STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER: Cottesmore of Life Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 2909 14th Avenue Northwest, Gig Harbor, WA 98335	

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on interview and record review, the facility failed to periodically review residents advanced directive (AD, a legal document that states your wishes for medical care if you are unable to make decisions for yourself) for 1 of 4 sampled residents (Resident 32) when reviewed for advanced directive. This failure placed the resident at risk of not having an established decisionmaker, lack of ability to direct care, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 32 readmitted to the facility on [DATE] with diagnoses that included heart failure and kidney failure. Resident 32 was able to make needs known. Review of a document titled Attachment H showed Resident 32 received information regarding establishing an AD on 02/26/2024. During an interview on 01/08/2025 at 2:07 PM, Staff F, Social Services Director (SSD), stated the facility informed residents of their right to formulate an AD on admission and the residents signed Attachment H once they received this information. Staff F stated the facility periodically reviewed the AD during care conferences. During an interview on 01/10/2025 at 10:43 AM, Staff F stated Resident 32 received information about formulating an AD on 02/26/2024 and had not had periodic review until 01/08/2025. During an interview on 01/13/2025 at 9:56 AM, Staff C, Regional [NAME] President, stated residents were informed of their right to formulate an AD on admission and the AD was reviewed quarterly. Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b), (3)(a-c)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to ensure residents' personal items were safe for 1 of 5 sampled residents (Resident 64) when reviewed for Personal Property and failed to ensure residents' rooms were homelike for 1 of 6 sampled residents (Resident 50) when reviewed for environment. These failures placed residents at risk of financial exploitation, feelings of worthlessness, decreased mood, and a diminished quality of life. Findings included . Resident 64 Review of the electronic health record (EHR) showed Resident 64 admitted to the facility on [DATE] with diagnoses of dementia (a group of brain conditions that cause a decline in mental abilities) and cognitive communication deficit (difficulty in communicating). Review of the modification of quarterly minimum data set assessment (MDS), an assessment tool, dated 11/25/2024, showed Resident 64's vision was adequate with corrective lenses. During an interview and observation on 01/09/2025 at 10:57 AM, Resident 64 stated they lost their glasses approximately a week prior and told facility staff they were missing. Observation showed a clear glasses case on the resident's overbed table which was empty. During an interview on 01/10/2025 at 11:18 AM, Resident 64 stated their glasses were still lost and they could not read without them. Review of an inventory list, dated 08/05/2024, showed Resident 64 admitted to the facility with glasses which were black with multicolor on the side. Observation on 01/13/2025 at 9:31 AM, showed Resident 64 in bed with eyes closed. Observation showed the clear glasses case was empty on the overbed table. Review of the facility grievance log from July 2024 to 01/13/2025 showed no grievance logged for Resident 64's missing glasses. During an interview on 01/13/2025 at 11:03 AM, Staff X, Certified Nursing Assistant (CNA), stated Resident 64 had lost their glasses a few days ago. Staff X stated they had not initiated a grievance for Resident 64's missing glasses. During an interview on 01/13/2025 at 11:12 AM, Staff F, Social Services Director (SSD), stated missing items should be written on a grievance form for Staff A, Administrator, to process. Staff F stated Staff A was currently out of the building and the grievance process was being handled by Staff T, Assistant Director of Nursing Services (ADON). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/2025 at 11:14 AM, Staff T stated when a missing item was reported to facility staff a grievance form should be generated. Staff T stated there was no grievance for Resident 64's missing glasses and this did not meet expectation. During an interview on 01/13/2025 at 11:57 AM, Staff C, Regional [NAME] President, stated facility staff should fill out a grievance form when a resident reported missing items. Staff C stated when Resident 64 reported their missing glasses facility staff should have completed a grievance form so the facility could search for them and coordinate obtaining new glasses, if needed. 38344 Resident 50 Review of Resident 50's EHR showed the resident admitted to the facility on [DATE] with diagnoses to include muscle weakness, need for assistance with personal care, depression, and was able to make needs known. Multiple observations on 01/07/2025, 01/08/2025, 01/09/2025, 01/10/2025 and 01/13/2025 showed Resident 50's over the bed light fixture metal pull cord had a clear plastic garbage bag tied to the end of a metal pull cord. During an interview on 01/07/2025 at 11:36 AM, Resident 50 stated that a staff member had tied the plastic bag to the overbed light cord so they could reach the cord to turn off and on the light fixture. During an interview on 01/13/2025 at 11:40 AM, Staff H, Floor Technician, stated they worked in the housekeeping and maintenance departments for about three years. Staff H stated that Resident 50's plastic bag attached to the overbed light fixture pull cord should not be there because it was not a cleanable surface. Staff H stated they were not aware that the bag was there. Reference WAC 388-97-0880

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide written notification of the reason for transfer to the hospital to the Office of State Long-Term Care Ombudsman (SLTCO, an advocacy group for residents in a nursing home) and/or to the resident/resident representative of discharges for 4 of 4 sampled residents (Residents 32, 54, 95, and 26) reviewed for hospitalization and/or discharge. These failures placed residents at risk for being inappropriately discharged , lack of access to an advocate who could inform them of their options and rights, and to ensure that the SLTCO and resident/ resident representative was aware of facility practices and activities related to transfers and discharges. Findings included . Resident 32 Review of the electronic health record (EHR) showed Resident 32 readmitted to the facility on [DATE] with diagnoses that included heart failure, kidney failure, and diabetes (too much sugar in the blood). Resident 32 was able to make needs known. Review of Resident 32's EHR showed a hospitalization on [DATE], readmission to the facility on [DATE], hospitalization on [DATE], and readmission to the facility on [DATE]. The EHR did not show documentation that transfer notices were provided for either discharge to the SLTCO. During an interview on 01/09/2025 at 2:48 PM, Staff B, Director of Nursing Services (DNS) stated social services should notify the SLTCO of transfer/discharges. During an interview on 01/10/2025 at 2:17 PM, Staff F, Social Services Director (SSD), stated the SLTCO was not notified of Resident 32's transfer/discharge to the hospital on 06/13/2024 or on 11/02/2024 and should have been. 46148 Resident 54 Review of the EHR showed Resident 54 admitted to the facility on [DATE] with diagnoses including congestive heart failure (when the heart fails to pump blood effectively) and kidney disease. Review of the EHR showed Resident 54 was discharged to the hospital on 06/06/2024. The EHR did not show documentation the resident or their representative was notified in writing of the reason for transfer. THe EHR did not show documentation the SLTCO office was notified of the transfer. During an interview on 01/09/2025 at 10:55 AM, Staff E, Registered Nurse (RN), stated they did not use a transfer form, We just call the residents power of attorney (POA). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 1:19 PM, Staff F, SSD, stated, We did not send any ombudsman notification for [Resident 54's] transfer to the hospital on 06/06/2024. 49926 Resident 95 Review of EHR showed Resident 95 admitted to the facility on [DATE] with diagnoses that included postprocedural hemorrhage of a digestive system organ or structure following a digestive system procedure (bleeding after procedure), cancer of pancreas and altered mental status. Review of Resident 95's discharge minimum data set assessment (MDS), an assessment tool, dated 10/26/2024, showed an unplanned discharge with return anticipated. Review of the EHR showed no documentation about SLTCO notification. Review of the EHR showed no documentation about nursing home transfer or discharge notice. During an interview on 01/10/2025 at 12:00 PM, Staff F, SSD, stated the social service department was to complete SLTCO notification, but it was not done in the past months. Resident 26 Review of EHR showed Resident 26 admitted to the facility on [DATE] with diagnoses that included cellulitis (infection) of right lower limb, anxiety and atrial fibrillation (an irregular heart rate that causes poor blood flow). Review of Resident 26's discharge MDS, dated [DATE], showed an unplanned discharge with return anticipated. Review of the EHR showed no documentation about nursing home transfer or discharge notice. During an interview on 01/10/2025 at 12:00 PM, Staff F, SSD, stated the nursing department would provide transfer and discharge notice when a resident was sent to the hospital. Staff F was not able to locate documentation regarding transfer/discharge notices for Residents 95 and 26. During an interview on 01/13/2025 at 10:45 AM, Staff B, Director of Nursing Services, stated the nursing department was responsible for the transfer/discharge notices and not having this documentation in the records was not an acceptable practice. Reference WAC 388-91-0120(2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to provide a bed-hold notice in writing at the time of transfer/discharge to the hospital and/or to provide/complete bed-hold notices within 24 hours of transfer/discharge to the hospital for 3 of 4 sample residents (Residents 32, 26, and 95) reviewed for hospitalization /discharge. This failure placed the residents at risk for a lack of knowledge regarding the right to a bed-hold while they were hospitalized . Findings included . Resident 32 Review of the electronic health record (EHR) showed Resident 32 readmitted to the facility on [DATE] with diagnoses that included heart failure, kidney failure, and diabetes (too much sugar in the blood). Resident 32 was able to make needs known. Review of Resident 32's EHR showed a hospitalization on [DATE] with readmission to the facility on [DATE] and a hospitalization on [DATE] with readmission to the facility on [DATE]. The EHR did not show documentation the resident and/or the resident's responsible party was offered a bed hold for either transfer/discharge to the hospital. During an interview on 01/09/2025 at 2:48 PM, Staff B, Director of Nursing Services (DNS), stated the Director of Admission should offer bed holds and follow up as needed. Staff B stated bed holds for Resident 32's transfer/discharges to the hospital were not done and should have been. 49926 Resident 95 Review of the EHR showed Resident 95 admitted to the facility on [DATE] with diagnoses that included postprocedural hemorrhage of a digestive system organ or structure following a digestive system procedure (bleeding after procedure), cancer of pancreas and altered mental status. Review of Resident 95 discharge minimum data set assessment (MDS), an assessment tool, dated 10/26/2024, showed an unplanned discharge with return anticipated. Review of the EHR did not show documentation of a bed hold. Resident 26 Review of the EHR showed Resident 26 admitted to the facility on [DATE] with diagnoses that included cellulitis (infection) of right lower limb, anxiety and atrial fibrillation (an irregular heart rate that causes poor blood flow). (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 26's discharge MDS, dated [DATE], showed an unplanned discharge with return anticipated. Review of the EHR did not show documentation of a bed hold. During an interview on 01/10/2025 at 12:00 PM, Staff F, Social Service Director, stated the nursing department was responsible for bed hold documentation when a resident was sent to the hospital. Staff F was not able to provide any documentation about bed holds for Residents 95 and 26. During an interview on 01/13/2025 at 10:45 AM, Staff B, DNS, stated the nursing department was responsible for providing and documenting bed holds, and not having this documentation in the records was not an acceptable practice. Reference WAC 388-91-0120(4)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASARR) assessments were accurately completed for 3 of 6 sampled residents (Residents 29, 49 and 40) reviewed for PASARRs and unnecessary medications. This failure placed the residents at risk for unidentified mental health care needs. Findings included . Review of a document titled, Pre-admission Screening and Resident Review (PASARR), dated 09/26/2024, showed the facility would ensure that potential admissions were to be screened for possible mental disorders or intellectual disabilities and related conditions. A positive Level I screen necessitated an in-depth evaluation of the individual by the state designated authority, known as PASARR Level II, which must be conducted prior to admission to a nursing facility. Resident 29 Review of Resident 29's admission minimum data set assessment (MDS, a required assessment), dated 07/29/2024, showed the resident admitted on [DATE] with multiple health conditions including bipolar disorder, (a mental illness that causes extreme shifts in mood, energy activity levels and concentration), depression, and post-traumatic stress disorder (PTSD, an anxiety disorder that develops in reaction to physical injury or severe mental or emotional distress). The resident was able to make their needs known. Review of Resident 29's electronic health record (EHR) showed a Level I PASARR, dated 07/24/2024, was completed by a social work staff at a local medical care facility. The PASARR form had documentation that 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. During an interview on 01/09/2025 at 8:40 AM, Staff F, Social Service Director (SSD), stated the PASARR was now incorrect since Resident 29 did not discharge within the designated 30 days from the facility. Staff F, SSD, stated the PASARR for Resident 29 would need to be corrected. During an interview on 01/09/2025 at 8:49 AM, Staff C, Regional [NAME] President, stated it was their expectation that the SSD corrected or redid the Level I PASARR to ensure the resident received the Level II PASARR evaluation by the state evaluator. 40817 Resident 49 Review of the EHR showed Resident 49 admitted to the facility on [DATE] with diagnoses of hemiplegia (inability to move one side of the body), dementia (a general term for a group of brain conditions that cause a decline in mental abilities), and depression. Resident 49 was not able to make needs known. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the PASARR Level I, dated 12/15/2023, showed Resident 49 required a PASARR Level II. During an interview on 01/09/2025 at 10:59 AM, Staff F, SSD, stated any resident with a mental health diagnosis should be referred for a PASARR Level II. Staff F stated Resident 49 had a mental health diagnosis and the PASARR Level I dated 12/14/2023 showed a PASARR Level II was required. During an interview on 01/10/2025 at 10:49 AM, Staff F stated Resident 49's PASARR Level I was not transmitted to the PASARR coordinator, and this did not meet expectation. During an interview on 01/13/2025 at 10:27 AM, Staff C, Regional [NAME] President, stated PASARR Level I should be transmitted timely and Resident 49's lack of PASARR Level II did not meet expectation. 46148 Resident 40 Review of the EHR showed Resident 40 admitted to the facility on [DATE] with diagnoses to include dementia and traumatic subarachnoid hemorrhage (a bleed in the brain). Review of Resident 40's EHR showed a PASARR Level I with a completion date of 11/18/2024. The recommendation was for the resident to be referred for a PASARR Level II evaluation which was required for a change of condition. Review of the EHR did not show PASARR Level II documentation. During an interview on 01/09/2025 at 10:32 AM, Staff F, SSD, stated they had not referred Resident 40 for a PASARR Level II. During an interview on 01/09/2025 at 1:44 PM, Staff B, DNS, stated it was their expectation that the SSD complete any PASARR Level II referrals and Resident 40 should have been referred. Reference WAC 399-97-1915 (1)(2)(a-c)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40817 Based on observation, interview, and record review, the facility failed to ensure care plans were reviewed and revised after each quarterly assessment for 3 of 4 sampled residents (Residents 32, 50, and 22) when reviewed for care planning. This failure placed residents at risk of not receiving required care, avoidable decrease in health status, and a diminished quality of life. Findings included . Resident 32 Review of the electronic health record (EHR) showed Resident 32 admitted to the facility on [DATE] with diagnoses that included heart failure, kidney failure, and diabetes (too much sugar in the blood). Resident 32 was able to make needs known. Review of Resident 32's modified annual minimum data set assessment (MDS, a required assessment), dated 12/11/2024, showed the resident received dialysis (treatment to filter wastes and water from the blood) and received a mechanically altered and therapeutic diet (a meal plan that is designed to treat a medical condition or symptom). During an interview and observation on 01/08/2025 at 8:46 AM, Resident 32 stated they did not think they were on a special diet and did not think they were on a fluid restriction (a diet that limits the amount of fluids consumed each day); however, there was a sign posted on the wall above the resident's bed that showed, No Water Pitcher at bedside Fluid Restriction. Review of the provider order, dated 01/03/2023, showed Resident 32 was prescribed an 1800 milliliter (ml) fluid restriction. Nursing to provide 240 ml on day shift, 240 ml on evening shift, and 240 ml on night shift. Fluids from the kitchen for meals: Breakfast 360 ml, lunch 360 ml, dinner 360 ml related to end stage renal disease (kidney failure). During a follow-up interview on 01/08/2025 at 8:54 AM, Resident 32 stated they went to dialysis three days a week and that that the dialysis access site was located on their left arm, and they had no access site on their chest. Review of Resident 32's dialysis focused care plan, initiated on 02/22/2024, showed an intervention dated 07/24/2024 for the resident to be on enhanced barrier precautions (EBP, an approach of targeted gown and glove use during high contact resident care activities) due to a peripherally inserted central catheter (PICC, an inserted flexible tube used to administer intravenous fluids and drugs) site on the chest. During an interview on 01/09/2025 at 9:35 AM, Staff L, Registered Nurse (RN), stated Resident 32 did not have a PICC site on their chest and was not on EBP. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 2:03 PM Staff M, RN/Unit Care Coordinator (RN/UCC), stated Resident 32's care plan did not meet expectations due to Resident 32 did not have a PICC site to the chest and the care plan needed to be revised. During an interview on 01/09/2025 at 3:46 PM, Staff B, Director of Nursing Services (DNS), stated Resident 32's care plan showed that they were on EBP due to a PICC site on their chest; however, the PICC was no longer there. Staff B stated that the care plan should have been revised. Review of Resident 32's nutrition focused care plan, revised on 01/08/2025, showed an intervention dated 03/29/2024 for fluid restriction of 1800 milliliters per day. This care plan did not show how much fluid would be provided during each meal or how much fluid could be provided each shift in between meals. During an interview on 01/09/2025 at 1:38 PM, Staff L, RN, stated residents on fluid restrictions should be care planned and should include how much fluid was provided by the kitchen for each meal and how much fluid was to be provided by nursing for each shift according to the provider order. During an interview on 01/09/2025 at 3:57 PM, Staff B, DNS, stated Resident 32's care plan for fluid restrictions did not meet expectations due to it needed to be more detailed of the breakdown of fluids to be provided as in the provider order and that did not happen for Resident 32. Staff B stated Resident 32's care plan needed to be revised. Review of the EHR showed Resident 32 had not been invited to a care conference after they admitted to the facility. During an interview on 01/10/2025 at 10:46 AM, Staff F, Social Services Director (SSD), stated Resident 32 had not had a care conference after admitting to the facility. Resident 50 During an interview on 01/07/2025 at 11:35 AM, Resident 50 stated they did not recall attending a care conference. Review of Care Plan Conference Record showed Resident 50's most recent care conference was held on 07/26/2024 and an invitation for a care conference had been mailed to Resident' 50's power of attorney on 12/30/2024. Review of the EHR showed Resident 50 had a quarterly MDS on 10/24/2024. During an interview on 01/10/2025 at 10:47 AM, Staff F, SSD, stated Resident 50 should have had a care conference after the 10/24/2024 quarterly assessment. Resident 22 During an interview on 01/07/2025 at 12:39 PM, Resident 22 stated it had been several months since their last care conference. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Care Plan Conference Record showed Resident 22's most recent care conference was held on 09/12/2024. Review of the EHR showed Resident 22 had a quarterly MDS on 12/10/2024. During an interview on 01/10/2025 at 10:47 AM, Staff F, SSD, stated Resident 22 should have had a care conference in December 2024 and was on the schedule to have a care conference in February 2025. During an interview on 01/08/2025 at 2:10 PM, Staff F, SSD, stated the facility was having difficulty maintaining the care conference schedule and some residents may not have had a quarterly care conference. Staff F stated residents should have care conferences when admitting to the facility, quarterly after the MDS assessment, and as need/requested. During an interview on 01/13/2025 at 10:22 AM, Staff C, Regional [NAME] President, stated care conferences should occur within the first 21 days after admitting to the facility, quarterly, and with change of condition. Staff C stated Resident 32's lack of care conference since admitting to the facility did not meet expectation. Staff C stated Residents 50 and 22 should have had care conferences after their comprehensive assessments. Reference WAC 388-97-1020(2)(c)(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505499	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottesmore of Life Care	2909 14th Avenue Northwest Gig Harbor, WA 98335

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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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46148

Based on observation, interview, and record review, the facility failed to ensure there was a system to provide care and services consistent with standards of quality of care for 2 of 3 sampled residents (Residents 57 and 71) when reviewed for edema/heart failure, for 4 of 8 sampled residents (Residents 7, 40, 57 and 78) when reviewed for bowel management, for 1 of 1 sampled residents (Resident 40) when reviewed for hospice service, and for 1 of 3 sampled residents (Resident 32) when reviewed for hospitalization . The failure to develop and implement person-centered edema/heart failure care plans (CPs) that included notifying the provider of changes in condition, routine monitoring of weights and fluid status, implementing bowel program orders when required, including the hospice plan of care and to provide speech evaluation upon return from hospital per provider orders, placed the residents at risk for unmet needs, medical complications, constipation, and a diminished quality of life.

Findings included .

<EDEMA/HEART FAILURE>

Review of an email dated 01/14/2025 showed Staff B, Director of Nursing Services (DNS), stated they did not have protocol for congestive heart failure (CHF, a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs) or edema (swelling of a body part) management and these are physician/provider driven and resident specific.

Review of the American Heart Association (Vol.8, No.3) Heart Failure Management in Skilled Nursing Facilities, published 04/08/2015, recommended for residents at risk for decompensation/exacerbation (decline in condition/a sudden worsening of a chronic illness or medical condition), residents should adhere to daily weight monitoring (same time of day-preferably first thing in the morning after the first toileting) and fluid volume evaluations. A weight gain of three to five pounds over three to five days should alert licensed staff to perform an advanced assessment of volume status, vital signs, and respiratory status; then promptly notify the physician with the findings. Routine daily symptom monitoring should occur for any degree of edema, abnormal lung sounds, cough (especially when lying down), jugular vein distention (JVD, a bulging of major veins in the neck and a key symptom of heart failure), difficulty breathing: at rest, when lying flat, and/or at night. Daily weights and symptom monitoring provided early identification of cardiac decompensation and minimized potential for re-hospitalization .

Resident 57

Review of the electronic health record (EHR) showed Resident 57 admitted to the facility on [DATE] with diagnoses that included heart failure, lymphedema (a chronic condition that causes swelling in the body's tissues) and an open wound to the left lower leg. The resident was able to make needs known.

Review of the EHR showed an order dated 11/28/2024 to check the resident's weight daily and notify the provider if the resident gained more than five pounds in a week or three pounds in a day.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cottesmore of Life Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2909 14th Avenue Northwest Gig Harbor, WA 98335	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR showed an order, dated 12/11/2024, for staff to apply a kerlex (gauze) wrap as needed for drainage to the left lower leg. The treatment administration record showed no documented bandages had been applied. Review of the EHR showed no care plan was initiated for lymphedema or heart failure. Review of a provider note, dated 01/03/2025, showed increasing swelling with redness and warmth in the left lower extremity. Appears to be developing infection in the left lower extremity. Nursing staff was requesting a vascular and wound team referral and adjustment of Lasix. Resident was noted to have swelling in the left lower extremity with bruising/redness and a draining wound in the calf. Review of a provider note dated 01/04/2025 at 7:43 AM showed, Continue local wound care. Wound care referral to assist with management of the wound. Elevate limb as tolerated. During an interview and observation on 01/07/2025 at 1:29 PM, Resident 57 stated the nurses did not do anything with their legs. The resident stated their recliner chair did not work and they could not raise their legs. The resident had bilateral lower extremity edema (swelling to both legs), drainage was pooling on the floor under the left leg, the skin was red, and there was no dressings/bandages present. Observation on 01/08/2025 at 2:15 PM, showed Resident 57 sitting in a recliner at the side of their bed and their legs were not elevated. There was a bandage wrapped around the left calf with drainage noted soaking through. Observation on 01/09/2025 at 9:27 AM, showed Resident 57 laid in bed with an incontinence pad under both legs, no bandages were present, and drainage was noted on the pad. Observation and interview on 01/10/2025 at 2:15 PM, showed Resident 57 sat in their recliner chair and their legs were not elevated. The bandages present on the left lower leg were saturated with pink and green drainage dripping on the floor. Resident 57 stated they wished the recliner would work. During an interview and observation on 01/13/2025 at 9:36 AM, Resident 57 stated staff sometimes put bandages on and sometimes they did not. A white cloth blanket was on the floor under the resident's feet and was saturated with wound drainage. Both legs were red and very swollen. The recliner was not plugged in, and the resident was unable to elevate legs. Resident 57 stated they rested in bed at night but during the day they did not have a way to elevate their legs. Review of the weight record showed Resident 57 weighed 252.8 pounds on 01/04/2025 and 258.4 pounds on 01/11/2025, a gain of 5.6 pounds in seven days. Review of the EHR on 01/13/2025 showed no documentation of provider notification of increased drainage, swelling, and redness to the left lower leg or weight gain. Review of the EHR on 01/13/2025 showed no documentation the resident was referred to wound team, vascular clinic or the lasix being adjusted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/2025 at 1:34 PM, Staff P, Registered Nurse, stated Resident 57 was not being seen by a wound care provider and that the dressings should be more than 'as needed.' Staff P stated they had not notified the provider yet but would now. Resident 71 Review of the EHR showed Resident 71 admitted to the facility on [DATE] with a diagnosis of CHF. The resident was able to make needs known. Observation on 01/07/2025 at 12:10 PM showed Resident 71 sat in an electric reclining chair that was unplugged with both feet on the floor and was noted to have swollen, red feet and ankles with drainage present on the socks. Observation and interview on 01/08/2025 at 2:13 PM, showed Resident 71 sat in the reclining chair with both feet on the floor. There was drainage present on their socks and both feet and ankles were swollen and red. Resident 71 stated they would like to elevate their legs, but they could not because the facility would not let them plug in the reclining chair. Resident 71 stated the facility turned all electric recliners off because someone fell , and it has been off for the last 14 days at least. Observation and interview on 01/09/2025 at 9:18 AM, showed Resident 71 sat in the electric recliner with their legs elevated and stated they plugged in the recliner. If the chair worked my feet would have been up. The sock on the right leg was saturated with fluid with thick white scabs that appeared wet. Observation on 01/10/2025 at 2:57 PM, showed Resident 71 sat in the recliner with feet elevated. They were red and swollen and drainage was noted on right leg ankle. Observation and interview on 01/13/2025 at 9:44 AM, showed Resident 71 sat in the recliner with their legs elevated, socks on both feet were saturated with drainage and redness was noted to the right leg. Resident 71 stated staff did not do any treatments to it and the redness was getting worse. Review of the EHR showed an order dated 12/27/2024 to check the resident's weight daily and notify the provider if the resident gained more than five pounds in a week or three pounds in a day. Review of the medication administration record (MAR) showed Resident 71 weighed 282.3 pounds on 12/31/2024 and 293.6 pounds on 01/07/2025, an 11.3 pound gain in seven days. Review of the EHR on 01/12/2024 showed no documentation that the provider was notified of the weight gain, no orders to monitor edema, and no care plan for CHF or edema. During an interview on 01/13/2025 at 9:49 AM, Staff K, Registered Nurse, stated if a resident had increased drainage, swelling and redness in their legs and/or had a weight gain of greater than five pounds in a week they would notify the provider and get orders for treatments. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 01/10/2024 at 1:45 PM, Staff B, Director of Nursing Services (DNS), stated the recliners had been unplugged related to a different resident's fall. The residents should be assessed for safety with use of the recliner if they needed it to elevate their legs. Staff B stated their expectation was for nursing staff to notify the provider of changes such as increased redness, swelling, drainage, and weight gain.

<Bowel Management>

Review of a document titled, Bowel Protocol dated 09/16/2024, showed that it was the policy of the facility to provide effective interventions for signs and symptoms of constipation that were consistent with current standards of practice. The licensed nursing staff were to record, in the electronic health record (EHR), each time a resident had a bowel movement (BM) and in coordination with the resident's attending practitioner implement standing orders to address a lack of BM.

Resident 57

Review of the EHR showed Resident 57 admitted to the facility on [DATE] with diagnoses that included heart failure. The resident was able to make needs known.

Review of the EHR showed a provider order for Miralax to be given as follows: 17 gram by mouth as needed for constipation daily. Mix with 4-8 ounces water or juice after 72 hours with no bowel movement.

Review of December 2024 MAR showed Resident 57 had no bowel movement on the 28, 29, 30 and 31. Further review showed Miralax was not administered.

Resident 7

Review of the EHR showed Resident 7 admitted to the facility on [DATE] with diagnoses including diverticulitis (abnormal folding of the intestines/bowel) and constipation. The resident was able to make needs known.

During an interview on 01/07/2025 at 1:53 PM, Resident 7 stated they had been constipated recently and the staff had not administered any medications to help with it.

Review of the bowel movement documentation showed no documented bowel movement from 12/20/2024 through 12/24/2024.

Review of the December 2024 MAR showed as needed or scheduled laxatives were not administered to Resident 7 in that month.

Resident 40

Review of the EHR showed Resident 40 admitted to the facility on [DATE] with diagnoses to include dementia and traumatic subarachnoid hemorrhage (a bleed in the brain) with cognitive communication deficit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the provider orders showed an order, dated 11/29/2024, for Miralax (a laxative medication) as needed for constipation to be administered after 72 hours with no bowel movement. Milk of Magnesia Suspension if Miralax ineffective given on day five. Review of the EHR showed no documented bowel movements from 12/14/2024-12/17/2024, and no laxative was documented as administered as ordered. Review of a provider note dated 12/18/2024 showed Patient was noted to have distention and is noted to be constipated. Bowel tones present in all 4 quadrants. Per nursing patient had bowel movement recently; provide encourage nursing to start bowel protocol. Review of the EHR showed Resident 40 had a documented bowel movement on 12/18/2024 at 11 AM. Resident 40 received laxative medications on 12/19/2024 which were documented as ineffective. Review of the EHR showed no documented bowel movement from 12/22/2024-01/01/2025. On 12/26/2024 milk of magnesia (MOM) was documented as given with unknown results and on 12/31/2024 with ineffective results. Review of a progress note dated 01/01/2025 at 3:01 PM, showed Resident 40 had a distended abdomen. During an interview on 01/09/2025 at 11:13 AM, Staff K, Registered Nurse, stated the staff should start the bowel protocol after 72 hours with no bowel movement. During an interview on 01/10/2025 at 10:57 AM, Staff R, Advanced Registered Nurse Practitioner (ARNP), stated the bowel protocol should be implemented after three days or 72 hours without a bowel movement and if ineffective they should notify the provider. During an interview on 01/09/2025 at 1:24 PM, Staff B, DNS, stated it was their expectation that staff review clinical alerts daily and if a resident had gone 72 hours or greater without a bowel movement, they would start the bowel protocol and follow the provider's orders. Staff B stated Residents 7 and 40 should have had the bowel protocols started after 72 hours without a bowel movement. 34567 Resident 78 Review of the admission minimum data set (MDS, a required assessment tool) dated 11/04/2024, showed that Resident 78 admitted on [DATE] with multiple diagnoses to include dysphagia (a condition related to difficulty or discomfort in swallowing) and constipation. The MDS showed the resident was able to make needs known and was dependent upon staff with activities of daily living (ADLs). During an interview on 01/07/2025 at 2:20 PM, Resident 78 stated they had problem with constipation. Review of Resident 78's care plan, dated 10/31/2024, for activities of daily living, showed the resident had or had potential for problems related to constipation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 78's EHR task section documentation for BM results for Resident 78 showed staff had documented the resident had no BM greater than 72 hours twice from 12/26/2024, 8:29 PM to 12/30/2024, 1:35 AM and no BM recorded from 12/30/2024, 8:34 PM to 01/03/2025, 5:25 AM. Review of the MAR, dated 12/01/2024 to 12/31/2024, showed that Resident 78 had several physician orders to administer medication for constipation. The following, as needed, medication for the treatment of constipation included: MiraLAX as needed for no BM after 72 hours and Senna as needed for constipation at bedtime. Reivew of the December 2024 and January 2025 MARs showed the ordered constipation medications were not administered as needed during the time in which no BM was documented for the resident from 12/26/2024 to 12/30/2024 and again from 12/30/2024 to 01/03/2025 dates. During an interview on 01/09/2025 at 11:29 AM, Staff T, Assistant Director of Nursing (ADON), stated their expectation would be for the licensed nurses (LNs) to start the bowel program whenever the resident had greater than 72 hours without a BM. 46067 <Hospice Care Plan> Resident 40 Review of the EHR showed Resident 40 admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease (condition that impacts the blood vessels in your brain) and diabetes (too much sugar in the blood). Resident 40 received hospice services and was able to make needs known. Review of EHR and medical record showed there was no hospice provider Plan of Care. During an interview on 01/08/2025 at 12:32 PM, Staff M, Registered Nurse/Unit Care Coordinator (RN/UCC), stated they were unable to locate the hospice provider Plan of Care in the medical record. Staff M stated the Plan of Care should have been in the medical record. During an interview on 01/10/2025 at 1:53 PM, Staff B, DNS, stated the expectation was that hospice residents had the Plan of Care in the medical record to ensure a comprehensive care plan. 38344 <Speech Evaluation> Resident 32 Review of the EHR showed Resident 32 readmitted to the facility on [DATE] with diagnoses that included heart failure, kidney failure, and dysphagia (difficulty swallowing foods or liquids). Resident 32 was able to make needs known. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 32's modified annual MDS, dated [DATE], showed the resident received dialysis (treatment to filter wastes and water from the blood) and received a mechanically altered/therapeutic diet (a meal plan that is designed to treat a medical condition or symptom). Review of the EHR showed Resident 32 was hospitalized on [DATE] and returned to the facility on [DATE]. Review of Resident 32's care management progress note dated 12/31/2024 at 3:08 PM showed, Hospital orders say diet texture is regular for safety of resident and Speech eval in facility recommendation is to be on mechanical texture and a referral to speech to evaluate accurate diet texture. Review of Resident 32's skilled progress note, dated 12/31/2024 at 11:56 PM, showed/included Admitting DX [diagnosis] of pneumonia and Able to eat independently with tray set-up. Review of Resident 32's EHR showed no documentation that that a speech evaluation had been completed after readmitting to the facility on [DATE]. During an interview on 01/10/2025 at 11:46 AM after reading Resident 32's care management progress note dated 12/31/2024, Staff N, Director of Rehabilitation Services, stated this should have been brought up in their clinical meeting so a screen could have been completed and orders obtained as needed and that did not happen for Resident 32. Staff N stated somehow the communication from the progress note got missed getting to rehabilitation services. Staff N stated Resident 32's last speech evaluation was completed on 11/16/2024 (prior to readmission to facility on 12/31/2024). During an interview on 01/10/2025 at 2:22 PM, Staff B, DNS, stated there should have been a speech evaluation upon Resident 32's return to the facility on [DATE] or by the next day. Reference WAC 388-97-1060 (1)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to implement pressure ulcer care for 2 of 4 sampled residents (Residents 78 and 72) reviewed for pressure injuries (injuries to skin and underlying tissue resulting from prolonged pressure on the skin). This failure placed the resident at risk for worsening pressure injuries, pain, and a decreased quality of life. Findings included . Review of a policy titled, Skin Integrity and Pressure Ulcer/Injury Prevention and Management, dated 07/09/2024, showed staff were to provide treatment and care of the resident wounds utilizing professional standards of the National Pressure Injury Advisory Panel (NPIAP). The facility must ensure resident care was provided to pressure ulcers consistent with professional standards of practice to promote healing and prevent infection. Resident 78 Review of the admission minimum data set (MDS, a required assessment tool), dated 11/04/2024, showed Resident 78 admitted on [DATE] with multiple diagnoses to include heart disease, stroke, muscle weakness, dysphagia (a condition related to difficulty or discomfort in swallowing), and constipation. The MDS showed the resident was able to make needs known and was dependent upon staff with activities of daily living (ADLs). The electronic health record (EHR) showed the resident had a pressure ulcer to the sacrum (the area of the lower back at the base of the spine and in the center of the pelvis). Review of Resident 78's focus care plan, dated 11/21/2024, showed the resident was at risk for unavoidable pressure injury development and interventions directed licensed nurses (LNs) to provide treatment as ordered. Observation and interview on 01/07/2024 at 2:18 PM, showed Resident 78 sat up in a wheelchair within their room. The resident stated they had a pressure wound on their buttocks area and staff provided wound treatment to that area but was unable to state whether it was healing, how large the wound was to the area or the treatment that was being provided. Review of Resident 78's providers orders showed they had a referral to outside wound provider for evaluation and treatment as indicated, dated 11/14/2024. The provider ordered additional wound care treatment (12/16/2024) to be provided to the resident's sacrum pressure wound with wound cleanser, allow to dry and apply medi honey (a wound mixture which contains compounds which contributes to antibacterial wound activity) every day and when necessary. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the outside wound provider notes dated 01/02/2025 and 01/09/2025 showed the provider had provided extensive treatment to Resident 78's sacral pressure wound that consisted of wound debridement (a procedure that removes dead or unhealthy tissue form a wound to help it heal). The outside wound provider had ordered a change in the resident's wound treatment that consisted of LNs to clean the resident's sacral wound with Dakins (a disinfectant wound cleanser) and for the LN to apply skin prep to the peri wound (area around the wound) and allow to dry, apply Santyl (a treatment method that assists in removing dead tissue from the wound bed while preserving healthy tissue) and fill the sacral cavity with moistened gauze and cover with a dry dressing every shift and when necessary if dislodged. Review of Resident 78's Treatment Administration Records (TAR) on 01/10/2025 at 10:46 AM, showed the outside wound provider's new treatment orders had not been transcribed / updated and the resident continued the previous sacral pressure wound orders. During an interview on 01/10/2025 at 9:04 AM, Staff U, Licensed Practical Nurse/Unit Care Coordinator (LPN/UCC), stated they did not follow the outside wound provider recently on 01/02/2025 or 01/09/2025 when they had provided treatment to Resident 78's sacral wound; however, Staff U stated the usual process would be for the facility LN to assist the outside wound provider in repositioning the residents for wound care and outside wound provider provided the actual wound measurements and treatment during these rounds. Staff U stated the outside wound provider faxed or emailed one of the Resident Care Mangers (RCM) who printed off the recommendations and updated the residents' orders. During an interview on 01/10/2025 at 9:47 AM, Staff V, LPN, stated the outside wound provider's additional recommendation was received on Thursday 01/09/2025 and they did not have access to those outside wound provider recommendations, but they had received them this AM from another LN. Staff V stated the medication orders that were recommended recently by the outside wound provider had been placed on hold by the facility's provider until an x-ray was obtained first for the resident; however, Staff V was unaware of the changes in the outside wound provider's treatment orders. During an interview on 01/10/2025 at 10:33 AM, Staff B, Director of Nursing Services, stated the expectation would be for the LN's who had received the recommendation from the outside wound provider on 01/02/2025 and 01/09/2025 would implement those orders as directed so that the LNs could start the correct treatment to the resident's (sacral) wound. 46148 Resident 72 Resident 72 admitted to the facility on [DATE] with diagnoses of left tibial vein thrombosis (a blood clot in the left leg), chronic obstructive pulmonary disease (COPD, a disease that effects one's ability to breath), peripheral vascular disease (PVD, a disease that restricts the flow of blood in the legs), pulmonary edema (fluid buildup in the lungs) and Alzheimer's disease (a disease that effects one's memory). Review of the admission skin assessment, dated 12/03/2024, showed the resident had red mushy heels on admission. Review of the admission MDS, dated [DATE], showed Resident 72 had no unhealed pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weekly skin assessments dated 12/10/2024, 12/17/2024, 12/24/2024 and 12/31/2024 showed Resident 72 had blanchable redness to the right heel and a black bruise to the left heel. There was no weekly skin assessment completed on 01/07/2025. Observation on 01/07/2025 at 1:20 PM showed Resident 72 sat on the edge of the bed with both feet appearing swollen and red. A bandage was noted on the left lower leg with drainage visible. The resident was grimacing and holding their left leg. Observation on 01/08/2025 at 2:09 PM showed Resident 72 sat in a wheelchair in the day room watching TV. There was a dressing in place to the left shin with discolored drainage on sock. The resident had on a pair of tennis shoes. Observation on 01/09/2025 at 10:26 AM showed Resident 72 up in a wheelchair independently moving down the hall. The resident's sock was wet with drainage on the left ankle. Observation and interview on 01/10/2025 at 10:27 AM showed Resident 72 with Staff J and an unidentified therapy staff who raised the resident's feet and both heels were noted to have round black/brown hard areas with the left larger than the right. Both staff stated these were new wounds. Review of the EHR on 01/13/2025 showed no documentation that the provider was notified of Resident 72's black/brown heels. There was no documentation found of Staff R, Advanced Registered Nurse Practitioner, assessing the resident. Review of the EHR on 01/13/2025 showed no wound assessment or notes addressing pressure injuries to bilateral heels. During an interview on 01/13/2025, Staff B, Director of Nursing Services, stated they had not been notified of a new or worsened pressure injury for Resident 72. It was their expectation the provider be notified, and an incident investigation be started and care plan or orders be updated for any new or worsened pressure injuries but this did not happen for Resident 72. Reference WAC 388-97 -1060 (3)(b)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to provide adequate fluids to maintain hydration for 1 of 2 sampled residents (Resident 40) when reviewed for hydration and failed to monitor and accurately document fluids consumed to ensure fluid restrictions were implemented per provider's orders for 1 of 5 sampled residents (Residents 32) reviewed for nutrition and/or dialysis (treatment to filter wastes and water from the blood). This failure placed residents at risk for over hydration, avoidable discomfort, and a diminished quality of life. Resident 40 Review of the electronic health record (EHR) showed Resident 40 admitted to the facility on [DATE] with diagnoses to include dementia and traumatic subarachnoid hemorrhage (a bleed in the brain). Review of the care plan, dated 12/04/2024, showed the resident was at risk for dehydration and had a diet which included regular thin liquids. The resident required assistance of two staff for transfers out of bed. Observation on 01/07/2025 at 1:11 PM, showed the resident sitting on the bedside. There were no fluids available in the room. The resident had dry lips and was frequently licking them while talking. Observation on 01/08/2025 at 9:01 AM, showed Resident 40 in bed. They were noted to be licking their lips and appeared to have a dry mouth when talking. There were no fluids available in the room. Observation on 01/09/2025 at 9:11 AM, showed Resident 40 in bed. There were no fluids available at the bedside. During an interview on 01/09/2025 at 11:04 AM, Resident 40 stated, I am so thirsty. My mouth is bone dry. During an interview on 01/09/2025 at 11:02 AM, Staff G, Certified Nursing Assistant (CNA), stated staff provided a water pitcher to residents during rounds twice a shift unless they had a fluid restriction. Staff G stated Resident 40 should have a water pitcher at the bedside. During an interview on 01/09/2025 at 1:37 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that staff provide water at the bedside for Resident 40 and this did not meet their expectations. 38344 Resident 32 Review of the EHR showed Resident 32 readmitted to the facility on [DATE] with diagnoses that included heart failure, kidney failure, and diabetes (too much sugar in the blood). Resident 32 was able to make needs known. (continued on next page)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of Resident 32's modified annual minimum data set assessment (MDS, a required assessment), dated 12/11/2024, showed the resident received dialysis and received a mechanically altered and therapeutic diet (a meal plan that is designed to treat a medical condition or symptom).

During an interview and observation on 01/08/2025 at 8:46 AM, Resident 32 stated they did not think they were on a special diet and did not think they were on a fluid restriction; however, there was a sign posted on the wall above the resident's bed that showed, No Water Pitcher at bedside Fluid Restriction.

Review of the provider order, dated 01/03/2023, showed Resident 32 was prescribed an 1800 milliliter (ml) fluid restriction. Nursing to provide 240 ml on day shift, 240 ml on evening shift, and 240 ml on night shift. Fluids from the kitchen for meals: Breakfast 360 ml, lunch 360 ml, dinner 360 ml related to end stage renal disease (kidney failure).

Review of Resident 32's January 2025 medication administration record (MAR) from 01/01/2025 - 01/08/2025, showed the provider order dated 01/03/2025 for 1800 ml per day fluid restriction which included what should be provided by nursing (for each shift) and the kitchen (for each meal) had missing documentation. Fifteen out of seventeen opportunities were documented with an X and not the ml of fluid consumed.

During an interview on 01/09/2025 at 1:30 AM, Staff W, CNA, stated they did not document how much residents drank that were on fluid restrictions but was to inform the nurse how much they drank during their shift. Staff W stated they knew that Resident 32 was on fluid restrictions and only gave fluids provided during meals. Staff W did not know how much fluids Resident 32 was allowed to consume during their shift.

During an interview on 01/09/2025 at 1:38 PM, Staff L, Registered Nurse, stated they documented how much fluid a resident consumed that was on fluid restrictions during medication administration in the resident's MAR. Staff L stated the CNA kept track of what residents drank during meals but was not sure where the CNA documented what they gave. Staff L stated they did not document what fluids the CNA gave to residents during meals on the MAR.

During an interview on 01/09/2025 at 2:08 PM, Staff M, Registered Nurse/Unit Care Coordinator (RN/UCC), stated the CNA were to report to the nurses how much fluids were consumed during their shift for residents on fluid restriction and the nurses were to document total fluids consumed for medication pass and what fluids the CNA provided in the MAR. Staff M stated that Resident 32's January 2025 MAR documentation did not meet expectations because fluids consumed should have been documented and that did not happen for Resident 32.

During an interview on 01/09/2025 at 3:57 PM Staff B, DNS, stated the January 2025 MAR was missing documentation of fluids consumed by Resident 32 and this did not meet expectations.

Reference WAC 388-97-1060 (3)(h)(i)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46148 Based on observation, interview, and record review, the facility failed to manage oxygen therapy consistent with professional standards of practice and the comprehensive person-centered care plan by not ensuring provider's orders and care plans were in place and/or followed for 2 of 4 sampled residents (Residents 71 and 72) when reviewed of respiratory care. These failures placed residents at risk for unmet needs and a decreased quality of life. Resident 71 Review of the electronic health record (EHR) showed Resident 71 admitted to the facility on [DATE] with a diagnosis of congestive heart failure (CHF, when the heart is not able to pump enough blood causing fluid to build up in the lungs and/or limbs). The resident was able to make needs known. Review of the EHR on 01/08/2025 at 4:45 PM showed no care plan had been initiated for oxygen use. A provider order was found showing Resident 71 was ordered oxygen at two liters per minute continuously per nasal cannula (NC, a tube that inserts into the nose). During an interview and observation on 01/07/2025 at 12:12 PM, Resident 71 sat in a recliner chair. They had an oxygen concentrator running at one liter per minute and the tubing was curled up and stored on the bedside table. Resident 71 stated they had oxygen for if they needed it, and they had not used it for a week. Observation on 01/08/2025 at 2:15 PM showed Resident 71 sat in a recliner chair. The oxygen machine was running at one liter per minute and the tubing was curled up on bedside table not inserted to the resident's nose. During an interview on 01/09/2025 at 1:49 PM, Staff B, Director of Nursing Services, stated this did not meet their expectations and Resident 71's order should have been updated to as needed and a care plan should have been initiated. Resident 72 Resident 72 admitted to the facility on [DATE] with diagnoses of left tibial vein thrombosis (a blood clot in the left leg), chronic obstructive pulmonary disease (COPD, a disease that effects one's ability to breath), peripheral vascular disease (PVD, a disease that restricts the flow of blood in the legs), pulmonary edema (fluid build-up in the lungs), and Alzheimer's disease (a disease that effects ones memory). Observation on 01/07/2025 at 1:22 PM showed Resident 72 sat at their bedside. Oxygen was being administered through an nasal cannula at two liters per minute. Observation on 01/08/2025 at 2:09 PM showed Resident 72 sat up in their wheelchair. There was a portable oxygen tank attached to the back of their chair running at one liter per minute through a nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR showed no care plan for oxygen therapy had been initiated and no order for oxygen use. During an interview on 01/10/2025 at 2:18 PM, Staff J, Registered Nurse, stated they would look at the provider's orders to see how much oxygen a resident required but could not find that for Resident 72. During an interview on 01/09/2025 at 1:55 PM, Staff B, DNS, stated Resident 72 should have an order and a care plan for oxygen therapy for respiratory issues but did not and this did not meet expectations. Reference WAC 399-97-1060 (3)(j)(vi)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure staff provided adequate pain management in a timely manner for 1 of 3 sampled residents (Resident 29) when reviewed for pain management. This failure had the potential for the resident to have a delay in treatment to receive the necessary pain medication as ordered, a diminished quality of life and unmet needs. Findings included . Review of a document titled, Pain Assessment and Management, dated 09/05/2024 showed the policy was based on the comprehensive assessment of a resident and the facility was to ensure the resident received the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Review of Resident 29's admission minimum data set (MDS, a required assessment tool), dated 07/29/2024, showed the resident admitted on [DATE] with multiple health conditions including heart and kidney disease, osteoarthritis (a chronic disease that breaks down joint cartilage and bone, causing pain, stiffness, and swelling) and chronic pain. The electronic health record (EHR) showed the resident had a history of traumatic fractures and was able to make their needs known. Review of Resident 29's care plan, revised on 01/03/2025, showed a focus care plan for pain related to degenerative joint disease (DJD), osteoarthritis, joint disorders, and history of fractures. The goal was for the resident to express pain relief through the review date. Interventions included an acceptable pain level 5/10 on a numeric pain scale. Licensed Nurses (LNs) were to evaluate the effectiveness of pain interventions and administer pain medication as ordered. Review of a document titled, Pain Evaluation Tool, dated 10/19/2024 showed Resident 29 was evaluated by LN who document the resident's stated physical activity and mobility was affected by pain and the administration of the pain medication MS Contin (a narcotic pain medication) was effective in their treatment and alleviating their pain. Observation and interview on 01/07/2025 at 2:30 PM, showed Resident 29 laid in bed within their room and stated they had a pain level on a scale of 8 over 10 pain (with 10 being severe pain). The resident stated they told the LN staff all the time they were in pain but noted the LNs don't want to give me any of my MS Contin. Review of Resident 29's MDS Section J (Pain Management) for 10/28/2024 and 12/12/2024 showed Pain Assessments were conducted by LNs who had documented the resident had pain or was hurting in the last five days and was frequent. The LNs had documented the resident was asked to rate their pain within the last five days on a scale 0-10 with zero being no pain and a 10 as the worst pain you could imagine. The LN documented on both occasions the resident indicated an 8. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 29's October 2024 medication administration records (MAR) showed a provider's order dated 09/05/2024 for LNs to administered as needed MS Contin 15 milligrams (MG) as needed for pain 5-10/10 related to chronic pain syndrome. The MAR showed the LNs had documented the resident had been administered the narcotic MS Contin on four separate occasions: 10/06/2024, 10/10/2024, 10/12/2024 and 10/13/2024. Resident 29's pain scale was documented to range between 7-10 /10 range. The LNs had documented that the administration of the MS Contin was effective in reducing the resident's pain level. Review of the resident's MARs for November 2024, December 2024, and January 2025 through 01/08/2025 showed no MS Contin was documented as being administered to Resident 29. During an interview on 01/09/2025 at 9:04 AM, Resident 29 continued to state they complained of pain every day; however, the LNs did not give them any MS Contin. During an interview on 01/09/2025 at 9:10 AM, Staff K, Registered Nurse, stated the resident had a provider's order for MS Contin for break-through pain; however, the resident had not requested it from them. During an interview on 01/09/2025 at 10:35 AM, Staff B, Director of Nursing Services, stated it was their expectation the providers order for MS Contin should have been administered especially for any for break through pain as indicated on the MDS pain assessments and stated the LNs should conduct accurate daily pain assessments and administer the pain medication MS Contin as directed. Reference WAC 388-97-1060 (1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to obtain an agreement/contract with a resident's dialysis provider to ensure all care and services necessary were being provided and coordinated for 1 of 1 sampled resident (Resident 32) reviewed for dialysis (treatment to filter waste and water from the blood). This failure placed the resident at risk for inadequate quality of care and decreased quality of life. Findings included . Resident 32 Review of the electronic health record (EHR) showed Resident 32 readmitted to the facility on [DATE] with diagnoses that included heart failure and kidney failure. Resident 32 was able to make needs known. Review of Resident 32's modified annual minimum data set assessment (MDS, an assessment tool) dated 12/11/2024 showed the resident received dialysis. During an interview on 01/08/2025 at 8:45 AM, Resident 32 stated they went to a dialysis center three days a week. Review of the provider order dated 12/31/2024 showed that Resident 32 was to be sent to a dialysis center on Mondays, Wednesdays and Fridays, 10:30 AM to 3:00 PM, on dayshift for dialysis treatment. This order further showed the name and address of the dialysis center. During an interview on 01/10/2025 at 9:59 AM, Staff C, Regional [NAME] President, stated they were unable to locate a contract/agreement for Resident 32's dialysis center and it should have been in place. Staff C stated they needed to contact the dialysis center to obtain a contract. Reference WAC 388-97-1900(1), (6)(a-c)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to consistently initiate non-pharmacological interventions prior to the administration of as needed pain medication for 2 of 5 sample residents (Residents 18 and 398) reviewed for unnecessary medications. These failures placed residents at risk for receiving unnecessary medications and a diminished quality of life. Findings included . Review of a facility document titled, Pain Assessment and Management, dated 09/06/2024 showed the facility must ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. In addition, the facility will address and treat the underlying causes of pain, to the extent possible by developing and implementing both non-pharmacological and pharmacological interventions and approaches to pain management whether the pain is episodic, continuous or both. Resident 18 Review of the admission minimum data set (MDS, a required assessment tool) dated 10/31/2024, showed that Resident 18 admitted on [DATE] with multiple diagnoses to include heart and lung disease, pneumonia, stroke, osteoporosis (a disease in which the density and quality of bone are reduced), depression, and chronic pain. The MDS showed the resident was able to make needs known. Review of Resident 18's focus care plan showed the resident had pain/discomfort related to their stroke and chronic pain syndrome. The goal was for the resident to express pain relief through the review date. Interventions included for Licensed Nurse (LNs) to evaluate the effectiveness of the pain interventions and provide pain medication as ordered. Review of Resident 18's providers order dated 12/03/2024, showed the resident was prescribed Roxicodone (a narcotic medication to treat moderate to severe pain) every two hours as needed for chronic pain. Review of Resident 18's Medication Administration Record (MAR) dated 12/01/2024 to 12/31/2024 showed that the resident had received Roxicodone 24 separate occasions, and again on 01/01/2025 to 01/07/2025 on eight separate occasions without any non-pharmacological approaches implemented and/or offered prior to administering the narcotic. Review of Resident 18's MDS Section J for pain management dated 12/03/2024 showed the resident was administered as necessary pain medication; however, the document indicated the resident was marked No, when asked whether they had received non-medication interventions for pain. During an interview on 01/09/2025 at 10:18 AM, Staff O, Registered Nurse (RN), stated nonpharmacological interventions were to be offered prior to the administration of any as needed narcotics. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2025 at 10:31 AM, Staff B, Director of Nursing Services, stated it was their expectation the license nurses were to complete non-pharmacological interventions prior to administering the narcotic and document what intervention were being completed. 49926 Resident 398 Review of EHR showed Resident 398 readmitted to the facility on [DATE] with diagnoses that included methicillin resistant staphylococcus aureus infection (infection caused by a type of bacteria that has become resistant to many of the antibiotic used to treat ordinary infection), retention of urine and diabetes (too much sugar in the blood). Resident 398 was able to make needs known. Review of provider's orders showed Resident 398 was prescribed oxycodone as needed for pain. Review of Resident 398's MAR showed the oxycodone was administered on January 3rd, 5th, 6th and 7th without documentation of nonpharmacological interventions attempted prior to administration of the pain medication. During an interview on 01/10/2025 at 1:34 PM, when asked what the process for documenting nonpharmacological interventions for pain medications was, Staff U, Licensed Practical Nurse/Unit Care Coordinator, stated We go by the orders. When asked specifically about Resident 398's documentation, Staff U stated the order for Resident 398 was missed. During an interview on 01/10/2025 at 1:43 PM, Staff B, DNS, stated the expectation was to have an order for documentation of nonpharmacological interventions in the Resident 398's record and to be documented. Reference WAC 388-91-1060(3)(k)(i)

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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** 49926 Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were securely locked for 3 of 26 sampled residents (Residents 90, 9, and 64) when reviewed for environment. This failure placed the resident at risk for consuming non-prescribed medications, unintended side effects of medications, medical complications, and a diminished quality of life. Findings included . Review of the facility policy titled Storage and Expiration of Medications, Biologicals revised on 08/07/2023, showed under General Storage Procedures Store all drugs and biologicals in locked compartments. Resident 90 Review of the electronic health record (EHR) showed Resident 90 admitted to the facility on [DATE] with multiple diagnoses that included fracture of right leg, respiratory failure and muscle weakness. Resident 90 was able to make needs known. Observation and interview on 01/07/2024 at 11:10 AM showed Resident 90 had multiple medications in pill form, inhalers, and nebulizing prescriptions at their nightstand and the sink countertop in their room. Resident 90 stated they took some of them. Observation on 01/08/2025 from 8:30 AM until 3:00 PM showed the medications continued unsecured in Resident 90's room. Resident 64 Review of the EHR showed Resident 64 admitted to the facility on [DATE] with diagnoses that included repeated falls, asthma, and lung cancer. Resident 64 was able to make needs known. Observation on 01/07/2025 at 9:50 AM showed Resident 64 had an inhaler medication at bed site on over the bed table. Resident 9 Review of the EHR showed Resident 9 admitted to the facility on [DATE] with diagnoses of laminectomy (surgical procedure that removes part or all the laminate of the spinal canal) in the lumbar low back region, urinary tract infection, and chronic kidney disease. Resident 9 was able to communicate needs. Observation on 01/10/2024 at 9:50 AM showed Resident 9 had a topical pain patch at bedside on an over the bed table. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/10/2025 at 1:48 PM, Staff B, Director of Nursing Services, stated the expectation was for medications to be securely stored and locked. Reference WAC 388-91-1300(2)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to provide dental services for 1 of 3 sample residents (Resident 78) reviewed for dental. This failure placed the resident at risk of difficulty eating and a diminished quality of life. Findings included . Review of the admission minimum data set (MDS, a required assessment tool) dated 11/04/2024, showed Resident 78 admitted on [DATE] with multiple diagnoses to include heart disease, stroke, muscle weakness, dysphagia (a condition related to difficulty or discomfort in swallowing) and constipation. The MDS showed the resident was able to make needs known, was dependent upon staff with activities of daily living (ADLs) and had obvious or likely cavity or broken natural teeth. Observation and interview on 01/07/2025 at 2:11 PM showed Resident 78 laid in bed and multiple lower teeth appeared broken or were shown missing. Resident 78 stated they had not seen a dentist since they had been admitted to the facility. Review of Resident 78's focus care plan dated 11/14/2024 showed the resident had ADL self-care performance deficits related to their stroke and interventions included for facility staff to assist with personal hygiene and oral care. Review of a provider's order dated 10/30/2024 showed an order May have dental care as needed. During an interview on 01/10/2025 at 10:13 AM, Staff Q, Licensed Practical Nurse / Minimum Data Set (LPN/MDS), stated the LN who had evaluated the resident during the November 2024 MDS dental assessment should have referred or communicated that condition (related to the residents missing or cracked teeth) back to the resident care manager so that a referral to dental could be generated. During an interview on 01/10/2025 at 10:43 AM, Staff B, Director of Nursing Services, stated it was their expectation Resident 78 had a referral placed to the dentist and received needed dental care after the MDS assessment. Reference WAC: 388-97-1060 (2)(c), (3)(j)(vii)

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NAME OF PROVIDER OR SUPPLIER Cottesmore of Life Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2909 14th Avenue Northwest Gig Harbor, WA 98335	

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to provide prompt dental services for 1 of 3 sample residents (Resident 50) reviewed for dental services. This failure placed the resident at risk for continued dental problems and a diminished quality of life. Findings included . Review of Resident 50's electronic health records (EHR) showed the resident admitted to the facility on [DATE] with diagnoses to include protein-calorie malnutrition (a condition where the body does not get enough protein, calories, and other nutrients), diabetes (too much sugar in the blood), need for assistance with personal care, and depression. Resident 50 was able to make needs known. During an interview and observation on 01/07/2025 at 11:39 AM, Resident 50 stated their upper dentures were chipped on the top center of the dentures and caused some pain at times when putting them in and they would like to get some lower dentures. Resident 50 stated they had told staff about wanting to get upper dentures fixed and getting new lower dentures but that had not happened yet. Observation showed Resident 50 did not have lower dentures in place. Review of the admission progress note dated 07/21/2024 showed Resident 50 stated they did not have teeth and their dentures were at home but were broken. Review of the admission minimum data set assessment (MDS, an assessment tool) dated 07/24/2024 showed the resident had no natural teeth or tooth fragments. Review of Resident 50's care plan revised on 12/04/2024 showed the resident had oral/dental health problems related to edentulous (no teeth) and had upper dentures. Review of Resident 50's dental visit document dated 09/23/2024 showed the dentist recommended for Resident 50 to have new upper and lower dentures. Review of the facility's documented scheduled dental visit on 12/16/2024 at 8:30 AM showed the list of residents to be seen; however, Resident 50's name was not on the list. Review of the facility's document of the scheduled dental hygiene visit on 01/08/2025 at 10:00 AM showed the list of residents to be seen and included Resident 50's name; however, it was check marked, circled, and handwritten Rescheduled 1/21/25, which indicated that Resident 50 was not seen. Review of Resident 50's document titled, Denture/Partial Appliance Request for Skilled Nursing Facility Client, dated 11/09/2024 showed, Dentist/Denturist signature below indicates that the requested service is medically necessary according to WAC [PHONE NUMBER]. However, a spot on the form for the dentist/denturist's signature was blank (no signature). The document did show a physician's signature dated 11/21/2024. Review of the EHR and paper chart showed no documentation to explain the delay in obtaining new dentures for Resident 50. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/2025 at 10:10 AM, Staff S, Medical Records Director, stated the dentist came to the facility every other month and they generated their own lists depending on who needed treatment. Staff S stated Resident 50's denture application request form was signed by the facility house provider on 11/21/2024. Staff S stated Resident 50's communication for a referral should have been provided sooner and this did not meet expectations. During an interview on 01/13/2025 at 10:59 AM, Staff T, Assistant Director of Nursing (ADON), stated Resident 50's denture issues were not addressed in a timely manner and a referral for dentures should have been obtained sooner. Reference WAC 388-97-1060 (1), (3)(j)(vii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40817 Based on observation, interview, and record review, the facility failed to prepare and store food in a sanitary manner in the main kitchen and 3 of 3 resident refrigerators (West, East, and Transitional Care Unit) when reviewed for kitchen. This failure placed residents at risk of consuming expired or spoiled food, foodborne illness, avoidable discomfort, and a diminished quality of life. Findings included . Observation on [DATE] at 9:10 AM to 9:26 AM of the kitchen showed the following: 1) Two freestanding refrigerators with temperature logs missing 5 of 13 temperatures. 2) One freestanding refrigerator with opened and undated whipped frosting. 3) Three plates of cooked and plated breakfast meal plates on the shelf above the steamtable without temperature controls. 4) Walk-in refrigerator/freezer combo temperature log missing 3 of 13 temperatures. 5) Freezer with frozen vegetable medley in a metal container with no labeling, pan of stuffing with a , d+[DATE] date, open bag of vegetable medley left open with no date, and a bag of chicken patties left open with no date. 6) Dry storage with box of rice left open with no labeling and four bags of powdered gravy opened without labeling. Observation on [DATE] at 11:33 AM to 1:07 PM of the kitchen showed the following: 1) Staff Y, Dietary Aide, performed hand hygiene, placed barehand on a rolling garbage can to pull it from beneath a counter, threw away the paper towel, and then returned to work. 2) Staff Z and Staff AA, Dietary Aides, with loose hair uncovered by hairnet working in the kitchen. Observation on [DATE] at 1:22 PM showed the Transitional Care Unit (TCU) resident refrigerator contained three hardboiled eggs unshelled without a date and one small plastic container with a shelled hardboiled egg without date. Observation on [DATE] at 1:27 PM showed the East Hall resident refrigerator contained an opened can of soda without labeling and a carton of oat milk with the date written over the use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 1:27 PM showed the East Hall resident refrigerator contained a bottle of chipotle spread with a use by date of [DATE], a bottle of jalapeno sauce with a use by date of [DATE], six bottles of vitamin water with use by dates of [DATE], and one bottle of vitamin water with a use by date of [DATE]. Observation showed the temperature log informed staff that the refrigerator temperature should be between 36- and 46-degrees Fahrenheit. During an interview on [DATE] at 3:11 PM, Staff BB, Food Service Director, stated food in the kitchen refrigerator should be dated with a use by date once opened and the observations of unlabeled items did not meet expectation. Staff BB stated food should not be prepared and left above the steamtable without temperature control. Staff BB stated all hair should be covered by hairnets when working in the kitchen and staff should use the foot operated garbage cans when performing had hygiene. Staff BB stated Staff Y should not have touched the garbage can when performing hand hygiene and Staff Z and AA should have had their hair completely covered. Staff BB stated the temperature log on the [NAME] Hall did not meet expectation because it was for monitoring vaccine refrigerators. Staff BB stated the food storage in the [NAME], East and TCU resident refrigerators did not meet expectation because of unlabeled or expired items. During an interview on [DATE] at 10:29 AM, Staff C, Regional [NAME] President, stated food in the refrigerators should be labeled and sealed once opened. Staff C stated food that was not served should be thrown away or kept on temperature controls. Staff C stated hairnets should cover all staff hair when in the kitchen and staff should not touch the garbage can when performing hand hygiene. Staff C stated the facility's resident refrigerators did not meet expectation. Reference WAC [DATE] (3), -2980

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49926 Based on observation, interview, and record review, the facility failed to ensure resident's medical records were accurately documented according to professional standards of practice for 2 of 26 sampled residents (Residents 398 and 71) when reviewed for medical records. This failure placed the residents at risk for isolation, unmet care needs, and diminished quality of life. Findings included . Resident 398 Review of electronic health record (EHR) showed Resident 398 readmitted to the facility on [DATE] with diagnoses that included methicillin resistant staphylococcus aureus infection (MRSA, an infection caused by a type of bacteria that has become resistant to many of the antibiotics used to treat ordinary infections), retention of urine, and diabetes (too much sugar in the blood). Resident 398 was able to make needs known. Observations from 01/07/2025 until 01/09/2025 showed Resident 398 had enhanced barrier precautions (infection control interventions designed to reduce transmission of resistant organisms) sign by the entrance of the door to prevent them from infection. Review of an alert note, dated 01/09/2025 at 3:59 AM, showed Resident 398 was on alert for respiratory syncytial virus (RSV, serious respiratory viral illness) and droplet precautions (set of infection control measures used to prevent the spread of illnesses that are spread through respiratory droplets) maintained on that shift. During an interview on 01/09/2025 at 9:08 AM, Staff CC, Licensed Practical Nurse (LPN), stated the alert note was wrong. Resident 398 had RSV the previous month, but it was now resolved. During an interview on 01/09/2025 at 10:27 AM, Staff DD, Infection Preventionist, stated the alert note was wrong, Resident 398 had no symptoms, and Staff DD had removed them from the droplet precautions. Resident 71 Review of the EHR showed Resident 71 admitted to the facility on [DATE] with a diagnosis of congestive heart failure (CHF, when the heart is not able to pump enough blood causing fluid to build up in the lungs and/or limbs). The resident was able to make needs known. Observations on 01/10/2025 and 01/13/2025 showed no isolation precautions sign posted outside of Resident 71's door. Review of the EHR showed progress notes for Resident 71 dated 01/11/2025 and 01/12/2025 which showed the resident was Currently on Droplet precautions due to RSV, ESBL and contact precautions for MRSA. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/13/2025 at 1:50 PM showed Staff P, Registered Nurse (RN), stood outside Resident 71's door and confirmed the resident did not have any isolation precautions in place. Staff P stated the resident used to be on precautions but had not needed precautions in a long time and the progress notes were not accurate. Staff P stated they copy and paste the previous note then edit the information and did not notice that was documented. During an interview on 01/13/2025 at 10:35 AM, Staff B, DNS stated expectations were to have accurate progress notes. Reference WAC 388-97-1720 (2)(a-m)