STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505525	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacey Post Acute & Rehabilitation	4524 Intelco Loop SE Lacey, WA 98503

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure residents and/or resident representatives were informed and provided consent before administering a psychotropic medication (medications capable of affecting the mind, emotions, and behaviors) for 1 of 5 sampled residents (56) reviewed for unnecessary medications. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about medications, and a diminished quality of life. Findings included . Resident 56 was admitted to the facility on [DATE]. The Annual Minimum Data Set assessment, dated 04/25/2025, documented Resident 56 was severely cognitively impaired, had multiple diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), depression (a mood disorder characterized by persistent sadness and loss of interest) and was taking an antipsychotic (a class of psychotropic medications used to treat symptoms of various mental disorders) and antidepressant (used to treat depression) medication. A physician's order, dated 11/05/2024, documented Resident 56 was prescribed quetiapine (a medication used to treat several mental health conditions such as bipolar disorder) 400 mg (milligrams) at bedtime. The Electronic Medication Administration Record (EMAR) showed Resident 56 was receiving quetiapine 400 mg daily. A physician's order, dated 11/05/2024, documented Resident 56 was prescribed duloxetine (a medication used to treat depression) 60 mg one time a day. The EMAR showed Resident 56 was receiving duloxetine 60 mg daily. Review of the Electronic Health Record did not show documentation of a consent from the resident or the resident's representative for the administration of quetiapine 400 mg or duloxetine 60 mg. On 06/05/2025 at 3:03 PM, Staff A, Administrator, and Staff B, Director of Nursing and Registered Nurse, said a consent should be completed when a resident is prescribed a psychotropic medication and/or if the dose was changed for the medication. Staff B said she could not find a consent for the quetiapine 400 mg and the duloxetine 60 mg and there should have been. Reference WAC 388-97-0260 (1)-(3) (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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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. . Based on interview and record review, the facility failed to ensure resident funds were conveyed to the resident's representative and/or to the state office of financial recovery (OFR) within 30 days of death or discharge for 1 of 1 discharged resident (311) reviewed for Trust Funds. This failure placed residents and/or their representatives at risk for delayed reconciliation of resident trust funds. Findings included . Review of Resident 311's Discharge Minimum Data Set assessment, dated 11/06/2024, showed resident 311 was discharged on 11/06/2024 with return anticipated. Resident 311's trust account statement showed Resident 311 had a balance of $1032.42 after a credit of $. 45 on 01/02/2025, 57 days after discharge. Resident 311's trust account statement showed Resident 311 had a balance of $1135.62 after a credit of $103.20 on 01/08/2025, 63 days after discharge. Resident 311's trust account statement showed Resident 311 had a balance of $1135.97 after a credit of $. 35 on 01/23/2025, 78 days after discharge. Resident 311's trust account statement showed, on 01/23/2025, a description, TO CLOSE ACCOUNT, with a debit of $1135.97, and a balance of $0.00, 78 days after discharge. It further showed Payee OFR .Issue date 02/26/2025. On 06/06/2025 at 10:59 AM, Staff A, Administrator, said after a resident discharges, they reach out to the power of attorney to determine how they want resident trust funds dispersed. Staff A said they dispersed funds within 30 days of discharge. Staff A said she did not see in Resident 311's Electronic Health Record that dispersing funds within 30 days of discharge was addressed and indicated it should have been. Reference WAC 388-97-0340(5) .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to obtain and/or maintain Advance Directives (AD) for 1 of 7 sampled residents (83) reviewed for AD. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . Resident 83 was admitted to the facility on [DATE], discharged with return anticipated on 04/16/2025, and re-admitted on [DATE]. The Quarterly Minimum Data Set assessment, dated 03/20/2025, documented Resident 83 was alert and oriented. The Social Service Initial Evaluation, dated 12/16/2024, showed in Section A.18., Resident 83 had a Health Care durable power of attorney (DPOA). A progress note, dated 01/15/2025, showed DPOA paperwork was supposed to be brought to the facility on [DATE]. The Social Services Quarterly Note, dated 03/06/2025, documented in section I. Advanced Directives, No change in status. Review of Resident 83's care plan did not document a Focus area addressing an AD. Review of Resident 83's Electronic Health Record did not show AD documentation, or that information or assistance was provided related to the development of ADs. On 06/04/2025 at 1:18 PM, Staff D, Social Services Director, said residents were asked if they had an AD at an initial care conference and asked to bring it into the facility if they have one. Staff D said if the AD was not brought in, they would periodically remind them and ask again to bring it in. Staff D said it was documented in Resident 83's EHR he had a POA. Staff D said they did not have paperwork for an AD or POA for Resident 83. Staff D said she would readdress obtaining a copy of the AD for residents during a quarterly care conference. Staff D said a copy of Resident 83's AD was not asked for at the quarterly care conference. Staff D said there was no documentation addressing an AD upon re-admission to the facility on [DATE]. At 1:50 PM, Staff A, Administrator, said a copy of the AD should be asked for and/or information offered quarterly with the care conference. Staff A indicated the AD should have been readdressed for Resident 83 upon readmission, stating, I don't see they followed our protocol for him. Reference WAC 388-97-0240 (3)(a)(b)(i-iii) .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to obtain an evaluation assessment, consent, and/or physician's order for 2 of 2 sampled residents (56 & 86) reviewed for physical restraints. This failure placed residents at risk of injury, unmet needs, and a diminished quality of life. Findings included . Review of the facility's policy entitled, Bed Rail Risk and Safety, revised 10/19/2022, documented: .Assess the Resident 1. Any resident being considered for using a bed with bed rail(s) is evaluated by the facility's interdisciplinary team to determine whether the resident's functional status and bed mobility is improved through the use of bed rail(s), to identify any bed rail that might constitute physical restraint, and to identify individual characteristics that may increase the risk of entrapment by bed rails or mattress . 3. If the resident's evaluation identifies him or her as appropriate for the use of bed rail(s), the following procedures will be followed: a. Educate the resident/resident representative on the risks and obtain consent for use. i. The resident and/or resident representative's consent for use of the bed rails will be documented in the medical record. b. The resident's representative will be notified as appropriate c. The physician/practitioner will be notified and a specific order for the use of bed rails (identify how many / type of rails, which side or sides of the bed, and when they are to be in place) will be obtained . 1) Resident 56 was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS) assessment, dated 04/25/2025, documented Resident 56 was severely cognitively impaired. On 06/02/2025 at 2:33 PM, Resident 56 was observed lying in bed with a quarter length bed rail on the upper left side of the bed. On 06/03/2025 at 2:33 PM, Resident 56 was observed lying in bed with a quarter length bed rail on the upper left side of the bed. On 06/04/2025 at 9:21 AM, Resident 56 was observed lying in bed with a quarter length bed rail on the upper left side of the bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:05 PM, Resident 56 was observed lying in bed with a quarter length bed rail on the upper left side of the bed. A second quarter length bed rail was observed to be on the ground to the right side of the head of the bed leaning against the wall. On 06/05/2025 at 8:49 AM, Resident 56 was observed lying in bed with quarter length bed rails on both the left and right upper sides of the bed. Review of Resident 56's Electronic Health Record (EHR) showed no evaluation assessment, resident and/or representative consent, or physician's order related to bed rails. 2) Resident 86 was admitted to the facility on [DATE]. The Significant Change MDS assessment, dated 04/18/2025, documented Resident 86 was alert and oriented. On 06/02/2025 at 2:12 PM, Resident 86 was observed lying in bed with a one-third length bed rail on the upper left side of the bed. On 06/03/2025 at 9:27AM, Resident 86 was observed lying in bed with a one-third length bed rail on the upper left side of the bed. Review of Resident 86's EHR showed no evaluation assessment, resident and/or representative consent, or physician's order related to bed rails. On 06/05/2025 at 12:50 PM, Staff C, Unit Manager and Licensed Practical Nurse, said when bed rails were used for a resident, an assessment, consent, and physician's order was needed. Staff C said he could not find an assessment, consent, or physician orders for Resident 56 or 86's bed rails and there should have been. At 1:26 PM Staff A, Administrator, and Staff B, Director of Nursing and Registered Nurse, said it was their expectation an evaluation assessment, consent, and physician's order was obtained for bed rails on a resident's beds. Reference WAC 388-97-0620 (4)(a)(b) .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) assessment accurately reflected mental health diagnoses for 2 of 6 sampled residents (409 & 410) reviewed for PASRR. This failure placed residents at risk of unmet mental health services and a diminished quality of life. Findings Included . Review of facility policy, entitled Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy, documented, 1) Prior to an individual's admission, The Social Worker, Admissions Coordinator, or designee will review the completed screening forms via e-PAS and obtain a copy for placement in the electronic medical record . 1) Resident 409 was admitted to the facility on [DATE] with diagnoses including depression and anxiety. The admission Minimum Data Set (MDS) assessment, dated 05/30/2025, documented Resident 409 was alert and oriented. Record review of Resident 409's Level 1 PASRR, dated 05/26/2025, did not document a serious mental illness indicator to include depression or anxiety. Resident 409's Level 1 PASRR, Section IV Service Needs and Assessor Data, was not completed and did not document if a Level II evaluation was indicated. 2) Resident 410 was admitted to the facility on [DATE] with diagnoses including depression, bipolar and anxiety. The admission MDS assessment, dated 05/30/2025, documented Resident 409 was alert and oriented. Record review of Resident 409's Level 1 PASRR, dated 06/04/2025, did not document a serious mental illness indicator to include depression, bipolar and anxiety. Resident 410's Level 1 PASRR, Section IV Service Needs and Assessor Data, was not completed and did not document if a Level II evaluation was indicated. On 06/04/2025 at 1:36 PM, Staff D and Social Services Director said PASRRs were reviewed for accuracy prior to admission by the admissions department. Staff D reviewed Resident 409's and 410's PASSR and said they were inaccurate and that new Level I PASRR had been sent out for evaluation. Reference WAC 388-97-1975 (1)(9) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 3 of 4 sampled residents (44, 32, & 83) reviewed for smoking, position/mobility, and anticoagulants (often called a blood thinner, a medication that inhibits blood clotting). This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . <Smoking> Resident 44 was admitted to the facility on [DATE] with multiple diagnoses to include Chronic Obstructive Pulmonary Disease (COPD, a lung disease blocking the airflow, making it difficult to breathe). The Quarterly Minimum Data Set (MDS) assessment, dated 04/09/2025, documented Resident 44 was alert and oriented. Facility policy, entitled Smoking Prohibited, dated 10/01/2021, documented: Evaluation of resident for ability to safely smoke without staff assistance / supervision in a location out of the facility and off the facility grounds. Evaluation will be maintained in the resident's record and the care plan will address the resident's desire to smoke outside of the facility or the facility grounds. On 06/02/2025 at 2:38 PM, Resident 44 was observed smoking independently off the facility property. Resident 44's Comprehensive Care Plan, did not show a Focus, Goal, or Interventions/Tasks area related to safe smoking, until being updated on 06/02/2025. On 06/06/2025, at 10:47 AM, Staff C, Unit Manager and a Licensed Practical Nurse (LPN), said he was aware Resident 44 smoked, despite residing in a non-smoking facility. Staff C said the facility educated the residents of risk and benefits of smoking, completed a smoking assessment, and updated the care plan accordingly. At 11:03 AM, Staff C reviewed Resident 44's care plan and said plan of care related to smoking should have been added prior to 06/02/2025. On 06/06/2025, Staff B, Director of Nursing and Registered Nurse, said Resident 44's smoking was addressed in her care plan, but due to a computer system change, it was canceled by a mistake and not put back until 06/02/2025. <Position/mobility> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 32 was admitted to the facility on [DATE]. The Quarterly MDS assessment, dated 04/30/2025, documented Resident 32 was alert and oriented, dependent for personal hygiene and transfers, and had hemiplegia or hemiparesis (paralysis of one side of the body). On 06/02/2025, at 12:14 PM, Resident 32 said she was unable to move her left hand. Resident 32 said she needed a hoyer lift (a mechanical device used to lift and transfers people unable to move themselves) to be transferred out of bed. On 06/04/2025 at 3:08 PM, Staff E, Certified Nursing Assistant (CNA), said he got information about the care needs of residents, like mobility and transfers, from the care plan and the Kardex, a brief overview of a resident's care. On 06/05/2025 at 8:46 AM, Resident 32 was observed lying in bed. Resident 32 said she can move her left leg just a little but is not able to move her left hand or arm at all. Resident 32 said she can move her left hand with her right hand, and demonstrated picking up her left hand with her right and moved it across her chest. Review of Resident 32's Comprehensive Care Plan did not show a Focus, Goal, or Interventions/Tasks area related to positioning, mobility and/or Activities of Daily Living (ADL) needs. <Anticoagulants> Resident 83 was admitted to the facility on [DATE], discharged with return anticipated on 04/16/2025, and re-admitted on [DATE] with multiple diagnosis to include pulmonary embolism (PE, a blood clot that traveled through the bloodstream and blocked an artery in the lungs). The Quarterly MDS assessment, dated 03/20/2025, documented Resident 83 was alert and oriented. A physician's order, dated 05/13/2025, documented Resident 83 was prescribed apixaban (an anticoagulant medication) for PE. The EMAR showed Resident 83 was receiving apixaban twice daily. Review of Resident 83's Comprehensive Care Plan did not show a Focus, Goal, or Interventions/Tasks area related to a PE diagnosis and/or anticoagulant medication. On 06/05/2025 at 10:44 AM, Staff B said the CNAs got information related to resident care from the Kardex, which is populated from the care plan. Staff B said the care plan should include ADL needs, disease processes, and high risk medications like anticoagulants. Staff B said she did not see a care plan addressing Resident 32's mobility and ADL needs and there should have been. Staff B said she did not see a care plan addressing Resident 83's diagnosis of PE and anticoagulant medication, and there should have been. Reference WAC 388-97-1020 (1), (2)(a) .

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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** 4) Resident 220 was admitted to the facility on [DATE]. The admission note, dated 05/22/2025 at 3:08 PM, showed Resident 220 was alert and oriented. Resident 220's admission care plan dated 05/29/2025 documented: SKIN IMPAIRMENT UPON ADMISSION/readmission - The resident has an area of impaired skin integrity. Left hip abrasion Left vascular wound to toes Left lower extremity vascular wound Left heel diabetic foot ulcer (DFU) stage 3 Right heel DFU unstageable Left lateral DFU unstageable. Resident 220's physician orders, dated 05/29/205, documented: Left hip abrasion clean with normal saline, pat dry, apply medihoney [wound treatment], and skin prep [skin protectant]. Cover with foam dressing. Change every other day until resolved. On 06/03/2025 at 11:43 AM, Resident 220 was observed sitting in his wheelchair with therapeutic cushion in place. He had bandages with kerlix wraps (gauze wrapping) covering both lower extremities. He informed me he was admitted with wounds to his heels. He said he also had a wound to his left buttock and the bandage wasn't changed the previous night. On 06/04/2025 at 10:06 AM, Resident 220 is observed sitting in his wheelchair with a therapeutic cushion in place. He has bandages and kerlix wraps covering both lower extremities. He informs me the bandages were changed later in the day as well as the one to his left buttock. On 06/04/2025, Review of Resident 220's treatment administration record shows treatment to left buttock was initiated on 05/29/2025 and treatments and dressing changes were to occur every other day. Treatment administration records for May 2025, and June 2025, showed treatments were signed for on 5/29/2025, 5/31/2025, 06/02/2025, and 06/04/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/04/2025 at 2:15 PM, Staff G, LPN, when asked about wound care for Resident 220 said she had completed treatments for his lower extremities. When asked about a treatment to Resident 220's left hip/buttocks she said she was unaware of a wound on his left hip/buttock. Staff G, stated,Let's go take a look at him because I need to know. Upon observation Resident 220 had a foam dressing to left lateral buttock/hip, dated 05/29/2025. Staff G, removed the dressing and noted an area of redness that was blanchable when touched. Staff G, said she would be notifying the Resident Care Manager and Director of Nursing Services. When asked about the signature on the treatment administration record for wound care to left hip/buttock, Staff G said she had a float nurse assisting her and this nurse was the one who signed the treatment record for left hip and buttock. On 06/04/2025 at 3:20 PM, Staff A, Administrator, indicated the treatment had been signed off in the treatment administration record without being completed. Reference WAC 388-97-1060 (1)(3)(b) Based on interview and record review, the facility failed to initiate bowel interventions for 3 of 10 sampled residents (16, 17 & 72) reviewed for quality of care related to bowel management. The facility also failed to provide treatment as ordered for 1 of 2 residents (220), reviewed for pressure ulcers. These failures placed residents at risk for health complications, unmet care needs and a diminished quality of life. Findings Included . 1) Resident 16 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 03/05/2025, documented Resident 16 was alert and oriented and required minimum assistance with activities of daily living (ADLs). The Bowel Movement (BM) task sheet documented Resident 16 had not had a BM on 05/06/25, 05/07/2025, and 05/08/2025. On 06/04/2025 at 2:53 PM, a joint review of May 2025 medication administration record (MAR) with Staff C, Unit Manager and Licensed Practical Nurse (LPN), did not show documentation of PRN (as needed) bowel medications having been administered between 05/06/2025 and 05/08/2025, nor documentation of a bowel assessment. Staff C said bowel protocol should have been initiated a day earlier. 2) Resident 17 was admitted to the facility on [DATE]. The Quarterly MDS assessment, dated 04/17/2025, documented Resident 16 was severely cognitively impaired and required moderate assistance with ADLs. The BM task sheet documented Resident 17 had not had a BM on 05/30/25, 05/31/2025, 06/01/2025, 06/02/2025 and 06/03/2025. On 06/04/2025 at 2:53 PM, a joint review of May and June 2025 MAR with Staff C, did not show documentation of PRN bowel medications having been administered between 05/30/2025 and 06/03/2025, nor documentation of a bowel assessment. Staff C said no PRN bowel medications were administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident 72 was admitted to the facility on [DATE]. The Quarterly MDS assessment, dated 04/18/2025, documented Resident 16 was severely cognitively impaired and required moderate assistance with ADLs. The BM task sheet documented Resident 72 had not had a BM on 05/31/2025, 06/01/2025, 06/02/2025 and 06/03/2025. On 06/04/2025 at 2:53 PM, a joint review of May and June 2025 MAR with Staff C, did not show documentation of PRN bowel medications having been administered between 05/31/2025 and 06/03/2025 nor documentation of a bowel assessment. Staff C said resident should have had a bowel assessment after 72 hours of no documented BM and bowel medications administered as needed. On 06/05/2025 at 11:16 AM, Staff D, Director of Nursing and Registered Nurse said it was the expectation that residents who had not had a BM in 72 hours are assessed, and PRN medications administered as ordered. Staff D reviewed Residents 16, 17 and 72's May/June 2025 bowel history and health record and said there was no documented bowel assessment between 05/30/2025 and 06/03/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505525	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacey Post Acute & Rehabilitation	4524 Intelco Loop SE Lacey, WA 98503

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview, observation, and record review, the facility failed to document completion and/or refusal of weights for 1 of 3 residents (223) reviewed for nutrition. This failure placed residents at risk for unplanned weight loss and decreased quality of life. Findings included . Resident 223 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment, dated 04/13/2025, showed Resident 223 was alert and oriented. Review of Resident 223's care plan showed no potential problems or goals related to nutrition or hydration were developed. Resident 223's electronic health record (EHR) showed the following weights: On 04/04/2025 admission weight showed 113.4 pounds On 04/06/2025 weight showed 111.0 pounds On 05/13/2025 weight showed 105.8 pounds On 06/05/2025 weight showed 104.6 pounds On 06/06/2025 at 9:14 AM, Staff H, Certified Nursing Assistant, said when residents were admitted they were weighed every day for four days, and then every week unless otherwise directed. Weights were obtained and reported to nursing staff. When asked if weights were documented in the EMR, Staff H said yes. The nurses documented in the EMR after weight were reported. When asked what the process was if a resident refused to be weighed, Staff H said this would be reported to the nursing staff. Staff H said Resident 223 often refused weights. Staff H said Resident 223 required assistance with meals. At 9:22 AM, Staff I, Licensed Practical Nurse and Resident Care Manager, said weights were to be completed upon admission, then for three days, and then weekly unless otherwise directed. Staff I said weights were to be documented in the EHR weight tab. Staff I said the CNA's obtained resident weights, reported them to the nurses, and the nurse would input the weights into the EHR weight tab. Staff I said the CNA's were not able to input weights into the EHR weight tab. When asked where resident refusals for weights would be located, Staff I said in the progress notes of the medical record. At 9:35 AM, Staff J, Registered Dietician, said residents were to be weighed upon admission, for three days after, and then weekly. When asked where resident weights could be found, Staff J said the EHR weight tab. When asked if weights were ever documented elsewhere, Staff J said no, they were only documented in the EHR. When asked how staff would document a resident refusal for a weight, Staff J said this would be documented in the EHR progress notes. (continued on next page)

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	505525	A. Building B. Wing	06/06/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:49 PM, Staff I said when a resident refused to be weighed, the CNA should report to the nurse so the nurse could speak with the resident, educate on risks and benefits, document in the medical record, and report to appropriate parties. Staff I said she was unable to locate weight refusal documentation for Resident 223 in the EHR. Reference WAC 388-97-1060 (3)(h) .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation and interview, the facility failed to ensure drugs, biologicals, and medical equipment were dated upon opening and discarded once expired for one of two medications rooms (2nd floor) and one of two treatment carts (1st floor) reviewed for medication and equipment storage. This failure placed the residents at risk for receiving compromised or ineffective medication and receiving treatment with outdated equipment. Findings included . <Medication Storage room [ROOM NUMBER]nd Floor> On [DATE] at 10:35 AM, a concurrent observation with Staff C, Unit Manager and Licensed Practical Nurse, showed as follows: 1. Medication Storage Room Refrigerator: One Vial of Tuberculin Purified Protein Derivative PPD (a solution used to test for tuberculosis) was observed opened with no date for when it was opened for use, and no date for when it should be disposed of. Two boxes of Bisacodyl Suppositories (rectal suppositories used to relieve constipation) with expiration date of [DATE]. 2. Medication Storage Room Shelve: One box containing 35 BD Vacutainer Safety Lock Blood Collection Sets (a device used to collect blood for laboratory analysis) was observed with an expiration date of [DATE]. <Treatment Cart 1st Floor> On [DATE], at 3:54 PM, a concurrent observation with Staff K, Licensed Vocational Nurse, showed as follows: One bottle of Hibiclens Solution (an antibacterial cleaning solution) was observed with an expiration date of 04/2024. Staff K said the Hebiclens should have been disposed of when it expired. On [DATE], at 11:30 AM, Staff C said medications and equipment in the medication storage room and refrigerator should be destroyed at time of expiration. At 11:45 AM, Staff A, Administrator, said staff had informed her of medication storage issues. Reference WAC 388-97-1300(2) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.