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	10/01/2024

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 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** 37890 Based on observation, interview and record review, the facility failed to immediately report to the state agency potential abuse and/or neglect for 3 of 5 residents (Residents 19, 61, and 62) reviewed for allegations of abuse and/or neglect. Failure to immediately report alleged abuse and/or neglect placed residents at risk for potential unidentified mistreatment and a poor quality of life. Findings included . Review of the facility's policy titled; Abuse Prevention revised 10/24/2022 showed the facility would report to the state survey agency allegations of abuse/neglect that did not involve serious bodily injury no later than 24 hours after the allegation/suspicion of abuse/neglect. Review of the Nursing Home Guidelines, or The Purple Book, guidelines, dated October 2015, showed facilities were required to report to the Complaint Resolution Unit (CRU) immediately when there was reasonable cause to believe abuse, neglect, substantial injuries of unknown source or on the reporting log within 5 days of discovery. <RESIDENT 19> Resident 19 admitted [DATE] and had cognitive impairment. In an interivew on 09/27/2024 at 10:07 AM, Collateral Contact (CC) 3 stated they had been in the facility on 09/12/2024 and had spoken to CC4 (responsible party for Resident 19) who had concerns with the care of Resident 19 which included hydration, oral care and positioning. CC3 stated the concerns were raised in the presence of Staff A, Administrator who CC3 stated had been dismissive and rude toward them when the concerns were raised. CC3 had concerns that there would be no follow up for CC4's concerns based on the interaction. Record review of the facility's grievance logs for the month of September 2024 showed no grievance entries related to Resident 19. Review of the facility state incident reporting log for the month of September 2024 showed no logging of any allegations of potential neglect for Resident 19. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/26/2024 at 11:57 AM, CC4 stated they were upset about several things but had already talked to the facility about it. CC4 stated overall things were good and they were reluctant to voice concerns. CC4 stated they did not feel Resident 19 was always being assisted to drink enough water or brush their teeth and this made them feel as though the staff did not care. CC4 stated when they arrived some days Resident 19's bed was elevated at both the head and the foot and since Resident 19's moves their feet a lot , their feet would get curled under them. CC4 said when they bring things like this up to the staff nothing happens, so they feel the staff did not listen to them. CC4 stated they wanted to talk to Staff A again because Staff A had told them not to worry. CC4 stated they have been waiting for Staff A to come back to talk to them. In an interview on 09/30/2024 at 9:45 AM, Staff B, Director of Nursing Services, stated they had not been made aware of any allegations related to Resident 19. Staff B confirmed there had been no prior reporting or initiation of any investigation for any grievances or allegations. In an interview on 10/01/2024 at 09:30 PM, Staff A stated when they had spoken to CC4, they felt that CC4 was happy with the care at the facility. Staff A was asked regarding the concerns that were raised during the interaction on 09/12/2024 and Staff A stated they had asked CC4 if they wanted to make a grievance but CC4 had said they did not. Staff A did not initiate any type of grievance or investigation process, report or investigate to rule out potential abuse and neglect. <RESIDENT 61> Resident 61 admitted [DATE] with diagnoses which included traumatic brain injury. In an observation and interview on 09/24/2024 at 10:19 AM, CC6 (family member of Resident 61) stated the facility had called them that morning because Resident 61's blood pressure cuff was left on too tight, causing some bruising to their arm. CC6 was observed to pull back the cover over Resident 61's arm and showed their left arm was deep red from the elbow to the fingers and there were streaked red marks above the elbow consistent with the shape of the wrinkles on a blood pressure cuff. CC6 stated Resident 61 had been having high blood pressures. Review of Resident 61's medical record on 09/24/2024 showed a progress note dated 09/24/2024 at 7:26 AM stating only that Resident 61 had left arm discoloration. A progress note dated 09/24/2024 at 10:00 AM stated there was an order placed to obtain an ultrasound test of the resident's left arm. Record Review of the state incident reporting log on 09/30/2024 showed nothing had been logged for Resident 61 within 5 days of the incident. Review of Resident 61's medical record on 09/30/2024 showed no evidence of an investigation of the circumstances of the incident. In an interview on 09/30/2024 at 9:45 AM, Staff B, DNS stated they had been aware of some discoloration to Resident 61's left arm but had heard nothing about any incident related to a blood pressure cuff. Staff B stated they would have to begin interviews and determine what had occurred. Staff B confirmed that no reporting or investigation had been initated to rule out abuse or neglect related to the incident. 47047 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 62> Resident 62 admitted to the facility on [DATE] with diagnoses that included anxiety disorder, depression, and spinal stenosis (spaces inside the bones of the spine get too small). In an interview on 09/24/2024 at 2:37 PM Resident 62 stated their roommate had called them derogatory names and used racial slurs. In an interview on 09/25/2024 at 8:30 AM Staff B, DNS, stated Resident 62 had reported concerns about their roommate to their mental health provider, Resident 62 was interviewed, as well as other residents, however there was no formal investigation completed and it was not reported. Staff B stated they consulted with their corporate team, and it was determined there was not a need to call the allegation into the state agency. In an interview on 09/25/2024 at 8:30 AM Staff A, Administrator, stated racial slurs were considered an allegation of verbal abuse. Review of Resident 62's mental health provider note dated 09/12/2024, showed they reported to their mental health provider that they were having difficulties with their roommate. In an interview on 09/26/2024 at 10:55 AM Staff F, Social Services Director, stated they were made aware of the alleged verbal abuse between Resident 62 and their roommate by Staff B, DNS. Staff F stated they did not report the allegation to the state agency. Staff F stated they spoke with Resident 62, offered them a room move which they declined, and interviewed other residents. Refer to WAC 388-97-0640(2)(b)(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation, interview, and record review the facility failed to ensure possible allegations of abuse/neglect were thoroughly investigated for 2 of 5 residents (Residents 41 and 62), reviewed for abuse/neglect investigations. This failure placed the resident at risk for unidentified abuse or neglect and a diminished quality of life. Findings included . Review of the facility policy titled, Abuse Prevention revised 10/24/2022 showed the facility would ensure that center staff were doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients. An investigation would be initiated within 24 hours of an allegation of abuse that included, whether abuse or neglect occurred and to what extent; clinical examination for signs of injuries, if indicated; causative factors and interventions to prevent further injury, thoroughly documented within the Risk Management Portal to include witness interviews. <RESIDENT 41> Resident 41 admitted to the facility on [DATE] with diagnoses that included stroke, diabetes mellitus (a condition in which the body has trouble controlling blood sugars) and left arm pain. In an interview on 09/25/2024 at 11:21 AM Resident 41 stated their arm had been wrapped up by a staff member and caused them pain. Resident 41 stated they did not know when this occurred, but the facility tried to keep the alleged staff member from their room. Resident 41 stated they had suffered falls from their bed a few times. In a review of Resident 41's Annual Minimum Data Set (MDS-an assessment tool) dated 08/04/2024 showed they had a Brief Interview for Mental Status (BIMS-tool used to screen and identify cognition) was completed with a score of 10/15 indicative of moderate cognitive impairment. Review of Resident 41's care plan dated 09/21/2021 had a focus on falls related to their immobility, generalized weakness, impulsivity, poor safety awareness and history of falls. The interventions included: -dated 09/27/2022 bilateral floor mats while resident in bed to help reduce risk of injury -dated 01/12/2023 encourage resident to leave their door open while in room/bed for closer supervision -dated 01/12/2023 encourage resident to use the call light and wait for assistance with transfers -dated 09/02/2022 maintain bed in the lowest position while the resident was in bed -dated 07/15/2022 medication review and obtain labs (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an incident report dated 01/05/2024 showed Resident 41 had fallen and was found sitting on the floor, against their bed, and facing the doorway. Resident 41 stated they were trying to go across the hallway and tell their neighbor to be quiet. The incident report showed that abuse and neglect was ruled out, but contained no witness or staff statements and no notation if the care plan interventions were in place at the time of the fall. Review of an incident report dated 09/24/2024 showed Resident 41 had reported they were handled roughly during care on the night of 09/23/2024. The facility suspended the alleged staff member, who was identified as the night nurse, and initiated an investigation. Staff and resident interviews were conducted. In review of Staff M, Registered Nurse, statement dated 09/24/2024 showed they had not provided any physical care and had no physical contact with Resident 41 recently. In a review of Resident 41's skin check completed 09/23/2024 showed Staff M, RN documented they completed Resident 41's skin check and had applied antifungal cream to their right forearm and thigh. In an interview on 09/30/2024 at 3:30 PM Staff B, Director of Nursing Services (DNS) stated the process for conducting investigations included interviews with the resident, witnesses, staff and other residents. Part of the investigation could include skin and pain assessments if indicated, and status of the resident's emotional state. Staff B stated the fall investigation for Resident 41 should have included statements. Staff B stated the abuse investigation for Resident 41 had the required information and Staff M's statement was interpreted as they had not provided them personal care. There was no additional information obtained about Staff M's written statement and the conflicting documentation of care they provided to Resident 41 on the day the alleged abuse occurred. <RESIDENT 62> Resident 62 admitted to the facility on [DATE] with diagnoses that included anxiety disorder, depression, and spinal stenosis (spaces inside the bones of the spine get too small). In an interview on 09/24/2024 at 2:37 PM Resident 62 stated their roommate had called them derogatory names and used racial slurs. In an interview on 09/25/2024 at 8:30 AM Staff B, DNS, stated Resident 62 had reported concerns about their roommate to their mental health provider, Resident 62 was interviewed, as well as other residents, however there was no formal investigation completed. Review of Resident 62's mental health provider note dated 09/11/2024, showed they reported to their mental health provider that they were having difficulties with their roommate. Review of the incident report dated 09/24/2024 showed Resident 62 had reported on 09/12/2024 to the behavioral health provider their roommate had made racial comments. Resident 62 was reported to have a history of bibolar and schizophrenia and was confused at times. Resident 62 was offered a room move and they declined. The incident report suggested there was an interview with Resident 62's roommate at which time they denied making any racial comments to them. There was no written or verbal statement from the roommate included in the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 62's care plan dated 08/17/2024 showed no diagnosis or focus on mental health related to diagnosis of schizophrenia and/or bipolar disorder. Refer to WAC 388-97-0640 (6)(a)(b)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) process (a federal requirement to help ensure that individuals who had a mental disorder or intellectual disabilities were offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and received the services they need in those settings), was followed for 3 of 5 residents (Residents 5,13 and 15) sampled for medication review. This failure placed residents at risk for not receiving specialized mental health services, unidentified mental health needs and a decreased quality of life. Findings included . <RESIDENT 15> Resident 15 was readmitted to the facility on [DATE] with diagnosis that included recurrent severe major depressive disorder, anxiety disorder and panic disorder. Review of Resident 15's medical record showed the resident had an updated Level I PASRR completed on 06/05/2024, that indicated an updated Level II evaluation was required related to serious mental illness. Review of the clinical record on 09/27/2024 showed there was no Level II evaluation completed. In an interview on 09/30/2024 at 10:56 AM, Staff F, Social Services Director (SSD), stated Resident 15 has been a level II PASRR resident since 2017. Staff F said they sent a Level II request to the PASRR evaluator on 06/05/2024 but they had not received the Level II evaluation yet. Staff F said they could not locate the documentation about communication to the PASRR evaluator. Staff F said they had been in communication with the PASRR Coordinator since the beginning of the survey. In an interview on 09/30/2024 at 11:34 AM, Staff A, Administrator provided a level II PASARR invalidation for Resident #15 dated 09/30/2024. Staff A confirmed there was no follow up documented after 06/05/2024 until 09/30/2024. In a joint interview on 10/01/2024 at 8:40 AM, Staff F, SSD and Staff A, Administrator, Staff F said they had been in contact with the PASRR evaluator and just didn't document it. Staff F said they would start documenting their follow up. Staff F provided an email they sent on 06/05/2024 at 1:16 PM. In the email, the PASARR evaluator responded that they acknowledged that they received this email the day (06/05/2024) it was sent, and they tended to communicate via telephone as opposed to email in responses. The PASARR evaluator documented that large volumes of assessments plus other duties of their PASARR position have impacted their ability to follow up with the facility in a timely manner. Staff F, SSD acknowledged they needed to document attempts to obtain the level II evaluation and include follow up communication in the medical record. 37890 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 13> Resident 13 admitted on [DATE] with diagnoses which included Bipolar disorder. Review of Resident 13's clinical record showed a level I PASARR dated 09/02/2022 which indicated the resident had indicators of serious mental illness, had experienced serious disruption to their living situation in the past two years and required level II evaluation. Review of Resident 13's clinical record showed no level II PASARR evaluation was present in the record, and no follow up documentation was found. In an interview on 09/25/2024 at 2:13 PM, Staff F, SSD, stated Resident 13 had gone to the hospital several times and had no significant changes. Staff F stated they believed that Resident 13 had a PASARR invalidation because there had been a level II evaluation done in the past but acknowledged that it was not found in the record or incorporated into the care plan. In a follow up interview on 09/25/2024 at 3:01 PM, Staff F stated they had just reached out to the PASARR Coordinator and had been sent a copy of the resident's level II PASARR from 2022. 44110 <RESIDENT 5> Resident 5 admitted to the facility on [DATE] with diagnoses including anxiety, depression, and cognitive communication deficit. The quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 07/15/2024 showed the resident had intact cognition, and was on an anti-depressant. Review of Resident 5's PASRR dated 06/14/2024 showed they had a serious mental illness (SMI) which was identified as a mood disorder - depressive or bipolar, and anxiety. Review of the service needs and assessor data showed the resident was determined that a Level II evaluation was indicated. Additional comments read that the resident's level 1 from the hospital was incorrect, and that the resident was positive for SMI and required a Level II. Review of Resident 5's medical record showed no documentation the PASRR had been validated or invalidated. The medical record showed no documentation there was any communication with the PASRR validator. In an interview on 09/27/2024 at 11:43 AM Staff F, SSD stated they review on admission any residents with diagnosis of SMI and verify if the PASRR evaluations are accurate on admission. Staff F stated if they see that the resident qualified for a Level II, and it was not completed then they will submit on new Level I. Staff F confirmed that they sent a new PASRR in June. Staff F confirmed they had not completed any more follow up since June 2024 for Resident 5 and their need for a Level II evaluation. Refer to WAC 388-97-1975

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 36787 Based on observation, interview and record review, the facility failed to assist five of nine dependent residents (3,15, 53, 62, and 122) with routine activities of daily living. Failure to provide routine hair brushing, routine oral care, and repositioning placed the residents at risk for poor hygiene,oral hygiene/health issues, skin breakdown, medical complications, discomfort, dignity issues, and diminished quality of life. Findings included . Review of facility policy titled, Activities of Daily Living (ADL's), revised 05/01/2023, showed a patient who is unable to carry out ADL's will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. <RESIDENT 3> Resident 3 admitted to the facility on [DATE] with diagnoses to include respiratory failure, tracheostomy, and was dependent on a ventilator. Review of Resident 3's Quarterly Minimum Data Set (MDS) assessment (an assessment tool) dated 07/23/2024, showed the resident was comatose and dependent for all care and mobility. The resident had impaired range-of-motion to both sides of their upper and lower extremities. Review of Resident 3's care ADL care plan initiated on 05/26/2015 directed staff to assist the resident in turning and repositioning every two hours and as needed, provide one-person total assist for grooming and provide two-person total dependence with bed mobility, making sure the resident has a pillow between knees while turning/repositioning. Review of the bed mobility and grooming documentation for July, August and September 2024 in the facility's electronic medical record (EMR) system, showed Resident 3 was dependent on staff for bed mobility and hygiene. In an observation on 09/24/2024 at 9:49 AM and 11:50 AM, Resident 3 was observed in bed on their back. The residents long hair was unkempt, 1/2 inch long white chin hair were observed. In an interview on 09/25/204 at 3:14 PM, Collateral Contact (CC) 1, family of Resident 3 said they would like their hair brushed as it gets tangled. CC 1 said their loved one should be checked on every two hours and turned but the staff don't. CC 1 said they can be at the facility six hours visiting and no staff come in during that time. CC 1 said the resident preferred bed baths, but they did not get enough of them. In observations on 09/25/2024 at 11:33 AM, 1:25 PM, 2:35 PM, Resident 3 was observed in bed on their back. Their hair was matted, and the white chin hairs remained. In observations on 09/26/2024 at 8:34 AM, 9:57 AM, 12:02 PM, 1:23 PM, and 2:17 PM, Resident 3 was observed in bed on their back. Their hair was matted, and the white chin hairs remained. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In observations on 09/27/2024 at 9:07 AM, 10:18 AM, 11:12 AM, 12:03 PM, 1:09 PM, and 2:00 PM, Resident 3 was observed in bed on their back. Their hair was matted, and the white chin hairs remained. In observations on 09/30/2024 at 9:00 AM, 9:57 AM, 10:02 AM, 11:08 AM,12:20 PM, 1:18 PM and 2:33 PM, Resident 3 was in bed observed on their back. Their hair remained matted, and the white chin were present. In an interview on 09/30/2024 at 3:53 PM, Staff B, Director of Nursing Services (DNS) said the expectation was that shaving, and hair combing should be done every day with ADL care. In a joint interview on 09/30/2024 at 4:22 PM, Staff D, Licensed Practical Nurse (LPN) said Resident 3's husband braids their hair. Staff D said that Staff G, Nurse's Aide Certified, tried to detangle Resident 3's hair yesterday but that it takes time. Staff L, LPN said they were going to have to goop the hair up with conditioner and work at it which may take a couple weeks. Staff D, LPN said Resident 3's husband was at the facility every day and that if they wanted to shave them, they would have. <RESIDENT 15> Resident 15 readmitted to the facility on [DATE] with diagnoses to include chronic respiratory failure with dependence on a ventilator, stage IV occipital (back of the head) pressure ulcer and muscle weakness. Review of Resident 15's Quarterly MDS assessment dated [DATE], showed the resident was cognitively intact. The resident was dependent on staff for personal hygiene, and grooming and they did not reject care. Review of Resident 15's current care plan revised 09/03/2024 , showed the resident was at risk for skin breakdown related to current health conditions including quadriplegia (paralysis to all extremities) and history of multiple pressure ulcers as well as current pressure ulcers. The care plan directed staff to assist the resident in turning and repositioning every 2 to 3 hours as tolerated. In observations on 09/26/2024 at 8:32 AM, 9:55 AM, 12:02 PM, 1:23 PM, and 2:17 PM, Resident 15 was observed in bed on their back. In observations on 09/27/2024 at 9:05 AM, 10:18 AM, 11:12 AM, 12:32 PM, and 1:43 PM, Resident 15 was observed in bed on their back. In an interview and observation on 09/30/2024 at 9:00 AM, Resident 15 was in bed on their back and stated they do not get turned unless they asked staff to reposition them. Resident 15 said they did not get turned every two hours as they should. In subsequent observations on 09/30/2024 at 10:18 AM, 11:02 AM, 12:21 PM, and 1:19 PM, Resident 15 was observed in bed on their back. In observations on 10/01/2024 at 8:31 AM Resident 15 was in bed on their back asleep. In an observation and interview on 10/01/2024 at 9:28 AM, Resident 15 was in bed awake on their back and stated they did not remember if they were turned last night. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/01/2024 at 9:40 AM, Staff I, Nurses Aide Certified (NAC) said Resident 15 was dependent on two staff for their care and mobility. Staff I said they were to turn the resident every two hours. Staff I said Resident 15 did not refuse care but if they were on a video call, they would decline repositioning until later. <RESIDENT 122> Resident 122 re admitted on [DATE] with diagnoses to include respiratory failure, with tracheostomy, ALS (amyotrophic lateral sclerosis, a nervous system disease that weakens muscles and impacts physical function), joint stiffness and a stage IV pressure ulcer (sores that extend through deep tissues, tendons and bone) to their sacrum (lower back). Review of Resident 122's quarterly MDS dated [DATE], showed the resident was dependent on staff for all care. Review of the resident's current care plan directed staff to assist to turn and reposition Resident 122 frequently and per their requests. The care plan showed the resident preferred laying on their back and left side only. Staff were to encourage Resident 122 to allow turning and repositioning every two to three hours. In observations on 09/24/2024 at 10:48 AM, 12:03 PM, 2:37 PM, Resident 122 was observed in bed on their back. In observations on 09/25/2024 at 8:50 AM, 10:00 AM, 12:04 PM, 1:25 PM, 2:36 PM and 3:02 PM, Resident 122 was observed in bed on their back. In observations on 09/26/2024 at 8:32 AM, 9:57 AM, 12:02 PM, 1:23 PM, and 2:17 PM Resident 122 was observed in bed on their back. In observations on 09/27/2024 at 9:07 AM, 10:18 AM, 11:12 AM, PM and 3:02 PM, Resident 122 was observed in bed on their back. In subsequent observations on 09/30/2024 at 9:19 AM, 10:00 AM, 11:02 AM, 12:21 PM, and 1:19 PM, Resident 122 was observed in bed on their back. In an interview on 09/30/2024 at 11:20 AM, Staff H, NAC said they would review the care plan to see what care was needed. Staff H said they were to turn residents every 2 hours. In an interview on 09/30/2024 at 2:17 PM, Staff D, LPN said Resident 122 was alert and oriented and would call us if they needed turned. In an interview on 09/30/2024 at 3:06 PM, Staff B, DNS was informed Resident 122 was observed on their back on all observations since 09/24/2024. No additional information was provided. In observations on 10/01/2024 at 8:34 AM Resident 122 was in bed asleep, on their back. In an observation and interview on 10/01/2024 at 9:28 AM, Resident 122 was in bed on their back. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/01/2024 at 9:36 AM, Staff I, NAC said Resident 122 was dependent on them for all care. Staff I said they would say they turn the resident every two hours. Staff I said the resident needed turned to their side soon. 47047 <RESIDENT 62> Resident 62 admitted to the facility on [DATE] with diagnoses that included anxiety disorder, depression, and spinal stenosis (spaces inside the bones of the spine get too small). Review of Resident 62's care plan dated 05/16/2024 showed they required assistance and was dependent on bathing, grooming and personal hygiene related to quadriparesis (a condition that causes muscle weakness in all limbs) and contractures (tightening of muscles, tendons and skin that limits the normal movement of a joint). Interventions included arranging Resident 62's environment as much as possible to facilitate ADL performance and provide total assist of one person for personal hygiene/grooming. Review of Resident 62's Admission MDS, dated [DATE] showed Resident 62 was dependent on staff for ADL's including oral hygiene. Resident 62's Brief Interview for Mental Status (BIMS-tool used to screen and identify cognition) was completed with a score of 14/15 indicative of intact cognition. On 09/24/2024 at 2:37 PM observed Resident 62's to have a few teeth on their bottom front covered in white debris. On 09/25/2024 at 10:20 AM observed Resident 62 to have their bottom teeth covered in white debris and a gray film. There was a rancid odor coming from their room. On 09/26/2024 at 10:49 AM Resident 62 stated they had not had their teeth brushed. Resident 62 stated it would be nice to have their teeth brushed and they could not recall the last time their teeth were brushed. When asked about the location of their toothbrush and toothpaste, Resident 62 stated they did to know. No toothbrush or oral swabs were observed in Resident 62's room or bathroom. In an interview on 09/27/2024 at 10:36 AM Staff N, NAC stated they provide Resident 62 with oral care, but had not completed it yet. Staff N stated they use a toothbrush and toothpaste or an oral swab to clean Resident 62's teeth. <RESIDENT 53> Resident 53 admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, diabetes mellitus type two, chronic respiratory failure (long term condition that occurs when the lungs can't get enough oxygen into the blood). In an interview on 09/25/2024 at 9:25 AM Resident 53 stated they had not had any assistance with brushing their teeth and were not being offered oral care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow up interview on 09/27/2024 at 8:29 AM with Resident 53 stated they had not had their teeth brushed since admission and staff had not offered or provided any assistance with oral care. There were no toothbrush, oral swabs, or toothpaste located in Resident 53's room or bathroom. In a review of Resident 53's care plan revised 09/17/2024 showed they were dependent on staff for ADL care. Interventions included providing Resident 53 with one person partial/moderate assistance for personal hygiene and grooming. In an interview on 09/27/2024 at 10:58 AM Staff C, LPN-Unit Manager, stated oral care was a daily task for the aides to complete for all residents. Staff C stated they do rounds to monitor for completion of resident hygiene and address any complaints about care as they arise. In an interview on 09/30/2024 at 3:30 PM Staff B, DNS, stated the expectation for oral care completion was at least daily. Refer to WAC 388-97-1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review the facility failed to ensure four of five residents (15, 53, 60 and 66) received treatment and care in accordance with professional standards of practice and ensure testing and labs and were completed as ordered, medications were given in accordance with physician order and blood pressure and specialty physician consult appointments were scheduled per physician order. These failed practices placed the residents at risk of adverse health events, diminished quality of life and unmet care needs. Findings included . Review of the facility's policy titled, Diagnostic Tests, revised 03/01/2024, showed diagnostic tests- including laboratory, and waived testing (fingerstick glucose monitoring , hemoccult testing). Laboratory services will be available seven days a week. All diagnostics results are reported to the patients medical provider. <RESIDENT 60> Resident 60 admitted to the facility on [DATE] with a diagnosis of anemia, high blood pressure, heart failure and a history of cardiac arrest. <MEDICATION PARAMETERS> Review of the resident's physician orders directed staff to administer blood pressure medications Doxazosin 2 MG enterally (through tube) at bedtime, Hydralazine HCL 100 MG three times daily, Losartan Potassium 25 MG twice daily, Carvedilol 12.5 MG twice daily and to hold the medications if the Systolic Blood Pressure (SBP) was below 100 or the heart rate was below 60. Review of the August 2024 Medication Administration Record (MAR) showed Resident 60 received the Doxazosin, Hydralazine, Losartan Potassium and Carvedilol were administered and not held on 08/07/2024 when the heart rate was 59. In an interview on 09/30/2024 at 4:21 PM, Staff L, Licensed Practical Nurse (LPN), confirmed the Doxazosin, Hydralazine, Losartan Potassium and Carvedilol should have been held for the heart rate of 59. In an interview on 10/01/2024 at 10:14 AM, Staff J, LPN said they usually check the vitals and if the vital is low, they enter the vital signs in the MAR and hold the medications per parameters. Staff J could not recall giving those medications on that day. <LABS> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 60's care plan developed on 05/10/2024 directed the staff to monitor for gastrointestinal (GI) symptoms or complaints related to a history of GI bleed. The staff were to ensure labs were drawn as ordered and report the results to the physician. Further, the staff were to monitor for signs and symptoms of obvious bleeding, frank blood in stool, frank blood in vomitus, bruising, nosebleeds, mouth/rectal bleeding, occult (hidden) blood. Resident 60 had a physician order beginning 06/18/2024 to draw a complete blood count (CBC) with Diff & Platelets and basic metabolic panel (BMP) every Monday and Thursday. The order directed staff to make sure the lab slip was filled out and in the lab book for the next draw. Review of the CBC and BMP lab results collected on 09/19/2024 at 7:28 AM were reported to the facility on [DATE]. The results showed the resident had low red blood cells and anemia. Review of a lab result late entry note on 09/20/2024 at 2:33 PM showed the labs were reviewed and Apixaban was held, and an order was given to repeat the CBC. Review of the Advanced Registered Nurse Practitioner (ARNP) note on 09/20/2024 showed the resident had two recent emergency department blood transfusions related to low hemoglobin (protein found in red blood cells that carries oxygen from the lungs to the body organs). The ARNP ordered to hold Apixaban (medication that makes blood flow through veins easily) for two days, order a fecal occult blood test (FOBT, a test to detect hidden blood in stool) and order a CBC on 09/22/2024. Review of the September MAR showed a nurse initialed the FOBT was done, and the CBC was drawn on 09/22/2024. Review of the clinical record showed there was no CBC results on 09/22/2024 or 09/23/2024. There were no results for a FOBT. Review of the next CBC results drawn and located in the clinical record was on 09/24/2024 at 10:55 AM and showed a critically low hemoglobin. In an interview on 09/27/2024 at 1:35 PM, Staff D, LPN said they made Resident 60's labs stat priority (lab tests required immediately to manage medical emergencies) on 09/24/2024. Staff D said they did not have the 22nd lab results back and stated they still did not have those results, five days later. Staff D said as soon as they received the results from the critical labs from the 09/24/2024 collection they immediately notified the doctor and sent Resident 60 out to the hospital. Review of the clinical record did not show a physician order to escalate the 09/24/2024 labs to stat priority. Review of Resident 60's critical care notes on 10/03/2024 showed the resident was hospitalized from 09/24/2024 until 10/03/2024 related to a gastrointestinal hemorrhage (bleeding in the digestive tract) and acute blood loss anemia. In an interview on 09/30/2024 at 2:20 PM, Staff D, LPN said the lab process was the physician's order the labs and that the unit managers update providers of lab results and missed labs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resdient 53 admitted to the faclity on 09/23/2024 with diagnoses that included chronic kidney disease, diabetes mellitus type two, chronic respiratory failure (long term condition that occurs when the lungs can't get enough oxygen into the blood). In an interview on 09/25/2024 at 9:34 AM Resident 53 stated they had a low blood sugar reading that morning and did not know the reason why. Review of Resident 53's care plan revised on 08/14/2024 showed Resident 53 had a diagnosis of diabetes and was non-insulin dependent. There was no goals or interventions related to Resident 53's use of insulin. Review of Resident 53's electronic health record showed they were out of the facility for dialysis services on Tuesdays, Thursdays and Saturdays. Review of Resident 53's September Medication Administration Record (MAR) showed they an order dated 09/23/2024 for Insulin Lispo Injection solution 100 unit/milliliters inject per sliding scale (a type of insulin prescription that adjusts the amount of insulin a patient receives based on their blood sugar levels). Administration times were daily at 6:30 AM, 11:30 AM , 4:30 PM, and 9:00 PM. The MAR showed Resident 53 was not administered their 11:30 AM dose of insulin on 09/24/2024. In an interview on 09/26/2024 at 9:21 AM Staff O, LPN, stated Resident 53 was at dialysis and they would not receive their 11:30 AM dose of insulin. In an interview on 09/26/2024 at 9:23 AM Staff C, LPN-Unit Manager, stated they would contact the dialysis center to find out if they were providing and administering insulin to Resident 53 when they were in dialysis. In a follow interview at 10:45 AM, Staff C stated the dialysis center was not providing insulin to Resident 53 and were monitoring for any signs and symptoms of low and high blood sugars. Staff C stated they would contact Resident 53's provider to review the order for insulin. <RESIDENT 66> Resident 66 admitted to the facility on [DATE] with diagnoses that included atrial fribrillation (irregular heartbeat), complications and disorders of the digestive system, and aquired absence of part of the stomach. In an interview on 09/24/2024 at 2:01 PM Resident 66 stated they had a loose bowel movement after each of their tube feedings and needed to stay close to the bathroom. Resident 66 stated they would like to have their tube feedings twice daily versus the three times daily as prescribed. Review of Resident 66's care plan dated 08/12/2024 showed they had a history of refusing their tube feed at times. There was no information found in the care plan as to the the reason for Resident 66's refusals. Review of Resident 66's provider progress note dated 08/16/2024 showed they were referred to GI clinic for their complaints of diarrhea with their tube feed. Review of Resident 66's Order Summary Report dated 09/24/2024, showed an order for Refer to GI for diarrhea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 66's progress notes dated 09/25/2024 showed they refused their tube feed stating they did not want to have diarrhea. In an interview on 9/27/2024 at 10:09 AM, Resident 53 stated they were not aware of a GI referral related to their complaints of diarrhea. Resident 53 stated they only knew they had a scheduled appointment with their cardiologist. In an interview on 09/27/2024 at 10:11 AM Staff P, Health Unit Coordinator (HUC), stated Resident 53 had an appointment scheduled with their cardiologist (heart physician) and they were coordinating with a team of phsyicians. When asked about the status of the GI referral, Staff P, stated there were three other phsycians working on the GI issues with the cardiologist. In an interview on 09/27/2024 at 11:01 AM Staff C, LPN-Unit Manager, stated they were not aware of a GI referral. Upon reviewing the phsyician order dated 08/16/2024, Staff C, stated they would follow up with Staff P. Staff C stated the process referrals consisted of when an order is written for a referral it is communicated to Staff P, HUC at which time they would secure an appointment. On 09/27/2024 at 1:30 PM Staff C, LPN-Unit Manager, provided documentation titled Appointment and Transportation Information which showed Resident 53 had an appointment with a GI clinic on 10/03/2024, 47 days after it was ordered by the provider. Refer to WAC 388-97-1060 (1)

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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** 47047 Based on observation, interview, and record review the facility failed to ensure oxygen (O2) tubing was appropriately maintained, changed regularly, and dated consistently according to with professional standards of practice and to ensure physician's orders were followed related to supplemental O2 for 1 of 4 sampled residents (Resident 11) reviewed for respiratory care and treatment. Findings included . Review of the facility policy titled Procedure: Oxygen: Nasal Cannula [a thin tube inserted into a person's nose to give oxygen], revised 08/07/2023 directed nursing staff to verify the order for oxygen, label the nasal cannula with the date, label the humidifier with the date, monitor and document the resident's response to oxygen therapy through respiratory rate, heart rate, breathing pattern and use of pulse oximetry. Resident 11 admitted to the facility on [DATE] with diagnoses that included high blood pressure, chronic pain, and muscle weakness. Review of Resident 11's September 2024 Medication Administration Record (MAR) showed they had a physician order for supplemental oxygen as needed at two liters per minute (LPM) via nasal cannula to keep their oxygen saturations (percent of oxygen in the blood) above 90 percent (%). There was no order or indication of when the oxygen tubing, nasal cannula, or humidifier would be changed/replaced. Review of Resident 11's significant change Minimum Data Set (an assessment tool) dated 04/12/2024 showed they had a change in their condition and decline in their activities of daily living and required supplemental oxygen. Review of Resident 11's progress notes dated 06/20/2024 and 06/21/2024 showed they received oxygen continuously at two LPM. Review of Resident 11's care plan most recently revised 09/16/2024 showed no care plan focus, or interventions related to oxygen use. Review of Resident 11's vital signs showed the only documented oxygen saturations were: -September 2024 were completed on 09/19/2024 and 09/24/2024. -August 2024 none were completed. -July 2024 were completed on 070/8/2024 and 07/09/2024. -June 2024 were completed on 06/06/2024, 06/19/2024, 06/20/2024, 06/21/2024 and 06/22/2024. In observations on 09/24/2024 at 1:33 PM, 09/25/2024 at 2:02 PM, 09/26/2024 at 8:57 AM, 09/27/2024 at 9:15 AM and 09/30/2024 at 9:05 AM Resident 11 was observed to be wearing an undated nasal cannula, attached to an oxygen concentrator using an undated humidifier. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/30/2024 at 9:07 AM Staff O, Licensed Practical Nurse (LPN) stated Resident 11 was on oxygen continuously. Staff O stated Resident 11 had a physician order for use of oxygen as needed, and checking Resident 11's oxygen saturation was not required, and they monitored Resident 11 for signs of high or low oxygen levels as well as their vital signs. When asked how they ensured Resident 11's oxygen saturations were maintained above 90%, Staff O stated it was not required during the day shift. Staff O stated nursing staff did not change or replace oxygen tubing and deferred to respiratory therapy. In an interview on 09/30/2024 at 9:24 AM Collateral Contact 5 (CC 5), Respiratory Therapist, stated their department was responsible for changing/replacing nasal cannula and oxygen tubing for the residents in the facility. CC 5 stated all the tubing is changed every Saturday night shift and was tracked either in the MAR or on an internal form. CC 5 provided a form labeled equipment rounds which showed that Resident 11 had a concentrator in their room, LPM was at two and a line through the space marked equipment changed. CC 5 stated they did not know what the line indicated and would find out. CC 5 provided no additional information. In an interview on 09/30/2024 at 10:54 AM Staff C, LPN-Unit Manager, stated the process for oxygen use included respiratory therapy changing/replacing the tubing, nursing checking oxygen saturations every shift and following physician orders. In an interview on 09/30/2024 at 3:30 PM Staff B, Director of Nursing Services, stated Resident 11 used the oxygen when they wanted. Staff B stated Resident 11 had an order for oxygen as needed. Refer to WAC 388-97-1060 (3)(j)(vi)

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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** 44110 Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (Resident 68) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to ensure appropriate indication for psychotropic medications and to monitor and document behaviors and or symptom. These failures placed the residents at risk for adverse side effects, and for receiving unnecessary psychotropic medication. Findings included . Review of the facility policy titled, Behavior Management of Symptoms, revised 07/01/2024 stated the facility will identify, prevent and manage behavioral symptoms but using non-pharmacological approaches, monitoring of outcomes of care plan interventions .staff will monitor and document in the medical record any exhibited behaviors and implement individualized, person-centered interventions, and monitor for adverse effects. Resident 68 admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a neurological disorder that occurs when a chemical imbalance in the blood affects the brain), and dementia. The admission Minimum Data Set (MDS - an assessment tool) assessment, dated 08/27/2024 showed the resident had moderate cognition impairment, and that the resident was on an antidepressant medication. Review of Resident 68's medical record on 09/24/2024 did not show the resident had a diagnosis of depression. Review of Resident 68's physician orders on 09/26/2024 showed an order for Sertraline HCl (antidepressant) tablet for 25 milligrams (mg) one time a day for dementia with behavioral disturbance with a start date of 09/07/2024. The physician orders did not reflect any orders for monitoring of depressive behaviors, symptom management, interventions to prevent, or adverse side effects. Review of Resident 68's care plan on 09/26/2024 showed no guidance for monitoring of depressive behaviors, symptom management, interventions to prevent, or adverse side effects for the treatment with an antidepressant medication. In an interview on 09/27/2024 at 11:47 AM, Staff E, Licensed Practical Nurse (LPN) stated the care plan and physician orders are what drive the care for each resident. Staff E stated that behaviors and non-pharmacological interventions are in the physician orders and the care plan. Staff E stated the unit manager nurse was responsible for updating the care plans and orders when a resident was on any psychotropic medication. (continued on next page)

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	505491	A. Building B. Wing	10/01/2024

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/30/2024 at 9:52 AM, Staff C, LPN/Unit Manager stated that the physician orders were where the nurse would document any behaviors the resident may have, non-pharmacological interventions used, and if they were effective. Staff C stated that the residents care plan should also reflect any monitoring for psychotropic medications. Staff C confirmed that Resident 68 was on an anti-depressant since 09/07/2024. Staff C was able to confirm that Resident 68's physician orders and care plan did not reflectthat the resident was being administered an anti-depressant, and that there was no monitoring for behaviors, non-pharmacological interventions, and adverse side effects of an anti-depressant. Staff C stated they were responsible for ensuring the medical record was updated appropriately and they were unclear as to why it had not been completed. In an interview on 09/30/2024 2:46 PM, Staff B, Director of Nursing Services stated every resident that was on a psychotropic medication should have an appropriate diagnosis, individualized behavior monitoring and non-pharmacological interventions, documentation of effectiveness and monitoring for adverse side effects. Staff B stated they had been made aware Resident 68 was lacking that information for the anti-depressant they had been prescribed and receiving. Staff B stated they were unaware the medical record had not been updated. Refer to WAC 388-97-1060(3)(k)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 51312 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent when four out of 26 medication opportunities resulted in a 15% medication error rate by two of three licensed nurses (Staff R and E) observed for medication administration. This failure placed residents at risk for adverse events and decreased quality of care. Findings included . <STAFF R> In an observation on 09/26/2024 at 10:40 AM, Staff R, Registered Nurse (RN), reviewed the orders for Resident 24 to include an order for a multivitamin tablet. Staff R was observed to dispense multivitamin liquid instead of the ordered tablet form. Staff R stated, I know that says tab (let), but we only have the liquid. In a continued observation, Staff R removed two OcuSoft eyelid cleansing pads from the medication cart for Resident 24. Staff R was observed to document in the electronic medical record that the eye cleansing wipes were administered. Staff R then entered Resident 24's room and administered the liquid multivitamin to Resident 24 through their gastrostomy tube (a tube directly into the stomach). Staff R was observed to place the two packages of OcuSoft eye cleansing wipes in a drawer in resident 24's room and stated the nursing assistant certified (NAC) would use them later. Record review of Resident 24's August 2024 Medication Administration Record (MAR) showed an order for a Multivitamin in tablet form. In an interview on 09/27/2024 at 10:13 AM, Staff Q, NAC, stated that they sometimes got eye pads out Resident 24's drawer but didn't know what they were called. <STAFF E> In an observation on 09/27/2024 at 12:00 PM, Staff E, Licensed Practical Nurse (LPN), reviewed the record for Resident 35's medication and dispensed Gabapentin 400 milligrams (mg) and Tizanidine 2mg. Staff E was observed to dispense the medications into a plastic cup. Staff E was observed to go into Resident 35's room and hand Resident 35 their cup containing the pills; Resident 35 stated they would take them later, and Staff E left Resident 35's room. In an interview on 09/27/2024 at 1:48 PM, Staff D LPN/RCM stated there were no residents on a self med program on unit two and they were unsure about unit one. In an interview on 09/30/2024 at 10:13 AM, Staff C, the unit manager, stated that residents are only allowed medications at the bedside if they are on the self-medication program. Staff C stated that they did not think Resident 24 and Resident 35 were on that program. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/30/2024 at 10:35 AM, Staff C returned after checking to ensure that neither Resident 24 or 35 were on the self-medication program. Staff C was asked what was the process staff should follow when medications were ordered in pill form and only the liquid form was available. Staff C stated that the resident's provider should be made aware of medications ordered in pill form and administered in liquid form and get the order clarified or changed. In an interview on 09/30/2024 at 2:46 PM, Staff B, Director of Nursing Services (DNS), stated that the nurses should return medications to the medication cart if the resident refuses. Staff B stated nurses could not leave medications in the room unless the resident had an assessment completed, there should be a physician's order and it should be on the care plan. Refer to WAC 388-97-1300(3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals were secure on two of two units (Units 1 and 2). The facility also failed to follow an established process to ensure accurate reconciliation of controlled medications. These failures placed residents at risk for unauthorized access to medications and biologicals, for receiving compromised medications and placed the facility at risk for the potential of narcotic diversion. Review of the facilty policy titled, Medications self-administration, revised 03/01/2022 showed patients who request to self'-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self-administer: o A physician/advanced practice provider (APP) order is required. o Self-administration and medication self-storage must be care planned. o When applicable, patient must be provided with a secure, locked area to maintain medications, o Patient must be instructed in self-administration. o Evaluation of capability must be performed initially, quarterly, and with any significant changes <MEDICATIONS AT BEDSIDE> <RESIDENT 54> Resident 54 admitted on [DATE] with diagnoses to include throat cancer and tracheostomy. The resident had no cognitive impairment. In an observation on 09/24/2024 at 11:37 AM, Resident 54 was standing up at their overbed table eating pudding with several white pills on top of the pudding. There was no nurse present in the room or in the hall. Review of Resident 54's physician orders showed they were not on a self-medication program. Review of Resident 54's care plan showed they were not on a self-medication program. Review of Resident 54's clinical record showed there was no assessment completed to assess if the resident was safe to self-administer their medications independently. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/27/2024 at 1:48 PM, Staff D, Licensed Practical Nurse (LPN), said they did not know about unit 1 but there was no one on unit 2 with a self medication program. Staff D was notified that on 09/24/2024, Resident 54 was obsesrved taking their pills in pudding with no nurse present or around. Staff D said the resident is alert and oriented so maybe the nurses left the medications for them. Staff D said they would have to look into this. No additional information was provided. In an interview on 09/30/2024 at 11:39 AM, Staff C LPN said they asked Resident 54 on Friday (09/27/2024) and the resident said they did not have pills in their pudding that day. Staff C was informed the observation was on 09/24/2024 at 11:37 AM. Staff C said that the resident even wrote a statement that they did not have meds in their pudding. Staff C acknowledged medications should not be left at the bedside. <RESIDENT 24> Resident 24 was admitted to the facility on [DATE] with a diagnosis of amyotrophic lateral sclerosis (ALS), a terminal progressive disease that affects nerve cells that control muscles in the body. In an observation on 09/26/24 at 10:40 AM, Staff R, Registered Nurse (RN) took OcuSoft eyelid cleansing pads from the medication cart for resident 24. Staff R was observed to place the two packages of OcuSoft eye cleansing wipes in a drawer in resident 24's room and stated the nursing assistant certified (NAC) would use them later. Review of Resident 24's physician orders showed they were not on a self-medication program. Review of Resident 24's care plan showed they were not on a self-medication program. Review of Resident 24's clinical record showed there was no assessment completed to assess if the resident was safe to self-administer their medications independently <RESIDENT 35> Resident 35 was admitted to the facility on [DATE] with diagnoses to include cancer, pain, and hip dislocation. In an observation on 09/27/2024 at 12:00 PM, Resident 35 was lying in bed when Staff C brought medications into Resident 35's room. Resident 35 was handed a cup of pills by Staff E, LPN; Resident 35 set the pills on the bedside table, and Staff 35 acknowledged that Resident 35 would take them later. Review of Resident 35's physician orders showed they were not on a self-medication program. Review of Resident 35's care plan showed they were not on a self-medication program. Review of Resident 35's clinical record showed there was no assessment completed to assess if the resident was safe to self-administer their medications independently. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 41> Resident 41 admitted to the facility on [DATE] with diagnoses that included stroke, diabetes mellitus (a condition in which the body has trouble controlling blood sugars) with high blood sugar, pain in the left arm. In an observation on 09/27/24 at 10:53 AM, Resident # 41 was lying in bed with pills sitting on the bedside table in a pill cup. There was no staff present in Resident 41's room. Resident 41 stated she would take the pills later, but they are not good for her stomach. In an observation on 09/27/24 at 10:56 AM, Staff R, Registered Nurse (RN), entered resident 41's room to bring in applesauce so the resident could take her pills. Staff R then left Resident 41's room. Review of Resident 41's physician orders showed they were not on a self-medication program. Review of Resident 41's care plan showed they were not on a self-medication program. A review of Resident 41's clinical record showed that no assessment was completed to determine whether the resident was safe to self-administer their medications independently. In an interview on 09/30/2024 at 2:46 PM, Staff B, Director of Nursing Services (DNS) said if resident did not take their pills at the time of admininstration then they needed to take the meds back. Staff B, DNS they were was upset that residents who were alert and oriented were having meds left at bedside. Staff B said this had been an issue at the facility in the past but they had not seen this in a while. Staff B said there should be an assessment, a physician order, and the care plan should reflect self medication programs. 37890 <MEDICATION RECONCILIATION> In an observation and interview on 09/26/2024 at 2:16 PM, Staff J, Registered Nurse (RN) and Staff S, RN were conducting the shift change narcotic count. Staff S was the offgoing nurse and Staff J was the oncoming nurse. Staff J opened the narcotic drawer and began reading off the numbers of the medication cards or bottles to Staff S. The narcotic cards and bottles in the drawer were not in any consecutive order. Staff S was observed to have two different books and was going back and forth in an unorganized manner between the two books and flipping through the pages until they found the page called out by Staff J. Staff S would then state the amount of tablets or liquids written on the page and Staff J would confirm that amount. There was no observation of each page of the book being reviewed. There was one medication Staff S was not able to find a page for and that was found to be in yet a third book that was found in the medication room. Staff S and Staff J stated this was the process they followed, one person reads the book and one person reads the cards. They stated the reason there was an extra book was because they had switched pharmacies and some medications had not been transferred over to the new books. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/30/2024 at 2:59 PM, Staff B, DNS stated when conducting the narcotic reconciliation at shift change the licensed nurses should go page by page or they may miss something. They had switched pharmacies and the nurses were in the process of transferring medications to the new books but they still currently may have some medications in the old books. 51312 Refer to WAC 388-97-1300 (1)(b)(ii)(2)