28/2025 showed Resident 360 received as needed acetaminophen two times and the as needed narcotic 23 times. This MAR showed no order for non-pharmacological interventions documented for Resident 360. During an interview on 01/29/2025 at 10:01 AM, Staff E, LPN, stated Resident 360 had no non-pharmacological interventions documented in their January 2025 MAR prior to receiving as needed pain medications and there should have been. During an interview on 01/29/2025 at 10:13 AM, Staff C, ADON, stated there were no non-pharmacological interventions documented on Resident 360's January 2025 MAR and there should have been, and this did not meet expectations. 46067 Resident 87 Review of EHR showed Resident 87 admitted to the facility on [DATE] with a diagnosis of dementia. Resident 87 required moderate assistance and was able to make needs known. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 87's provider's orders showed an order dated 07/19/2024 for acetaminophen two tablets every six hours as needed for mild pain. Review of the December 2024 MAR showed Resident 87 received acetaminophen five times. The December MAR showed no non-pharmacological interventions were documented for Resident 87. During an interview on 01/27/2025 at 1:55 PM, Staff B, DNS, stated the expectation was that non-pharmacological interventions were attempted and documented prior to administering pain medications. Reference WAC 388-97-1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to conduct gradual dose reduction (GDR, a trial attempt to discontinue a medication) were free from excessive dosages and durations without adequate monitoring and indications for use, or in the presence of adverse consequences, related to the use of psychoactive (affecting the mind) medications for 1 of 5 sampled residents (Resident 94) and failed to monitor for psychoactive medication side effects for 2 of 5 sampled residents (Residents 87 and 92) when reviewed for unnecessary medication use. The facility's failure to monitor behaviors and side effects and conduct GDR related to use of psychoactive medications placed the residents at risk for adverse side effects, medical complications, and a diminished quality of life. Findings included . <Gradual Dose Reduction> Review of a policy titled, Tapering Medications and Gradual Drug Dose Reduction, dated July 2022, showed after medications were ordered for a resident, the staff and provider shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. All medications shall be considered for possible tapering. Tapering that are applicable to psychotropic (affecting the mind) medications were to be referred to as GDRs. Residents who used psychotropic medications shall receive GDRs and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Resident 94 Review of the quarterly minimum data set (MDS, a required assessment tool), dated 01/01/2025, showed Resident 94 admitted on [DATE] with multiple diagnoses to include heart disease, stroke, dementia, anxiety, and depression. The MDS showed the resident with significant level of cognition (brain) impairment and was dependent on staff for assistance with activities of daily living (ADLs). Review of Resident 94's January 2025 medication administration record (MAR) showed a provider had ordered two psychotropic medications: Clonazepam (a psychotropic medication used to prevent and treat anxiety disorders) on 10/07/2024 and duloxetine (a psychotropic medication used to treat depression) ordered on 10/08/2024. Review of Resident 94's current care plan showed the resident was at risk for complications related to the use of psychotropic medications: duloxetine and clonazepam. The goal was for the resident to have the smallest most effective dose without side effects. Interventions included for licensed staff to conduct a GDR as ordered and obtain a psychiatrist evaluation (a meeting with a psychiatrist to evaluate a resident's mental health and develop a treatment plan) as ordered. During an interview on 01/28/2025 at 12:37 PM, Staff S, Social Services Director (SSD), stated the facility staff had held a recent interdisciplinary (IDT) meeting that discussed Resident 94's behavioral health needs, and a report was forwarded to the Director of Nursing Services. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 94's electronic health record (EHR) showed no GDR was conducted since admission or a psychiatrist evaluation. During an interview on 01/28/2025 at 1:13 PM, Staff C, Assistant Director of Nursing (ADON), stated Resident 94, when initially admitted to the facility, was placed into hospice and their behavioral health (BH) services dropped off and there was no follow through with BH/GDRs. Staff C stated when the resident graduated from hospice services, the BH service was never restarted but it should have been. <Behavioral/Side Effect Monitoring> Resident 87 Review of EHR showed Resident 87 admitted to the facility on [DATE] with diagnoses to include dementia (a condition affecting memory, thinking and social abilities). Resident 87 required moderate assistance and was able to make needs known. Review of Resident 87's current physician's orders, January 2025, showed an order for risperidone (an antipsychotic medication). Review of the December 2024 and January 2025 MAR showed staff were to check orthostatic blood pressure twice monthly related to the use of the risperidone when lying and sitting. Review showed no documented blood pressure readings. During an interview on 01/27/2025 at 2:00 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was that staff were obtaining and documenting orthostatic blood pressures for those residents who were receiving antipsychotic medication. 38344 Resident 92 Review of the EHR showed that Resident 92 admitted to the facility on [DATE] and was able to make needs known. Review of the quarterly MDS dated [DATE] showed Resident 92 had diagnoses of atrial fibrillation (irregular heart rate), high blood pressure, insomnia (sleeplessness), and received a hypnotic medication (used to include sleep). Review of Resident 92's provider's orders showed an order dated 11/15/2024 for Zolpidem Tartrate (hypnotic medication) as needed for severe intermittent insomnia at bedtime. An order dated 09/19/2024 showed to monitor side effects related to hypnotic drug use with side effects listed every shift. An order dated 09/19/2024 showed to Monitor hours of Sleep 6+ hours at night for hypnotic drug use, document non-drug interventions used and showed listed non-pharmacological interventions, every shift, and document results if (+) effective or (-) ineffective every shift. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 92's January 2025 MAR from 01/01/2025 - 01/24/2025 showed Zolpidem Tartrate was provided 10 times out of 23 opportunities. It showed the order to monitor side effects had a Y documented four times; however, it did not show which side effect from the list was observed. It showed the order to monitor (#, number) of hours of slept all had 0 (zero) documented for all shifts, and it showed non-drug interventions were documented 0 or NA (not applicable) and area for results (R) showed 0 or NA documented. During an interview on 01/27/2025 at 9:26 AM, Staff E, Licensed Practical Nurse (LPN), stated Resident 92's January 2025 MAR showed the resident had side effects four times but did not show what the side effects were and should have. Staff E stated that hours of sleep were not documented on the January 2025 MAR and should have been. Staff E stated that non-pharmacological interventions were documented 0 or NA even though Resident 92 received the hypnotic medication 12 times, and this did not meet expectations. During an interview on 01/27/2025 at 9:39 AM, Staff B, Director of Nursing Services (DNS), stated Resident 92's documentation for monitoring hypnotic medication use, to include side effects, non-drug use interventions, and hours of sleep, did not did not meet expectations. Reference WAC 388-97-1060(3)(k)(i)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 38344 Based on interview and record review, the facility failed to ensure that the Quality Assessment and Performance Improvement (QAPI) program self-identified deficiencies and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Failure to have an effectively functioning QAPI program that consistently self-identified deficient practices led to repeated deficiencies, and a pattern of deficiencies that placed residents at repeated risk for unmet needs that could negatively impact their safety, quality of life and quality of care. Findings included . <Self-Identify Areas of Concern> Refer to the following citations identified during the Long Term Care survey, dated 01/29/2025, which were not identified or were identified and not addressed. (D = Isolated, E = Pattern): REFER TO F609 (E) Reporting of Alleged Violations. The Long Term Care survey dated 01/29/2025: the facility failed to identify and investigate allegations of abuse/neglect for 6 of 7 sampled residents. REFER TO F686 (E) Treatment/Services to Prevent/Heal Pressure Ulcer. The Long Term Care survey dated 01/29/2025: the facility failed to ensure an ordered intervention (Low Air Loss Mattress - LALM, a mattress used to redistribute pressure evenly and can help prevent pressure ulcers, also known as bedsores) was being monitored and used as directed in the prevention of pressure ulcers for 3 of 7 residents. REFER TO F865 (E) Quality Assurance and Performance Improvement (QAPI) Program/Plan, Disclosure/Good Faith Attempt. During an interview on 01/29/2025 at 1:34 PM, Staff A stated the above listed areas had not been a concern prior to survey. <Sustain Plan of Corrections> Refer to the following citations identified during survey which had ineffective plans of correction to sustain correction by the QAPI program which led to repeated deficiencies and pattern of deficiencies. (D = Isolated, E = Pattern): REFER TO F552 (E) Right To Be Informed and make Treatment Decisions: Previous deficiency dated 11/2018 (D), 11/2019 (D), 10/2022 (D), and 01/26/2024 (D). The Long Term Care survey dated 01/29/2025: The facility failed to have psychotropic medication (medications that affect a person's mental state) consents completed, signed, and in place prior to residents receiving these medications for 3 of 5 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the facility was cited for this area and found back in compliance. Staff A stated he did not know why compliance was not maintained and would have to review. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFER TO F578 (D) Request/Refuse/Discontinue Treatment; Formulate Advance Directive: Previous deficiency dated 11/2018 (E), 11/2019 (E), and 01/26/2024 (D). The Long Term Care survey dated 01/29/2025: The facility failed to periodically review a resident's advanced directive (AD, a legal document that states your wishes for medical care if you are unable to make decisions for yourself) and obtain and maintain a court-appointed guardianship (legal process where a court appoints someone to make decisions for a person who is unable to do so for themselves) documentation for 1 of 2 sampled residents On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F584 (D) Safe/Clean/Comfortable/Homelike Environment: Previous deficiency dated 11/2018 (E), 11/2019 (D), and 01/26/2024 (D). The Long Term Care survey dated 01/29/2025: the facility failed to provide a safe, sanitary, and homelike environment for 1 of 4 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F604 (D) Right To Be Free From Physical Restraints: Previous deficiency dated 12/05/2024 (D). The Long Term Care survey dated 01/29/2025: the facility failed to obtain provider's order, assessment and consent for the use of a low bed for 3 of 3 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F623 (D) Notice Requirements Before Transfer/Discharge: Previous deficiency dated 11/2019 (E) and 01/26/2024 (D). The Long Term Care survey dated 01/29/2025: the facility failed to provide written notification of the reason for transfer to the hospital to resident or responsible party for 2 of 4 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F625 (D) Notice Of Bed Hold Policy Before/upon Transfer: Previous deficiency dated 11/2019 (E). The Long Term Care survey dated 01/29/2025: the facility failed to provide written bed hold notice at the time of transfer to the hospital for 2 of 4 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F641 (D) Accuracy Of Assessments: Previous deficiency dated 10/2022 (D). The Long Term Care survey dated 01/29/2025: the facility failed to accurately assess the status for 1 of 5 sampled residents reviewed for Pre-Admission Screening and Resident Review (PASARR, a mental health screening tool). (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFER TO F645 (D) Pre-admission Screening and Resident Review: Previous deficiency dated 01/26/2024 (D). The Long Term Care survey dated 01/29/2025: the facility failed to ensure Pre-Admission Screening and Resident Review (PASARR, a mental health screening tool) assessments were accurately or timely completed for 2 of 7 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F656 (D) Develop/Implement Comprehensive Care Plan: Previous deficiency dated 11/2019 (D) and 10/2022 (D). The Long Term Care survey dated 01/29/2025: the facility failed to develop and implement comprehensive person-centered care plans for 2 of 24 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F657 (D) Care Plan Timing and Revision: Previous deficiency dated 11/2018 (D), 11/2019 (E), and 01/26/2024 (E). The Long Term Care survey dated 01/29/2025: the facility failed conduct timely care planning meetings with residents or responsible party for 2 of 4 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F658 (D) Services Provided Meet Professional Standards: Previous deficiency dated 10/2022 (D). The Long Term Care survey dated 01/29/2025: the facility failed to meet professional standards of practice for 1 of 5 sampled residents reviewed for use of unnecessary medications. REFER TO F684 (E) Quality Of Care: Previous deficiency dated 01/26/2024 (E). The Long Term Care survey dated 01/29/2025: the facility failed to ensure a mobility device was available for 1 of 5 sampled residents and failed to implement a bowel program for 2 of 5 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was aware of this area of concern depending on what it is. REFER TO F689 (D) Free of Accident Hazards/Supervision/Devices: 11/2018 (D), 11/2019 (D), 10/2022 (E), and 01/26/2024 (D). The Long Term Care survey dated 01/29/2025: the facility failed to ensure risk factors were consistently monitored and addressed to minimize the risk for accident hazards for 2 of 7 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F692 (D) Nutrition/Hydration Status Maintenance: Previous deficiency dated 10/2022 (D). The Long Term Care survey dated 01/29/2025: the facility failed to ensure the facility's Registered Dietician's (RD) recommendations were administered as ordered to prevent continued weight loss for 1 of 3 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFER TO F695 (D) Respiratory/Tracheostomy Care and Suctioning: Previous deficiency dated 11/2018 (D). The Long Term Care survey dated 01/29/2025: the facility failed to provide respiratory care consistent with professional standards of practice for 1 of 2 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of the concerns in this area. REFER TO F727 (E) Registered Nurse 8 Hours/Seven days/Week, Full Time Director of Nursing Services: Previous deficiency dated 11/2019 (F) and 05/30/2024 (F). The Long Term Care survey dated 01/29/2025: the facility failed to ensure there was a registered nurse (RN) working a minimum of eight hours each day for 60 of 92 days. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was aware of this area of concern and were actively trying to recruit. REFER TO F756 (D) Drug Regimen Review, Report Irregularities, Act on pharmacist recommendations: Previous deficiency dated 11/2018 (D). The Long Term Care survey dated 01/29/2025: the facility failed to act on the consultant pharmacist's medication regimen review (MRR) recommendations and/or to have clearly documented rationale for not following the recommendation for 1 of 5 sampled residents. REFER TO F757 (E) Drug Regimen Is Free from Unnecessary Drugs: Previous deficiency dated 10/2022 (D), and 01/26/2024 (E). The Long Term Care survey dated 01/29/2025: the facility failed to provide non-pharmacological (non-medicated) interventions (NPI) prior to as needed (PRN) pain medications for 6 of 8 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of concerns in this area. REFER TO F758 (D) Free from Unnecessary Psychotropic Medications/as need (PRN) use: Previous deficiency dated 10/2022 (D), and 01/26/2024 (E). The Long Term Care survey dated 01/29/2025: the facility failed to conduct gradual dose reduction (GDR, a trial attempt to discontinue a medication) were free from excessive dosages and durations without adequate monitoring and indications for use, or in the presence of adverse consequences, related to the use of psychoactive (affecting the mind) medications for 1 of 5 sampled residents. On 01/29/2025 at 1:34 PM, Staff A stated the QAPI committee was not aware of concerns in this area. During an interview on 01/29/2025 at 1:34 PM, Staff A stated the QAA Committee meet once a quarter and sometimes monthly. Staff A stated the QAA committee know when an issue arose in any department by reviewing grievances, complaints, and results from audits. Staff A stated the QAA committee knew corrective action had been implemented by utilizing Performance Improvement Plans (PIPs) and reviewing the action plan to ensure it was implemented with audits turned in for review. When asked why there were repeated citations in various areas of concern, Staff A stated the Director of Nursing Services had been there a year; we continue to work to make improvements. We have had some key staff on leave and new staff trying to step up and help out. Staff A stated QAPI was effective in some areas; however, they needed to improve in other areas. Reference WAC 388-97-1760(1)(2)