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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
	505513	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puget Sound Transitional Care	2800 South 224th Street, Des Moines, WA 98198

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 46471

Based on interview and record review, the facility failed to obtain and/or offer assistance to residents and/or their representatives to formulate Advance Directives (AD) for 8 of 17 residents (Residents 11, 59, 65, 80, 24, 77, 48, & 62) reviewed for ADs. These failures placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care.

Findings included .

<Facility Policy>

The facility policy, Care and Treatment - Advance Directives, revised November 2016, showed the staff should inform and provide residents written information to formulate an AD. The policy showed, prior to, upon, or immediately after admission, the Admission Nurse or Social Service staff would ask residents and/or their family members about the existence of any AD and should they indicate that they had one, the facility would require that a copy of such AD be included in the medical record.

<Resident 11>

According to the 05/09/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 11 had clear speech and understood others during communication. The MDS showed Resident 11 had medical conditions including heart, respiratory, and kidney failure, unstable blood sugar levels, adult failure to thrive, and was dependent on dialysis (a procedure to clean and filter the body's waste products) treatment.

On 06/05/2024 at 2:13 PM, Resident 11 stated their family member was in-charge with healthcare decision-making.

Review of Resident 11's 05/03/2024 AD Acknowledgement form showed [Family member] working on it and presented with a hand-written note by staff in quotations.

Review of Resident 11's progress notes from 05/03/2024 until 06/06/2024 did not show any documentation that staff followed-up regarding the resident's AD status.

(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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint interview on 06/06/2024 at 11:39 AM with Staff F (Social Services Director) and Staff G (Resident Advocacy Resource), Staff G stated formulating an AD was important because it informed the facility of the resident's healthcare wishes and provided directions for the staff on the necessary people to call and/or notify for any issues and/or significant resident changes. Staff F added it was important to ensure the facility was aligning their care to their resident's wishes and expected ADs to be accessible to all staff. Staff's G and F confirmed Resident 11's Acknowledgement form was incomplete and stated the facility was unable to establish Resident 11's AD status as required. <Resident 59> According to the 03/12/2024 Annual MDS, Resident 59 admitted to the facility on [DATE], had clear speech and understood others during communication. The MDS showed Resident 59 had medical conditions including kidney failure, chronic respiratory failure, brain activity malfunction causing involuntary muscle movements, anxiety, and Schizophrenia (a mental disorder). On 06/05/2024 at 9:19 AM, Resident 59 stated they were unsure if they had an AD in place, .maybe my brother? and could not recall if AD assistance was offered or provided for them to formulate an AD. Review of Resident 59's medical records on 06/06/2024 did not show an AD or an AD Acknowledgement form was completed for the resident upon admission. Review of Resident 59's progress notes from 07/21/2023 until 06/06/2024 did not show a follow-up was conducted regarding the resident's AD status. The facility was not able to provide any documentation to support education and/or assistance to formulate an AD was provided to Resident 59. In an interview on 06/06/2024 at 11:46 AM, Staff G confirmed Resident 59 did not have any AD paperwork on file and stated they were unable to establish the resident's AD status as required. <Resident 65> According to the 05/16/2024 Admission MDS, Resident 65 had clear speech and understood others during communication. The MDS showed Resident 65 had medical conditions including kidney failure and was dependent on dialysis treatment, malnutrition, unstable blood sugar levels, and underwent a left below the knee amputation (the loss or removal of a body part). On 06/05/2024 at 10:14 AM, Resident 65 stated they were unsure if they had an AD, .[family member] does all the paperwork and decision-making for me. Review of Resident 65's 05/10/2024 AD Acknowledgement form showed the resident had no AD in place. The form was incompletely filled out and did not indicate if the facility provided assistance and education to Resident 65 regarding formulating an AD as required. Review of Resident 65's progress notes from 05/10/2024 until 06/06/2024 did not show any documentation that a follow-up was conducted regarding the resident's AD status. In an interview on 06/06/2024 at 11:49 AM, Staff G confirmed Resident 65's AD Acknowledgement form was incomplete and stated they were unable to establish the resident's AD status as required. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 80> According to the 05/16/2024 Admission MDS, Resident 80 had clear speech and understood others during communication. The MDS showed Resident 80 had medical conditions including kidney failure, brain damage, malnutrition, and infected wounds. On 06/05/2024 at 1:31 PM, Resident 80 stated they did not have an AD. Review of Resident 80's 05/10/2024 AD Acknowledgement form showed the resident had no AD in place. The form was incompletely filled out and did not indicate if the facility provided assistance and education to Resident 80 regarding formulating an AD as required. Review of Resident 80's progress notes from 05/10/2024 until 06/06/2024 did not show any documentation that a follow-up was conducted regarding the resident's AD status. In an interview on 06/06/2024 at 11:50 AM, Staff G confirmed Resident 80's AD Acknowledgement form was incomplete and stated they were unable to establish the resident's AD status as required. <Resident 24> According to the 05/02/2024 Quarterly MDS, Resident 24 had clear speech and understood others during conversation. The MDS showed Resident 80 had medical conditions including chronic wounds, kidney failure and was dependent on dialysis treatment, malnutrition, and unstable blood sugar levels. On 06/05/2024 at 11:14 AM, Resident 24 stated they did not have an AD. Review of Resident 24's 01/26/2024 AD Acknowledgement form showed the resident had no AD in place. The form was incompletely filled out and did not indicate if the facility provided assistance and education to Resident 24 regarding formulating an AD as required. Review of Resident 24's progress notes from 01/26/2024 until 06/06/2024 did not show any documentation that a follow-up was conducted regarding the resident's AD status. In an interview on 06/06/2024 at 11:51 AM, Staff G confirmed Resident 24's AD Acknowledgement form was incomplete and stated they were unable to establish the resident's AD status as required. <Resident 77> According to the 05/06/2024 Admission MDS, Resident 77 had clear speech and understood others during conversation. The MDS showed Resident 77 had medical conditions including a severe lung infection with respiratory failure. On 06/05/2024 at 12:45 PM, Resident 77 stated they did not have an AD. Review of Resident 77's 04/20/2024 AD Acknowledgement form showed the resident had no AD in place. The form was incompletely filled out and did not indicate if the facility provided assistance and education to Resident 77 regarding formulating an AD as required. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 77's progress notes from 04/30/2024 until 06/06/2024 did not show any documentation that a follow-up was conducted regarding the resident's AD status. In an interview on 06/06/2024 at 11:51 AM, Staff G confirmed Resident 77's AD Acknowledgement form was incomplete and stated they were unable to establish the resident's AD status as required. Staff G stated the facility's AD process needed improvement. 45941 <Resident 48> According to the 05/13/2024 Quarterly MDS, Resident 48 was cognitively intact and able to understand others. The MDS showed Resident 48 had Bipolar disease (a disorder with episodes of mood swings). Review of an AD Acknowledgement form showed a blank form signed by facility staff on 04/30/2024 and did not tell if Resident 48 or their representative was involved in the discussion. In an interview on 06/10/2024 at 10:06 AM, Staff F reviewed the AD form and stated the form should be filled and discussed with the resident or their representative before the staff signed the form, but they did not. Staff F stated staff should have offered assistance to fill an AD paperwork with the resident or their representative, but did not. <Resident 62> According to the 05/22/2024 Quarterly MDS, Resident 62 was cognitively intact and able to understand others. The MDS showed Resident 62 had a memory loss disorder and inability to control blood sugars. On 06/05/2024 at 11:02 AM, Resident 62 stated they were unsure if they had an AD in place. Resident 62 stated they could not recall if they were educated by staff regarding the importance of having an AD and if assistance was offered to formulate one. Review of Resident 62's record showed Resident 62 signed an AD Acknowledgement form on 02/24/2024 upon admission. This form showed Resident 62 had no AD paperwork but they would like to formulate an AD. There was no documentation to show the facility followed up on Resident 62's request to formulate an AD. In an interview on 06/10/2024 at 11:23 AM, Staff B (Director of Nursing) stated ADs were important because the AD determined who would be responsible for a resident if residents was unable to make decisions for themselves. Staff B stated the staff should have followed up on Resident 62's request to formulate an AD, but did not. REFERENCE: WAC 388-97-0280(3)(c)(i-ii).

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45941

Based on observation, interview, and record review, the facility failed to ensure a safe, clean, and comfortable environment was provided to residents. Facility failure to maintain a homelike and odor-free environment left residents at risk for an unpleasant living situation, infectious diseases, and a decreased quality of life.

Findings included .

<Resident Rooms>

Observations on 06/04/2024 at 9:01 AM showed in room [ROOM NUMBER] A had gouges on the wall at the head of the resident's bed and a deep gouge on the bathroom wall.

Observations on 06/04/2024 at 8:55 AM showed room [ROOM NUMBER] A had deep gouges on the wall at the head of the resident's bed.

Observations on 06/04/2024 at 9:08 AM showed room [ROOM NUMBER] A had gouges on the wall at the head of the resident's bed and had multiple white paint patches on the wall.

Observations on 06/04/2024 at 8:44 AM showed room [ROOM NUMBER] with the lower part of the bathroom door had gouges.

Observations on 06/04/2024 at 9:20 AM showed room [ROOM NUMBER] with the lower wall by the bathroom door had gouges and missing paint.

Observations on 06/04/2024 at 10:20 AM showed room [ROOM NUMBER] with the lower part of the bathroom door had gouges.

Observations on 06/04/2024 at 10:56 AM showed room [ROOM NUMBER] sink had trims with sharp edges.

Observations on 06/04/2024 at 10:33 AM showed room [ROOM NUMBER] had a sink with trims, sharp edges and covered with paper tape. The paper tape was observed wet and was coming off.

In an interview and observation on 06/06/2024 at 12:19 PM, Staff E (Resident Care Manager - RCM) confirmed the damage to the walls and stated they needed to be fixed.

<Incomplete Blinds>

Observation on 06/04/2024 at 10:02 AM showed the blinds to the window in room [ROOM NUMBER] was missing slats and did not offer the resident adequate privacy.

Observation on 06/05/2024 at 12:05 PM showed the blinds to the window in room [ROOM NUMBER] was missing slats and the curtain dressing was barely hanging from the curtain rod.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/2024 at 9:58 AM, Staff Q (Maintenance Director) confirmed all the gauges on the walls in resident's rooms and bathrooms, missing blind slats, and damaged sinks, and stated all these damages should be fixed in resident's rooms. Staff Q stated it was not a homelike environment for these residents. In an interview on 06/11/2024 at 10:02 AM, Staff A (Executive Director) stated their expectation was for residents to have a homelike environment. Staff B stated the damaged walls and sink trims should be fixed. Staff A stated the blinds/curtains in resident rooms should be maintained in good condition and provide full privacy for residents. 46471 <Soiled Garbage Bags> Observation on 06/05/2024 at 10:15 AM showed room [ROOM NUMBER] had two clear plastic bags filled with soiled linen and garbage leaning against the wall next to door inside the room. In an interview on 06/05/2024 at 10:23 AM, Staff K (RCM) stated it was important to ensure the residents' environment was clean and homelike because this [facility] is their home. Staff K went to room [ROOM NUMBER] and stated they expected the staff to take soiled garbage bags out and disposed of immediately, not just to ensure the room remained clutter-free, but also for infection prevention. <Urine Smell> Observation and interview on 06/05/2024 at 9:00 AM showed room [ROOM NUMBER] had a strong urine smell; two empty urinals were observed sitting on top the nightstand. Resident 59 stated they were incontinent of urine and would often have leaks and accidents while using the urinals on their own. In an interview on 06/11/2024 at 8:51 AM, Staff R (Housekeeping Manager) confirmed the strong urine smell in room [ROOM NUMBER]. Staff R stated it was important to ensure resident rooms were cleaned, sanitized, and kept odor-free so the residents were comfortable in their environment to promote healing, especially for those residents who were on the short-stay unit (2nd floor). REFERENCE: WAC 388-97-0880.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review, the facility failed to ensure a system by which residents and Long-Term Care Ombudsman Office (LTCO) received required written notices at the time of transfer/discharge, or as soon as practicable, for 3 of 4 residents (Residents 48, 64, & 59) reviewed for hospitalization . Failure to ensure a written notification was provided to the resident and/or representative of the reasons for the discharge and in a language and manner the resident and/or representative understood placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Failure to ensure a notification was provided to LTCO of the reason for transfer/discharge prevented the LTCO the opportunity to educate residents and advocate them regarding the discharge process. Findings included . <Facility Policy> The facility policy, Discharge and Transfer/Washington State revised 02/2016, showed staff should notify the resident and/or representative in writing in language the resident understands, the reason for, date of, and destination of the transfer or discharge. This policy also showed staff should provide a copy of the transfer/discharge notice to the Office of the State LTCO. <Resident 48> Resident 48 admitted to the facility on [DATE]. Record review showed Resident 48 was discharged to an acute care hospital on 02/01/2024 Return anticipated and readmitted to the facility on [DATE]. Record review showed no documentation indicating the facility provided a written notification to the resident, their representative, or the LTCO of the transfer as required for the 02/01/2024 transfer. The facility was unable to provide documentation showing the resident/representative and LTCO were notified of Resident 48's transfer to the hospital on 02/01/2024. In an interview on 06/10/2024 at 09:13 AM, Staff F (Social Services- SD) stated they were unaware there was a process requiring the facility to send a written notification to Resident 48's representative of the reason for the transfer. Staff F stated they started working in the facility few a weeks back and were unable to locate any records for the LTCO notifications for the transfers/discharges. Staff F reviewed Resident 48's record and was unable to locate any documentation for LTCO notification. Staff E stated they should have sent the written notification to the resident's representative and LTCO for transfers, but they did not. <Resident 64> Resident 64 admitted to the facility on [DATE]. Record review showed Resident 64 was discharged to an acute care hospital on 02/04/2024 Return anticipated and readmitted to the facility on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed no documentation indicating the facility provided a written notification to the resident/ their representative and the LTCO of the transfer as required for the 02/04/2024 transfer. The facility was unable to provide documentation showing the resident/representative and LTCO were notified of Resident 64's transfer to the hospital on 02/04/2024. In an interview on 06/10/2024 at 09:13 AM, Staff F stated they were unaware of the process of sending a written notification to the resident/representative of the reason for the transfer. Staff F reviewed Resident 64's record and was unable to locate any documentation for LTCO notification of the transfer. Staff E stated staff should have sent the written notification to the resident's representative and LTCO for transfers, but they did not. 46471 <Resident 59> According to the 07/02/2023 Discharge Minimum Data Set (MDS- an assessment tool), Resident 59 was discharged to the hospital on 07/02/2023. Review of the facility census showed Resident 59 readmitted back to the facility on [DATE]. On 06/05/2024 at 8:58 AM, Resident 59 stated they remember being sent out to the hospital from the facility but could not exactly recall the reason. A 07/02/2023 nursing progress note showed Resident 59's condition worsened after the resident suffered a seizure (brain activity malfunction causing involuntary muscle movements) attack in the facility. The note showed Resident 59 was sent to the hospital for further evaluation. Review of Resident 59's medical records did not show a written transfer/discharge notice was provided to the resident and/or their representative as required. The facility was not able to provide any documentation to support the LTCO was notified of Resident 59's hospitalization as required. In an interview on 06/10/2024 at 9:13 AM, Staff F stated they were unaware of the process of sending a written notification to the resident and/or their representative of the reason for the resident's transfer/discharge. Staff F stated they should have notified the LTCO, but did not. REFERENCE: WAC 388-97-0120(2)(a-d), -0140(1)(a)(b)(c)(i-iii).

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 46471 Based on interview and record review the facility failed to encode and transmit resident assessment data to the Centers for Medicare & Medicaid Services (CMS) within the required timeframe, for 2 of 2 residents (Residents 6 & 68) reviewed for timeliness in encoding and transmission of Minimum Data Set (MDS - an assessment tool). This failure affected federal health information data gathering and placed residents at risk for inaccurate monitoring of the residents' decline or progress over time, untimely comprehensive review of residents' health data/information, and a diminished quality of life. Findings included . <Resident Assessment Instrument - RAI> According to the October 2023 Long-Term Care Facility RAI 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), a discharge (death) MDS assessment must completed within seven days and submitted within 14 days from the date of discharge or death. The manual showed a discharge return anticipated MDS assessment must be completed within 14 days from the date of discharge and transmitted within 14 days of MDS completion. The manual showed MDS encoding (completion) and transmission requirements applied to all MDS 3.0 records used to meet both federal and state requirements. <Resident 6> Review of the facility census showed Resident 9's status was at stop billing on 02/28/2024. The 02/28/2024 Death in Facility MDS showed it was completed on 05/15/2024, more than two months after the resident's death and was past the seven days of encoding as required. The MDS assessment remained export ready in the facility's software system and was not transmitted timely as required. In an interview on 06/07/2024 at 9:34 AM, Staff D (MDS Coordinator) stated they use and follow the RAI manual for coding guidance. Staff D stated they were responsible for encoding and transmitting MDS assessments. Staff D stated it was important to ensure MDS assessments were encoded and transmitted timely for responsible reporting of MDS data. Staff D confirmed Resident 6's Death in Facility MDS was completed late and was still pending transmission and stated it was an oversight on their part. <Resident 68> Review of the facility census showed Resident 68 was discharged to the hospital on 05/20/2024. Review of Resident 68's nursing progress notes showed the resident was discharged to the hospital for a scheduled procedure on 05/17/2024 and did not return back to the facility. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/2024 at 11:52 AM, Staff P (Business Office Manager) confirmed Resident 68's facility discharge date to the hospital was 05/17/2024 and the date recorded on the facility census was incorrect. Review of Resident 68's MDS schedule showed there was no discharge assessment initiated or completed for Resident 68. The MDS record in the facility software showed Resident 68's discharge MDS was overdue. In an interview on 06/12/2024 at 12:03 PM, Staff B (Director of Nursing) reviewed Resident 68's MDS records and stated the MDS coordinator should have completed and transmitted the resident's discharge MDS as required, but did not. REFERENCE: WAC 388-97-1000 (4)(b), (5)(b).

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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 46471

Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) of 3 of 17 residents (Residents 80, 48, & 67) were completed accurately to reflect the resident's condition and overall health status. The facility failed to assess and identify the presence of loose dentures (Resident 80), a fall while in the facility (Resident 48), and a Range of Motion (ROM) limitation (Resident 67). These failures placed residents at risk for aspiration (when food, liquid, or other material enters a person's airway and eventually the lungs by accident), fall triggers, decreased mobility, contractures, unidentified and/or unmet care needs, and a decreased quality of life.

Findings included .

<Facility Policy>

The facility policy, Resident Assessment and Associated Processes, revised December 2023, showed residents would be assessed comprehensively and accurately using the Resident Assessment Instrument (RAI) manual and the findings would be documented in their standardized reproducible assessment. The policy showed the assessment process would include direct observation and communication with residents and the assessment information would be used to develop, review, and revise the resident's comprehensive Care Plan (CP).

<Resident 80>

According to the 05/16/2024 Admission MDS, Resident 80 had clear speech and intact memory. The MDS showed Resident 80 likely had a cavity and broken natural teeth. The MDS did not show Resident 80 had loose upper dentures.

Review of the revised 06/02/2024 dental CP showed Resident 80 had oral/dental health problems and instructed staff to monitor, document, and report any signs and symptoms of oral/dental problems needing attention including missing, loose, or broken teeth.

Observation and interview on 06/05/2024 at 1:24 PM showed Resident 80's upper dentures were very loose when the resident was talking. Resident 80 confirmed their upper dentures were ill-fitting and stated they would often have issues eating/chewing their food.

A 05/23/2024 dental visit note showed the dentist identified Resident 80's loose upper dentures.

In an interview on 06/07/2024 at 9:34 AM, Staff D (MDS Coordinator) stated they use and refer to the Resident Assessment Instrument manual for MDS coding guidance. Staff D stated MDS assessments should be accurate so the staff could provide quality nursing care to the residents since CPs were derived from the comprehensive MDS assessments. Staff D confirmed the presence of Resident 80's loose upper dentures and stated they should have captured the dental issue for aspiration risk and nutrition monitoring, but did not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/10/2024 at 11;22 AM, Staff B (Director of Nursing) stated they expected MDS assessments to be accurate, .so all resident needs are identified in the CP and the daily cares are provided safely. 45941 <Resident 48> According to the 02/01/2024 Discharge MDS, Resident 48 was transferred to the hospital on 02/01/2024. The MDS showed Resident 48 had no fall in the facility during the assessment period. Review of Resident 48's clinical record showed Resident 48 had a fall on 01/31/2024 in their room. The resident was sent out to the hospital for further evaluation. Record review showed Resident 48 readmitted to the facility on [DATE]. In an interview on 06/10/2024 at 10:42 AM, Staff D confirmed Resident 48's fall in the facility on 01/31/2024 was during the MDS assessment period and stated the 02/01/2024 Discharge MDS was inaccurate. Staff D stated the fall should have, but was not captured in the Discharge MDS. <Resident 67> According to the 05/03/2024 Quarterly MDS, Resident 67 had multiple medical diagnoses including weakness to one side of the body sustained from a stroke (brain injury). The MDS showed Resident 67 had no functional limitation in their ROM. Observation and interview on 06/10/2024 at 6:34 AM showed Resident 67's right leg was deformed due to hardening of the muscles/tendons so the resident could not lift their right leg up. In an interview on 06/11/2024 at 9:32 AM, Staff D stated Resident 67's limited ROM should have, but was not captured in the MDS. Staff D stated the 05/03/2024 Quarterly MDS was inaccurate. In an interview on 06/12/2024 at 10:02 AM, Staff B stated staff should have assessed the residents and completed the MDS accurately to reflect residents current status, but they did not. REFERENCE: WAC 388-97- 1000 (1)(b).

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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.

47836

Based on observation, interview, and record review, the facility failed to develop comprehensive Care Plans (CP) for 2 of 17 residents (Residents 37 & 65) whose comprehensive CPs were reviewed. Failure to develop and implement a CP to address a resident's pain (Resident 37), provided care instructions regarding leg immobilizer device use (Resident 65), and establish individualized CPs with identified goals that accurately reflected the resident's condition placed residents at risk for unmet care needs.

Findings included .

<Facility Policy>

The facility's Care and Treatment - Comprehensive Person-Centered Care Planning policy, revised August 2017, showed the interdisciplinary team would develop a comprehensive person-centered CP for each resident that included measurable objectives and timeframe's to meet a resident's medical and nursing needs.

<Resident 37>

According to a 06/10/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 37 received scheduled pain medication during the assessment period and required additional pain medications for breakthrough pain. The assessment showed Resident 37 stated their pain would affect their sleep, interfere with therapy activities and their day to day activities. The MDS showed Resident 37 had a fall acquiring a right hip fracture which required surgical repair. The assessment showed Resident 37 reported they experienced 5/10 pain levels.

Review of the revised 05/28/2024 CP showed Resident 37 did not have a pain CP addressing the management of their pain status post fall with right hip fracture which required surgical repair.

During an observation and interview on 06/07/2024 at 9:07 AM Resident 37 stated they were having right hip pain and had just received their scheduled pain medication which would help. Resident 37 stated they experienced pain daily to their right hip and leg.

In an interview on 6/11/2024 at 10:11 AM Staff B (Director of Nursing) stated Resident 37 did have pain and they should have a pain management CP in place to ensure they were managing the resident's pain well, but they did not.

46471

<Resident 65>

According to the 05/16/2024 Admission MDS, Resident 65 had medical conditions including a left Below the Knee Amputation (BKA - the loss or removal of a part of the leg). The MDS showed Resident 65 suffered an injury fall resulting in a left leg fracture and underwent surgical repair.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/05/2024 at 10:00 AM showed Resident 65 was sitting on the wheelchair inside their room. The remaining part of Resident 65's left leg was secured with a long leg immobilizer/brace and their leg was elevated on the wheelchair's footrest padding. Review of Resident 65's revised 06/02/2024 fall CP showed the resident was at risk for falls because of their impaired mobility and left BKA status. The CP did not identify Resident 65's use of an immobilizer or provided instructions for the nursing staff on how and when to put the immobilizer on or when to remove it. There was no CP developed or implemented for Resident 65 that directed staff to check the skin that was directly in contact with the immobilizer and/or monitor for potential skin breakdown. Review of the June 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not show any order or instruction for staff regarding Resident 65's immobilizer use. Review of Resident 65's 05/10/2024 hospital notes from the vascular physician (a medical provider managing issues with blood flow) showed the plan was to keep the immobilizer on at all times except when the resident was working with therapy or when a staff was performing range of motion exercises on Resident 65's knee. In an interview on 06/07/2024 at 11:39 AM, Staff U (Licensed Practical Nurse) confirmed there was no order or care instructions in the TAR regarding Resident 65's immobilizer use. Staff U stated there should be written instructions for staff to follow, either in the TAR, CP, or Kardex (an individualized facility's visual bedside report that listed directions for staff on how to provide care), but there was none. In an interview on 06/07/2024 at 11:54 AM, Staff K (Resident Care Manager) stated it was important for the CP to be accurate because it served as the staff's guide in providing for resident care needs. Staff K stated development of the CP was an interdisciplinary collaboration between departments, .it's a group effort . for accountability and continuity of care. Staff K stated it was important to capture Resident 65's immobilizer use after having a left BKA and surgical repair of their fracture for proper wound healing and safety. 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. 47836 Based on interview and record review the facility failed to ensure residents were provided an opportunity for a Care Conference (CC) for 5 of 17 sampled residents (Resident 44, 46, 2, 37, & 48). Failure to ensure residents were given the opportunity to participate in care conferences left residents at risk for unmet care needs, lessened participation in care planning, and a diminished quality of life. Findings included . <Resident 44> According to a 03/04/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 44 had complex medical conditions including heart failure, end stage kidney disease, and depression. The assessment showed Resident 44 had no memory impairment and could make themselves understood and understand others without difficulty. In an interview on 06/05/2024 at 10:40 AM Resident 44 stated they could not remember ever having a CC. Review of Resident 44's medical records on 06/10/2024 showed no documentation to support staff performed quarterly CC's. <Resident 46> According to a 03/20/2024 Quarterly MDS, Resident 46 had complex medical conditions including heart failure, high blood pressure, bipolar disorder, depression, and need for assistance with personal care. The assessment showed Resident 46 had no memory impairment and could make themselves understood and understand others without difficulty. In an interview on 06/06/2024 at 9:07 AM Resident 46 stated they couldn't remember having any CC's for over a year now. Review of Resident 46's medical records on 06/10/2024 showed no documentation to support staff performed quarterly CC's. <Resident 2> According to a 05/05/2024 Significant Change MDS, Resident 2 had neurological conditions, high blood pressure, unstable blood sugar levels, a stroke, a seizure disorder, depression, a psychotic disorder, and schizophrenia. The assessment showed Resident 2 had severe memory impairment and family assisted with the assessment. According to a revised 05/06/2024 CP, Resident 2 had a Durable Power of Attorney (DPOA) for healthcare and financial needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/2024 at 1:23 PM Resident 2's representative stated they had not had a CC to discuss the resident's care. Review of Resident 2's medical records on 06/10/2024 showed no documentation to support staff performed quarterly CC's. <Resident 37> According to a 06/10/2024 Admission MDS, Resident 37 had diagnoses of, but not limited to, heart failure, high blood pressure, end stage kidney disease, unstable blood sugar levels, and a hip fracture. The assessment showed Resident 37 experienced moderate memory impairment. Review of Resident 37's medical records on 06/10/2024 showed no documentation to support staff performed quarterly CC's. In an interview on 06/11/2024 at 11:22 AM Staff F (Social Services Director) stated Resident 37 had not received a CC in June or Sept of 2023 but they should have had one quarterly. Staff F stated Residents 44, 46, & 2 also had not received their CC's quarterly but should have. Staff F stated it was important for residents and resident representatives to be able to participate in CC's to ensure they were providing the required care for each resident. Staff F stated it was expected residents receive a CC within 72 hours of admission and then quarterly and as needed with any changes or requests. REFERENCE: WAC 388-97-1020(2)(c)(d). 45941

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 45941 Based on observation, interview, and record review the facility failed to ensure Physician's Orders (POs) for 5 of 17 residents (67, 64, 24. 44, 46) reviewed for acquiring, implementing, and documenting physician orders. These failures left residents at risk for not receiving care they required, potential for new skin issues, and negative health outcomes. Findings included . <Air Mattress> <Resident 67> According to the 05/03/2024 Quarterly Minimum Data Set (MDS- an assessment tool), Resident 67 admitted to the facility with a pressure ulcer and had pressure reduction mattress on their bed. Observations on 06/05/2024 at 8:41 AM, 06/06/2024 at 11:23 AM, and on 06/10/2024 at 9:37 AM showed Resident 67 lying in bed with an air mattress set at patient weight 320 lbs [pounds]. (The resident's weight is one of the parameters staff should enter on the air mattress pump to ensure the air mattress was safely installed for the specific resident and help alleviate pressure to prevent pressure ulcers) Review of Resident 67's Care Plan (CP) revised on 06/03/2024 showed Resident 67 had pressure ulcer on their coccyx area and was at high risk of developing more pressure ulcers. Resident 67's weight records showed they weighed 76.8 lb on 06/11/2024, 77.0 lb on 06/05/2024, and 79.5 lb on 06/01/2024. Review of June 2024 POs showed Resident 67 did not have a PO for the air mattress settings required to manage the air mattress so it benefited the resident. In an interview on 06/10/2024 at 7:43 AM Staff C (Staff Development Coordinator) observed the air mattress pump setting were inaccurate and stated they were inaccurate. In an interview on 06/11/2024 at 8:17 AM Staff B (Director of Nursing) stated air mattresses should have a PO, be monitored every shift for proper setting and function, but staff were not instructed to do so. Staff B stated they should be setting the air mattresses at the resident's current weight. Staff B stated staff should have followed the instructions on the pump for proper setting, but they did not. <Failure to follow POs> <Resident 64> According to the 05/06/2024 Quarterly MDS, Resident 64 had diagnoses including kidney failure and liver failure. This MDS showed Resident 64 received diuretic medications (help the body to get rid of extra fluid) during the assessment period. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 06/05/2024 at 11:18 AM, 06/06/2024 at 2:49 PM, and on 06/10/2024 at 10:09 AM showed Resident 64 had swelling on both lower legs and feet. Review of the June 2024 PO showed an 02/23/2024 order that directed staff to apply an elastic tubular bandage to provide support for managing the swelling to both of the resident's lower legs during the daytime for compression and were to be off at bedtime related to swelling. Observations on 06/05/2024 at 11:18 AM showed Resident 64 with no elastic bandage on their lower legs, on 06/06/2024 at 2:49 PM Resident 64 had the elastic bandage only on the right lower leg, on 06/07/2024 at 9:33 AM Resident 64 was not wearing any elastic bandages on either leg, and on 06/11/2024 at 9:00 AM Resident 64 had only an elastic bandage on the left lower leg. In an interview on 06/11/2024 at 9:04 AM, Staff D (Licensed Nurse) observed Resident 64 with the elastic bandage on only on one leg. Staff D reviewed Resident 64's POs and stated staff should have applied the elastic bandage on both lower legs but they did not. In an interview on 06/11/2024 at 9:38 AM, Staff B (Director of Nursing) stated staff should have follow the doctor's orders to apply the elastic bandages on both lower legs to manage swelling, but they did not. Staff B stated if the resident refused the elastic bandages, staff should have notified the provider and documented the refusal, but they did not. 46471 <Resident 24> According to the 05/02/2024 Quarterly MDS, Resident 24 had clear speech and understood others during communication. The MDS showed Resident had a kidney failure, bone infection, and a chronic wound to their right buttock. The MDS showed Resident 24 had almost constant pain, and was administered narcotic (a strong pain medication) during the assessment period. The revised 01/28/2024 pain CP showed Resident 24 had pain issues and instructed staff to monitor and document the probable cause of Resident 24's pain episodes using the pain severity scale (0-1: no pain; 2-3: mild pain; 4-5: moderate pain; 6-7: severe pain; 8-9: very severe pain; and 10: worst pain possible). A 01/26/2024 CP intervention directed staff to conduct pain assessment every shift. Review of the June 2023 Medication Administration Record (MAR) showed a 04/23/2024 order to administer two tablets of narcotic medication as needed for pain severity of 1-5. The MAR showed on 06/10/2024 at 11:47 AM, Resident 24 rated their pain as 0 (zero) but was administered two tablets of narcotic medication. In an interview on 06/11/2024 at 9:04 AM, Staff K (Resident Care Manager) stated pain management was important to ensure residents remained comfortable for quality of life. Staff K confirmed Resident 24 was administered two tablets of narcotic medication despite having no pain and stated the nurse should not have given the narcotic. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview on 06/11/2024 at 11:07 AM, Staff B stated they did not expect nurses to administer narcotic medications to residents who did not verbalize pain because narcotics were high-risk medications that could cause serious adverse effects including excessive sedation and constipation. Staff B stated, narcotic medication should be given with caution.

47836

<Resident 44>

According to a 03/04/2024 Quarterly MDS, Resident 44 had complex medical conditions including end stage renal disease. The assessment showed Resident 44 had no memory impairment.

Review of Resident 44's revised 06/03/2024 CP showed the resident had an urinary catheter for obstructive uropathy. The CP showed staff should change the catheter bag and tubing as ordered.

Review of Resident 44's PO on 06/06/2024 showed an order to change the catheter and catheter bag as needed. The catheter order did not include what size of catheter to use or the size of the balloon to secure the catheter once inserted into the bladder.

In an interview on 06/10/2024 at 9:47 AM Staff B stated Resident 44's catheter order was incomplete and should include the size of the catheter and how much saline to inject into the balloon securing the device to hold the catheter in place, but it did not. Staff B stated it was important to include the size of the catheter and amount of saline to inject the securing balloon device to decrease the risk of injury and infection.

<Resident 46>

According to the 03/20/2024 Quarterly MDS, Resident 46 had a Continuous Positive Airway Pressure (CPAP- machine to treat a sleep breathing disorder) in use.

Review of Resident 46's PO's showed an order for CPAP, with a start date of 07/12/2022, to be on at bedtime and turned off once resident awakens.

Review of the revised 7/29/2023 CP, Resident 46 had an alteration in respiratory status which had the potential for respiratory distress.

In an interview on 06/08/2024 11:35 AM Resident 46 stated their CPAP was broken for about five to six months.

Review of a May 2024 TAR for CPAP, nurses documented not available daily for the CPAP administration.

During an interview and record review on 06/10/2024 at 6:33 AM Staff M (Licensed Practical Nurse) stated they wrote in the communication book back in February and even wrote a reminder note that it was broken. Staff M showed this surveyor a communication book with a 02/01/2024 notification of Resident 46's CPAP machine broken and another notification for the same thing on 02/27/2024 with an additional note next to it stating order is in. Staff M stated the nurse manager during the day shift was responsible for ordering Resident 46 a new CPAP.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/10/2024 at 10:15 AM Staff B stated they were recently made aware of Resident 46's broken CPAP as they observed Resident 46's MARs showing NA on residents February 2024 to current (June 2024) MARs. Staff B stated they expected the nurse to notify the nurse manager and the nurse manager would order a new one immediately. Staff B stated it was important to supply the CPAP as ordered by the physician to reduce the risk of Resident 46 having respiratory distress. REFERENCE: WAC 388-97-1620(b)(i)(ii),(6)(b)(i).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 47836 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL), related to cleanliness and grooming for 5 (Residents 15, 44, 2, 80, & 24) of 17 sample residents reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with bathing (Residents 15, 44, & 2), shaving (Residents 24 & 80), and nail care (Resident 24), placed the residents at risk for poor hygiene, long facial hair, embarrassment, and diminished quality of life. Findings included . <Bathing Assistance> <Resident 15> According to a 03/22/2024 Quarterly Minimum Data Set (MDS - an assessment tool), it was very important for Resident 15 to choose between a tub bath, shower, bed bath, or sponge bath. Review of a revised 05/15/2024 Care Plan (CP) on 06/11/2024, Resident 15 preferred to have a shower once weekly and required staff assistance with bathing. This CP showed Resident 15 required one staff max assistance with moving in bed/repositioning, they used a wheelchair for locomotion, one staff max assistance with feeding meals, and staff assistance to clean and change resident after incontinent episodes. In an interview on 06/04/2024 at AM Resident 15 stated they were supposed to get cleaned up by staff but had not received a shower or even a bed bath for as long as they could remember. Resident 15 stated they depended on staff to provide bathing assistance because they did not have the strength to shower/bath on their own anymore. Review of Resident 15's Shower schedule on 06/06/2024 showed Resident 15 was not offered or received bathing assistance for the previous 30 days. Review of Resident 15's medical records on 06/07/2024 at 11:43 AM showed no hospice documentation showers were being provided. In an interview on 06/10/2024 at 10:30 AM Staff L (Certified Nursing Assistant - CNA) stated Resident 15 was on hospice so they were not responsible for their bathing any longer and were not providing bathing assistance for Resident 15 since they were on hospice care. In an interview on 06/11/2024 at 9:15 AM Staff B (Director of Nursing) stated their expectation was the shower aide would ensure residents on hospice were receiving bathing as written in the CP. Staff B stated there was no hospice CNA documentation for showers and all hospice care provided was already scanned into the resident's chart. <Resident 44> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 03/04/2024 Quarterly MDS, Resident 44 had no cognitive impairment and they required maximum staff assistance with shower/bathing. Review of a revised 03/17/2024 Care Plan (CP), Resident 44 preferred to have a shower twice weekly and as needed. This CP showed Resident 15 required two staff assistance with mechanical lift to get out of bed and one staff max assistance with bathing/showers. Observation's on 06/04/2024 at 10:17 AM, 06/05/2024 at 10:44 AM, 06/06/2024 at 10:01 AM, 06/07/2024 at 10:59 AM, 06/10/2024 11:20 AM, 06/11/2024 at 2:43 PM, showed Resident 44 lying in bed wearing a gown. In an interview on 06/04/2024 at 10:17 AM, Resident 44 stated they did not been receive showers twice a week and they liked to be clean. Review of Resident 44's shower schedule on 06/06/2024 showed Resident 44 received a full body bath six of nine minimal opportunities in the last 30 days. Review of the shower schedule on 06/06/2024 showed Resident 44 had not received a shower/bath since 05/29/2024, eight days prior. In an interview on 06/10/2024 at 10:29 AM Staff L stated they normally staff two shower aides for the third floor, but the other shower aide was on maternity leave so it was only Staff L to give all residents on the third floor a shower and they could not get to all the assigned showers for all residents. Staff L stated management directed them to complete what they could until they could hire another shower aide and Resident 44 was not receiving showers as ordered because of this. Staff L stated Resident 44's medical records were documented incorrectly as they never gave the resident a full body bath and it was probably supposed to be documented as a sponge bath. In an interview on 06/11/2024 at 9:15 AM Staff B stated they expected staff to provide showers/bathing as ordered for each resident and if they were unable or residents refused, staff would notify the nurse manager's so they could ensure a shower/bath was re-attempted or completed. Staff B stated they were not notified of any shower/baths not being completed. <Resident 2> According to a 05/05/2024 Significant Change MDS showed Resident 2 preferred showers or bed baths. The assessment showed Resident 2 was dependent on staff for shower/bathing hygiene. According to a revised 05/06/2024 CP, Resident 2 required extensive assistance from staff for shower needs. The CP showed Resident 2 would receive a shower once weekly. This CP showed Resident 2 had an assigned DPOA. Review of Resident 2's medical records on 06/05/2024 showed Resident 2 had a Durable Power of Attorney (DPOA) for their healthcare and financial needs. In an interview on 06/05/2024 Resident 2's DPOA stated family had reported when they would visit Resident 2 did not appear to be clean and had a bad odor like they needed a shower. In an interview on 06/10/2024 at Staff L stated Resident 2 was on hospice so they were not responsible to ensure they received showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/11/2024 at 9:15 AM Staff B stated the shower aides were responsible to ensure Resident 2 received showers. Staff B stated there was no hospice documentation showing they were providing Resident 2 showers and they expected facility staff to make sure the resident was receiving showers/baths as ordered. 46471 <Shaving and Nail Care> <Resident 24> According to the 05/02/2024 Quarterly MDS, Resident 24 had clear speech, understood others during communication, and had medical conditions including kidney failure and muscle weakness. The MDS showed Resident 24 was assessed to require one-person assistance with their grooming and personal hygiene. Review of Resident 24's 01/28/2024 ADL CP showed the resident had self-care performance deficits and the CP directed staff to provide Resident 24 with routine ADL cares including personal hygiene. In an interview and observation on 06/05/2024 at 9:40 AM, Resident 24 was observed with matted hair, long facial hair, and their fingernails were long with black residue underneath the nails. Resident 24 stated the staff did not provide them any personal hygiene assistance in weeks and would like staff to help them shave their facial hair and trim and clean their fingernails. In an interview on 06/05/2024 at 9:48 AM, Staff C (Resident Care Manager) stated it was important to provide ADL care for residents who were dependent on staff for dignity and quality of life. Staff C stated they expected staff to follow the CP when providing resident care for safety. Staff C confirmed the condition of Resident 24's grooming needs and stated the staff should have but did not provide personal hygiene assistance to Resident 24. <Resident 80> According to the 05/16/2024 Admission MDS, Resident 80 had clear speech, understood others during communication, and had medical conditions including brain damage, kidney failure, and malnutrition. The MDS showed Resident 80 was assessed to require one-person assistance with their grooming and personal hygiene. Review of Resident 80's 05/11/2024 ADL CP showed the resident had self-care performance deficits because of their recent hospitalization , weakness, and deconditioning. The CP directed staff to provide Resident 80 with routine ADL cares including personal hygiene. In an observation and interview on 06/05/2024 at 1:22 PM, Resident 80 was observed with long facial hair. Resident 80 stated they asked the evening shift staff for a razor about a week ago but had not received one. Resident 80 stated they would appreciate staff assistance with shaving their facial hair because it was bothersome. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/2024 at 1:58 PM, Staff B stated the facility kept disposable razors in the clean utility room. Staff B stated when residents ask for a razor, they expected staff, not just to hand them one, but to provide the grooming assistance for resident safety, .razors are sharp and it is dangerous to have the resident do it on their own . Staff B stated they expected the nursing staff to provide ADL help to residents who were not capable of doing it themselves to ensure residents' quality of life in the facility. REFERENCE: WAC 388-97-1060(2)(c).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 47836 Based on observation, interview, and record review the facility failed to ensure activity programs met the needs of each resident for 1 of 1 resident's (Residents 2) reviewed for activities. Failure to provide residents with meaningful activities left residents at risk for boredom, frustration, and a diminished quality of life. Findings included . <Resident 2> According to a 05/05/2024 Significant Change Minimum Data Set (MDS - an assessment tool) showed Resident 2 preferred listening to music, attending group activities, and participating in religious activities. The assessment showed Resident 2 had severe cognitive impairment. The MDS showed Resident 2 had diagnoses of dementia, a stroke with left sided paralysis, seizure disorder, depression, psychotic disorder, schizophrenia, a cognitive communication disorder, and a need for assistance with personal care. Review of a revised 05/06/2024 Care Plan (CP) showed Resident 2 was dependent on staff for activities related to their physical limitations. The CP showed Resident 2 would participate in activities five to seven times a week. The CP showed Resident 2 would be invited to all group activities provided. In an interview on 06/05/2024 Resident 2's representative stated they brought a radio in for the resident and staff would unplug it but not assist the resident with turning it on. Resident 2's representative stated that music was so important to the resident, and they had expressed this to the activities department staff when they notified them of the radio. Resident 2's representative stated they brought a computer tablet in for the resident and was told by staff they needed to bring it home because the resident was unable to utilize on their own and staff don't have time to do this with them. Review of a 30 day look back of the activity documentation on 06/06/2024 showed Resident 2 had not been offered to attend any activities. Daily observations on 06/04/2024, 06/05/2024, 06/06/2024, 06/07/2024, 06/10/2024, and 06/11/2024 showed Resident 2 sitting in w/c in room without a TV or radio on, no reading material or any sort of entertainment. In an interview on 06/11/2024 at 10:44 AM Staff O (Activities Supervisor) stated Resident 2 should have activities offered five to seven times a week per their CP. Staff O stated Resident 2 was dependent on staff for all activities due to their mental and physical disabilities. Staff O stated they had not documented any activities and understood they should be offering and documenting activities per CP direction but did not. Staff O stated they understood the importance of activities improving resident's quality of life and overall enjoyment. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/2024 at 10:15 AM Staff A (Executive Director) stated they expected staff to offer activities to all residents. Staff A stated they expected activities staff to document when they offered an activity and if a resident accepted, refused, or was unavailable. REFERENCE: WAC 388-97-0940 (1).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45941 Based on observation, interview, and record review, the facility failed to ensure 2 of 4 residents (Residents 64 & 59) reviewed for non-pressure skin alterations and 1 of 4 residents (Resident 2) reviewed for constipation were provided quality care and services. The failure to ensure resident skin issues were assessed, treated, and/or monitored, and the failure to initiate facility bowel care protocol left residents at risk for unmet care needs, pain/discomfort from constipation, and a decreased quality of life. Findings included . <Facility Policy> The facility's Skin and Wound Monitoring and Management policy, revised December 2023, showed a licensed nurse would assess/evaluate a resident's skin at least weekly and areas identified must be documented in the appropriate weekly assessment form. The policy showed skin monitoring would be captured daily via medication and treatment administration records. <Resident 64> Observations on 06/05/2024 at 11:18 AM, 06/06/2024 at 2:49 PM, and on 06/10/2024 at 10:09 AM showed Resident 64 had multiple scattered dark purple bruises on their right forearm. Resident 64 stated they had bruises on their right forearm for a few days. Resident 64 stated they must have bumped the door or their wheelchair. Review of the weekly skin assessments completed on 06/07/2024 showed Resident 64 had old bruises on both hands and both legs were swollen. There was no documentation showing Resident 64 had multiple bruises on their right forearm. Review of the June 2024 Physician Orders showed there were no orders to monitor the bruises for worsening and to notify the provider as of 06/11/2024. In an interview on 06/11/2024 at 9:04 AM, Staff D (Licensed Nurse covering for RCM) stated the facility process was to do weekly skin check on all residents. For any new bruising, staff had to initiate investigation to rule out abuse and neglect, notify the provider and receive orders to monitor the bruises for worsening. Staff D stated they were not aware of the bruises on Resident 19's right forearm bruising. Staff D observed Resident 64's right forearm with bruising and stated there should be POs to monitor the bruises for worsening. Staff D stated they should have notified the provider regarding Resident 64's bruises and received a PO, but they did not. In an interview on 06/11/2024 at 9:31 AM, Staff B (Director of Nursing) stated staff should have documented the bruising on the weekly skin check. Staff B stated there should be a PO from the provider to monitor Resident 64 for new bruises, but staff did not obtain one. 46471 (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

<Resident 59>

According to the 03/12/2024 Annual MDS, Resident 59 had clear speech and understood others during communication. The MDS showed Resident 59 was at risk for skin breakdown.

The revised 04/23/2024 skin CP showed Resident 59 had fragile and sensitive skin and was potentially at risk for skin integrity impairment. A 08/01/2023 CP intervention instructed staff to observe Resident 59 for any red or open areas, and to report any skin issues identified.

Observation and interview on 06/05/2024 at 9:02 AM showed the skin on Resident 59's arms was paper-thin and very dry; their left outer forearm had a diffused, raised, red rash that measured five inches long. Resident 59 stated they did not know how they sustained the skin issue or when it came about. Resident 59 was observed with the same skin issue on their left arm on 06/10/2024 at 12:18 PM and on 06/11/2024 at 8:57 AM.

Review of Resident 59's weekly skin assessment on 06/10/2024 showed the skin evaluation had not been completed and was six days overdue.

Review of the June 2023 Treatment Administration Record (TAR) did not show Resident 59's left arm rash had been identified or was being monitored by staff as instructed in the resident's CP.

In an interview on 06/11/2024 at 9:08 AM, Staff U (Licensed Practical Nurse) stated they were aware of Resident 59's left outer forearm rash and that the skin issue comes and goes.

In an interview on 06/12/2024 at 9:10 AM, Staff K (Resident Care Manger) confirmed the presence of the skin rash on Resident 59's left arm, the weekly skin assessment that was overdue in Resident 59's medical records, and the lack of monitoring in the TAR. Staff K stated they expected the nursing staff to assess identified skin issues, notify the provider, document the treatment and update the CP, and to monitor the skin condition.

47836

<Resident 2>

According to a 05/05/2024 Significant Change MDS, Resident 2 had severe cognitive impairment with a diagnosis of dementia. The assessment showed Resident 2 was dependent of staff for toileting hygiene and required maximal staff assistance for transfers to the toilet. The assessment showed Resident 2 was frequently incontinent of bowels and required maximal staff assistance for incontinence hygiene care.

Review of a revised 05/06/2024 CP showed Resident 2 would have a Bowel Movement (BM) every two to three days. The CP showed staff would monitor and document when Resident 2 had a BM every shift.

In an interview on 06/05/2024 11:33 AM Resident 2's representative stated family was in to visit with resident and assisted them to the toilet. Resident 2's representative stated the family member heard Resident 2 experiencing pain on 05/22/2024 while trying to have a BM in the bathroom and they notified staff.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's BM record on 06/06/2024 for the previous 30 days showed Resident 2 had medium a BM on 05/17/2024 and did not have a BM until the night of 05/22/2024. Review of the May 2024 Medication Administration Record showed no laxatives offered or given to Resident 2 when they were showing signs of constipation with no BM for five days (05/17/2024-05/22/2024). In an interview on 06/11/2024 at 9:10 AM Staff B stated the facility policy was if a resident did not have a BM in three days staff would administer an oral laxative by mouth. Staff B stated if there were no results from the oral laxative the next shift would administer a rectal suppository or enema and if there were no results from that, staff were expected to notify the provider for further orders. Staff B stated Resident 2 should have been offered a laxative when they did not have a BM for three days, but they were not. REFERENCE: WAC 388-97-1060 (1).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47836 Based on observation, interview, and record review the facility failed to ensure 3 of 6 sampled residents (Residents 44, 46, & 67) reviewed for Restorative Nursing Program (RNP) services received the care and services they were assessed to require. These failures placed residents at risk for a decline in Range of Motion (ROM), increased dependence on staff, and a decreased quality of life. Findings included . <Facility Policy> Review of the facility policy titled, Restorative Care, dated 05/2016, showed restorative care would be provided to each resident according to their individual needs and as determined by the interdisciplinary team. The policy showed documentation of RNP would be in each resident's electronic health record when it was offered, if a resident refused, or when a resident was not available to participate in their RNP. <Resident 44> According to a 03/04/2024 Quarterly Minimum Data Set (MDS- an assessment tool), Resident 44 had no memory impairment. The assessment showed Resident 44 had diagnoses of, but not limited to, depression, generalized muscle weakness, and difficulty in walking. Review of a revised 03/10/2024 Care Plan (CP) showed a RNP for ROM to both arms and legs and a RNP for bed mobility to be done three to six times a week. In an interview on 06/06/2024 at 11:33 AM Resident 44 stated they were supposed to be receiving restorative nursing services but were not offered the RNP that many times. Review of RNP documentation on 06/06/2024 showed Resident 44 was only offered their arms and legs ROM RNP 6 of 24 opportunities and their bed mobility RNP 1 of 24 opportunities over the previous 30 days. <Resident 46> According to a 03/20/2024 Quarterly MDS, Resident 46 had no memory impairment. The assessment showed Resident 46 had diagnoses of, but not limited to, depression, generalized muscle weakness, abnormal posture, and a need for assistance with personal care. The MDS showed Resident 46 received zero days/minutes of restorative nursing services during the seven day look back period of this assessment. Review of Resident 46's Physician Orders (POs) showed an order for restorative therapy initiated 03/02/2021. Review of a revised 03/18/2024 CP showed Resident 46 was to receive both arms and legs active ROM RNP three to six times a week and passive ROM RNP to both legs three to six times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/05/2024 at 11:33 AM Resident 46 stated their restorative gal didn't work there anymore so they hadn't been receiving it like they used to. Resident 46 stated they had received RNP to their arms a few times but had not received their RNP to their legs. Review of RNP documentation on 06/06/2024 showed Resident 46 was only offered their RNP to both arms and legs 5 of 24 opportunities and passive ROM to both legs 5 of 24 opportunities over the previous 30 days. In an interview on 06/10/2024 at 5:40 AM Staff I (Restorative Nursing Aide -RNA) stated they were the only RNA and they had to many programs to complete so they could not offer everyone their RNP as ordered. Staff I stated when they were pulled to work as an aide on the floor the facility did not staff restorative so the programs would not get done those days at all. Staff I stated Residents 44 & 46 did not receive their RNP's as ordered because they were unable to get to them. In an interview on 06/10/2024 at 9:46 AM Staff H (Rehab Director) stated RNP's are important for the maintenance of a resident's ability to perform their activities of daily living independently and to prevent a decline in their level of function. Staff H stated they completed the evaluation on the residents and the RNA was already educated on how to provide to the residents. Staff H stated they would follow up on these RNPs as needed. In an interview on 06/11/2024 Staff A (Executive Director) stated they expected RNP to be completed as ordered and documented when it was offered, if a resident refused, or when a resident was unavailable. <Resident 67> According to the 05/03/2024 Quarterly MDS, Resident 67 had multiple medical diagnoses including weakness to one side of the body sustained from a stroke (brain injury). The MDS showed Resident 67 received zero days/minutes of RNP during the assessment period. Review of the 02/01/2024 Self-Care Deficit CP instructed staff to provide Resident 67 Passive ROM exercises to both legs three to six times a week. Review of the RNP documentation for the last 30 days (on 06/10/2024) showed Resident 67 received their RNP passive ROM to both legs only for seven times in 30 days. In an interview on 06/10/2024 at 6:06 AM, Staff I stated they were the only staff to provide RNP to residents and had too many programs to complete. Staff I stated they could not offer and provide the RNP to residents as ordered. Staff I stated Resident 67 did not receive their RNP as ordered. In an interview on 06/10/2024 at 9:46 AM Staff H stated RNP's were important for the maintenance of a resident's ability to perform their daily activities and to prevent a decline in their level of function. Staff H stated they completed the evaluation on the residents and the RNA was already educated on how to provide to the residents. Staff H stated they would follow up on these RNPs as needed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/11/2024 Staff A (Executive Director) stated they expected RNP to be completed as ordered and documented when it was offered, if a resident refused, or when a resident was unavailable. REFERENCE: WAC 388-97-1060 (3)(d), (j)(ix). 45941

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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. 47836 Based on observation, interview, and record review the facility failed to ensure fall prevention interventions were in place for 1 of 4 sampled residents (Resident 37) reviewed for falls. This failure placed residents at risk for potential injuries that could affect the resident's quality of life and safety. Findings included . <Facility Policy> Review of the facility policy titled, Fall Best Practice Guidelines, dated 03/2016, showed the facility would implement interventions to minimize the potential for injury. This policy showed prevention protocol would be initiated based on each category and individualized plan of care. The policy showed nursing would conduct shift to shift reports with walking safety rounds following report checking on high fall risk residents. <Resident 37> According to a 06/10/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 37 had a history of falls in the last month. The MDS showed Resident 37 had a fall with right hip fracture that required surgical repair. The MDS showed Resident 37 had moderate memory impairment and diagnoses of, but not limited to, heart failure, hip fracture, stroke with one side of body paralysis, depression, unsteadiness on feet, need for assistance with personal care, and epilepsy. Review of a revised 05/28/2024 Care Plan (CP) showed Resident 37 would have their bed in lowest position and have bilateral floor mats by the bed. Observations on 06/04/2024 at 11:17 AM, 06/05/2024 at 9:08 AM, 06/062024 at 9:37 AM and 12:16 PM, 06/07/2024 at 10:32 AM, 06/10/2024 at 6:33 AM, and 06/11/2024 at 10:08 AM showed Resident 37's bed not in the lowest position and no floor mats on the floor by their bed. In an observation and interview on 06/11/2024 at 9:34 AM Staff AA (Registered Nurse) stated Resident 37 should have their bed in the lowest position and bilateral floor mats next to bed but they must have been packed up when the resident went to the hospital after their fall with fracture and the mats were never replaced when the resident returned from the hospital. In an interview on 06/11/2024 at 10:08 AM Staff B (Director of Nursing) stated Resident 37 had fall interventions such as bilateral floor mats next to bed and bed in lowest position while in bed put in place after their fall with fracture. Staff B stated they expected nurses to follow resident 37's CP and have interventions in place. Staff B stated the interventions were important to decrease the risk of injury if Resident 37 had another fall. REFERENCE: WAC 388-97-1060 (3)(g).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46471 Based on observation, interview, and record review the facility failed to implement ongoing communication and care coordination with the dialysis (a procedure to clean and filter the body's waste products) facility regarding treatment and services for 2 of 2 residents (Residents 24 & 11) reviewed for dialysis care. This failure placed residents at risk for unmet care needs, unidentified medical complications, adverse health outcomes, and a decreased quality of life. Findings included . <Facility Policy> The facility's 03/2016 Specialty Care - Dialysis Services policy showed a contract and plan would be developed between the dialysis center and the facility in order to coordinate care and services. The policy showed the dialysis center would be asked to provide information with regards to the resident's visit, weights, and other pertinent information and a facility dialysis documentation form would accompany the resident to all appointments. <Resident 24> According to the 05/02/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 24 had clear speech, understood others during communication and had medical conditions including kidney failure. The MDS showed Resident 24 was dependent on dialysis and received dialysis treatment during the assessment period. The 03/27/2024 dialysis Care Plan (CP) showed Resident 24 needed dialysis due to end-stage kidney failure. The CP listed the frequency of Resident 24's dialysis treatment during the week and the name, address, and contact information of the dialysis center. The CP did not show a coordinated CP was developed for Resident 24's dialysis treatment that included directions and/or interventions for nursing staff on how to collaborate with the dialysis facility regarding ongoing resident care. In an observation and interview on 06/05/2024 at 9:46 AM, Resident 24 stated they needed dialysis because their kidneys were no longer functioning. Resident 24's left arm was observed to have the dialysis access site. Resident 24 was observed telling Staff K (Resident Care Manager) they did not feel they could go to their dialysis treatment on that day because of abdominal pain. At 11:28 AM, Resident 24 was observed up in their wheelchair and being transported by staff to the facility's main entrance for dialysis pick-up. Review of Resident 24's medical records showed there was no transfer communication from the facility to the receiving dialysis center that indicated Resident 24's abdominal pain prior to their dialysis treatment. Review of the 06/05/2024 nursing progress notes did not show any documentation to support the nursing staff documented or reported the presence of Resident 24's abdominal pain to the receiving dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/11/2024 at 11:34 AM, Staff B (Director of Nursing) stated they expected the nursing staff to complete the facility's transfer communication form for residents going to dialysis treatments for resident safety. Staff B stated dialysis care coordination was important because it ensured continuity of care. <Resident 11> According to the 05/09/2024 Admission MDS, Resident 11 had clear speech, understood others during communication, and had medical conditions including heart and kidney failure, respiratory diseases, and adult failure to thrive. The MDS showed Resident 11 was dependent on dialysis and received dialysis treatment during the assessment period. The 05/20/2024 dialysis CP showed Resident 11 needed dialysis due to end-stage kidney failure. The CP listed the frequency of Resident 11's dialysis treatment during the week and the name, address, and contact information of the dialysis center. The CP did not show a coordinated CP was developed for Resident 24's dialysis treatment that included directions and/or interventions for nursing staff on how to collaborate with the dialysis facility regarding ongoing resident care. On 06/05/2024 at 2:02 PM, Resident 11 stated they go for dialysis two times a week on Mondays and Fridays. In an interview on 06/07/2024 at 11:12 AM, Staff K (Resident Care Manager) stated the facility's dialysis care coordination process with the dialysis center involved sending residents a packet including the face sheet, a copy of the resident's medication list, and the facility transfer communication form. Observation on 06/07/2024 at 1:00 PM showed Resident 11 came back from dialysis treatment. Resident 11's dialysis packet was observed without a transfer communication form attached. When asked where the transfer communication form for Resident 11 was to show how the dialysis treatment went and/or if there was any recommendation made by the dialysis facility, Staff K stated there was none. Staff K stated the nurses should have, but did not complete a transfer communication form for Resident 11. REFERENCE: WAC 388-97-1900(1)(6) (a-c).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47836 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 Percent (%). Failure to properly administer 16 of 26 medications for 2 of 4 residents (Residents 28 & 15) observed during medication pass resulted in a medication error rate of 61.54%. This failure placed residents at risk for not receiving the correct dose or receiving less than the intended therapeutic effects of Physician Ordered (PO) medication. Findings included . <Facility Process> On 06/04/2024 at 8:52 AM Staff B (Director of Nursing) stated the facility's process was medications were expected to be administered within 1 hour prior to scheduled time until one hour after the scheduled time. <Resident 28> Observation of medication pass on 06/10/2024 at 7:01 AM, showed Staff M (Licensed Practical Nurse) enter Resident 28's room and administered the resident's morning medications. Review of resident 28's records on 06/10/2024 showed a PO with an immeasurable dose of one unit into each eye. 7 of the 12 medications administered to Resident 28 were not to be administered until 9:00 AM, or within an hour before or after 9:00 AM. In an interview on 06/10/2024 at 7:10 AM, Staff M stated they should not have administered the medications that were due at 9:00 AM to Resident 28 because they were not in the window to be administered yet. Staff M stated it was important to administer medications on time so they wouldn't end up being administered to close to the resident's last dose. Staff M stated the eye drop order was inaccurate and there was no way of drawing up one unit since they came in an eye drop bottle. Staff M stated they should have clarified with the Physician prior to administering and had assumed the Physician wanted one drop because that's how that medication was normally prescribed. <Resident 15> Observation of medication pass on 06/10/2024 at 7:22 AM, showed Staff M enter Resident 15's room and administered eleven medications to the resident. Review of Resident 15's PO's on 06/10/2024 showed 8 of the 11 administered were not to be administered until 9:00 AM, or within an hour before or after 9:00 AM, and one of the orders for an inhalation medication was inaccurate with an immeasurable dose ordered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/10/2024 at 7:33 AM Staff M stated they should not have administered the 9 medications that were scheduled at 9:00 because it was too early to give them. Staff M stated the inhalation medication order was inaccurate and there was no way to measure one application as the order read and they should have clarified with the Physician before they administered it, but they did not. In an interview on 06/10/2024 at 9:51 AM Staff B stated they expected staff to administer medications within the allotted time window of one hour before or after the scheduled time. Staff B stated this was important to ensure residents were not receiving medications to close to one another. Staff B stated the 9:00 AM medications should have been administered between 8:00-10:00 AM and if staff was unable to administered within that timeframe they were to notify the provider and update the order. REFERENCE: WAC 388-97-1060(3)(k)(ii).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on observation and interview, the facility failed to keep the kitchen environment clean and sanitary and failed to ensure food was stored, prepared, and served under sanitary conditions for 1 of 1 kitchen observed. Facility staff failed to: Label and date food; discard damaged/expired/spoiled food (including after thawing); and perform Hand Hygiene (HH) when handling raw eggs during food preparation. These failures contributed to an unsanitary and unsafe storage and preparation of food, and placed residents at risk for life-threatening food-borne illness and a decreased quality of life. Findings included . <Facility Policy> Review of an undated facility provided document, Food Procurement, Storage and Distribution, showed the facility staff would keep track of when to discard perishable foods including covering, labeling, and dating of all food items stored in the refrigerator and/or freezer as indicated. The document showed the facility staff would inspect food items from safe transport and quality upon receipt and would ensure proper storage of food. The facility policy, Egg Storage and Preparation, revised [DATE], showed safe handling instructions of raw eggs for kitchen staff. The policy showed food handlers ensured they washed their hands before and after handling eggs, kept raw eggs separated from ready-to-eat foods, and ensured equipment and food contact surfaces were cleaned and sanitized before and after each use. <Kitchen Environment> Observation and interview on [DATE] at 7:14 AM showed the surface layer of the kitchen floor was peeling; next to the stove was a significant area of exposed, cracked cement with crevices (narrow openings) filled with dirt and debris. Staff T (Dietary Aide) stated it had been in that condition for years. Observation and interview on [DATE] at 8:21 AM showed the kitchen stove tops were dirty and full of grime and burnt debris. Staff S (Dietary Supervisor) stated the stove should be kept clean to prevent cross-contamination and food-borne illnesses especially since the facility was catering to a vulnerable and elderly population. Observation and interview on [DATE] at 8:28 AM showed all the wire racks located inside the walk-in refrigerator holding stored produce (fruits and vegetables) and plated ready-to-eat food were dirty and full of rust underneath. Staff S stated the racks should be replaced because they were uncleanable and unsanitary to be used for food storage. In an interview on [DATE] at 9:27 AM, Staff A (Executive Director) conducted a kitchen walk-through, confirmed all the environmental issues observed, and stated they should be addressed immediately. Staff A stated it was important to ensure the kitchen remained clean and sanitary for resident safety. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Cleaning Solution> Observation and interview on [DATE] at 7:11 AM showed a bucket of sanitizing solution (used to wipe kitchen counters and surfaces) was located on top of the sink next to the tray line service area. Staff S was asked to test the cleaning solution. Staff S was observed dipping the testing strip into the bucket and obtained a test strip reading of 0 (zero) parts per million (indicating that the chemical in the solution could no longer effectively sanitize); the staff performed the testing procedure twice and obtained the same result on both occasions. Staff S stated the test strip reading did not pass chemical testing and the cleaning solution in the bucket would not be effective in sanitizing the kitchen. Staff S stated it was important to ensure the chemicals in the sanitizing solution remained potent (of great effect) to effectively remove harmful bacteria sitting on kitchen counters and surfaces that could cause food-borne illnesses. <Food Preparation> On [DATE] at 7:40 AM during breakfast tray line service observation, Staff T was observed wearing gloves while preparing and plating food. With their gloved hands, Staff T went to the adjacent skillet, got two raw eggs from the container on top of the prep cart, cracked them open, and the raw egg dripped into their gloves. Staff T then returned back to the tray line, got a plate, and grabbed two pieces of bread (ready-to-eat food) from the serving pan without taking off their contaminated gloves and/or performing HH. When asked if they should remove their contaminated gloves first and wash their hands before resuming food service (since their gloves came in contact with raw eggs), Staff T stated, .oh yes, that's right. Staff T stated raw eggs were high-risk for Salmonella (a bacteria related to severe food poisoning) and could cause death. In an interview on [DATE] at 8:21 AM, Staff A stated it was important for kitchen staff to ensure all eggs were pasteurized (gently heated in their shells enough to kill the bacteria at a minimum required temperature for a specified time) and served with caution, [staff] should avoid cross-contamination when handling raw eggs during food preparation and service to prevent food-borne illnesses that could kill. 50511 <Food labeling> Observation and interview on [DATE] at 8:51 AM during a tour led by Staff S showed the walk-in freezer had foods that did not have dates labeled on food containers including two packages of croissants (one opened and one closed), one opened bag of breakfast sausages, two unopened frozen bags of corn, and one unopened frozen broccoli. Staff S confirmed all food items that were observed undated/unlabeled and stated they should all be thrown away. Observation on [DATE] at 9:17 AM showed a shelf in the kitchen next to the entrance to the cook's refrigerator had a container of brown sugar covered with plastic wrap and was undated. <Food Storage> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the dry food storage on [DATE] at 9:09 AM showed the following: Two dented cans (one can of cranberry sauce and one can of mild cheddar sauce); two boxes of buttermilk biscuits with a use date of [DATE]; a half empty box of fudge icing with an expiration date of [DATE]; one case of raspberry dessert sauce bottles with an expiration date of [DATE]; one box of chocolates with a use by date of [DATE]; and one jar of peanut butter with an open date of [DATE] and the use-by date of [DATE]. According to facility provided food storage guidelines, the peanut butter was seven months past the posted guideline recommendations. In a joint interview on [DATE] at 9:11 AM with Staff's T and S, Staff T stated expired foods should be gone and removed. Staff T stated it was important to check foods for expiration dates per guidelines. Staff S stated the staff was frequently checking dried food storage for expiration dates but didn't catch these items. Staff S confirmed the presence of the two dented cans and stated, these cans should not be here . and removed them. Observation on [DATE] at 9:17 AM showed cold storage guidelines posted on the cooks' refrigerator. The guideline's showed ham was to be stored for three to five days, cheese for one week after opening, and fresh chicken should be stored for one day. The following items were observed past the food storage guidelines: one ham dated [DATE] was four days past guidelines for ham; one package of opened Parmesan cheese with a preparation date of [DATE] was four days past guidelines; one bag of thawed mixed chicken parts was not dated but had a used by date of [DATE]. In an interview on [DATE] at 8:51 AM Staff S stated the chicken mixed parts bag was pulled on [DATE] and thawed. Staff S acknowledged the food guidelines posted on the refrigerator that stated fresh (raw) chicken should only be stored for one day. Staff S stated the chicken was not on the menu for today's dinner and would get rid of it. In an interview on [DATE] at 10:30 AM Staff A stated expectations for staff were to follow policy and processes to date food as soon as opened and to review expiration and used-by dates. Staff A stated kitchen staff should throw away and discard food items that were thawed more than what was allowed per food safety guidelines. Staff A stated for resident safety, the chicken found thawing past the guidelines for storage should be thrown out immediately because chicken was a high-risk food and was probably contaminated. REFERENCE: WAC [DATE](3).

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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. 46471 Based on interview and record review, the facility failed to ensure residents and/or their representatives were informed of the nature and implications of entering into a binding Arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) Agreement (AA) for 2 of 3 residents (Residents 37 & 67) reviewed for arbitration. The facility failed to explain the AA in a form or manner that the resident and/or their representative understood (Resident 37) and failed to ensure the Durable Power of Attorney for Financial (DPOA-F) was the signatory on the AA (Resident 67) on behalf of the resident as required. These failures placed Residents 37 and 67 and other residents at risk of lacking understanding of the legal document signed, forfeiture (loss or giving up of something) of the right to a jury or court, and a diminished quality of life. Findings included . <Resident 37> Review of Resident 37's AA showed the contract was signed by the resident's DPOA-F on 05/29/2024. In an interview on 06/12/2024 at 11:38 AM, Resident 37's representative confirmed they were the resident's DPOA-F and stated they were not fully educated by the admissions staff regarding the details surrounding AA, .I was told by the staff that it [AA] was a part of the admission process .they [staff] made us sign several documents during [Resident 37's] admission and it was difficult to keep up with all the information being given . When the contract was read and explained to Resident 37's representative, the representative stated they did not want to enter into the binding AA and would like to revoke the contract, .if it meant waiving [Resident 37's] rights to a jury or court, then no, we don't want it. Resident 37's representative stated they would contact the facility's admissions department and take action. <Resident 67> Review of Resident 67's AA showed the contract was signed by the resident's representative on 02/22/2024. Review of Resident 67's medical records did not show an Advance Directive was formulated delegating Resident 67's representative as the resident's DPOA-F. In an interview on 06/12/2024 at 11:46 AM, Staff J (Admissions Director) stated they were responsible for the facility's AA process. Staff J confirmed Resident 67 did not have a delegated DPOA-F and stated the representative should not sign the AA contract on Resident 67's behalf. Staff J stated they could have done a better job explaining the AA to Resident 37's representative before having them sign the contract. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/12/2024 at 2:01 PM, Staff A (Executive Director) stated it was important to educate residents and/or their representatives of the AA process so they know what they were entering into. Staff A stated they expected the admissions department to be knowledgeable of the AA and to ensure residents and/or their representatives understood all the legalities incorporated into the binding AA contract before letting them sign, .we do not want to rush them [resident/representative] because it is the resident's right we are talking about. REFERENCE WAC: 388-97-1620(2)(a)(b)(i), -0180(1-4).

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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** 45941 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe environment to prevent placing residents at risk for facility acquired infections. The facility staff failed to follow Transmission Based Precautions (TBP) recommendations for 2 (room [ROOM NUMBER] & 325) of 2 rooms on contact precautions reviewed, and ensure indwelling catheter (tubing to facilitate urinary drainage) bags were secured. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . <room [ROOM NUMBER]> Observations on 06/06/2024 at 9:00 AM showed a contact precaution sign outside of room [ROOM NUMBER] that instructed staff to don (apply) Personal Protective Equipment (PPE) as follows; don gown, glove, and mask prior to entering room [ROOM NUMBER]. Observation and interview on 06/06/2024 at 12:33 PM showed Staff Y (receptionist) and Staff D (MDS Coordinator) enter room [ROOM NUMBER] without donning any PPE. Staff Y stated they should have followed the sign and applied gloves, gown, and mask prior to entering the room. Staff D stated they were trained to only apply PPE if they were working with the resident that was on the contact precautions and would follow up with the Infection Preventionist of the building. During the interview two other staff entered the room without donning PPE, Staff Z (Certified Nursing Assistant) and Staff P (Business Office Manager). Staff Z stated they were instructed to only don PPE when working with the resident in the room that had the infection. Staff P stated the sign instructed them to don PPE prior to entering the room, not prior to working with a particular resident, so they should have donned PPE prior to entering room [ROOM NUMBER], but they did not. In an interview on 06/06/2024 at 12:35 PM Staff C stated all staff have received training on contact precautions and they should have followed what the sign directed them to do. Staff C stated this was important to not spread infections and keep the residents safe. <room [ROOM NUMBER]> Observation on 06/06/2024 at 9:12 AM showed a contact precaution sign outside of room [ROOM NUMBER] instructing staff to don PPE as follows; don gown, glove, and mask prior to entering room [ROOM NUMBER]. Observation on 06/06/2024 at 1:02 PM and 1:08 PM showed Staff D enter a contact precaution room (room [ROOM NUMBER]) without donning PPE prior to entering both times. In an interview on 06/06/2024 at 1:10 PM Staff D stated the sign directed them to don PPE (gown, gloves, and mask) prior to entering the room. Staff D did not want to comment further and stated they would talk to the Infection Preventionist for further direction. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/06/2024 at 2:21 PM Staff C stated they would inservice all staff again on following the TBP signs directions. <Resident 61> According to the 03/18/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 61 was unable to move lower part of the body due to spinal cord injury. The MDS showed Resident 61 required an indwelling catheter. Observation on 06/04/2024 at 2:00 PM showed Resident 61 lying in bed and their catheter bag was hanging on the trash can on the floor. Observation on 06/06/2024 at 12:33 PM showed Resident 61 was sitting in their wheelchair (w/c) in the hallway, and their catheter bag was observed on the floor under their w/c with no privacy bag and dragged on floor when Resident 61 moved their w/c towards the nursing station. Observation on 06/10/2024 at 11:35 AM showed Resident 61 was lying in their bed and their catheter bag was hanging on the trash can. In an interview on 06/11/2024 at 8:48 AM Staff C (Infection Preventionist) stated it was important to handle catheter bags appropriately to ensure the bag maintained its integrity and prevent urine from contaminating the facility environment. Staff C stated staff should have Resident 61's catheter bag in a privacy bag and should be secured on the bed frame, not on the trash can. <Resident 62> According to the 05/22/2024 Quarterly MDS, Resident 62 was admitted to the facility on [DATE] with multiple medical complex conditions. The MDS showed Resident 62 required an indwelling catheter. Observation on 06/05/2024 at 9:59 AM showed Resident 62 lying in bed and their catheter bag was hanging on the trash can on the floor. Observation on 06/07/2024 at 9:12 AM showed Resident 62 was sleeping in their bed and their catheter bag was hanging on the trash can. Observation and interview on 06/07/2024 at 11:33 AM, showed Resident 62 was walking to the nursing station in hallway and was holding their catheter bag in their hand. After talked to a staff, Resident 62 went back to their room, sat in their bed and their catheter bag was on the floor. In an interview on 06/11/2024 at 8:48 AM, Staff C confirmed Resident 62's catheter bag was hanging on a trash can. Staff C stated staff should not hang the catheter bag on the trash because it was infection control issue. Staff C stated they would educate the staff. REFERENCE: WAC 388-97-1320 (1)(a)(c), (3). 47836