STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505491	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Everett Center	1919 112th Street Southwest Everett, WA 98204

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview and record review, the facility failed to conduct thorough investigations for 4 of 8 residents (Residents 58, 71, 73 and 78) whose investigations were reviewed for thorough investigations. The failure to conduct thorough investigations placed residents at risk for repeat incidents, injury, and for unmet care needs due to a lack of thorough investigations after incident occurred, and there was a failure to preserve evidence necessary for thorough investigations. These failures placed residents at risk for repeat incidents and injury. Findings included . Review of the facility policy Abuse Prohibition dated 10/24/2022 showed actions to prevent abuse, neglect, exploitation, or mistreatment , including injuries of unknown source will include providing patients, families, and staff with information on how and to whom they may report concerns, incidents, grievances , without fear of retribution and provide feedback regarding the concerns that have been expressed. The facility will identify, correct and intervene in situations in which abuse, neglect, and or misappropriation of property is more likely to occur. The facility will initiate an investigation within 24 hours of an allegation of abuse that focuses on: - Whether abuse or neglect occurred and to what extent - Clinical examination for sings of injuries, if indicated. - Causative factors; and - Interventions to prevent further injury The investigation will be thoroughly documented within the risk management Portal. Ensure that documentation of witnessed interviews is included. The facility is to take steps to revise the care plan, take steps to resolve patient and family concerns and allegations, and clearly recording the same. <RESIDENT 71> (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis following a stroke, epilepsy, depression, anxiety, Post Traumatic Stress Disorder and muscle weakness. According to their admission Minimum Data Set (MDS) assessment, dated 02/03/2025, they had moderate cognitive impairment, and no fall history. The MDS indicated they needed extensive assistance of 2-persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. 1ST FALL Review of an incident investigation, dated 02/18/2025 at 6:40 AM, showed a nurse found the resident on the floor a little bit away from their bed. The nurse noted the resident had a minor bump on their head which the report showed the resident said it had been there a while. The report showed the resident denied hitting their head. The Provider was notified, and orders were received for continuous monitoring and cold compression to the bump on the head. A scoop mattress was added as an intervention although the fall was reported to be from trying to go out of the room. The investigation was not thorough, it did not include on what side of the bed or if the resident was at the foot of the bed. There was no documentation as to where the bump was located or the size of the injury or why ice was necessary for an old injury. The investigation did not include a witness statement from the Nurse's Aide Certified (NAC) who had cared for the resident that night. 2ND FALL Review of an incident investigation, dated 02/25/2025, showed at 4:15 AM, a NAC notified the Registered Nurse (RN) that the resident was on the floor lying on his left side facing the bed with their back facing the door, legs straight facing the sink. The resident's head was at the head of the bed, and they were supporting their head with a pillow. The intervention added was close observation in the nurse's station while the patient is awake and becoming agitated. The incident investigation did not note the resident had been agitated. The investigation showed the resident could not remember why they fell . The facility conclusion was that the resident got out of bed without assistance, due to lack of awareness of their physical limitation. The investigation included a change in condition evaluation for 02/27/2025, 2 days after the fall (there was a fall on 02/27/2025 as well). The investigation was not thorough, it didn't include: - medication information, though the resident was on medications from several of the classes of medications listed on the investigation form, -predisposing situational factors included, though there was a section Predisposing Situational Factors on the investigation form, -statement section showed there were no statements, although a statement was attached. 3rd FALL (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an incident investigation, dated 02/27/2024, showed at 7:00 AM, a NAC found the resident on the floor sitting in front of the roommate's bed. The residents tube feeding pump and pole was on their bed and the tubing was stretched but still connected. The roommate stated the resident crawled to their side of the bed and tried to take their wheelchair. The intervention added as one on one observation to prevent further falls and injury. The care plan showed a fall matt was added to the care plan on 03/04/2025, 8 days after the fall. The investigation was not thorough, it didn't include: - medication information, though the resident was on medications from several of the classes of medications listed on the investigation form, -predisposing situational factors included, though there was a section Predisposing Situational Factors on the investigation form, -statement section showed there were no statements, a statement was attached and noted the fall to occur at 5:30 AM rather than 7:00 AM on incident report. The NAC documented the resident said they slid when trying to pull their wheelchair. The NAC who provided care to the resident and completed the statement did not include when the resident was last toileted or checked on. -neuro checks started at 7:15 AM although NAC stated they found the resident on the floor at 5:30, a conflicting time. Did not address conflicting times. -no information documented about when the resident had last been toileted or checked on. -The investigation showed staff assisted the resident back to bed using a gait belt. The resident's plan of care is for mechanical lift with two staff for transfers. There was no mention this was addressed with the involved staff. <ABUSE/NEGLECT ALLEGATIONS> (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/11/2025, Collateral Contact (CC) 3 reported their loved one had to wait an hour to get changed. CC 3 stated most of the aides were good but there were a few aides that stand in the hall visiting and ignoring call lights. CC 3 stated this was frustrating while waiting an hour to get the soiled brief changed while staff is laughing and visiting with each other. CC 3 stated their loved one had falls and the staff try to make them feel bad by saying they are heavy care. CC 3 stated they knew that there are standards of care, and this facility was not meeting them. They said there were two grievances filed for them. The first one was a few weeks after they admitted , and they never received follow up. CC 3 said a male night aide hurt (Resident 71's) wrist and another time a male aide made their right upper arm hurt and it popped. CC 3 said they were both male aides who worked at night. The resident and CC 3 did not know their names but could point them out if they saw them. CC 3 stated they told the doctor about both incidences. CC 3 stated the staff used to lock the wheelchair brake on their bad side, and they would go in circles, unable to move their wheelchair forward. CC 3 stated their loved one would become frustrated and, staff observed the locked wheelchair and (Resident 71's) frustration and did not help them. Resident 71 stated a male nurse, Staff U, RN told them they would not take their vital signs unless they took pain medications. The resident stated they refused the medications and felt harassed. CC 3 stated they had talked with Staff D, RN/Resident Care Manager and the other nurse manager and they tried to spin the issues on (Resident 71). They said staff respond to their concerns with Well if (Resident 71) didn't do that, then we wouldn't do this. CC 3 said the facility had called them about all the falls but one. Resident 71 stated they hit their head a couple of times during the fall, and they were scared to go to sleep after because the nurse did not take their vital signs. CC 3 asked if staff should be taking vital sings every 15 minutes after a fall, then every 30 minutes, then hourly. CC 3 stated another concern is the staff purposely move the residents call light out of their reach. Resident 71 and CC 3 both stated they were concerned about retribution from administration. In an interview on 03/11/2025 at 1:56 PM, the delay in incontinent care, two separate incidences of rough handling with pain by 2 male NAC's, locked wheelchair brakes, call light out of reach on multiple occasions were discussed with Staff A, Administrator and Staff B, Director of Nursing. Staff A stated Resident 71 had behaviors and used to push his call light all the time. Staff A said they had not heard any of this and did not believe there were any grievances for Resident 71. Staff B stated Resident 71 was receiving one on two supervision because of his falls. In an interview on 03/12/2025 at 9:12 AM, Resident 71 was alert and oriented and said the staff took their call light away from them again last night. The call light was observed to be clipped at the bottom left corner of their bed, out of reach. CC 3 stated the call light is either there when they come in or wrapped over the outlet on the wall. CC 3 stated Staff A came into the room last night and asked them why they did not fill out a grievance form. CC 3 stated they told Staff A that they should not have to fill out a form, they reported concerns to the nurse which they thought was the chain of command. CC 3 stated that Staff A told them that they were bending over backwards for them. CC 3 stated Staff A was dismissive to their concerns. At 2:20 PM, CC 3 stated they showed Staff A the finger shaped bruise on (Resident 71's) right bicep and Staff A responded, That is not much of a bruise. CC 3 stated the nurse on last night came in and confronted them and asked if I had reported a bruise had occurred on their shift to Staff A. CC 3 said the nurse seemed scared and afraid they were going to get reprimanded. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 03/13/2025 at 1:31 PM, Resident 71 was in bed with CC 3 at bedside. Resident 71's was observed to have a left inner calf fingerprint shaped 1 cm by 1 cm brown bruise. CC 3 stated they did not know where the bruise came from. CC 3 said the resident had 4 falls at the facility, twice they hit their head and one they purposely crawled out of bed to get help as their call light was not in reach. Resident 71 stated they had a concern last night with Staff U, RN who did not wake them up and gave them medications in their tube. The resident stated he woke up when Staff U was plunging something into his tube, and they did not like that. The resident said they asked Staff U what medications they were given at that time, and the nurse would not tell them what the medications were. CC 3 said they did not like when staff do anything with their tube when they were not awake. In an interview on 03/13/2025 at 3:42 PM, Staff B, DNS was asked about the left leg and arm bruising as they were not on the incident report log. Staff B informed CC 3 is reporting bruises of unknown origin. Staff B stated, But the skin check And did not finish their statement. In an interview and observation on 03/14/2025 at 8:32 AM, Resident 71 motioned to me to come in from the hall. Resident 71 stated that the nurse on right now tried to give them medications and they wanted to wait until their wife arrived first and the nurse said no. This surveyor went to interview Staff E, RN. Staff E stated they administered Resident 71's medications, and the resident kept saying they were waiting for their wife. Staff E said they were not aware of the residents' concerns with medication administration and they assumed the resident was just saying they were waiting for their wife. Staff B, DNS walked up and stated they had updated the care plan for nurses to make sure the resident is awake, tell them what medications you are giving, seek permission first. Staff B said Staff U had been in serviced and they were going to in-service the other nurses today. Review of the care plan on 03/14/2025 at 8:40 AM up until 03/17/2025 at 11:00 AM, showed no revision to the care plan on the resident's preference for medication administration. Review of the change in condition evaluation dated 03/11/2025 at 1:57 PM, showed Staff D, RN noted an abuse allegation was reported by the resident's wife. In an interview on 03/17/2025 at 9:20 AM, Staff D, RN stated they had not heard any concerns about rough handling from Resident 71. Staff D stated the resident did complain about staff but could not say if the staff was male or female. Staff D did not probe into further details when the resident complained about staff. In an interview on 03/17/2025 at 10:47 AM, Staff B was asked about the allegation involving Staff U. Staff B stated they completed a grievance on this matter, and they revised the care plan. Staff B was informed this surveyor could not see any care plan revisions about this. Staff B stated the leg bruise was probably from a fall and showed up days later. In an interview on 03/17/2025 at 11:47 AM, Staff E, RN stated if a resident had concerns with the way they were treated, they would notify the RCM, DNS and then an investigation had to be done to make sure or see if it really happened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/17/2025 at 12:30 PM, Collateral Contact 4, Resident 71's sister asked to talk to me outside and stated the nurses were still not waiting for (Resident 71) to wake up before attempting to give medications. CC 4 said the past weekend staffing was terrible and there was not enough staff. CC 4 said one aide got in trouble and was crying for reporting something to management. CC 4 stated staff are scared to get in trouble with management. During our interview, staff in the Administrator office kept looking out the window. Staff A, Administrator came outside at one point. CC 4 said when they report something, administration avoids eye contact with them. They said it was not worth reporting anything because nothing changes. CC 4 said the resident is very guarded with their tube after it had been placed inappropriately at the hospital, and it was very upsetting to them, and they try to protect that area of their stomach. CC 4 stated the resident was developing a pressure sore and they had been asking for an air mattress for weeks. CC 4 stated the resident sat in their BM for 3 hours Saturday morning. CC 4 stated the day shift aide was upset and told them the bed was messy and wet. CC 4 said the resident reported their call light was taken away from them at 1:30 PM. They said almost every single time they arrive, the call light was out of the residents reach. In a joint interview on 03/17/2025 at 1:38 PM, Staff A and B stated they were unaware investigations were not thorough and did not include indicated statements from assigned caregivers, review of conflicting times, or circumstances and what the root cause was. Staff A and B were informed of the allegation that Resident 71 had been in their soiled brief for 3 hours on Saturday. Staff A and B did not ask for further details. At 3:48 PM, this surveyor met with Staff A and B to ensure they were going to investigate the prolonged exposure to the soiled brief. At that time, Staff B wrote down the details. Staff A stated they had offered placement at another facility as the resident as family did not seem happy there. Review of the neglect allegation investigation for Resident 71 dated 03/11/2025 at 1:45 PM, showed patient and spouse complained to the surveyor they were waiting one hour to get help to change the (incontinent brief), and they had some problems with NAC's but did not remember who they were. CC 3 stated they filed two grievances and never heard back from the staff about them. One was the night a NAC hurt Resident 71's right wrist and right arm and it popped. Another concern was staff locked the resident's wheelchair breaks which made the resident upset. The resident felt harassed because the staff blame them. Also, staff hide the call light from them. The investigation showed the DNS completed a new Brief Interview for Mental Status (BIMS, an assessment to determine cognitive status) during the investigation and documented the resident was an unreliable historian and was consistently confused. The report showed Resident 71 was placed on one-on-one supervision rather than the two on one for 12 hours reported. The investigation showed the residents consistent state of confusion and cognitive impairment, it is reasonable to conclude the resident was confused about the source of their wrist pain. The investigation was not thorough, it didn't include: - An investigation of resident reporting being harassed - An investigation of withholding the call light - An investigation of locked wheelchair brakes, impairing the resident's ability to self-propel - An investigation of lying in feces for an extended period of time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Review of staffing for the Resident - Did not include statements from each assigned nurse and NACs for Resident 71 or in immediate area who had cared for Resident 71 - Interviews from each interviewable resident on this resident's unit <RESIDENT 78> Resident 78 admitted on [DATE] with diagnoses to include traumatic brain injury, muscle weakness and multiple fractures as a result of a motor vehicle accident. Review of the 01/21/2025 MDS showed the resident was cognitively intact and had no falls. Review of the physician orders beginning 01/15/20205 showed activity restrictions as helmet to be worn when out of bed. Hard cervical collar on neck at all times. Non weight bearing to right leg and boot to be worn when out of bed. Review of the fall incident report investigation dated 03/07/2025 at 12:00 AM, showed resident 78 was found on the floor by Physical Treatment (PT) after the resident had a shower. The report showed the resident stated they got up to reach out for their hairbrush when their leg gave up and they fell to the floor. There was no mention of their right leg brace being on or off at the time of the fall. Review of the attached statement showed the Physical Treatment Assessment (PTA) walked into the Resident 78's room and found the resident on the floor by their bed next to their wheelchair. The resident stated they were walking taking a few steps to get a brush on the counter and lost their balance and fell to the floor. The statement showed the residents helmet was on the floor and the neck brace was on the bed and wheelchair was not locked. There was no mention of the time they were found or if their right leg brace was on at the time of the fall. Review of a progress note dated 03/07/2025 at 11:21 AM showed Resident 78 was found on the floor by PT. The resident had just had shower and was dressed up by the NAC 5 minutes before the incident. PT who was passing by found resident on the floor by the bedside. Call light was within reach prior to the fall, bed in the lowest position, floor clean dry with no clutter and adequate lighting within the room. The investigation was not thorough, it didn't include: - Statement from assigned nurse's aide and shower aide who provided care minutes before the fall - Mental status - Predisposing Situation factors - Or address the helmet being removed on the floor, neck brace off on the bed or if the left leg brace was on at time of fall. - Clarification as to what time the fall occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The intervention was education to the resident on calling for help before attempting to transfer and did not include ensuring personal items were within reach. 44110 <RESIDENT 58> Resident 58 admitted to the facility on [DATE], with diagnoses that included history of stroke, post-polio syndrome (causes paralysis), and diabetes. The admission MDS assessment dated [DATE] showed the resident was in a vegetative state, with impairments to one side of their body, and was dependent for all cares. The assessment stated the resident currently had an unhealed pressure ulcer. Review of Resident 58's initial wound assessment dated [DATE], by a contracted wound provider, showed the resident had a stage 3 pressure ulcer to their left lateral calf. The wounds to right leg and sacrum were noted to have been resolved. Review of Resident 58's weekly wound assessment dated [DATE], by a contracted wound provider showed the resident continued to have one Stage 3 pressure ulcer to their left lateral calf. Review of Resident 58's progress notes showed on 02/21/2025 at 4:39 PM, the nurse documented left lateral leg had two separate areas. The note only reflected measurements for one area, and did not specify if it was the old pressure ulcer or new wound. Review of Resident 58's weekly wound assessment dated [DATE], by a contracted wound provider showed the resident had two new wounds. The first wound was located on the right heel and was classified as a Stage 3 full thickness wound. The second wound was located on the residents left heel and was classified as a deep tissue pressure injury. Review of the facility state reporting log for February 2025 showed an entry for a other skin on 02/26/2025. The log showed there was no injury. The log showed the findings where the origin had been established, and the action taken was a care plan revision and medical treatment. Review of the facility investigation dated 02/26/2025 showed during wound rounds the contracted wound provider found a new pressure injury to the right heel, and a new deep tissue pressure injury (DTPI) to the left heel. The immediate action taken was to update the care plan and update the treatment orders, provider and family notified. The section of the investigation that showed predisposing environmental factors listed none. The section of the investigation that showed predisposing situation factors listed other (describe in note below) which showed the resident was bed bound, limited activities, diabetic and malnourished. The summary stated the root cause of the skin issue was due to the resident's diagnosis, and medical history, and that after gathered information from staff the facility was able to rule out abuse and neglect. The investigation included a note from a nursing aide that stated the resident had a new skin area, and from the nurse that had rounded with the contracted wound provider that stated there was a new wound. The investigation did not reflect a thorough investigation, there was no collection of evidence or information related to the resident's care that would of show that the residents' new wounds were unavoidable. The investigation did not show the facility had ruled out neglect. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/17/2025 at 1:12 PM, Staff B, stated that they ruled out neglect for Resident 58 through review of the medical records, and staff. Staff B was asked why that was not included in the investigation and stated they probably should have done more to show the staff had been compliant with the care plan interventions in place to prevent or worsening of the ongoing pressure ulcers. 42927 <RESIDENT 73> Review of a facility investigation showed Resident 73 obtained a skin tear to their right calf on 02/26/2025. The nurse that found the skin tear documented that the skin tear happened because of poor positioning of Resident 73's Lower extremities (legs). The nurse's statement did not state if the skin tear had just occurred or why the positioning caused the skin tear. The investigation summary did not show evidence that the cause of the skin tear was identified. The summary did not include any environmental factors, any assessment if the staff had positioned Resident 73's legs appropriately or if staff had caused the skin tear during care. During a joint interview and record review on 3/17/2025 at 7:50 AM, Staff A reviewed the investigation summary for the skin tear incident. Staff A stated the summary did not show how the skin tear occurred. Staff B stated they did not determine the cause of the skin tear. Staff B stated the investigation was not thorough. Staff B stated they did not identify the cause of the skin tear and put no interventions in place to prevent any further skin tears from occurring. This is a repeat deficiency from 10/01/2024. Reference: (WAC) 388-97-0640 (6)(a)(b)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to ensure the Resident Assessment Instrument (RAI), an assessment of a resident's needs, strengths, goals, and preferences, were completed within the required timeframes and/or included thorough summaries of the Care Area Assessments (CAA's), an assessment of a specific resident care or medical issue, to holistically analyze the plan of care for nine of sixteen residents (Residents 13, 58, 66, 67, 71, 73, 78, 80, and 334) reviewed for comprehensive assessments. This failure placed the residents at risk of not having appropriate services provided based on the resident's individualized needs and placed all other residents at risk of their needs and preferences not met. Findings included . Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1, dated October 2024, showed: A comprehensive admission minimum data set (MDS- assessment tool) assessment was required to be completed by 14th calendar day of the resident's admission day. A comprehensive annual MDS assessment was required to be completed by 14th calendar day of the assessment reference date (ARD). The RAI consisted of three basic components: the MDS assessment, the CAA process, and the RAI Utilization Guidelines (instructions for when and how to use the RAI that include instruction for completion of the RAI as well as structured frameworks for synthesizing the MDS and other clinical information). The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified is the basis of the CAA process and can help provide additional information for the development of an individualized care plan. Review of the facility's policy titled, MDS Clinical System Process Part 4 - CAA and Care Planning Process, dated 11/01/2024, showed the CAA process provides clarification of a patient's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care. <RESIDENT 71> Resident 71 admitted on [DATE] with diagnoses to include with diagnoses that included hemiplegia (unable to move one side of the body) affecting their left side, depression, anxiety and Post Traumatic Stress Disorder. (continued on next page)

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Everett Center	1919 112th Street Southwest Everett, WA 98204

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission MDS dated [DATE] included the following triggered CAA's: functional abilities, falls, psychotropic drug use, psychosocial well-being, and pressure ulcers. Review of the MDS assessment, dated 02/02/2025 showed the CAAs did not contain comprehensive summaries or analysis that included the current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's CP was needed. The CAAs were blank except for the auto populated information from the MDS assessment. <RESIDENT 78> Resident 78 admitted on [DATE] with diagnoses to include traumatic brain injury and multiple fractures after a motor vehicle accident. Review of the admission MDS assessment, dated 01/21/2025, included the following triggered CAA's: psychotropic drug use, falls and functional abilities. Review of the MDS assessment, dated 01/21/2025, showed the CAAs did not contain comprehensive summaries or analysis that included the current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's CP was needed. The CAAs were blank except for the auto populated information from the MDS assessment. 44110 <RESIDENT 58> Resident 58 admitted to the facility on [DATE], with diagnoses that included history of stroke, post-polio syndrome (causes paralysis), and diabetes. In a review of Resident 58's admission MDS dated [DATE] showed the resident had unhealed pressure ulcers, and was not able to take anything by mouth and received all of their nutrition and hydration from a enteral feeding (providing nutrition directly into the gastrointestinal (GI) tract through a tube). The CAA was triggered for pressure ulcers, feeding tube, and nutrition. Review of each CAA showed all areas were blank and incomplete. 42927 <RESIDENT 66> Resident 66 admitted to the facility on [DATE] with diagnosis of intracerebral hemorrhage (bleeding in the brain which causes abnormal function of thought, movement and function), dysphagia (affects ability to swallow). Review of Resident 66's physician orders, showed the diet order, dated 02/05/2025, was nothing by mouth. Resident 66 had orders to have nutrition via enteral tube/feeding tube. Review of a Braden assessment (assessment for risk of developing bed sores), dated 02/05/2025, showed Resident 66 was at high risk of developing a pressure ulcer (bed sores). (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Area Assessments for Activities, feeding tube, and pressure ulcer, dated 02/18/2025, showed that the sections for resident and/or family representative input and the section to describe impact of this problem/need on the resident and your rationale for care plan decision were blank. There was no documentation or assessment if these areas were a concern for Resident 66. There was no documentation of complications or risk factors or how to mitigate the risk with specific interventions which should be carried onto the care plan or the need for any referrals to other health professionals. <RESIDENT 73> Resident 73 admitted to the facility on [DATE] with diagnosis of a pressure ulcer. Review of Resident 73's Pressure ulcer CAA, dated 10/25/2024, showed that the sections for resident and/or family representative input and the section to describe impact of this problem/need on the resident and your rationale for care plan decision were blank. There was no documentation or assessment if these areas were a concern for Resident 73. There was no documentation of complications or risk factors or how to mitigate the risk with specific interventions which should be carried onto the care plan or the need for any referrals to other health professionals. 51551 <RESIDENT 67> Resident 67 admitted to the facility on [DATE]. Review of Resident 67's comprehensive admission MDS assessment dated [DATE], showed the assessment completion date was 10/25/2024, 22 days after admission. <RESIDENT 80> Resident 80 admitted to the facility on [DATE]. Review of Resident 80's comprehensive admission MDS assessment dated [DATE], showed the assessment completion date was 02/18/2025, 19 days after admission. <RESIDENT 334> Resident 334 admitted to the facility on [DATE]. Review of Resident 334's comprehensive admission MDS assessment dated [DATE], showed the assessment completion date was 03/14/2025, 16 days after admission. <RESIDENT 13> Resident 13 admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (mental health condition that disrupts thought process, and perception mixed with depression), major depression and panic disorder. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 13's MDS information on 03/13/2025, an annual comprehensive assessment was scheduled to be started on 02/20/2025, with an expected completion date of 03/06/2025. Review showed that out of the 18 areas to assess only six had been completed. The MDS was incomplete and past due. In an interview on 03/14/2025 at 9:44 AM, Staff X, Registered Nurse/MDS Coordinator, stated they were aware of the late completion of MDS assessments. In the follow up interview on 03/14/2025 at 12:10 PM, Staff X stated they did not know the deadline for comprehensive admission MDS assessment was 14 calendar days of the resident's admission day, not the ARD. During an interview on 03/14/2025 at 2:26 PM, Staff X, Registered Nurse (RN)/MDS Coordinator, stated that when they complete a CAA worksheet, they review the area to make sure the issue is still appropriate for the resident. If the issue was still pertinent, they click on the square to show that the issue will be care planned. Staff X stated they did not document risk factors or complete an analysis of the issue, nor did they include resident/family input if they were going to include the issue on the care plan. Staff X stated if the care area was no longer an issue for the resident, they would document a short summary as to why it was no longer an issue for the resident. During a phone interview on 03/14/2025 at 2:28 PM, Staff Z, RN/MDS Coordinator stated they reviewed the clinical record when completing the CAA's but did not document any assessment or analysis of the issue on the CAA worksheet or in the clinical record. In an interview on 03/14/2025 at 03:25 PM, Staff B, Director of Nursing, stated they expected all MDS assessments be completed timely. Reference: (WAC) 388-97-1000 (b)(c)(ii)(2)(f)(g)(p)(3)(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on observation, interview and record review, the facility failed to assist 3 of 5 residents (Residents 52, 67, and 28) with routine activities of daily living. Failure to provide routine repositioning and/or assist residents to get out of bed transfer placed the residents at risk for skin breakdown, medical complications, discomfort, and diminished quality of life. Findings included . Review of facility policy titled, Activities of Daily Living (ADL's), revised 05/01/2023, showed ADLs were provided in accordance with the care plan and a patient who was unable to carry out ADL's will receive the necessary level of ADL assistance. <RESIDENT 52> Resident 52 admitted on [DATE] with diagnoses to include persistent vegetative state (lack of awareness of themselves or the surroundings) and was dependent on a ventilator (a machine to assist with breathing). Review of Resident 52's Quarterly Minimum Data Set (MDS) assessment (an assessment tool) dated 12/08/2024, showed the resident was comatose and dependent for bed mobility and transfer. The resident had impaired range-of-motion to both sides of their upper and lower extremities. <Out of Bed to Wheelchair> In an interview on 03/11/2025 at 1:21 PM, Collateral Contact (CC2), family of Resident 52, stated nurses did not get Resident 52 out of bed to wheelchair and the resident was supposed to be up in their wheelchair daily. In an interview on 03/12/2025 at 2:58 PM, CC2 stated Resident 52 did not get out of bed to their wheelchair on that day. In an observation on 03/12/2025 at 8:40 AM, 10:30 AM, 11:17 AM, 12:32 PM, 1:34 PM, and 2:58 PM, Resident 52 was observed lying in bed. Review of Resident 52's current care plan showed Resident 52 required total assistance for transfer and encourage the resident's spouse to not keep the resident up in wheelchair more than two hours daily. Review of Resident 52's March 2025 Medication Administration Record (MAR) showed an order of getting up resident on wheelchair for two hours every day shift for mobilization. The documentation showed Resident 52 did not get up on 03/06/2025, 03/10/2025 and 03/12/2025. Review of the 30 days plan of care transfer documentation, copy date 03/16/2025, showed not applicable on 03/03/2025, 03/05/2025, 03/06/2025, 03/07/2025, 03/08/2025, 03/10/2025, 03/11/2025, 03/12/2025, 03/13/2025, 03/14/2025 and 03/15/2025. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with an anonymous staff member, they stated Resident 52 did not get out of bed daily if they did not have time to get them up. In an interview on 03/14/2025 at 8:39 AM, Staff C, Registered Nurse/Resident Care Manager, stated Resident 52 might not get out of bed on shower days but they were not sure why Resident 52 did not get out of bed if not a shower day. In an interview on 03/17/2025 at 10:50 AM, Staff K, Nurse Assistant Certified (NAC) stated Resident 52 did not get out of bed every day. Staff K stated Resident 52 needed two persons total assist for transfer and got out of bed every other day when the family requested or on Bingo Day on Thursday. In an interview on 03/17/2025 at 11:24 AM, Staff M, NAC stated Resident 52 required two-person total assist for transfer and Resident 52 did not get out of bed to wheelchair on 03/11/2025. Staff M stated not applicable on the transfer documentation meant Resident 52 did not get up and the transfer did not happen. In an interview on 03/17/2025 at 11:32 AM, Staff N, NAC stated Resident 52 were two persons total assist on ADLs. Staff N stated they did not transfer him out of bed to wheelchair on 03/10/2025 and that was why they documented not applicable on the transfer documentation on 03/10/2025. <REPOSITIONING> In an observation on 03/11/2025 at 10:06 AM and 12:58 PM, Resident 52 was observed in bed on their back with a pillow under the right shoulder. In an observation and interview on 03/11/2025 at 1:21 PM, Resident 52 was observed in bed on their back with a pillow under the right shoulder. CC2 stated nurses only turned or repositioned Resident 52 during brief changes about every four to five hours. In an observation on 03/12/2025 at 8:40 AM, 10:30 AM, 11:17 AM, 12:32 PM, 1:34 PM, and 2:58 PM, observed Resident 52 was lying in bed on their back with a pillow under the right shoulder. In an observation on 03/13/2025 at 8:10 AM, observed Resident 52 was lying in bed on their back with a pillow under the right shoulder. During a continuous observation on 03/13/2025 from 8:39 AM to 10:44 AM, no staff entered their room. Observed Resident 52 was lying in bed on their back with a pillow under right shoulder. In an observation on 03/14/2025 at 8:53 AM, 10:32 AM, 11:31 AM, 12:43 PM,1:40 PM, Resident 52 was observed lying in bed on their back with a pillow under right shoulder. Review of the bed mobility and transfer documentation dated 02/16/2025 to 03/16/2026, showed Resident 52 was dependent on staff for bed mobility and transfer. Review of Resident 52's ADL care plan initiated on 12/13/2023 directed staff to assist the resident in turning and repositioning every two to three hours, provide total assist for bed mobility and transfer. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 03/13/2025 at 3:20 PM, Staff L, Licensed Practice Nurse (LPN), stated NACs should follow the care plan for nursing care. In an interview on 03/14/2025 at 8:39 AM, Staff C, Registered Nurse/Resident Care Manager, stated Resident 52 was dependent on ADLs and was to be repositioned every two to three hours and NACs should follow the care plan. <RESIDENT 67> Resident 67 admitted to the facility on [DATE] with diagnoses to include persistent vegetative state and was dependent on a ventilator. Review of Resident 67's MDS assessment dated [DATE], showed the resident was comatose and dependent for bed mobility and transfer. The resident had impaired range-of-motion to both sides of their upper and lower extremities. In observations on 03/11/2025 at 9:43 AM,10:46 AM and 12:23 PM, Resident 67 was in bed on their back. In observations on 03/12/2025 at 11:46 AM, 12:32 AM, 1:40 PM, and 3:16 PM, Resident 67 was lying in bed on their back. In an observation on 03/13/2025 at 8:07 AM, Resident 67 was lying in bed on their back. During a continuous observation on 03/13/2025 from 8:39 AM to 10:43 AM, observed Resident 67 was lying in bed on their back. Two NACs went to the room at 9:30 AM with the door closed and came out from the room at 9:57 AM, observed Resident 67 was the same position, still lying in bed on their back. In observation on 03/14/2025 at 8:55 AM, 10:30 AM, 11:33 AM, 12:45 PM,1:50 PM, Resident 67 was lying in bed on their back. Review of Resident 67's care plan initiated on 10/04/2024 directed staff to assist the resident in turning and repositioning every one to two hours, provide two-person total assist for bed mobility. Review of Resident 67's Kardex (care instruction to aides), copy date 03/13/2025, directed staff to turn and reposition the resident every one to two hours. In an interview on 03/13/2025 at 2:51 PM, Staff K stated Resident 67 was dependent on two staff for their bed mobility. Staff K stated Resident 67 needed to be turned every two hours and they had turned them at 9:00 AM and turned again at about 11:30 AM to 12:00 PM. In an interview on 03/13/2025 at 3:20 PM, Staff L, stated nurses should follow the care plan for nursing care. In an interview on 03/14/2025 at 8:39 AM, Staff C, stated Resident 67 was dependent on ADLs and was to be repositioned every one to two hours and nurses should follow the care plan. 51312 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	<Resident 28> Resident 28 admitted [DATE] with a diagnosis to include a persistent vegetative state (lack of awareness of self or surroundings) and was dependent on a ventilator (a machine to assist with breathing). During record review of MDS dated [DATE], section GG, functional abilities coded resident as dependent for all daily needs and care. During the record review of Resident 28's care plan with a print date of 03/16/2025, it was noted that Resident 28 should be assisted in turning and repositioning every 2-3 hours and as needed. During record review of a document titled KARDEX (visual bedside report), Resident 28 should be turned and repositioned every 2-3 hours. In an observation on 03/13/2025 at 10:03 AM, 1:01 PM, and 1:59 PM, Resident 28 was in bed, lying on his back with his heels elevated. In an observation on 03/14/2025 at 8:14 AM, 9:10 AM, Resident 28 was in bed, lying on his back with his heels elevated, covered by a sheet that was partially pulled down. In a continuous observation on 03/14/2025 starting at 10:20 AM and ending at 12:08 PM no staff has entered resident 28's room. Resident 28 was lying on his back with his heels elevated. Covered by a sheet. In an observation on 03/14/2025 at 2:18 PM Resident 28 was in bed, lying on his back with his heels elevated and boots on his feet. In an interview on 03/14/2025 at 3:25 PM, Staff B, Director of Nursing, stated the facility standard practice for all residents were repositioned every two to three hours and as needed. Staff B stated they expected the nurses to follow the care plan and had to do as what the care plan documented. This is a repeat deficiency from SOD dated 10/01/2024. Reference WAC 388-97-1060 (3)(b)(c)(d)(e)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36787 Based on observations, interview and record review, the facility failed to provide sufficient qualified staff to provide care and services for 14 of 23 residents (Residents 22, 35, 40, 52, 53,55, 71, 74, 78, 82, 134, 284, 384 and 385) and 3 of 6 family members (for Residents 80, 334, and 1 anonymous) that had concerns related to staffing on 2 of 2 units (Unit 1 and 2) reviewed for sufficient staffing. Failure to timely respond to resident call lights, administer medications timely or as ordered, to provide adequate nursing supervision and oversight to the Nursing Assistant Certified (NAC's), resulted in delay of repositioning, meeting residents health and safety, and a delay of meeting other needs which placed residents at risk for unmet care needs, feelings of frustration and vulnerability, diminished quality of life, and negative outcomes. Findings included . <FACILITY ASSESSMENT> Review of the facility's assessment, revised 02/13/2025, showed 5-7 nurses and 5-10 NACs were to work at any given time for an average census of 70 to 75. The assessment showed the facility averaged 25-35 residents with tracheostomies (a surgical procedure to create an opening in the neck into the windpipe), and 25-35 residents with ventilators (a medical device that provided a resident with oxygen when they were unable to breathe on their own). The facility assessment showed 39 residents were dependent for bathing, 25 residents for dressing, 44 residents for transfers, 28 residents for toileting and 26 residents for eating. The facility had 2-4 residents who were independent with activities of daily living (ADL's). <ADMISSION CENSUS> Review of the facility's last 30 days of admission data on 03/11/2023, showed the facility admitted 11 residents. <PAYROLL STAFFING DATA REPORT> Review of the facility past four quarter reports, dated 10/01/2024 through 09/30/2024, showed the facility had excessively low weekend staffing each quarter with no change over the past year. Quarters 1 (10/01/2023 to 12/31/2023) and 2 (01/01/2024 to 03/31/2024) showed the facility was rated a one out of five stars in staffing. Quarters 3 and 4 (04/01/2024 to 09/30/2024 showed they were unable to assess for one star staffing as the rating was suppressed related to the facility's designation as a Special Focus Facility (a program established from Centers for Medicare and Medicaid with increased oversight and twice per year surveys to improve care in the poorest performing nursing homes). <STAFFING PATTERN> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of the staffing from 02/09/2025 to 03/11/2025, showed the facility had variances of staffing from day to day. The AM (6:00 AM to 2:30 PM) shift staffing showed they had 5 to 8 nurses with one shift staffed for 9 nurses, 9 to 12 NAC's. The PM (2:00 PM to 10:30 PM) shift, had 5 to 6 nurses and 9 to 10 NACs, and the night (10:00 PM to 6:00 AM shift had three nurses with 6 shifts of 4 nurses and five to seven NAC's. <RESIDENT INTERVIEWS> Residents were asked: Do you feel there was enough staff available to make sure you get the care and assistance you need without having to wait a long time? <RESIDENT 78> In an interview on 03/11/2025 at 9:19 AM, Resident 78 stated when they push the call button, it literally takes forever, over an hour to get help. Every time I push the button; on rare occasions it is only 20 minutes. I understand they (staff) are busy. I am not supposed to go to the bathroom by myself, but I have to. <RESIDENT 74> In an interview on 03/11/2025 at 10:45 AM, Resident 74 stated that they have long call light wait times. <RESIDENT 134> In an interview on 03/11/2025 at 11:11 AM, Resident 134 stated call light response times take a half an hour or more. <RESIDENT 284> In an interview on 03/11/2025 at 11:16 AM, Resident 284 stated it takes too long for the staff to answer their call light, and they have waited for the nurse to come for an hour or longer. <RESIDENT 52> In an interview on 03/11/2025 at 1:21 PM, Resident 52 stated there are not enough nurses all the time, night is worse. The resident stated staff always keep them in the bed, because there is nobody to get them out of bed because of no staff. The resident stated they were supposed to be out of bed daily and up in their wheelchair for 2.5 hours. The resident stated this happened only 2 days a week even though it is ordered. The resident stated there were not enough nurses, aides, and they are not getting up, so they are not getting better. <RESIDENT 71> In an interview on 03/11/2025 at 1:26 PM, Resident 71 and Collateral Contact 3 (CC3) stated they have to wait an hour to get changed which results in agitation and losing their cool. CC3 stated it was frustrating to have their loved on wait to get their soiled brief changed for an hour while staff are out laughing and visiting with each other outside the room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	<RESIDENT 40> In an interview on 03/11/2025 at 2:03 PM, Resident 40 stated that when they put their call light on, staff don't answer it, especially at night. <RESIDENT 53> In an interview on 03/12/2025 at 8:46 AM, Resident 53 stated sometimes they wait an hour or two to get they call light answered. The resident stated yesterday they reported to their nurse they had waited an hour. <FAMILY MEMBERS> <RESIDENT 334> In an interview on 03/11/2025 at 10:18 AM, CC 8, spouse of Resident 334 stated every weekend, staff were slow to respond to call lights, and all the time they wait more than 30 minutes. <RESIDENT 80> In an interview on 03/11/2025 at 11:03 AM, CC 7, spouse of Resident 80 stated every time they come here, the facility is short staffed. CC 7 said the bed was a mess, there was poo on the bed that nobody has cleaned, and they had to tell staff to clean them. CC 7 said weekends are worse. <RESIDENT 71> In an additional interview on 03/17/2025 at 12:30 PM, CC 4, stated there was not enough staff here. This weekend the staffing was terrible. CC 4 stated their family member sat in their BM for 3 hours on Saturday morning and the day shift aide was upset the bed was messy and wet when they came on shift. <ANONYMOUS FAMILY MEMBER> In an interview with an Anonymous family (AF-1) member, stated they were apprehensive to speak with surveyor about staffing as the last administrator went after them for talking to them before and their interviews made it into the inspection report. AF-1 stated there was a resident there that requires two hours of care which takes two aides off the floor to assist their family member for 2 hours every morning. AF-1 stated there was still not enough staff to meet the residents' needs in a timely manner. AF-1 stated they had voiced their concerns to the current Administrator and Director of Nursing (DNS), but nothing changes so they do not bother. AF-1 stated the administration's response to them is that every facility is short staffed. Date, time, and name were not included to maintain anonymity. <OBSERVATIONS> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505491	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Everett Center	1919 112th Street Southwest Everett, WA 98204

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	In an observation on 03/13/2025 at 9:10 AM, Staff V, Registered Nurse administered Resident 5's 8:00 AM medication. In an interview at 9:20 AM, Staff V stated they have to prioritize what medications they can give on time which are seizure and pain medications and tube feedings. Staff V stated they give the high priority medications first. <GRIEVANCE CONCERN LOG> Review of the grievance concerned log showed the following staffing concerns: November 2024: Four of the 19 grievances were call light related: -On 11/02/2024 Resident 385 reported a call light concern -On 11/12/2024 Resident 55 reported a call light concern -On 11/14/2024 Resident 82 reported a call light concern -On 11/16/2024 Resident 55 reported a call light concern December 2024 Three of the 13 grievances were call light related -On 12/10/2024 Resident 54 reported a call light wait time concern -On 12/10/2024 Resident 35 reported a call light wait time concern -On 12/11/2024 Resident 22 reported a call light wait time concern February 2025 Two of the 12 grievances were call light related -On 02/14/2024 Resident 384 reported a call light response concern -On 02/20/2025 Resident 71 reported a call light response concern <GRIEVANCE REPORTS> Review of a handwritten grievance form from Resident 385, dated 11/04/2024, showed the resident reported a concern with long call light times in the evening. The grievance form showed the facility completed an in-service on 11/14/2024. Review of a handwritten grievance form from Resident 55, dated 11/12/2024, showed the resident reported a concern with call light times are too long, up to an hour and a half, at least once a week. The grievance form showed the facility completed an in-service on 11/14/2024. Review of a handwritten grievance form from Resident 82, dated 11/14/2024, showed the resident reported a concern with call light response not being goof at night. The grievance form showed the facility completed an in-service on 11/14/2024. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Review of a handwritten grievance form from Resident 54, dated 12/10/2024, showed the resident reported a concern with long call light times, all shifts, every day. The grievance form showed the facility completed an in-service. Review of a handwritten grievance form from Resident 35, dated 12/10/2024, showed the resident reported a concern with long call light times. The grievance form showed the facility completed an in-service. Review of a handwritten grievance form from Resident 22, dated 12/11/2024, showed the resident reported a concern with all shifts not responding to call lights in a timely manner. The grievance form showed the facility completed an in-service on 12/12/2024. Review of a handwritten grievance form from Resident 384, dated 02/14/2025, showed the resident had a concern that staff was not responding to their call light in a timely manner. The grievance form showed the facility would in-service staff on answering call lights. An in-service was initiated on 02/14/2025. Review of a handwritten grievance form from Resident 71, dated 02/20/2025, showed the resident had a concern with call light time. The grievance form showed the facility would in-service station 2 staff on answering call lights. An in-service was initiated on 02/21/2025. <QUALITY ASSURANCE PERFORMANCE IMPROVEMENT MEETING (QAPI)> Review of the QAPI (a data driven and proactive approach to quality improvement) documents from 02/13/2025 showed there was a call light performance improvement plan (PIP). The root cause analysis listed workload and complexity of the patient. Tho goal or plan was to answer timely by everyone needing to answer the call light. The follow up showed the PIP was a work in progress. <STAFF INTERVIEWS> In an interview on 03/13/2025 11:03 AM, Staff DD, Staffing Coordinator said the facility was still hiring staff, the more the better. Staff DD said as census increases, they add more NAC's. Staff DD said the NACs were responsible to complete their own showers in addition to their duties and they were thinking of adding shower staff. Staff DD also stated that there was one room that required one on one supervision. Anonymous Staff A(AS-A), date and time not included to protect anonymity, stated the nursing staff are unable to get residents out of bed as they unfortunately do not have the time. AS-A said it is not that the staff do not want to, they cannot even take lunches. In an interview on 03/17/2025 at 11:47 AM, Staff E, RN stated they were not able to complete their duties during their shifts and they had to work past their shift to get all tasks completed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	In a joint interview on 03/17/2025 at 1:10 PM, Staff B, DNS stated that staffing levels were based on the census or how many residents we have. and the level of assistance they need. Staff B stated the facility population was very dependent residents. They stated they increased nursing staff to 5 some days 6 on the vent/trach unit. Staff A, Administrator acknowledged they were aware of call light concerns and staff, residents and families have brought concerns to them. Staff A stated they had the highest PPD (allotted hours per patient day) in the company, but they were also a unique population with vents and tracheostomies. Staff A stated their annual employee turnover was at 52%. This was a repeat citation from 09/20/2023. Reference: (WAC) 388-97-1080(1)