STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505500	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Healthcare at Bellevue	2424 156th Avenue Northeast Bellevue, WA 98007

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to inform the resident and/or their resident representative before administering psychotropic (mind-altering) medication for 1 of 5 residents (Resident 5), reviewed for unnecessary medications. This failure placed the resident and/or their representative at risk of not being fully informed of the risks and benefits before making decisions about medications prior to administration. Findings included . Review of the facility's policy titled, Psychotropic Drug Utilization, last updated in November 2017, showed, In the event a psychoactive [mind-altering] medication is indicated in the plan of care, licensed staff will obtain informed consent for the use of the medication. Resident 5 admitted to the facility on [DATE]. Review of the admission Minimum Data Set (an assessment tool) dated 09/25/2024 showed Resident 5 had moderately impaired cognition and received an antidepressant (medication for depression). Review of the order summary report as of 10/15/2024 showed Resident 5 had an order for an antidepressant and antianxiety (medication for anxiety). Review of the September 2024 and October 2024 medication administration record showed Resident 5 received an antidepressant and antianxiety medications. Review of Resident 15's Electronic Health Record (EHR) showed no informed consent obtained for the use of antidepressant and antianxiety medications. During an interview and joint record review on 10/15/2024 at 11:34 AM, Staff J, Licensed Practical Nurse/Charge Nurse, stated that informed consent would be obtained before administration of psychotropic medications. Joint record review of Resident 5's EHR (and hard copy) of Resident 5's informed consent for antidepressant and antianxiety medications dated 09/19/2024 was not signed by the resident or their representative. Staff J stated that they received a verbal consent, which was not documented in the EHR or a hard copy of the consent form. On 10/17/2024 at 10:33 AM, Staff B, Director of Nursing, stated that it was the facility's policy to obtain informed consent before administering psychotropic medication. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0260 (2) (a-d)

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, interview, and record review, the facility failed to ensure residents were evaluated, assessed, and obtained a physician order for safe administration of medications for 2 of 3 residents (Residents 193 & 34), reviewed for self-medication administration. The failure to complete a self-administration of medication assessment and obtain a physician's order placed the residents at risk for medication errors, adverse medication interactions, and complications. Findings included . Review of the facility's policy titled, Self-Administration of Medications, dated August 2018 showed the following: 1. As part of their overall evaluation, the staff and practitioner may assess the patient's [resident's] mental and physical abilities to determine whether self-administering medications is clinically appropriate for the patient. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the patient's: a) ability to read and understand medication labels; b) comprehension of the purpose and proper dosage and administration time for his or her medication; c) ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d) ability to recognize risks and major adverse consequences of his or her medication. RESIDENT 193 Resident 193 admitted to the facility on [DATE]. Observation on 10/09/2024 at 2:40 PM, showed Resident 193 had a Ventolin FHA (an inhaler, medication used to treat breathing problem) on their bed side table. Observation and interview on 10/11/2024 at 8:12 AM, showed a Ventolin FHA inhaler was on the resident's bedside table. Resident 193 stated they last used the inhaler the night of 10/10/2024. Observations on 10/11/2024 at 12:34 PM and on 10/14/2024 at 9:41 AM, showed Resident 193 had Ventolin FHA inhaler and Stiolto Respimat (an inhalation spray drug used to treat wheezing and shortness of breath) on their bedside table. Resident 193 stated they used both medications at night and the last time they used it was the night before10/14/2024. Review of Resident 193's Electronic Health Record (EHR) for medication self-administration assessment dated [DATE] showed the assessment was in progress and it was not completed. Review of Resident 193's order summary report printed on 10/11/2024, showed an order for Ventolin FHA and Okay to keep at bedside with order start date of 10/10/2024. Further review of the order summary report showed no order to keep the Stiolto Respimat at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 10/14/2024 at 2:48 PM with Staff J, Licensed Practical Nurse/Charge nurse, showed Resident 193's self-administration of medication assessment dated [DATE] was not completed and signed. Staff J stated self-administration of medication assessment must be completed to keep medication at bed side. Joint observation of Resident 193's room showed the resident had Ventolin FHA inhaler and Stilton Respimat inhaler on their bedside table. Staff J stated that these medications should have not been left at bedside before the self-administration of medication assessment was completed and order obtained. On 10/16/2024 at 3:14 PM, Staff B, Director of Nursing, stated that their expectation was that residents were assessed for self-administration of medication, a physician order was obtained, and a care plan was initiated before leaving medication at bedside. 46912 RESIDENT 34 Review of Resident 34's admission record printed on 10/11/2024, showed Resident 34 admitted to the facility on [DATE]. Review of Resident 34's October 2024 medication administration record showed no orders for Aspercreme (a topical pain medication) or Xylimelts (treats dry mouth). Observations on 10/10/2024 at 10:22 AM and on 10/11/2024 at 10:57 AM, showed a bottle of Aspercreme and a container of Xylimelts on Resident 34's bedside table. Observation and interview on 10/14/2024 at 2:08 PM, showed Resident 34 had a bottle of Aspercreme and a container of Xylimelts on their bedside table. Resident 34 stated these were their home medications that have been cleared by the doctor and the doctor and the nurse looked at them and cleared them for use. An interview, joint observation, and joint record review on 10/14/2024 at 2:54 PM, Staff BB, Registered Nurse, stated that residents could keep medications at the bedside, but need to have an assessment and an order. A joint observation of Resident 34's bedside table showed Aspercreme and a container of Xylimelts. Staff BB stated that these were considered medications. A joint record review of Resident 34's EHR showed no order and no assessment for self-administration of medications. Staff BB stated that there should be an order and an assessment for self-administration of medications and medications should not be at the bedside if these were not done. In an interview on 10/17/2024 at 8:57 AM, Staff J stated that they would not expect medications to be at a resident's bedside unless there was an order and an assessment for self-administration of medications. In an interview on 10/17/2024 at 11:55 AM, Staff B stated that they would not expect residents to have medications in their room, unless we have an order, an assessment and a care plan for self-administration of medications. Reference: (WAC) 388-97-1060(3)(l), 0440

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 45146 Based on observation, interview, and record review, the facility failed to ensure the survey result binder included the results for 1 of 2 years (2021) recertification and complaint surveys that resulted in citations. In addition, the facility failed to post notice of the availability of survey reports in areas of the facility that are prominent and accessible to the public. These failures prevented residents, residents' representatives and visitors from exercising their right to review past survey results and the facility's plan of corrections. Findings included . Review of the facility's undated document titled, Resident Rights and Responsibilities, showed that resident has the right to examine the facility's latest survey inspection results. During a residents' meeting on 10/11/2024 at 1:41 PM, Resident 2 and Resident 16 who routinely attended residents monthly meeting, stated they were not aware of the availability of survey reports. Observation of the first and second floor on 10/11/2024 at 1:55 PM, showed there was no posting or notice to show the availability of the facility's survey reports. Review of the facility's survey binder labeled Survey Result, showed the binder did not contain recertification and complaint surveys that resulted in citations during the three preceding years. Further review of the binder showed recertification and complaint surveys results, and associated plans of corrections for year 2021 were missing. The missing survey results were complaint survey results for 02/22/2021, 03/26/2021, 09/15/2021, 10/13/2021, and recertification survey result for 06/23/2021. An interview and joint record review on 10/11/2024 at 2:41 PM, Staff A, Executive Director, stated that the facility used to have a posting for the availability of the survey reports. Joint record review of the survey result binder showed it did not contain the recertification and complaint survey results and associated plan of corrections for the year 2021. Staff A stated that all [annual] recertification and complaint surveys results with citation should be in the binder. Reference: (WAC) 388-97-0480(1)(a)(b)(c)(2)(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to ensure allegations of abuse was reported to the State Agency as required for 1 of 1 resident (Resident 7), reviewed for abuse allegations. This failure placed the resident at risk for potential unidentified abuse and lack of protection from abuse. Findings included . Review of the facility's policy titled, Abuse Investigation and Reporting, dated November 2017, showed, All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies, as applicable and per Washington State and federal regulations .State Agency. It further showed, it will be reported immediately, but no later than twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious injury. According to the Nursing Home Guidelines, The Purple Book, dated in October 2015 (sixth edition), a nursing home employee (or other mandated reporter) is required to make a report if they had reasonable cause to believe abuse, neglect, abandonment, mistreatment, personal and/or financial exploitation, or misappropriation of resident property has occurred. It showed, Federal law requires the facility to report all allegations of abuse or neglect. This would include taking seriously any allegation from residents or others with a history of making allegations. It further showed under Appendix D (Reporting Guidelines for Nursing Homes), staff to resident abuse was marked to report to the hotline and log within five days. Additionally, it showed that mental abuse was defined as a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Review of the admission Minimum Data Set (an assessment tool) dated 09/18/2024, showed that Resident 7 admitted to the facility on [DATE] and that they were cognitively intact. In an interview on 10/09/2024 at 9:41 AM, Resident 7 stated two weeks ago something started happening to their food on their tray after they complained about the food. Resident 7 stated that they got two bowls of throw away food and when they ordered soup, it tasted like goopy [sticky] food. Resident 7 stated that they considered that a threat and was afraid. Resident 7 further stated that they told Staff DD, Registered Nurse, about it and the next day Staff C, Dietary Manager, came. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/09/2024 at 4:05 PM, Staff A, Administrator, stated that they were aware that Resident 7 had made complaints of the food. Staff A stated that Resident 7 complained of the meat loaf and everything they have eaten since they got to the facility. Staff A stated that Staff C went to speak to Resident 7 about their concerns and that it was never mentioned to them about Resident 7 receiving throw away food or goopy food. Staff A stated that all Resident 7 told them was that the casserole and the meat loaf had fillers in it and that they never said that they were afraid of anybody or anything. Staff A stated that they did not hear anything about Resident 7 feeling threatened or was afraid. Staff A stated that they spoke to Resident 7 and that they never stated they were afraid, threatened, or used the words, goop/goopy or throw away food. Staff A stated, none of those words where used. Review of the progress note written by Staff A dated 10/09/2024 at 4:16 PM, showed that it was reported to them that Resident 7 reported she felt afraid and threatened. I followed up and spoke to [Resident 7]. [Resident 7] stated the kitchen had threatened her by putting throw away food on her tray because she complained about the food. When asked what is throw away food [Resident 7] described meat and beans in two containers on tray. It was only that one time that she felt afraid and has never felt that way again and is not fearful of anyone here. It further showed that Staff A had never heard Resident 7 say that they were ever afraid. Additionally, it showed, Social Services Director, a nurse and caregiver stated [Resident 7] has never expressed she has felt afraid. [Resident 7] stated if she felt afraid, she would have left. Review of the facility's October 2024 incident log did not show that Resident 30's concerns of feeling threatened or afraid were logged. Review of the facility's October 2024 grievance log showed a log for Resident 7 with grievance type of food/afraid dated 10/09/2024 with resolution date of 10/10/2024. In an interview on 10/16/2024 at 2:24 PM, Staff A stated that their process for reporting and investigating abuse was to make sure the resident was safe, report it to the nurse, report to the hotline and start an investigation. When asked what they did with the information provided to them about Resident 7's concerns of feeling afraid and threatened, Staff A stated that they went and spoke to the resident, wrote a progress note and looked in the Purple Book. Staff A stated they did not see that it needed to be called in to the State Agency. Staff A stated that they completed a grievance form and spoke to the resident. Staff A further stated that they did not call it in because in the abuse book [Purple Book], there was no harm and with how they read it, they did not need to. Additionally, Staff A stated that they did not log it in the incident log and that it was logged in the grievance log. In a follow-up joint record review of the Purple Book and interview on 10/17/2024 at 11:30 AM, with Staff A, showed the definition of verbal abuse and when to report staff to resident abuse. Staff A stated that they should have called it in to the State Agency and logged it in the incident reporting log. Reference: (WAC) 388-97-0640 (5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to identify an abuse allegation and failed to ensure the abuse allegation was thoroughly investigated for 1 of 1 resident (Resident 7), reviewed for abuse investigation. This failure placed the resident at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions. Findings included . Review of the facility's policy titled, Abuse Investigation and Reporting, dated November 2017, showed, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse, neglect, exploitation and misappropriation investigations will also be reported. Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. It further showed that mental abuse was defined as a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Review of the admission Minimum Data Set (an assessment tool) dated 09/18/2024, showed Resident 7 admitted to the facility on [DATE] and that they were cognitively intact. In an interview on 10/09/2024 at 9:41 AM, Resident 7 stated two weeks ago something started happening to their food on their tray after they complained about the food. Resident 7 stated that they got two bowls of throw away food and when they ordered soup, it tasted like goopy [sticky] food. Resident 7 stated that they considered that a threat and was afraid. Resident 7 further stated that they told Staff DD, Registered Nurse, about it and the next day Staff C, Dietary Manager, came. In an interview on 10/09/2024 at 4:05 PM, Staff A, Administrator, stated that they were aware that Resident 7 had made complaints of the food. Staff A stated that Resident 7 complained of the meat loaf and everything they have eaten since they got to the facility. Staff A stated that Staff C went to speak to Resident 7 about their concerns and that it was never mentioned to them about Resident 7 receiving throw away food or goopy food. Staff A stated that all Resident 7 told them was that the casserole and meat loaf had fillers in it and that they never said that they were afraid of anybody or anything. Staff A stated that they did not hear anything about Resident 7 feeling threatened or was afraid. Staff A stated that they spoke to Resident 7 and that they never stated they were afraid, threatened, or used the words, goop/goopy or throw away food. Staff A stated, none of those words where used. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note written by Staff A dated 10/09/2024 at 4:16 PM, showed that it was reported to them that Resident 7 reported she felt afraid and threatened. I followed up and spoke to [Resident 7]. [Resident 7] stated the kitchen had threatened her by putting throw away food on her tray because she complained about the food. When asked what is throw away food [Resident 7] described meat and beans in two containers on tray. It was only that one time that she felt afraid and has never felt that way again and is not fearful of anyone here. It further showed that Staff A had never heard Resident 7 say that they were ever afraid. Additionally, it showed, Social Services Director, a nurse and caregiver stated [Resident 7] has never expressed she has felt afraid. [Resident 30] stated if she felt afraid, she would have left. Review of the facility's October 2024 incident log did not show that Resident 7's concerns of feeling threatened or afraid were logged. Review of the facility's October 2024 grievance log showed a log for Resident 7 with grievance type of food/afraid dated 10/09/2024 with resolution date of 10/10/2024. In an interview on 10/16/2024 at 2:24 PM, Staff A stated that their process for reporting and investigating abuse was to make sure the resident was safe, report it to the nurse, report to the hotline and start an investigation. When asked if they completed an investigation for Resident 7's concerns of feeling afraid and threatened, Staff A stated that they completed a grievance report and that there was an investigation portion on the form. Staff A further stated that they did not do an investigation report and that maybe they should have. When asked if they interviewed other residents, Staff A stated they did not and that other residents have not expressed complaints as Resident 7 complained on every food item. In a follow-up joint record review of the Purple Book and interview on 10/17/2024 at 11:30 AM with Staff A, showed the definition of verbal abuse and when to report/log staff to resident abuse. Staff A stated how could they investigate something that happened two weeks ago. Staff A stated that they spoke to the resident and that Resident 7 stated that they were afraid just that one time and that they completed a grievance form. Staff A further stated that they should have completed an investigation report and that it gets logged in the incident reporting log. Reference: (WAC) 388-97-0640 (6)(a)(b)(c)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to provide written notice of transfer/discharge to the resident and/or their representatives and failed to notify the Office of the State Long Term Care (LTC) Ombudsman (an advocacy group for residents), describing the reason for transfer/discharge for 1 of 1 resident (Resident 25), reviewed for hospitalization . These failures placed the resident at risk for not having opportunities to make informed decisions about transfer/discharge. Findings included . Review of the facility's policy titled, Transfers and Discharge Notices, dated June 2018, showed that the patient and/or representative will be notified in writing and the notice will be given as soon as it is practicable when an immediate transfer or discharge is required by the patient's urgent needs. In addition, it showed that a copy of the notice will be sent to the Office of the State Long-Term Ombudsman. Review of the discharge Minimum Data Set (an assessment tool) dated 09/05/2024, showed Resident 25 admitted to the facility on [DATE] and discharged to an acute hospital on 09/05/2024. Review of the nursing progress notes dated 09/05/2024, showed Resident 25 was transferred to the hospital for further evaluation. Review of the clinical health record (electronic health record and paper chart) did not show documentation that a written notice of transfer/discharge was provided to Resident 25 and/or their representative or to the Office of the State LTC Ombudsman. In an interview on 10/15/2024 at 1:25 PM, Staff V, Registered Nurse, stated that nurses called families when residents were transferred to the hospital. Staff V stated that the nurses did not provide written notices. In an interview on 10/15/2024 at 1:40 PM, Staff J, Licensed Practical Nurse/Charge Nurse, stated that nurses notified residents and their families verbally when residents were transferred to the hospital. Staff J stated that they did not provide written notification. In an interview on 10/15/2024 at 1:42 PM, Staff F, Social Services, stated that nurses notified the residents and their families verbally when residents transferred to the hospital. Staff F further stated that Staff CC, Receptionist, notified the ombudsman by fax on a monthly basis for residents that were transferred to the hospital. In a joint record review and interview on 10/15/2024 at 1:45 PM, Staff CC showed a list of residents discharged in September 2024 that had been sent to the ombudsman. It further showed that Resident 25 was not on the list. Staff CC stated, [Resident 25] is not on there. I missed her. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and a joint record review on 10/17/2024 at 10:37 AM, Staff A, Executive Director, stated that nurses were responsible for notifying families when residents were transferred to the hospital. Staff A stated that I don't believe they provided written notices. Staff A further stated that the ombudsman should be notified. A joint record review of the list sent to the ombudsman for residents discharged /transferred in September 2024, showed Resident 25 was not on the list. Staff A stated that Resident 25 was not on the list, so no, [the ombudsman] was not notified of Resident 25's transfer to the hospital. Reference: (WAC) 388-97-0120 (2) (a-d)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 47680 Based on interview and record review, the facility failed to transmit resident assessment data to the Centers for Medicare & Medicaid Services within the required timeframe for 1 of 3 residents (Resident 30), reviewed for discharge assessments. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.19.1, revised in October 2024, showed discharge (non-comprehensive) Minimum Data Set (MDS-an assessment tool) assessments must be completed no later than 14 days after the discharge date (discharge date plus 14 days), and it must be submitted/transmitted within 14 days of the MDS completion date (Z0500 plus 14 days) to the database as required. Review of the nursing progress notes dated 06/30/2024, showed Resident 30 discharged to a community. Review of Resident 30's MDS schedule in their electronic health record on 10/09/2024 did not show that a discharge MDS was completed (87 days late). In a phone interview on 10/16/2024 at 2:01 PM, Staff H, MDS Registered Nurse, stated that when a resident discharged , they would complete a discharge return anticipated or a discharge return not anticipated MDS. Staff H stated that the discharge MDS needed to be completed within 14 days from the discharge date and would usually transmit it within the week. Staff H further stated that Resident 30's discharge MDS was not completed and that it was missed. In an interview on 10/17/2024 at 11:51 AM, Staff B, Director of Nursing, stated that they expected the discharge MDS to be completed timely. Reference: (WAC) 388-97-1000 (5)(e)(ii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to accurately assess 2 of 21 residents (Residents 5 & 40), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding bladder continence and discharge status placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). The RAI's urinary continence coding instruction directed to code 9, not rated if during the 7-day look-back period the resident had an indwelling bladder catheter (a device that drains urine from your urinary bladder). RESIDENT 5 Resident 5 admitted to the facility on [DATE]. Review of the admission MDS dated [DATE] showed Resident 5 had an indwelling catheter. Further review of the assessment showed that under Section H, urinary continence was coded as occasionally incontinent [involuntary leakage of urine]. In a phone interview and joint record review on 10/16/2024 at 2:04 PM with Staff H, MDS Registered Nurse, stated if a resident had an indwelling urinary catheter, urinary continence would be coded as not rated. Joint record review of Resident 5's admission MDS dated [DATE] showed continence was coded as occasionally incontinent. Staff H stated that Resident 5's MDS section H was coded inaccurately, and the assessment would be modified. On 10/17/2024 at 10:38 AM, Staff B, Director of Nursing, stated that their expectation was that staff should follow the RAI manual and complete the MDS accurately. 46912 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 40 Review of the discharge MDS dated [DATE] showed Resident 40's MDS was marked as discharged to acute hospital. Review of a nursing progress note dated 08/03/2024, showed Resident 40 discharged to an Assisted Living Facility (ALF) on 08/03/2024. A joint record review of Resident 40's electronic health record and phone interview on 10/16/2024 at 2:16 PM with Staff H, showed Resident 40 discharged to an ALF. Staff H stated that Resident 40's discharge MDS assessment should have been coded as discharge to the community. In an interview on 10/17/2024 at 11:55 AM, Staff B stated that they expected the MDS to be accurate. Reference: (WAC) 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to review and validate the Preadmission Screening and Resident Reviews (PASARR-an assessment to ensure individuals with Serious Mental Illness [SMI] or Intellectual/Developmental Disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) had the required Level II referral sent if residents had a positive Level I PASARR, or corrected/updated the resident's PASARR as needed for 1 of 5 residents (Resident 25), reviewed for PASARR. This failure placed the resident at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR or PASRR) Level I Screening Process, dated 07/06/2024 and amended on 08/23/2024, showed a positive Level I PASARR screen (that would then require a referral for a Level II PASARR) was if Any of the questions in Section 1A (1, 2, and/or 3) are marked Yes. Review of the facility's policy titled PASRR, dated June 2018, showed, it is the facilities responsibility to ensure the Level I PASRR is completed and accurate prior to admission. Review of Resident 25's admission record printed on 10/11/2024, showed the resident was admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental health condition that causes extreme mood swings). Review of Resident 25's Level I PASRR dated 11/02/2023, showed under Section I for SMI/ID was marked yes to include the diagnosis of bipolar disorder. It further showed that in Section IV, No Level II evaluation indicated. Review of Resident 25's clinical health record (electronic record and paper chart) showed no documentation that a Level II PASARR referral was sent for review. In an interview on 10/15/2024 at 11:00 AM, Staff F, Social Services, stated they were responsible for reviewing resident's PASARR and checking for accuracy when they were admitted from the hospital. In an interview and joint record review on 10/17/2024 at 10:25 AM, Staff A, Executive Director, stated they knew there was new guidance about PASARRs. In a joint record review of the Dear Nursing Home Administrator letter that showed the guidance that if any of the questions in Section 1A (I, 2, and/or 3) are marked yes then it would require a referral for a Level II PASARR. A joint record review of Resident 25's Level I PASARR dated 11/02/2023, showed under Section I for SMI/ID was marked yes to include the diagnosis of bipolar disorder. Staff A stated that the PASARR should have been reviewed and sent for a Level II evaluation and I will have [Staff F] do that today. Reference: (WAC) 388-97-1915 (1)(2) (a-c)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to develop a baseline care plan and/or provide a written summary of the baseline care plan to the residents and/or their representatives for 5 of 10 residents (Residents 94, 194, 15, 20 & 5), reviewed for baseline care plan. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Plans - Baseline, dated June 2018, showed that a baseline plan of care to meet the patient's immediate needs shall be developed for each patient within forty-eight hours of admission. It further showed, the patient and their presentative will be provided a summary of the baseline care plan. RESIDENT 94 Review of the admission record printed on 10/16/2024, showed Resident 94 admitted to the facility on [DATE]. Review of the form titled, Patient [resident] Baseline Person-Centered Care Plan, dated 09/28/2024, showed that it was not marked for Patient and/or representative were provided a written summary of the baseline care plan by providing a copy of this document. In an interview and joint record review on 10/16/2024 at 12:39 PM with Staff I, Registered Nurse/Charge Nurse, stated that they did not provide a written summary of the baseline care plan to the residents or their representatives. Staff I stated they reviewed it with the resident, have them sign it and placed it in their closet. Joint review record of Resident 94's baseline care plan showed that it was not marked that Resident 94 and/or their representative was provided with a written summary. Staff I stated that they did not give residents a written summary of their baseline care plan. In an interview on 10/16/2024 at 3:27 PM, Staff B, Director of Nursing, stated that they expected staff to provide a written summary of their baseline care plan to the residents. 45146 RESIDENT 194 Resident 194 admitted to the facility on [DATE]. On 10/15/2024 at 10:57 AM, Resident 194 stated that they did not remember receiving a written summary of their baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 10/15/2024 at 11:12 AM with Staff J, Licensed Practical Nurse)/Charge Nurse, showed Resident 194's Electronic Health Record (EHR) titled, Patient Baseline Person Centered Care Plan, dated 10/04/2024, revealed a written summary was not provided to the resident or their representative. Staff J stated that a written summary of the baseline care plan would be provided if the resident requested it. RESIDENT 15 Resident 15 admitted to the facility on [DATE]. On 10/15/2024 at 11:27 AM, Resident 15 stated that they were unsure about receiving a written summary of their baseline care plan. A joint record review and interview on 10/15/2024 at 11:29 AM with Staff J, showed Resident 15's EHR titled, Patient Baseline Person Centered Care Plan, dated 09/19/2024, did not show a written summary was provided to the resident or their representative. Staff J stated that a written summary of the baseline care plan would be provided if the resident requested it. RESIDENT 20 Resident 20 admitted to the facility on [DATE]. Review of Resident 20's EHR showed there was no baseline care plan, or a written summary was provided to the resident or their representative. During a joint record review and interview on 10/15/2024 at 11:25 AM with Staff J, showed there was no baseline care plan or written summary was provided to the resident or their representative in Resident 20's EHR. Staff J stated they could not find Resident 20's baseline care plan. RESIDENT 5 Resident 5 admitted to the facility on [DATE]. On 10/15/2024 at 11:01 AM, Resident 5 stated that they were unsure about receiving a written summary of their baseline care plan. A joint record review and interview on 10/15/2024 at 11:39 AM with Staff J, showed Resident 5's EHR titled, Patient Baseline Person Centered Care Plan, dated 09/19/2024, showed a written summary was not provided to the resident or their representative. Staff J stated that a written summary of the baseline care plan would be provided if the resident requested it. On 10/16/2024 at 3:04 PM, Staff B stated that their expectation was that the written summary of baseline care plan offered and provided a copy to the residents. Reference: (WAC) 388-97-1020(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, interview, and record review, the facility failed to develop and/or implement care plans for 4 of 20 residents (Residents 23, 193, 9 & 29), reviewed for comprehensive care plans. The failure to develop care plans for tilt in space wheelchair (a wheelchair that has reclining function) and Self-Administration of Medications, and the failure to implement dysphagia (difficulty swallowing foods or liquids) care plan placed the residents at risk for unmet care needs, related complications, and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated August 2018, showed a comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the patient's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the facility's policy titled, Assistive Devices and Equipment, dated August 2018, showed that recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the patient's plan of care. RESIDENT 23 Resident 23 admitted to the facility on [DATE] with diagnoses that included Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning). Review of the annual Minimum Data Set (MDS-an assessment tool) dated 09/25/2024 showed Resident 5 had severely impaired cognition. Observations on 10/10/2024 at 10:46 AM, at 11:20 AM and at 1:40 PM, on 10/11/2024 at 9:07 AM, at 10:07 AM, and at 11:43 AM, on 10/14/2024 at 9:20 AM, and on 10/15/2024 at 9:02 AM, showed Resident 23 was on their tilt in space wheelchair with the wheelchair tilted back, leg elevated, and wheel locked. Review of Resident 23's comprehensive care plan printed on 10/10/2023 showed no comprehensive care plan for the use of tilt in space wheelchair. During a joint record review and interview on 10/16/2024 at 10:41 AM with Staff J, Licensed Practical Nurse (LPN)/Charge Nurse, showed Resident 23's comprehensive care plan had no care plan for the tilt in space wheelchair. Staff J stated that Resident 23 was placed on the tilt in space wheelchair for positioning and it should be addressed in the resident's care plan. On 10/16/2024 at 3:08 PM, Staff B, Director of Nursing, stated that when a resident was placed on tilt in space wheelchair and there should be a care plan for it. RESIDENT 193 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 193 admitted to the facility on [DATE]. Observation on 10/09/2024 at 2:40 PM, showed Resident 193 had a Ventolin FHA (an inhaler medication used to treat breathing problem) on their bedside table. Another observation on 10/11/2024 at 8:12 AM, showed the Ventolin FHA inhaler was on the resident's bedside table. Resident 193 stated they last used their inhaler on the night of 10/10/2024. Review of Resident 193's comprehensive care plan printed on 10/10/2024, showed no care plan for Self-Administration of Medications. Review of Resident 193's order summary report printed on 10/11/2024, showed an order for Ventolin FHA and Okay to keep at bedside with order start date of 10/10/2024. During a joint record review and interview on 10/14/2024 at 2:48 PM with Staff J, showed Resident 193's comprehensive care plan had no care plan for self-administration of medication. Staff J stated that when a resident was placed on self-administration of medication, there should be a care plan for it. On 10/16/2024 at 3:14 PM, Staff B stated that their expectation was that the residents assessed for self-administration of medication, a physician order should be obtained and a care plan initiated before leaving medication at bed side. 47680 RESIDENT 9 Review of the admission record printed on 10/17/2024, showed Resident 9 admitted to the facility on [DATE]. Observation on 10/10/2024 at 10:15 AM, showed one bottle of Afrin (nasal decongestant medication) on top of Resident 9's bedside table. Review of Resident 9's October 2024 Medication Administration Record (MAR) showed an order for Afrin Nasal Spray Nasal Solution one spray in both nostrils as needed for dry nose or nosebleed, unsupervised self-administration, dated 10/01/2024. Review of the Self-Administration of Medication assessment dated [DATE], showed Resident 7 was able to self-administer medications. Review of the comprehensive care plan printed on 10/11/2024, did not show that Resident 7 had a care plan for self-administration of medication for Afrin. In an interview on 10/15/2024 at 8:10 AM, Staff K, LPN, stated their process for residents who self-administers their medication would need an assessment completed, have an order in the MAR, medication stored in the beside drawer and that it should be care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 10/15/2024 at 8:19 AM, Staff I, Registered Nurse/Charge Nurse, stated that that their policy was to complete a self-administration assessment, obtain a physician order, and initiate a care plan. Joint record review of Resident 7's care plan did not show a care plan for self-administration of medication. When asked if they care planned self-administration of medications, Staff I stated that they usually do. In an interview on 10/15/2024 at 11:27 AM, Staff B stated that residents on a self-administration program should have a care plan. RESIDENT 29 Review of the admission MDS dated [DATE], showed Resident 29 admitted to the facility on [DATE] with diagnoses that included dysphagia following cerebral infarction (stroke). Review of the tube feeding (a medical device used to provide nutrients through a tube directly into the stomach) related to dysphagia care plan, revised on 09/24/2024, showed Resident 29 was at high risk for aspiration (when something you swallow enters your airway or lungs). It further showed an intervention that ALL food, fluids must be supervised. DO NOT leave anything at bedside. Observation on 10/10/2024 at 8:18 AM, showed Staff N, Certified Nursing Assistant, delivered Resident 29's breakfast tray and placed it on their bedside table. Staff N elevated Resident 29's head of bed and removed the covers from the plate and the cups. Resident 29 drank from the cup independently as Staff N supervised. Staff N removed their gloves, performed hand hygiene and left the resident's room. Resident 29's breakfast tray was left in front of them without supervision. At 8:24 AM, Resident 29 drank from a cup independently without supervision. At 8:26 AM, Staff N returned to the resident's room and brought two cups of fluids with them. In an interview and joint record review on 10/10/2024 at 8:41 AM, Staff N stated that Resident 29 required supervision with eating due to swallowing issues. Staff N stated that Resident 29 was on aspiration precautions and was on thicken liquids. Joint record review of Resident 29's care plan showed, ALL food, fluids must be supervised. DO NOT leave anything at bedside. Staff N stated that Resident 29 said that they did not want to eat and that they knew the resident would not eat from the tray. In an interview on 10/14/2024 at 2:59 PM, Staff K stated that Resident 29 needed assistance to ensure they were sitting up, eating small bites one at a time and needed one on one eating assistance to avoid aspiration. Staff K further stated that Staff N should have followed Resident 29's care plan and expected them to provide one on one supervision and to not leave food at resident's bedside. In a joint record review and interview on 10/15/2024 at 8:46 AM with Staff I, showed Resident 29's care plan had an intervention that ALL food, fluids must be supervised. DO NOT leave anything at bedside. Staff I stated that they expected Staff N to follow the care plan. In an interview on 10/15/2024 at 11:29 AM, Staff B stated that they expected staff to follow the care plan. Reference: (WAC) 388-97-1020 (1)(2)(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47680 Based on interview and record review, the facility failed to conduct care conferences for 2 of 2 residents (Residents 37 & 193), reviewed for care planning. This failure placed the residents and/or their representatives at risk for not having input regarding care goals, unmet needs, and a diminished quality of life. Findings including . Review of the facility's policy titled, Patient [resident] Care Conferences-Social Services Procedures, dated June 2018, showed, After admission, an initial care conference will be scheduled by Social Services with the patient and responsible party (if the patient chooses) to be held within 7 [seven] days. The initial care conference is completed only for the first admission .The initial care conference will be documented on the Patient Care Conference form located in Point Click Care [Electronic Health Record (EHR)]). RESIDENT 37 Review of the admission record printed on 10/11/2024, showed Resident 37 admitted to the facility on [DATE]. Review of Resident 37's EHR (under assessments, progress notes, and documents) did not show that a care conference was held with the resident and/or their representative. In an interview on 10/10/2024 at 12:38 PM, Resident 37's representative stated that they have not had a care conference. In an interview on 10/15/2024 at 11:43 AM, Staff F, Social Services, stated that they had care conferences usually two to four days from admission but sometimes family are not available and would have to go a week out. Staff F stated that Resident 37 have not had a care conference and would need to schedule one. Staff F further stated that Resident 37 should have had a care conference. In an interview on 10/16/2024 at 3:18 PM, Staff B, Director of Nursing, stated that they expected care conferences to be held within seven days of admission per their policy. In an interview on 10/17/2024 at 11:03 AM, Staff A, Executive Director, stated that they expected care conferences were completed timely. 45146 RESIDENT 193 Resident 193 admitted to the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set (an assessment tool) dated 08/27/2024 showed Resident 5 had intact cognition. On 10/09/2024 at 2:27 PM, Resident 193 stated that there was no care conference held regarding their care since admission. During an interview and joint record review on 10/15/2024 at 12:36 PM, Staff F stated that for new residents a care conference would be held with the resident and/or their responsible party within a week of their admission. Joint record review of Resident 193's EHR showed no record of a care conference. Staff F stated Resident 193 should have had a care conference. On 10/17/2024 at 11:39 AM, Staff A stated that their expectation was that care conferences should be held within seven days of admission. Reference: (WAC) 388-97-1020(2)(f)(4)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, interview, and record review, the facility failed to ensure 1 of 3 licensed staff (Staff T) followed professional standards for proper insulin (a hormone that lowers the level of sugar) administration, and ensure medications were not left unattended for 1 of 1 resident (Resident 10), reviewed for medication administration. In addition, the facility failed to ensure blood pressure (BP), and heart rate (HR) were checked prior to blood pressure medication administration for 1 of 5 resident (Resident 25), reviewed for unnecessary medication. These failures placed the residents at risk for unmet care need, adverse effects and potential negative outcomes. Findings included . MEDICATION ADMINISTRATION According to the KwikPen (insulin pen) manufacturer's instruction, revised in July 2023 and approved by the U.S. Food and Drug Administration, priming insulin pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the insulin pen is working correctly. Not priming before each injection, may lead to getting too much or too little insulin. During a medication administration observation on 10/14/2024 at 11:59 AM, Staff T, Registered Nurse (RN), was observed preparing insulin pen to administer for Resident 195. Staff T was observed turning the insulin pen's dose knob and selected 6 units of insulin prior to priming the insulin pen. Staff T entered Resident 195's room and administered the insulin. In an interview on 10/14/2024 at 12:06 PM, when Staff T was asked about priming the insulin pen prior to dose selection, Staff T stated they knew air bubbles should be removed from the insulin pen prior to dose selection. Staff T further stated they did not prime the insulin pen prior to turning the knob to 6 units. On 10/16/24 at 2:50 PM, Staff B, Director of Nursing, stated that their expectation was that the licensed nurse primes the insulin pen prior to selecting the dose. 46912 UNATTENDED MEDICATION RESIDENT 10 Review of Resident 10's admission record printed on 10/11/2024, showed Resident 10 admitted to the facility on [DATE]. In a joint observation and interview on 10/10/2024 at 1:59 PM, Resident 10 had two medication cups with crushed medications in applesauce on their bedside table. Resident 10 stated one is Tylenol [a pain medication] and one is vitamins. Resident 10 stated, I told them it was just [vitamins and Tylenol], there's no harm in it [leaving the medications on the table] and she [staff] left them here. It further showed that no licensed nurse was in the room to ensure Resident 10 took their medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint observation and interview on 10/10/2024 at 2:13 PM with Staff V, RN, showed two medication cups with crushed medications in applesauce on Resident 10's bedside table. Staff V stated that medications should not be left unattended and we don't usually do that, it's not ok. In an interview on 10/17/2024 at 8:57 AM, Staff J, Licensed Practical Nurse (LPN)/Charge Nurse, stated medications need to be taken in front of the nurses and no medications are to be left at the bedside and the nurse should stay until the resident takes the medication. In an interview on 10/17/2024 at 11:55 AM, Staff B stated it was not ok for licensed nurses to leave medications with residents and expected them to not leave the room until finished taking the medications. BLOOD PRESSURE MEDICATION RESIDENT 25 Review of the quarterly Minimum Data Set (an assessment tool) dated 08/13/2024, showed Resident 25 admitted to the facility on [DATE] with diagnosis that included hypertension (high BP). Review of the October 2024 Medication Administration Record (MAR) showed Resident 25 had an order for Carvedilol (a medication for hypertension) to be given twice a day. It showed that the medication should be held if the Systolic Blood Pressure (SBP-the pressure in the arteries when the heart contracts) was less than 100 or the HR was less than 55. In an interview and joint record review on 10/16/2024 at 1:20 PM, Staff U, LPN, stated that if an order showed parameters to hold a BP medication for SBP less than 100 or pulse less than 55, then you should hold the medication. Staff U stated that vital signs (measurements of the body's essential functions including BP and HR) should be done before each time the Carvedilol was administered to Resident 25. A joint record review of the October 2024 MAR showed Resident 25 was given Carvedilol on 10/15/2024, one dose in the morning and one dose in the evening. A joint record review of the vital signs tab in the electronic health record, showed Resident 25 had vitals done on 10/15/2024 at 8:13 AM and showed no documentation that vital signs were done in the evening. Looking at additional dates in October 2024 showed Resident 25 received Carvedilol twice a day and had their vitals checked once a day. Staff U stated, looks like it's [vital signs] only being done once a day and they [nurses] didn't chart it [vital signs]. In an interview on 10/16/2024 at 1:30 PM, Staff J stated they expected vital signs to be taken prior to a resident receiving a BP medication. Staff J stated for a resident taking Carvedilol twice a day, they would expect vitals [vital signs] to be done each time before administration. In an interview on 10/17/2024 at 11:55 AM, Staff B stated they expected vital signs to be checked prior to a medication that had parameters. Staff B further stated that if a resident was taking Carvedilol twice a day, they expected vital signs to be taken before each dose was administered. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, record review, and interview, the facility failed to provide necessary assistance with nail care and wheelchair transfer for 1 of 3 residents (Resident 20), reviewed for Activities of Daily Living (ADL). This failure placed the resident at risk for decreased self-esteem, decline in mobility and function, and a diminished quality of life. Findings included . Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting dated February 2018, showed, Patients [residents] who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Resident 20 admitted to the facility on [DATE] with diagnoses that included diabetes (a disease that occurs when the body can not properly regulate blood sugar levels), muscle weakness, and need for assistance with personal care. Review of the admission Minimum Data Set (an assessment tool) dated 10/07/2024, showed Resident 20 had intact cognition and required partial/moderate assistance with personal hygiene, and substantial/maximal assistance with chair/bed-to-chair transfer. Observation on 10/09/2024 at 2:03 PM, showed Resident 20's fingernails were long and had brown debris underneath their nails. Observations on 10/11/2024 at 12:53 PM, on 10/14/2024 at 1:20 PM, and on 10/15/2024 at 9:22 AM, showed Resident 20 was laying in their bed and their fingernails were long, untrimmed and had brown debris underneath them. Further observation of the fingernails showed Resident 20 had a split nail on their left thumb. An interview on 10/11/2024 at 12:53 PM, Resident 20 stated their left thumb split fingernail was catching their clothing and bothering them. Resident 20 further stated the dirt underneath their untrimmed fingernails looked gross and they needed someone to trim, file or clean for them. Another interview on 10/15/2024 at 9:22 AM, Resident 20 stated they were up in their wheelchair once with therapy staff since their admission and would like to be up in their wheelchair. Review of the ADL care plan initiated on 10/07/2024, showed Resident 20 had self-care deficit for ADL related to comorbidities, decreased mobility, and muscle weakness. Further review of the care plan directed staff to provide assistance needed. Review of the ADL documentation for October 2024 showed transfer from a bed to a chair (or wheelchair) was documented as NA [not applicable] on 10/02/2024, 10/03/2024, 10/04/2024, 10/05/2024, 10/06/2024, 10/11/2024, 10/13/2024, 10/15/2024, 10/16/2024, and 10/17/2024. There was no documentation that the resident refused any transfer in October 2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/16/2024 at 8:58 AM, Staff S, Certified Nursing Assistant/Shower Aid, stated fingernail care would be done with showers except for residents with diagnosis of diabetes. Staff S stated Resident 20 did not refuse shower or fingernail care. A joint record review and interview on 10/16/2024 at 9:49 AM with Staff T, Registered Nurse, showed Resident 20's fingernail care was not scheduled on the October 2024 Treatment Administration Record (TAR). Staff T stated that Resident 20 did not refuse fingernail care. A joint record review on 10/16/2024 at 10:09 AM with Staff J, Licensed Practical Nurse/Charge Nurse, showed fingernail care was not scheduled for October 2024 TAR. Staff J stated for residents with diagnosis of diabetes, fingernail care would be provided by licensed nurses, and it would be documented in the TAR. Staff J further stated they expected staff to offer and encourage Resident 20 to be up in their wheelchair. An interview on 10/16/2024 at 12:41 PM, Resident 20's collateral contact stated that the facility was not offering Resident 20 to trim their fingernail. A joint observation and interview on 10/17/2024 at 8:40 AM with Staff J, showed Resident 20's fingernails were long, and their left thumb nail had a split. Resident 20 stated they would like their fingernail trimmed. On 10/17/2024 at 10:20 AM, Staff B, Director of Nursing, stated they expected Resident 20's fingernail care be on the TAR and to be provided weekly by licensed nurses. Staff B further stated nurse aids were expected to offer and assist residents with transfers to their wheelchairs. Reference: (WAC) 388-97-1060 (1)(2)(a)(ii)(c)

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility to provide care and services consistent with professional standards for significant weight gain and use of diuretic medication (that helps to reduce fluid buildup in the body) for 1 of 1 resident (Resident 20), reviewed for quality of care. In addition, the facility failed to implement the bowel management protocol when indicated for 1 of 2 residents (Resident 9), reviewed for bowel management. These failures placed the residents at risk of unmet care needs, medical complications, and diminished quality of life. Findings included . RESIDENT 20 Resident 20 admitted to the facility on [DATE] with diagnosis that included heart failure (occurs when the heart muscle does not pump blood as well as it should, and blood often backs up and causes fluid to build up in the lungs and in the legs). Review of the October 2024 Medication Administration Record (MAR) showed Resident 20 had an order for Torsemide (a drug used to treat edema [swelling] and excess fluid held in body tissues) 20 milligram (mg-unit of measurements) as needed (PRN) for fluid retention (a build-up of trapped fluid in a body), edema or weight gain, with the order start date of 10/01/2024. Review of the weight record showed Resident 20's weight was 205 pounds on 10/01/2024 and was 217.2 pounds on 10/04/2024 (a 5.9 percent weight gain in three days, which was significant weight gain). Review of the October 2024 MAR and Electronic Health Record (EHR) showed no action taken for Resident 20's significant weight gain. During an interview and joint record review on 10/16/2024 at 9:51 AM, Staff T, Registered Nurse (RN), stated that for significant weight gain, they would report to the charge nurse and the resident's physician. Joint record review of the October 2024 MAR showed Resident 20 had a PRN Torsemide order for fluid retention, edema or weight gain. Staff T stated Resident 20's Torsemide order did not specify for how much weight gain and when the medication should be given. Staff T further stated Resident 20 had gained 12 pounds and it was a significant weight gain, and they would inform the charge nurse and the resident's physician. During a joint record review and interview on 10/16/2024 at 10:16 AM with Staff J, Practical Licensed Nurse/Charge Nurse, the October 2024 weight record showed Resident 20 had a significant weight gain. Further joint record review of Resident 20's October 2024 MAR and EHR showed that no PRN Torsemide was administered, or the physician was contacted for the significant weight gain. Staff J stated that when a resident had a significant weight gain, the resident would be reassessed, and physician would be contacted. On 10/17/2024 at 10:28 AM, Staff B, Director of Nursing, stated that their expectation was that for the license nurses to follow Resident 20's physician order in weight monitoring. Staff B further stated if there was an order for PRN diuretic for weight gain, the medication should be given. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47680 RESIDENT 9 Review of the facility's undated document titled, Bowel Protocol, showed, Milk of Magnesia (MOM-medication to treat constipation)-Give 30 milliliters (ml-unit of measurement) by mouth every 24 hours PRN for bowel management if no bowel movements in three days. Review of the admission record printed on 10/17/2024, showed Resident 9 admitted to the facility on [DATE]. Review of the October 2024 MAR showed the following orders: -Milk of Magnesia Give 30 ml by mouth every 24 hours PRN for bowel management if no bowel movement in three days dated 08/30/2024. -Bisacodyl Laxative (medication to treat constipation) suppository (dosage form used to deliver medication by inserting into the body opening) 10 mg insert one suppository rectally every 24 hours PRN for no bowel movement from MOM, report to the doctor if ineffective dated 08/30/2024. Review of the bowel continence report printed on 10/11/2024, showed Resident 9 did not have a bowel movement for the following dates: - 09/19/2024 through 09/23/2024, for five days. - 09/26/2024 through 09/29/2024, for four days. - 10/01/2024 through 10/05/2024, for five days. Review of Resident 9's September 2024 MAR showed that MOM was given on 09/24/2024 (day six) and 09/30/2024 (day five). Review of Resident 9's October 2024 MAR showed that MOM or Bisacodyl suppository was not given. Review of the nursing progress notes printed on 10/14/2024, did not show that Resident 9 declined MOM or Bisacodyl suppository. In an interview and joint record review on 10/14/2024 at 3:25 PM, Staff R, RN, stated that they have a bowel protocol that they followed. Staff R stated that if a resident had no bowel movement for three days, they would give MOM, then they would give a suppository and if that did not work, they would give an enema (a procedure that involves inserting fluid or gas into the rectum to help clear out stool or waste matter). Staff R stated that night shift would run a bowel report and would pass it on to the oncoming nurse. Joint record review of the bowel continence report showed Resident 9 did not have a BM for more than three days in September 2024 and October 2024. Joint record review of the October 2024 MAR showed Resident 9 was not given MOM or a Bisacodyl suppository. Staff R stated that Resident 9 should have received MOM and was qualified to receive it. Staff R further stated that if MOM was refused, it should have been documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 10/15/2024 at 8:19 AM with Staff I, RN/Charge Nurse, showed that Resident 9 did not have a bowel movement from 09/19/2024 through 09/23/2024, from 09/26/2024 through 09/29/2024, and from 10/01/2024 through 10/05/2024. Staff I reviewed Resident 9's September 2024, and October 2024 MAR. Staff I stated that MOM should have been given on the fourth day the resident did not have a bowel movement and if they refused, it should be documented. In an interview on 10/15/2024 at 11:16 AM, Staff B stated that staff should have followed their bowel protocol and if the resident declined, they should be documenting it. Reference: (WAC) 388-97-1060 (1)(3)(4)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure services were consistently provided to increase Range of Motion (ROM) and/or to prevent decrease in ROM for 1 of 1 resident (Resident 145), reviewed for restorative services. This failure placed the resident at risk for a decline in ROM, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Patient Mobility and Range of Motion, dated August 2018, showed patients [residents] with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. Review of the annual Minimum Data Set (an assessment tool) dated 07/19/2024, showed Resident 145 admitted to the facility on [DATE]. It further showed that Resident 145 had limited ROM in their upper extremity on one side. Review of the mobility care plan revised on 09/13/2024, showed Resident 145 was on a restorative program. Review of the facility's document titled, Nursing Rehab [Rehabilitation]: Active ROM rt [right] UE [upper extremity], printed on 10/14/2024, showed missing documentation for the task of providing active ROM for multiple days including the entire week of 10/07/2024 to 10/11/2024. Review of the facility's document titled, Nursing Rehab: Ambulation [walk] with FWW [front wheeled walker] 15 min [minutes] 6x [times]/wk [week], printed on 10/14/2024, showed missing documentation for the task of training and skill practice in walking, including the entire week of 10/07/2024 to 10/11/2024. Observation on 10/11/2024 at 8:35 AM and at 1:00 PM, showed Resident 145 was in bed. In an interview on 10/11/2024 at 1:55 PM, Resident 145 stated that no one had done any exercises with them that day. In an interview on 10/14/2024 at 11:18 AM, Resident 145 stated, I used to get in and out of bed, but no one works with me in the hallway, for exercise. Resident 145 further stated that no one had done exercises with them recently. In an interview on 10/15/2024 at 9:20 AM, Staff Y, Certified Nursing Assistant (CNA)/Restorative Aide, stated that Resident 145 was on a restorative program that included ambulation and active ROM for right UE with some assistance. When asked when the last time the restorative program was done with Resident 145, Staff Y stated, I wasn't here last week and yesterday I worked the floor [as a CNA]. Staff Y further stated, if someone [a CNA] calls out, I cover them [as a floor CNA]. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 10/15/2024 at 9:54 AM, Staff B, Director of Nursing, stated that Staff Y was responsible for carrying out the restorative program for residents. Staff B stated that Staff Y gets pulled to the floor to cover CNA's that call off from work and then no one is doing restorative. Staff B stated that Resident 145 was on a restorative program. In a joint record review of the documents, Nursing Rehab: Active ROM rt UE, and Nursing Rehab: Ambulation with FWW 15 min 6x/wk, Staff B stated that it looked like there was only documentation that these tasks occurred four times out of the past 14 days. In a follow up interview on 10/17/2024 at 11:55 AM, Staff B stated that there was missing documentation for the restorative program for Resident 145, missing days due to staffing. Staff B stated that the restorative program for Resident 145 was not carried out and it should have been. Reference: (WAC) 388-97-1060 (3)(d)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure the hallway carpet was safe for 1 of 2 floors (First Floor Hallway) and failed to provide adequate supervision for 1 of 1 resident (Resident 29), reviewed for accident/hazards. These failures placed the residents at risk for accidents, injury, and other negative outcomes. Findings included . FIRST FLOOR HALLWAYS Review of the facility's assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents), updated 06/14/2024, showed that the majority of our patients [residents] are short term and receive rehabilitative services. Observation on 10/11/2024 at 8:38 AM, showed multiple areas of bubbling [an area in the carpet where it lifts and creates a hill or bump in the floor] in the carpet in the first-floor hallways. It further showed one large area of bubbling in the hallway of room [ROOM NUMBER] to 143. Observations on 10/11/2024 at 1:58 PM and on 10/14/2024 at 11:48 AM, showed Resident 22 was walking with their walker in the hallway toward their room (room [ROOM NUMBER]) and walking directly over the bubbling of the carpet. A joint observation and interview on 10/15/2024 at 2:19 PM with Staff Y, Certified Nursing Assistant (CNA)/Restorative Aide, showed Staff Y was walking with Resident 2 who was using their cane and walked over the bubbling carpet in the hallway of room [ROOM NUMBER] to 143. Staff Y, described the bubbling, like a bump in the carpet. Staff Y stated that Resident 2 had to lift up [their] feet a little bit when walking over the carpet. Staff Y further stated that residents could trip on the raised parts of the carpet. In an interview and joint observation on 10/15/2024 at 2:27 PM, Staff D, Plant Maintenance Director, stated that the facility had been trying to get the carpet replaced/fixed since last February. Staff D stated that corporate sent someone to come look at the carpet about two months ago. A joint observation of the carpet in the First Floor Hallway, Staff D described it as having bubbles and the underneath was eating itself. Staff D further stated that they thought the facility was waiting on a quote to have the carpet repaired/replaced. In an interview on 10/17/2024 at 10:25 AM, Staff A, Executive Director, stated the facility served mainly short-term rehabilitation residents that were getting therapy in the halls and in the gym. Staff A stated they were aware of the bubbling in the carpet in the first-floor hallways and when asked if it was safe for residents, Staff A stated, it could be safer. Staff A further stated that it had been a known issue for awhile and that they thought the quotes from the carpet company had gone to the corporate president and had been waiting for a response. 47680 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 29 Review of the admission Minimum Data Set (an assessment tool) dated 07/25/2024, showed Resident 29 admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing foods or liquids) following cerebral infarction (stroke). Review of the tube feeding (a medical device used to provide nutrients through a tube directly into the stomach) related to dysphagia care plan, revised on 09/24/2024, showed Resident 29 was at high risk for aspiration (when something you swallow enters your airway or lungs). It further showed an intervention that ALL food, fluids must be supervised. DO NOT leave anything at bedside. Review of Resident 29's speech therapy note dated 10/09/2024, showed under precautions, Diet: Pureed solids, recreational feeding; NT [nectar thick]/Mildly thick liquids. 1:1 [one on one] supervision for all PO [oral] intake. Review of the facility's document titled, Swallowing Precautions to Prevent Aspiration of Food and Liquids, dated 09/06/2024, that was posted on Resident 29's bedroom wall showed, 1:1 supervision. Observation on 10/10/2024 at 8:18 AM, showed Staff N, CNA, delivered Resident 29's breakfast tray and placed it on their bed side table. Staff N elevated Resident 29's head of bed and removed the covers from the plate and the cups. Resident 29 drank from the cup independently as Staff N supervised. Staff N removed their gloves, performed hand hygiene and left the resident's room. Resident 29's breakfast tray was left in front of them without supervision. At 8:24 AM, Resident 29 drank from a cup independently without supervision. At 8:26 AM, Staff N returned to the resident's room and brought two cups of fluids with them. In an interview and joint record review on 10/10/2024 at 8:41 AM, Staff N stated that Resident 29 required supervision with eating due to swallowing issues. Staff N stated that Resident 29 was on aspiration precautions and was on thickened liquids. A joint record review of Resident 19's care plan showed, ALL food, fluids must be supervised. DO NOT leave anything at bedside. Staff N stated they wanted to bring the resident more water and apple juice. Staff N further stated that Resident 29 said that they did not want to eat and that they knew the resident would not eat from the tray. On 10/14/2024 at 2:59 PM, Staff K, Licensed Practical Nurse, stated that Resident 29 needed assistance to ensure they were sitting up, eating small bites one at a time and that they needed one on one eating assistance to avoid aspiration. Staff K further stated that Staff N should have followed Resident 29's care plan, expected them to provide one on one supervision and to not leave food at their bedside. On 10/16/2024 at 3:18 PM, Staff B, Director of Nursing, stated that they expected staff to follow residents' care plans. Staff B further stated that Staff N should not have left Resident 29's fluids/food without supervision and within their reach. Reference: (WAC) 388-97-1060 (3)(g)

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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** 45146 Based on observation, interview, and record review, the facility failed to label/date and properly store nebulizer (a small machine that turns liquid medication into a mist that can be inhaled to treat respiratory conditions) treatment set for 1 of 3 residents (Resident 193), reviewed for respiratory care. This failure placed the resident at risk for respiratory infections and related complications. Findings included . Review of the facility's policy and procedure titled, Administering Medication through a Small Volume (Handheld) Nebulizer, dated August 2018, directed staff to change the equipment and tubing every seven days. Resident 193 admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a common lung disease that makes it difficult to breathe). Review of the order summary report as of 10/11/2024, showed Resident 193 had an order for Albuterol Sulfate Nebulization Solution (a breathing treatment used to prevent and treat wheezing and shortness of breath caused by breathing problems such as COPD) via nebulizer every four hours as needed for wheezing and shortness of breath with a start date of 09/23/2024. Review of the September 2024 and October 2024 Medication Administration Records showed Resident 193 had been taking a breathing treatment via nebulizer. Observations on 10/11/2024 at 8:12 AM and on 10/14/2024 at 10:02 AM, showed Resident 193's nebulizer machine treatment set, and tubing was sitting on top of their chair. Further observation showed the nebulizer's treatment set and tubing was not labeled or stored in a bag. During a joint observation and interview on 10/14/2024 at 2:58 PM with Staff J, Licensed Practical Nurse/Charge Nurse, showed Resident 193's nebulizer machine treatment set, and tubing was sitting on top of their chair and was not labeled or stored in a bag. Staff J stated that the nebulizer treatment set, and tubing should have been labeled, dated and bagged. On 10/16/2024 at 3:16 PM, Staff B, Director of Nursing, stated that their expectation was that the nebulizer set should be changed weekly and labeled when it was changed. Staff B further stated that the nebulizer's mouthpiece should be rinsed and stored in the bag after each breathing treatment. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 47680 Based on observation, interview, and record review, the facility failed to ensure nurse staffing information postings were posted in prominent locations for 1 of 2 floors (Second Floor), reviewed for Nurse Staffing Information. This failure placed residents and visitors at risk for not being fully informed of current nurse staffing levels and resident census information. Findings included . Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, dated August 2018, showed that within two hours of the beginning of each shift, the number of Licensed Nurses and the number of unlicensed nursing personnel directly responsible for patient care will be posted in prominent location (accessible to patients and visitors) and in a clear and readable format. Observations on 10/10/2024 at 2:01 PM, on 10/11/2024 at 9:30 AM, on 10/14/2024 at 10:50 AM, on 10/15/2024 at 11:07 AM, and on 10/16/2024 at 8:06 AM, showed the nurse staffing information was posted on the first floor by the administration office. Observations on 10/14/2024 at 10:55 AM, on 10/15/2024 at 11:12 AM, and on 10/16/2024 at 8:19 AM, showed that the nurse staffing information was not posted on the second floor. In an interview on 10/16/2024 at 9:59 AM, Staff G, Scheduler/Staff Development, stated that the nurse staffing information was posted by the administration office on the first floor and that they changed it each morning. When asked if it was posted anywhere else in the building, Staff G stated no and that it was posted just by the administration office. When asked if it was in a prominent place that was readily accessible to residents and visitors, Staff G stated, I don't think so, and that in their opinion it should be near the receptionist. Staff G further stated that a visitor would not be able to see the posting if a visitor was visiting the second floor and that the second floor did not have a nurse staffing information posting. In an interview on 10/17/2024 at 11:58 AM, Staff A, Administrator, stated that they expected the nurse staffing information posting to be changed every day, that it was up to date/current and that it was posted in a high visible area. Staff A stated that the nurse staffing information was posted by the administration office on the first floor and that it was not posted on the second floor. Staff A stated that the posting was visible for all visitors and residents. Staff A stated that the first floor was where the offices were, admission office, and the first floor dining room where all the activities and entertainment were held. Staff A stated that the second floor residents went to the first floor activities. Staff A further stated that the location where it was posted now was in a prominent location where it was readily accessible to residents and visitors. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A joint observation and interview on 10/17/2024 at 12:34 PM with Resident 15, showed the nurse staffing information posting was posted by the administration office on the first floor. When asked if the posting was in a prominent place where resident/visitors could see it, Resident 15 stated that it could be in bigger letters, that older people would not come here and that they would not be able to see it. When asked if a resident was on the second floor would be able to see it, Resident 15 stated no. Resident 15 further stated that it should be posted in other places and that they should have one posted upstairs [second floor]. No associated WAC

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to develop and implement a care plan and interventions to address dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life) care needs for 1 of 1 resident (Resident 25), reviewed for dementia care. This failure placed the resident at risk for having unidentified and/or unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Dementia-Clinical Pathway, dated June 2018, showed that for the individual with confirmed dementia, the IDT [Interdisciplinary Team] will identify a patient [resident]-centered plan to maximize remaining function and quality of life. Review of the quarterly Minimum Data Set (an assessment tool) dated 08/13/2024, showed Resident 25 admitted to the facility on [DATE] with diagnoses that included dementia. Review of Resident 25's comprehensive care plan, printed on 10/10/2024, showed no documentation of a dementia care plan or interventions to address dementia care needs for Resident 25. Observations on 10/11/2024 at 8:52 AM, on 10/14/2024 at 11:09 AM, and on 10/15/2024 at 9:01 AM, showed Resident 25 was up in their wheelchair and placed in front of a television in the first-floor lounge. In an interview on 10/17/2024 at 8:49 AM, Staff U, Licensed Practical Nurse (LPN), stated they knew how to care for a resident with dementia from information [given] from the previous nurse but was unsure if there should be a care plan. In an interview and joint record review on 10/17/2024 at 8:55 AM, Staff J, LPN/Charge Nurse, stated they expected residents with a dementia diagnosis to have a care plan for dementia. Staff J stated that Resident 25 had a dementia diagnosis and expected that there would a be a care plan that showed interventions and specific needs for Resident 25. In a joint record review of Resident 25's comprehensive care plan showed no dementia care plan. Staff J stated, I'm not seeing it here. In an interview on 10/17/2024 at 11:55 AM, Staff B, Director of Nursing, stated that if a resident had a diagnosis of dementia, they expected there to be a dementia care plan. Staff B stated that Resident 25 had a dementia diagnosis and should have a care plan for that. Reference: (WAC) 388-97-1040 (1)

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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** 45146 Based on interview and record review, the facility failed to ensure residents were free from unnecessary medication for 2 of 5 residents (Residents 20 & 25), reviewed for unnecessary medications. This failure placed the residents at risk for side-effects related to the medications, medical complications, and a diminished quality of life. Findings included . RESIDENT 20 Resident 20 admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS - an assessment tool) dated 10/07/2024, showed Resident 20 had intact cognition and was on PRN (as needed) pain medication. A review of the October 2024 Medication Administration Records (MAR) showed Resident 20 had an order for oxycodone (an opioid drug used to treat moderate to severe pain) 2.5 milligram every four hours PRN for severe pain rated 7 to10 on the pain scale 1 to 10. Further review of the MAR showed Resident 20 received oxycodone for pain level less than 7 on the following days: - On 10/02/2024 for pain level 5 - On 10/03/2024 for pain level 4, 6, and 5 - On 10/05/2024 for pain level 6 - On 10/07/2024 for pain level 5 - On 10/09/2024 for pain level 5 - On 10/11/2024 for pain level 6 - On 10/13/2024 for pain level 6 - On 10/14/2024 for pain level 6 On 10/16/2024 at 9:51 AM, Staff T, Registered Nurse (RN), stated that oxycodone should only have been administered for Resident 20 for pain level 7 to10. During a joint record review and an interview on 10/16/2024 at 10:16 AM with Staff J, Licensed Practical Nurse, showed Resident 20's had a physician order for oxycodone for pain level of 7 to10. Staff J stated Resident 20 should not have been given an oxycodone for pain level less than 7. Staff J further stated licensed nurses should have followed the physician order. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2024 at 10:31 AM, Staff B, Director of Nursing, stated they expected staff to follow the physician order for administration of PRN pain medication. Staff B further stated staff should have followed Resident 20's physician order for oxycodone administration and administering oxycodone for pain level less than 7 was unnecessary. 46912 RESIDENT 25 Review of the quarterly MDS dated [DATE], showed Resident 25 admitted to the facility on [DATE] with diagnosis that included hypertension (high Blood Pressure [BP]). Review of the July 2024, August 2024, and September 2024 MARs showed Resident 25 had an order for Carvedilol (a medication for hypertension) to be given twice a day. It showed that the medication should be held if the Systolic Blood Pressure (SBP-the pressure in the arteries when the heart contracts) was less than 100 or the heartrate (HR) was less than 55. It further showed the following documentation of SBP and HR and that the Carvedilol were given on the following dates: - 07/14/2024: SBP 96 - 08/18/2024: SBP 96 - 08/29/2024: SBP 98 - 08/30/2024: SBP 97 and HR was 54 - 09/01/2024: SBP 96 An interview on 10/16/2024 at 1:20 PM, Staff U, Licensed Practical Nurse, stated that if an order showed parameters to hold a BP medication for SBP less than 100 or pulse less than 50, then you should hold the medication. An interview and joint record review on 10/16/2024 at 1:30 PM, Staff J stated that they expected nurses to follow orders and if the order showed to hold a medication for SBP less than 100 or HR less than 55, then it should be held. A joint record review of the July 2024 MAR showed Resident 25 received Carvedilol on 07/14/2024 when their SBP was 96. Staff J stated that it should not have been given. A joint record review of the August 2024 MAR showed Resident 25 received Carvedilol on 08/18/2024 with SBP of 96, on 08/29/2024 with SBP of 98, and on 08/30/2024 with SBP of 97 and HR of 54. Staff J stated on those days that parameters were not met; the Carvedilol should have been held. A joint record review of the September 2024 MAR showed Resident 25 received Carvedilol on 09/01/2024 with a SBP of 96. Staff J stated the Carvedilol should have been held. On 10/17/2024 at 11:55 AM, Staff B stated they expected nurses to follow medication orders and any parameters. Staff B further stated that if a resident's SBP or HR were outside of parameters, the BP medication should be held. Reference: (WAC) 388-97-1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to ensure resident was free of unnecessary psychotropic (a drug that affects behavior, mood, thoughts, or perception) medication for 1 of 5 residents (Resident 5), reviewed for unnecessary medications. The failure to ensure licensed pharmacist's monthly Medication Regimen Reviews (MRRs) and physician recommendations were carried out in a timely manner placed the resident at increased risk for receiving medications they no longer needed, adverse side effects, and negative outcomes. Findings included . Review of the facility's policy titled, Medication Regimen Review, revised on 03/14/2019, showed that a designated facility staff member should monitor for weekly reports to ensure recommendations are completed in a timely manner and prior to patient discharge. Resident 5 admitted to the facility on [DATE]. Review of the admission Minimum Data Set (an assessment tool) dated 09/25/2024 showed Resident 5 had moderately impaired cognition. Review of the order summary report as of 10/15/2024 showed Resident 5 had an order for antidepressant medications. Review of the September 2024 and October 2024 Medication Administration Records (MAR) showed Resident 5 was receiving Citalopram (an antidepressant) and Mirtazapine (an antidepressant) medications for diagnosis of depression. Review of the Pharmacist's Recommendation to Prescriber, dated 09/24/2024, documented that Resident 5 was taking Mirtazapine and it was recommended to discontinue Mirtazapine 15 milligram (mg) via taper (gradual reduction) by administering Mirtazapine 7.5 mg nightly for two weeks. Further record review showed Resident 5's physician agreed on the recommendation and signed it on 09/24/2024 and noted by a licensed nurse on 10/04/2024. Review of the order summary report as of 10/15/2024 showed Resident 5 was still taking Mirtazapine 15mg (21 days after the resident physician agreed on the pharmacist recommendation to taper and discontinue it). During a joint record review and an interview on 10/16/2024 at 10:47 AM with Staff J, Licensed Practical Nurse/Charge Nurse, showed Resident 5 had a recommendation by consultant pharmacist to discontinue the Mirtazapine via tapering dated 09/24/2024. Joint record review of the October 2024 MAR showed Resident 5 was still taking Mirtazapine 15mg. Staff J stated the consultant pharmacist recommendation would be implemented unless the resident refused the recommendation. Staff J further stated there was no documentation that showed Resident 5 had refused the recommendation, and the recommendation should have been implemented. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2024 at 10:35 AM, Staff B, Director of Nursing, stated that their expectation was that if the physician agreed with the recommendation of the consultant pharmacist, the recommendation should be implemented within 72 hours. Reference: (WAC) 388-97-1060 (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. 45146 Based on observation, interview, and record review, the facility failed to ensure expired medications were disposed timely and drugs were properly labeled and stored in accordance with current accepted professional standards for 2 of 2 medication carts (First Floor Team 1 & Team 2), reviewed for medication storage and labeling. These failures placed the residents at risk for receiving compromised and ineffective medications. Findings included . Review of the facility's policy titled, Storage of Medications, dated August 2018, showed, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. FIRST FLOOR TEAM 1 MEDICATION CART A joint observation of the first floor Team 1 medication cart on 10/15/2024 at 1:32 PM, with Staff U, Licensed Practical Nurse, showed the following medications stored in the cart: - An open bottle of Senna plus (a stool softener) tablets, expired in September 2024. - An open bottle of Iron (a supplement) 27 milligram (mg) tablets, expired in April 2024. - An open bottle of Bisacodyl (a stool softener) 5 mg tablets, expired in September 2024. - An open bottle of Aspirin (drug used to reduce pain or inflammation) 325 mg tablets, expired in September 2024. - An open bottle of Vitamin D3 (a supplement) tablets, expired in September 2024. - An open bottle of Fish oil (a supplement) 500 mg capsule, expired in September 2024. - An open bottle of Tylenol (a pain reliever and fever reducer) 5mg/15milliliter (ml) liquid, was not labeled with date it was opened or date should be discarded. On 10/15/2024 at 1:36 PM, Staff U stated that the liquid medications should have been labeled with date it was opened, and the expired medications found in the cart should have been discarded. FIRST FLOOR TEAM 2 MEDICATION CART A joint observation of the first floor Team 2 medication cart on 10/15/2024 at 2:09 PM, with Staff V, Registered Nurse, showed the following medications stored in the cart: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An open bottle of Vitamin D3 125 microgram (unit of measurement) tablets, expired in September 2024. - An open bottle of Aspirin 325 mg tablets, expired in September 2024. - One Fexofenadine hydrochloride (used to relieve allergy) 180 mg, expired in May 2024. - An open bottle of Melatonin (a sleep aid) 3 mg tablets, expired in July 2024. - An open bottle of Lactulose (a laxative) 100mg/15ml solution was not labeled with a date it was opened or date it should be discarded. On 10/15/2024 at 2:14 PM, Staff V stated that the expired medications found in the cart should be discarded, and liquid medication should have been labeled when they were opened. On 10/16/2024 at 2:54 PM, Staff B, Director of Nursing, stated that their expectation was that expired medication should be discarded and liquid medications should be labeled when they were opened. Reference: (WAC) 388-97-1300 (2)

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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** 47680 Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 1 of 1 kitchen, for 4 of 5 staff (Staff O, P, Q & C), and for 2 of 2 floors (First Floor and Second Floor), reviewed for food services. The failure to date and discard food items, perform hand hygiene, use appropriate hair covering and ensure food items were covered during meal delivery placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included . Review of the facility's policy titled, Food Receiving and Storage, dated July 2018, showed, All food stored in the refrigerator or freezer will be covered, labeled and dated (use by date). Review of the undated online document titled, Washington State Food Worker Manual, showed to wash your hands after you enter the kitchen and handle garbage, dirty dishes, money, or chemicals. It further showed, Remember these rules for using gloves: Wash hands before putting on gloves and Remove gloves and wash hands after working with raw food. WALK-IN REFRIGERATOR Joint observation of the Walk-in Refrigerator and interview on 10/09/2024 at 8:39 AM with Staff C, Dietary Manager, showed one plastic covered container labeled, Cheryis [cherries], preparation date of 10/02/2024 with no use by date. Staff C stated that it was a canned product and was good for 30 days. Staff C further stated that staff should have labeled them with use by date. Observation of the Walk-in Refrigerator on 10/14/2024 at 8:42 AM, showed the following: - One metal container of sausage gravy, with preparation date of 10/11/2024 and use by date of 10/13/2024. - One metal container of Greavy [gravy], with preparation date of 10/10/2024 and use by date of 10/12/2024. - One plastic container of cheese, with preparation date of 10/08/2024 and use by date of 10/12/2024. - One plastic container of ham, with preparation date of 10/07/2024 and use by date of 10/11/2024. - One plastic container of cheddar, with preparation date of 10/08/2024 and use by date of 10/12/2024. (continued on next page)

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	505500	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Healthcare at Bellevue	2424 156th Avenue Northeast Bellevue, WA 98007

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a joint observation and interview on 10/14/2024 at 9:54 AM with Staff C, showed the above food items. Staff C stated that the container labeled ham was egg salad and that it had the wrong lid on. Staff C further stated that the Swiss cheese, cheddar, egg salad, sausage gravy and gravy should have been discarded. DRY STORAGE ROOM An interview and joint observation on 10/09/2024 at 8:34 AM, Staff C stated that food items passed the use by date would be thrown away. Joint observation of the Dry Storage Room with Staff C showed one opened container of molasses dated 10/26/19 [10/26/2019] and three cinnamon raisin bread with use by date of 10/8 [10/08/2024]. Staff C stated that they would discard them. HAND HYGIENE/GLOVE USE IN THE KITCHEN STAFF O Observation on 10/14/2024 at 11:13 AM, showed Staff O, Cook, took the temperature of the asparagus in a metal container with a thermometer. When they were done, they sanitized the thermometer and placed the asparagus in the steamer. Staff O removed their gloves, walked to the walk-in refrigerator and took the temperature of a chocolate cake. Staff O then walked to the kitchen refrigerator and took the temperatures of the milk and orange juice, sanitizing the thermometer before and after each item. When Staff O was done, they took a metal tray of macaroni and cheese out of the oven, took the temperature and placed it in the steamer. Staff O took an empty metal tray, placed it in the sink across the dishwashing machine and performed hand hygiene. Staff O did not perform hand hygiene after removing their gloves. In an interview on 10/14/2024 at 12:49 PM, Staff O stated that they performed hand hygiene after touching raw meats, something dirty, before touching ready to eat items and stated that you cannot go from dirty to clean. When asked about glove use, Staff O stated, technically wash his hands. Staff O further stated that they should have performed hand hygiene after removing their gloves. STAFF P Observation on 10/14/2024 at 12:17 PM, showed Staff P, Kitchen, rolled a cart of empty boxes through the kitchen. Staff P stopped before exiting the kitchen door to remove their gloves and exited the door. At 12:19 PM, Staff P returned to the kitchen with an empty cart, rolled it through the kitchen, placed the cart against the wall, and performed hand hygiene at the sink across the kitchen entrance. In another observation on 10/14/2024 at 12:40 PM, showed Staff P pushed a rack of dirty dishes into the dishwashing machine with gloves on. Staff P removed their gloves, applied new gloves and touched the rack of clean dishes that went through the dishwashing machine. Staff P placed the clean cups on the shelf and stored them away. When Staff P was done, they removed their gloves and performed hand hygiene. Staff P did not perform hand hygiene after they removed their soiled gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 10/14/2024 at 12:46 PM, Staff P stated that they were taught to perform hand hygiene when they entered the kitchen and passed the yellow line. When asked about hand hygiene with glove use, Staff P stated that they sometimes wash their hands and that they tries to wash their hands before they put on their gloves. Staff P further stated that they should have performed hand hygiene when they entered the kitchen and before glove use. STAFF Q Observation on 10/14/2024 at 12:24 PM, showed Staff Q, Kitchen, removed their gloves, took a paper towel, placed it on the doorknob, opened the door and exited the kitchen with a cart full of desserts. Staff Q did not perform hand hygiene after removing their gloves. In an interview on 10/14/2024 at 12:53 PM, Staff Q stated that they performed hand hygiene every time they entered and exited the kitchen. Staff Q stated that they sometimes performed hand hygiene after removing their gloves and depended on what they were working on. Staff Q further stated that they performed hand hygiene after removing their gloves and that they think they may have forgotten. In an interview on 10/15/2024 at 10:41 AM, Staff C stated that they expected staff to perform hand hygiene before and after glove use. USE OF HAIR COVERING IN THE KITCHEN STAFF C Observation on 10/14/2024 at 12:07 PM, showed Staff C was not wearing a hairnet/hair covering. Staff C went behind the steamer into the kitchen area and took a metal tray on a shelf below the steamer and took it to the preparation area. Staff C opened a bag of broccoli and placed it inside the metal container. Staff C then cut the broccoli in half and placed them in the metal container. An observation and interview on 10/15/2024 at 10:41 AM, showed Staff C in the preparation station with gloves on and was putting spices in a pot. Staff C was not wearing a hairnet/hair covering. When asked about their process for hair covering, Staff C stated, typically, hairnet on and hair pulled back. Staff C further stated that they should have been wearing a hairnet. In an interview on 10/16/2024 at 11:25 AM, Staff E, Infection Preventionist, stated that they expect staff to perform hand hygiene between glove use and prior to entering the kitchen. Staff E further stated that they would expect staff to wear a hair covering in kitchen. In an interview on 10/16/2024 at 2:17 PM, Staff A, Administrator, stated that they expected staff to follow their policy. Staff A stated that food items past the use by date should have been discarded. Staff A further stated that they expected staff to perform hand hygiene when they go from dirty to clean, take their gloves off, and when they enter the kitchen. Staff A further stated that staff should have been wearing a hairnet or hat to cover their hair. 45146 UNCOVERED FOOD ITEMS/HAND HYGIENE (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 10/10/2024 at 11:51 AM, showed Staff AA, Certified Nursing Assistant (CNA), removed a lunch tray from a tray cart that was parked in front of the first-floor nurse's station. Observation showed the dessert bowl was not covered. Staff AA walked down the hallway with uncovered dessert bowl and entered room [ROOM NUMBER] located at the end of the hallway. Staff AA placed the tray on the resident's bedside table in room [ROOM NUMBER]A, moved the resident's bed side table and left the resident's room. No hand hygiene performed after touching the resident's bedside table. Staff AA walked to the meal tray cart, grabbed a sauce and placed it on the resident's tray and left the resident's room. Staff AA walked back to the meal tray cart and opened the cart. No hand hygiene was performed prior to opening the meal tray cart. On 10/10/2024 at 11:58 AM, Staff AA was observed removing a lunch tray from the meal tray cart parked in front of the first-floor nurse's station. Observation showed the dessert bowl was not covered, and Staff AA walked down the hallway with uncovered dessert bowl, entered room [ROOM NUMBER] and delivered the tray to the resident in room [ROOM NUMBER]B. On 10/10/2024 at 12:02 PM, observation showed Staff AA was removing a lunch tray from the meal tray cart parked in front of the first-floor nurse's station. Observation showed the dessert bowl was not covered, and Staff AA walked down the hallway with uncovered dessert bowl, entered room [ROOM NUMBER] located at the end of the hallway. On 10/10/2024 at 12:46 PM, Staff AA stated that they would perform hand hygiene before and after delivering meal tray. Staff AA stated they should have washed their hands after they touched the resident's bedside table in room [ROOM NUMBER]A. Staff AA further stated the dessert bowl on the lunch meal trays of room [ROOM NUMBER]A, 127B and 129 were not covered. On 10/17/2024 at 10:09 AM, Staff C stated that food items would be covered before they were placed in the hall meal tray carts. When asked whether the desserts should be covered, Staff C stated that desserts were not covered because of the frosting. 46912 Observation on 10/10/2024 at 12:35 PM and at 12:38 PM, showed an unidentified staff carrying uncovered desserts on meals trays down the hallway to room [ROOM NUMBER] and room [ROOM NUMBER]. A joint observation and interview on 10/11/2024 at 12:19 PM, showed Staff X, CNA, taking a meal tray with an uncovered dessert down the hallway to room [ROOM NUMBER]. Staff X took another meal tray with an uncovered dessert down the hallway to room [ROOM NUMBER] and take another uncovered dessert to room [ROOM NUMBER]. Staff X took another meal tray with an uncovered dessert down the hallway to room [ROOM NUMBER] past a housekeeping staff who was vacuuming. Staff X stated the dessert was a pound cake and that it was uncovered. In an interview on 10/17/2024 at 10:09 AM, Staff C stated that they expected fruit, soup, drinks and the plate to be covered on the meal tray. Staff C stated that it's hard to cover up the dessert .if there's frosting, it's hard to cover. In an interview on 10/17/2024 at 11:20 AM, Staff E stated they would like staff to take the meal cart down the hallway when delivering trays and not park it centrally. Staff E further stated that staff shouldn't be taking them [uncovered food] long distance. Someone could cough on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/17/2024 at 11:44 AM, Staff B, Director of Nursing, stated their expectation for food items in the hallway was if [staff] are carrying [meal trays] all the way down the hall, [food] should be covered. Reference: (WAC) 388-97-1100 (3)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure the facility was managed in a manner that utilized its resources to maintain the residents' highest practicable physical, mental, and psychosocial well-being. The failure to properly maintain the carpet placed the residents at risk for accidents, injuries, and a diminished quality of life. Findings included . Review of the facility's assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents), updated 06/14/2024, showed that the majority of our patients are short term and receive rehabilitative services. It further showed that the facility assessment was used to assess facility resources needed to provide competent care for our residents including .physical environment and building needs. Observation on 10/11/2024 at 8:38 AM, showed multiple areas of bubbling [an area in the carpet where it lifts and creates a hill or bump on the floor] in the carpet in the first-floor hallways. It further showed one large area of bubbling in the hallway of room [ROOM NUMBER] to 143. Observations on 10/11/2024 at 1:58 PM and on 10/14/2024 at 11:48 AM, showed Resident 22 was walking with their walker in the hallway toward their room (room [ROOM NUMBER]) and walking directly over the bubbling of the carpet. In a joint observation and interview on 10/15/2024 at 2:19 PM, showed Staff Y, Certified Nursing Assistant, was walking with Resident 2 who was using their cane, and walked over the bubbling carpet in the hallway. Staff Y described the bubbling, like a bump in the carpet. Staff Y stated that Resident 2 had to lift up [their] feet a little bit when walking over the carpet in the Maple Hallway. Staff Y further stated that residents could trip on the raised parts of the carpet. In an interview and joint observation on 10/15/2024 at 2:27 PM with Staff D, Plant Maintenance Director, stated that the facility had been trying to get the carpet replace since last February. Staff D stated that corporate sent someone to come look at the carpet about two months ago. A joint observation of the carpet in the First Floor Hallway, Staff D described it as having bubbles and the underneath was eating itself. Staff D further stated that they thought the facility was waiting on a quote to have the carpet repaired or replaced. In an interview on 10/17/2024 at 10:25 AM, Staff A, Executive Director, stated the facility served mainly short-term rehabilitation residents that were getting therapy in the halls and in the gym. Staff A stated they were aware of the bubbling in the carpet in the first-floor hallways and when asked if it was safe for residents, Staff A stated, it could be safer. Staff A stated that it had been a known issue for awhile and that they thought the quotes from the carpet company had gone to their corporate president and had been waiting for a response. Staff A provided emails between a carpet company and the corporate office from July 2024 that documented the carpet issue. In a follow-up interview at 12:50 PM, Staff A stated that they had contacted the corporate president today and the corporate president stated they did not have any quotes from the carpet company or they can't find it. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1620 (1)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure the facility assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) was updated to accurately determine and identify the resources needed for the facility's resident care needs. This failure placed the residents at risk for unmet care needs. Findings included . Review of the facility assessment, updated on 06/14/2024, showed the assessment did not address or include the following: - Resources necessary to care for residents including nights and weekends, - Contracts, memorandums of understanding ([NAME]), or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies, - Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. - Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. - Plan to maximize recruitment and retention of direct care staff. In an interview on 10/17/2024 at 10:25 AM, Staff A, Executive Director, stated there was nothing in my assessment that shows that the facility assessed and evaluated the resources necessary to care for residents including nights and weekends. Staff A stated that it was not documented in the facility assessment that the facility had contracts, MOUs, or other agreements with third parties such as hospice. Staff A further stated that it was not documented in the facility assessment that the facility considered specific staffing needs for each resident unit for each shift (day, evening, night) and when asked if the facility assessment had a staffing and retention plan, Staff A stated, we don't have that. No associated WAC

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure hand hygiene practices and/or proper use of gloves were followed before, during, and after resident care and passing meal trays for 2 of 6 staff (Staff K & G), failed to implement Enhanced Barrier Precautions (EBP- precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections]) for 3 of 3 residents (Residents 37, 193 & 5), and failed to ensure appropriate indwelling catheter (a semi-flexible tube inserted into the bladder to drain urine) care for 1 of 3 residents (Resident 37), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . HAND HYGIENE/GLOVE USE Review of the facility's policy titled, Handwashing/Hand Hygiene, dated July 2018, showed that all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections. It showed to use an alcohol-based hand rub .or, alternatively, soap .and water for the following situations: before and after direct contact with patients .after contact with objects in the immediate vicinity of the patient .after removing gloves. It further showed that the use of gloves does not replace hand washing/hand hygiene. STAFF K Observation on 10/09/2024 at 12:35 PM, showed Staff K, Licensed Practical Nurse (LPN), taking a meal tray into room [ROOM NUMBER] without performing hand hygiene before entering. Staff K put on gloves, touched the bedside table, removed their gloves and left room [ROOM NUMBER] without performing hand hygiene. Staff K then brought a meal tray to room [ROOM NUMBER] without performing hand hygiene prior to entering. Staff K put on gloves to set up the meal tray, took off the gloves and left the room without performing hand hygiene. In an interview on 10/09/2024 at 12:53 PM, Staff K stated that they washed their hands before we deliver our trays. Staff K further stated that after they removed gloves they would wash hands. In an interview on 10/17/2024 at 11:20 AM, Staff E, Infection Preventionist, stated they expected hand hygiene to be done between residents. Staff E further stated that they expected staff to perform hand hygiene after removing their gloves. In an interview on 10/17/2024 at 11:55 AM, Staff B, Director of Nursing, stated that they expected staff to perform hand hygiene before and after going into resident rooms and after removing gloves. 47680 STAFF G (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/09/2024 at 12:08 PM, showed Staff G, Scheduler/Staff Development, gave Resident 25 a glass of water. Resident 25 spat up water in a cloth, Staff G took the cloth to the sink and performed hand hygiene. Staff G took a paper towel, wiped Resident 25's shirt with it and sat next to them. Staff G did not perform hand hygiene after wiping Resident 25's shirt. At 12:15 PM, Resident 23 was sliding off their wheelchair. Staff G stood up, took gloves and walked over to the other side of the dining room, applied the gloves and assisted Staff W, CNA, to pull Resident 23 up in their wheelchair. Staff G did not perform hand hygiene before glove use. In an interview on 10/09/2024 at 1:05 PM, Staff G stated that they were supposed to perform hand hygiene before putting on their gloves and that was their mistake. In an interview on 10/16/2024 at 11:25 AM, Staff E stated they expected Staff G to perform hand hygiene before glove use. EBP/CATHETER CARE According to Centers for Disease Control and Prevention (CDC) website, dated 04/02/2024, showed that nursing home residents with indwelling medical devices (e.g. urinary catheter should be placed on EBP. When implementing EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use and access to appropriate supplies. To accomplish this: Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required Personal Protective Equipment (PPE - protective devices, garments, or coverings like gloves, gown and mask). For EBP, signage should also clearly indicate the high-contact resident care activities (dressing, hygiene care, transferring, changing brief and linens) that require the use of gown and gloves. Review of the facility's policy titled, Catheter Care, dated August 2018, showed, Maintain clean technique when handling and manipulating the catheter, tubing, or drainage bag. It further showed, Be sure the catheter tubing and drainage bag are kept off the floor. RESIDENT 37 Review of the admission Minimum Data Set (MDS-an assessment tool) dated 09/30/2024, showed that Resident 37 admitted to the facility on [DATE], with diagnoses that included retention of urine (difficulty to urinate and completely emptying the bladder). It further showed that Resident 37 had an indwelling catheter. Observation on 10/10/2024 at 8:54 AM, showed Resident 37's catheter tubing was touching the floor. There was no EBP signage on the resident's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 10/10/2024 at 12:42 PM, showed Staff K was not wearing a gown while they dressed and repositioned Resident 37. Staff K stated that Resident 37 took their gown off and that they were putting it back on. Staff K moved Resident 37's urinary catheter bag from one side of the bed to the other. Staff L, Certified Nursing Assistant (CNA), entered the room and applied gloves. While Staff L was raising the resident's bed, their pants touched the resident's bed linens. Staff K and Staff L were on each side of the resident's bed, they lifted the drawsheet under the resident and repositioned the resident to the head of the bed. Staff L turned Resident 37 to their side towards the window. Resident 37's gown was touching Staff L's top and pants as they were turning the resident towards them. Staff K and Staff L were not wearing a gown when they provided high contact care to Resident 37. Observation on 10/11/2024 at 8:14 AM, showed Resident 37's bed was low, and their catheter tubing was touching the floor. There was no EBP signage on the resident's door. At 11:29 AM, Staff M, CNA, and Staff K entered Resident 37's room, performed hand hygiene and applied gloves. Staff M touched the catheter bag/tubing, removed it from the foot of the bed and hung it on the bed frame closer to the resident. Staff M and Staff K pulled Resident 37 up in bed and repositioned Resident 37 on their left side. Staff M and Staff K were not wearing a gown when they provided high contact care to Resident 37. Observation on 10/15/2024 at 8:53 AM, showed Resident 37's bed was low, and their catheter tubing was touching the floor. At 8:58 AM, Staff L applied gloves and washed Resident 37's face with a washcloth. Staff L raised the resident's bed and repositioned Resident 37 to the center of the bed. Staff L was not wearing a gown when they provided high contact care to Resident 37. An interview and joint observation on 10/15/2024 at 9:18 AM, Staff L stated that if a resident was on precautions they would have a signage outside the resident's room, and that they would get report from the nurse. When asked if Resident 37 was on EBP, Staff L stated not that they knew of, and that Resident 37 was not on any precautions requiring them to wear a gown. Joint observation of Resident 37's catheter tubing showed that it was touching the floor. Staff L stated that the catheter tubing was touching the floor and that their bed needed to be in the lowest position. In an interview on 10/16/2024 at 10:55 AM, Staff K stated that they did not have any residents on EBP. Staff K stated that Resident 37 was not on EBP and that they did not need to wear a gown when providing care to the resident. Staff K further stated that Resident 37's catheter tubing should not be touching the floor. A joint record review and interview on 10/16/2024 at 11:09 AM with Staff E, showed that per facility's catheter care policy, catheter tubing should be off the floor. Staff E stated that they would expect the catheter tubing to be off the floor. Staff E further stated that they did not have a policy in place for EBP. An interview on 10/16/2024 at 3:22 PM, Staff B stated they would not expect the catheter tubing to be touching the floor. Staff B further stated that residents who had a catheter were not on EBP but they are now. 45146 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505500	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Healthcare at Bellevue	2424 156th Avenue Northeast Bellevue, WA 98007

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 193 Resident 193 admitted to the facility on [DATE].Review of the admission MDS dated [DATE] showed Resident 193 had an indwelling catheter. Observations on 10/09/2024 at 2:36 PM, on 10/10/2024 at 2:19 PM, and on 10/11/2024 at 7:58 AM, showed Resident 193 had an indwelling urinary catheter and no EBP signage on the resident's room door. On 10/11/2024 at 8:47 AM, Staff X, CNA, stated that they had just assisted Resident 193 with a transfer, and they used gloves only as a PPE. When asked if Resident 193 was on precaution, Staff X stated that Resident 193 was not on precaution and if they were on precaution, signage would have placed on the resident's room door. Observation on 10/14/2024 at 9:51 AM, showed Staff Y, CNA, was preparing to provide incontinence care for Resident 193. Staff Y applied gloves and removed Resident 193's soiled incontinence brief and provided peri care (cleaning the private areas). Staff Y did not wear gown when they provided incontinence care. Staff Y changed their gloves and applied a new incontinence brief to Resident 193. Staff Y did not perform hand hygiene in between glove use. On 10/14/2024 at 12:15 PM, Staff Y stated they were supposed to perform hand hygiene between glove use. When asked if Resident 193 was on precaution, Staff Y stated they did not know if the resident was on precaution. Staff Y further stated that if Resident 193 was on precaution, there would be a signage on the resident's door with the type of precaution they were on. During a joint record review and interview on 10/15/2024 at 9:44 AM with Staff E showed the EBP signage found in the first-floor nurse station drawer showed staff must wear gloves and a gown for high-contact resident care activities. Staff E stated that they were not aware of the EBP requirements. A joint observation on 10/15/2024 at 9:50 AM with Staff E, showed no EBP signage on Resident 193's room door. Another joint record review of Resident 193's active orders on 10/15/2024 at 9:57 AM with Staff E, showed the resident had an indwelling urinary catheter. RESIDENT 5 Resident 5 admitted to the facility on [DATE]. Review of the admission MDS dated [DATE] showed Resident 5 had an indwelling catheter. Observations on 10/10/2024 at 9:45 AM, on 10/11/2024 at 8:36 AM, and on 10/15/2024 at 9:12 AM, showed Resident 5 had an indwelling urinary catheter and there was no EBP signage on the resident's room door. Observation on 10/14/2024 at 11:31 AM, showed Staff Z, CNA, was making Resident 5's bed and was not wearing gown. On 10/14/2024 at 11:27 AM, Staff Z stated that they assisted Resident 5 with oral care and making bed using gloves as PPE. When asked if Resident 5 was on precaution, Staff Z stated that Resident 5 was not on precaution and if they were on precaution, they would be notified by their nurse and signage would have been placed on the resident's room door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505500	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Healthcare at Bellevue	2424 156th Avenue Northeast Bellevue, WA 98007

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/14/2024 at 11:41 AM, when asked if Resident 5 was on precaution, Staff V, Registered Nurse, stated that Resident 5 was not on precaution. Staff V further stated that if Resident 5 was on precaution, it would be written in the resident's medical record and there would be a signage on the resident's door. During an observation and joint record review on 10/15/2024 at 10:00 AM with Staff E, showed there was no EBP signage on Resident 5's room door. Joint record review of the order summary report as of 10/15/2024 showed Resident 5 had indwelling urinary catheter. Staff E stated that Resident 5 should have been placed on EBP. On 10/16/2024 at 2:59 PM, Staff B stated that the facility in-serviced staff on EBP and residents that required EBP would be placed per CDC recommendation. Staff B stated their expectation was that staff should perform hand hygiene after glove removal. Reference: (WAC) 388-97-1320 1(a)(c)

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	505500	A. Building B. Wing	10/17/2024

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46912 Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) had the required twelve hours of training, including dementia (memory loss) management training annually for 1 of 5 staff (Staff N). This failure placed the residents at risk for potential negative outcomes and unmet care needs. Findings included . Review of the facility's assessment, updated on 06/14/2024, showed Required in-service training for nurse aides [will] be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. It further showed that all staff will be required to complete Care/management for persons with dementia, annually. Review of the facility's employee record for Staff N, CNA, showed they were hired on 01/09/2023. It further showed no documentation that Staff N received the required 12 hours of annual training, including dementia management training. In an interview and joint record review on 10/17/2024 at 12:40 PM, Staff E, Staff Development, stated that CNAs needed 12 hours of training yearly. A joint record review of Staff N's training record from 01/09/2023 to 01/09/2024 showed they received 7.83 hours of trainings. Staff E stated based off the documentation, [Staff N] does not have 12 hours of annual training. Staff E further stated that Staff N did not have any dementia training from 01/09/2023 to 01/09/2024. In an interview on 10/17/2024 at 2:14 PM, Staff B, Director of Nursing, stated they expected that CNA's, including Staff N, had 12 hours of required annual training, including dementia training. Reference: (WAC) 388-97-1680 (2)(b)