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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505507	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelton Health & Rehab Center	153 Johns Court Shelton, WA 98584

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to ensure the transfer of funds, from a resident trust account, was completed within 30 days following their discharge for 2 of 5 residents (Residents 165 and 166) reviewed for resident trust. This failure placed the resident and/or their representatives at risk for loss of funds and the interest accumulated. Findings included . A review of the electronic medical record showed Resident 165 discharged on [DATE] and a review of their account showed it contained a balance of $40.00. On [DATE] at 12:51 PM, Staff Q, Business Office Manager, said Resident 165's account was closed on [DATE]. A review of the electronic medical record showed Resident 166 died on [DATE] and a review of their account showed it contained a balance of $189.51. On [DATE] at 12:51 PM, Staff Q, Business Office Manager, said Resident 166's account was closed on [DATE]. On [DATE] at 2:00 PM, Staff A, Administrator, acknowledged the resident's accounts were not closed within 30 days of their discharge and said the expectation was for the checks to be issues timely within 30 days. Reference WAC [DATE](4)(5)

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

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

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F 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** 50392 Based on interview and record review, the facility failed to ensure an allegation of abuse, neglect, or mistreatment that was identified by staff was reported to the Administrator and/or the state agency as required for 1 of 3 residents (Resident 18) reviewed for allegations related to abuse/neglect. This failure prevented the facility from conducting an immediate investigation, taking steps to protect residents from further abuse/neglect if necessary, conducting a thorough investigation and monitoring and treating residents as needed for potential harm. Findings included . Resident 18 admitted to the facility on [DATE]. The Quarterly Minimum Data Set (an assessment tool), dated 01/15/2025, documented Resident 18 was cognitively intact. Resident 18 had diagnoses of bipolar disorder (mood swings ranging from depressive lows to manic highs), borderline personality disorder (unstable moods, behaviors, and relationships), major depressive disorder (Depression) and unspecified dementia (thinking and social symptoms that interfere with daily functioning). On 03/11/2025 at 9:43 AM, Resident 18 reported that after a fall they thought was approximately 7-8 weeks ago, a nurse had told them to get up and that Resident 18 had said they had just had surgery and could not. Resident 18 said the nurse had pushed their bed remote to make them sit up straight and was so mean. Resident 18 was unsure of the nurse's name. Resident 18 became tearful and said they did not tell anyone at the time as they were afraid they would be in trouble. At 11:02 AM, Staff B, Director of Nursing Services (DNS), was made aware of Resident 18's allegation. Review of a Nursing progress note, dated 07/20/2024, documented Pt [patient] educated on repositioning in bed to reduce the discomfort/pain [Resident 18] c/o [complains of] to Left shoulder, back and right hip. Pt takes education as a personal attack on [Resident 18]. When educating and showing [Resident 18] bed positioning to improve wellbeing, pt turns everything around and states to why [Resident 18] can't position that way in bed. Pt stated to kitchen staff passing snacks that this writer was being mean to [Resident 18] and not allowing [Resident 18] to lay in bed the way [Resident 18] wants to. Review of the 07/2024 Accident and Incident log showed no entry regarding the above incident. On 03/17/2025 at 12:24 PM, Staff B, DNS, said the 07/20/2024 Nursing progress note was likely referring to the incident that Resident 18 had described. Staff B said the incident should have been reported at the time so it could have been investigated. On 03/18/2025 at 3:08 PM, Staff A, Administrator, said their expectation was for the documented incident to have been reported by staff at the time it happened so an investigation could have been done. Reference WAC 388-97-0640(5)(a)

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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** 46793 Based on interview and record review, the facility failed to accurately assess Minimum Data Sets (MDS, an assessment tool) for 4 of 18 sampled residents (Resident 29, 49, 13 & 14) reviewed. Failure to ensure accurate assessments regarding Wander guard (alarm), resident refusals, and signficant weight loss placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included . 1) Resident 29 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 29 was severely cognitive impaired and had no physical restraints, to include wander/elopement alarm. On 03/18/2025 at 10:28 AM, observation made of the Wander guard attached to the left side of wheelchair. Staff T, Registered Nurse, said wander guards are required to be attached to the left side of the wheelchair. Resident 29's wander/elopement risk care plan, revision dated 09/05/2024, documented Resident 29 was at risk for elopement and the wander guard was attached to the left side of Resident 29's wheelchair. A physician's order, dated 01/13/2025, documented Resident 29 had a Wander Guard attached to the left side of their wheelchair and was to be checked daily for placement. On 03/17/2025 at 2:38 PM, Staff D, Resident Care Manager (RCM), with Staff C, RCM, present, said Resident 29 was mobile and cognitively impaired with a history of exit seeking. When shown the MDS stating no wander/elopement restraints used, Staff D said the MDS was incorrect and needed to be changed. On 03/18/2025 at 12:53 PM, Staff B, Director of Nursing Services (DNS), with Staff E, Divisional Director/Regional Registered Nurse present, said for the use of a wander guard, it required an assessment, a care plan, a consent and an order. When shown the MDS stating no wander/elopement restraints used, Staff B said the MDS was incorrect and should have been addressed. 37044 2) Resident 49 admitted to the facility on [DATE]. Review of the 02/14/2024 Admission MDS, dated [DATE], showed the resident did not use a wander/elopement alarm. Review of the electronic health record showed an order was obtained and consent provided for placement of a wander guard to Resident 49's left wrist. On 03/18/2025 at 8:02 AM, Staff B, DNS, confirmed Resident 49's wander guard should have been coded on the Admission MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50945 3) Resident 13 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed Resident 13 was severely cognitively impaired and was dependent on staff for cares. Review of the Significant Change MDS dated [DATE], showed it did not code for refusals. During an interview on 03/17/2025 at 11:23 AM, Staff AA, MDS Nurse, when asked about the Significant Change MDS, dated [DATE], said the review dates were from 02/14/2025 to 02/21/2025. When asked about a progress note reporting a refusal for a bed bath on 02/18/2025 and refusals of medications on the medication administration record from 02/15/2025 to 02/21/2025 for 6 of 7 days reviewed, Staff AA said there was no reason the refusals were not included on the MDS and it should have been documented. 4) Resident 14 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 14 was severely cognitively impaired, dependent on staff for cares, and during the assessment period had required supervision or touch assistance for eating. Resident 14 had two MDS assessments, dated 11/13/2024 and 01/07/2025 that did not correctly identify significant weight loss. Review of the 11/13/2024 MDS showed Resident 14 weighed 118 pounds (lbs.), the box for significant weight loss (loss of 5% or more in the last month or loss of 10% or more in the last 6 months) was not selected. Review of Resident 14's weights showed the most current weight was taken on 11/03/2024 at 117.6 lbs. and the closest weight to 30 days preceding that weight was on 10/01/2024 at 125 lbs. This was a -5.92 % loss of weight in about 30 days. Review of the 01/07/2025 showed Resident 14 weighed 112 lbs., and the box for weight loss was not selected. Review of Resident 14's weights showed that the most current weight was taken on 01/06/2025 at 111.6 lbs and the closest weight to 30 days preceding that weight was on 12/07/2025 at 119.6 lbs. This was a -6.69% loss of weight in about 30 days. During an interview on 03/14/2025 at 2:10 PM, Staff AA, MDS Nurse, said the dates they used for the 11/13/2024 MDS were 11/03/2024 and 10/18/2024. When asked about reviewing weight loss over a two-week period, Staff AA said the rule was to take the Assessment Reference Date (ARD, date listed on the MDS) and review the weight from the month prior which was closest to the ARD. When asked about accuracy of this, Staff AA said there was no rule about the weight being in the ARD window. Regarding the 01/07/2025 MDS, Staff AA said that one was an error, it should have been coded for significant change for weight loss. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During follow up interview on 03/17/2025 at 11:08 AM, when asked about the second weight being 30 days preceding the current weight, regarding the 11/13/2024 MDS, Staff AA reviewed the weights and said the 11/03/2024 weight would have been used as the current weight, and agreed the weight taken on 10/01/2024 should have been used as the 30 days preceding the current weight. Staff AA said yes it should have been coded for significant weight loss on the 11/13/2024 MDS. During an interview on 03/18/2025 at 2:04 PM, Staff B, DNS, said if Resident 14 was having significant weight loss then it should have been coded on the MDS. Reference F692 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** 46793 Based on interview and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Reviews (PASRR) were complete and accurate for 3 of 5 sampled residents (Resident 53, 49 & 13) reviewed for PASRR. This failure placed the residents at risk of unmet and unidentified care needs, and a diminished quality of life. Findings included . <Resident 53> Resident 53 was admitted to the facility on [DATE], with diagnoses that included Major Depressive Disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life), Unspecified Psychosis (is a diagnosis used when a person experiences symptoms of psychosis but does not meet the full criteria for a specific psychotic disorder) and Post Traumatic Stress Disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying events). The Quarterly, Minimum Data Set, (MDS, an assessment tool), dated 02/04/2025, documented Resident 53 was cognitively intact. Resident 53's PASRR Level I, dated 12/05/2024, documented Resident 53 was diagnosed with PTSD. No other diagnoses were included on the PASRR Level I. On 03/17/2025 at 2:38 PM, Staff D, Resident Care Manager (RCM), with Staff C, RCM, present, said Resident 53's mental health diagnoses included PTSD, Unspecified Psychosis, Insomnia, & MDD. When asked to review Resident 53's PASRR, Staff D said the Unspecified Psychosis & MDD were missing from the form. Staff D said that should have been caught. On 03/18/2025 at 12:53 PM, Staff B, Director of Nursing Services (DNS), with Staff E, Divisional Director/Regional Registered Nurse present, said Resident 53's mental health diagnoses included PTSD, Psychosis, Insomnia & MDD. After reviewing the PASRR Level I, Staff B, said the PASRR was incorrect and should have been corrected. 37044 <Resident 49> Resident 49 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident's diagnoses included non-Alzheimer's dementia, psychotic disorder (severe mental illness that causes abnormal thinking and perceptions) and depression, and the resident was treated with antipsychotic and antidepressant medication during the assessment period. Review of Resident 49's Level I PASRR, dated 02/04/2025, showed the resident had a diagnosis of major depressive disorder, but not a diagnosis of psychotic disorder. The assessment determined Level II PASRR evaluation for serious mental illness (SMI) was not indicated. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2025 at 1:22 PM, Staff F, Social Services Director (SSD), said Resident 49's PASRR was inaccurate and should have included a diagnosis of psychotic disorder and acknowledged a referral for a Level II evaluation for SMI was required. 50945 <Resident 13> Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Level I PASRR, dated 09/12/2024, showed anxiety disorder was selected. Review of the Electronic Health Record showed Resident 13 did not have a diagnosis of anxiety at that time. During an interview on 03/18/2025 at 12:11 PM, Staff D, RCM, said Resident 13 did not have anxiety on their diagnosis list. During an interview on 03/19/2025 at 4:48 PM, Staff F, SSD, acknowledged the box for anxiety disorder should not have been checked for Resident 13. Reference WAC 388-97-1915 (1)(2)(a-c)

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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** 37044 Based on observation, interview and record review, the facility failed to ensure care plans (CPs) were reviewed, revised and accurately reflected resident care needs for 5 of 18 sampled residents (Resident 51, 41, 49, 38 & 14) reviewed for care plans. This placed residents at risk for unmet care needs and a diminished quality of life. Findings included . 1) Resident 51 admitted to the facility on [DATE]. Review of the Admission Minimum Data Set Assessment (MDS), dated [DATE], showed the resident was cognitively intact, had diagnoses of schizophrenia and neurogenic bladder, received antipsychotic medication and required the use of an indwelling urinary catheter. A 01/15/2025 provider note documented Resident 51 had neurogenic bladder and required chronic urinary catheterization. An indwelling catheter care plan, initiated 01/14/2025, showed it did not identify why Resident 51 required the use of an indwelling catheter. It did not identify or address the resident's neurogenic bladder diagnosis. On 03/18/2025 at 11:02 AM, Staff D, Resident Care Manager (RCM), said the resident's diagnosis of neurogenic bladder should have been care planned. An anxiety behavior monitoring care plan, initiated 01/15/2025, directed staff to monitor for the target behavior delusions. The care plan did not identify what, if any, delusions the resident had experienced in the past; what, if any, affect the delusions had on the resident (e.g. calming versus distressful etc.), or indicate if attempts should be made to reorient the resident to reality or not. On 03/08/2025 at 11:42 AM, Staff D, RCM, said the care plan should have been resident specific and included what delusions the resident had, their effect and what action staff should take when observed. 2) Resident 41 admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact and required moderate assistance (staff holds, or supports trunk or limbs, but provides less than half the effort) with oral care. A at risk for functional decline due to right upper extremity deformity care plan, initiated 10/24/2025, directed staff to set up oral care supplies and cue the resident to brush their own teeth. On 03/10/2025 at 3:53 PM, Resident 41 reported they couldn't brush their teeth because they were right-handed and couldn't get arm up to their mouth without assistance. On 03/18/2025 at 1:21 PM, Staff D, RCM, said the care plan should be updated to reflect Resident 41's increased need for physical assistance with oral care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Resident 49 admitted to the facility on [DATE]. Review of the electronic health record showed an order was obtained and consent provided for placement of a wander guard to Resident 49's left wrist. An elopement risk care plan, initiated 02/07/202, documented the resident had a wander guard on the left wrist. On 03/10/2025 at 2:55 PM, Resident 49 had a wander guard attached to the right ankle not on left wrist. On 03/18/2025 at 8:43 AM, Staff B, Director of Nursing (DNS), said the care plan was inaccurate and needed to be updated. Review of a Nutrition Hydration Skin Committee Review Form showed resident 49 was reviewed for weight loss and a recommendation was made to start the resident on nutritionally enhanced meals (NEM) and an order was obtained. Review of the comprehensive care plan showed no documentation or indication Resident 49 was to receive NEM. On 03/18/2025 at 8:43 AM, Staff B, DNS, said the care plan needed to be updated/revised to reflect the resident's current diet order. 4) Resident 38 admitted to the facility on [DATE]. Review of the resident's shower record showed they were to be showered on Monday and Thursday day shift. Review of a at risk for decline in activites of daily living care plan, revised 12/09/2024, documented Resident 38 was to be showered on Wednesdays. On 03/18/2025 at 11:05 AM, Staff D, RCM, stated the care plan needed to be updated. 50945 5) Resident 14 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 14 was severely cognitively impaired, dependent on staff for cares, and during the assessment period had required supervision or touch assistance for eating. Resident 14's nutrition care plan, reviewed on 03/13/2025, had an outdated intervention of House supplement per MD orders initiated on 10/30/2024 and an Offer snacks between meals intervention, initiated on 12/18/2024, that was not implemented. The care plan mentioned a fluid restriction of 1800 ml/24 hours, last revised on 11/20/2024, that was not updated to mention this was a past intervention. The care plan did not reassess the intervention of up in chair and in dining room for all meals, initiated on 09/21/2022. The care plan did mention refusal of food/fluids, but did not mention any interventions specific to this concern, including what staff should do in response to a refusal (such as offering a snack, what food preferences Resident 14 liked when not verbally responding to staff, etc.). Also, the care plan did not identify significant weight loss for the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/2025 at 11:16 AM, Staff D, RCM, when asked what was care planned in regards to Resident 14's weight loss, said they could see the Cal Dense and House supplement, that this probably had changed, and that they refused food and fluids. Staff D said that Resident 14's significant weight loss, and interventions specific to refusals related to weight loss, should have been included in the care plan. During an interview on 03/17/2025 at 12:47 PM, Staff D, RCM, said the facility tried to send Resident 14 to the dining room with all meals but that there were frequent refusals and that snacks were only offered at bedtime. During an interview on 03/18/2025 at 2:04 PM, Staff B, DNS, when asked their expectation for care plans related to significant weight loss, said interventions to stop or slow weight loss, preferences, if the resident preferred the dining room. When asked if they expected interventions and how they worked in the care plan, said at times. Staff B said they did not expect all preferences on the care plan, but that the care plan could include if the resident liked chocolate over vanilla. Regarding Resident 14, Staff B said the care plan should have been updated to have removed the house supplement as an active intervention. Reference F692, F641 Reference WAC 388-97 -1020(2)(c)(d),(5)(b)

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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** 42960 Based on interview and record review the facility failed to provide assistance with bathing for 5 of 16 residents (Residents 163, 51, 41, 38 and 14) reviewed for activities of daily living (ADLs). The failed practice placed residents at risk for a decline in care and quality of life. Findings included . 1) Resident 163 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS, an assessment tool), dated 03/09/2025, documented the resident was moderately cognitively impaired and needed substantial to maximal assistance with showers, bathing, and personal hygiene. On 03/10/2025 at 10:25 AM, Resident 163 stated, I have not had a shower yet, I have been nine days, I requested one today. Resident 163's care plan interventions, initiated on 03/03/2025 documented resident wanted a shower two times a week on Wednesday and Saturday evenings. A review of the Point of Care (nursing assistant task documentation) response history for 30 days, the task Bathing - Shower, two times weekly on Wednesday and Saturday evenings documented on 03/08/2025 as not applicable and there was no other documentation listed. On 03/14/2025 at 10:19 AM, Staff C, Resident Care Manager (RCM)/Registered Nurse, said while looking at Resident 163's Electronic Health Record (EHR) that he did not see a shower documented in the system and his expectation was for the staff to follow the resident's admission orders. At 2:02 PM, Staff B, Director of Nursing Services (DNS), said she could not find documentation of Resident 163 receiving a shower and her expectation was for the staff to provide resident showers unless they refused. 37044 2) Resident 51 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident was cognitively intact and required substantial to maximal assistance with bathing/showering. On 03/10/2025 at 3:19 PM, Resident 51 reported they were supposed to be bathed every Monday and Thursday, but staff don't show up. Review of Resident 51's bathing flowsheet showed the resident was scheduled to be bathed every Thursday and Sunday on evening shift. Review of the bathing record showed for the 30-day period from 02/13/2025 - 03/13/2025, showed the resident was offered/provided bathing 02/23/2025, 03/02/2025 and 03/09/2025. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2025 at 11:02 AM, when asked if Resident 51 was consistently offered/provided bathing per their bathing schedule Staff D, Resident Care Manager (RCM), stated, No. 3) Resident 41 admitted to the facility on [DATE]. Review of the 01/25/2025 Quarterly MDS showed the resident was cognitively intact. On 03/11/2025 at 11:21 AM, Resident 41 said staff didn't always show up on their scheduled shower days, but indicated they knew it was probably because the staff was so busy. Review of the comprehensive care plan showed the resident was schedule to be bathed twice a week and was dependent on staff. Review of the bathing flowsheet showed the resident was scheduled to be showered on Tuesday and Saturday day shift. Review of Resident 41's February 2025 shower record showed staff offered bathing on five of the resident's nine scheduled shower days. On 03/18/2025 at 11:05 AM, Staff D, RCM, confirmed bathing was not consistently offered/provided as scheduled. 4) Resident 38 admitted to the facility on [DATE]. Review of the bathing flowsheet showed the resident was scheduled to be showered on Mondays and Thursdays, day shift. Review of the shower record for the 30-day period from 02/13/2025 - 03/13/2025, showed the resident was offered /provided bathing on two of nine scheduled shower days, with no documented refusals. On 03/18/2025 at 11:05 AM, confirmed bathing was not consistently offered/provided to Resident 38 as scheduled. 50945 5) Resident 14 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 14 was severely cognitively impaired and dependent on staff for cares including showers and personal hygiene. Review of Resident 14's shower log on 03/14/2025, showed their last shower was on 02/24/2025. During an interview on 03/14/2025 at 11:16 AM, Staff D, RCM, looked in the EHR and the shower binders, and said as far as they could tell, Resident 14 had not had a shower since 02/24/2025. Staff D said Resident 14 was to get showers on Monday and Thursdays. During an interview on 03/17/2025 at 4:43 PM, Staff B, DNS, said their expectation was for the resident be bathed per preference. Staff B said it did not meet expectations that Resident 14, when reviewed on 03/14/2025, had not had a shower since 02/24/2025. Reference WAC 388-97-1060 (2)(c)

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NAME OF PROVIDER OR SUPPLIER Shelton Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 153 Johns Court Shelton, WA 98584	

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F 0684 Level of Harm - 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** 50945 Based on interview and record review, the facility failed to ensure physician ordered laboratory values were obtained for 1 of 3 residents (Resident 14) who was declining, found unresponsive and had to be hospitalized , and failed to ensure the bowel protocol was followed for 2 of 7 residents (Residents 13 & 49) reviewed for bowel protocol. Resident 14 experienced actual harm when the facility failed to follow physician orders, failed to provide adequate hydration and failed to consistently monitor and document resident's change in condition and the resident developed altered mental status and sepsis (infection of the blood) and urinary tract infection (infection in the urine) and required intensive care level hospitalization . This failure placed residents at risk for unidentified and untreated sepsis, dehydration, constipation, decline, and a diminished quality of life. Findings included . <hospitalization > Resident 14 was admitted to the facility on [DATE] with diagnoses including epilepsy (seizure disorder) and surgical aftercare following surgery on the genitourinary system. The Significant Change, Minimum Data Set Assessment (MDS, an assessment tool), dated 01/07/2025, showed Resident 14 was severely cognitively impaired and dependent on staff for cares. Review of the Electronic Health Record (EHR) showed Resident 14 was hospitalized from 10/12/2024 to 10/18/2024 to have bilateral urethral stents placed (a thin tube was placed in each ureter to keep them open, to allow movement of urine from the kidneys to the bladder). Resident 14 was re-hospitalized from 10/19/2024 to 10/29/2024 for acute encephalopathy (when the brain does not function as well), obstructive hydronephrosis (issue with urine draining out of kidney) status post bilateral urethral stent, complicated urinary tract infection, acute kidney injury, and possible recurrent seizure. A progress note, dated 11/09/2024, showed Resident 14 was diagnosed with hemorrhagic cystitis (inflammation of the bladder lining that causes bleeding and pain with urination). Resident 14 was placed on a 10-day course of an antibiotic. During the antibiotic period of 10 days, on 11/14/2024 a progress note reported Resident 14 required intravenous (IV) fluids for electrolyte imbalance. Review of the November 2024 MAR showed that Resident 14 on 11/12/2024 had received IV fluids for dehydration (dehydration can cause elevated sodium levels). Review of the 11/12/2025 laboratory results from 8:59 AM collection time, showed Resident 14 had an elevated sodium level of 149 (normal range listed as 135-146). Review of the 11/14/2025 laboratory result from 8:50 AM collection time, showed Resident 14 had an elevated sodium level of 154 (normal range listed as 135-146). Review of the EHR showed Resident 14 completed their 10-day course of an antibiotic on 11/19/2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	After the antibiotic had completed on 11/20/2024, a progress note showed Resident 14 was placed on an 1800 milliliter (ml) fluid restriction per day and a no added salt diet. Review of the Medication Administration Record (MAR) by the licensed nurses (LNs) and the Point of Care Fluids by the Certified Nursing Assistants (CNAs) showed the following amount of fluid consumed recorded: 11/20/2024: order started at 2:00 PM, 1,330 ml (milliliters)(400 ml recorded by LN, 93 ml by CNA) 11/21/2024: 1,480 ml (1000 ml by LN, 480 ml by CNA) 11/22/2024: 1,060 ml (700 ml by LN, 360 ml by CNA) 11/23/2024: 1,600 ml (1,000 ml by LN, 600 ml by CNA) 11/24/2024: 540 ml (300 ml by LN, 240 ml by CNA) 11/25/2024: 640 ml (240 ml by LN, 400 ml by CNA) 11/26/2024: 780 (560 ml by LN, 220 ml by CNA) 11/27/2024: 1,340 ml (980 ml by LN, 360 ml by CNA) 11/28/2024: 1,960 ml (1,000 ml by LN, 960 ml by CNA) 11/29/2024: 944 ml (200 ml by LN, 744 ml by CNA) 11/30/2024: 960 ml (600 ml by LN, 360 ml by CNA) Review of the 11/05/2024 nutritional evaluation form, completed by the Registered Dietician, documented Resident 14's hydration needs as 1500 ml of fluid. The documented fluid amounts during 11/21/2024-11/30/2024 showed that Resident 14 was not meeting their daily hydration needs for 8 of 10 days reviewed. Review of a 11/21/2024 progress note showed Resident 14 had a decline in condition and needed increased assistance. Review of a 11/22/2024 progress note showed the provider had requested a nephrology (doctor whom specializes in kidney disease) referral, a urinalysis (UA, analyzes the urine) with culture and sensitivity (if an organism was present would show which one, and allow better selection of what antibiotic to use), a complete blood count (CBC, can detect infection or low red blood cells or platelets), and an abdominal x-ray. The progress note said the resident was on alert for decline and labs. A review of the 11/23/2024 progress note showed Resident 14 continued to have decline and weakness, with hematuria (blood in the urine). EHR showed the next progress note was seven days later on 12/01/2024 which documented Resident 14 was found unresponsive and unable to arouse with the following abnormal vital signs: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Temperature 102.5 (fever is anything over 100.4) Heart rate 132 (60-100 generally considered normal for an adult) Blood pressure 89/59 (normal adult blood pressure typically considered 120/80) Resident 14 was then sent to the hospital. Review of the hospital update documentation showed Resident 14 arrived to the hospital with altered mental status, a fever, was hypotensive (low blood pressure) and required fluid boluses and IV Levophed (vasopressor used for treating severely low blood pressure) for pressure support. Review of the hospital discharge summary, dated showed Resident 14 was diagnosed with a urinary tract infection and sepsis. Review of the EHR showed neither the UA or the CBC (from the 11/22/2024 progress note) were obtained/completed. One administration note for the UA and CBC showed Unable to obtain at this time will try again on 11/23/2024. No additional documentation was found. On 03/17/2025 a request was made for the facility policy on vitals. On 03/17/2025 at 10:32 AM, Staff B, Director of Nursing Services (DNS) documented via email that there was no vital signs policy. During an interview on 03/17/2025 at 12:47 PM, Staff D, Resident Care Manager (RCM), when asked what services were provided by the facility to prevent the hospitalization on [DATE], said it looked like Resident 14 was placed on a fluid restriction and an abdominal x-ray was obtained. Staff D said they looked in the chart and called the hospital but there was no record of the UA or the CBC being obtained, and their expectation was it would have been drawn and collected, and acknowledged neither was done. When asked about the alert charting for decline and how long the resident should have charting done for, Staff D said they did not know and they did not have a policy specific to this area of concern. Regarding Resident 14, Staff D said they could see a lot of charting was not completed while they were on alert and they continued to decline, and their expectation was for staff to have charted on them every shift. When asked if there was documentation of Resident 14's clinical status during that time, Staff D said no. Staff D confirmed there were no vitals taken for Resident 14 between 11/23/2024 and 12/01/2024. During an interview on 03/18/2025 at 2:24 PM, Staff B, Director of Nursing Services (DNS), when asked how the facility prevented the hospitalization , stated they did not prevent it when they did not get the laboratory tests, and they could have potentially prevented the hospitalization by getting the UA. <Bowel Protocol> Review of the facility's policy titled, Bowel Protocol, dated with a revision date of 03/2018, showed that if the resident did not have a bowel movement for three days, then the nurse was to administer the physician ordered bowel program. The bowel protocol showed the residents were supposed to receive the following medications to stimulate a bowel movement: a) Milk of Magnesia, if no bowel movement for three days, administer on day four. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	b) If no result from Milk of Magnesia, then Bisacodyl suppository (small bullet sized medication inserted via rectum) on the next shift during waking hours c) If no result from suppository, then an Enema (liquid inserted via rectum) on the next shift, during waking hours If after the enema there was no bowel movement, then the facility was to notify the provider. <Resident 13> Resident 13 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed Resident 13 was severely cognitively impaired and was dependent on staff for cares. Review of the past 30-day bowel monitor showed Resident 13 did not have a bowel movement from 02/09/2025 to 02/18/2025 (10 days). Review of the MAR showed Resident 13 had as needed bowel medications ordered, the same as from the bowel protocol and in the same order. The February 2025 MAR showed a fleet enema was given on 02/14/2025 but did not indicate whether or not there were results Review of the nursing progress notes, from 02/10/2025 to 02/18/2025, showed no alert charting for Resident 13 regarding and the intervention of the enema, lack of bowel movement, or alert charting. Review of the EHR showed no explanation of why the fleet enema was given out of order from the bowel protocol/instructions in the provider order. During an interview on 03/17/2025 at 12:35 PM, Staff D, RCM, when asked about this period without a bowel movement, looked in the EHR and said they were given an enema on 02/14/2025 and this did not follow the orders or the bowel protocol. Staff D was unable to find any documentation of refusals of less invasive routes per the bowel protocol for this time period. Staff D said their expectation once a resident was on the no bowel movement list, that staff would place on alert charting and documenting about the lack of bowel movement and treatments. During an interview on 03/17/2025 at 4:44 PM, Staff B, DNS, said their expectation for the bowel protocol was that on day four it would be started. Staff B said Resident 13's records did not meet expectations, as staff needed to follow physician orders. 37044 <Resident 49> Resident 49 admitted to the facility on [DATE] with the following bowel care orders: a) Milk of Magnesia, if no bowel movement for three days, administer on day four. b) If no result from Milk of Magnesia, then Bisacodyl suppository on the next shift during waking hours (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	c) If no result from suppository, then an Enema on the next shift, during waking hours If after the enema there was no bowel movement, then the facility was to notify the provider. The February 2025 bowel record showed Resident 49 had no bowel movement from 02/16/2025 - 02/19/2025 (four days). Review of the February 2025 MAR showed Resident 49 was not administered Milk of Magnesia on the fourth day without a bowel movement as ordered. On 03/18/2025 at 8:33 AM, Staff B, DNS, said the nurse should have administered Resident 49's Milk of Magnesia on 02/19/2025 as ordered, but failed to do so. Reference WAC 388-97-1060 (1)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on observation, interview and record review, the facility failed to ensure resident meal intake was accurately recorded, nutritional supplements were provided as ordered, weights were timely obtained and evaluated, significant weight loss was identified, and nutritional interventions were implemented and evaluated for effectiveness for 3 of 5 sampled residents (Residents 14, 49, & 29) reviewed for nutrition. Resident 14 experienced harm when they had a severe weight loss of 14.89% over six months. Resident 49 experienced harm when they had a 11.09% weight loss in 34 days before it was identified by staff. This failure placed all residents at risk of malnourishment, weakness, unidentified care needs, and a diminished quality of life. Findings included . Review of the facility's policy, titled Nutrition Hydration Skin Committee, updated 11/2012, showed the facility held the committee for evaluating residents with declining nutrition, hydration, and skin status. Residents to be reviewed could include residents with significant decline or improvement in condition, trending or significant weight change, changes in meal intake, requiring thickened liquids, having a decline in diet food texture, or due to intake and output. The committee was to meet routinely to address identified issues and track residents being monitored. For residents being reviewed, the committee was to review and revise the care plan with measurable goals and appropriate interventions. For any medically unavoidable weight loss or gain, the committee was to place a referral to the physician for request of documentation on unavoidable weight change. Review of the facility's policy, titled Weights, last revised 07/20/2024, showed new admission residents were to have weekly weights for one month. If stable, then the resident could have monthly weights. The policy provided guidelines for residents that may need weekly weights, with wording saying it was not all inclusive, for residents that had the following: a) Food intake declined and persisted b) Slow trending of weight loss or gain c) Significant weight loss or gain d) Significant change in condition If a resident had a 5-pound variance between weights, a re-weigh would be required. If the significant weight loss was still present after the re-weigh, the nurse was to document in the medical record/progress note, revise the care plan, refer to the Nutrition Hydration Committee, and to notify the provider and the resident/resident representative. Progress notes by the nurse were to include any responses by the provider. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy, titled Preparation and Serving of Nutritionally Enhanced Meals (NEM), updated 11/2018, showed the facility was to add NEM designation to the resident's tray ticket, each tray would have 8 ounces (oz) of whole milk, and dietary would provide enriched cereal topping to the breakfast and extra margarine to breads, potatoes, pasta, rice, vegetables or other appropriate foods. Resident meal trays could also have extra high calorie and high protein foods to further enhance nutrition, such as yogurt, ice cream, pudding, extra egg at breakfast, and/or peanut butter. <Resident 14> Resident 14 was admitted to the facility on [DATE] and had diagnoses of weakness, major depressive disorder (depression), and dehydration. The Significant Change Minimum Data Set Assessment (MDS/an assessment tool), dated 01/07/2025, showed Resident 14 was severely cognitively impaired, dependent on staff for cares, and during the assessment period had required supervision or touch assistance for eating. Review of the weights showed: 1 month: On 02/02/2025, the resident weighed 110.8 lbs. On 03/02/2025, the resident weighed 104 pounds which is a -6.14 % Loss. 3 months: On 12/07/2024, the resident weighed 119.6 lbs. On 03/02/2025, the resident weighed 104 pounds which is a -13.04 % Loss. 6 months: On 09/01/2024, the resident weighed 122.2 lbs. On 03/02/2025, the resident weighed 104 pounds which is a -14.89 % Loss. Review of progress notes showed: On 08/12/2024, Resident 14 had a 5.4% weight loss in 30 days, that the resident was declining to eat in the dining room, and there were no new orders. On 10/30/2024, Resident 14 was reviewed by the nutrition committee related to the weight loss of 5.10% over 28 days, it was acknowledged that the resident may have lost weight due to hospitalization and illness, and a house supplement was added one time daily (it was discontinued on 12/07/2024). Between 12/07/2024 and 03/10/2025 Resident 14 was not on a calorie dense supplement/house supplement. On 03/10/2025, Resident 14 was noted to have 5.8% weight loss over 30 days. Interventions at that time included encouraging to go to dining room, offering snacks, and adding back/administering Cal dense (nutritional supplement) 60 milliliters with medication pass two times a day. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 01/06/2025, Resident 14 was reviewed by the nutrition committee for weight loss of 10.7% in less than two months. It was identified Resident 14 had poor oral intake and would at times refuse food/fluids/medications. On 01/13/2025, Resident 14 was noted to have a 15.8% weight loss in the previous three months. Provider was notified and NEM was added to diet on 01/06/2025. During an observation on 03/12/2025 at 9:42 AM, Resident 14 was seen with two drinks in front of them, a water and a thin dark brown drink, presumably coffee. No milk was seen (the facilities identified NEM intervention) At 12:56 PM, Resident 14 was seen eating lunch, without milk (the facilities identified NEM intervention) On 03/13/2025 at 12:58 PM, Resident 14 was seen eating lunch, without milk (the facilities identified NEM intervention). Resident 14's tray slip said soft bite sized regular, NEM, thin liquids. The slip had standing orders of 8 oz juice and 8 oz of beverage of choice. Dislikes did not include milk. Resident 14 was observed to have the head of their bed at 30 degrees, was leaning over their left side, and was seen to drop a small amount of food on themselves and their bed. Staff N, Certified Nursing Assistant (CNA) entered and exited Resident 14's room, said it was not good for Resident 14 to have been eating in that position but did not provide assistance. Resident 14 did not eat all of their meal. On 03/14/2025 at 8:34 AM, Resident 14 was seen with a neck pillow around their neck, ate from a red bowl, did not eat anything off their plate, and did not have milk (the facilities identified NEM intervention) with their breakfast. At 8:40 AM, Resident 14 closed their eyes and stopped attempting to eat. At 9:25 AM, a CNA entered the room, attempted to wake Resident 14 up, said they were going to take their tray, and left the cup with juice. On 03/17/2025 at 1:15 PM, Resident 14 was seen with their tray slip saying NEM, with it listing juice and beverage of choice. No milk was observed (the facilities identified NEM intervention). Resident 14 did not eat their chopped-up meat or side of beans. The record showed that Resident 14 did not have weekly weights obtained; despite having the following guidelines identified in the facilities policy as indicators a resident may need weekly weights: a) Food intake declined and persisted b) Trend of weight loss c) Significant weight loss d) Significant change in condition (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a phone interview on 03/13/2025 at 2:33 PM, Staff G, Registered Dietician (RD), said Resident 14 had a significant weight loss over 30 days. Staff G said their expectation was for staff to follow the diet order with NEM, to provide Cal Dense two times a day, and that they would recommend weekly weights to catch weight loss sooner than a month away. When asked about the intervention of snacks between meals, Staff G said this was a standard for every person in the building, and under the tab to document snacks (excluding PM snack) there was no documentation. During an interview on 03/14/2025 at 9:30 AM, Staff H, CNA, said they had been working with Resident 14 since October, and that Resident 14 was not great at eating their meals, and did not eat a whole lot. Staff H, when asked about Resident 14's breakfast, said they had only eaten 0-25% of their meal, and they were unsure if Resident 14 needed an alternative as they tried to wake them, but they were hard to wake up. When asked what helps Resident 14 eat more, Staff H said sitting them up, making sure they were awake helps. When asked when Resident 14 was offered snacks, Staff H responded at around 8:00 PM. Staff H reported Resident 14 liked the chocolate flavor. At 10:59 AM, Staff I, Licensed Practical Nurse (LPN), said Resident 14 hated the Calorie Dense, and it was a vanilla flavor. Staff I went into the room to see if Resident 14 would take the Calorie Dense, Resident 14 was heard saying It's crap. Staff I asked if Resident 14 liked vanilla and was told no. Resident 14 reported they liked chocolate. At 11:16 AM, when asked about what triggered the significant change MDS assessment, Staff D, Resident Care Manager (RCM), said Resident 14 had gone to the hospital, had urinary stent (thin tube to allow flow of urine) placements, blood in the urine, significant decline requiring two person assistance, slumping over during meals, refusing to go to the dining room most of the time, and a decrease in activities of daily living. When asked how the facility was reassessing interventions for effectiveness, Staff D said, resident weights. Staff D said Resident 14 should have had weekly weights and did not. When asked about the house supplement being discontinued on 12/07/2024, if there was an intervention in place at that time, Staff D said no. Regarding the NEM diet added on 01/06/2025, when asked how the facility assessed it was effective, Staff D said if there was continued weight loss, it had failed, and they needed to come up with something else. Staff D said anytime Resident 14 came up for significant weight loss, it should have been reviewed for effectiveness. Staff D said Resident 14 had not been willing to eat a whole meal but did drink fluids well with a two-handed cup. Staff D checked with dining on if milk was on Resident 14's dislikes, and said it was not on their dislikes, and they should receive whole milk due to the NEM diet. When asked about the slip mentioning NEM but not anything about whole milk, Staff D said the CNAs usually encourage milk but the resident had the right to refuse. When asked if the facility had attempted an alternative to white milk (the resident stated they liked chocolate milk), Staff D said, not to my knowledge. Staff D said the CNAs provided Resident 14 with what they liked to drink if they would not answer. When asked if there had been a discussion of an appetite stimulant for Resident 14, Staff D said no. At 12:03 PM, when asked about NEM on the resident's tray slip, Staff J, CNA, said they did not know what it meant when the slip said NEM. When asked what they do for drinks, Staff J said they did not know and asked if that was protein shakes. At 12:08 PM, when asked about NEM, Staff H, CNA, said they were not sure what it meant. When asked about what they do for drinks, Staff H said they did not know. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 12:09 PM, Staff K, CNA, when asked about NEM, said they did not know what it was and did not know what it meant for drinks. At 12:18 PM, Staff M, Registered Nurse (RN), said they had not received training on what NEM diets were or if there were specific beverages the resident should or should not receive. At 1:16 PM, Staff L, Advance Registered Nurse Practitioner, said they had been working with Resident 14 for six months. When asked about the significant weight loss, Staff L said that most recently the facility had provided them with a fax communication of a certain percentage of weight loss and that they had added a supplement to the meal, with only the previous 30 days of weight loss discussed. After being told about the past one month, three months, and six months of weight loss numbers, Staff L said they were not aware of the prolonged weight loss. Staff L said they were not aware of any attempt to add an appetite stimulant, and they might need to look into implementing something to stimulate appetite. Staff L said their expectation was that the facility provided everything Resident 14 needed to maintain a healthy weight for life purposes, the diet promoted decreased skin breakdown, and the facility provided the nutrients needed for their diet. During an interview on 03/18/2025 at 2:04 PM, Staff B, Director of Nursing Services (DNS), said their expectation for residents with significant weight loss was that the nutrition hydration committee followed them, and the provider and registered dietician would be notified. Regarding significant weight loss, Staff B said weights should be done weekly times 4, and for Resident 14 they should have been changed back to weekly and were not. When asked about the role CNAs have with NEM diets, Staff B said the meal try slip should direct the aids to serve whole milk, which would allow them to participate in NEM without knowing what it was. When told about the observations of Resident 14 without whole milk and no mention of whole milk on the meal tray slips, Staff B said their expectation was that the meal tray slip would have said milk on it. When asked about snacks between meals and how the facility evaluated it for effectiveness, Staff B said the only documentation they could find was the bedtime snack, and Resident 14 was only receiving a bedtime snack since 11/05/2024. When asked how the facility was evaluating the effectiveness of the NEM diet added on 01/06/2025, Staff B said NEM was not happening as they were not giving the whole diet (not giving whole milk). 37044 <Resident 49> Resident 49 admitted to the facility on [DATE]. Review of the Admission MDS, dated [DATE], showed the resident had moderate cognitive impairment, diagnoses of non-Alzheimer's dementia and unspecified nausea and vomiting, required setup assistance with meals and had no known significant weight loss in the previous six months. A Nutrition/Hydration care plan, revised 02/17/2025, directed staff to encourage Resident 49 to eat 50% or more of their meal; if meal intake was 50% or less, to offer a substitute meal or supplement; and to provide diet as ordered. (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

Hospital transfer orders, dated 02/04/2025, showed Resident 49 weighed 192 lbs., was on a regular, low sodium diet, and had an orders for Ensure Plus (a liquid nutritional supplement that provides concentrated calories and protein to help gain or maintain a weight for patients with malnutrition or otherwise at nutritional risk) two times a day. One carton was to be provided with breakfast and the other with dinner.

Resident 49's weight record showed the following:

02/04/2025- 193 lbs.

02/09/2025- 189 lbs.

02/10/2025- 188 lbs.; - 5 lbs. in six days.

A Nutrition Evaluation Form, dated 02/10/2025, documented Resident 49 weighed 188 lbs., was on a regular, no added salt diet, and was independent with meals after setup. Staff G, RD, identified the residents who took diuretic medication (medication to draw fluid from body) as having the potential to cause fluctuations in weight, but documented the resident had no edema at that time. Resident 49's average meal intake was estimated to be 80% of breakfast, and 75% of the lunch and dinner. Staff G, RD, concluded that Resident 49's overall nutrition status was stable and adequate. Review of the evaluation form showed Resident 49's 02/10/2025 weight of 188 lbs. was used as the resident's baseline weight. Under Additional Weight History staff documented not applicable. The facility's 02/04/2025 admission weight of 193 lbs., which was consistent with the hospitals 02/04/2025 discharge weight of 192, was not acknowledged nor was the 5 lbs. weight loss the resident in the six days since admission. There was no information provided to indicate if the facility had provided the supplement or whether the resident had been drinking it.

Review of Resident 49's Electronic Health Record (EHR) and physicians' orders showed the Ensure Plus order had not been transcribed and/or implemented.

A progress note, dated 02/11/2025, documented Resident 49 reported being nauseas and vomiting twice. Review of the February and March 2025 MARs revealed a 02/04/2025 order for Ondansetron (anti-nausea medication) and showed it had been requested and administered on the following dates:

02/11/2025 at 3:48 PM

02/12/2025 at 8:02 AM

02/18/2025 at 3:40 PM

02/19/2025 at 9:48 AM

02/22/2025 at 11:55 AM

02/26/2025 at 11:27 AM

03/07/2025 at 10:17 AM

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/02/2025 at 11:02 AM, Resident 49's weight was 177.8 lbs. A reweigh was obtained at 2:02 PM, and was 178 lbs. This showed a significant weight loss of 7.8% in 28 days. Review of the EHR showed Resident 49 was not reviewed in the facility's 03/04/2025 weekly nutrition meeting. No documentation was present in the record to indicate facility staff had identified the significant weight loss, notified the physician or developed and implemented any nutritional interventions to address it. On 03/09/2025 at 11:04 AM, Resident 49's weight was 172 lbs. A reweigh was obtained at 2:04 PM and was 171.6 lbs. This confirmed the resident's consistent and unplanned significant weight loss, which was now at -11.09% in 34 days without identification by facility staff, or the development and implementation of nutritional interventions. A 03/10/2025 Nutrition Hydration Skin Committee Review Form, identified the reason for review as significant weight loss of greater than 5%. The sections for weight loss of 7.5% and 10% respectively, remained unchecked. The review identified the resident had consumed 51-100% of most meals over the previous seven days, and did not receive any nutritional supplements. The Interdisciplinary Team (IDT) determined the resident's current meal and fluid intake were adequate to meet the resident's needs but recommended adding NEM to Resident 49's diet. There was no evaluation of the conditions impacting the resident's intake or effectiveness of current interventions. On 03/14/2025 at 1:07 PM, Resident 49 was observed sitting up in bed, their lunch tray was on the bedside table, which was pushed away from the edge of the bed. Observation of the tray showed the pork patty, mixed vegetables, dinner roll with packet of butter, and cake were untouched. The silverware was clean and unused. There was one cup on the tray that had a few drops of red liquid remaining in it. When asked why he had not eaten anything, Resident 49 stated, I drank the juice, but I just don't have an appetite. The resident reported it was not due to the quality of the food and reiterated I just don't have an appetite. Resident 49's tray showed a NEM diet was not provided (No whole milk was on the tray, they had drank their juice and may have drank the milk) and they ate 0% of the meal. Review of the March 2025 meal monitor showed staff documented on 03/14/2025 at 12:00 PM that Resident 49 ate 51- 75% of lunch and drank 480 milliliters (ml) of fluid, despite lunch meal service for Hall 2 being at 12:30 PM, the resident only being provided one 240 ml cup of juice on their tray and not eating any of the meal. On 03/18/2025 at 7:59 AM, Staff B confirmed there was no documentation to show the facility provided the resident Ensure Plus (or a therapeutic interchange) twice a day as ordered. When asked why Resident 49 was not reviewed for significant weight loss during the facility's 03/04/2025 weekly nutrition meeting, given on 03/02/2025 the resident showed a significant weight loss of 7.8% in 28 days, Staff B, DNS, said they did not have a nutrition meeting that week because the RD was out of town, but acknowledged Resident 49 should have still been reviewed and assessed by the rest of the nutrition IDT, but was not. Staff B shared that Resident 49 was reviewed the following week by the nutrition IDT and NEM was added to their diet. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/18/2025 at 8:08 AM, when informed that observation of Resident 49's meal trays showed they were not provided NEM, and interviews showed facility staff did not know what NEM on a resident's tray car meant, or what action, if any, it called for them to do. Staff B, DNS, indicated there was a need for education and acknowledged someone from the IDT should be following up on nutritional recommendations to ensure they were fully implemented, and to assess the effectiveness. When asked if that occurred for Resident 49's nutritional interventions Staff B, DNS, said no. Surveyor: [NAME], Tnesa E. <Resident 29> Resident 29 was admitted to the facility on [DATE]. The Annual MDS dated [DATE], documented Resident 29 was severely cognitive impaired. The EHR documented Resident 29 weighed 91.6 pounds on 10/01/2024. On 02/02/2025 Resident 29 weighted 87.0 pounds and on 03/02/2025 weighed 82.2 pounds. This resulted in a -5.75 % loss in 30 days and a -10.48 % loss in six months. The EHR documented Resident 29 was prescribed a therapeutic diet on 02/14/2024 to include a regular diet, regular texture with thin liquids with NEM. Resident 29 was also prescribed a calorie dense supplement three times a day and to be offered again when Resident 29 ate less than 50% of their meal. A Nutrition Assessment, dated 02/05/2025, documented Resident 29 was maintaining weight, was to continue a regular diet, regular texture with thin liquids with NEM and had no concerns at the time of the assessment. On 03/13/2025 at 12:07 PM, observations of Resident 29's meal card documented resident was on a regular diet with think liquids and beverage of choice was whole milk and resident did not have any dislike. Meal ticket did not document NEM diet. At 12:25 PM, Resident 29 was observed wheeling themselves away from the table and out of the dining room. No staff approached Resident 29 or offered an alternative meal or supplement. Resident had only eaten a few bites of beef tips (more than 75 % still on plate), 2-3 spiral noodles were eaten (more than 75% still on plate), all the vegetables were still on the plate, the dinner roll had been eaten and all the juice in the cup had been drank. No milk was on the table. No NEM diet was provided or documented on meal card. At 12:26 PM, when asked what should happen when a resident ate less than 50% of their meal, Staff P, CNA, said they should be offering the resident an alternative meal or supplements. Staff P said per Resident 29's Power of Attorney, they had been directed not to offer Resident 29 an alternative or supplement meal. They had provided Resident 29 with two peach yogurts prior to lunch. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/14/2025 at 11:00 AM, Collateral contact 1, Resident 29's POA, was sitting in the lobby with Resident 29. Collateral contact 1 said a while back Resident 29 was having difficulty eating and the facility was in the process of conducting a nutritional assessment with Resident 29. Collateral contact 1 said they told the facility not to offer Resident 29 extra food during the assessment period because they wanted a accurate assessment on Resident 29's ability to swallow. Collateral contact 1 said they wanted Resident 29 to be offered alternative food, if Resident 29 was eating less than 50% of the meal. Collateral contact 1 said she would expect the staff to help Resident 29 choose food that was soft and easy for Resident 29 to chew, due to swallowing difficulties. Collaterals contact 1 said they facility should be cutting up large portions foods too. When observations of Resident 29's meal for March 13 and 17 were explained, including no NEM, Collateral contact 1 said they did not know Resident 29 was on an NEM diet. Collateral contact 1 asked how much Resident 29 weighed. When February and March's weights were provided, Collateral contact 1 said no one had notified them that Resident 29 had lost weight. On 03/17/2025 at 12:13 PM, observations of Resident 29's meal card documented resident was on a regular diet with think liquids and beverage of choice was whole milk and resident did not have any dislike. At 12;19 PM, Resident 29 was observed wheeling themselves away from the table and out of the dining room. No staff approached Resident 29 or offered an alternative meal or supplement. Resident had only eaten half the bowl of soup with crackers, 1/4 of the ham and cheese sandwich, two bites of dessert and 90% of her juice. Left on the plate included 3/4 of the sandwich, half cup or sop with crackers, a full unopened bag of chips and a full salad cup. No NEM diet was provided or documented on meal card. A Nutrition-Meal Monitor Follow Up Question Report, dated 03/01/2025-03/17/2025, documented on 03/13/2025 at 1:04 PM, Resident 29 ate between 0-25% of the meal, no alternative meal/supplement was provided. On 03/17/2025 at 1:37 PM, documented Response Not Required. Documentation showed no alternatives meals were offered for March 13th and 17th. A phone interview was completed on 03/13/2025 at 2:33 PM, with Staff G, RD. When asked about Resident 29's diet, Staff G said Resident 29's weight had been in the 80-90's for the last year and Resident 29 had just recently triggered for weight loss and they did not know if it had been struck out (meaning determined to be a false weight). Staff G said Resident 29 was on a regular, regular diet with thin liquids and NEM. Resident 29 was also receiving a calorie supplement. When observation of no NEM diet was reported and no documentation on the meal card of NEM diet, Staff G said Resident 29 should have received the NEM diet and the meal card should reflect the correct diet type to include NEM. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/17/2025 at 2:38 PM, Staff D, RCM, with Staff C, RCM, present, said the process for when a resident has been identified as losing weight included bringing the concerns to the weekly nutrition meeting. Staff, including the Registered Dietitain, would make recommendations, review current interventions and complete a new assessment for the resident. Staff C said it also included notifying the family and provider of the resident's weight loss. When asked about Resident 29's weight loss, Staff D said Resident 29 was not triggered for weight loss. Staff D was shown Resident 29's weight loss calculations, Staff D said they were not aware Resident 29 had lost weight. Staff D confirmed there were no progress notes or current evaluations completed for Resident 29's weight loss. Staff D said Resident 29 was on regular diet with thin liquids with NEM. Staff D said staff should be offering Resident 29 an alternative meal or supplements if the resident ate less than 50% of the meal. Staff D said it was the responsibility of the RCMs to ensure residents received the correct diet that matched the meal card. March 13th and 17th observations were explained about no NEM diet on meal card and no staff had offered Resident 29 an alternative meal. Staff D said it was the expectation that residents received the correct diet, and staff would offer an alternative meal. On 03/18/2025 at 12:53 PM, when asked about Resident 29's weight loss, Staff B, DNS, with Staff E, Divisional Director/Regional RN present, said they were aware Resident 29 had lost some weight over the past year and had been trending down recently. Staff B said Resident 29 was on a regular, regular diet with thin liquids and NEM. Staff B said the NEM diet should have been documented on the meal card. Staff B said they provided documentation of Resident 29 being offered alternative meal, the Nutrition-Meal Monitor Follow Up Question Report. When asked about the observations that no staff had offered an alternative meal to Resident 29, Staff B said an alternative meal was offered, surveyor just didn't observe it. Reference WAC 388-97 -1060 (3)(h) 46793

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to administer oxygen (O2) in accordance with physicians' orders, to monitor and replace humidifier bottles when empty, and to ensure O2 concentrator filters (used to protect the resident from inhaling dust and particulate matter) were routinely cleaned and maintained for 3 of 3 residents (Residents 51, 38 & 32) reviewed for respiratory care. These failures placed residents at risk for respiratory compromise, dry nares and other negative healthcare outcomes. Findings included . 1) Resident 51 admitted to the facility on [DATE]. Review of the electronic health record (EHR) showed a 01/14/2025 order for O2 at two liters per minute (2L/min) via nasal canula (NC) to keep oxygen saturation (SpO2) greater than 90%. On 03/10/2025 at 11:19 AM, Resident 51 was in bed receiving O2 at 2L/min via NC. Observation of the O2 concentrator showed the external filter was covered with light grey stringy debris, and the humidifier bottle was undated and empty. On 03/10/2025 at 3:34 PM, Resident 51 was up in their wheelchair receiving O2 at 3L/min from a portable liquid O2 tank attached to the back of the wheelchair. On 03/11/2025 at 10:53 AM, Resident 51 was not in their room, but observation of the O2 concentrator showed the filter was still covered with debris and the empty undated humidifier bottle was still in place. Review of Resident 51's physicians' orders and March 2025 Medication Administration Record (MAR) showed there was no order for, or direction to, check or replace the humidifier bottle or to clean the O2 concentrator external filter On 03/11/2025 at 2:51 PM, Staff C, Resident Care Manager (RCM), confirmed Resident 51's humidifier bottle was empty and the external filter was covered with light grey stringy debris. Staff C said the nurse was expected to observe the O2 rate to validate it was at ordered L/min and observe the humidifier bottle as part of their assessment during daily interaction, and replace it as needed but acknowledged that had not occurred. When asked who was responsible for cleaning or replacing the external filter on the O2 concentrator Staff C said they didn't know. 2) Resident 32 admitted to the facility on [DATE]. Review of the EHR showed a 01/30/2025 order for O2 at 2-3L/min via NC to keep SpO2 greater than 92%. On 03/11/2025 at 2:27 PM, Resident 32 was in bed receiving O2 at 2L/min via NC. Observation of the O2 concentrator showed the humidifier bottle was empty and undated, and the external filter heavily matted with grey debris. Review of Resident 32's physicians' orders and March 2025 MAR showed there was no order for, or direction to, check/replace the humidifier bottle or to clean the O2 concentrator external filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/11/2025 at 2:30 PM, Staff O, Licensed Practical Nurse, confirmed Resident 32's humidifier bottle was empty. When asked to describe the external filter on the O2 concentrator Staff O said, Dirty. Then stated, I didn't even know that was there. I don't know who is supposed to clean it. I don't think we (nurses) do that. Staff R, Registered Nurse, also indicated they did not think nursing was responsible for cleaning the external filter on the O2 concentrator. 3) Resident 38 admitted to the facility on [DATE]. Review of the EHR showed a 11/06/2024 order for O2 at 0-5 L/min to keep SpO2 greater than 92%. If receiving 3L/min or greater contact the provider. On 03/10/2025 at 2:32 PM and 03/11/2025 at 11:41 AM, Resident 38 was lying in bed receiving O2 at 2L/min via NC. Observation of the O2 concentrator showed the humidifier bottle was empty and undated. Review of Resident 38's physicians' orders and March 2025 MAR showed there was no order for, or direction to, check/replace the humidifier bottle. On 03/11/2025 at 2:45 PM, Staff C, RCM, confirmed the humidifier bottle was empty and needed to be replaced. On 03/14/2025 at 3:20 PM, Staff B, Director of Nursing, said staff should be cleaning the O2 concentrator external filters weekly and as needed. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to consistently document pre and post dialysis (a treatment to filter wastes and water from the blood) assessments and medications received, by making sure there was consistent ongoing follow-up with the dialysis center regarding the dialysis care and services for 1 of 1 sampled resident (Resident 163) reviewed for dialysis. This failure placed the resident at risk for unmet care needs and medical complications. Findings included . Resident 163 was admitted to the facility on [DATE] with a diagnosis of end stage renal disease (when the kidneys have deteriorated to the point where they can no longer perform their essential functions) and dependence on renal dialysis. The Admission Minimum Data Set (a required assessment tool), dated 03/09/2025, showed Resident 163 was moderately cognitively impaired and received hemodialysis. A review of Resident 163's Electronic Medical Record (EMR) showed an order, dated 03/03/2025, that said dialysis days were on Monday, Wednesday and Friday with the pickup time at 11-11:30 AM and the return time of 4:20-4:50 PM. The dialysis location was [NAME] Dialysis Center which was located at 1930 Olympic Highway N, [NAME], 98584. A review of the dialysis contract, dated 04/03/2006, listed an agreement with [NAME] Dialysis Center, located at 1872 North 13th street [NAME], WA 98584. On 03/17/2025 at 11:23 AM, Staff A, Administrator acknowledged the contract provided was dated 2006 and it did not contain the name or address listed in Resident 163's orders. Staff A said the contracting office was currently working on getting a new contract for Davita Dialysis. On 03/18/2025 at 12:55 PM, Staff A provided a nursing home dialysis transfer agreement, signed by Total Renal Care Incorporated on 03/18/2025, and listed [NAME] County Dialysis care of Davita Incorporated at 1930 Olympic Highway N [NAME], WA 98584. A review of Resident 163's EMR showed an order, dated 03/08/2025, that documented to send 2:00 PM midodrine (a medication used to treat low blood pressure) dose with resident to dialysis every Monday, Wednesday and Friday for hypotension (a medical condition characterized by abnormally low blood pressure) to be administered by dialysis. An order, dated 03/03/2025, said Ceftazidime (a medication used to treat bacterial infections in many different parts of the body) intravenously (into or by means of a vein) every Monday and Wednesday to be given at Dialysis. A review of Resident 163's EMR showed Pre-Dialysis Evaluations on 03/06/2025, 03/07/2025, and 03/12/2025 and a Post-Dialysis Evaluation dated 03/12/2025. The EHR also showed notes from Davita dated 03/07/2025 with documentation that stated no showers and midodrine given. A review of Resident 163's EMR also showed a progress note dated 03/10/2025 at 1:50 PM that documented, Resident out of facility for Dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/2025 at 10:19 AM, Staff C, Resident Care Manager (RCM)/Registered Nurse said they did not see pre-dialysis documentation for 03/10/2025 and said there should have been because they found a progress note stating the resident went to dialysis that day. When Staff C was asked what no showers means, they said I don't know. I will have to call and find out. At 11:11 AM, Staff C said they called Davita Dialysis this day and no showers means no showers on the days of dialysis and they would update the care plan with this information and change the showers days from Wednesday. At 1:27 PM, Staff C said the information from dialysis, regarding showers and medication, was not clarified on the 7th. Staff C said the information should have been reviewed by nurse management when it was noticed. On 03/17/2025 at 1:33 PM, Staff C said Resident 163 should take a form with them to dialysis and they should get information back from the dialysis center. The information received should be looked at by the nurse and if there was something for the doctor, the doctor should be notified. When asked if Resident 163 received their Ceftazidime and midodrine at dialysis, Staff C said, we only know [Resident 163] received midodrine on the 7th. Staff C said the floor nurse was not following up with Davita when Resident 163 returned from dialysis. Staff C said they had contacted Davita, requesting information on the medications Resident 163 received while at dialysis, so they would have it for their records. On 03/17/2025 at 2:17 PM, Staff B, Director of Nursing Services, said they did not see a pre-dialysis evaluation for the 10th and it should have been completed by the nurse. Staff B said they did not see any documentation that the resident received medications at dialysis except on the 7th. Staff B said they did not know if Resident 163 received Ceftazidime when it was ordered to be received at dialysis. Staff B said the expectation was Resident 163 would have a list of what occurred at dialysis and that we would communicate with them, and they would communicate with us. Staff B said the RCM was calling to get that information. Reference WAC 388-97-1900 (1), (6)(a-c)

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Shelton Health & Rehab Center	153 Johns Court Shelton, WA 98584

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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 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

50392

Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent, when 15 of 32 medication administration opportunities resulted in a 46.88% error rate due to late administration and omitting administration for 3 of 4 sampled residents (Residents 6, 12, and 57) reviewed for medication administration. These failures placed residents at risk for ineffective treatment of underlying medical conditions and/or adverse side effects, and other potential negative outcomes.

Findings included .

The facility policy, titled Medication Administration General Guidelines, dated 01/23, documented, medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes.

<Resident 6, late medications>

On 03/11/2025 at 11:34 AM, Staff R, Registered Nurse (RN), was observed preparing and then performing a medication pass for Resident 6. Review of the physician's orders (which included medications scheduled times) for Resident 6 showed the following medications were given later than 60 minutes after their scheduled time:

Polyethylene Glycol (constipation medication), scheduled at 8:00 AM

Duloxetine (antidepressant, prescribed to Resident 6 for chronic pain), scheduled at 8:00 AM

Meloxicam (pain medication), scheduled at 9:00 AM

Doxycycline (antibiotic), scheduled at 8:00 AM

Loratadine (allergy medication), scheduled at 9:00 AM

<Resident 12, late medications>

On 03/11/2025 at 11:46 AM, Staff R, RN, was observed preparing and then performing a medication pass for Resident 12. Review of the physician's orders (which included medications scheduled times) for Resident 12 showed the following medications were given later than 60 minutes after their scheduled time:

Famotidine (acid reflux [when stomach acid flows into the food pipe irritating the lining] medication), scheduled at 7:30 AM

Metoprolol (medication to treat Resident 12's Atrial Fibrillation, a heart condition) scheduled at 8:00 AM

Vitamin D3 (a supplement), scheduled at 8:00 AM

(continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Eliquis (a blood thinner to prevent blood clots), scheduled at 8:00 AM Gabapentin (pain medication), scheduled at 8:00 AM Glipizide (used to treat high blood sugar), scheduled at 8:00 AM Novolin N (used to treat high blood sugar), scheduled at 8:00 AM Potassium Chloride (prescribed to remove excess fluids for resident 12), scheduled at 8:00 AM Torsemide (removes excess fluid), scheduled at 8:00 AM On 03/13/2025 at 2:57 PM, Staff B, Director of Nursing Services (DNS), said medications should be administered either one hour before or one hour after the scheduled administration time. At 3:18 PM, Staff B, DNS, when reviewing Resident 6 and Resident 12's late medication administrations, said this did not meet expectations, medications should be administered 1 hour on either side of the medication due time. <Resident 57, omitted medication> On 03/12/2025, at 9:13 AM, Staff S, Licensed Practical Nurse, was observed preparing medications for medication pass for Resident 57. Review or resident 57's orders showed Breo Ellipta Inhalation Aerosol Powder (Breo Ellipta, a medication to treat asthma, a lung condition) was due daily. Staff S looked in the medication drawer for the medication Breo Ellipta and was unable to locate it. Staff S said, we must be out of it. Review of Resident 57's Medication Administration Record (MAR) for 03/10/2025, 03/11/2025 and 03/12/2025 showed Breo Ellipta was not administered on those days and the code for On Order from Pharmacy (OO) was chosen as the reason the medication was not given. On 03/12/2025 at 12:27 PM, Staff C, Resident Care Manager, acknowledged that Breo Ellipta had not been administered on 3/10/2025, 03/11/2025 and 03/12/2025, and could not provide documentation the pharmacy had been contacted, or the provider had been notified regarding the unavailable medication. Reference WAC 388-97-1060 (3)(k)(ii) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50392 Based on observation and interview, the facility failed to ensure medications were secured in a locked storage area and inaccessible to unauthorized staff and residents, for 1 of 2 medication carts (Team 3 Med Cart) observed for medication cart review and 1 of 4 residents (Resident 12) observed for medication administration. These failures placed residents at risk for unauthorized access to medications, medical complications, and a diminished quality of life. Findings included . <Medication Cart> On 03/11/2025 at 11:09 AM, an observation of a medication cart, Team 3 Med cart, near the nursing station showed that a bottle of MiraLAX (Constipation medication) and a white pill in an unlabled medication cup were left unattended on the medication cart. At 11:18 AM, Staff R, Registered Nurse (RN), regarding the MiraLAX bottle left on top of medication cart, said that because the cart was in their station they leave the MiraLAX bottle out while using it. Regarding the white pill in the medication cup, Staff R said they had pulled the pill out earlier because it was due for the next patient, and left it on top of the medication cart while taking care of someone else. Staff R said the pill should have been put in the medication cart and labeled. On 03/12/2025 at 9:29 AM, the Team 3 Medication cart was observed with a pill on the cart in an unlabeled medication cup. Staff S, Licensed Practical Nurse, was observed to come out of a resident room, took the pill, and emptied it into the sharp's container. At 12:50 AM, the Team 3 Medication cart was observed with an insulin pen on the cart without staff attendance. On 03/17/2025 at 1:09 PM, Staff D, Resident Care Manager (RCM), said their expectation for medication storage when a licensed nurse (LN) leaves the medication cart was that the cart was locked and medications should not be left on the cart. When informed of the observations of the unmarked pills and MiraLAX left on the cart, Staff D said it did not meet expectations. On 03/17/2025 at 4:39 PM, Staff B, Director of Nursing Services, when asked their expectation for LNs storing medications when away from the cart, said the medication should be locked inside the cart. When informed of the observations of the unmarked pills, MiraLAX, and insulin pen left on the cart, Staff B said it did not meet expectations. <Bedside> On 03/11/2025 at 11:56 AM, an observation of medication administration showed Staff R, RN, placed an insulin pen on Resident 12's bedside table and then left the room, leaving the medication at bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/2025 at 12:27 PM, Staff C, RCM, said that medications were not supposed to be left at the bedside. Reference WAC 388-97-1300(2) 50945

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview, and record review, the facility failed to ensure residents' records were complete, accurate, and/or accessible, for 3 of 23 sampled residents (Resident 60, 35 & 13) reviewed for accurate and complete medical records. Failure to maintain complete and accurate medical records placed residents at risk for medical complications, unmet care needs, and for diminished quality of life. Findings included . 1) Resident 60 was admitted to the facility on [DATE] and died in the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated [DATE], documented Resident 60 was moderately cognitively impaired and was dependent on staff with all activities of daily living (ADL's). A progress note, dated [DATE], documented Resident 60 was participating in the restorative program with goals to roll, hold and participate in self-cleaning. Resident 60 said he was fine with this program. A progress note, service date [DATE], documented Resident 60 was seen by a provider, for nausea and vomiting. Resident 60 died on [DATE]. The progress note was completed on [DATE]. No other documentation was found in the Electronic Health Record (EHR), regarding Resident 60's death. On [DATE] at 2:38 PM, Staff C, Resident Care Manager (RCM), with Staff D, RCM, present, reviewed Resident 60's EHR and said they saw nothing in the chart regarding documentation related to the Resident 60's death. Staff C said it was the expectation there should have been documentation leading up to Resident 60's death, and documentation of notification to the family and provider. On [DATE] at 12:53 PM Staff B, Director of Nursing Services (DNS), with Staff E, Divisional Director/Regional Registered Nurse (RN), present, said they were aware of the concern regarding no documentation for Resident 60's death. Staff B said there should have been documentation. 42960 2) Resident 35 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 35 was severely cognitively impaired and needed set up assistance for being independent with ADLs. A review of the EHR showed a progress note, dated [DATE] at 7:35 PM, documented Resident 35 was taken to the hospital. There were no other progress notes that documented when Resident 35 returned to the facility from the hospital. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:47 PM, Staff C, RCM/RN, confirmed Resident 35 was sent to the hospital on [DATE] and he said they returned to the facility on [DATE]. Staff C said he did not see a progress note in the EHR and he had to look at the census to see when Resident 35 returned to the facility from the hospital. Staff C said his expectation was for staff to write a progress note when a resident came back from the hospital. At 2:30 PM, Staff B, DNS, said there was not a nursing note from when Resident 35 came back to the facility, and her expectation was that the nursing staff documented when a resident came back to the facility and what occurred at the hospital, including any new diagnoses and orders. 50945 3) Resident 13 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed Resident 13 was severely cognitively impaired and was dependent on staff for cares. Review of the EHR showed Resident 13 had a stage 2 pressure ulcer on the sacrum (bones at the base of the spine, just above the tailbone) on [DATE], which was resolved on [DATE]. The next full skin assessment was done on [DATE], documenting Resident 13 had a stage 2 pressure ulcer on the coccyx (tailbone). Following that assessment in September, October, November, and [DATE], there were only weekly assessments, saying yes or no to new skin impairment, but no skin assessments to show if the facility was monitoring the documented pressure ulcer. Review of the Quarterly MDSs from [DATE] and [DATE], showed Resident 13 had no pressure ulcers. During an interview on [DATE] at 12:45 PM, Staff AA, MDS Nurse, regarding the [DATE] skin assessment, said there was no stage for the description in the assessment. When asked if the [DATE] MDS used the same skin assessment from [DATE], Staff AA said there was a skin assessment on [DATE] and none until [DATE], and to them this meant there were no skin issues at that time. During an interview on [DATE] at 3:00 PM, Staff B, DNS, said the [DATE] skin assessment was completed by a licensed practical nurse (LPN) and not an RN, and the staff should not have staged it as a stage 2 pressure ulcer. Staff B said the staging was due to a lack of knowledge and only an RN could stage the pressure ulcer. Staff B said that Staff AA was a LPN and should have clarified the [DATE] assessment with an RN to confirm it was not a level 2 pressure ulcer. Reference WAC [DATE] (1)(a)(i-iv)(b)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50945 Based on interview and record review, the facility failed to ensure the facility's binding arbitration agreements (legal document that required the use of a third party to resolve disputes) were reviewed in a manner that explicitly informed the resident or their representative of their right not to sign the binding arbitration agreement and/or to explain what a binding arbitration agreement was in a manner they could understand, for 3 of 3 sampled residents (Residents 32, 51, & 54) reviewed for binding arbitration agreements. This failure placed residents at risk for legal complications and a diminished quality of life. Findings included . 1) Resident 32 was admitted to the facility on [DATE]. During an interview on 03/12/2025 at 9:31 AM, Resident 32 when asked if they understood they were giving up their right to litigation in a court proceeding, said no. When asked if they were told the facility could not require them to enter into an arbitration agreement to be admitted or remain at the facility, said they thought they were told they had to sign it to be admitted . At the end of the interview, Resident 32 said, Are you telling me I can't go to court? I don't like that. 2) Resident 51 was admitted to the facility on [DATE]. During an interview on 03/12/2025 at 12:40 PM, Resident 51 said they did not remember signing the arbitration agreement and did not know what it was. Resident 51 said if a dispute came up, they would just leave the facility. When asked if they were told the facility could not require them to enter into an arbitration agreement in order to be admitted or remain at the facility, said no. When asked if they were told they had the right to terminate or withdraw from the agreement within 30 days of signing, said no. 3) Resident 54 was admitted to the facility on [DATE]. Resident 54 had a Power of Attorney (POA). During an interview on 03/18/2025 at 2:44 PM, Collateral Contact 2, POA for Resident 54, said they were distressed when Resident 54 was admitted (for hospice, end of life care), reviewed a lot of paperwork with admission, and they were not aware of what they were signing. Collateral Contact 2 said when Resident 54 came to the facility, they had just been given a diagnosis of just 6 months to live. Collateral Contact 2 said they did not realize they did not have to sign the arbitration agreement or that they could rescind (cancel) the agreement within 30 days, did not understand the scope of what the agreement encompassed, and did not realize the arbitration agreement expanded past discharge and into any future admissions. Collateral Contact 2 said they would not sign this agreement now that they knew that if Resident 54 was discharged and came back the agreement would still be in place. They said if they came back, they considered that a whole new admission (with different circumstances), and they would like the right to either sign it or say no at that point of time. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/18/2025 at 3:51 PM, Staff V, Admissions, said that arbitration agreements were gone over during admission agreement paperwork, within 72 hours of admission. When asked how the facility ensures the resident's physical condition and/or their cognitive status may contribute to understanding the agreement, including their ability to make an informed and appropriate decision, said that was determined by nursing or the hospital before they would go to the resident with the agreement. When asked how they knew the POA was cognitively able to understand, said if the paperwork said they were POA they went by that. When asked about readmissions, Staff V said that for readmissions, the residents or representatives were asked to sign a readmission form that reinstated the previous agreement. When asked for clarification, Staff V said they provided the residents or representatives with a whole new packet, told them they were signing the readmission packet and reagreeing to the original paperwork. When asked if they re-review the binding arbitration paperwork (as there would be a new date and signature on the agreement), Staff V said no, they did not specifically ask if the resident or representative wanted to agree or decline the arbitration agreement again, and they only went over the form that lists everything the resident or representative agreed to before. When asked what if the resident or representative did not remember signing the binding arbitration agreement or what it was, Staff V said that would be an assumption they would be making. During an interview on 03/19/2025 at 10:24 AM, Staff A, Administrator, said their expectation regarding binding arbitrations was for residents or their representatives to be fully aware of what they are signing, that they knew it was optional and not required, and they would know they had 30 days to rescind the agreement. 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** 37044 50945 Based on observation, interview and record review, the facility failed to operationalize an effective Infection Prevention and Control Program (IPCP) in accordance with facility policy, state, federal and or local infection control guidelines, regulations and practices when the facility failed to follow standard precautions (common sense practices to prevent the spread of infection in healthcare), enhanced barrier precautions (EBP, a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) and transmission based precautions used when someone has confirmed or suspected infections) for 3 of 5 (Residents 13, 14, & 12) reviewed for infection control. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications and a decreased quality of life. Findings include . <Resident 13> Resident 13 was admitted to the facility on [DATE]. Review of the Significant Change Minimum Data Set (MDS/an assessment tool), dated 02/21/2025, showed Resident 13 was severely cognitively impaired and was dependent on staff for cares. During an observation on 03/13/2025, Staff Y, CNA (certified nursing assistant), with another CNA, cleaned Resident 13 who had a liquid bowel movement. Gloves were not changed, and hand hygiene did not occur before cleaning the urinary catheter tubing. During an observation on 03/17/2025 at 2:53 PM, Resident 13 had EBP signage outside of their room, due to the resident having pressure ulcers and a urinary catheter. Staff M, Registered Nurse, and Staff Z, CNA, entered Resident 13's room without gowns. After Staff M took off the prior dressing from Resident 13's coccyx (tailbone) region, they took off and put on new gloves without hand hygiene between. Staff Z was seen with Resident 13's gown pressing against their clothing (was not wearing a staff gown), as Staff Z was holding Resident 13 on their side. Staff Z, with the same gloves as when they entered the room, removed Resident 13's brief, put a new brief on, and then was observed to hold the urinary catheter (the section right before it inserts into the penis) with gloved fingers (contaminated), while their other hand used the wipe to clean the rest of the tubing. Staff Z, with the same gloves, then helped to reposition the resident. Afterwards, Staff Z was then observed to take off their gloves and wash their hands. Staff M at this time (had just helped reposition the resident) also took off their gloves, did not perform hand hygiene, and then put new gloves on. Staff M started to examine the left heel, took off the padded heel protector and then removed the wrap and gauze. Staff M left the heel, now exposed, go back into the padded heel protector (not clean, had a prior drainage stain on it) as they left the room to get more gauze. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff Z was observed to touch the resident's sheets with their bare hands, the bed positioning remote, the call light, took trash and put on the resident's wheelchair. Then without hand hygiene, took gloves from the glove box. Staff M and Z then lifted Resident 13's left heel for wound care. Afterwards, Staff M was observed to take off gloves, did not perform hand hygiene or put on new gloves. They then performed wound care on Resident 13's right heel. After, Staff M then touched trash and put in trash can, grabbed a pillow and placed under Resident 13's legs, took off their gloves, touched their scrub bottoms, took scissors and put them in their scrub bottoms, and then went to the sink to wash their hands. Staff M was then observed with bare hands to take out the trash in the room. Then grabbed wound cleanser, put back on the bedside tray, took out a new black trash bag for lining the trash can, put wipes in the resident's drawer, and took the wound cleanser (contaminated) and put in the treatment cart outside of the room. During an interview on 03/17/2025 at 4:32 PM, Staff B, Director of Nursing Sservices, said their expectation for an EBP room, was that staff for direct care would gown and glove if touching a resident or linen. Staff B said it did not meet expectations staff did not wear gowns for wound or catheter care for Resident 13. When asked if it met expectations that hand hygiene was not done with every glove change, Staff B said no. Regarding the heel having the wrapping taken off and the heel put into the padded heel protector, said this did not meet expectations and that the wound should have been covered or had a barrier to keep it clean. Regarding the wound cleanser, Staff B said the wound cleanser should have been left in the resident's room. Regarding urinary catheter care, Staff B said hand hygiene and new gloves should have happened. 42960 <Resident 14> On 03/10/2025 at 12:13 PM, Staff U delivered a lunch tray to Resident 4's room. Resident 4 had a sign outside their door that notified staff they were on contact precautions. Staff U was not wearing PPE, a gown or gloves, when she entered the room. Staff U touched Resident 4's water pitcher and cut up their food. Staff D, RCM/LPN walked by Resident 4's room and saw Staff U in Resident 4's room without PPE on. Staff D said to Staff U you did not gown up. Staff D told Staff U to wash her hands using soap and water. Staff U immediately washed her hands using soap and water and put on PPE, a gown and gloves. 50392 <Resident 12> Resident 12 admitted to the facility on [DATE]. According to the Quarterly Minimum Data Set, (MDS, an assessment tool), dated 02/19/2025, Resident 12 was cognitively intact. Review of Resident 12's medication orders showed an order for Novolin N FlexPen, with 2 units to be subcutaneously (fatty tissue layer) injected two times a day. On 03/11/2025 at 11:56 AM, Staff R, Registered Nurse, was observed performing Resident 12's insulin injection. Staff R opened an alcohol wipe, wiped resident 12's right upper arm, and injected the insulin. Staff R did not don (put on) gloves for the insulin injection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:20 PM, Staff R, when asked about not wearing gloves for Resident 12's insulin injection said, I wash my hands regularly, so I have never known there to be a reason to wear gloves for an injection of any kind. On 03/12/2025 at 12:27 PM, Staff C, Resident Care Manager, said the observation of staff not wearing gloves for an insulin injection did not meet his expectations. On 03/13/2025 at 2:57 PM, Staff B, Director of Nursing Services, said that her expectation is that staff put on gloves for insulin administration. Reference WAC 388-97-1320 (1)(c), (2)(b)