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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on observation, interview, and record review, the facility failed to ensure a dignified existence was maintained for 1 of 1 sampled resident (Resident 58) reviewed for resident rights. The facility failed to ensure Resident 58's dignity, based on reasonable person as their roommate (Resident 29) watched and listened to pornography video (sexually explicit) on their laptop that could be overheard in the hallway. This failure placed all residents at risk for a diminished self-worth and a diminished quality of life. Findings included . According to Center for Medicare and Medicaid (CMS), document titled, Psychosocial Outcome Severity Guide, revised October 2022, states reasonable person concept was used to determine whether an individual's actions or responses align with what a hypothetical reasonable person would do under similar circumstances. It defines the behavior expected of an ordinary, prudent, and rational individual. Review of the facility policy titled, Resident Rights, revised on 02/01/2023 stated the purpose was to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their self-esteem and self-worth. Resident 58 admitted to the facility on [DATE], with diagnoses that included history of stroke, post-polio syndrome (causes paralysis), and diabetes. The Admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE] showed the resident was in a vegetative state (a disorder of consciousness or an altered consciousness) and was dependent on staff for all cares. In a continuous observation on 03/12/2025 1:35 PM, outside Resident 58's room, moaning and sexual conversation was heard from the doorway into the hallway. Resident 58's roommate (Resident 29), who has lying in their bed (closest to the doorway) was watching pornography, loudly on their laptop that sat across the front of their bed, while Resident 58 lay in their bed in the same room approximately four feet away. At 1:40 PM, several staff members were observed to walk past the doorway to the room where the audio/video could be heard, no staff reacted or responded to this. At 1:48 PM, another staff member walked up to the doorway, paused and stuck their head into to the room (made a listening motion with the head) then walked away. At 2:02 PM, an unnamed nurse assistant certified (NAC) stopped at the door, again stuck their head in to listen, then walked away. At 2:12 PM another staff member was observed to respond to the noise and stopped in front of the door then quickly walked away. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 03/12/2025 at 2:20 PM, Staff O, Licensed Practical Nurse (LPN) walked up to the doorway of room [ROOM NUMBER] (Resident 58's) to listen to where the moaning was coming from. Staff O stated that the resident (Resident 29) watches pornography all the time, and since they are hard of hearing they tend to turn the volume up very loud. Staff O stated they try to remind them to turn it down. Review of Resident 58's care plan on 03/12/2025, showed no documentation that the resident was content to listen to pornography all the time from the resident's roommates (Resident 29's) laptop. Review of Resident 29's care plan on 03/12/2025 showed there was no documentation the resident chose to watch pornography loudly on their laptop. In an interview on 03/17/2025 at 8:56 AM, Staff Q, NAC stated they have worked at the facility for over [AGE] years. Staff Q stated they used the care plan and Kardex to drive their care for each resident. Staff Q stated Resident 58 requires full dependent care from the staff, they are not able to advocate for themselves and they anticipate all their care. Staff Q stated that they know Resident 58's roommate (Resident 29) watches pornography loudly and will get aggressive if you attempt to disturb them, so they will get the nurse when it happens. In an interview on 03/17/2024 at 9:17 AM, Staff T, LPN stated they have worked at the facility for about five years. Staff T stated the care plan and Kardex are the driver to what level of care each resident requires. Staff T stated Resident 58's roommate (Resident 29) watches pornography on their laptop and will curse at you if you attempt to interfere with them. Staff T stated they (Resident 29) used to not have a roommate so they would just close the door so others could not hear or see from the hallway. Staff T stated they know that Resident 29's son will try and block the websites on the laptop, but they always find a way. Staff T stated they remember in the past they offered headphones, but Resident 29 refused. Staff T stated the facility would need to do something since Resident 58 was living in that room now. In an interview on 03/17/2025 11:54 AM, Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) stated they have been the RCM for about 4 months, and they had worked at the facility a year ago previously. Staff D stated they are usually the primary responsible party to update the care plan for their unit of residents. Staff D stated they were aware of Resident 58's roommates (Resident 29's) behavior to watch pornography on their laptop. Staff D stated the roommate was hard of hearing, so they tended to play the volume loudly. Staff D stated they will get really upset if you approach them so they would usually just close the door. Staff D stated they were aware of the situation, however since Resident 58 was in a vegetative state they had not initiated any interventions. Staff D stated they had not reapproached Resident 29 to try and get them to wear headphones. In an interview on 03/17/2025 at 12:06 PM, Staff B, Director of Nursing Services (DNS) stated this was the first time they had heard about Resident 58's roommate (Resident 29) watching pornography loudly on their laptop. In a joint interview on 03/17/2025 at 1:12 PM, Staff A, Administrator and Staff B stated they were not aware that Resident 58's roommate (Resident 29) had been watching pornography loudly. Staff A and Staff B stated that Resident 58 was in a vegetative state. Staff A and Staff B were asked if a reasonable person would want to lie in bed and listen or even see graphic pornography played over and over in their room, both agreed they would not. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0180(1)(2)(3)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review, the facility failed to ensure call lights (an alerting device for staff to assist residents in need) were within reach for 3 of 4 residents (Residents 47, 71 and 78), reviewed for accommodation of needs. This failure placed the residents at risk for delayed care, accidents/falls, anxiety and a diminished quality of life. Findings included . Review of the facility's policy titled, Call Light Policy, dated 02/01/2023 showed that patients will always have a call light or alternative communication device within their reach, when unattended. Staff will respond to call lights and communication devices promptly to ensure safety and communication between staff and patients. <RESIDENT 71> Resident 71 admitted to the facility on [DATE] with diagnoses that included hemiplegia (unable to move one side of the body) affecting their left side, depression, anxiety and Post Traumatic Stress Disorder. In a joint interview on 03/11/2025 at 1:26 PM, Resident 71 and their spouse, Collateral Contact (CC3) 3 stated staff purposefully move their call light out of their reach. Both stated they were worried about retribution for reporting their concern. In an interview on 03/11/2025 at 1:56 PM, Staff A, Administrator was informed about Resident 71 and CC3s concerns about the call light purposefully being moved out of the residents reach. Staff A stated Resident 71 had behaviors and used to push their call light on all the time. In an interview on 03/12/2025 at 9:12 AM, Resident 71 stated the staff took their call light away from them again last night. CC1 stated they or Resident 71's sister (CC 4) came to visit at 9:00 AM and the resident's call light was hanging up on the wall, out of their reach. In an interview on 03/12/2025 at 2:20 PM, Resident 71 was in bed with CC 3 at the bedside. The call light was found clipped at the bottom of the left corner of the mattress, out of their reach. CC 3 said the call light was either there or wrapped over the outlet on the wall when they arrive. At 3:28 PM, the call light remained out of the residents reach. In an observation on 03/13/2025 at 9:00 AM, the privacy curtain was pulled mostly around Resident 71. The call light was observed pinned to the lower portion of the left upper mattress corner and out of the residents reach. In an interview and observation on 03/13/2025 at 1:31 PM, CC3 stated that Resident 71 had four falls since admission, one of which was when they purposely crawled out of bed to look for help when the staff had left their call light out of reach, and they needed help. (continued on next page)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In observations on 03/14/2025 at 10:30 AM, Resident 71 was in bed and their call light was observed clipped to the bottom upper left corner of their mattress, out of their reach. At 1:30 PM and 2:26 PM, the call light remained in the same location out of the residents reach. In an interview on 03/17/2025 at 11:43 AM, Resident 71 was in bed with the curtain mostly closed and their call light was out of reach. In an interview on 03/17/2025 at 12:30 PM, CC4 stated Resident 71 reported to them this morning that their call light was taken away from them at 1:30 AM and left on the counter. CC4 stated they are at the facility several days a week and almost every single time they arrive to visit the residents call light is out of their reach. <RESIDENT 78> Resident 78 admitted to the facility on [DATE] with diagnoses to include a traumatic brain injury and multiple fractures after a motor vehicle accident. In an observation on 03/14/2025 at 10:28 AM, Resident 78 was up in their wheelchair in their room playing cards. Their call light was out of reach on the other side of their bed. In an interview on 03/17/2025 at 9:20 AM, Staff D, Registered Nurse (RN)/ Resident Care Manager (RCM) stated call lights should be in reach of the resident and answered in 15 to 20 minutes. In an interview on 03/17/2025 at 11:47 AM, Staff E, RN stated the expectation is that call lights be within reach of the resident. 44110 <RESIDENT 47> Resident 47 admitted to the facility on [DATE] with diagnoses that included glaucoma (eye disease that leads to vision loss), Dementia, and anxiety. The resident's native tongue was Mandarin (a Chinese dialect) and understands little English. In a continuous observation and interview on 03/12/2025 starting at 1:11 PM, Resident 47's call light was observed to be wrapped in a circular motion under the bed, and not within reach of the resident. At 1:49 PM, activity staff were observed to enter room to speak with Resident 47's roommate, then leave. The call light was observed to continue to lay on the ground. At 2:04 PM, an unknown Nursing Assistant Certified (NAC) was observed to investigate the room and leave, the call light remained on the ground. At 2:11 PM another unknown staff member went into the room, then exited, no change to the position of the call light. At 2:19 PM, Staff O, Licensed Practical Nurse (LPN) was observed to enter the room, look at the resident and then exit the room. Staff O was asked why they had entered the room, and responded they thought they heard the resident yelling for help. Staff O was asked if the resident was able to use their call light, and Staff O stated yes, they have a soft to touch light they use frequently. Staff O was asked if the call light should be within reach for the resident and they responded that the call light should always be within reach. Staff O then walked back into the room and observed the call light wrapped in a circular ball under the bed and retrieved the call light and placed it within reach of the resident. (continued on next page)

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F 0558 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 03/14/2025 at 12:50 PM, Staff P, NAC, stated that they round frequently on all their residents and will always ensure they have their call light within reach. Staff P stated Resident 47 will always use their call light and calls often. In observations on 03/17/2025 at 8:51 AM, 9:16 AM, and 10:02 AM, Resident 47's call light was observed to be lying on the floor under bed out of reach of the resident. In an interview on 03/17/2025 at 8:56 AM, Staff Q, NAC stated that they round frequently on all their residents and will always ensure they have their call lights are within reach. Staff Q stated Resident 47 will always use their call light and calls often. In an interview on 03/17/2025 at 11:54 AM, Staff D stated it was their expectation that staff are ensuring that residents always have their call lights within reach. Staff D was advised of observations of Resident 47's call light on the floor, and stated staff should be checking every time they are in the room. In a joint interview on 03/17/2025 at 1:38 PM, Staff A, Administrator and Staff B, Director of Nursing Services stated they were not aware call lights were out of reach of residents. Reference: (WAC) 388-97-0860 (2)

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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> 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 (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 02/18/2025 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 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, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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> 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. (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 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 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. - 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review, the facility failed to ensure that 2 of 5 residents (Residents 71 and 74) reviewed for Pre-Admission Screening and Resident Review (PASRR) assessments, were accurately completed prior to or upon admission to facility, or updated if resident's conditions change. This failure placed residents at risk for not receiving timely and necessary mental health services, and decreased quality of life. Findings included . Review of the facility policy titled, Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients dated 02/16/2024 showed the Social Worker or designated staff will assure that all patients with Mental Disorders (MD) and/or Intellectual Disability (ID) receive appropriate pre-admission screenings according to federal and/or state regulations. The purpose is to ensure that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs. Social Services will be responsible for coordinating updates as needed and per state requirements and notifying the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a patient who has a MD or ID for patient review. <RESIDENT 71> Resident 71 admitted to the facility on [DATE] with diagnoses to include major depressive disorder, anxiety disorder and Post Traumatic Stress Disorder (a mental condition caused by an extremely stressful or terrifying event). Review of the Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 02/04/2024, showed the resident was being treated with antipsychotic, antianxiety and antidepressant medications and there were indications for the use. Review of Resident 71's Level 1 Pre-Admission Screening and Resident Review (PASRR), dated 01/28/2025, showed the resident had a mood disorder and no psychotic disorder, or anxiety disorder. The PASRR was marked exempted hospital discharge with the attending physician certifying that the resident would require fewer than 30 days of nursing facility services. The PASRR was marked No Level II evaluation indicated at this time due to exempted hospital discharge. A Level II must be completed if scheduled discharge does not occur within 30 days. Review of a social service progress note on 01/30/2025 at 5:00 PM, showed Resident 71 admitted on [DATE] from the hospital and a PASRR Level 1 was received, noting the resident was positive for SMI (significant mental illness) with diagnosis of Mood Disorder, negative for intellectual disability with no level II evaluation indicated due to exempted hospital discharge. The note showed a Level II would need to be completed if scheduled discharge did not occur within 30 days and social services would follow up as needed. Review of Resident 71's psychotropic drug use care plan dated 02/01/2025 directed staff to arrange for PASRR re-evaluation if there was a significant change in status that results in new evidence of possible mental disorder, intellectual disability and/or related condition. (continued on next page)

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	505491	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 71's January Medication Administration Records (MARs), showed they were receiving the following medications: -Aripiprazole (antipsychotic, a drug that changes the activity of natural substances in the brain) daily for moderate episode of major depressive disorder. -Lorazepam (antianxiety medication) as needed every 8 hours for anxiety and depression. -Sertraline (antidepressant medication) daily for depression Review of Resident 71's February MAR, showed they were receiving Aripiprazole, Lorazepam and Sertraline and the following psychotropic medications were added: -Quetiapine (antipsychotic medication) twice daily for agitation was ordered on 02/27/2025 -Remeron (antidepressant) at bedtime for major depressive disorder was added 02/27/2025 and Sertraline was discontinued. Review of Resident 71's March MAR, showed they were receiving Lorazepam, Remeron, and the following psychotropic medications were added: -Clonazepam (antianxiety medication) twice daily as needed for confusion and agitation was added on 03/05/2025. Lorazepam was discontinued. -Benadryl (medication to relieve allergy symptoms with known side effect of drowsiness) as needed nightly at bedtime for insomnia was added 03/14/2025. Benadryl is no longer recommended for older adults related to the high risk of side effects and safer alternatives available. Review of Resident 71's clinical record on 03/17/2025 at 11:00 AM, showed there was no referral for a Level II PASRR, and the resident had admitted on [DATE], 48 days prior. In an interview on 03/17/2025 at 1:38 PM, Staff A, Administrator stated they were unaware of any PASRR issues in the facility including for Resident 71 and 74. Staff A stated they were cited for PASRR last survey, and they had audited PASRR's and had not missed any until these ones. 51312 <Resident 74> Resident 74 admitted to the facility on [DATE] with diagnoses to include mild cognitive impairment and bipolar disorder (a mental health condition that causes extreme mood swings). Review of Resident 74's Level 1 PASRR, dated 1/15/2025, showed the resident had a diagnosis of bipolar disorder (a mood disorder). Sections IIA, IIB, and III were blank, and the PASRR was not signed by a physician as required for hospital exemption. Section IV was marked; No Level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 74's records on 3/12/2025 at 1:02 PM showed there was no referral for Level II PASRR, and the resident had admitted on [DATE], 38 days prior. In an interview on 03/13/2025 at 11:28 AM, Staff F, Social Services, stated that they were responsible for PASRR's and worked with admissions to ensure accuracy. While reviewing resident records, Staff F stated that they had not yet contacted the PASRR coordinator regarding Resident 74 and that the resident should have had their PASRR completed on 02/24/2025. Reference WAC 388-97-1915(1)(2)(a)(c)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review the facility failed to ensure the baseline care plan included the minimum healthcare information necessary to properly care for the resident and/or ensure the resident and/or responsible party were informed of the initial plan for delivery of care and services within 48 hours of admission for 5 of 5 (Residents 66, 71, 78, 284, and 334) residents reviewed for baseline care plan. These failures placed residents at risk for clinical complications, of not receiving person centered care and being at risk of unmet care needs. Findings included . Review of a facility policy, titled, Person-Centered Care Plan, revised date 10/24/2022, showed the center must develop and implement a baseline person-centered care plan within 48 hours of admission. <RESIDENT 284> <COMMUNICATION> Resident 284 was admitted to the facility on [DATE] with diagnoses to include aphasia (language disorder that affects a person's ability to understand, use or produce language) following cerebral infarction (ischemic stroke - a condition where blood flow to the brain is interrupted, causing brain cells to die), dysphagia (difficulty swallowing foods or liquids). According to admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], resident was cognitively intact, with unclear speech. In an interview on 03/11/2025 at 11:05 AM, Resident 284 was using pen and paper on a clipboard to write what they were trying to convey their needs. There were also some pictures on the clipboard as well. The resident was able to verbalize, short simple words and when they couldn't say the word, they would write it down. The resident wrote down that staff sometimes did not understand them. Record review of Resident 284's care plan with a print date of 03/12/2025, did not show anything about the resident's speech and how they communicated. In an interview on 03/13/2025 at 10:12 AM, Staff J, Nursing Assistant Certified (NAC) stated that Resident 284 required set up for dressing and were independent with toileting and used their call light. Staff J added that the resident wrote notes on the paper to inform the staff what they want. When asked how they get information about newly admitted residents, Staff J stated that the nurse would give them information, then they would look at what's in the resident's care plan and other parts of the chart. Staff J added that the NAC from previous shift would also give them report. When asked how they found out that the resident uses pen and paper to communicate, Staff J stated that they had observed a family member doing it when they were talking to resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 03/13/2025 at 1:46 PM, Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) stated that they do admissions at the facility. They stated that when they admit a resident they do their assessment and initiate a care plan. Staff D stated the initial care plan consisted of resident's activities of daily living (ADL's -person's ability to function daily such as eating, dressing, toileting, bathing, transferring in and out of bed), pain, risk for fall, and skin. When asked about Resident 284's speech, Staff D stated that they were able to understand resident's speech and sometimes the resident wrote down what they were trying to convey. Staff D added that if you give the resident time and in a quiet room, you could understand what the resident was saying. Staff D was unable to locate the resident's communication information in the care plan. <DIET> In a record review on 03/17/2025, Resident 284's electronic chart showed the provider ordered, nectar thick liquids for meals and medications, and the resident could take thin water between meals every shift beginning 03/13/2025. In an interview on 03/17/2025 at 12:36 PM, Staff W, NAC, stated that they looked at the care plan to find out if a resident was on thickened liquids. In an interview on 03/17/2025 at 12:37, Staff J, NAC stated that they looked at the Kardex (quick reference used to condense key patient information for easy access and updating during each shift) or care plan and the nurse would also notify them if a resident was on thickened liquids. Record review on 03/17/2025 showed that Resident 284 was working with Speech Therapist five times per week for oral function treatments, speech language treatment, and group therapy to address cognitive communication deficit, aphasia, apraxia (a neurological disorder that affects the brain's ability to plan the sequence of movements needed for speech), and oropharyngeal dysphagia. Record review of Resident 284's care plan and Kardex with a print date of 03/12/2025, did not show anything about the resident being on a thickened liquid. 51551 <RESIDENT 334> Resident 334 was admitted to the facility on [DATE]. In an interview on 03/11/2025 at 10:33 AM, Collateral Contact 1 (CC1), family of Resident 334, stated staff had not yet communicated with them regarding the plan of care, appointment, or discharge planning. Review of Resident 334's Electronic Health Record (EHR), showed no documentation of communication with the resident or representative about the resident centered care and goals of the care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview on 03/14/2025 at 08:39 AM, Staff C, Registered Nurse/Resident Care Manager, stated during the admission process they set up a baseline care plan including pain, skin check, vital signs, fall risk, ADLs etc. depending on the situations and they communicated the findings with the resident and/or family members. Staff C stated there was no written copy about baseline care plan provided for residents and/or representatives nor documentation they communicated the baseline care plan with the resident and/or representatives within 48 hours. Staff C stated the interdisciplinary team documented they communicated the care plan with residents and/or representatives in the initial care conference which usually was set up during 72 hours upon resident's admission. Staff C stated Resident 334's initial care conference was scheduled on 03/06/2025, eight days after admission, but the initial care conference did not occur until 03/12/2025, fourteen days after admission. In an interview on 03/14/2025 at 3:25 PM, Staff B, Director of Nursing (DNS), stated the baseline care plan was set up on the admission day but there was no documentation of baseline provided to residents and/or representatives. Staff B stated social services did the initial care conference and documented they communicated with the resident and/or representative about the care plan. Staff B stated the initial care conference should be set up within 72 hours depending on the representative's availability. Staff B stated they were not sure why Resident 334's initial care conference was not done until day fourteen since the spouse was at the bedside every day. 36787 <RESIDENT 71> Resident 71 admitted on [DATE]. Reviews of Resident 71's care plan initiated on 02/01/2025 showed Resident/Patient or healthcare decision maker shall participate in decisions regarding medical care and treatment through next review date and inform resident/patient and/or healthcare decision maker of any change in status or care needs. The care plan directed staff to promote opportunities for Resident/Patient/Health Care Decision Maker to participate in decisions regarding care Review of Resident 71's medical record showed no documentation that staff had discussed the goals of care with the resident or resident representative within 48 hours of admission. Review of the Post Admission Patient-Family Conference assessment showed it was done on 02/04/2025, seven days after admission. The assessment showed the copy provided to resident or responsible party was not marked /left blank. Review of a social service progress note on 01/31/2025 at 8:50 AM, showed social services met with resident, introduced self, role in facility and provided facility orientation. Social services conducted a psychosocial assessment and invited the resident to participate in care plan meeting and left a message with the resident's family for a care plan meeting. In an interview on 03/13/2025 at 1:31 PM, CC3 stated they would like to see their family members care plan. CC3 said they never received a copy of it and at the last facility the care plan was kept in the closet. CC3 said they would feel more comfortable knowing the plan of care and what the staff know about their family members care and preferences. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	<RESIDENT 78> Resident 78 admitted on [DATE]. Review of Resident 78's medical record showed no documentation that staff had discussed the goals of care with the resident or resident representative within 48 hours of admission. Review of the Post Admission Patient-Family Conference assessment showed it was done on 01/20/2025, five days after admission. The assessment showed the copy provided to resident or responsible party was not marked /left blank. In an interview on 03/17/2025 at 11:28 AM, Staff B, DNS was informed the baseline care plans were late for Resident 71 who admitted on [DATE] and had their care conference on 02/04/2025. Also, Resident 78 admitted on [DATE] and their care conference was held on 01/20/2025. Further, the box was not marked for copy provided to resident and or responsible party. Staff B stated they would look into it that. 42927 <RESIDENT 66> Resident 66 admitted to the facility on [DATE]. Review of Resident 66's medical record showed no documentation that staff had discussed the goals of care with the resident or resident representative within 48 hours of admission. Review of the Post Admission Patient-Family Conference assessment showed it was done on 02/11/2025, six days after admission. During an interview on 03/13/2025 at 3:17 PM, Staff X, Social Worker, stated the facility does not have a meeting with the resident/ representative within 48 hours. Staff SSD stated they set up the first meeting with the resident and/or representative, with the goal of this occurring within the first week after admission. During an interview on 03/17/2025 at 7:44 AM, Staff B, DNS, stated the baseline care plan was to be developed on admission and then staff were to meet with the resident within 72 hours. Staff B stated the meeting is documented on the care conference assessment under in the clinical record. During a record review and interview on 03/17/2025 at 11:44 AM, Staff B provided a copy of Resident 66's Post Admission Patient-Family Conference, dated for 02/11/2025. Staff B reported that the conference was not held within 48 hours of admission. Refer to WAC 388-97-1020(3)(4)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview, and record review the facility failed to review and revise care plans for 3 of 7 residents (Residents 43, 71 and 334) reviewed for care planning. The failure to review and revise care plans to accurately reflect the residents' conditions and needs placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the policy dated 10/24/2022, titled Person-Centered Care Plan showed the care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals. <RESIDENT 71> Resident 71 admitted to the facility on [DATE] with diagnoses to include a swallowing disorder, major depressive disorder, anxiety disorder and Post Traumatic Stress Disorder (mental health condition caused by stressful or terrifying event). Review of the Admission Minimum Data Set (MDS - an assessment tool) assessment, dated 02/04/2024, showed the resident had a swallowing disorder including coughing or choking during meals or when swallowing medications and they received nutrition enterally (through a tube surgically inserted into the stomach). In an interview and observation on 03/13/2025 at 1:31 PM, Resident 71 was in bed and 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 they woke up when Staff U was plunging something into their 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 and observation on 03/14/2025 at 8:32 AM, Resident 71 motioned to this surveyor 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 their nurse, 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, Director of Nursing Services (DNS) walked up and stated they had updated the care plan for nurses to make sure the resident was awake, tell them what medications are being given and to seek permission first. Staff B said Staff U had been in serviced and they were going to in-service the other nurses about this today. Review of the care plan on 03/14/2025 and 03/17/2025 showed the care plan had not been revised to the resident's medication and handling their tube preferences. (continued on next page)

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F 0657 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 03/17/2025 at 10:47 AM, Staff B, DNS stated they filled out a grievance on Resident 71's preference for medications and had updated their care plan. Staff B was informed, there was no care plan revision with the resident's concern with medication administration and their feeding tube preferences. 51312 <Resident 43> Resident 43 is a long-term care resident at this facility. According to the most recent MDS dated [DATE], Resident 43 was severely cognitively impaired. During an observation on 03/11/2025 at 9:50 AM, Resident 43 was in their wheelchair being pushed by Collateral Contact CC 6. While pushing Resident 43 through the doorway, Resident 43 suddenly slid forward, dropping to their knees in front of the wheelchair. Two unknown staff members and Staff BB arrived immediately from the nearby nursing station to help the resident off of the floor. Staff BB then stated, The Hoyer sling should not have been under resident, that was why they fell , they slipped on the sling. In an observation on 03/11/2025 at 9:50 AM, Staff C, Resident Care Manager, was heard asking Staff CC, NAC, Why did you not remove sling? Staff CC replied, We were going to put (Resident 43) back to bed, so I just left it under (Resident 43). In an interview on 03/11/2025 at 10:22 AM, Staff C stated that Resident 43's sling should always be removed after the transfer. They said staff were informed and educated all the time about this. Staff C said that removal of the sling was also part of the care plan. In an interview on 03/11/2025 at 10:18 AM, Staff CC, NAC, stated that staff did not usually remove the sling after Resident 43 transferred to their wheelchair unless they were going out. During record review of the document titled Care Plan, with a print date of 3/11/2025, showed that Resident 43 was to be transferred to their wheelchair using a sling-style Hoyer lift, a patient lift that may be either a sling lift or a sit-to-stand lift. No instructions were provided for removing the Hoyer Sling. In an interview on 03/14/2025 at 3:54 PM, Staff C, stated that the removal of Resident 43's sling should be on the care plan. While reviewing Resident 43's records, Staff C said that they could not locate the removal of the sling on the care plan. During record review of the care plan showed a revision date of 03/13/2025 and instructions were provided for removing the Hoyer Sling. Reference WAC 388-97-1020 (5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview and record review, the facility failed to ensure professional standards were met for 1 of 3 nurses (Staff G) observed for medication administration and 1 of 5 residents (Resident 334) reviewed for blood pressure parameters prior to medication administration. This failure place residents at risk for adverse effects, complications and potential for drug diversion. Findings included . According to the facility policy titled: Medication Administration, dated 01/2025, showed: - Medications are to be given at the time they are prepared. - The person who prepares the dose for administration is the person who administers the dose. - If a dose of regularly scheduled medication is refused the nurse shall document in the Electronic Medication Administration Record that the dose with refused and enter and explanatory note. <RESIDENT 38> Resident 38 admitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes Mellitus (a long term condition which body has trouble controlling blood sugar and using it for energy), osteoarthritis ((type of arthritis that occurs when flexible tissues at the ends of the bones wears down) and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). According to the quarterly Minimum Date Set (MDS- and assessment tool) assessment dated [DATE], showed Resident 38 had moderate cognitive impairment. In an observation and interview on 03/13/2025 at 8:05 AM, Staff G, Registered Nurse (RN) was preparing Resident 38's morning medications. The medications that Staff G placed in the medicine cup were, Oxycodone 5 milligram (mg) - 1 tablet (tab), Tylenol 325 mg - 2-tab, Gabapentin 300 mg - 2 capsules (cap), Duloxetine 60 mg- 1 cap, Amlodipine 10 mg - 1 tab, Lisinopril 20 mg - 1 tab and Januvia 100 mg - 1 tab. Staff G went to resident's room. As soon as staff was inside the room and informed resident that they have their medications, resident stated, they did not want the medicine and told staff to get out of their room. Staff tried to inform the resident again that they have their medication, resident's voice got louder, and they again informed staff they don't want to take the medicine and told Staff G to get out of their room. Staff G went outside the room to their medication cart. Staff G stated that they would re-approach the resident later and stated that resident has a history of refusing medications and sometimes would take the medication later. Staff G was observed to place the medicine cup containing the medications on top of their medication cart. There was no resident name labeled on the medicine cup and it was not covered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an observation and interview on 03/13/2025 at 8:35 AM, Staff G stated that another staff member would approach Resident 38 and attempt to give the medication to Resident 38. Staff H, Infection Preventionist Nurse/Licensed Practical Nurse (LPN) went to Resident 38's room then Staff G took the medicine cup with medications and handed it to Staff H. Staff G informed Staff H what medications they were then left the room and went to their medication cart. Staff G did not wait to see if resident accepted and swallowed the medications. Staff H was in the room with the resident, the door to the resident's room was partially closed and you could not see inside the room. In an interview on 03/13/2025 at 12:55 PM, Staff I, LPN, stated that if a resident refuse to take their medication, they would first ask the resident why they were refusing to take their medication and would try to explain what the medications were and what they were for and if the resident continued to refuse the medications, then they would try to re-approach at a later time. Staff I stated that they would write down the name of the resident on the medicine cup and lock it in their medication cart. If a resident refused twice, they would dispose the medication in the drug buster and notify the provider and family, then they would document in resident's chart of the refusal and inform the oncoming nurse. In an interview on 03/13/2025 at 1:46 PM, Staff D, RN/Resident Care Manager (RCM) stated that if a resident refused to take their medication, they would find out why resident refused to take their medications and if resident continued to refuse then they would ask another nurse to take over the resident's care and notify their RCM. They added that if a resident that was refusing to take their medication was confused, they would attempt to build a rapport with the resident and re-approach. When asked what they would do with the medication that they had prepared and the resident refused to take them, Staff D stated that they were not sure of the facility policy. They said they would put the medications in their medication cart or if they would have to dispose it. When asked what was their process on having another nurse give the medication that another nurse has prepared, Staff D stated that if there's narcotic in the medication cup then they would watch the other nurse give the medication to the resident to confirm that the resident actually took their medication and both the nurses would sign in the Medication Administration Record (MAR). In an interview on 03/14/2025 at 3:25 PM, Staff B, Director of Nursing Services (DNS) stated that if a resident refused to take their medication, the staff would attempt to give it two more times and if the resident still refused them then they would dispose of the medication and notify the provider, family and update the care plan. When asked what the expectation was on what the nurse should do to the prepared medication that resident refused to take, Staff B stated that per policy the nurse must dispose of the medication. They added that some staff know which residents change their minds when re-approached so they would hold on to the medication and place it in their medication cart. However, per their facility policy, the medication must be disposed if resident refuses to take them. When asked what's the process when one nurse prepares the medication and another nurse will give it to the resident, they stated that the nurse that prepared the medication should explain what medications were in the cup by listing the medications and keeping an eye on the nurse while they were giving the medicine to the resident to prevent any drug diversion. 51551 <RESIDENT 334> Resident 334 admitted on [DATE] with diagnoses to include hypertension (high blood pressure). (continued on next page)

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	505491	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident 334's March 2025 MAR, showed Resident 334 had three different types of antihypertensive medications to be given at 9:00 AM and 5:00 PM. The MAR showed all the three medication orders directed nurses to hold the medications for systolic blood pressure (top number of blood pressure reading) less than 100. There was no blood pressure recorded on the MAR. Review of Resident 334's March 2025 vital signs record, showed no blood pressure were recorded at 9:00 AM on 03/02/2025, 03/03/2025, 03/04/2025, 03/06/2025, 03/08/2025, 03/11/2025 and 03/12/2025. There was no blood pressure recorded at 5:00 PM on 03/01/2025, 03/02/2025 and 03/07/2025. Review of Resident 334's electronic health record showed no blood pressure record on the above dates and times. In an interview on 03/13/2025 at 1:20 PM, Staff Y, LPN, stated blood pressures should be checked prior to giving antihypertensive medications and documented under vital signs. Staff Y stated they could not locate the blood pressure record on the above dates and times, and they were not sure why the blood pressures were not documented. In an interview on 03/13/2025 at 3:02 PM, Staff L, LPN, stated they were to check blood pressures prior to giving antihypertensive medications. Staff L stated the blood pressures should be documented under vital signs or progress notes. Staff L stated they could not locate the record either under vital signs or in the progress notes. In an interview on 03/14/2025 at 8:39 AM, Staff C, RN/RCM, stated all nurses were to check blood pressures before administering antihypertensive medications and blood pressures should be recorded under vital signs. Staff C stated they could not find blood pressures record on the above dates and times and would look for them and get back to the surveyor. No further information was provided. In an interview on 03/14/2025 at 3:25 PM, Staff B, Director of Nursing, stated nurses had to follow the order and take blood pressures prior to administering antihypertensive medications. Staff B stated the blood pressures were to be documented in the MAR, or under vital signs, or in the progress notes. Staff B stated if no documentation could be found, the nurses missed taking blood pressure. Reference WAC 388-97-1620 (2)(b)(ii)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51312 Based on observation, interview, and record review, the facility failed to ensure that the resident was assisted by staff with activities as outlined in the care plan for 1 of 4 residents (Resident 43) reviewed for activities. This failed practice placed the resident at risk for isolation and decreased opportunities for a meaningful life in their areas of wellness. <Resident 43> Resident 43 was a long-term resident of the facility. According to the Minimum Data Set assessment dated [DATE], showed the resident was severely cognitively impaired and requires extensive assistance with daily activities. Record review of policy titled Recreation Services Policies and Procedures dated 08/07/2023 stated the purpose of the policy was 'to provide individuals with a wide variety of experiences that are available on a regularly scheduled basis consistent with their assessed life routines, preferences, interests, and personal engagement styles'. Review of a document titled, PASARR level II dated 2/24/2022, showed Resident 43 like to be around people, is young and curious and would like to explore their environment and could manipulate objects. Review of a document titled Care Plan with a print date of 03/11/2025, showed Resident 43 should be assisted to activities, assisted to sit at the nurse station, and be provided with sensory items. Resident 43 also enjoys watching TV and listening to music. During an observation on 03/12/2025 at 11:07 AM, Resident 43 was sitting on their bed with the TV turned off, holding a stuffed animal with one of their legs on the mattress on the floor. During an observation on 03/12/2025 at 1:29 PM, Resident 43 was sitting on their bed with the TV turned off. Resident 43 was hitting their leg and moaning while looking around the room. During an observation on 03/12/2025 at 2:00 PM, Resident 43 was sitting on their bed with the TV turned off. Resident 43 was hitting their leg and moaning. At the same time, BINGO was being played in the dining room. During an observation on 03/12/2025 at 3:25 PM, Resident 43 was sitting on their bed with the TV turned off. During an observation on 03/13/2025 at 1:00 PM Resident 43 was sitting in their wheelchair in their room, the TV is on. During an observation on 03/13/2025 at 1:59 PM, Resident 43 was sitting on their bed, making noises and fidgeting. The TV was on, and cartoons were playing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation on 03/13/2025 at 2:44 PM, Resident 43 was sitting on their bed grinding their teeth. During an observation on 03/13/2025 at 2:53 PM Resident 43 was in their room and there was a painting activity occurring in the dining room. During an observation on 03/14/2025 at 12:06 PM, Resident 43 was in their room sitting in their wheelchair. The wheelchair was facing the wall, and the TV was behind them. Resident 43 was trying to position themselves so they could watch TV. During an observation on 03/14/2025 at 2:16 PM, Resident 43 was in their room sitting in their wheelchair. The wheelchair was facing the wall, and the TV was behind them. Resident 43 was trying to position themself so they could watch TV. At the same time, an activity called 'BINGO' was being held in the dining room. During an interview on 03/14/2025, at 2:16 PM, Staff AA, Activities Director, stated that Resident 43 was one of the residents who received person-centered rounding, and they attempted to take them to parties or movies. Staff AA stated that Resident 43 had not been taken to any activities this week, and there had been no room visits due to being too busy and their brain getting scattered, so (Resident 43) had fallen through the cracks. Reference WAC 388-97-0940 (2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51312 Based on observation, interview, and record review, the facility failed to accurately assess and ensure 1 of 1 resident (Resident 28) received the necessary care and services in accordance with professional standards of practice and maintained the highest practicable level of well-being. Failure to ensure that Resident 28 received services related to a midline IV (an 8-12 cm catheter inserted in the upper arm with the tip located just below the armpit) was adequately managed potentially placed Resident 28 at risk for infection and unmet care needs. Findings include . <Resident 28> Resident 28 was a long-term care resident, with a diagnosis 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 facilities policy titled, Dresing Change for Vascular Access Devices on 03/14/2025 showed, Sterile dressings are to be maintained on all peripheral and central vascular access devices to protect site, provide microbial barrier, and provide device securement. To prevent local and systemic infection related to the IV catheter. Review of facility policy titled Maintaining Patency of Peripheral and Central Vascular Access Devices, on 03/14/2025, stated that vascular access devices are flushed after each infusion to clear the infused medication from the catheter lumen. l. A prescriber's order is needed for all IV flushes. 2. All vascular access devices should be flushed routinely when not in use to maintain patency. Review of document titled PICC/Midline Insertion Sheet dated 02/12/2025 at 6:30 PM showed Midline IV was placed by contract staff in Resident 28s' right arm on 02/12/2025. During an observation on 03/11/2025, at 1:35 PM, Resident 28 was found with a midline IV in the right arm. The IV dressing appeared discolored, with its edges curled up, exposing the IV catheter insertion site. The area around the catheter insertion site was purple directly around the catheter and red surrounding the purple area. The needless connector contained a brown substance, and the catheter tubing that was connected to the insertion site was unclamped and had a brown substance in it. The IV dressing was dated 2/12 and bore initials. During a record review of doctor orders with a print date of 03/11/2025, directed the nurses to DC (discontinue) midline IV on 02/25/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview at Resident 28's bedside on 03/11/2025 at 1:42 PM, Staff C Registered Nurse (RN)/Resident Care Manager (RCM) stated that they did not know when the dressing had been changed. Staff C stated that dressing changes should be on Tuesdays and as needed, and Staff C agreed that Resident 28's IV dressing was not intact and should have been changed. Staff C stated the date on the dressing was 02/12. In an interview at Resident 28's bedside on 03/11/2025 at 1:56 PM, Staff E, RN, stated they had been Resident 28's nurse that day and they had not flushed the IV because there were no orders to flush the IV and that the IV dressing was not intact and was dated 2/12. During an interview on 03/14/2025, at 11:39 AM, Staff H, Licensed Practical Nurse/Infection Preventionist nurse, stated that IV dressings should be changed weekly and as needed and that IV lines should be flushed after the administration of medication. While reviewing Resident 28's record, Staff H noted that Resident 28 did not have orders for IV flushes or dressing changes. Staff H was unsure if the resident had any IV flushes or dressing changes and stateded that the doctor's orders showed the IV should have been removed and taken out on 02/25/2025. This is a repeat deficiency from SOD dated 10/01/2024. Reference WAC 388-97-1060(4)

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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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	505491	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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)

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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)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 4 residents (Resident 284) reviewed for medically related social services. The Social Worker (SW) was out for an extended absence; a plan was not implemented to ensure continuous social service coverage. Failure to ensure residents were informed of their care, treatment, and services available to them and continuously monitor and thoroughly assess and advocate for residents' rights, placed resident at risk for harm, diminished quality of life and unmet care needs. Findings included . Resident 284 was admitted to the facility on [DATE] with diagnoses to include aphasia (language disorder that affects a person's ability to understand, use or produce language) following cerebral infarction (ischemic stroke - a condition where blood flow to the brain is interrupted, causing brain cells to die), dysphagia (difficulty swallowing foods or liquids). According to admission Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], resident was cognitively intact, with unclear speech. In a record review on 03/11/2025, there were no advance directive seen in Resident 284's chart, there were no documentation that resident was asked about advance directives. In an interview on 03/11/2025 at 11:03 AM, Resident 284 stated that they have not had care conference and resident did not know their plan of care. In a record review on 03/13/2025 at 11:24 AM, Resident 284's electronic chart showed a Social Work assessment dated [DATE] which was 9 days after resident was admitted . In the assessment it showed resident's prior living status, resident support system, discharge goals and follow up on Advance Directives. In an interview on 03/13/2025 at 1:46 PM, Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) stated that they schedule care conferences within 72 hours from admit and they schedule the care conference depending on the family's availability. Staff D stated that during care conference, they provide printed copies of resident's medication, orders, and care plan and they discuss resident's plan of care and answer questions from resident or family. In an interview on 03/13/2025 at 3:15 PM, Staff F, SW, stated that they set up care conferences within 72 hours of admission and they coordinate with the family and their availability. Staff F stated Resident 284's care conference was scheduled for 03/17/2025. This was 14 days after admission. When asked why Resident 284's care conference was not set up within 72 hours from admission, Staff F stated that they were on leave when resident was admitted and there were no staff to set it up. In an interview on 03/14/2025 at 8:15 AM, Resident 284 stated that they have talked to the SW, and they have a scheduled care conference on 03/17/2025 and resident stated they were looking forward to it. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/14/2025 at 3:35 PM, Staff B, Director of Nursing Services stated that care conferences were set up within 72 hours from admission and depending on family availability or preference on when they want it. Staff B stated setting up the appointment was usually noted in the progress note on residents' electronic chart. When asked why Resident 284's care conference was not set up within 72 hours from admission, Staff B stated that the SW was off for 2 weeks and the business office manager or MDS nurse covered for the SW. Staff B would find out where they have documented that they tried to set up resident's care conference and followed up on resident's Advance Directive. There was no documentation provided. In an interview on 03/17/2025 at 12:20 PM, Staff A, Administrator stated that they assign different staff to cover the SW duties when the SW goes on vacation. Staff A stated that their receptionist was the one that approached resident regarding care conference, but the note was just added today because they were new and did not know what to do. Reference WAC 388-97-0960(1)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44110 Based on interview and record review, the facility failed to act on the consultant pharmacist's monthly medication regimen review (MRR) recommendations in a timely manner for 1of 5 residents (Resident 13) reviewed for unnecessary medications and 1 of 6 months (November) reviewed for timely completion. Failure to act timely on the pharmacist's recommendations placed all residents at risk for experiencing adverse side effects, medical complications, and a decreased quality of life. Findings included . Review of the facility policy titled, Medication Monitoring, Medication Regimen Review and Reporting, revised 01/2024 stated the MRR was a thorough evaluation of the medication regimen of the residents with a goal to promote positive outcomes and minimize adverse consequences and potential risks .the consultant pharmacist will conduct the MRR at least monthly to monitor the medication regimen and that the resident receives medications that are clinically indicated .a report would be available to the facility within 48 hours of completion of the MRR .recommendations are acted upon within 30 calendar days. <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. Review of Resident 13's physician orders showed an order for ziprasidone (antipsychotic medication) 40 milligrams (mg) one capsule a day to treat schizoaffective disorder. Review of MRR recommendation dated 01/29/2025 state the resident was on an antipsychotic medication and there was no Abnormal Involuntary Movement Scale (AIMS) assessment completed great than six months and based on monitoring guidelines recommendation were to complete. The provided had checked the box that they agree with the recommendation to complete an AIMS assessment and signed and dated by the provider on 02/24/2025. At the bottom of the recommendation there was a note that was written Done and was initialed (not legible) dated 02/25/2025. Review of Resident 13's medical record showed the last AIMS assessment completed was dated 05/09/2024. In an interview on 03/17/2024 at 9:17 AM, Staff T, Licensed Practical Nurse (LPN) stated the AIMS assessment is usually completed by the Resident Care Manager (RCM), however if they are triggered to complete on their shift, they will complete the assessment. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/17/2025 11:54 AM, Staff D, Registered Nurse (RN)/RCM they are usually responsible for completing the assessments that are triggered. Staff D was not sure why Resident 13's AIMS assessment was not triggered to be completed every six months. Staff D stated they assist with the pharmacy recommendations, usually the nursing ones, and will also follow up with the provider ones if they are not completed timely. Staff D was not aware that the pharmacy recommendation for Resident 13 was not completed timely. <NOVEMEBER MRR> Review of the November MRR executive summary from the consultation pharmacist report dated 11/20/2024 showed there was 104 recommendations forwarded to the facility: 93 recommendations to the medical provider, and 11 for nursing recommendations. In a review of the November MRR on 03/14/2025 of the 93 physician/provider recommendations the following was documented: - 60 were addressed on 01/06/2025 (47 days after the initial report), - 19 were addressed on 01/17/2025 (58 days after the initial report), - 6 were addressed on 01/19/2025 (60 days after the initial report). - 3 were addressed on 01/23/2025 (64 days after initial report). RESIDENT 70 Review of MRR dated 11/18/2024 for Resident 70, showed a recommendation to clarify an order for injectable (inserted into the body via a syringe) heparin (blood thinning medication) for duration of use, and if long term use was needed to switch to an oral agent. The order had been agreed to by the provider on 01/19/2025, and initialed (not legible) and dated 01/24/25. The recommendation stated the medication had already been discontinued. Review of Resident 70's medical record showed the medication was discontinued on 01/17/2025, 58 days after the report was made. RESIDENT 34 Review of MRR dated 11/20/2024 for Resident 34, showed a recommendation to clarify an order for injectable (inserted into the body via a syringe) heparin (blood thinning medication) for duration of use, and if long term use was needed to switch to an oral agent. The order had been noted by the provider on 01/19/2025, it stated to discontinue the heparin and to start the resident on aspirin 81 mg every day, it was initialed (not legible) and dated 01/20/25. Review of Resident 34's medical record showed the medication was discontinued on 01/19/2025, 60 days after the report was made. <RESIDENT 19> (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of MRR dated 11/19/2024 for Resident 19, showed a recommendation to clarify an order for injectable (inserted into the body via a syringe) heparin (blood thinning medication) for duration of use, and if long term use was needed to switch to an oral agent. The order had been agreed to by the provider on 01/19/2025, and initialed (not legible) and dated 01/20/25. Review of Resident 19's medical record showed the medication was discontinued on 01/19/2025, 60 days after the report was made. <RESIDENT 72> Review of MRR dated 11/19/2024 for Resident 72, showed a recommendation to clarify an order for injectable (inserted into the body via a syringe) enoxaparin (blood thinning medication) and oral aspirin 81 mg both for deep vein thrombosis (DVT) prevention as the resident should only be on one or the other. The order had been agreed to by the provider on 01/07/2025 and requested to discontinue the enoxaparin. Review of Resident 72's medical record showed the medication was discontinued on 01/10/2025, 51 days after the report was made. <RESIDENT 69> Review of MRR dated 11/19/2024 for Resident 69, showed a recommendation to clarify an order for injectable (inserted into the body via a syringe) enoxaparin (blood thinning medication) for duration of use, and if long term use was needed to switch to an oral agent for deep vein thrombosis (DVT) prevention. The order had been agreed to by the provider on 01/19/2025 and requested to discontinue the enoxaparin and to start the resident on aspirin 81 mg every day, it was initialed (not legible) and dated 01/20/25. Review of Resident 69's medical record showed the medication was discontinued on 01/19/2025, 60 days after the report was made. In an interview on 03/14/2025 at 11:14 AM, Staff B, Director of Nursing Services (DNS) stated that they receive the MRR report from the pharmacist usually within 48 hours of the completion of the review. They have the expectation that all the MRR's will be completed with in 30 days. In an electronic interview on 03/14/2025 at 2:39 PM, Collateral Contact 5 stated that their expectation was that the facility would implement the recommendations into the medical record in a timely manner. In a combined interview on 03/17/2025 at 1:12 PM, Staff A, Administrator and Staff B, DNS were unaware that the MRR for the month of November were completed and implemented late. No further information was provided. Refer to WAC 388-97-1300(4)(c) 51312

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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** 50725 Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were removed when expired in 3 of 5 medication carts. The facility failed to monitor daily temperatures for 2 of 3 refrigerators that stored medications. The facility failed to ensure Schedule II-V (Substances with a high potential for abuse which may lead to severe physical or psychological dependence) controlled medications were in a separate locked permanently affixed compartment not accessible to others. The facility failed to ensure 1 of 1 resident (Resident 78) was assessed for self-medication program. These failures placed residents at risk for receiving expired medications and vaccines, and potential for drug diversion from not securely locking controlled medications. Findings included . According to facility policy titled Medication Storage dated 01/2025 showed: - . Controlled substances stored in a refrigerator should be secured such as separately locked, permanently affixed compartment. - . The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily .if no vaccines are stored in the refrigerator, document temperature checks at least once daily. - Outdated, . discontinued . are immediately removed from stock, disposed of according to procedures for medication disposal. <MEDICATION CARTS> In an observation and interview on 03/12/2025 at 1:20 PM, the Medication Cart 4 in Station 2 had 1 expired medication bottle of Iron (Ferrous Sulfate) 27 milligram (mg). According to Staff E, Registered Nurse (RN), the nurses were supposed to check the medication cart for any expired medications. Staff E took the expired medication out of the cart and stated they would dispose of it. In an observation and interview on 03/12/2025 at 2:20 PM, Medication Cart 3 in Station 1 had 2 expired medications found. They were a bottle of Omeprazole (Delayed Release) 20 mg with expiration date of 12/2024 and a bottle of Saline Nasal Spray 1.5 fluid ounce, with expiration date of 01/2025. Staff S, Licensed Practical Nurse (LPN) stated that the pharmacist was the one that inspects their medication cart for expired medications and that they were just at the facility inspecting the medication carts 2 days ago. Staff S stated they will dispose the expired medications. In an observation and interview on 03/12/2025 at 2:30 PM, Medication Cart 2 in Station 1 had 1 expired medication bottle of Naloxone HCl 4 mg. nasal spray with expiration date of 10/2024. Staff L, LPN stated they would dispose of the expired medication. <REFRIGERATORS WITH MEDICATIONS> (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 observation and interview on 03/11/2025 at 2:30 PM, refrigerator inside the medication room in Station 1 contained medications such as insulin pens, a box of Mounjaro medication(a glucagon-like peptide 1 medication injected weekly to treat type 2 diabetes [too much sugar in the blood] to be stored at 36-46 degrees Fahrenheit), emergency kit (E kit) that contains insulin vials, Gabapentin liquid medications with sticker that showed refrigerate. Review of daily temperature log which was placed on the door of the refrigerator showed missing temperature logs for March 1,2,5 and 7, 2025. Staff H, LPN/Infection Preventionist Nurse (IP Nurse) stated they were responsible for checking the vaccine refrigerator to ensure they were checked twice a day. In an observation and interview on 03/11/2025 at 2:50 PM, refrigerator inside the medication room in Station 2 contained some insulin pens, a box of Mounjaro medication, a locked metal container and a Prevnar (a vaccine to protect against pneumococcal pneumonia) 20 milliliter (ml) single dose syringe. Review of the temperature log showed missing temperature logs for 03/082025 and 03/10/2025 and temperature logs were only done once a day. Staff D, Resident Care Manager (RCM) stated that the Prevnar medication should not have been stored at that refrigerator instead they would bring it to the refrigerator in Station 1 that stored just vaccines. <CONTROLLED MEDICATION STORAGE> In an observation and interview on 03/11/2025 at 2:30 PM, the refrigerator in the medication room in Station 1 did not have a lock and inside was a plastic container that was not affixed inside the refrigerator. The plastic container had a red zip tie with numbers. Inside plastic container were multiple things, some were not visible to see but there was a box of Lorazepam 2 mg/ml (a controlled substance, to treat anxiety and seizures). Staff H, Iinfection Preventionist (IP) Nurse stated they think it was an E kit but was not able to find the list of medications that was inside the plastic container. Staff H stated they would ask and find out. In an interview on 03/11/2025 at 3:20 PM, Staff H, IP Nurse stated that the container was not an E kit and provided a copy of what was in the container. The paper given showed it was for a specific resident, and it listed Lorazepam 2 mg/ml with 5 vials. There were more things inside the container, but Staff H did not provide me any more list. In an observation and interview on 03/11/2025 at 2:50 PM, the refrigerator inside the medication room in Station 2 showed a locked metal box that was not affixed inside the refrigerator. Staff D, RCM used a key to open the box and inside showed a box of Lorazepam liquid for a specific resident. Staff D stated the resident no longer was at the facility. In an interview on 03/13/2025 at 1:05 PM, Staff C, Registered Nurse/Resident Care Manager (RCM), stated that the red zip tie used for the plastic container that stored controlled medication in Station 1 was considered as being locked. They stated that when a staff breaks the zip tie, the staff would write down the number in the narcotic book. (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 03/14/2025 at 3:25 PM, Staff B, Director for Nursing Services stated that Medication Cart nurses were supposed to check expired medications in their carts, the RCM does weekly checks for expired medications and their pharmacy consultant comes in once a month to check on expired medications in the medication carts. Staff B stated the temperature checks for the refrigerator with vaccines inside should be done twice a day and the temperature checks for refrigerators with medications should be checked daily. Staff B stated night shift nurse were responsible for checking and documenting the temperatures for the refrigerators and the IP Nurse audits the temperature logs daily. When asked about the storage of controlled medications inside the refrigerators, Staff B stated they should be double locked and considered the zip tie as a lock for the plastic container that was inside the refrigerator in Station 1. They stated that when the nurse breaks the zip tie, they write down the number that was on the zip tie in their narcotic book and replace it with a new one and write down the number of the new zip tie in the narcotic book. Staff B stated they planned to change that plastic container. Staff B stated they were not aware that containers that stored controlled medications should be permanently affixed inside the refrigerator. 36787 Review of the facilty policy titled, Medications self-administration, revised 10/15/2024 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 78> Resident 78 admitted on [DATE] with diagnoses to include traumatic brain injury. The resident had no cognitive impairment. In an observation on 03/12/2025 at 11:04 AM, Resident 78 was sitting up on the side of the bed. There was a bottle of Blue [NAME] pain ointment with an expiration date of 6/2019 and a bottle of Papaya Enzyme Plus pills with an expiration date of 6/2027 on the nightstand to the right of their bed. Both bottles were labeled Keep Out of Reach of Children. There was no nurse present in the room or in the hall. (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 observation on 03/13/2025 at 8:24 AM, Resident 78 was in their wheelchair eating breakfast, the Blue [NAME] pain ointment and bottle of Papaya Enzyme Plus remained on the nightstand. There was no nurse present in the room or in the hall. At 3:20 PM, similar observations of the bottles were present. Resident 78 stated she used the Blue [NAME] for pain relief and the Papaya pills for digestion. There were observations of the medications at bedside on 03/14/2025 at 8:31 AM, 10:28 AM, and 12:45 PM. There was no nurse present in the room or in the hall. The medications remained in the same location on the nightstand on 03/17/2025 at 8:53 AM. Review of Resident 78's physician orders showed they were not on a self-medication program. Review of Resident 78's care plan showed they were not on a self-medication program. Review of Resident 78's clinical record showed there was no assessment completed to assess if the resident was safe to self-administer their medications independently. In an interview on 03/17/2025 at 9:20 AM, Staff D, RN stated they had one resident on a self-medication program which was not Resident 78. In an interview on 03/17/2025 at 11:47 AM, Staff E, RN the assigned nurse for Resident 78, stated they had no residents on a self-medication program. Staff E stated if they found resident medications at bedside, they would explain to them they would need to have a self medication program or they would take the medications after explaining that to them. In an interview on 03/17/2025 at 1:38 PM, Staff B, Director of Nursing Services stated they were unaware Resident 78 had unsecured medications at bedside and lack of assessment and care plan for a self-medication program. No additional information was provided. This is a repeat deficiency from SOD dated 10/01/2024. Refer to WAC 388-97-1300(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on interview and record review the facility failed to ensure a system in which residents' records were complete, accurate, accessible, and systematically organized for 4 of 5 residents (Residents 40, 52, 71 and 78) reviewed for unnecessary medication. This failure included incomplete assessments, restorative care and incomplete documentation involving resident incidents. This placed residents at risk for unmet needs, condition deterioration, unrecognized changes in condition and adverse outcomes. Findings included . Review of a facility policy titled, Charting and Documentation, revised 02/24/2025, showed the purpose to provide a complete account of the patient's total stay from admission through discharge, provide information about the patient that will be used in developing a plan of care, and as a tool for measuring the quality of care provided to the patient. -Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the patient's medical records in accordance with state law. -Document pertinent changes in the patient's condition, reaction to treatment, medication. etc. as well as routine observations. -Documentation shall be completed during the shift in which the assessment, observation, or care service occurred -Documentation shall be accurate, relevant, and complete, containing sufficient details about the patient's care and/or responses to care. <RESIDENT 71> Resident 71 admitted to the facility on [DATE]. Review of the January Medication Administration Record (MAR) documented Resident 71 received Clopidogrel (blood thinner) daily and included an Anticoagulant Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or V/S, SOB, nose bleeds- Nurses were directed to document -Y if monitored and none of the above observed. -N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings. every shift beginning 01/28/2025. Review of Resident 71's January 2025 anti-coagulant monitor: N documented on 01/29/2025 day shift and evening shift, and 01/31/2025 day shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 71's February 2025 MAR documented nursing staff did not obtain and or document blood pressures and heart rates before administration of Metoprolol (blood pressure medication) 02/19/2025 through 02/28/2025. Review of Resident 71's February anti-coagulant monitor documented N on the following: 02/01/2025 evening and night shift. 02/02/2025 evening and night shift 02/04/2025 evening and night shift 02/05/2025 all shifts (day, evening and night shifts) 02/06/2025 evening and night shift 02/07/2025 evening and night shift 02/08/2025 day shift 02/10/2025 evening and night shift 02/11/2025 all shifts 02/12/2025 all shifts 02/14/2025 evening shift 02/15/2025 all shifts 02/16/2025 all shifts 02/17/2025 evening and night shift 02/19/2025 evening and night shift 02/20/2025 all shifts 02/21/2025 evening and night shift 02/22/2025 all shifts 02/24/2025 evening and night shift 02/25/2025 evening and night shift 02/26/2025 all shifts 02/27/2025 day shift (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/28/2025 evening and night shift Review of the progress notes for Resident 71 showed the resident had a fall on 02/18/2025 at 6:40 AM. There was not assessments and documentation every shift for 72 hours after the fall. There was fall documentation on 02/19/2025 at 11:35 AM, 3:30 PM and 10:13 PM, 02/20/2025 at 8:20 PM and 02/21/2025 at 8:20 PM. Review of the progress notes for Resident 71 showed the resident had a fall on 02/25/2025 at 4:15 AM and another fall on 02/27/2025 at 7:00 AM. There was not assessments and documentation every shift for 72 hours after the fall. There was fall documentation on 02/26/2025 at 6:40 PM, 02/27/2025 at 7:00 AM, 1:47 PM ad 11:18 PM then on 02/28/2025 at 9:36 AM and 3:57 PM. There was no alert documentation on 03/01/2025. Review of Resident 71's March anti coagulation monitors documented N on: 03/01/2025 day, evening and night shifts Review of Resident 71's progress notes for the January, February and March 2025 showed there were no progress notes in relation to the anti-coagulation monitors marked N see progress notes for any of the dates. Review of Resident 71's March 2025 MAR showed nursing staff did not obtain and or document blood pressures and heart rates before administration of Metoprolol (blood pressure medication) 03/01/2025 through 03/16/2025. <RESIDENT 78> Resident 78 admitted on [DATE]. Review of the January MAR showed the resident received Enoxaparin (blood thinner) injections twice a day from 01/15/2025 to 01/29/2025 and included an Anticoagulant Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or V/S, SOB, nose bleeds- Nurses were directed to document -Y if monitored and none of the above observed. -N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings. every shift beginning 01/23/2025. Review of Resident 78's January anti-coagulant monitor: N documented 01/24/2025 day shift 01/26/2025 day shift 01/27/2025 day and evening (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/28/2025 day shift 01/29/2025 day shift 01/30/2025 X documented instead of Y or N Review of Resident 78's February anti-coagulant monitor N documented on: 02/01/2025 day shift 02/02/2025 day shift 02/04/2025 day shift 02/07/2025 day shift 02/10/2025 day shift Review of the progress notes for the January and February 2025 showed there were no progress notes in relation to the anti-coagulation monitors marked N see progress notes for any of the dates. Review of fall incident investigation on 03/07/2025 showed the time of the fall was midnight. Review of the progress note dated 03/07/2025 at 11:21 AM, showed the resident was found on the floor by Physical Therapy (PT) after the resident had reached for a brush and their leg gave up. The note did not say when the fall occurred. The note lacked information on which leg indicated and if the resident had been wearing their right leg brace. There was not assessments and documentation every shift for 72 hours after the fall. There was fall documentation on 03/07/2025 at 11:22 AM, then 03/10/2025 at 6:05 PM and 6:18 PM. There was no alert documentation on 03/08/2025 or 03/09/2025. In an interview on 03/17/2025 at 9:20 AM, Staff D, Registered Nurse (RN) stated the expectation was nurses document any change of condition, skin issues, any new medications or changes. Staff D said medical records runs the report every day for missing documentation. Then gives them a report for us to follow up on. Staff D reviewed Resident 71 and 78s' anticoagulation monitors and stated the documentation was correct and if a side effect was observed the nurses would document that. In an interview on 03/17/2025 at 11:47 AM, Staff E, RN stated the review the MARS to ensure everything is documented. Staff E said that nurses are to document every shift for 72 hours for alert charting and include a head-to-toe assessment to make sure there are no injuries. Staff E stated if there were no adverse effects for the anti-coagulation monitor, they would document a Y and they would document a N if there were side effects and then we would follow up, call the provider and document that. 50725 <RESIDENT 40> (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 40 admitted on [DATE] with admitting diagnosis to include Stroke. According to the quarterly Minimum Date Set (MDS - an assessment tool) assessment, dated 02/19/2025 resident had mild cognitive impairment. In a record review on 03/13/2025 at 1:30 PM, Resident 40's electronic chart did not show any notes regarding the allegation the resident made from a staff member who laughed at them when they requested to be turned, that was reported to Staff B, Director for Nursing Services (DNS) on 03/11/2025. In an interview on 03/14/2025 at 3:10 PM, Staff D, RN/Resident Care Manager stated that the facility does alert charting (refers to a system where a patient's chart is tagged or flagged to indicate special charting procedures or precautions that need to be followed for a specific time). Staff D stated they initiate alert charting for residents who had change in condition such as abnormal vital signs, skin issues, falls, behaviors. They document every shift for 72 hours. In an interview on 03/13/2025 at 3:25 PM, Staff B, DNS stated that the facility initiates alert charting when there's a change in condition for the resident such as, skin issues. Staff B stated that resident reporting an allegation will be put on alert charting. Staff B explained that they had a new system in their electronic chart that when a nurse starts a change in condition tab it will automatically initiate alert charting. With this new system, the nurses were not documenting alert charting in the progress note rather it will be in the Assessment tab under Skilled nursing assessment. In an interview on 03/17/2025 at 8:30 AM, Staff D stated the electronic chart is where you can find Resident 40's alert charting documentation. It showed some chronological charting dated from 03/11/2025 to 03/14/2025. In an interview on 03/17/2025 at 10:05 AM, Staff V, RN, stated that there will be one change of condition entry and then after that it would show skilled notes which is for the alert charting. Record review on 03/17/2025 at 10:33 AM, Resident 40's electronic chart under assessment tab showed Change of Condition assessment where it talked about resident's allegation of a staff laughing at them when resident requested to be turned. Effective date showed 03/11/2025 but created date was 03/14/2025 which was 3 days after allegation was reported. In the body of the note, it also showed Late Entry. Further review on the skilled notes, there was an effective date of 03/11/2025 then Late Entry on top of the note but did not show for what day the late entry was and the vital signs that were in the note was dated 03/14/2025. There was no mention about the allegation in the body of the note. Another skilled note showed an effective date of 03/12/2025, then Late Entry on top of the note but did not show for what day the late entry was, vital signs were dated 03/12/2025. There was no mention about the allegation in the body of the note. Another skilled note seen with an effective date of 03/13/2025 then Late Entry was on top of the note, but it did not show for what day the late entry was. The vital signs were dated 03/14/2025 and there was no mention about the allegation in the body of the note. The notes were not done every shift but rather daily. 51551 <RESIDENT 52> Resident 52 admitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 52's Quarterly MDS assessment dated [DATE], showed the resident was dependent for bed mobility and transfers. The resident had impaired range-of-motion to both sides of their upper and lower extremities. Review of Resident 52's current care plan showed Resident 52 had restorative programs for passive range of motion and splint three to five days a week. Review of the electronic health record (EHR) showed there was no documentation of restorative programs evaluation or restorative progress notes. In an interview on 03/14/2025 at 9:44 AM, Staff X, Registered Nurse/Resident Care Manager, stated they had a restorative review meeting every week with the rehab manager and the restorative aide. Staff K stated they discussed if residents' s restorative programs needed to be adjusted. Staff X stated they only wrote the meeting minutes on paper, but they did not document evaluation or notes in EHR. In an interview on 03/14/2025 at 3:25 PM, Staff B, Director of Nursing (DNS), stated they expected restorative programs to be evaluated and should be documented in the EHR. In an interview on 03/17/2025 at 1:38 PM, Staff A, Administrator and Staff B, DNS stated they were unaware of incomplete documentation. Reference WAC 388-97-1720 (1)(a)(i)(ii)(iii)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation and interview the facility failed to replace sharps containers (a specialized, puncture-resistant, and leak-proof container designed for the safe disposal of sharp medical instruments, like needles, syringes, and scalpels, to prevent accidental injuries and ensure proper waste handling) in 1 of 5 medication carts, 1 of 2 shower rooms, and 1 resident room at Station 2 when it reached the full line when the environment was reviewed for safe and comfortable environment. This failure placed residents and staff at risk for injury, and potential exposure to diseases. Findings included . In an observation on 03/12/2025 at 1:20 PM, the sharps container at the side of Medication Cart 5 located at Station 2 was full, it showed the things inside the sharp's container was above the full line. There were insulin pens and lancets almost to the level of the opening of the container. In an observation on 03/12/2025 at 2:05 PM, the sharps container in Resident room [ROOM NUMBER] was very full, it showed the contents inside the sharp's container was above the full line. In observation on 03/14/2025 at 12:41 PM, the sharps container for Medication Cart 5, Resident room [ROOM NUMBER] and Station 1 shower room remained full and contents were showing above the full line. In an interview on 03/14/2025 at 12:52 PM, Staff R, Registered Nurse (RN) stated that they were not sure who was supposed to replace the full sharps container. They stated that they were new and did not know but will ask the Resident Care Manager (RCM). A few minutes later, Staff R stated that per their RCM the Infection Preventionist Nurse (IP nurse) is the one in charge of changing the full sharps container. In an interview on 03/14/2025 at 1:18 PM, Staff H, IP Nurse/Licensed Practical Nurse (LPN) stated that they were not aware that they were responsible for checking the sharps containers, what they knew was the nurses on the floor were responsible for replacing sharps containers as soon as they reach the full line. Staff H went to look at Medication Cart 5 at Station 1 and they stated that the container was abnormally full and needed to be replaced right away. Staff H then went to room [ROOM NUMBER] and looked at the sharps container and stated it was very full and need to be replaced right away and the full container did not seem to be affixed to the stand. In an interview on 03/14/2025 at 3:10 PM, Staff D, Resident Care Manager stated that the nurses were responsible in replacing the sharps container when they were full, they have the keys with them and the IP Nurse was overall in charge for monitoring sharps container. In an interview on 03/14/2025 at 3:25 PM, Staff B, Director of Nursing Services stated that all nurses were responsible for replacing full sharps containers and the IP nurse was the one that inspects them at rounds. 51551 (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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an observation on 03/11/2025 at 12:35 PM, the sharps container inside the shower room at Station 1 was showing full. There were blue disposable razors inside and the razors were above the full line of the container. In an observation on 03/14/2025 at 1:15 PM the sharp container inside the shower room at Station 1 was showing full. There were blue disposable razors inside and the razors were above the full line of the container. In an observation and interview on 03/14/2025 at 4:14 PM, the sharp container inside the shower room at Station 1 was full over the full line of the container. Staff B shook the sharp container. After Staff B shook the sharp container, there were still blue disposable razors above the full line. Staff B stated the sharp container looked ok and they would change the sharp container. Reference: WAC 388-97-3220(1)