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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
	505517	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Veteran Home-Retsil	1141 Beach Drive PT Orchard, WA 98366

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50488 Based on observation, interview and record review, the facility failed to ensure care and services were provided in a respectful and dignified manner for 1 of 2 residents (Resident 87) reviewed for dignity. This failure placed residents at risk for being treated with a lack of dignity and respect and a diminished quality of life. Findings included . The facility's admissions packet, undated, documented, You have the right to be treated with respect and dignity. Resident 87 admitted to the facility on [DATE], with diagnoses including hemiplegia (stroke that caused left sided weakness) affecting resident's left nondominant side, depression (mood disorder that causes a persistent feeling of sadness), and polyneuropathy (malfunction of many peripheral nerves throughout the body). The significant change Minimum Data Sets (MDS), a comprehensive assessment tool, dated 03/29/2024, documented Resident 87 was referred to hospice (end of life care). Resident 87 required maximum assistance with most activities of daily living (ADL's). On 04/15/2024 at 11:15 AM, Resident 87 was observed lying on his back in his bed, hair was not brushed, long stubble on his face and neck, a small amount of light-yellow discharge in his left eye, and food particles around the mouth. Resident 87's door was open and could be seen from the hallway. On 04/16/2024 at 8:56 AM, Resident 87 was observed lying on his back in bed, hair was not brushed, stubble remained and resident continued to have discharge from their left eye. At 9:05 AM, Staff S, Food Services Worker, brought in Resident 87's breakfast tray and stated, I have to feed him and placed a shirt protector on the resident. At 10:49 AM, Resident 87 was observed on his back, with purple, dried food around the mouth, the shirt protector with food on it was still in place. At 12:09 PM, Resident 87 was observed on his back, with purple dried food around the mouth, the shirt protector with food on it was still in place. Resident 87's hair had not been brushed, stubble was on his face and neck, and left eye discharge was present. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/2024 at 8:50 AM, Resident 87 was observed lying on their back in bed wearing a shirt protector that had dried food on it. At 10:44 AM, Resident 87 was observed wearing the dirty shirt protector. Resident 87's hair had not been brushed, stubble was on his face and neck, and their left eye had discharge present. At 9:00 AM, Staff Q, CNA, and Staff R, CNA, said shirt protectors should be removed and oral care should be provided after meals. Staff R stated, not enough staff to shave, oral care, or to feed. We only have time to complete basic tasks like changing them and getting them up. Staff Q stated, feeders have to wait until last to eat. On 04/18/2024 at 10:06 AM, Resident 87 was observed lying on his back in bed, wearing a shirt protector that had dark brown spots on it. Resident 87's Ensure (high calorie drink) was across the room and out of reach of the resident. On 04/17/2024 at 9:20 AM, Staff T, Assistant Director of Nursing Services, said the expectation was that people who needed assistance with meals would have their shirt protector removed and be provided with oral care after each meal. At 9:36 AM, Staff B, Director of Nursing Services, said the expectation was that people who needed assistance with meals would have the shirt protector removed and be provided with oral care after each meal. Reference WAC 388-97-0180 (2)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to offer and/or honor bathing choices for 3 of 5 residents (Residents 97, 102 & 125) reviewed for choices. The failure to promote and facilitate resident self-determination by offering and honoring residents' choices related to bathing frequency, placed residents at risk for poor hygiene, feelings of powerlessness, and diminished quality of life. Findings included . 1) Resident 97 admitted to the facility on [DATE]. Review of the 04/09/2024 Significant Change Minimum Data Set (MDS, an assessment tool), showed the resident had moderate cognitive impairment, no behaviors or rejection of care, and choices about bathing were, very important. On 04/16/2024 at 11:32 AM, Resident 97 indicated he was not provided a choice about how frequently he would be bathed. He said the facility just tells you that you get one and they don't ask about what the resident wants and stated, I would prefer three a week. I think that's fair since I was used to bathing daily. My wife got upset and finally went to [Staff Y, Psychiatric Social Worker 3], and said it was a bunch of bulls**t. Now I get two a week, well, sometimes. Staff tell me my second shower is extra, so if they are busy I don't get it. Review of Resident 97's electronic health record (EHR) showed no documentation was present to show facility staff attempted to identify Resident 97's preferences or that he was included in making choices about aspects of care in the facility that were important to him. An activities of daily living (ADLs) care plan, revised 04/16/2024, showed the resident was scheduled for a shower on Monday evening and an extra shower on Friday evening. Review of the April 2024 bathing record showed Resident 97 was showered on 04/01/2024 and then again on 04/08/2024. The resident's extra Friday evening shower was not provided. Staff documented NA (Not Applicable). On 04/18/2024 at 11:38 AM, Staff H, Charge Nurse, confirmed that residents scheduled for more than one shower a week were sometimes informed it would not be provided. Staff H stated, Yes. If staffing affected showers on a previous day, we have to shower the residents who have did not have showers, before we give a second shower to a resident who wanted an extra shower. 2) Resident 102 admitted to the facility on [DATE]. Review of the 02/08/2024 Quarterly MDS showed the resident was cognitively intact, demonstrated no behaviors or rejection of care, and choices about bathing were very important. On 04/15/2024 at 3:12 PM, Resident 102 indicated he did not get to choose his frequency. He stated, you only get one per week. When asked how he knew that, Resident 102 stated, They [staff] tell you. Resident 102 said he would prefer three a week but indicated sometimes staff don't even provide the one shower. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 102's EHR showed no documentation was present to show facility staff attempted to identify his preferences or that he was included in making choices about aspects of care in the facility that were important to him. An ADL care plan, revised 02/09/2024, showed Resident 102 was scheduled to be showered once a week on Wednesday on day shift. Review of Resident 102's February 2024 bathing record, showed from 02/01/2024- 02/20/2024 (20 days) the resident was offered/provided one shower on 02/14/2024. 3) Resident 125 admitted to the facility on [DATE]. Review of the 03/06/2024 Admission MDS showed the resident was cognitively intact, demonstrated no behaviors or rejection of care, and choices about bathing were somewhat important. On 04/15/2024 at 2:47 PM, Resident 125 said he did not get to choose his frequency of bathing. He stated, They [staff] tell you that you get one a week [and] they don't come on the same day each week. They show and tell you they will shower you and then start to get you ready. When asked if one shower a week was acceptable, Resident 125 stated, no, I would prefer at least a couple showers a week. An ADL care plan, revised 03/11/2024, showed Resident 125 was scheduled to be showered once a week on Thursday day shift. Review of Resident 125's April 2024 bathing record from 04/01/2024- 04/18/2024, showed the following: a) 04/04/2024- showered. b) 04/11/2024- not offered/provided bathing as scheduled. c) 04/18/2024- showered. On 04/19/2024 at 10:35 AM, Staff B, Director of Nursing, confirmed staff failed to provide bathing at the frequency Residents 97, 102 & 125 were care planned to receive. Additionally, when asked who identified resident care preferences, when, and where it would be documented Staff B said it should be documented on the care plan but was unsure who obtained the preferences, when or whether bathing frequency was included. Staff B indicated she would check. No further information was provided. Reference WAC 388-97--0900(1)-(4)

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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** 42960 Based on interview and record review the facility failed to accurately assess 1 of 2 sample residents (Resident 137) reviewed for change of condition. This failure placed residents at risk for not receiving adequate and/or appropriate care and services. Findings included . Resident 137 was admitted on [DATE] with a diagnosis of Parkinson's disease (a brain disorder that causes uncontrollable movements), Lewy Body Dementia (a disease with abnormal deposits of protein in the brain), and a UTI (urinary tract infection). The Quarterly Assessment MDS (Minimum Data Set), an assessment tool, dated 02/28/2024, indicated the resident was cognitively intact and was independent to needing supervision with ADLs (Activities of Daily Living). The medical record showed Resident 137 was admitted to hospice on 03/20/2024. A review of the Significant Change in Status Assessment MDS, dated [DATE], showed Resident 137 was not receiving hospice care. On 04/19/2024 at 8:32 AM Staff V, MDS Coordinator, said that hospice care should have been marked in the MDS because that was the whole point of the significant change, that resident 137 had elected to go on hospice care. At 8:55 AM, Staff B, Registered Nurse (RN) and Director of Nursing, said the MDS had been corrected, and she said the hospice section should have been marked. Reference WAC 388-97- 1000 (1)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 4 of 52 sample residents (Residents 116, 97, 239 & 87) whose care plans were reviewed. These failures placed residents at risk for unmet care needs and diminished quality of life. Findings included . 1) Resident 239 readmitted to the facility on [DATE]. Review of the 04/10/2024 readmission skin assessment showed Resident 239 had a double lumen Peripherally Inserted Central Catheter (PICC/ a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) to the left upper arm. Review of Resident 239's comprehensive care plan, revised 04/11/2024, showed the type and location of the resident's venous access device and care instructions were not care planned. On 04/22/2024 at 8:23 AM, Staff B, Director of Nursing, said Resident 239's care plan should identify the type, location, and pertinent care instructions, but acknowledged it did not. Staff B said the care plan needed to be revised/updated. 2) Resident 97 admitted to the facility on [DATE]. Review of the resident's electronic health record showed a new Level I Pre-Admission Screening and Resident Review (PASRR) was performed. The assessment identified Resident 97's indicators of serious mental illness (SMI) included mood and anxiety disorders and a Level II referral was required for SMI. Review of Resident 97's comprehensive care plan showed the assessed need to be referred for a Level II PASRR assessment secondary to indicators of SMIs was not care planned. On 04/22/2024 at 8:54 AM, Staff B, DNS, said Resident 97's referral for a Level II PASRR assessment due to indicators of SMI, should have been care planned, but was not. Staff B said the care plan needed to be revised/updated. An altered respiratory status care plan, revised 10/12/2023, showed nurses were directed to administer oxygen via nasal cannula at 0-3 liters per minute, to maintain an oxygen saturation greater than 90%. Review of Resident 97's electronic health record (EHR) showed Resident 97 did not have an order for as needed (PRN) oxygen use. On 04/19/2024 at 12:58 PM, Staff B, DNS, confirmed Resident 97 did not have a PRN oxygen order and said the care plan needed to be revised/updated. 3) Resident 116 admitted to the facility 11/15/2023. Review of the resident's physician's orders showed a 11/15/2023 order to keep sage boots (pillowy heel protector boots) in place at all times. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/2024 at 9:31 AM, Resident 116 was observed lying on his back on an Envella air fluidized bed covered by a single top sheet with his feet exposed. Both of the resident's heels were observed to be resting flat on the bed, without sage boots in sight. Similar observations of the resident lying in bed without sage boots in place were made on 04/16/2024 at 12:21 PM and on 04/19/2024 at 10:38 AM. On 04/19/2024 at 10:42 AM, Staff B, DNS, confirmed Resident 116 was care planned to have sage boots in place at all times. Staff B said because the resident was on an Envella air fluidized bed, the sage boots were no longer required while in bed, but should be applied when Resident 116 gets up to their wheelchair. Staff B said the care plan needed to be revised. 50488 4) Resident 87 admitted to the facility on [DATE], with diagnoses to include hemiplegia (stroke that caused left sided weakness) affecting left non-dominant side, depression (mood disorder that causes a persistent feeling of sadness), and polyneuropathy (malfunction of many peripheral nerves throughout the body) and Parkinson's Disease (a disorder of the central nervous system that affects movement) with right upper and lower body tremors. The significant change Minimum Data Sets (MDS), a comprehensive assessment tool, dated 03/29/2024, documented Resident 87 was referred to hospice (end of life care). Resident 87 required maximum assistance with most activities of daily living (ADLs). Resident 87's POC (plan of care) on 04/16/2024 indicated the following for mobility: -Power wheelchair for use independently - revised 03/05/24. -Resident has a recliner for use in room. Resident independent with use - revised 10/27/2022. -Bed mobility program #1 per AML RCS clinic, supine to sit work both sides sit to stand repeat 10 reps progress to 2 sets. Per physical therapy, resident is independent with therapies. Sign to be placed in room - revised 10/27/2022 -Please assist the resident to put on his shoes and then sit in the wheelchair to have his meals. Please do not sit at the edge of the bed to eat - revised 03/05/2024. -Remind resident to not walk to the bathroom. Keep his wheelchair staged/locked next to bed when he is in bed - dated 01/23/2023. -Resident encouraged to use call bell when toileting himself at night as knees gave out resulting in fall - dated 10/27/2022. -Resident encouraged to use the call bell to call for assistance prior to transferring to bathroom - dated 10/27/2022. -Ensure that resident is wearing well-fitting footwear when ambulating or mobilizing in wheelchair - dated 10/27/2022. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice RN (registered nurse) notes, dated 03/20/2024, showed the plan of care for mobility was bedbound with transfers from bed to chair with maximum assist and Hoyer (mechanical non-weight bearing assistance) lift. Resident 87's care plan showed the following goal for continence of bowel and bladder, He will be continent at all times through the review date. Initiated 10/18/2018, revised 04/16/2024, with a target date of 07/19/2024. Hospice intake notes, dated 03/17/2024, documented Resident 87 was incontinent of both bowel and bladder with a goal of comfort. On 04/15/2024 at 11:15 AM, Resident 87 was observed resident on back in bed. On 04/16/2024 at 9:05 AM, Resident 87 was observed resident on back in bed. On 04/17/2024 at 8:50 AM, Resident 87 was observed resident on back in bed. On 04/18/2024 at 10:06 AM, Resident 87 was observed resident on back in bed. On 04/16/2024 at 10:22 AM, Staff R, Certified Nursing Assistant (CNA), and Staff Q, CNA, said they provided all care for Resident 87. They said Resident 87 does not get out of bed, was usually incontinent and was toileted in bed. On 04/19/2024 at 8:54 AM, Staff X, CNA, stated, his care plan was from when he was able to get up but that hasn't happened for a long time. He hasn't done most of the things on our task assignments for a long time. Honestly, we just mark them off. At 9:00 AM Staff B, Director of Nursing Services (DNS), said she wasn't sure who was responsible for the accuracy of the care plan, but she thought it must be the MDS Coordinator. She said she was not aware the CNAs were signing off on tasks that were not being done. At 9:10 AM Staff V, MDS Coordinator, said she completed the significant change MDS for Resident 87. Staff V said that a team meets and completes each section of the care plan for their area. She said she was the person on the team that would have been responsible for the accuracy and revision of the nursing care area. Hospice RN notes, dated 03/20/2024, documented instructions were given to facility nursing staff to provide small, attractive, frequent meals with minimal odor and to eat slowly, offer small amounts of fluid frequently. These instructions were not added to the care plan. Hospice RN notes, dated 03/29/2024, documented instructions were given to facility nursing staff about cleansing skin frequently with warm water and a mild cleansing agent. Apply moisturizers and lotions to maintain skin suppleness and pliability. These instructions were not added to the facility care plan. Hospice RN notes, dated 04/12/2024, documented instructions were given to facility nursing staff for proper positioning to avoid skin breakdown. Instructions included, proper positioning/repositioning, bolster, folded towels/foot cradles. Reduce friction/shearing with use of draw sheets, soft linens and towels, be gentle when moving patient. These instructions were not added to the facility care plan. Reference WAC 388-97 - 1020(2)(c)(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 4 of 30 sample residents (Residents 239, 97, 116, 125) reviewed. Facility nurses' failure to obtain, accurately transcribe, follow, and clarify physician's orders when indicated, and to only sign for tasks that were completed, placed residents at risk for medication errors, delays in treatment, unmet care needs and potential negative outcomes. Findings included . 1) Resident 239 admitted to the facility on [DATE]. Review of the resident's physician's orders showed a 11/16/2022 order directing nurses to hold the resident's dose of metoprolol, carvedilol, atenolol and propranolol (blood pressure medications) for a systolic blood pressure (SBP) less than a 100, a diastolic blood pressure (DBP) less than 60 or a pulse less than 60. Review of the February and March 2024 Medication Administration Record showed on the following dates the resident's 8:00 AM metoprolol was administered outside of the physician ordered parameters: 02/09/2024 DBP= 56, 02/15/2024 DBP= 58, 02/26/2024 DBP= 57, and 03/16/2024 SBP= 98 On 04/19/2024 at 3:13 PM, Staff B, Director of Nursing (DNS), said on the above referenced occasions facility nurses administered Resident 239 the 8:00 AM dose of metoprolol, instead of holding the medication as ordered. 2) Resident 97 admitted to the facility on [DATE]. A provider order, dated 11/13/2021, directed staff to assist residents with placing their CPAP (continuous positive airway pressure) mask nightly. Set to pre-programmed setting while in use. Turn humidifier on for use & off when not in use. Review of the resident's physician's orders showed the following bilevel positive airway pressure (BiPap or BiPap, a type of ventilator that helps with breathing): - Assist resident with placing BiPAP mask nightly. - Set to pre-programmed setting while in use. The order did not include what the ordered settings were, so nurses could validate the pre-programmed settings were accurate. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 04/11/2024 order directed staff to remove BiPAP mask daily and to turn the humidifier of while in use. Review of Resident 97's orders showed there were no order directing staff when to check/refilled the humidifier or what it should be filled with (H20, sterile water, distilled water etc.) Review of the April 2024 MAR and Treatment Administration Record (TAR), showed there was no order directing staff to check/refill the the resident's humidifier, or what solution to use when refilling it (e.g. H20, sterile water, distilled water etc.) On 04/22/2024 at 9:10 AM, Staff B, DNS, said the ordered BiPAP settings should have been included in the BiPAP order and said facility nurses should have clarified the order and said Resident 97's BiPAP orders were incomplete and should have instructed staff when to check the humidifier reservoir, and that distilled water was to be used to refill it. 3) Resident 116 admitted to the facility on [DATE]. Review of a provider order for Resident 116, dated 11/26/2023, showed an order for 12 units of Glargine insulin twice daily and directed staff to hold the insulin for a blood glucose (BG) level less than 100. Review of the February 2024 MAR showed on the following occasions facility nurses administered the Glargine insulin outside of the physician ordered parameters: a) 02/06/2024 at 8:00 AM for a BG of 88. b) 02/09/2024 at 8:00 AM for a BG of 81. c) 02/09/2024 at 8:00 PM for a BG of 81 On 04/22/2024 at 9:41 AM, Staff B, DNS, said on the above referenced occasions, facility nurses failed to follow the physician order, and administered Resident 116's insulin outside of the ordered parameters. Resident 116 had a 12/06/2023 order to administer metoprolol (a blood pressure medication) daily at 8:00 AM. The order did not include any hold parameters. Review of the March 2024 MAR showed facility nurses held Resident 116's metoprolol on 03/09/2024 for a pulse (P) of 58; 03/11/2024 for a P of 59, and 03/12/2024, for a P of 55, without a documented assessment or physicians order to do so. On 04/22/2024 at 9:38 AM, Staff B, DNS, explained they commonly received orders to hold blood pressure medications if the systolic blood pressure less than 100 or a P less than 60, but acknowledged Resident 116's metoprolol order did not include hold parameters, Staff B said facility nurses should have administered the medication as ordered or called and clarified the order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) Resident 125 admitted to the facility on [DATE] with orders for a 1500 milliliter (ml) per day fluid restriction secondary to hyponatremia (low blood sodium level). Nursing was allotted 780 ml (260 ml per shift), and dietary 720 ml (240 ml per meal) for a total of 1500 ml/day. Review of the April 2024 MAR showed nurses signed off on Resident 125's 1500 ml/day fluid restriction each shift but did not document the residents intake on their shift as a place was not provided to do so. Additionally, there was no order that directed nursing to tally 24-hour intake total for Resident 125. On 04/19/2024 at 9:13 AM, Staff B, DNS, said Resident 125's fluid restriction orders were incomplete due to the failure to provide a place for nurses to record the resident's fluid intake and the failure to calculate the resident's 24 hour fluid intake totals. Staff B, DNS, said facility nurses should have identified the orders were incomplete and clarified them. Reference WAC 388-97-0860(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Washington Veteran Home-Retsil		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 Beach Drive PT Orchard, WA 98366	

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to provide the necessary care and services to ensure a resident's ability to participate in activities of daily living did not diminish for 3 of 3 residents (Resident 97, 102 & 48) reviewed for rehabilitation and restorative services. The failure to provide restorative programs at the frequency residents were assessed to require, placed residents at risk for avoidable decline in activities of daily living (ADL), and increased dependence on facility staff to meet their ADL needs. Findings included . 1) Resident 102 admitted to the facility on [DATE]. Review of the 02/08/2024 quarterly MDS, showed the resident was cognitively intact, had limited range of motion to one lower extremity and to both upper extremities, but received no restorative services during the assessment period. A restorative nursing care plan, revised 02/09/2024, directed staff to provide Resident 102's restorative ambulation program six times a week. Review of Resident 102's restorative flowsheets from 03/20/2024 - 04/18/2024 showed the ambulation program was offered 15 of 25 times during the 30-day period. The resident participated nine times and had six documented refusals. No documentation was found in the electronic health record to indicate why the facility restorative aides were unable to offer/provide resident restorative programs at the frequency they were assessed to require. 2) Resident 48 admitted to the facility on [DATE]. Review of the 03/13/2024 quarterly MDS, showed the resident had severe cognitive impairment, limited range of motion on one side to the upper and lower extremities, and participated in a restorative bed mobility program on two days during the assessment period and a restorative transfer program on three days during the assessment period. Review of the restorative nursing care plan, initiated 03/20/2024, showed the resident had a restorative transfer program six times a week, and a standing exercise program six times a week. Review of Resident 48's restorative flowsheets for 03/20/2024 - 04/18/2024, showed the transfer program was offered 12 of 25 times during the 30-day period. No documentation was present in the electronic health record, to indicate why facility restorative aides were unable to offer/provide resident restorative programs at the frequency they were assessed to require. 3) Resident 97 admitted to the facility on [DATE]. Review of the 04/09/2024 significant change MDS showed the resident had moderate cognitive impairment, no limitations in functional range of motion to their upper or lower extremities, but participated in a restorative range of motion program once, a transfer program once and a ambulation program three times during the assessment period. A restorative nursing services care plan, revised 04/16/2024, showed staff were to provide a restorative ambulation program three times a week and a lower extremity exercise program three times a week. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 97's restorative flowsheets from 03/20/2024 - 04/18/2024 showed the lower extremity exercise program was offered/provided on nine of 12 occasions and the ambulation program was offered/provided on four of 12 occasions. Five times during the 30 days, facility staff documented that the restorative gym was unavailable. On 04/22/2024 at 10:36 AM, when asked if there was something preventing restorative staff from providing resident restorative programs at the frequency they were assessed to require, Staff G, Restorative Aide (RA), stated, Staffing. We get pulled frequently. Staff G said Two [RAs] were pulled on Friday [04/19/2024], one was pulled on Saturday [04/20/2024] and one was pulled on Sunday [04/21/2024]. The day before you came [Sunday 04/14/2024] all four RAs were pulled. At 10:38 AM, Staff F, Restorative Nurse, confirmed at least one RA had been pulled the previous three days and that all four RAs were pulled on Sunday 04/14/2024. When asked if it was unusual for the RAs to be pulled that frequently due to staffing issues, Staff F, Registered Nurse 3 (RN3) said it was not unusual, and explained that at least one RA was pulled every Saturday and Sunday, and also periodically during the work week. Staff F, RN3, said staffing was the primary issue/barrier, preventing RAs from providing residents restorative programs at the frequency they were assessed to require. Reference WAC 388-97-1060(2)(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to provide the necessary care and services to maintain the highest practicable level of well-being for 5 of 7 residents (Residents 239, 91, 155, 175 & 82) reviewed for bowel management and 1 of 1 resident (Resident 125) reviewed for a fluid restriction. The failure to initiate bowel care in accordance with physicians' orders and to accurately document, total, and assess fluid intake, placed residents at risk for fluid and electrolyte imbalances, nausea/vomiting, pain/discomfort and other health complications related to untreated constipation. Findings included . Review of the facility's Bowel Regimen, dated 11/03/2023, showed the following direction to nursing staff: a) If a resident goes 72 hours without a bowel movement (BM), administer Miralax 17 grams; b) If no results within 12 hours of Miralax administration, administer Milk of Magnesia (MOM) 30 ml; c) If no results six hours after administration of MOM, administer a bisacodyl suppository rectally; d) If no results six hours after administration of the bisacodyl suppository, administer a Fleets enema rectally; e) If no results after following the facility's bowel regimen, nursing would notify the the provider. >Fluid Restriction< <Resident 125> Resident 125 admitted to the facility on [DATE] with orders for a 1500 milliliter (ml) per day fluid restriction secondary to to hyponatremia (low blood sodium level). Nursing was allotted 780 ml (260 ml per shift), and dietary 720 ml (240 ml per meal) for a total of 1500 ml/day. A nutrition care plan, revised 03/11/2024, showed Resident 125 was on a 1500 ml/day fluid restriction for hyponatremia, with direction to staff to monitor and record the resident's intake. Review of Resident 125's meal monitor for the 30 day period between 03/19/2024- 4/17/2024, showed the resident exceeded the 720 ml of fluid per day, allotted for meals, on the following occasions: March April 03/19/2024=1140 ml. 04/01/2024=1050 ml. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/20/2024=1320 ml. 04/02/2024=1100 ml. 03/22/2024=1240 ml. 04/03/2024=1010 ml. 03/23/2024=1080 ml. 04/04/2024=960 ml. 03/24/2024=940 ml. 04/05/2024=1080 ml. 03/25/2024=940 ml. 04/06/2024=1080 ml. 03/26/2024=840 ml. 04/08/2024=930 ml. 03/27/2024=1240 ml. 04/13/2024=1290 ml. 03/28/2024=880 ml. 04/14/2024=900 ml 03/29/2024=1080 ml. 04/15/2024=1120 ml. 03/30/2024=1160 ml. Review of the March and April 2024 Medication Administration Records MARs, showed Resident 125's 1500 ml/day fluid restriction order did not provide a place for the nurse to record the resident's fluid intake on their shift. Facility nurses initialed off on the fluid restriction each shift without recording what the resident's fluid intake was. Additionally, there was no direction or documentation to show facility staff had been calculating what Resident 125's 24-hour fluid intake was. If facility nurses provided 260 ml per shift or 780 ml/day as they signed for, when tallied with the residents fluid intake with meals, the resident would have exceeded the 1500 ml/day fluid restriction on 21 of the 30 days reviewed. Review of Resident 125's electronic health record showed no documentation was present to indicate facility staff identified Resident 125 was exceeding the 1500 ml/day fluid restriction, that patient education was done, or that the physician was notified. On 04/17/2024 at 1:53 PM, Staff H, Charge Nurse, confirmed that facility nurses failed to record the amount of Resident 125's fluid intake on their shift and that staff had not been tallying the resident's 24 hour total fluid intake. When asked if one could tell if the resident was exceeding the fluid restriction or was adherent with it, without calculating the 24 hour total, Staff H stated, No. On 04/19/2024 at 9:13 AM, Staff B, Registered Nurse (RN), Director of Nursing (DNS), said Resident 125's fluid restriction orders were incomplete and should have provided a space for nursing to record the residents fluid intake from nursing each shift and included instruction and a place for nursing to calculate/record the residents' 24 hour total intake. >Bowel Management< <Resident 239> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 239 admitted to the facility on [DATE]. Review of the resident's bowel care orders showed the following: a) A 07/31/2023 order to administer Miralax as needed, may take if no BM (Bowel Movement) for 48 hours. May repeat time one after six hours, if no results from first dose; b) A 02/25/2022 order to administer a bisacodyl suppository as needed for constipation not relieved MOM. Review of the physician's orders showed the resident did not have an order for MOM. Review of Resident 239's March 2024 bowel record showed the resident had no BM from 03/13/2024-03/16/2024 (4 days). Review of the March 2024 MAR showed no PRN bowel medication was administered. On 04/22/2024 at 9:29 AM, Staff B, DNS, said Resident 239 should have been administered an as needed bowel medication after 72 hours without a BM. When asked if there was any documentation to show that occurred Staff B, stated, No. 42960 <Resident 91> Resident 91 was admitted on [DATE] with a diagnosis of cirrhosis of the liver (liver damage), umbilical hernia (the intestine is protruding through an opening in the abdominal muscles) and constipation. The Quarterly Assessment MDS (Minimum Data Set), an assessment tool, dated 03/06/2024, indicated the resident was moderately cognitively impaired and needed substantial assistance with ADLs (Activities of Daily Living). A review of the bowel record for Resident 91 showed the resident did not have a BM from 01/29/2024 - 01/31/2024 and 02/16/ 2024 - 02/19/2024. On 04/22/2024 at 8:56 AM, Staff W, RN and RCM (Resident Care Manager) said, Resident 91 was not given bowel medications and should have after 72 hours of no documented BM. <Resident 155> Resident 155 was admitted on [DATE] with a diagnosis of cerebral infarction (a disruption in blood flow to the brain), hypertension, and Chronic Obstructive Pulmonary Disease (difficulty breathing because of constriction of the airways). A Quarterly Assessment MDS, dated [DATE], indicated resident was moderately cognitively impaired and needed moderate to substantial assistance with ADLs. A review of the bowel record for resident 155 showed the resident did not have a BM 03/8/2024 - 03/10/2024. At 8:56 AM, Staff W RN and RCM said Resident 155 went three days without a BM and should have received bowel medications at the 72 hour mark. On 04/22/02024 at 10:02 AM, these findings for Residents 91 and 155 were reviewed with Staff B, DNS and she confirmed the bowel protocol was not followed per the orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46067 <Resident 175> Resident 175's quarterly MDS, dated [DATE], showed Resident 175 was diagnosed with dysphagia and a neurocognitive disorder. Review of the electronic health record (EHR) for Resident 175's report task sheet (30 day look back period) for toileting showed the resident had no BM for greater than three days. The following dates showed greater than three days in which Resident 175 had no documentation for a BM: 03/22/2024 to 03/23/2024 and 03/24/2024. Review of the March 2024, MAR, showed nursing had not documented the administration of the as needed constipation medication as instructed. During an interview on 04/19/2024 at 12:17 PM, Staff CC, Neighborhood Coordinator, said Miralax 17g should have been administered the morning of 03/25/2024 but was not. During an interview on 04/19/2024 at 2:32 PM Staff B, DNS, said Miralax should have been administered on 03/25/2024 and that the expectation was that staff would follow the bowel protocol as directed. <Resident 82> Resident 82's MDS showed Resident 82 admitted to the facility on [DATE] with a cognitive deficit. Review of the EHR for Resident 82's report task sheet (30 day look back period) for toileting showed the resident had no BM for greater than three days on multiple occasions. The following dates showed greater than three days in which Resident 175 had no documentation for a BM: 03/21/2024 to 03/23/2024; 03/26/2024 to 03/28/2024; 03/31/2024 to 04/03/2024; and 04/06/2024 to 04/09/2024. Review of the March and April 2024 MAR showed nursing had not documented the administration of the as needed constipation medication as instructed. During an interview on 04/19/2024 at 12:17 PM Staff CC, Neighborhood Coordinator, stated the bowel protocol was not followed but should have been. Staff CC, stated an order for Miralax should have been input upon admission but was not. During an interview on 04/19/2024 at 2:32 PM Staff B, DNS, stated the expectation was that staff would follow the bowel protocol as directed. Reference WAC 388-97-1060 (1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to ensure residents were safe from falls for 1 of 6 sampled residents (Residents 171) reviewed for accidents and hazards. This failure placed residents at risk for fall related injury and a diminished quality of life. Findings included . Resident 171 admitted to the facility on [DATE] with a diagnosis of dementia. Review of Resident 171's fall care plan showed the resident had falls on: 11/22/2023 (6:20 AM) 11/22/2023 (2:10 PM) 11/23/2023 (8:30 AM) 03/29/2024 (5:16 AM) 04/09/2024 (12:45 PM) 04/15/2024 (11:45 AM). Review of the medical record showed a safe assessment for a recliner chair, dated 04/05/2023, and no additional assessments were located. Review of an unwitnessed incident report, dated 03/29/2024, showed Resident 171 was found on the floor between the bed and recliner chair after rolling out of bed. Review of the care plan intervention dated 04/01/2024 showed bilateral assist bed handles on bed for sense of security and to help increase independence with mobility. On 04/15/2024 at 11:30 AM, Resident 171 pointed to the floor in front of the recliner and said they fell out of the recliner and hurt their left side and left thigh. A staff member entered the room and stated the resident had slid out of the recliner a week ago also. At 2:51 PM, Resident 171's bed was observed without bedrails installed. Review of the care plan intervention, dated 04/06/2023, showed review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter/remove any potential causes if possible. Educate resident/family/caregivers/IDT [interdisciplinary team] as to causes. On 04/19/2024 at 11:59 AM, Resident 171 was observed laying in the recliner watching television. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/19/2024 at 12:18 PM, Staff CC, Neighborhood Coordinator, stated the plan was to have Resident 171's wife replace the electric chair with a manual chair however it would take about two weeks. Staff CC stated the resident slept in the chair so it wouldn't be fair to just take it out of the room. When asked about the bedrails, Staff CC stated there was lack of communication between the two departments so the bedrails were never installed but should have been. Staff CC stated they did not know how often safety assessment should have been conducted after the initial assessment for recliners. During an interview on 04/19/2024 at 2:49 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that interventions such as bedrails would be implemented as soon as possible for resident safety. Staff B stated the recliner should have been removed from Resident 171's room when it was identified as the root cause and a safety assessment for the recliner should have been conducted quarterly but was not. Reference WAC 388-97-1060 (3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview, and record review, the facility failed to ensure urinary catheter (a tube inserted into the bladder which drains urine into a collection bag outside the body) tubing and drainage bags were covered, appropriately positioned off the floor, below the level of the bladder, and in a manner to ensure unobstructed urine flow for 2 of 4 residents (Residents 164 & 116) reviewed for urinary catheter use. These failures placed residents at risk for catheter associated urinary tract infections, bladder pain and other medically related consequences. Findings included . 1) Resident 164 admitted to the facility on [DATE]. Review of the 02/08/2024 admission Minimum Data Set (MDS), an assessment tool, showed the resident had severe cognitive impairment, a diagnosis of obstructive uropathy and required the use of a indwelling urinary catheter. A catheter care plan, revised 02/20/2024, showed Resident 164 had a suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder through a cut in the abdomen) secondary to obstructive uropathy. Staff were directed to position catheter bag and tubing below the level of the bladder and away from the room door. On 04/15/2024 at 2:37 PM, Resident 164 was observed in a tilt-in-space wheelchair in the hallway next to the H2 nurse's station. The resident's catheter drainage bag was secured by the front right corner of the wheel chair cushion without a dignity cover and in plain view. The tilting of the resident's wheel chair to 45 degrees caused the urinary drainage bag to rise above the level of the bladder. Resident 164 was observed in the same position until 3:06 PM. Although multiple staff members were observed to pass by and even greet the resident between 2:07- 3:06 PM, none identified the residents drainage bag was in clear view or inappropriately positioned above their bladder. On 04/22/2024 at 9:02 AM, Staff B, Director of Nursing (DNS), indicated she had been informed of Resident 164's being in the hallway with the drainage bag uncovered and secured to the front right of the wheelchair causing the drainage bag to be at or above the level of the bladder when the wheelchair was tilted back. Staff B said the drainage bag should have had a dignity cover and the drainage bag should have been maintained at a level below the bladder to prevent back flow and a potential urinary tract infection. 2) Resident 116 admitted to the facility on [DATE]. Review of the 02/21/2024 quarterly MDS showed the resident was severely cognitively impaired, had a stage IV pressure ulcer and required the use of a indwelling urinary cather. A urinary catheter care plan, revised 02/22/2024, showed the resident had the catheter secondary to a stage IV sacral pressure ulcer (wound that may involve muscles, tendons, ligaments and sometimes bone). Staff were directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/2024 at 9:41 AM, Resident 116 was observed in their room lying in bed. The resident's urinary drainage bag was attached to the left side of the bed frame without a dignity cover in place. On 04/19/2024 at 12:15 PM, Resident 116's drainage bag was observed on the left side of the bed without a cover and lying directly on the floor. On 04/19/2024 at 12:39 PM, Staff A, Administrator, entered Resident 116's room and confirmed the drainage bag was lying on the floor without a cover. Staff A acknowledged the catheter drainage bag should have been attached to the bed frame or otherwise secured to keep it out of contact with the floor. On 04/19/2024 at 12:47 PM, Staff B, DNS, said when urinary drainage bags are in direct the catheter drainage bag and floor get contaminated and it increases the risk for development of a catheter associated urinary tract infection. Staff B indicated staff needed to secure the drainage bag to the bed frame to prevent contact with the floor. Reference WAC 388-97-1060 (3)(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure intravenous (IV) access devices were assessed, maintained and monitored in accordance with professional standards of practice for 1 of 1 resident (Residents 239) reviewed for IV therapy. The facility failed to ensure Peripherally Inserted Central Catheter (PICC/ a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart) orders included direction to perform weekly PICC dressing changes, replace needleless injection caps, assess, and record external length upon admission/insertion and then weekly and as needed. Additionally, the facility failed to ensure nursing staff were trained and competent in the use of dial-a-flow infusion sets. These failures placed residents at risk for loss of vascular access, infection, IV medication errors and other potential negative outcomes. Findings included . Resident 239 readmitted to the facility on [DATE]. Review of their current physician's orders showed a 04/10/2024 order for IV ceftriaxone (an antibiotic) every 12 hours until 05/12/2024 for urinary tract infection (UTI) with associated endocarditis (a potentially life-threatening inflammation of the inner lining of the heart's chambers and valves), and a 04/18/2024 order for IV ampicillin (antibiotic) every six hours until 05/12/2024 for UTI/endocarditis. Review of the 04/10/2024 readmission skin assessment showed Resident 239 had a double lumen PICC to the left upper arm. The assessment did not identify/document what the PICC line external length was upon admission. On 04/16/2024 at 12:52 PM, Resident 239 was lying in bed with eyes closed. A valved double lumen PICC was observed to the left upper arm. IV ampicillin was infusing via a dial-a-flow infusion set, which was set to infuse at 200 milliliters per hour (ml/hr). An IV infusion pump was at bedside, but not in use. Review of the electronic health record on 04/16/2024, showed the following 04/10/2024 PICC maintenance and monitoring orders: a) Replace IV tubing every 24 hours, label, and date tubing. Use separate tubing for each antibiotic. b) Flush PICC line with 10 ml of normal saline before and after medication administration to maintain patency. The PICC orders did not include direction to: Measure PICC external length upon admission and then weekly and as needed (PRN); change the PICC line dressing weekly and PRN; change needleless injection caps weekly and PRN; or monitor the PICC insertion site for signs and symptoms of infection, infiltration, and phlebitis (inflammation of the vein). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024
NAME OF PROVIDER OR SUPPLIER Washington Veteran Home-Retsil		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 Beach Drive PT Orchard, WA 98366	

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dial-a-Flow package instructions showed that the flow regulator infusion rates were only estimated infusion rates, due to multiple environmental factors that could affect the infusion rate on gravity infusion sets, such as height of the IV bag, distance from patient, etc. The manufacturer recommended all infusion set drip rates be confirmed by counting the drops per minute and then comparing it to the provided chart, to validate the infusion rate was accurate. On 04/18/2024 at 7:08 AM, Staff H, Charge Nurse, was observed administering Resident 239's 8:00 AM dose of IV ceftriaxone. The ceftriaxone was in a 100 ml bag with instruction to infuse over 30 minutes after priming the tubing from a Dial-a-Flow administration set and flushing the PICC with 10 ml of normal saline. At 7:13 AM, Staff H connected the Dial-a-Flow tubing and turned the dial to 200 ml/hour, as ordered, performed hand hygiene, and exited the room. Staff H did not validate that the Dial-a-Flow infusion set was infusing at the desired rate. At 8:05 AM, 52 minutes after the infusion was started, Resident 239's ceftriaxone had infused less than 50 ml of the 100 ml dose, which was supposed to infuse over 30 minutes. At 8:42 AM, 1 hour and 29 minutes after the infusion was started, Resident 239's IV ceftriaxone was still infusing with approximately 20 ml left to count. When asked how she validated the Dial-a Flow infusion set was infusing at the correct rate, Staff H said she turned the dial to 200 (ml/hour). When asked why she did not do an initial drop count Staff H indicated she had never heard checking a Dial-a-Flow infusion set to ensure it was infusing at the ordered rate. On 04/19/2024 at 11: 49 AM, Staff B, DNS, confirmed Staff H, Charge Nurse, should have manually verified the infusion rate, but acknowledged that was done. On 04/22/2024 at 8:29 AM, Staff B, Director of Nursing (DNS), said Resident 239's PICC line maintenance and monitoring orders were incomplete and should have included weekly PICC line dressing changes, weekly replacement of needleless injection caps and weekly measuring of the PICCs external length. Reference WAC 388-97-1060 (3)(j)(ii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on observation, interview, and record review, the facility failed to ensure sufficient qualified nursing staff were available to provide care and services as evidenced by information provided in Resident/Surveyor interviews for 7 residents (Residents 84, 389, 14, 6, 41, 184 & 67) interviewed, and 9 staff (Staff Q, R, J, K, L, M, N, O & P) interviewed. The facility had insufficient staff to ensure residents received assistance with restorative services, meal tray delivery times, and Activities of Daily Living (ADLs) including showers and shaving. Additionally, the aides from the Restorative Nursing Program (RNP) department were removed from restorative nursing duties to cover direct care staff absences resulting in the RNPs not being done for 3 of 3 residents (Residents 48, 97 & 102) reviewed for RNP. These failures placed residents at risk for unmet care needs and a diminished quality of life. Findings included . <Resident Interviews/Observations> On 04/15/2024 at 10:55 AM, Resident 84 stated, I would prefer to be shaved daily. When asked if the aides or nurses have helped you, Resident 84 stated, [NAME], they are too busy for stuff like that. Resident 84 was observed with scruff on their face. At 11:16 AM, Resident 389 said staff took a long time to respond to call lights, Resident 389 said she has waited up to an hour for staff to respond. When asked how she knew it was an hour, Resident 389 pointed to the clock on the wall. At 11:22 AM, when asked do you need assistance with shaving, Resident 14 stated, Yes, I have asked at least 4 times in the last week, but everybody is too busy. Resident 14 was observed with scruff on face. At 1:23 PM, Resident 6 said the facility is always short of staff. Resident 6 said he would press the call light and staff will respond, but they will come in turn off the call light and leave saying they will return. Resident 6 stated he has waited up to an hour for staff to return. At 1:34 PM, Resident 41 said staffing is an issue, the facility uses a lot of agency staff and agency staff do not answer call lights. On 04/16/2024 at 8:31 AM, Resident 184 said the facility had a shortage of staff, across all shifts. Resident 184 said residents were allowed one shower a week. Resident 184 said the previous Thursday he did not get a shower and was told staff were too busy to give him a shower. Resident 184 said call light response times depended on how many staff working that shift. Resident 184 said he was waited up to an hour for staff to respond to his call light. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/19/2024 at 8:45 AM, Resident 67 said he on average has had to wait 20-30 minutes for staff members to respond to his call light to use the bathroom. Resident 67 said there had been multiple incidents of having bowel and/or bladder movements either in his chair or bed waiting for staff to respond. <Staff Interviews> On 04/17/2024 at 9:00 AM, Staff Q, Certified Nursing Assistant, with Staff R, CNA present, stated, supposed to be a minimum of 2 staff on floor, but we have 9 Hoyer [mechanical lift] residents, too many people that need feeding. Staff R, CNA, stated, not enough staff to shave, oral care, or to feed. We only have time to change people and get them up. Last Sunday and Monday we were off, and they only had one aide down this hall. On 04/18/2024 at 5:26 AM, Staff K, CNA, said she did not feel like she had enough time to complete all her assigned tasks during the shift. Staff K said at breakfast and lunch there were only 4 CNAs on that side of the building and a lot of call lights going off. Staff K said sometimes were not enough staff to meet all the resident care needs. At 5:46 AM, Staff J, Licensed Practical Nurse (LPN), said she did not feel like she had enough time to complete all her assigned tasks during the shift. Staff J said she was responsible for 40 residents and was not able to respond to call lights. At 6:01 AM, Staff L, CNA, when asked if there was enough time to complete assigned tasks, said it depended on the situation. Staff L said it was hard for one CNA to care for 20 residents. Staff L said there was only one CNA per hall on night shift, there was supposed to be a float CNA, but if one CNA called out, then the float CNA would be pulled to cover that area. Staff L said it was difficult to complete last rounds (resident checks), respond to call lights and get residents up for breakfast before the morning shift arrives. Staff L said this happened 4-5 days a week. At 6:46 AM, Staff M, LPN, said she tried her best to complete her assigned tasks every day, but time management was hard. Staff M said she was responsible for about 14 residents and was supposed to have 2 CNAs on the hall with her. Staff M said recently she has had only had one CNA and was often pulled from her duties to help the CNA with resident care. Staff M said the resident care and comfort come first, many times the paperwork must wait. At 8:59 AM, Staff N, CNA, said there was not enough time to complete all assigned tasks. Staff N said charting and resident Activities of Daily Living (ADLs) including shaving, showers and nail care were often not completed. Staff N said the only Range of Motion (ROM) services she was able to complete with residents was when she dressed them in the morning. Staff N said she was responsible for about 15 residents by herself and it was worse on weekends. Staff N said today they were supposed to have one CNA per hall and one float CNA to help on the EFGH Neighborhood, but a CNA had called out on the ABCD Neighborhood, and the float CNA was pulled to the other side of the building. At 9:43 AM, Staff O, CNA, said she did not have enough time to complete all her assigned tasks, including getting residents up in the morning and charting. Staff O said this happened 6-7 days a week. Staff O said she was not able to complete ROM services. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 10:10 AM, Staff P, LPN, said he was able to complete most assigned tasks when there were two CNAs on the hall. Staff P said if he was short CNAs, it was harder due to being pulled from his assignments to help change and feed residents. Staff P said he would triage the workload and some tasks like skin checks, that take a long time do not get completed. At 10:40 AM, Staff B, Director of Nursing Services, said staff determination is based on resident acuity, including one person or two person assists/transfers, cognitive levels, behaviors, resident care needs including IVs, multiple treatments, etc. Staff B said more resident means more staff. At 12:07 PM, observation of meal tray cart on ABCD Neighborhood Staff Q, CNA, stated, the two bed bound residents needing assistance are last, could be 15 minutes or 30 minutes, depending on needs as they go down the hall. One returns to the dining room, and one feeds both residents one at a time. We just don't have enough help. <Resident Council Meeting Minutes> On 11/16/2023 Resident Council Town Hall meeting minutes documented Resident 25, has concerns with nurses not following up with care. On 12/21/2023 Resident Council meeting minutes documented Resident 178, had concerns about the way he was treated. Stated he was ordered to use the bathroom and wasn't allowed to wash hands. When used to call button, it was unanswered for an hour. Eventually a custodian assisted. He said he isn't always sure what day it is. Had the impression that our system is broken and staff is non responsive to call buttons. Concerns were forwarded to social workers. On 03/05/2024 Resident Council meeting minutes documented Resident 25, asked why we are still low staffed when we are continuing to use on-call staff and daily staff workers. [Staff A] said because some must go on the 10-12 resident appointment; they are using those to assist in safe escort. Had to terminate 4 CNAs last month because of attendance issues difficult to fill those vacancies, but the time payroll staff is fixing that, but unfortunately and fortunately she was a CNA. On 03/21/2024 Resident Council Town Hall meeting minutes documented Staff/staffing is a huge focus. We want to recruit on the way we recruit people. Our online app is challenging. We have identified that Indeed is a great tool, 66 NACs applied but didn't complete the process. We know what the problem is. Looking at simplified app and help them when on site. 37044 <Restorative Nursing Services> On 04/22/2024 at 10:36 AM, when asked what was preventing the restorative staff from providing resident restorative programs at the frequency they were assessed to require, Staff G, Restorative Aide (RA), stated, Staffing, we get pulled frequently. Two [RAs] were pulled on Friday [04/19/2024], one was pulled on Saturday [04/20/2024] and one was pulled on Sunday [04/21/2024]. The day before you came [Sunday 04/14/2024] all four RAs were pulled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 10:38 AM, Staff F, Restorative Nurse, confirmed at least one RA had been pulled the previous three days and that all four RAs were pulled on Sunday 04/14/2024. When asked if it was unusual for the RAs to be pulled that frequently due to staffing issues, Staff F said no and explained that at least one RA was pulled every Saturday and Sunday, and then periodically on weekdays. Staff F acknowledged that staffing was the primary barrier that prevented the restorative aides from providing residents' restorative programs at the frequency they were assessed to require. <Provision of Care Bathing and AM Care> On 04/18/2024 at 11:38 AM, when asked if staffing affected the ability to shower residents at their desired frequency Staff H, Charge Nurse, stated, Yes. If staffing affected showers on a previous day, we have to shower the residents who have had no showers, before we give a second shower to a resident who wanted an extra shower. At 1:50 PM, Staff I, CNA, said the facility was short staffed several times a week. When asked if staffing affected their ability to provide resident bathing at their desired frequency and on their scheduled shower days, Staff I said, yes, it affects everything. Especially if we must make up a missed shower from the previous day. This hall (G2 hall) has seven residents who transfer with a Hoyer lift [a mechanical lift that requires two staff members to be present] and two more residents who must have two caregivers during care due to their behaviors. That's why when we are short staffed, sometimes we are not able to get all the residents up before we must go to the dining room for breakfast. If a resident is scheduled for an extra shower [two per week] they may not get the second one because we must make up showers from previous days. <Timely Delivery of Meals to Residents on Hall Trays> On 04/18/2024 at 11:38 AM, when asked how frequently they worked short staffed, Staff H, RN/Charge Nurse, stated, Every day we work short, once or twice a week we are fully staffed. Several days a week we are significantly short staffed. When asked if it affected staffs' ability to timely deliver meals trays to resident rooms Staff H said yes, because the dining room is served first, once it is done, all the CNAs rush to the steam table to get their residents' hall trays. The G2 hall only has four residents on hall trays, but the E and F halls have about 15 per hall and less residents that eat in the dining room. So, they [E2 and F2 aides] are done in the dining room first and get in line for room trays first. It's first come first serve. So, we must wait for the meals of all their hall tray residents to be passed before we can get the hall trays for our four residents on room trays. At 1:50 PM, when informed there were multiple residents who ate in their rooms that complained their food was already cold when it was delivered Staff I, CNA, said that it was true and explained that the dining room was served first. After assisting the residents in the dining room, then each aide had to get in line at the steam table to get their residents' hall trays. Staff I said because there were less residents in the dining room from the E2 and F2 halls, the aides from those halls were able to get in line for hall trays first, so the four residents with hall trays on G2 had to wait until after all the residents on E2 and F2 were served their hall trays, before they could get and deliver the four hall trays on G2. Staff I confirmed that the residents' eggs on G2 were often already cold. (continued on next page)

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Washington Veteran Home-Retsil	1141 Beach Drive PT Orchard, WA 98366

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/19/2024 at 12:01 PM, Staff A, Administrator, said the facility has had issues hiring CNAs after the pandemic, due to no Nursing Assistant Training (NAT) Program being completed. Staff A said the facility had partnered with a local college to recruit CNAs. Last year the facility started its own NAT Program, to address the staffing issues. Staff A said we want to have the staffing we that need, but it has been challenging. Reference F550 Resident Rights/Dignity Reference F561 Self Determination Reference F676 Activities of Daily Living Reference F684 Quality of Care Reference WAC 388-97-1080

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review the facility failed to provide consistent behavior monitoring for the use of psychotropic medications (affecting the mind) for 2 of 5 residents (Resident 175 and 82) reviewed for unnecessary medications and psychotropic medication side effects. Failure to develop target behaviors, adequately monitor the behaviors and interventions for effectiveness, and monitor changes in orthostatic blood pressures, placed the residents at risk for incorrect dose and duration of psychotropic medications, unwanted side effects, medical complications, and decreased quality of life. Findings included . 1) Resident 175's quarterly minimum data set (MDS), a required assessment tool, dated 03/28/2024, showed Resident 175 was diagnoses including (a neurocognitive disorder). It further showed Resident 175 received an antipsychotic medication on a routine basis. A provider's order dated 03/27/2024 showed that Resident 175 was prescribed an antipsychotic medication to be provided once a day for delusions (a belief that is clearly false and that indicates an abnormality in the affected person's content of thought) related to dementia (a group of thinking and social symptoms that interferes with daily functioning) with psychotic (symptoms that affect the mind, where there has been some loss of contact with reality) disturbance. Resident 175's March and April 2024 medication administration record (MAR) showed that there was no documentation the resident's behaviors were monitored for the use of the antipsychotic medication. On 04/19/2024 at 12:28 PM, Staff CC, Neighborhood Coordinator, said a resident that received an antipsychotic medication should have behavior monitoring documented in the resident's MAR but was unable to locate any documentation. At 2:37 PM, Staff B, Director of Nursing Services (DNS), said Resident 175 did not have behavior monitoring documented for the use of antipsychotic medication and there should have been. Staff B further stated that this did not meet expectations. 2) Resident 82's MDS showed Resident 82 admitted to the facility on [DATE] with diagnoses including dementia. It further showed Resident 82 received an antipsychotic medication on a routine basis. A provider's order dated 03/05/2024 showed Resident 82 was prescribed Zyprexa, an antipsychotic medication to be provided once a day. Resident 82's March and April 2024 medication administration record (MAR) showed there was no documentation that the resident's behaviors were monitored for the use of the antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/19/2024 at 12:28 PM, Staff CC, Neighborhood Coordinator, stated that a resident that received an antipsychotic medication should have behavior monitoring documented in the resident's MAR but was unable to locate any documentation. At 2:37 PM, Staff B, DNS, said Resident 82 did not have behavior monitoring documented for the use of antipsychotic medication and there should have been. Staff B further stated that this did not meet expectations. Reference WAC 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37044 Based on observation, interview and record review, the facility failed to ensure medications were dated when opened when required and expired drugs and biologicals were discarded in accordance with currently accepted professional standards of practice for 2 of 4 medication carts (G2 & G1) and 2 of 3 medication rooms (G2/H2 & A2/B2) reviewed. Additionally, the facility failed to ensure medications were secured in locked storage for 2 of 2 residents (Resident 116 and 125) observed with medications at bedside. This placed residents at risk for accidentally taking another resident's medication and/or receiving expired/outdated medications and biologicals. Findings included . >Medication Rooms< <G2/H2> On 04/18/2024, at 5:57 AM, Staff Z, Registered Nurse (RN) 3, confirmed there was an opened and undated multiuse vial of tubersol (used to complete Tuberculosis testing) in the G2/H2 medication room refrigerator. Staff Z said the tubersol needed to be discarded because it was not dated when opened, and was only good for 28 days after opening. <A2/B2> On 04/18/2024 at 6:24 AM a bottle of bismuth (Pepto-Bismol) with an expiration date of February 2024 was observed in the A2/B2 medication room. At that time, Staff Z, RN 3, said the bismuth was expired and should have been discarded. >Medication Carts< <G2 cart> An audit of G2 hall medication cart on 04/18/2024 at 6:56 AM showed the following: a) An opened and undated bottle of Resident 102's fluticasone propionate nasal spray. b) An opened and undated bottle of Resident 76's fluticasone propionate nasal spray. Direction on the fluticasone bottles instructed that it should be discarded 42 days after opening. c) An open and undated bottle of Refresh eye drops (No resident name on box) d) An opened and undated bottle of Refresh eye drops for Resident 98. Direction on the Refresh box said the eye drops should be discarded 90 days after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/2024 at 6:56 AM, Staff H, Charge Nurse, said the Fluticasone nasal sprays and refresh eye drops should have been dated when opened. <G1 cart> An audit of the G1 medication cart on 04/19/2024 at 7:20 AM showed the following: a) An opened and undated bottle of Resident 52's latanoprost eye drops. Direction on the bottle said to discard the eye drops 42 days after opening. b) An opened and undated bottle of timolol maleate eye drops for Resident 82. Direction on the package directs that the eye drops should be discarded 28 days after opening. On 04/19/2024 at 7:20 AM, Staff BB, Registered Nurse 2, said facility nurses should have dated the latanoprost and Timolol eye drops upon opening, but failed to do so. >Unsecured Medications< <Resident 116> On 04/16/2024 at 1:24 PM, 04/17/2024 at 2:23 PM and 3:08 PM a bottle of TUMS was observed sitting on the table located to the right of the bed against the wall. <Resident 125> On 04/18/2024 at 1:06 PM and 04/19/2024 at 12:28 PM a Dulera inhaler was observed in a plastic bin on the resident's bedside table. On 04/19/2024 at 12:54 PM, Staff A, Administrator, confirmed Resident 125's Dulera inhaler was at bedside. On 04/19/2024 at 1:01 PM, Staff B, Director of Nursing, said Resident 116's TUMS and Resident 125's Dulera inhaler should have been secured and not left at bedside. Reference WAC 388-97-1300 (2)

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NAME OF PROVIDER OR SUPPLIER Washington Veteran Home-Retsil		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 Beach Drive PT Orchard, WA 98366	

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview and record review, the facility failed to provide food at appetizing temperatures when reviewed for kitchen services. This failure placed residents at risk of lowered nutritional intake, potential weight loss, and a diminished quality of life. Findings included . <Dining Room Service> On 04/17/2024 at 11:57 AM the start of tray line service for the lunch meal was observed. None of the items on the steam table had the temperatures taken prior to being served. Further observation showed that a stack of plates was next to the plate warmer and were not being warmed within the plate holder. At 12:24 PM, Staff EE, Lead Food Service Worker was observed plating food for each hallway using only the top insulator. At 12:53 PM, Staff EE, said they usually took the temperature of all food prior to service however they were in a rush and thought a different staff member had taken the temperatures. Staff EE said the facility did not use the bottom plate insulator because the top keeps the food warm. At 3:39 PM, Staff FF, Dietary Manager said they expected staff to take the temperature of food prior to it being placed on the steam table and thirty minutes into the meal service. Staff FF said insulated plate bases and lids were to be used at meals to ensure food quality is preserved. On 04/22/2024 at 12:43 PM, Staff A, Administrator (ADM), said the facility had recently ordered new plate insulators that had not yet arrived. Staff A, ADM, said they expected staff to be taking the temperature of food to ensure safe and palatable delivery to the residents. 37044 <Meals at Beside> 1) Resident 97 admitted to the facility on [DATE]. Review of the 01/10/2024 quarterly Minimum Data Set (MDS, an assessment tool) showed the resident was cognitively intact. On 04/16/24 at 11:45 AM, Resident 97 stated, The eggs are cold every morning, so I never eat them. I like eggs, but they have to be hot. Other meals are cold sometimes, but the eggs daily because we don't get breakfast until at lest 9:15 AM. 2) Resident 2 admitted to the facility on [DATE]. Review of the 02/16/2024 quarterly MDS showed the resident was cognitively intact. On 04/16/2024 at 1:12 PM, Resident 2 complained that his breakfast was often delivered cold. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505517	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/22/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/17/2024 at 9:24 AM, staff were observed to start passing room trays. On 04/18/2024 at 11:38 AM, when informed that residents who eat in their rooms were complaining about being served cold food, specifically for breakfast Staff H, Charge Nurse, said yes, because the dining room is served first, once it is done, all the CNAs rush to the steam table to get their residents' hall trays. The G2 hall only has four residents on hall trays, but the E and F halls have about 15 per hall and less residents that eat in the DR. So, they [E2 and F2 aides] are done in the dining room first and get in line for room trays first. It's first come first serve. So, we must wait for the meals of all their hall tray residents to be passed before we can get the hall trays for our four residents on room trays. At 1:50 PM, when informed that there were multiple residents who ate in their rooms that complained their food was already cold when it was delivered Staff I, CNA, said that it was true and explained that the dining room was served first. After assisting the residents in the dining room, then each aide had to get in line at the steam table to get their residents' hall trays. Staff I said because there were less residents in the dining room from the E2 and F2 halls, the aides from those halls were able to get in line for hall trays first, so the four residents with hall trays on G2 had to wait until after all the residents on E2 and F2 were served their hall trays, before they could get and deliver the four hall trays on G2. Staff I confirmed that the residents' eggs on G2 were often already cold. Reference WAC 388-97-1100 (1), (2) .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42960 Based on interview and record review, the facility failed to develop and maintain a current hospice Plan of Care (POC) in collaboration with hospice, which identified what services were to be provided, and which delineated hospice versus facility responsibilities for 4 of 4 sampled residents (Resident 137, 118, 37 & 87) reviewed for hospice. This failure placed residents at risk for not receiving necessary care and services and a diminished quality of life. Findings included . The facility's hospice contract titled, Hospice Services Agreement, dated 2017, under article 4.2 stated, hospice shall deliver to facility the following information: (a) the most recent individualized Hospice Plan of Care for each Hospice Patient. 1) Resident 137 was admitted on [DATE] with a diagnoses including Parkinson's disease (a brain disorder that causes uncontrollable movements), Lewy Body Dementia (a disease with abnormal deposits of protein in the brain), and a UTI (urinary tract infection). The Quarterly Assessment MDS (Minimum Data Set), an assessment tool, dated 02/28/2024, indicated the resident was cognitively intact and was independent to needing supervision with ADL (Activities of Daily Living). The medical record showed Resident 137 was admitted to hospice on 03/20/2024. A review of the electronic health record did not have documentation of hospice services being provided since 03/21/2024. On 04/18/2024 at 12:17 PM Staff W, RN (Registered Nurse) and RCM (Resident Care Manager) said I don't get the Hospice paperwork. When asked if she knows when the Hospice staff visit resident 137, she said I don't know. At 12:33 PM Staff U RN, indicated in an interview the Hospice Nurse comes every week. At 1:51 PM Staff B, RN and Director of Nursing Services, said, while looking in the electronic medical record for Resident 137, that she did not see any notes the Hospice nurse visited. Staff B said we received a fax today from Hospice of all their documentation and her expectation would be for the floor staff to document when the Hospice nurse visits the resident. 46793 2) Resident 118 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 118 had a change in condition and was receiving hospice services. Resident 118 was severely cognitively impaired. The electronic health record (EHR) documented no hospice POC. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/18/2024 at 10:22 AM, Staff C, Neighborhood EFGH Coordinator/Registered Nurse, said the hospice POC for each resident should be in PCC and was also kept at the nurse's station in the hospice binder. Staff C was unable to locate the hospice POC in the EHR. Staff C, then retrieved the hospice binder and was unable to locate the hospice POC for Resident 118 in the hard chart. When asked if the facility should have a copy of the hospice POC, Staff C, said yes, there should be a copy of the hospice POC. On 04/18/2024 at 10:40 AM, Staff B, DNS, said she was aware of the situation regarding the hospice POC and was reaching out to hospice provider for the hospice POC. Staff B said the Neighborhood Coordinators and MDS Coordinator are responsible for obtaining the hospice POC for each resident in their assigned areas. When asked if the facility should have had a copy of the hospice POC, Staff B, said yes. 50488 3) Resident 37 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], documented Resident 37 had a change in condition and was receiving hospice services. Resident 37 was moderately cognitively impaired. The EHR documented no hospice POC. On 04/17/2024 at 1:34 PM, Staff B, DNS, said there should be a hospice POC in the EHR. Staff B was unable to locate Resident 37's hospice POC in the EHR. On 04/17/2024 at 1:34 PM, Staff T, Assistant DNS, said there was a hospice binder on each wing that should have the POC in it. Staff T was unable to locate Resident 37's hospice POC in the EHR. 4) Resident 87 was admitted to the facility on [DATE]. The Significant Change MDS dated [DATE], documented Resident 87 had a change in condition and was receiving hospice services. Resident 87 was severely cognitively impaired and was rarely or never understood. The EHR documented no hospice POC. On 04/17/2024 at 1:34 PM, Staff B, DNS, said there should be a hospice POC in the EHR. Staff B was unable to locate Resident 87's hospice POC in the EHR. On 04/17/2024 at 1:34 PM, Staff T, Assistant DNS said there was a hospice binder on each wing that should have the POC in it. Staff T was unable to locate Resident 37's hospice POC in the EHR. No Associated WAC.