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	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Veteran Home-Retsil	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 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** <Dignity for Urinary Catheter> Resident 74 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (an assessment tool), dated 04/21/2025, showed the resident was cognitively intact, had a diagnosis of neurogenic bladder (nerve damage disrupts communication between brain and bladder) and required the use of an indwelling urinary catheter. On 04/24/2025 at 2:17 PM, Resident 74's urinary drainage bag was visible from the hallway hanging from the right side of the bed frame (door side) without a dignity cover in place. On 04/25/2025 at 12:25 PM, Resident 74's urinary drainage bag was visible from the door hanging from the right side of the bed frame without a dignity cover. The drainage bag contained 250 milliliters of blood-tinged urine. On 04/28/2025 at 1:53 PM, Staff K, Neighborhood Coordinator, observed Resident 74's urinary drainage bag from the hallway and stated, There should be a dignity cover. <Right to Privacy of Personal Mail> Review of the electronic health record (EHR) showed Resident 166 admitted to the facility on [DATE] with a diagnosis of obstructive and reflux uropathy (functional hindrance of urine flow). Resident 166 was dependent on staff for most activities of daily living. During an interview on 04/22/2025 at 10:17 AM, Resident 166 said they had ongoing issues with their roommate and believed the roommate was tampering with their mail. Resident 166 said the mail was delivered to the outside of the room and they had requested that staff deliver the mail directly to them or in the room. Review of a progress note dated 01/31/2025 at 11:06 AM, showed Resident 166 asked Social Services if the staff delivering mail could please come all the way into the room with new mail. Resident 166 said their roommate was getting into their mailbox. Social Service staff documented that they had informed administration who facilitated the delivery of mail to residents. Observation on 04/24/2025 at 9:00 AM, showed mail in Resident 166's mailbox outside their room. (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	During an interview on 04/24/2025 at 10:55 AM, Staff EE, Veteran Benefit Specialist, said they were unaware of any special request for mail delivery related to Resident 166. Staff EE said they had delivered mail as recently as the day prior to Resident 166's mailbox. During an interview on 04/24/2025 at 11:31 AM, Staff A, Administrator, said Resident 166's mail preference should have been honored as requested. Staff A said the lack of communication between staff did not meet their expectation. <Right to Medical Appointments> 1) During an interview on 04/22/2025 at 12:28 PM, Resident 166 said they missed their recent surgery consultation appointment because the facility was unable to provide an escort. Review of a progress note dated 02/20/2025, showed Resident 166 had an appointment with urology scheduled for 04/11/2025 at 10:20 AM. Review of a progress noted dated 04/11/2025 at 7:20 AM, showed Resident's appointment to urology was canceled due to no aide being made available. During an interview on 04/24/2025 at 9:08 AM, Staff R, Licensed Practical Nurse, said there were no certified nursing assistants to escort several residents to their appointments that day. During an interview on 04/25/2025 at 12:05 PM, Staff B, Director of Nursing Services (DNS), said the facility had staff call outs and had to cancel appointments. Staff B said the appointment had not yet been rescheduled and they were working on a new system for escorts and appointments. 2) Review of the EHR showed Resident 132 was admitted to the facility on [DATE] with diagnoses to include acute heart failure, anxiety, and lymphedema (swelling in legs, caused by blockage in lymphatic system). Resident 132 was able to communicate needs. During an interview on 04/21/2025 at 10:13 AM, Resident 132 said they had early breakfast and have been prepared to go to an appointment this morning. Resident 132 said the appointment was long awaited and important about their feet. Resident 132 said the nurse came when they were about to leave and told them the facility canceled the appointment because there was no escort. Resident 132 said they did not need an escort, they have been to an appointment with the driver in the past. During an interview on 09/24/2025 at 9:08 AM, Staff R, Licensed Practical Nurse, said there was no certified nursing assistant to escort Resident 132 and that was the reason for the cancellation. During an interview on 04/25/2025 at 9:56 AM, Staff B, DNS, said the facility had call outs and had to cancel the appointments. Staff B said they understand how Resident 132 was upset, and the facility was working on a new system for escorts and appointments. Reference WAC 388-97-0180(1-4) (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide care and services in a manner that promoted dignity for 1 of 1 sampled residents (Resident 184) reviewed for dining services and 1 of 3 sampled residents (Resident 74) reviewed for urinary catheter (thin tube to remove urine). The facility failed to honor resident rights related to privacy of personal mail and/or medical appointments for 2 of 4 residents (Resident 166 & 132) when reviewed for resident rights. These failures placed residents at risk for feelings of diminished self-worth, embarrassment and a diminished quality of life. Findings included . <Dignity During Dining Services> On 04/23/2025 at 12:38 PM, the E/G Unit Dining room started plating food for residents sitting in the dining area. At 1:04 PM, Resident 184 was brought to the dining room by a staff member and seated at their assigned table. Staff D, Certified Nursing Assistant (CNA), immediately told Staff E, Food Services Worker (FSW) and Staff F, FSW, Residents 184 had been seated and asked if they could prepare the resident's plate. At 1:10 PM, Staff D, CNA, returned to the serving area and asked Staff E, FSW, and Staff F, FSW, if they could prepare the resident's plate. At 1:21 PM, Staff D, CNA, returned to the serving area a third time and asked Staff E and Staff F to prepare the resident's plate. At 1:28 PM, Resident 184 got up, walked out of the dining area without eating, and returned to E Hall. At 1:29 PM, Staff E, FSW, and Staff F, FSW, prepared Resident 184's lunch meal and provided it to Staff H, Registered Nurse. At 1:32 PM, Staff H brought Resident 184 back to the dining area and provided them with their lunch. On 04/25/2025 at 10:56 AM, Staff G, Food Service Manager, said residents should be provided with their meal plates as they entered the dining area and were seated, and the entire table should be serviced all at once. When asked about providing food to a resident that entered the dining area late and the table had already been served, Staff G said the resident should be provided with their meal as soon as possible. When the observation of Resident 184 waiting 24 minutes for their meal and finally exiting the dining room without eating was reported, Staff G said it was not acceptable and Resident 184 should have been provided with their meal sooner than that.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure resident funds were transferred to the resident's representative or the resident's estate within 30 days of death or discharge, for 2 of 2 discharged residents (Resident 259 & 260) reviewed for trust accounts. This failure placed the residents and/or their representatives at risk for loss of funds and the interest accumulated. Findings included . 1) Review of Resident 259's Death in Facility Minimum Data Set (MDS, an assessment tool), dated 11/25/2024, showed the resident was discharged from the facility on 11/25/2024. Resident 259's trust account ledger, showed the resident had a trust balance of $83 on 11/25/2024. The check sent to the resident's representative/estate for $83, was dated 02/04/2025, 70 days after the resident discharged . On 04/28/2025 at 11:04 AM, Staff S, Fiscal Analyst 1, confirmed the facility failed to convey Resident 259's trust balance within 30 days as required. 2) Review of Resident 260's Death in Facility MDS, dated [DATE], showed the resident discharged from the facility on 11/29/2024. Resident 260's trust account ledger showed a balance of $50 on 11/29/2024. The check sent to the resident's representative/estate for $50, was dated 02/04/2025, 66 days after discharge. On 04/28/2025 at 11:04 AM, Staff S, Fiscal Analyst 1, confirmed the facility failed to convey Resident 260's trust balance within 30 days as required. Reference WAC 388-97-0340(5) .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to initiate, investigate, and resolve a grievance for 1 of 3 sampled residents (Residents 63) reviewed for grievances. This failure placed the residents at risk for emotional distress and a diminished quality of life. Findings included . Review of the electronic health record, showed Resident 63 admitted to the facility on [DATE] with a diagnosis that included insomnia (difficulty falling and or staying asleep). Resident 63 was able to make needs known. During an interview on 04/21/2025 at 10:21 AM, Resident 63 stated they were upset that staff said they were no longer able to use their essential oils due to the strong smell. Resident 63 stated a member of nursing staff made a complaint about the smell. Review of a progress note, dated 04/02/2025 at 12:22 PM, showed Staff N, Social Services, informed Resident 63 that they could no longer use their diffuser (a scent producing item) in the facility. Resident 63 expressed their discontent and was provided a Centers for Disease Control and Prevention fragrance free facility policy. Review of the grievance log for April 2025, showed no grievances filed for Resident 63 related to the aromatherapy diffuser. During an interview on 04/24/2025 at 7:25 AM, Staff N, Social Services, said they did not offer to file a grievance as Resident 63 could initiate a grievance on their own. During an interview on 02/11/2025 at 12:32 PM, Staff A, Administrator, said the expectation was that staff would initiate a grievance for concerns expressed by residents. Reference WAC 388-97-0460 .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) Resident 108 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident could usually understand and was understood, participated in the interview for daily preferences, but a BIMS was not conducted due to Resident 108 being rarely or never understood. Instead a Staff Assessment for Mental Status was performed. A 02/06/2025 nurse's note documented the resident was alert and oriented to person and place with intermittent confusion. Review of the Annual MDS, dated [DATE], showed Resident 108 was usually able to understand, be understood, and participated in the interview for daily preferences, but a BIMS was not conducted due to the resident being rarely or never understood. Instead a Staff Assessment for Mental Status was performed. A 11/10/2024 nurse's note documented Resident 108 was alert to person, place, time of day, and able to make some needs known. Review of the Quarterly MDS, dated [DATE], showed Resident 108 was usually able to understand, be understood, and participated in the interview for daily preferences, but a BIMS was not conducted due to the resident being rarely or never understood. Instead a Staff Assessment for Mental Status was performed. A 08/17/2024 nurse's note documented the resident was alert and oriented to person/ place and able to verbalize needs. Review of the Quarterly MDS, dated [DATE], showed Resident 108 was usually able to understand, be understood, and participated in the interview for daily preferences, but a BIMS was not conducted due to the resident being rarely or never understood. Instead a Staff Assessment for Mental Status was performed. A 05/19/2024 nurse's note documented the resident was alert and oriented to person/ place and able to verbalize needs. On 04/23/2025 at 4:23 PM, Staff N, PSW3, said Resident 108's BIMS should have been conducted on all five above referenced MDSs. 4) Resident 74 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident could understand and was understood, participated in the interview for daily preferences, but a BIMS was not conducted due to Resident 74 being rarely or never understood. Instead a Staff Assessment for Mental Status was performed. On 04/24/2025 at 11:52 AM, Staff M, PSW3, said Resident 74's MDS should have been coded as not assessed instead of the BIMS should not be conducted due to the resident being rarely or never understood. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Resident 75 was admitted to the facility on [DATE]. Review of the Quarterly MDSs, dated 07/22/2024, 10/21/2024, 01/20/2025 and 04/15/2025, showed the resident was non-verbal, usually able to understand and be understood, participated in the interview for daily preferences, but a BIMS was not conducted due to the resident being rarely or never understood. Instead a Staff Assessment for Mental Status was performed. A communication care plan, initiated 07/15/2024, documented the resident was able to use thumb up, thumb down for answering questions. For more complex answers, the resident could type questions and responses on their phone. On 04/24/2025 at 11:52 AM, Staff M, PSW3, said a written BIMS assessment should have been conducted for Resident 75 on the four above referenced MDSs, as the resident could reply via text. Reference WAC 388-97-1000 (1)(b) Based on interview and record review, the facility failed to accurately assess Minimum Data Sets (MDS, an assessment tool) for 5 of 35 sampled residents (Resident 41, 42, 108, 74 &75) reviewed. The failure to ensure complete and accurate assessments regarding appropriate diagnoses, communication, nutrition and mobility placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included . Review of the Resident Assessment Instrument Manual (RAI, a manual that directs staff on how to accurately assess and code the MDS), dated [DATE], showed staff should attempt to conduct a Brief Interview for Mental Status (BIMS, used to assess cognitive status in elderly patients) on all residents unless the resident was rarely/never understood; could not respond verbally, in writing, or by using another method; or an interpreter was needed but not available. Staff should not complete the Staff Assessment for Mental Status [SAMS] if the resident's interview should have been conducted but was not done. 1) Resident 41 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 41 was cognitively intact, was able to make their needs known and was diagnosed with a traumatic brain injury (a disruption in the normal function of the brain caused by an external force, such as a blow or jolt to the head), no diagnoses of Alzheimer's disease or dementia (a general term for the decline in mental abilities that affects memory, thinking, and reasoning, leading to difficulties with daily tasks). A physician's note, dated 07/26/2023, documented the registered nurse reported Resident 41 was having alterations in mental status. A physician's note, dated 12/12/2023, documented decreased cognitive function secondary to dementing illness. Resident 41's plan included dementia-wander guard to right wrist, and speech therapy to follow resident for cognitive functioning. A physician's note, dated 12/18/2023, documented past medical history included diagnoses of dementia. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's note, dated 01/31/2024, documented, Dementia without behavioral disturbance with the plan to provide supportive care. On 04/25/2025 at 10:11 AM, Staff I, Medicare Coordinator, said Resident 41 did not have a diagnosis of dementia or Alzheimer's disease. When asked to pull the physician notes from December 2023 and January 2024, Staff I, said the providers documentation indicated Resident 41 was diagnosed with dementia. Staff I said the provider's diagnoses would trump any of the facility's assessments or notes. Staff said the dementia diagnosis should have been caught and reflected in the MDS. On 04/28/2025 at 9:38 AM, Staff J, Neighborhood Coordinator, with Staff L, Social Services, present, said Resident 41 did not have a diagnosis of dementia or Alzheimer's disease, but was lost and confused cognitively most of the time, not knowing where they were, who they were or what is going on around them. When asked to pull the physician notes from December 2023 and January 2024, Staff J said they did not know if that was written in error, but Resident 41 never had a diagnosis of dementia or Alzheimer's disease. Staff J, Neighborhood Coordinator, and Staff L, Social Services, said if the diagnosis was correct, then the MDS was incorrect. At 04/28/2025 at 11:00 AM, Staff C, Interim Assistant Director of Nursing Services, read Resident 41's diagnosis list from the electronic heath record (EHR) and confirmed Resident 41 did not have a diagnosis of dementia or Alzheimer's disease. When asked to pull the physician notes from December 2023 and January 2024, Staff C, confirmed Resident had been given a diagnosis of dementia by the provider. Staff C said the MDS was incorrect and should have been caught. 2) Resident 42 admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], showed the resident was understood, able to understand, and participated in the interview for daily preferences, but the Brief Interview for Mental Status (BIMS, a structured interview for assessing cognitive status in elderly patients) was not assessed. Review of the EHR showed Resident 42 was present in the facility throughout the assessment period. On 04/23/2025 at 11:53 AM, Staff O, Psychiatric Social Worker 3 (PSW3), said staff should have attempted to conduct Resident 42's BIMS.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure the Level I Preadmission Screening and Resident Reviews (PASRR) were complete and accurate for 4 of 7 sampled residents (Resident 69, 129, 150 & 78) reviewed for PASRR. This failure placed the residents at risk of unmet and unidentified care needs, and a diminished quality of life. Findings included . 1) Resident 69 was admitted to the facility on [DATE] with a diagnosis that included major depressive disorder (a mental disorder characterized by persistent feelings of sadness, loss of interest or pleasure in activities, and other symptoms that significantly impair daily functioning), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry or fear that can interfere with daily life), and unspecified psychosis (a diagnosis used when someone experiences symptoms like hallucinations or delusions). The Annual Minimum Data Set (MDS), an assessment tool, dated 03/13/2025, documented Resident 69 was cognitively intact. Resident 69's PASRR Level I, dated 01/18/2023, documented Resident 69 had depressive mood disorder and a Level II evaluation was not indicated. Resident 69 PASRR Level I, dated 06/22/2023, documented Resident 69 had depressive mood disorder, anxiety disorder, and unspecified psychosis, and a Level II evaluation was not indicated. On 04/25/2025 at 8:50 AM, regarding the PASRR Level I, dated 01/18/2023, Staff O, Social Services, said they did not send a new referral for Resident 69, even with the change in protocols, because Resident 69 was stable. The PASRR Level I, dated 06/22/2023, was resubmitted because there was an error and a Level II PASRR evaluation was not completed. 2) Resident 129 was admitted to the facility on [DATE] with a diagnosis of post-traumatic stress disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event), major depressive disorder, anxiety disorder and schizoaffective disorder (a mental health condition characterized by a combination of symptoms from both schizophrenia and mood disorders, such as depression or mania). The Quarterly MDS, dated [DATE], documented Resident 129 was cognitively intact. Resident 129's PASRR Level I, dated 09/15/2025, documented no serious mental illness (SMI) indicators checked. On 04/24/2025 at 2:50 PM, Staff M and N, Social Services (SSD), said the PASRR Level 1 should have included anxiety, schizoaffective disorder, depression and PTSD, and it was wrong.3) Resident 150 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, unspecified dementia with behavioral disturbances (a general term for the decline in mental abilities that affects memory, thinking, and reasoning, leading to difficulties with daily tasks) and Parkinson disease with dyskinesia (involuntary, jerky, or writhing movements that can affect various parts of the body, including the limbs, face, and trunk). The Quarterly MDS, dated [DATE], documented Resident 150 was severely cognitively impaired. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 150's PASRR Level I, dated 06/06/2023, documented Resident 150 had no SMI and a Level II evaluation was not indicated. On 04/24/2025 at 2:50 PM, Staff M, SSD, with Staff N, SSD, present, said when a resident was admitted to the facility they must have a PASRR Level I completed and the facility would review it for accuracy. If there was an inaccuracy on the PASRR, the facility would completed a corrected PASRR and send it in for review. When shown Resident 150's PASRR Level I did not have the correct diagnoses on the form, Staff N, said they would look into the PASRR form. On 04/25/2025 at 7:47 AM, Staff N, SSD, said Resident 150's PASRR Level I form was incorrect and should have included the correct diagnoses. 4) Resident 78 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, unspecified dementia and anxiety disorder. The Quarterly MDS, dated [DATE], documented Resident 78 was moderately cognitively impaired. Resident 78's PASRR Level I dated 02/23/2023, only documented the diagnosis of mood disorder, and did not include anxiety disorder. No PASRR Level II evaluation was indicated. On 04/25/2025 at 7:47 AM, Staff N, SSD, said Resident 78's PASRR Level I was incorrect and should have included the correct diagnoses. Reference WAC 388-97-1915 (1)(2)(a-c) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Resident 2 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had impaired functional range of motion (ROM) to both upper and lower extremities (UEs, LEs) and received a passive ROM restorative nursing program (RNP) on four of seven days during the assessment period. On 04/21/2025 at 2:29 PM, Resident 2 said they were supposed to receive their RNPs daily, but staff did not come every day to perform them. A RNP care plan, revised 02/11/2025, showed Resident 2 had the following RNPs: a) Passive ROM to bilateral (both) UEs six times a week on Monday, Wednesday and Friday. b) Passive ROM to bilateral LEs six times a week on Monday, Wednesday and Friday. On 04/28/2025 at 12:49 PM, Staff DD, Restorative Nurse, said Resident 2's care plan needed to be updated/revised. Staff DD said the passive ROM to bilateral UEs program was to be provided every Monday, Wednesday and Friday, and passive ROM to bilateral LEs every Tuesday, Thursday and Saturday. Staff DD indicated the two passive ROM programs were intended to be provided on an alternating basis. Reference WAC 388-97-1020(2)(c)(d) Based on interview and record review, the facility failed to accurately complete care plans for 2 of 35 sampled residents (Resident 41 & 2) reviewed for care planning. The failure to ensure complete and accurate care plans regarding appropriate diagnoses, mobility and restorative programs, placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included . 1) Resident 41 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/24/2025, documented Resident 41 was cognitively intact, was able to make their needs known and was diagnosed with a traumatic brain injury (a disruption in the normal function of the brain caused by an external force, such as a blow or jolt to the head), no diagnoses of Alzheimer's disease or dementia (a general term for the decline in mental abilities that affects memory, thinking, and reasoning, leading to difficulties with daily tasks). A physician's note, dated 01/31/2024, documented that the diagnosis and assessment dementia without behavioral disturbance plan included supportive care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/28/2025 at 9:38 AM, Staff J, Neighborhood Coordinator, with Staff L, Social Services, present, said Resident 41 did not have a diagnosis of dementia or Alzheimer's, but was lost and confused cognitively most of the time, not knowing where they were, who they were or what was going on around them. When asked to pull the physician notes from December 2023 and January 2024, Staff J said they did not know if that was written in error, but Resident 41 never had a diagnosis of dementia or Alzheimer's disease. When asked about the Resident 41 dementia care plan, Staff J, Neighborhood Coordinator, and Staff L, Social Services, said there was no dementia care plan for Resident 41. At 04/28/2025 at 11:00 AM, Staff C, Interim Assistant Director of Nursing Services, read Resident 41's diagnosis list from the electronic heath record and confirmed Resident 41 did not have a diagnosis of dementia or Alzheimer's disease. When asked to pull the physician notes from December 2023 and January 2024, Staff C, confirmed Resident 41 had been given a diagnosis of dementia by the provider. Staff C said the MDS was incorrect and should have been caught. When asked about Resident 41's dementia care plan, Staff C confirmed there was no dementia care plan for Resident 41 and said there should have been a dementia care plan based on the diagnosis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 6) Review of Resident 108's EHR showed a 03/01/2025 order for amlodipine (antihypertensive), and a 04/17/2025 order for metoprolol (antihypertensive), with instruction to hold for a systolic blood pressure (SBP) of less than 100, for diastolic blood pressure (DBP) less than 60 or for a pulse (P) less than 60. Review of the March 2025 Medication Administration Record (MAR) showed on 03/02/2025 the resident's DBP was 50. The nurse administered both the amlodipine and metoprolol instead of holding them for a DBP less than 60 as ordered. On 04/28/2025 at 1:53 PM, Staff K, Neighborhood Coordinator, said the amlodipine and metoprolol should have been held as ordered. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i) Based on interview and record review, the facility failed to ensure residents were administered Covid vaccinations in a timely manner, informed consent was obtained (review risk/benefits), and/or physicians orders were followed for 6 of 35 sampled residents (Residents 78, 75, 167, 204, 132 & 108). These failures placed residents at risk of contracting disease, not understanding services consented for, and medical complications. Findings included . 1) Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's vaccination consents showed consent was obtained on 08/19/2024 for the Covid vaccination. Review of Resident 78's immunization lists, showed the Covid vaccination was last administered on 01/18/2024. No immunization was found after consent on 08/19/2024. On 04/25/2025 at 8:25 AM, Staff Q, Infection Preventionist (IP), looked in the electronic health record (EHR) and said there was not documentation for Resident 78 that the risk/benefits for Covid vaccination was reviewed. Regarding the delay in vaccination, Staff Q said Staff C, Interim Assistant Director of Nursing Services (ADNS), might have more information. On 04/25/2025 at 10:22 AM, Staff C, ADNS, when asked if influenza/ Covid/ pneumococcal vaccinations should be reviewed and ordered soon after admission, said yes. When asked what their expectation was for informed consent, they said the resident or their representative would be provided teaching and educated on the risk/benefits, and this would be documented. Staff C looked in the EHR and said they did not see any documentation of a refusal or an administration for Resident 78. When asked if Resident 78 should have had their consented Covid vaccination by now, said yes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/28/2025 at 10:42 AM, Staff B, Director of Nursing Services (DNS), when asked what the risk would be for not giving a vaccine, such as the influenza/ Covid/ pneumococcal vaccines, in a timely manner, said a risk would be the resident not having antibodies to help prevent infection of the said viruses. When asked if it met expectations that risk/benefits/Vaccine Information Statement (VIS) were not documented on for every vaccine administration, Staff B said no. Staff B said the delay for Resident 78's covid vaccination did not meet expectations. 2) Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's vaccination consents showed consent was obtained on 03/27/2025. Review of Resident 75's immunization lists, showed the Covid vaccination was administered on 04/01/2025. On 04/25/2025 at 8:25 AM, Staff Q, IP, looked in the EHR for Resident 75 and said there was not documentation the risk/benefits for Covid vaccination was reviewed although they remembered going over the VIS. 3) Resident 167 was admitted to the facility on [DATE]. Review of Resident 167's vaccination consents showed consent was obtained on 10/03/2024 for Covid vaccination. Review of Resident 167's immunization lists, showed the Covid vaccination was administered on 03/31/2025 (almost 6 months after consent). On 04/25/2025 at 8:25 AM, Staff Q, IP, when asked about the delay in getting the Covid vaccination completed for Resident 167, said they were unsure why it took so long and their process was for it to be done the next couple of days after consent, if the vaccine was available. On 04/28/2025 at 10:42 AM, Staff B, DNS, said the delay for Resident 167's Covid vaccination did not meet expectations. 4) Resident 204 was admitted to the facility on [DATE]. Review of Resident 204's immunizations list showed pending administration for Covid vaccination. On 04/25/2025 at 8:25 AM, Staff Q, IP, said they had talked to Resident 204's daughter and she agreed to all the vaccinations. When asked if Staff Q reviewed the risks/benefits of each vaccine for Resident 204, Staff Q said they reviewed the vaccine itself but did not go over risk/benefits and did not offer the VIS. 5) Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's immunizations list, showed they had refused the Covid immunization on 03/26/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/2025 at 8:25 AM, Staff Q, IP, looked in the EHR for Resident 132 and said there was not documentation the risk/benefits for the refusal for the Covid vaccination was reviewed. When asked why Resident 132 was not offered Covid vaccination on admission, Staff Q said for admission the expectation was for the admission nurse to offer, and they had not personally followed up until March 2025. On 04/28/2025 at 10:42 AM, Staff B, DNS, when asked if it meet expectations that Resident 132 was not offered the Covid vaccination until 03/26/2025, after being admitted [DATE], said no.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to provide assistance with activities of daily living (ADLs) for 1 of 3 residents (Resident 166) reviewed for ADLs. Failure to provide oral care for Resident 166, who was dependent on staff for oral care, placed the resident at risk for unmet needs, poor hygiene and diminished quality of life. Findings included . Review of the electronic health record showed Resident 166 was admitted to the facility on [DATE], with diagnoses of diabetes (too much sugar in the blood), obstructive and reflux uropathy (functional hindrance of urine flow) and depression. Resident 166 was dependent on staff for most activities of daily living. During an interview on 04/22/2025 at 10:32 AM, Resident 166 said staff were inconsistent with providing assistance with oral care. Review of Resident 166's care plan, dated 04/24/2024, showed they received oral care in the morning, after meals, and at bedtime, with substantial dependent assistance. During an interview on 04/24/2025 at 10:19 AM, Staff FF, Certified Nursing Assistant, said they did not assist Resident 166 with oral care the past few days due to lack of time and short staffing. During an interview on 04/25/2025 at 12:03 PM, Staff B, Director of Nursing Services, said their expectation was for oral care to be provided on day shift and evening shift. Reference WAC 388-97-1060 (2)(c) .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, the facility failed to ensure quality of care for bowel management for 1 of 6 residents (Resident 60) reviewed for bowel management, and services for 1 of 1 resident (Resident 132) reviewed for edema. These failures placed residents at risk of medical complications, delay in care and services, and a diminished quality of life. Findings included . <Bowel Management> Review of the facility's document titled, Bowel Care Protocol, dated 02/01/2018, showed the night nurse would review bowel records and compile a list of residents who had not had a bowel movement for three days. The list would be passed on to the day shift nurse, who would initiate the bowel protocol as follows: a) Administer Polyethylene Glycol (laxative) at the beginning of day shift on day four. b) Administer Bisacodyl Suppository at the beginning of day shift on day five. c) Administer a Mineral oil enema at the beginning of day shift on day six. Note: If there were no results from the above interventions by day four, the provider should have been notified for further intervention. 1) Resident 60 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/05/2025, documented Resident 60 was moderately cognitively impaired. A review of Resident 60's April 2025 Medication Administration Record (MAR) showed Resident 60 had orders for: - Milk of Magnesia (MOM) to be given as needed for constipation one time daily. - Bisacodyl oral tablet to be given as needed for constipation if not relieved by MOM one time daily. - MiraLax to be given as needed for constipation every 24 hours. - Bisacodyl Rectal Suppository to be given as needed every 24 hours for no bowel movement for over 3 days. - Fleet Enema Rectal Enema to be given as needed for constipation. A review of Resident 60's bowel movement record documented the resident had no bowel movement on 04/09/2025, 04/10/2025, 04/11/2025, 04/12/2025, 04/13/2025, and 04/14/2025, a span of 6 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 60's April 2025 MAR showed milk of Magnesia and Bisacodyl were given on 04/14/2025. On 04/25/2025 at 10:53 AM, Staff X, Registered Nurse/Neighborhood Coordinator, said staff should have administered bowel medications starting on 04/12/2025. If Resident 60 refused bowel medications, they should have been placed on alert and monitored, but there was no documentation that Resident 60 refused the bowel medications. On 04/28/2025 at 11:11 AM, Staff B, Director of Nursing Services (DNS), said her expectation was for staff to follow the standing order for bowel care.<Edema Management> Review of the electronic health record showed Resident 132 was admitted to the facility on [DATE] with diagnoses that included acute heart failure, anxiety, and lymphedema (swelling in legs, caused by blockage in lymphatic system). Resident 132 was able to communicate needs. During an interview on 04/21/2025 at 10:58 AM, Resident 132 said a nurse came to measure their feet twice for compression stockings, and they still did not have them. During observations on 04/21/2025 at 10:58 AM, 04/22/2025 at 11:00AM, 04/23/2025 at 10:32AM, 04/24/2025 at 8:58AM, Resident 132 had no compression stockings on, their feet were in a lower position on the floor, and their feet were observed to look dark grayish purple and discolored, with swollen skin to their lower extremities. Review of Resident 132's MAR for April 2025, showed licensed nurses had signed for Resident 132's compression stockings having been worn on 04/21/2025 and 04/22/2025. During an observation on 04/24/2025 at 8:58 AM, Resident 132's room had compression stockings seen in a clear plastic bag on top of the refrigerator. Resident 132 opened the bag, but was not sure what size they were. There was no label observed on the compression stockings. During an interview on 04/24/2025 at 9:08 AM, Staff R, Licensed Practical Nurse, said Resident 132 has had different sizes, and the one they should have been using was their 3XL size. When in the room, Staff R could not verify the size of the compression stockings. During an interview on 04/25/2025 at 9:52 AM, Staff B, DNS, said nurses were to follow providers orders, and documentation on the compression stockings for Resident 132 did not meet expectation. Reference WAC 388-97-1060(1) .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Resident 27 was admitted to the facility on [DATE] with diagnoses of Bipolar disorder (a mental health condition characterized by significant shifts in mood, energy, and activity levels, ranging from periods of intense happiness or irritability (mania or hypomania) to periods of deep sadness or hopelessness (depression)), depression (a common mental health condition characterized by a persistent low mood, loss of interest or pleasure in activities, and other symptoms that can significantly interfere with daily life) and anxiety (a normal human emotion characterized by feelings of unease, worry, or fear, often about something that is about to happen or could happen in the future). Resident 27 required substantial assistance with most activities of daily living. Resident 27's provider's orders showed an order dated 03/20/2025, for hydrocodone-acetaminophen 5-325 milligrams two every six hours as needed for severe pain. Review of the MAR dated April 2025 from 04/01/2025 - 04/24/2025 showed the ordered, as needed, hydrocodone/acetaminophen was provided eight times in April with no NPI documented as offered or provided. During an interview on 04/25/2025 at 12:01 PM, Staff B, Director of Nursing Services (DNS), said NPI should be offered/provided and documented in the MAR and/or progress notes prior to giving any as needed pain medication Based on interview and record review, the facility failed to provide non-pharmacological interventions (NPIs, health interventions/approaches used instead of medication) for 3 of 6 sampled residents (Resident 150, 27 & 15) reviewed for unnecessary medications/pain. This failure placed the residents at risk for receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included . 1) Resident 150 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 150 was severely cognitively impaired. Resident 150 had an order, dated 12/12/2024, for a oxycodone (an opioid) 10 milligram (mg) tablet once every four hours as needed for pain. The order included documentation of non-pharmacological interventions that were attempted prior to the administration of the opioid. The Medication Administration Record (MAR) and Treatment administration Record (TAR) for April 2025 documented Resident 150 was given oxycodone on 04/02/2025, twice on 04/09/2025 and 04/18/2025 with no non-pharmacological interventions documented. On 04/28/2025 at 11:00 AM, Staff C, Interim Assistant Director of Nursing Services (ADNS), said the facility had acknowledged a previous concern with non-pharmacological interventions not being documented. Staff C said Resident 150's non-pharmacological interventions should have been documented per the order. 3) Resident 15 was admitted to the facility on [DATE] with diagnoses to include paroxysmal atrial fibrillation (an irregular heart rate), chronic pain, depression, diabetes (high blood sugar) and fungal infection. Resident 15 was able to communicate needs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 04/21/2025 at 2:15PM, Resident 15 was lying in bed with worried facial expression. Resident 15 said the provider discontinued the strong pain medicine were experiencing a lot of pain. Resident 15 stated, my hands are always painful, my feet ache with pain, sometimes it feels like they are stuck in fire. Review of April 2025 MAR showed Resident 15 was administered oxycodone (narcotic pain medicine) 20 times without providing NPI prior to the medicine. During an interview on 04/24/2025 at 11:07 AM, Staff R, Licensed Practical Nurse, said NPI's were available for some orders, but not for Resident 15 and it should have been. During an interview on 04/25/2025 at 10:03 AM, Staff B, DNS, said NPI should be offered and documented when nurses are administering pain medications. Resident 15's pain medication records did not meet expectations. Reference WAC 388-97-1060(3)(k)(i) .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review the facility failed to ensure a Gradual Dose Reduction (GRD, progressively minimizes a patient's medication levels over time) was completed for 1 of 5 sampled residents (Resident 78) reviewed for unnecessary medications. The failure to complete a GDR placed residents at risk for overuse of psychotropic (mind altering) medication, health complications and a diminished quality of life. Findings included . Resident 78 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/04/2025, documented Resident 78 was moderately cognitively impaired. The Quarterly MDS documented a GDR had been completed on 06/13/2024 and documented as clinically contraindicated by the physician. The electronic health record (EHR) provided no supporting documentation a GDR had been completed on 06/13/2024 for any psychotropic medications. Resident 78 was prescribed Sertraline (an antidepressant) 10 milligrams (mg) twice a day for depression starting 02/16/2023. A GDR was completed on 09/24/2024 reducing the dose for depression. The EHR documented no other attempted GDRs, showing only one GDR attempt was made in the previous 2 years and 2 months. The EHR had no documentation from either the pharmacy or provider requesting a GDR or supporting contraindications for GDR. Resident 78 was prescribed Zyprexa (an antipsychotic) 5 mg in the morning and 10 mg at night for dementia with psychotic disturbance. On 08/23/2023, Resident 78 had a GDR, decreasing Zyprexa to 10 mg once a day. On 02/20/2024 Resident 78 had a GDR, decreasing Zyprexa to 7.5 mg once a day. The EHR documented no other attempted GDRs, showing only one GDR attempt was made in the previous 13 months. The EHR had no documentation from either the pharmacy or provider requesting a GDR or supporting contraindications for GDR. On 04/25/2025 at 10:11 AM, Staff I, Medicare Coordinator EF, with Staff K, Neighborhood Coordinator EFG, present said the facility does a GDR review every three months and follows pharmacy guidelines. All pharmacy reviews were documented in the behavioral health team notes. Staff I said social services was responsible for scheduling those meetings and following the guideline recommendations. When asked when Resident 78's previous GDR was completed, Staff I said per the MDS, it showed the last GDR was completed 06/13/2024. Staff I said they had sent an email on 02/06/2025 to Staff L, Social Service, informing them Resident 78 needed to have another GDR completed. Staff K, Neighborhood Coordinator EFG, said they would check with Staff L, Social Service, to see if there was any further documentation. No further documentation was provided. On 04/28/2025 at 11:00 AM, Staff C, Interim Assistant Director of Nursing Services, said they did not know the requirements for GDRs and would defer to Staff B, Director of Nursing Services. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:36 AM, Staff B, Director of Nursing Services, said GDRs were to be completed twice a year upon admission or start of a new antipsychotic medication and completed in two different quarters one month apart. Staff B said GDRs can be completed annually if contraindicated. When asked if Resident 78 should have had a GDR completed, Staff B said no, because his last GDR was contraindicated, so the facility only had to do it annually. When asked where it stated contraindications completed be completed annually, Staff B said in their policy. Staff B was asked to send the policy to psychotropic medications. Review of policy titled, Psychopharmacological Drugs, dated 01/26/2024, documented no time frame requirements for GDR attempts. Reference WAC 388-97 -1060 (3)(k)(i)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. On 04/21/2025 at 3:27 PM, Staff T, LPN, on G Hall (dementia unit) was standing at the medication cart speaking to a resident and then escorted the resident to his room. Observation of medication left unlocked. Three other residents were standing and or sitting within 10 feet of the medication cart. At 3:29 PM, Staff T returned to the medication cart. When asked to open the medication, Staff T opened the cart without using a key. When asked what needs to be completed when stepping away from the medication cart, Staff T said it should have been locked. On 04/25/2025 at 10:11 AM, Staff I, Medicare Coordinator EF, said the expectation was staff would lock the medication cart and the computer screen when stepping away from the medication cart. When observation of unlocked medication cart was reported, Staff I said that was not acceptable and the cart should have been locked. On 04/28/2025 at 11:00 AM, Staff C, Interim Assistant Director of Nursing Services, said nursing staff should lock the medication cart and computer screen when stepping away from the cart. When observation of unlocked medication cart was reported, Staff C said that was not acceptable. At 11:36 AM, Staff B, Director of Nursing Services, said the expectation was that staff lock the medication cart and computer screen when walking away form the medication cart. When observation of unlocked medication cart was reported, Staff B said that was not acceptable. Reference WAC 388-97 -1300 (2), 2340 Based on observation and interview, the facility failed to maintain locked medication carts for 2 of 11 medication storage carts (Cart D and Cart G) when reviewed for medication storage. This failure placed the residents at risk for missing medications, medication discrepancies and impaired quality of life. Findings included . During an observation on 04/24/2025 at 9:08 AM, Medication Cart D was left unlocked, as Staff R, Licensed Practical Nurse (LPN) was on the other side of the cart working with a resident and after that was walking away to the nurse's station. During an interview on 04/24/2025 at 9:18 AM, Staff R, stated the medication cart should have been locked.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. . Based on observation, interview and record review the facility failed to store, prepare and serve food to residents in accordance with professional standards for 1 of 1 kitchen reviewed for food service safety. The failure to maintain documented dishwasher temperatures, to throw out expired/moldy foods and maintain sanitary conditions placed residents at risk of foodborne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and diminished quality of life. Findings included . <Dishwasher temperatures> Review of dishwasher temperature logs for January 2025 showed: Main dining room (MDR)- no temperatures were recorded. AC 1 Hall dining room (AC)- no temperatures were recorded. ABCD Hall dining room (ABCD)- some temperatures were recorded, but not consistently. EFGH Hall dining room (EFGH)- no temperatures were recorded. EG 1 Hall dining room (EG)- no temperatures were recorded. Review of dishwasher temperature logs for February 2025 showed: Main dining room (MDR)- no temperatures were recorded. AC 1 Hall dining room (AC)- no temperatures were recorded. ABCD Hall dining room (ABCD)- some temperatures were recorded, but not consistently. EFGH Hall dining room (EFGH)- no temperatures were recorded. EG 1 Hall dining room (EG)- no temperatures were recorded. Review of dishwasher temperature logs for March 2025 showed: Main dining room (MDR)- no temperatures were recorded. AC 1 Hall dining room (AC)- no temperatures were recorded. ABCD Hall dining room (ABCD)- some temperatures were recorded, but not consistently. EFGH Hall dining room (EFGH)- no temperatures were recorded. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EG 1 Hall dining room (EG)- no temperatures were recorded. Review of dishwasher temperature logs for April 2025 showed (up to date of Survey): Main dining room (MDR)- no temperatures were recorded. AC 1 Hall dining room (AC)- no temperatures were recorded. ABCD Hall dining room (ABCD)- some temperatures were recorded, but not consistently. EFGH Hall dining room (EFGH)- no temperatures were recorded. EG 1 Hall dining room (EG)- no temperatures were recorded. On 04/23/2025 at 11:14 AM, Staff U, Food Service Manager, said they do not write down the dishwasher temperatures, the staffs signatures indicate the dishwasher temperatures were within the required ranges. When asked about missing signatures days, Staff U said all dates should have been filled in. At 11:19 AM, when asked about the dishwashing process, Staff W, Food Service Worker (FSW), said dirty dishes were started at the left side of the cleaning area. The dishes are rinsed, ran through the dishwasher (wash, rinse and sanitized) and then come out of the machine. The dishes are then stacked on the rack to dry and then put away. Observation of all 3 thermometers on the dishwasher included- 1st thermometer was on 0, 2nd thermometer was on 168 degrees, and 3rd thermometer was on 0. At 11:20 AM, Staff W (FSW), was asked to complete a cycle of dishes to confirm that temperatures were running at appropriate temperatures. Staff W started the first test, empty cart. Observation the thermometers did not move. When asked why the thermometers did not move, Staff W, said possibly because the tray was empty. At 11:20 AM, Staff W (FSW), loaded a large shallow metal pan onto the tray and started a second test. Observation showed the thermometers did not move. When asked about the thermometers not moving, Staff W said they did not know why the machine was not working. When asked about the machine not working, how did they know if the dishes were being adequately washed, rinsed and sanitized, Staff W, said they could not confirm if the dishes were adequately cleaned. At 11:28 AM, Staff U, Food Service Manager, returned to the kitchen and was provided with the details about the two failed tests with the dishwasher. Staff U said they would contact maintenance to have them fix the issue. When asked about confirming the temperatures for the dishwasher cycles, Staff U said they could not verify the temperatures. On 04/25/2025 at 10:56 AM, Staff G, Food Services Manager, confirmed when staff provided a signature on the temperature log sheet, it meant the temperatures were within appropriate temperature range. When asked how they could confirm the temperature range, Staff G, said they could not confirm the temperature ranges. Observation of two failed dishwasher tests were explained, Staff G, said they understood the concern and could not confirm the temperatures. <Expired/moldy foods> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/2025 at 10:17 AM, during a tour of the produce cooler, observations included: One Gallon Lime juice expired 02/23/2025 One Gallon Stone Ground Mustard expired 01/30/2025 4 of 6 containers 16 oz Strawberries growing mold At 10:40 AM, Staff V, Cook, said the coolers were cleaned out every three days, usually Sundays and Thursdays, that included looking for expired foods and leftover foods being thrown out. Staff said it was all staffs responsibility to help keep the coolers clean. When shown the lime juice and mustard expiration dates, Staff W, said those should have been thrown out. When shown the molding strawberries, Staff W said those should have been thrown out too. On 04/25/2025 at 10:56 AM, Staff G, Food Services Manager, said the refrigerators should be cleaned out everyday, but any staff who were in the refrigerators and if in doubt about any food, it should be thrown out. When observations of expired and moldy food were reported, Staff G said expired and moldy food were not acceptable and should have been thrown out. <Sanitary conditions> On 04/23/2025 at 12:38 PM, Staff E, Food Services Worker (FSW) and Staff F, Food Service Lead, started plating lunch meals for residents. Staff E placed potatoes on the plate and then returned the potatoes using a gloved hand. Staff E grabbed the next plate and grabbed potatoes out of the pan with same gloved hand. On 04/23/2025 at 12:39 PM, Staff E grabbed fish out of the pan with same gloved hand. At 12:40 PM, Staff E grabbed potatoes and out of pan with same gloved hand, then grabbed a new plate with same gloved hand and then put the fish on the plate with utensil. Staff then placed the fish back in the pan with same gloved hand. At 12:40 PM, Staff E grabbed potatoes out of pan with same gloved hand. At 12:45 PM, Staff E and Staff F were asked to stop tray line. When asked if Staff E should be touching the food, Staff E said they were touching the food with gloved hands. Staff F said no, Staff E should not have touched the food, they should have used a utensil. No glove change or hand hygiene was completed during this observation. At 1:00 PM, Staff E scooted fish on the plate with gloved hand. At 1:01 PM, Staff E scooted potatoes on plate with gloved hand. On 04/25/2025 at 10:56 AM, Staff G, Food Services Manager, said staff should not touch the food that was served to residents. Staff G said staff should be changing their gloves to prevent cross contamination. When observation of meal tray services was reported, Staff G said that it dd not meet expectations for staff to touch resident food, they should have used utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97 -1100 (3), 2980 .

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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** . Based on observation, interview and record review, the facility failed to ensure staff-maintained infection control practices by donning and doffing their Personal Protective Equipment (PPE) for 1 of 1 COVID (G2 Hall) unit and to correctly carry out hand hygiene by staff when reviewed for infection control. The facility also failed to perform urinary catheter (thin tube to remove urine) care per standards of practice for 2 of 2 residents (Resident 26 & 135) reviewed for catheter care observation. This failure placed residents at risk for the spread of infection and a diminished quality of life. Findings included . <Donning and Doffing of PPE on G2 Unit with COVID Positive Residents> On 04/23/2025 at 2:22 PM, observed a cart with different types of N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) masks on a cart outside the closed double doors to the G2 Unit where COVID positive residents are located. A review of the sign posted on the closed double doors of the G2 Unit said, Notice COVID-19 Outbreak .Staff must wear appropriate PPE when entering positive resident rooms - removing PPE after exiting room and ensuring to exchange N95 . Resident 104 was admitted to the facility on [DATE]. A review of Resident 104's orders, showed an order dated 04/16/2025 for Aerosol precautions (a set of infection control measures used to prevent the spread of airborne diseases that can be transmitted through small particles in the air) for COVID-19 infection until 04/26/2025. On 04/23/2025 at 2:30 PM, Staff Z, Custodian, was cleaning Resident 104's room. An aerosol precautions sign was posted outside the doorway. Observation showed Staff Z wore a N95 mask and did not change the mask or get a new one after they finished cleaning the resident's room. When asked, Staff Z said they had not changed the mask and the last time they put on a new mask was when they entered the unit. Resident 174 was admitted to the facility on [DATE]. A review of Resident 174's orders showed an order, dated 04/21/2025, for Aerosol isolation precautions in place for COVID-19 until 04/30/2025. On 04/23/2025 at 2:31 PM, Staff AA, Certified Nursing Assistant (CNA) was observed to not change their N95 mask when they came out of Resident 174's room. An aerosol precautions sign posted outside the doorway. At 2:34 PM, Staff AA said they had not changed their mask, was told to change it often, but the N95 masks were located outside the unit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 308 was admitted to the facility on [DATE]. A review of Resident 308's orders showed an order, dated 04/16/2025, for Aerosol precautions every shift for Covid-19 infection until 04/26/2025. On 04/23/2025 at 2:44 PM, Staff BB, Nursing Assistant, observed removing their PPE after coming out of Resident 308's room. An aerosol precautions sign posted outside the doorway. At 2:50 PM, Staff BB did not dispose of their N95 mask or put on a new one when they came out of Resident 308's room. At 2:54 PM, when asked and changing their mask, Staff BB said they changed it before they had entered the unit. Staff BB said they remove their masks when they leave the unit and put on a new one when they entered the unit. Staff BB was asked if there were any N95 masks on the unit, and Staff BB said all N95 respirators were on the cart outside the unit. When Staff BB was asked when the last time they changed their mask, stated, after my break, at 1:45pm, I changed my mask when I came back on the unit. On 04/25/2025 at 11:41 AM, Staff Q, Infection Preventionist (IP), said staff must change their N95 masks when they come out of a COVID positive room. Staff Q said the would provide education for the staff. On 04/25/2025 at 1:19 PM, Staff B, Director of Nursing (DNS), said the expectation was for the staff to change masks when coming out of a COVID positive room. On 04/28/2025 at 9:30 AM, Staff Q, IP, said they provided education on Friday and told the staff changing N95 masks was mandatory and it was not acceptable to not change your mask when they exited a room with a covid positive resident. <Hand Hygiene> On 04/23/2025 at 2:30 PM, Staff Z, Custodian, was observed wearing gloves and using hand sanitizer on their gloves and rubbing their gloved hands together. Staff Z was asked, Are you washing your hands with hand sanitizer while you have your gloves on? Staff Z said yes. On 04/28/2025 at 9:30 AM, Staff Q, IP, said staff should not be using hand sanitizer when they have gloves on and that was not expectable practice. At 10:57 AM, Staff Q, IP, said they provided staff education about proper hand hygiene and not using hand sanitizer on gloved hands. At 11:11 AM, Staff B, DNS said that was not appropriate, they need to change their gloves. <Urinary Catheter Care> 1) Resident 26 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 26's orders showed an order for Enhanced Barrier Precautions (EBP): [NAME] (put on) gloves and gown for the following High Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: Urinary Catheter. On 04/23/2025 at 8:33 AM, Staff CC, CNA collected their PPE supplies for catheter care for Resident 26. Staff CC took all the supplies into the bathroom and set it down in the bathroom and put on the PPE inside the bathroom before providing catheter care to Resident 26. At 8:38 AM, Staff CC removed their PPE's to go get a leg bag out of clean utility room because there was not one in Resident 26's room. When Staff CC came back with their PPE supplies and the catheter bag, they set it down in the bathroom and put on their PPE. Staff CC was asked how did they know Resident 26 was on EBP, and Staff CC said there was a blue star outside Resident 26's room. Staff CC was asked where was the PPE located, and they said, in the supply room. Staff CC was asked if they normally put on PPE in the bathroom, and Staff CC said yes, they were told in the bathroom or anteroom, not in the hallway. On 04/28/2025 at 9:30 AM, Staff Q, IP, said they encouraged the staff to put on their PPE before providing care but the bathroom might be contaminated. Staff Q stated, I would not put on my PPE in the bathroom. On 04/28/2025 at 11:11 AM, Staff B, DNS stated, I am not sure why they choose the bathroom, but I would have chosen the common area there between the rooms to put on my PPE. 2) Resident 135 was admitted to the facility on [DATE]. Review of Resident 135's progress notes from 04/16/2025 showed a urinary catheter was inserted for urinary retention in the bladder. Review of Resident 135's orders showed the following orders: 1. EBP: don gloves and gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: urinary catheter 2. Catheter care every morning and at bedtime On 04/25/2025 at 11:02 AM, Staff P, CNA, entered Resident 135's room for catheter care without a gown on. Staff P put on gloves, then prepped for the procedure in the bathroom by getting water from the sink to wet small towels to use as wipes. Staff P, with the same gloves on, was observed to touch the bed, the resident, and the trash can to move it closer to the resident. Staff P then touched the resident's pants, went into the bathroom to get a portable urinal (container for emptying urine into), went next to the resident to empty the urine bag, and went back to the bathroom to empty the urinal into the toilet. Staff P took off their gloves and washed their hands. Wearing new gloves, Staff P touched the resident's pants, the urine bag, and the resident's right foot to reposition the leg to get the urine bag through the pant leg. The resident's brief was opened, and Staff P started catheter care without changing gloves or performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After performing catheter care, Staff P, without changing gloves or hand hygiene, then cleaned the tubing at the connection piece (where the urinary catheter and the urinary catheter tubing connect), disconnected the tubing, wiped over the opened catheter end (an entry area for potential organisms) with the water towel wipe, then connected the urinary catheter to tubing for a leg bag. No hand hygiene or glove change was performed after this. Staff P was observed to continue touching items in the room and the resident, as they assisted Resident 135 in getting dressed and moving into their wheelchair to use the bathroom. At 11:36 AM, Staff P was asked about Resident 135's precautions and was unsure what the blue star outside of the room meant. Staff P acknowledged they did not wear a gown during Resident 135's catheter care and they should have. When asked about hand hygiene, Staff P said it should be done every time they go from dirty to clean, and they had only washed their hands one time during the care (excluding entering and exiting the room, which Staff P had done). On 04/25/2025 at 12:32 PM, Staff C, Interim Assistant Director of Nursing Services, said their expectation when a resident was on EBP was for staff to wear a gown and gloves during high contact cares, including catheter care, to prevent the spread of organisms. After reviewing the observation of the catheter being disconnected, Staff C said their expectation was for the staff to use an alcohol wipe on the catheter end and the tubing before disconnecting, and the warm water towel wipe should not have gone over the top of the catheter while it was open (disconnected from tubing). Reference WAC 388-97-1320 (1)(c), (2)(b) .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure residents were screened on admission and/or during influenza season for influenza and/or pneumococcal vaccination and failed to obtain informed consent for vaccination for 5 of 5 residents (Residents 78, 75, 167, 204 & 132) reviewed for immunizations. This failure placed residents at risk of contracting disease, increased complications, not understanding services consented for, and a diminished quality of life. Findings included . 1) Resident 78 was admitted to the facility on [DATE]. Review of Resident 78's vaccination consents showed consent was obtained on 08/19/2024 for the influenza vaccination. Review of Resident 78's immunization lists, showed the influenza vaccination was administered on 10/10/2024. On 04/25/2025 at 8:25 AM, Staff Q, Infection Preventionist (IP), looked in the electronic health record (EHR) and said there was not documentation the risk/benefits for influenza vaccination was reviewed. 2) Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's vaccination consents showed a refusal was obtained on 09/18/2024. On 04/25/2025 at 8:25 AM, Staff Q, IP, looked in the EHR for Resident 75 and said there was not documentation the risk/benefits for the refusal for the influenza vaccination was reviewed. 3) Resident 167 was admitted to the facility on [DATE]. Review of Resident 167's vaccination consents showed consent was obtained on 10/03/2024 for influenza vaccination. Review of Resident 167's vaccination consents showed the influenza immunization as administered on 10/30/2024. On 04/25/2025 at 8:25 AM, Staff Q, IP, looked in the EHR for Resident 167 and said there was not documentation the risk/benefits for the influenza vaccination was reviewed. 4) Resident 204 was admitted to the facility on [DATE]. Review of Resident 204's immunizations lists, showed they had received the influenza vaccination on 03/13/2025, and they had a pending administration for the pneumococcal vaccine. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/2025 at 8:25 AM, Staff Q, IP, said they had talked to Resident 204's daughter and she agreed to all the vaccinations. When asked if Staff Q reviewed the risks/benefits of each vaccine, Staff Q said they reviewed the vaccine itself but did not go over risk/benefits and did not offer the Vaccination Information Sheet (VIS). 5) Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's immunizations list, showed Resident 132 had not been offered a influenza or pneumococcal vaccine since admission. On 04/25/2025 at 8:25 AM, Staff Q, IP, when asked if Resident 132 was up to date with their pneumococcal vaccination, said based on the Centers for Disease Control and Prevention recommendations, it was recommended that Resident 132 be given another pneumococcal vaccination. When asked if this was reviewed with admission to the facility, Staff Q said this was not part of the admission process, and they had not yet reviewed Resident 132 for pneumococcal vaccination. When asked about the influenza vaccination, Staff Q said they did not believe they had offered one to Resident 132 and this was most likely missed. On 04/28/2025 at 10:42 AM, Staff B, Director of Nursing Services, when asked what the risk would be for not giving a vaccine, such as the influenza/ Covid/ pneumococcal vaccines, in a timely manner, said a risk would be the resident not having antibodies to help prevent infection of the said viruses. When asked if it met expectations that risk/benefits/VIS were not documented on for every vaccine administration, Staff B said no. When asked if it meet expectations Resident 132's pneumococcal vaccination status had not been reviewed or that they had not been offered a influenza vaccine, said no. Reference WAC 388-97-1340(1),(2),(3) .