STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505509	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Veterans Home	222 East Fifth Spokane, WA 99202

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 37544 Based on interview and record review, the facility failed to promote and facilitate resident self-determination by honoring resident choices and/or refusals for 1 of 3 sampled residents (Resident 94), reviewed for choices. This failure placed residents at risk of being unable to exercise their rights, not having their choices honored, and a diminished quality of life. Findings included . According to the 02/02/2025 admission assessment, Resident 94 was cognitively intact and able to clearly verbalize their needs. Review of provider orders showed an active 01/27/2025 order for Resident 94 to utilize a wheelchair (WC) and bed position change alarms to alert staff for the need of assistance. The order instructed staff to remove the alarm if signs of distress were observed and report to the Resident Care Manager (RCM) so the position change alarm could be removed from the care plan as needed. Review of the 01/27/2025 risk for fall care plan showed Resident 94 utilized a fall mat on the right side of the bed, automatic locking WC brakes, a scoop mattress (mattress with defined lip or raised edges), the bed in the lowest position, and bed/WC position change alarms to alert staff when Resident 94 attempted to self-transfer. Review of the 01/27/2025 informed consent for safety/assistive devices showed the position change alarm consent was signed by Resident 94's representative. Review of the 01/28/2025 consent for device form showed Resident 94 utilized a bed alarm for notification of position changes to alert staff to provide assistance. Device use was discussed with Resident 94 and their representative. Review of January 2025 through February 2025 nursing progress notes showed on 02/13/2025, Resident 94 removed the position change alarm from their bed, tore the wire in half and stated, I don't want this on my bed. On 02/21/2025, Resident 94 was awake throughout the night, sat up on the edge of the bed, broke the bed alarm pad when beeping, and staff replaced the alarm pad. The notes further showed staff continued to utilize the bed position change alarm after Resident 94's documented refusals. (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 03/17/2025 at 8:51 AM showed Resident 94 had a white position change alarm pad on their bed. Similar observations were made at 10:32 AM and on 03/18/2025 at 2:12 PM. In an interview on 03/25/2025 at 9:06 AM, Staff P, Nursing Assistant, stated a resident's care plan would inform staff what care needs a resident required. Staff P acknowledged Resident 94 utilized position change alarms in their bed and WC. Staff P further stated if they were aware a resident refused to use a position change alarm, they would notify the RCM. In an interview on 03/24/2025 at 2:19 PM, Staff W, Licensed Practical Nurse, stated they were unsure what the facility process was if or when a resident with dementia refused a position change alarm and would need to refer to the RCM for guidance. In an interview on 03/25/2025 at 9:21 AM, Staff F, RCM, stated they would assess a resident if a bed/WC alarm was causing distress to determine what choices could be implemented and to remove the alarm per resident wishes. Staff F explained resident progress notes were reviewed by nurse managers and discussed in the morning meeting. Staff F reviewed Resident 94's medical record. Staff F acknowledged Resident 94 refused the bed position bed alarm on 02/13/2024 and 02/21/2025. Reference WAC 388-97-0900 (1)-(4)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on interview and record review, the facility failed to address required documentation for advance directives for 1 of 4 sampled residents (Resident 49) reviewed for Advance Directives. This failure placed the resident at risk of losing their right to have their preferences/decisions regarding end-of-life care followed. Findings included . Review of a 02/10/2025 assessment showed Resident 49 admitted to the facility on [DATE]. This assessment showed the staff identified Resident 49 had moderately impaired cognition and, along with the family and significant other, participated in the assessment and goal setting of care. Review of a 09/28/2023 facility admission agreement showed it was signed by Resident 49 and a staff. Under the subject of Power of Attorney, Yes and No questions were asked to help the facility identify if the resident had a healthcare Power of Attorney (POA), advance directives, if copy of the advance directives were provided to the facility, and if they desired information and required assistance in obtaining documents to formulate advance directives. None of the questions were answered and handwritten next to them were the words, [Resident] doesn't know. Similar findings were identified in a 03/05/2024 facility admission agreement, also signed by Resident 49 and a staff, where none of the questions were answered and handwritten next to the questions were the words, [Resident] doesn't remember. Will forward to Social Services. Review of the progress notes and care plan showed no documentation the facility ascertained the status of Resident 49's Advance Directives wishes. The above findings were shared with Staff C, Social Services Director, on 03/19/25 at 10:37 AM. Staff C acknowledged the lack of closure to Resident 49's advance directives status. In a follow-up interview at 12:36 PM, Staff C stated they had not found anywhere where the advance directives status for Resident 49 had followed up on. Staff C stated they never had POA paperwork, but had offered the information to Resident 49's spouse that day, 03/19/2025, and had documented it. Staff C acknowledged the facility should have but did not ensure follow-up of advance directives status at either instance. Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b), (3)(a-c).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42802 Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, safe and homelike environment for 3 of 4 sampled residents (Resident 92, 58 and 35), reviewed for environment. Specifically, Resident 92's wall in their room was in disrepair and had a screw that protruded out of the wall, and Resident 58 and 32's walls were in disrepair. These failures placed all residents at risk for avoidable injuries and a diminished quality of life. Findings included . <Resident 35> An observation on 03/18/2025 at 9:09 AM showed an approximately 2 feet by 2 feet section of peeled, scraped paint on the wall, right next to the Resident 35's bed. The curved paint scrapes appeared to be from the bed's upper rail scraping the wall, when it was swung up or down. Similar observations of the wall damage were made on 03/19/2025 at 2:06 PM, 03/20/2025 at 2:58 PM and 03/24/2025 at 9:45 AM. On these subsequent observations, a cloth band-aide was observed stuck to the wall, over one of the gouges. <Resident 58> An observation on 03/18/2025 at 9:43 AM showed gouges in the wall next to the Resident 58's bed. Some of the gouges were deep into the drywall, where the bed and upper rail scraped it and around the wall box for the call light. The wall had dark gray paint, and the chalky white drywall exposed by the gouges were quite noticeable. Similar observations of the wall damage were made on 03/19/2025 at 2:04 PM, 03/20/2025 at 8:50 AM, 03/24/2025 at 9:46 AM, and 03/25/2025 at 9:12 AM. Neither Resident 35 nor 58 were able to verbalize about how long ago the walls were damaged. During an interview on 03/24/2025 at 9:58 AM, Staff U, Nursing Assistant (NA), stated that if they saw any maintenance issues, they would tell the nurse or the desk person, who would put in a work order. Staff U further stated they did not know how long the walls in Resident 35 or 58 had been in disrepair and were not aware if a work order had been submitted or not. During an interview on 03/25/2025 at 10:33 AM, Staff AA, Maintenance Mechanic, stated that their department received work orders in the computer system, then they would review the orders and prioritize them. Staff AA confirmed that they did not have any work order requests for Resident 35 or 58's rooms. After looking at the rooms with the surveyor, Staff AA verified that they should be repaired, and they would do so. <Resident 92> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 03/17/2025 at 12:37 PM, Resident 92 was sitting in their wheelchair in their room. Resident 92's room had multiple gouges in their drywall on the wall next to their bed and there was a screw that protruded out of the wall within the resident's reach. The resident stated they did not feel like it was a homelike environment. Subsequent observations of the wall in disrepair and the screw protruding out of the wall were made on 03/19/2025 at 9:01 AM and 03/20/2025 at 8:36 AM. On 03/21/2025 at 10:31 AM and 03/25/2025 at 8:56 AM, the screw had been pushed into the wall but was not flush and still within the resident's reach. In an interview on 03/25/2025 at 9:03 AM, Staff D, Maintenance Director, stated the staff notified them when repairs were needed. Staff D stated they were unaware the room needed repairs and removed the screw from the wall and stated it was a safety concern. When Staff D was asked if the above observations were homelike, they stated, No, and it was important for the resident to have a homelike environment because this was their home. Reference: WAC 388-97-0880. 46115

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37544 Based on observations, interview and record review, the facility failed to develop and implement care plan interventions for aspiration precautions (measures taken to prevent food, liquid, or other substances from entering the lungs instead of the stomach) for 1 of 2 sampled residents (Resident 81), reviewed for hospitalization . In addition, the facility failed to follow care planned interventions when providing cares for Resident 91. This failure placed residents at risk of aspiration, unmet care needs, and diminished quality of life. Findings included . <Resident 81> According to the 02/17/2025 quarterly assessment, Resident 81 had diagnoses that included gastro-esophageal reflux disease (GERD, condition where stomach acid and contents back up into the throat) and diabetes. The assessment documented Resident 81 required a mechanically altered therapeutic diet, was cognitively intact and was able to clearly verbalize their needs. Review of the 10/31/2024 hospital discharge summary showed Resident 81 was to receive antibiotics for aspiration pneumonia (lung infection that occurred when food, liquid, or vomit entered the lungs instead of the stomach) upon hospital discharge. Review of the 10/31/2024 hospital discharge orders showed Resident 81 was receive an easy to chew diet and follow aspiration precautions to include providing oral care before eating or drinking, clearing secretions from oral cavity, moistening the mouth, being in an upright position as close as possible to 90-degree angle for oral intake, and elevating the head of the bed to at least 30-degree angle after eating for at least an hour. These were implemented by the facility provider on 10/31/2024. The 01/24/2024 nutrition care plan documented Resident 81 received a therapeutic diet and had a history of aspiration pneumonia. Staff were instructed to provide adaptive equipment, provide nutritional supplements to promote weight gain, and monitor for signs and/or symptoms of swallowing difficulties. The care plan had no goals or interventions developed and no instructions for staff related to the resident's need for aspiration precautions. Review of January 2024 through March 2025 nursing progress notes showed no documentation Resident 81 was non-compliant with following aspiration precautions as ordered. During an observation on 03/17/2025 at 8:57 AM, Resident 81 laid in bed, nearly flat (30 degrees or less), with a large round can to their left side. Resident 81 ate peanuts out of the large can while they watched television. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During continuous observation on 03/18/2024 from 9:03 AM until 9:17 AM, Resident 81 again laid in bed, nearly flat (30 degrees or less), with a bitten chocolate candy bar sitting on their stomach and snack size bag of plain potato chips to their right side. Resident 81 ate the chocolate candy bar and plain potato chips while they watched television. At 9:17 AM Staff G, Nursing Assistant, entered Resident 81's room to assist their roommate but did not address Resident 81 eating while laying in bed nearly flat. In an interview on 03/24/2025 at 2:25 PM, Staff W, Licensed Practical Nurse, stated Resident 81 was on aspiration precautions but was not compliant. In an interview on 03/25/2025 at 9:10 AM, Staff P, Nursing Assistant, stated they were not aware Resident 81 had difficulty swallowing or required aspiration precautions. In an interview on 03/25/2025 at 9:36 AM, Staff F, Resident Care Manager, reviewed Resident 81's medical record. Staff F acknowledged Resident 81 had orders for aspiration precautions in place, but the care plan did not include goals or interventions for the ordered aspiration precautions. 46115 Resident 91> The 01/25/2025 admission assessment documented Resident 91 had diagnoses that included Multiple Sclerosis (a disease that caused nerve damage and affected communication between the brain and the body), dementia, and anxiety. Resident 91 was cognitively intact and had no behaviors. The 01/06/2025 behavioral care plan documented Resident 91 had a behavior problem and made repeated accusations toward staff. The care plan documented the staff were to provide care in pairs to rule out accusations that were made. In an observation on 03/20/2025 at 9:51 AM, Staff L, Nursing Assistant (NA), entered Resident 91's room and assisted them to the restroom and there were no other staff members present. At 12:08 PM that same day, Staff L assisted the resident in the bathroom by themselves. In an interview on 03/21/2025 at 10:08 AM, Staff G, NA, stated Resident 91 was in the shower with Staff M, NA. In an interview on 03/21/2025 at 10:20 AM, Staff M stated Resident 91 required assistance of one staff for showers. On 03/21/2025 at 10:32 AM, Staff L was observed in the resident's room providing cares and there were no other staff members present. In an interview on 03/24/2025 at 1:45 PM, Staff L stated they looked at the resident's care plan to see what care they needed. Staff L stated Resident 91 needed cares in pairs if they were having behavioral issues. Staff L stated it was important to have two person cares as care planned to protect the resident and themselves from allegations. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/24/2025 at 3:08 PM, Staff F, Resident Care Manager, stated care should have been provided in pairs to protect Resident 91 and the staff from accusations. Reference: WAC 388-97-1020(1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40297 Based on observation, interview and record review, the facility failed to ensure residents or their representatives were provided the opportunity to participate in care planning for 2 of 3 sampled residents (Resident 29 and 35) whose medical records were reviewed for care planning. This failure placed the residents at risk for unmet needs and a diminished quality of life. Findings included . A revised 04/2016 facility policy titled Resident/Family Participation - Assessment/Care Plans documented the facility invited each resident and their family members to participate in the development of the resident assessment and care planning conference. The policy instructed the Social Services Director (SSD) or designee to maintain records that showed their efforts to invite the resident and family to the care planning conference, including refusal of participation. The policy showed the facility scheduled care conferences shortly after admission, quarterly, and at discharge to ensure resident needs and preferences were met and documented the care conferences in the medical record. <Resident 29> On 03/17/2025 at 12:35 PM, Resident 29 was observed in their room sitting in a wheelchair. Resident 29 stated the staff would bring in a copy of the care plan, say they had a new one, then hang the document in the closet. Resident 29 stated they never done a team care plan meeting. Staff came one by one but not as a team and the resident stated they had No input. Resident 29's family member, who lived with the resident, showed the surveyor a Delivery Guide they brought from the closet and stated, No nursing diagnoses, no nursing goals. Review of a 01/06/2025 quarterly assessment showed Resident 29 was readmitted to the facility on [DATE] from the hospital with medically complex conditions that included heart failure and diabetes. The assessment showed Resident 29 was cognitively intact. Review of Resident 29's medical record showed the facility completed quarterly assessments on 07/15/2024, 10/13/2024, and 01/06/2025. Further review showed the last time a care conference was held with Resident 29's participation was on 01/26/2024, as documented in a Care Conference Summary. The above findings were shared with Staff C, Social Services Director, on 03/20/2025 at 11:36 AM. When asked what process the facility used to ensure residents or their representatives were able to participate in their care planning, Staff C stated they were in the process of getting care plan conferences caught up and this was something they had been working on. They had noticed when they began their employment at the facility that care plan conferences had been hit and miss, but they had tackled other projects at that time. Staff C stated the facility completed care planning conferences within one to two weeks of a resident's admission, then typically followed the MDS (Minimum Data Set, an assessment tool) schedule or when a significant change happened. Staff C stated the facility identified the lack of care planning conferences the week of 12/20/2024. <Resident 35> (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 01/27/2025 quarterly assessment showed Resident 35 readmitted to the facility from a hospital on 09/19/2022 with medically complex conditions that included stroke, seizures, and mood disorder. The assessment documented Resident 35 had severe cognitive impairment. Further review of the resident's medical record showed they had an appointed guardian. Review of a 03/05/2025 audit completed by Staff B, Director of Nursing Services, showed the facility identified a total of 84 out of 97 residents who had not participated in care planning conferences. The audit showed Resident 35's last care planning conference was on 08/22/2023. Review of MDS schedules provided by the facility showed a total of 78 annual and quarterly completed assessments between 12/16/2024 to 03/14/2025. Review of the medical records with Staff C on 03/24/2025 at 8:55 AM showed there was no documentation the facility offered 47 of the 78 residents or their representatives the opportunity to participate in the development, review, and revision of their care plan, to include Resident 29 and 35. Staff C stated that care planning conferences occurred, not regularly and expected them to occur relatively close after the MDS completion, within a week or so. Reference WAC 388-97-1020 (2)(f), (4)(b).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on observation, interview and record review the facility failed to identify, evaluate and analyze risks, and implement safety interventions to reduce risks and hazards for 2 of 3 sampled residents (Resident 95 and 2), reviewed for substance use disorder (SUD). In addition, the facility failed to monitor for injury and add interventions to the care plan after a fall was sustained, and failed to ensure a position change alarm was in working order for 2 of 6 sampled residents (Residents 13 and 92), reviewed for falls. These failures placed residents at risk of leaving the facility without staff knowledge, potentially avoidable accidents, and diminished quality of life. Findings included . The facility policy titled, Fall Management dated 01/01/2025 documented residents were to be placed on alert charting for further monitoring after a fall occurred. The fall would be reviewed and interventions would be added to the care plan as indicated. <Resident 95> According to the 02/03/2025 admission assessment, Resident 95 admitted to the facility on [DATE] with diagnoses that included anemia and alcohol abuse. Resident 95 was cognitively intact and able to clearly verbalize their needs. Review of the 01/25/2025 hospital progress notes showed Resident 95 had a significant alcohol abuse history and their spouse had been weaning the resident off of it over the three weeks prior to their hospital admission. The resident had most recently been drinking only one beer daily and did not show signs or symptoms of alcohol withdrawals. The 01/28/2025 nursing admission assessment documented Resident 95 was confused, oriented to self only, and had a past history of alcohol use. No additional details of Resident 95's significant alcohol abuse history were documented. The 01/28/2025 baseline care plan contained no documentation that Resident 95 had a significant history of alcohol abuse and had no interventions implemented to address potential risks associated with the SUD. Review of the 01/28/2025 wandering risk assessment showed Resident 95 could move without assistance while in their wheelchair (WC), did not wander, and had no exit seeking behaviors documented in the record prior to admission. No documentation was found to show Resident 95 had a significant alcohol abuse history or their risk for leaving the facility without staff notification. The January 2025 nursing progress notes documented Resident 95 had a history of heavy alcohol use, progressive cognitive impairment, was alert to self only, confused, forgetful, was agitated, refused meals and began adamantly wanting to go home on 01/30/2025, two days after their admission. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 02/20/2025 wandering risk assessment showed Resident 95 showed exit seeking behaviors, could move without assistance while in their wheelchair, had wandered aimlessly within the facility or off the grounds, and wanted to get outside to go home. The assessment identified Resident 95 as a high risk to wander. Review of the 02/20/2025 impaired safety awareness care plan showed Resident 95 was confused, wanted to go home, had a wanderguard (a device placed on an individual that alarmed when an exit door was approached) placed on their WC and instructed staff to verify proper function nightly. No documentation was found to show Resident 95 had a significant history of alcohol abuse or interventions implemented to address potential risks associated with the SUD. <Resident 2> According to the 01/24/2025 assessment, Resident 2 admitted to the facility on [DATE] with diagnoses that included weakness and depression. Review of the 12/30/2024 nursing admission assessment showed Resident 2 was cognitively intact, had clear speech and clearly understood others. The assessment documented Resident 2 had past use of alcohol and Marijuana (cannabis), no additional details were documented. The 12/31/2025 social service assessment documented Resident 2 had a history of alcohol or drug abuse and had [AGE] years of sobriety. No documentation or details of Resident 2's Marijuana use history was found. The January 2025 nursing progress notes documented on 01/10/2025 Resident 2's spouse brought in an edible marijuana product and Resident 2 had consumed it the prior evening. Resident 2 had an elevated heart rate (HR) of 129 beats per minute (average HR ranges from 60-100). A care conference was held with Resident 2 and their spouse. They were both educated that edibles contained cannabis and were not permitted on the facility grounds. Resident 2's spouse stated Resident 2 had requested they bring the cannabis edibles into the facility. Resident 2's spouse acknowledged they had placed more edibles in Resident 2's nightstand drawer. Staff requested the additional cannabis edibles be removed from the facility grounds. The 01/10/2025 care conference assessment documented Resident 2 had edibles brought in from home and the provider was notified. Resident 2 was monitored, and additional edibles were taken home. The 01/14/2025 behavior care plan documented Resident 2's family members brought medications that included edibles to the facility without notifying staff. Staff were instructed to educate family, resident and staff of the dangers of bringing in outside medications without consent and instructed staff to inquire after each family visit if any outside items such as medications were brought into the resident. No documentation was found to show Resident 2 had a history of alcohol abuse. In an interview on 03/21/2025 at 10:34 AM, Staff G, Nursing Assistant, stated a SUD was when an individual had issues with substances such as alcohol, drugs or controlled substances. Staff G explained they received SUD training during new employee orientation (NEO). Staff G further stated they would go the nurse to deal with potential emergencies related to substance use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/21/2025 at 10:54 AM, Staff H, Registered Nurse, stated a SUD was when a person was addicted to narcotics, alcohol or any sort of drug. Staff H stated they were unsure of the facility process for dealing with potential emergencies related to substance use, which facility staff had been trained to recognize signs and/or symptoms of substance use, how residents were assessed for potential risks associated with substance use, or how resident safety was maintained. Staff H further stated staff should not be offering alcohol to residents with an alcohol abuse history and the SUD should be care planned with identified interventions. Staff H acknowledged Marijuana in any form was not allowed on the property. In an interview on 03/21/2025 at 11:06 AM, Staff F, RCM, stated a SUD was when someone abused a substance that caused an ill effect in a person's health, change in mood or behavior and became a danger to themselves or others. Staff F further stated all facility staff were trained on SUD during NEO. Staff F was asked how the facility assessed residents for potential risks associated with SUDs. Staff F stated illegal substances were not permitted in the facility and if a resident had a SUD, it would be care planned but nursing had no specific assessment to complete. Staff F stated they were unsure if they cared for any residents with a history of SUDs and acknowledged Marijuana edibles were not allowed in the facility. In an interview on 03/21/2025 at 11:21 AM, Staff E, Social Service Director, explained they used to be a certified SUD counselor but did not utilize those credentials in the facility. Staff E stated all staff were trained to recognize signs and/or symptoms of substance use. Staff E further stated social services did not assess for potential risks associated with SUDs but if a resident had a history of substance use it should be care planned with interventions implemented for direct care staff to follow. Staff E acknowledged Marijuana was not allowed in the facility and Resident 2's edibles were removed from the facility property, on 01/10/2025. 46115 <Resident 13> The 12/23/2024 quarterly assessment documented Resident 13 had diagnoses that included diabetes, high blood pressure and a stroke. Resident 13 had moderate cognitive impairments and was able to make their needs known and had sustained two or more falls. The 03/19/2025 fall risk evaluation documented Resident 13 had a history of falls and was at risk for additional falls. The 12/21/2022 risk for falls care plan documented Resident 13 was at risk for falls related to deconditioning and problems with balance. The care plan had multiple fall interventions in place. A 02/11/2025 progress note documented Resident 13 had slid out of bed onto their fall mat. The incident investigation documented Resident 13 would be gotten up at 6:00 AM to prevent them from getting out of bed on their own. This intervention was not found on the care plan. A 02/18/2025 progress note stated Resident 13 was found on the floor sitting on their fall mat next to the bed. There was no further documentation in the resident's record regarding the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/24/2025 at 2:11 PM, Staff P, Nursing Assistant, stated they knew what care to provide the residents by looking at the care plan. During an interview on 03/24/2025 at 2:15 PM, Staff Q, Registered Nurse, stated after a fall the resident was placed on alert charting to monitor for latent injury. Staff Q stated interventions after a fall should have been placed on the care plan and said this was important for the safety of the resident. In an interview on 03/24/2025 at 3:14 PM, Staff F, Resident Care Manager, stated fall interventions should have been on the care plan and said this was important to ensure the safety of the resident and that interventions were followed. Staff F stated after a fall the residents were placed on alert charting to monitor for latent injuries and pain. <Resident 92> The 01/08/2025 admission assessment documented Resident 92 had diagnoses that included stroke, dementia and anxiety. Resident 92 had severe cognitive impairments, had fallen prior to and after admission, and had sustained a fracture in the past six months. The 01/02/2025 fall risk evaluation documented Resident 92 had a history of falls and was at risk for additional falls. The 01/03/2025 risk for falls care plan documented Resident 92 was at risk for falls related to confusion, deconditioning and problems with balance. The care plan had multiple fall interventions. An incident investigation for 03/01/2025 stated Resident 92 was found on the floor in the dining room and the safety alarm in use had not sounded. The safety alarm was not assessed for the reason it had not functioned properly. In an interview on 03/24/2025 at 1:53 PM, Staff L, Nursing Assistant, stated safety alarms were checked to ensure they were working properly when they checked on the residents during their shift. In an interview on 03/24/2025 at 1:58 PM, Staff R, Registered Nurse, stated the nurses checked each resident's safety alarms every shift. In an interview on 03/24/2025 at 3:21 PM, Staff F, stated the nurses were to check the alarms every shift to ensure they functioned properly. Staff F stated the safety alarm not sounding should have been a part of the fall investigation and it was important that safety alarms functioned properly for the safety of the residents. Reference: WAC 388-97-1060 (3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40297 Based on observation, interview and record review, the facility failed to ensure a resident received appropriate treatments and services to restore bladder continence to the extent possible for 1 of 2 sampled residents (Resident 69) reviewed for bowel and bladder incontinence. Failure to comprehensively assess the causes of incontinence and provide treatments and services to restore bladder function, placed the resident at risk for continued decline in urinary function, skin issues, and embarrassment. Findings included . The 01/01/2024 facility policy titled Incontinent Care cumented the facility provided incontinence care to keep the residents clean, dry and free from skin irritations, and to reduce the risk of urinary tract infections. The policy documented the facility assessed all residents upon admission for voiding patterns and the residents potential to participate in a bladder retraining program (helped the resident to begin to hold more urine for longer periods of time overcome bladder problems that included urgency, frequency and incontinence). Once the staff identified incontinence, the resident's care plan included interventions to promote or manage incontinence. On 03/17/2025 at 2:45 PM, Resident 69 was observed in bed fully dressed. Resident 69 stated they experienced episodes of urinary incontinence, quite a bit. You can't expect staff to be lined up waiting to care for you. Resident 69 stated the staff did not come on their own to take them to the bathroom; the resident had to call the staff. Resident 69 stated that they wore an incontinence brief. The 02/01/2025 quarterly assessment documented Resident 69 had diagnoses that included stroke. The resident had moderate cognitive impairment and did not reject care. Resident 69 required physical assistance from the staff to complete transfers and toileting. The resident was frequently incontinent of urine but on no toileting program, such as scheduled toileting, prompted voiding, or bladder training. Prior assessments dated 08/15/2024 and 11/04/2024 also showed Resident 69 was frequently incontinent and on no toileting program. An 08/19/2024 care areas worksheet associated with the 08/14/2024 assessment documented the staff identified Resident 69 experienced mixed incontinence (stress incontinence with urgency). The worksheet documented the staff addressed the incontinence in the care plan with goals for improvement, avoid complications, and minimize risks and will continue to offer toileting assistance/incontinence cares on comfort rounds. The worksheet showed the staff determined no referral to other disciplines was warranted for the identified urinary incontinence and to continue working with therapy. Review of the Bladder Elimination flowsheets documented Resident 69 was incontinent of urine, on an average of two to three times a day, between 02/19/2025 to 3/20/2025. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 08/08/2024 care plan documented Resident 69 required limited to extensive assistance for cleansing, changing incontinence products, and adjusting clothing and extensive assistance to move to and from bed to wheelchair. An 08/09/2024 intervention showed Resident 69 required a mechanical lift to complete transfers. Because of falls, the facility added an intervention on 08/27/2024 to check in on the resident every 30 minutes and, if awake, offer toileting. On 02/26/2025, an intervention was added to the care plan that Resident 69 preferred to keep the urinal at bedside while in bed and on the bedside table.On 03/24/2025 at 10:50, the resident's urinal was observed inside their bathroom and not at the bedside. In an interview on 03/24/2025 at 11:25 AM, Staff U, Nursing Assistant (NA), stated that they were familiar with the cares of Resident 69. Staff U stated that Resident 69 did not use a urinal and considered the resident continent 90% of the time if we went there right away and the resident experienced incontinence because we don't make it on time. Staff U stated that Resident 69 required a one person assist for transfers to the bathroom, required no lift, and would attempt to transfer on their own to go to the rest room. Staff U considered Resident 69's severity of bladder incontinence unchanged from admission to the facility and tried to manage incontinence by offer toileting before and after meals. They stated the resident was usually pretty good about letting them know. In an interview on 03/25/2025 at 8:44 AM, Staff V, NA, stated that Resident 69 required extensive assist for transfers, pulled the call light when ready to use the bathroom, and was continent of urine 50% of the time. They stated sometimes the resident did not make it to the bathroom. Staff V also stated that sometimes Resident 69 felt the urge to urinate but then did not void after being helped to the bathroom and the resident constantly went to the bathroom. Staff V stated Resident 69 drank a lot of coffee, and coffee was a diuretic (medication that increased urine output). Staff V stated they checked on Resident 69 every hour. In an interview on 03/24/2025 at 11:33 AM, Staff N, Resident Care Manager stated Resident 69 had a recent stroke that negatively affected their continence and made it harder for them to go to the bathroom when they wanted to. Staff N stated the resident relied on staff for transfers. When asked how the facility assessed for risks, causes, types, patterns of incontinence, and potential treatments to address or reverse any resident's urinary incontinence, Staff N answered the staff completed a Bowel and Bladder Assessment on admission and quarterly. Staff N reviewed Resident 69's medical record but could not locate the assessment. Staff N stated the Bowel and Bladder Assessment alerted the staff of the need to revise interventions to address unimproved incontinence. Staff N was asked what types of interventions were attempted to improve Resident 69's bladder continence. Staff N stated they had not done that, and the resident had moisture associated skin damage (response to prolonged skin exposure to moisture) related to their incontinence. Staff N stated it would be good to get the resident on a toileting schedule. Staff N confirmed no referrals had been made to therapy or the provider for the mixed incontinence identified on 08/19/2024. No further information was provided. Reference WAC 388-98-1060 (3)(c).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37544 Based on interview and record review, the facility failed to ensure a resident received doses of Ozempic, a medication used to control blood sugar levels, as ordered, and failed to notify the provider timely after the omissions for 1 of 5 sampled residents (Resident 36), reviewed for unnecessary medications. This failure placed residents at risk of complications secondary to high blood sugar levels, unmet care needs, and diminished quality of life. Findings included . According to the 01/06/2025 quarterly assessment, Resident 36 had diagnoses that included diabetes and stroke. Resident 36 received hypoglycemic (blood sugar lowering) medication including insulin (medication that lowered blood sugar levels) injections. Resident 36 was cognitively intact and able to clearly verbalize their needs. The 08/16/2019 diabetes care plan instructed staff to administer diabetes medications per provider orders and monitor for signs and/or symptoms of high or low blood sugar levels. On 04/20/2024 a provider order was given for Resident 36 to be administered an Ozempic injection once weekly on Saturday mornings for diabetes. Review of the March 2025 Medication Administration Record (MAR) showed Resident 36 did not receive two doses of the Ozempic; a code 9 was documented for the 03/08/2025 dose and a code 7 was entered for the 03/15/2025 dose. The key at the bottom of the MAR indicated a code 9 meant other /see progress note and a code 7 meant not given; MD notified. Review of March 2025 nursing progress notes showed Resident 36's Ozempic was not administered on 03/08/2025 because the medication was unavailable, no documentation was found to show the provider was notified of the Ozempic omission at that time. On 03/15/2025 the Ozempic was again not administered because it was not available. The notes documented Resident 36's Ozempic was ordered on 03/01/2025, 03/08/2025, and again on 03/15/2025 and that the provider was notified on 03/15/2025. A Provider Communication Form dated 03/15/2025 documented Resident 36 did not receive their Ozempic injection on 03/08/2025 or on 03/15/2025 related to the medication being unavailable. No documentation was found to show the provider was notified of the 03/08/2025 missed Ozempic dose prior to 03/15/2025. Review of provider progress notes showed no provider progress notes for March 2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/20/2025 at 9:33 AM, Staff Y, Pharmacist, reviewed Resident 36's record. Staff Y stated Resident 36's Ozempic was filled on 02/19/2025 and was not due to be refilled when ordered by the facility on 03/01/2025, 03/08/2025, or on 03/15/2025 so the refill was rejected and placed into a que to be automatically filled at the next appropriate time frame. Staff Y stated Ozempic was a specialty medication that required approval from Staff A, Administrator, or Staff B, Director of Nursing, if the medication was to be refilled earlier than scheduled. Staff Y stated they emailed the facility an authorization form for approval of an early refill if needed. Staff Y reviewed email correspondences between the pharmacy and the facility, and stated they had no document authorizing an early refill of Ozempic for Resident 36. In an interview on 03/20/2025 at 9:51 AM, Staff Z, Medical Records, stated all provider communication forms for Resident 36 were scanned into their record. Staff Z reviewed Resident 36's medical record. Staff Z acknowledged the only provider communication form for Resident 36 for March 2025, was the 03/15/2028 form, no other provider communication forms were found. In an interview on 03/20/2025 at 10:28 AM, Staff F, Resident Care Manager (RCM), stated the facility reordered resident medications when there was a one week supply remaining. Staff F stated if the facility ran out of a medication, staff were to check the facility's emergency medication storage machine or order medications from two back up emergency pharmacies the facility utilized. Staff F reviewed Resident 36's medical record and acknowledged Resident 36's Ozempic was ordered on 03/01/2025, 03/08/2025, and again on 03/15/2025. In an interview on 03/24/2025 at 2:21 PM, Staff W, Licensed Practical Nurse, explained nursing staff were to order new insulin pens as soon as the fourth dose was administered when ordered for weekly administration and the pharmacy would fill it. Staff W further stated they would notify the RCM if/when there was a medication refill issue, so appropriate follow-up could be taken. In a follow-up interview on 03/25/2025 at 9:30 AM, Staff F, RCM, stated they expected the provider to be notified timely if/when a medication was not available for administration, as ordered. Reference WAC 388-97-(3)(k)(iii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46115 Based on observation, interview and record review, the facility failed to ensure meals were served at palatable temperatures for 1 of 6 sampled residents (Resident 12) reviewed and 1 of 1 meal test trays sampled.This failure put residents at risk of decreased enjoyment of their meals, and possible reduced dietary intake. Findings inculded . According to the Washington State Food Handlers Guide Website, the Washington State Department of Health Safety and Licensing Division recommended that all potentially hazardous foods be held at a temperature of 41 F or below in commercial refrigerators and freezers. This included meats, fish, poultry, eggs, dairy products, cooked vegetables, cooked rice and pasta, cut melons, and other perishable items. All frozen foods were to be stored at 0 F or below. Hot food items were to be held at a temperature of 140 F or above. The 03/10/2025 quarterly assessment documented Resident 12 had diagnoses that included obesity, high blood pressure and diabetes. The assessment further documented the resident was cognitively intact and was able to make their needs known. In an observation and interview on 03/18/2025 at 8:38 AM, Resident 12 was sitting in their wheelchair in their room. Resident 12 stated residents had the choice to eat in their room or in the dining room. They stated when they ate in the dining room the food was hot. If they ate in their room the food was served cold at times. In an interview on 03/19/2025 at 8:42 AM, Resident 12 stated breakfast was good but could have been hotter. In additions to cold cereal, they had an English muffin, sausage patty, hard boiled egg, and hashbrowns. The kitchen food temperature logs for March 2025 were reviewed. Temperatures for hot foods had been documented on the logs but not the cold food. There was a line through the box that asked for the temperature of the cold items. During an observation and sampling of the lunch meal served on 03/24/2025, the temperatures of the food items were outside of the acceptable parameters and were as follows: buttered noodles 119 F, oriental style mixed vegetables 100 F, and cubed seasoned potatoes 125 F. In an interview on 03/24/2025 at 12:31 PM, Staff S, Food Supervisor, stated it was important to check hot and cold food temperatures.This ensured the food was safe for consumption. Reference: WAC 388-97-1100 (1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Failure to ensure expired foods were discarded for 1 of 3 refrigerators, 1 of 1 dry storage areas, opened dates were placed on food items in the refrigerator and freezer, appropriate hair coverings were worn, and hand hygiene was performed when indicated. The facility further failed to ensure the kitchen was cleaned and dishwasher temperatures were maintained at the appropriate temperatures. These failures placed residents at risk for food-borne illnesses and food served from unsanitary conditions. Findings included . <Expired/undated food> During an initial tour of the kitchen on [DATE] at 08:41 AM, the dry storage area revealed 12 containers of grits that had expired on [DATE], an opened box of spice mix cake that had no open or expiration date, and five bottles of honey that had expired on [DATE]. The refrigerator in the main kitchen contained a stock of celery that was brown and wilted, and a box of mushrooms that had no received or use by date. Staff S, Food Supervisor threw the mushrooms away and stated they should have been dated. The freezer contained an opened bag of blueberries, two opened bags of cinnamon rolls, 10 loaves of bread, box of opened enchiladas, bag of opened fried chicken, bag of opened tater tots, bag of opened sweet potato fries and an opened box of French toast, that had no open or expiration dates. In an interview on [DATE] at 09:33 AM, Staff S stated all food items that were opened needed an open date so they would know how long the product was good for. Staff S added it was important to get rid of expired food to prevent illness. <Sanitary Practices> During an observation of tray line on [DATE] at 10:41 AM, Staff T took the plate of food from the cook, put butter on the meal trays and placed them in the cart. Staff T wiped their nose on their shirt and kept putting the plates onto the trays and hand hygiene was not performed. At 11:53 AM, Staff T wiped their nose on their bare skin of their forearm, kept putting plates on meal trays and had not performed hand hygiene. In an interview on [DATE] at 12:32 PM, Staff S stated Staff T should have washed their hands after they wiped their nose and should have worn a mask if they had a drippy nose, and this was important for sanitary reasons. <Dishwasher temperatures> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a second observation of the kitchen on [DATE] at 10:41 AM, Staff S stated the dishwasher was a high temperature dishwasher and the final rinse had to reach 180 degrees. The [DATE] through [DATE] dishwasher temperature logs documented the temperature was below the required temperature on 34 occasions. In an interview on [DATE] at 10:50 AM, Staff S stated it was important for the final rinse to reach the proper temperature to kill the germs. <Cleaning> On [DATE] the kitchen cleaning schedules were requested and Staff S presented sheets that had [DATE] written on them but had no days of the week listed. There were numerous days in which there was no documentation that stated the daily cleaning had occurred. In an interview on [DATE] at 1:31 PM, Staff S stated the kitchen needed to be cleaned daily for sanitization reasons. Staff S stated the sheets needed to have the dates included. <Hair Covering> In an observation on [DATE] at 11:43 AM, Staff T was assisting with putting food on trays. Staff T, Food Service Worker, was observed with short hair, a mustache and short beard. Staff T was not wearing hair coverings as required when working with food. In an interview on [DATE] at 12:32 PM, Staff S stated the policy was to wear hair coverings when working with food in the kitchen. At 12:36 PM, Staff S stated it was important to wear a hair net to ensure everything was sanitary. Reference: WAC [DATE] (3), 2980

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42802 Based on interview and record review, the facility failed to ensure that consents for psychotropic medications (drugs that affected behavior, mood, thoughts or perception) were completed accurately for 1 of 5 residents (Resident 43) reviewed for unnecessary medications. Specifically, some consents were not documented as late entries, and two consents were not completed before the medication was resumed. Failure to ensure clinical records were accurate placed residents at risk of not having their needs met. Findings included . A quarterly assessment, dated 01/20/2025, documented Resident 43 had diagnoses of Parkinsons Disease (an illness that affected the part of the brain that controlled movement), depression and anxiety. The assessment further showed that they were alert and made their needs known. Resident 43's Medication Administration Record for March 2025, showed they were taking the following psychotropic medications, that required documented consents: 1) Quetiapine (a medication that treated symptoms such as delusions, hallucinations or paranoia) daily in the evening 2) Prazosin (a medication used to treat nightmares) daily at bedtime 3) Trazodone (an antidepressant medication) twice daily 4) Lorazepam (an antianxiety medication) every 8 hours A review of the medical record showed consents for the medications. The consent form had an Effective Date with the date at the top, further down a box that showed Date followed by the name of the medication, then a box to fill in the name of the resident or representative who provided verbal consent. The last line of the form was for the electronic signature of the staff and the date the document was signed. 1) The Quetiapine consent showed the effective date as 10/03/2024, the date box showed 10/18/2024, and the final line showed the document was signed by Staff N, Registered Nurse/Resident Care Manager (RN/RCM) on 01/28/2025. 2) The Prazosin consent showed both the effective date and the date box as 01/09/2025 and the last line showed the document was signed by Staff N on 01/28/2025. 3) The Trazodone consent showed both the effective date and the date box as 11/15/2024 and the last line showed the document was signed by Staff N on 01/28/2025. A review of the provider orders showed that Trazodone was discontinued on 11/01/2024 and resumed 14 days later, on 11/15/2024. (continued on next page)

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	505509	A. Building B. Wing	03/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Veterans Home	222 East Fifth Spokane, WA 99202

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) The Lorazepam consent showed both the effective date and the date box as 11/15/2025 and the last line showed the document was signed by Staff N on 01/28/2025. A review of the provider orders showed that Lorazepam was discontinued on 11/01/2024 and resumed 3 days later, on 11/04/2024. During an interview on 03/24/2025 at 2:15 PM, Staff W, Licensed Practical Nurse, stated that consents for psychotropic medications needed to be done before the first dose was given. They further stated that if the medication was stopped, then reordered, the consent needed to be redone. During an interview on 03/25/2025 at 9:16 AM, Staff N verified that consent for psychotropic medications needed to be done when the medication was started and when the dose changed. When asked about the differing dates on the consents, they stated they had not realized that the new facility process was to redo the consent if the dose changed. Staff N further explained that on 01/28/2025, they looked back and actually did those consents as late entries and manually put in the first two dates on the consent, as when the order started. Staff N acknowledged that the documents were not labeled as late entries, that it was not clear that the consents were actually obtained on 01/28/2025, and that the consents for Trazodone and Lorazepam should have been done when the medications were resumed. Reference: WAC 388-97-1720(1)(a)(i-iv)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37544 Based on observation, interview, and record review the facility failed to ensure infection control practices were followed during meal service to include performing hand hygiene (HH) when indicated. In addition, staff did not follow Enhanced Barrier Precautions (EBP) when indicated for 1 of 3 sampled residents (Resident 91), reviewed for infection control. These failures placed the residents at risk for the spread of infections, illnesses and unintended health consequences. Findings included . Review of the facility policy titled, Hand Washing/Hand Hygiene revised March 2024, showed hand hygiene was the primary means of preventing the spread of infections. The policy further showed staff should perform hand hygiene before and after direct contact with residents, after contact with a resident's intact skin, after contact with objects in the immediate vicinity of a resident, before and after assisting a resident with a meal. Review of the facility policy titled, Enhanced Barrier Precautions revised March 2024, defined EBP as the use of a gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a multi-drug-resistant organism (MDRO) or at increased risk of acquiring an MDRO. The policy defined high-contact care activities as dressing, bathing, transferring, providing hygiene, changing linens, changing an incontinence brief or assisting with toileting, invasive device (medical device that entered a person's body) care, or performing wound care that required a dressing. The policy instructed staff to use EBP for the duration of the affected resident's stay in the facility or until the wound healed or the invasive medical device was removed. HAND HYGIENE During an observation on 03/17/2025 at 11:44 AM, Staff G, Nursing Assistant, sanitized their hands, grabbed a meal tray, poured drinks, and then leaned down and picked up cups that had fallen onto the floor. Staff G had not performed hand hygiene and passed the tray to a resident. During an observation on 03/17/2025 at 11:46, Staff J Nursing Assistant (NA), used alcohol based-hand rub (ABHR), placed a clothing protector on a resident in the dining room, obtained a new tray off the meal cart without hand hygiene performed, poured fluids into plastic cups, and delivered the tray to the assisted dining room. Staff J obtained another tray from the meal cart and hand hygiene was not performed. During an observation on 03/17/2025 at 11:49 AM, Staff J, obtained a tray off the meal cart, poured fluids, and delivered the tray to the assisted dining room. Staff J opened the large round trash with their hand, hand hygiene was not performed and they entered room [ROOM NUMBER]. During an observation on 03/17/2025 at 11:52 AM, Staff J, Nursing Assistant, passed a tray, then grabbed another tray and hand hygiene was not performed in between trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 03/17/2025 at 11:51 AM until 11:59 AM, Staff K, NA, delivered a tray to room [ROOM NUMBER] and exited the room and no hand hygiene was performed. Staff K obtained a second tray off the meal cart, poured drinks into cups, delivered the tray to room [ROOM NUMBER], and again exited the room and no hand hygiene was performed. Staff K obtained a third tray off the meal cart, grabbed a clothing protector, delivered the tray to room [ROOM NUMBER], adjusted the bedside table and opened/set up the tray. Staff K again exited the room and no hand hygiene was performed. During an interview on 03/21/2025 at 9:26 AM, Staff J, NA, stated hand hygiene was keeping hands clean or sanitizing, wearing gloves, and not getting stuff on hands I guess. Staff J acknowledged staff should have performed hand hygiene after touching a resident's immediate environment and between passing different resident trays. During an interview on 03/21/2025 at 9:34 AM, Staff H, Registered Nurse, stated hand hygiene was washing hands with soap and water or using ABHR. Staff H further explained staff were expected to perform hand hygiene at various times including between passing different resident trays during meal service to prevent the spread of infection between residents and staff. During an interview on 03/21/2025 at 9:42 AM, Staff I, Infection Preventionist, stated staff should have performed hand hygiene between passing meal trays and after the lid on the trash can was touched to prevent the spread of germs During a follow-up interview on 03/24/2025 at 1:34 PM, Staff I, stated hand hygiene should have been performed after the cups were picked up off the floor. Staff I stated it was important to sanitize after touching things to prevent the spread of germs. 46115 ENHANCED BARRIER PRECAUTIONS According to the 01/05/2025 admission assessment, Resident 91 had diagnoses including repeated falls and neurogenic bladder (bladder control issues caused by nerve damage). The assessment further showed Resident 91 had an indwelling urinary catheter (flexible tube inserted into the bladder to drain urine). Review of the 12/23/2024 provider orders showed active orders for Resident 91 to follow enhanced barrier precautions (EBP, use of gloves and gowns) during high-contact resident care activities such as dressing, bathing, transferring, changing linens, providing hygiene, or assisting with toileting. Review of the 02/26/2025 suprapubic catheter (catheter inserted directly into the bladder through a cut in the abdomen) care plan documented Resident 91 was on EBP. Interventions instructed staff to follow signage posted on the resident's door for application and removal of PPE (personal protective equipment, gown and gloves) to include use when dressing, bathing, transferring, providing hygiene, changing linens, during invasive device care. In an interview on 03/18/2025 at 9:02 AM, Staff P, Nursing Assistant, stated when precautions were implemented it would be documented in the resident's care plan for staff to reference and follow. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/20/2025 at 12:08 PM, an EBP sign was observed posted outside of Resident 91's room. Staff L, Nursing Assistant, assisted Resident 91 into the bathroom and helped them stand at the bar. Staff L was not wearing a gown as required to assist with transferring Resident 91. In an interview on 03/20/2025 at 12:17 PM, Staff L stated Resident 91 was on EBP because they had a catheter. Staff L acknowledged they did not wear a gown when they assisted Resident 91 transfer and should have worn a gown to protect the resident and themselves from germs. Reference: WAC 388-97-1320 (1)(c)(2)(b),