STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505527	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Post Acute	21008 76th Avenue West Edmonds, WA 98026

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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** 47218 Based on interview and record review, the facility failed to inform the resident and/or their representative before administering psychotropic (mind altering) medications for 1 of 5 residents (Resident 10), reviewed for unnecessary medications. This failure placed the resident and/or their representative at risk of not being fully informed of the risks and benefits before making decisions about their medications. Findings included . Review of the facility policy titled, Psychotropic Medication Use, revised in July 2022, showed: Residents will not receive medications that are not clinically indicated to treat a specific condition . The policy further showed that when determining whether to initiate, modify, or discontinue medication therapy, the IDT [Interdisciplinary Team] conducts an evaluation of the resident. The evaluation will attempt to clarify whether: other causes for symptoms (including symptoms that mimic a psychiatric disorder [disturb thinking and altered mood and behavior]) have been ruled out; signs and symptoms are clinically significant enough to warrant medication therapy; medication is clinically indicated to manage the symptoms or condition; and the actual or intended benefit of the medication is understood by the resident/representative. Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. Resident 10 admitted to the facility on [DATE] with diagnoses that included depression (constant feeling of sadness), insomnia (trouble sleeping), and anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations). Review of the November 2024 Medication Administration Record (MAR) showed Resident 10 was taking the following psychotropic medications: - Trazodone (an antidepressant) 100 milligrams (mg- unit of measurement) tablet every 12 hours as needed for insomnia that started on 11/04/2024. - Sertraline (an antidepressant) 50 mg tablet once a day for depression that started on 11/05/2024. - Buspirone (an antianxiety) 5 mg tablet three times a day for anxiety that started on 11/10/2024. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical records in the evaluations tab did not show that risks and benefit were provided to the resident or their representative for Resident 10's sertraline, trazodone, and/or buspirone use. On 12/16/2024 at 3:20 PM, Staff D, Resident Care Manager, stated they expected that resident on psychotropic medications had a consent and side effect monitoring. Staff D further stated that psychotropic medication consents were obtained prior to administering psychotropic medications to the residents. Staff D stated that psychotropic consents were under the evaluation tab with the name of Informed Consent - Psychotropic Medication and that the facility obtained verbal consents for each psychotropic medication. A joint record review and interview on 12/16/2024 at 3:30 PM with Staff D and Staff F, Regional Clinical Nurse, showed the evaluation tab did not have records that Resident 10 or their representative were informed prior to providing or giving Resident 10 their psychotropic medications. Staff F stated that the inform consent for psychotropic medications evaluation/form had the medications risks and benefits in it. Staff F stated there were no initial psychotropic medication informed consents for Resident 10's trazodone, sertraline, and buspirone, and that they should have been completed before Resident 10 started taking their psychotropic medications. On 12/16/2024 at 3:45 PM, Staff B, Assistant Director of Nursing, stated that residents on psychotropic medications required to have an informed consent for each psychotropic medication before they started taking psychotropic medications. Staff B further stated they expected staff to provide information related to risks and benefits to the residents and/or their representative before starting a psychotropic medication. Joint record review and interview with Staff B showed Resident 10 had orders for trazadone, sertraline, and buspirone. Further record review showed no documentation that Resident 10 or their representative were informed and/or provided risk and benefits about the use of psychotropic medications. Staff B stated that there were no informed consents provided for Resident 10 prior to buspirone, trazodone, and sertraline use. Reference: (WAC) 388-97-0260 (2) (a-d) (3)(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to ensure a comfortable bed sheet was provided for 1 of 1 resident (Resident 10), reviewed for accommodation of needs. This failure placed the resident at risk for unmet care needs, insufficient sleep or discomfort, and a diminished quality of life. Findings included . Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, revised in March 2018, showed that appropriate care and services would be provided for resident who were unable to carry out ADLs independently. Review of the admission Minimum Data Set (an assessment tool) dated 11/10/2024 showed Resident 10 required maximum physical assist for bed mobility and total assist for transfers. On 12/12/2024 at 10:16 AM, Resident 10 stated, they [the facility] do not have fitted sheets, that they wake up at night sweaty with their back lying on the cold [mattress] vinyl [water proof synthetic material], the flat sheet slips behind my back, it is uncomfortable, I can't sleep, I wake up in the middle of the night because my back is cold from being on the cold vinyl without a bed sheet. Resident 10 stated that they had mentioned to staff about wanting a fitted sheet for their mattress and that they were informed that [it] is against regulation to have fitted sheets on this type of mattress [air mattress - an inflatable mattress designed to prevent and treat pressure wounds/bedsores that occur due to prolonged pressure on the skin]. On 12/13/2024 at 11:23 AM, Resident 10 stated that their pillows, blankets, and flat sheets would slide down and that they had to push themselves backwards [against the mattress] to not fall on the floor. Resident 10 further stated that they have asked staff many times about fitted sheet for their air mattress and was informed that they cannot have fitted sheets, because it is not safe. Observations on 12/13/2024 at 11:30 AM, showed the clean utility room between room [ROOM NUMBER] and room [ROOM NUMBER] had two clean fitted sheets. Observations on 12/16/2024 at 10:12 AM, showed the linen room in the 500 unit had clean fitted sheets. In another observation at 10:16 AM, showed the linen room between rooms [ROOM NUMBERS] had clean fitted sheets. Observation on 12/16/2024 at 10:59 AM, showed Resident 10 did not have fitted sheets on their mattress and the upper part of the air mattress was uncovered showing the blue vinyl. On 12/16/2024 at 10:22 AM, Staff V, Laundry, stated that the facility had fitted sheets and that fitted sheets fit everything because it stretches. Staff V further stated that the fitted sheet fits all mattress size. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint observation on 12/17/2024 at 1:33 PM, Staff W, Certified Nursing Assistant, stated they do not use fitted sheet, only flat sheet when they make beds for air mattress. A joint observation with Staff W showed the air mattress in Resident 119's room had a fitted sheet. Staff V stated that they can only use the flat sheet on air mattress beds for safety. In a joint observation and interview on 12/17/2024 at 1:42 PM with Staff M, Licensed Practical Nurse, showed Resident 119 had a fitted sheet on their mattress. Staff M stated that Resident 119 had an air mattress. Another joint observation showed that Resident 10 had a flat sheet on their air mattress. Resident 10 stated that their flat sheet would slide off the bed and that they would be awake all night. Resident 10 further stated that staff mentioned to them that it was illegal to use fitted sheets on their air mattress. Staff M stated they were not aware Resident 10 had concerns about their bed sheets. On 12/17/2024 at 2:11 PM, Staff B, Assistant Director of Nursing, stated the facility used flat sheets on air mattresses. Staff B further stated that staff should have checked with Resident 10 about their bed sheet preferences to accommodate their needs. Reference: WAC 388-97 0860 (2)

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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. 48298 Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care-a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so) was obtained and completed for 1 of 10 residents (Resident 4), reviewed for advance directives. This failure placed the resident and their representative at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice. Findings included . Review of the facility policy titled, Advance directives, revised in September 2022, showed that prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and /or his or her legal representative, about the existence of any written advance directives. The policy further showed that if the resident or representative indicated that they had not established an advance directive, the facility staff would offer assistance in establishing advance directives. Review of Resident 4's Electronic Health Records (EHR-documents) showed a DPOA form had been signed and dated 10/16/2019 by Resident 4. In an interview and joint record review on 12/16/2024 at 3:03 PM with Staff G, Social Services Director, stated that they provide information to residents and their representatives about advance directive and if they have it [advance directives], should be in their medical records. Staff G stated that they reviewed and discussed advance directives during their care conferences. A joint record review of Resident 4's EHR showed a DPOA form that had been signed and dated 10/16/2019 by Resident 4. The DPOA form showed that, Washington State requires this directive to be notarized or witnessed by two different witnesses. Staff G stated that Resident 4's DPOA form had not been notarized or had no signature from two witnesses. Staff G further stated, [Resident 4] has a guardian. I will look into it. In an interview on 12/18/2024 at 10:07 AM, Staff A, Administrator, stated that they expected staff to have reviewed Resident 4's advance directives and made sure it was completed. Reference: (WAC) 388-97-0280 (3)(a)(d)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48298 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident and/or their representative for 1 of 1 resident (Residents 27), reviewed for hospitalization . This failure placed the resident and/or their representative at risk for not having an opportunity to make informed decisions about transfers/discharges. Findings included . Review of the facility policy, titled, Notice of Transfer or Discharge, reviewed in April 2020, showed, It is the policy of this center to provide written notice of transfer/discharge in accordance with state and federal regulations. Review of Resident 27's discharge Minimum Data Set (an assessment tool) dated 10/03/2024 and 11/06/2024, showed Resident 27 was discharged to an acute hospital on 10/03/2024 and on 11/06/2024. Review of the nursing progress notes dated 10/03/2024 and 11/06/2024, showed Resident 27 had a change in condition and was transferred to an acute hospital. Review of Resident 27's Electronic Health Record (EHR-under evaluations, nursing progress notes and documents) did not show documentation that a written notice of transfer/discharge was provided to Resident 27 and/or their representative. In a joint record review and interview on 12/17/2024 at 10:48 AM with Staff F, Regional Nurse, showed Resident 27's EHR did not show documentation that a written notice of transfer/discharge was provided to Resident 27 and/or their representative. Staff F stated, We did not do it [written notice of transfer]. In an interview on 12/17/2024 at 1:32 PM, Staff B, Assistant Director of Nursing, stated that no written notice of transfer/discharge was provided to Resident 27 and/or their representative. In an interview on 12/18/2024 at 10:07 AM, Staff A, Administrator, stated that they expected staff to provide a written notice of transfer/discharge to the resident and/or their representative. Reference: (WAC) 388-97-0120 (1)(b), (2) (a-d)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48298 Based on interview and record review, the facility failed to ensure bed hold (the opportunity to reserve a resident's current occupied bed while out of the facility to ensure their room was available when ready to return) notice was offered/provided for 1 of 1 resident (Resident 27), reviewed for hospitalization . This failure placed the resident or their representative at risk for lack of knowledge regarding the right to hold their bed while in the hospital. Findings included . Review of the facility policy, titled, Bed Hold, revised on 04/07/2023, showed, It is the policy of this facility that upon transfer to offer the resident and/or resident representative the option to hold the bed. The policy further showed, Upon transfer or discharge the nursing department will provide the resident and/or resident representative a copy of the bed hold policy. Review of Resident 27's discharge Minimum Data Set (an assessment tool) dated 10/03/2024, showed Resident 27 was discharged to an acute hospital on 10/03/2024. Review of the nursing progress notes dated 10/03/2024, showed Resident 27 had changes in condition and was transferred to an acute hospital. Review of Resident 27's Electronic Health Record (EHR-under evaluations, nursing progress notes and documents) did not show documentation that a notice of bed hold was offered or provided to Resident 27 and/or their representative. In a joint record review and interview on 12/17/2024 at 10:48 AM with Staff F, Regional Nurse, showed Resident 27's EHR did not show documentation that a notice of bed hold was offered or provided to Resident 27 and/or their representative. Staff F stated Resident 27 and/or their representative was not offered or provided a bed hold notice. In an interview on 12/17/2024 at 1:32 PM, Staff B, Assistant Director of Nursing, stated that Resident 27 and/or their representative had not been offered or provided a bed hold notice when Resident 27 was transferred/discharged to the hospital on 10/03/2024. In an interview on 12/18/2024 at 10:07 AM, Staff A, Administrator, stated that a bed hold notice should have been offered or provided to the resident and/or their representative. Reference: (WAC) 388-97-0120 (1)(b), (4) (a-c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to accurately assess 2 of 21 residents (Residents 10 & 11), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding antibiotic (medication to treat infection) use and surgical wound care treatment placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The MDS manual further showed to mark/code medications given to the resident by any route. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 10 Review of the November 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed Resident 10 received bacitracin (a topical [applied on the skin] antibiotic) ointment twice a day from 11/04/2024 to 11/08/2024, a total of five days. Review of Resident 10's admission MDS dated [DATE] showed antibiotic use was not marked in Section N (Medications). In an interview on 12/18/2024 at 9:15 AM, Staff J, MDS Coordinator, stated they follow the RAI manual for completion of MDSs. Joint record review of Resident 10's admission MDS with Staff J, showed use of antibiotic was not marked in Section N. Joint record review of the November 2024 MAR showed Resident 10 received bacitracin ointment from 11/04/2024 to 11/08/2024. Staff J stated that bacitracin antibiotic was a superficial ointment and that they would look for information about it. In another interview on 12/18/2024 at 9:49 AM, Staff J stated that bacitracin should have been included in Resident 10's MDS and that it was inaccurate. RESIDENT 11 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's admission MDS dated [DATE] showed it was marked for surgical wound care in Section M (Skin Conditions). Review of the November 2024 MAR and TAR showed Resident 11 did not have a surgical wound care treatment order during the look back period (from 11/25/2024 to 12/01/2024). A joint record review and interview on 12/18/2024 at 9:23 PM with Staff J, showed Resident 11 had orders in the November 2024 TAR to flush their drain (tubes placed near surgical incisions in the post-operative patient [resident], to remove pus, blood or other fluid, preventing it from accumulating in the body). Staff J stated that flushing the drain was not a skin treatment and that Resident 11's MDS was inaccurate. Reference: (WAC) 388-97-1000 (1)(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** 47218 Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Reviews (PASARR-an assessment to ensure individuals with Serious Mental Illness [SMI] or Intellectual/Developmental Disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) Level I was completed for 1 of 7 residents (Resident 11), reviewed for PASARR screening. This failure placed the resident at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the facility's policy titled, PASRR Process, reviewed in March 2019, showed that upon admission to the facility the Admissions Coordinator, Medical Records Director or designee will ensure that a PASRR Level I was included in the admission paperwork . If there is no PASRR Level I, the Medical Records Director or designee will contact the hospital to obtain a Level I PASRR . If a Level II Evaluation is indicated the Social Worker will ensure within a timely period that a LMHP [Licensed Mental Health Provider] is scheduled to evaluate. Resident 11 admitted to the facility on [DATE] with a diagnosis of major depressive disorder (constant feeling of sadness). Review of Resident 11's Level I PASARR dated 11/22/2024 showed, under Section 1A. SMI Indicators, none was marked for mood disorder. Review of the November 2024 Medication Administration Record showed Resident 11 had an order for an antidepressant medication dated 11/25/2024. In an interview on 12/17/2024 at 12:53 PM, Staff H, Social Services Director (SSD), stated that social services reviewed PASARR forms for accuracy, update them and sent it to the PASARR coordinator for evaluation. Joint record review and interview on 12/17/2024 at 1:07 PM with Staff H, showed Resident 11 had diagnosis of depression. Resident 11's Level I PASARR dated 11/22/2024 did not have depression marked under SMI Section I and that it was marked that no level II PASARR evaluation was required. Staff H stated that Staff G, SSD, made a progress note related to Resident 11's PASARR and that they would ask Staff G about Resident 11's updated Level I PASARR form. On 12/17/2024 at 3:07 PM, Staff G stated that they could not find Resident 11's updated Level I PASARR. Staff G stated that they completed a new Level I PASARR and had sent it to the PASARR evaluator for a Level II evaluation today [12/17/2024], 22 days after Resident 11 admitted to the facility. Staff G further stated that Resident 11's PASARR should have been updated and sent it to the PASARR evaluator when the resident was admitted . On 12/18/2024 at 10:19 AM, Staff A, Administrator, stated they expected Level I PASARR forms were reviewed for accuracy, updated, and sent for Level II evaluation if needed. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-1915 (1)(2) (a-c) (4), 1975(1)(4)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to notify the State PASARR (Pre-Admission Screening and Resident Review-an assessment used to identify people [resident] referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities, or related conditions are not inappropriately placed in nursing facility for long term care) Coordinator after a significant change in status occurred for 1 of 7 residents (Resident 27), reviewed for PASARR. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . A review of the facility's policy titled, PASRR Process, reviewed on March 2019, showed, If there is a significant change in condition that could affect their diagnosed need for a PASARR II, staff should refer for a NEW PASRR Level II. The policy showed, The Level I evaluator will determine if the resident's current care needs are able to be met at the NF [nursing facility]. The policy further showed to follow-up as needed per Federal PASRR rules. Resident 27 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental health condition that causes extreme mood swings), anxiety disorder (a mental health condition that involves intense feeling of fear and worry), major depressive disorder (a mental health condition that involves intense feeling of sadness). A review of Level I PASARR dated 01/13/2023 showed Resident 27 had SMI and had been referred for a Level II PASARR evaluation (a comprehensive evaluation for a positive Level I screening). A review of Level II PASARR evaluation summary dated 01/24/2023 showed Resident 27 had completed a psychiatric/mental evaluation. A review of the Notification of Nursing Home Room and Board Coordination with Hospice (medical care for people who are expected to live six months or less) form showed Resident 27 had elected to receive hospice services effective 11/22/2024. A review of the Certification of Terminal Illness dated 11/26/2024, showed Resident 27 had a terminal illness with a life expectancy of six months or less. A review of the Minimum Data Set (an assessment tool) look up page, showed Resident 27 had a significant change in status assessment dated [DATE]. In an interview on 12/16/2024 at 3:29 PM, Staff G, Social Services Director, stated that Resident 27 had a Level II PASARR related to SMI. Staff G stated that they did not notify the state mental health authority or the PASARR Coordinator about Resident 27's significant change in status. In an interview on 12/18/2024 at 10:07 AM, Staff A, Administrator, stated that they expected staff to notify the State PASARR Coordinator when Resident 27 had a significant change in status. (continued on next page)

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	505527	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-1975 (7)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to develop and/or implement care plans for 2 of 19 residents (Residents 11 & 20), reviewed for care planning. The failure to develop person-centered care plans for skin impairment, antibiotic (medication that treats infection) use, urostomy (a surgical procedure that creates an [ostomy-artificial opening] to drain urine), vision, pain, and nail care placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Planning - Interdisciplinary Team, revised in March 2022, showed that the interdisciplinary team was responsible for the development of resident care plans. Comprehensive, person-centered care plans were based on resident assessments and developed by an interdisciplinary team. RESIDENT 11 Resident 11 admitted to the facility on [DATE]. Review of Resident 11's admission Minimum Data Set (MDS- an assessment tool) dated 12/01/2024 showed ostomy, antibiotics, and opioids (controlled pain medication) were marked/coded on the MDS. Review of the care plan printed on 12/12/2024 showed the following care plans for Resident 11 were incomplete and/or not person-centered for skin, pain/opioid use, vision, antibiotic use and urostomy. A joint record review and interview on 12/18/2024 at 2:05 PM with Staff E, Resident Care Manager, showed Resident 11's care plans for skin, pain/opioid use, vision, antibiotic use, and urostomy were incomplete. Staff E stated that Resident 11's care plans were incomplete and that Resident 11's care plans should have had goals and interventions. On 12/18/2024 at 2:22, Staff B, Assistant Director of Nursing, stated that each residents' care plans should have a focus topic, goals, and interventions. Joint record review and interview with Staff B showed Resident 11 care plans for skin, pain/opioid use, antibiotic use, and urostomy were incomplete. Staff B stated that Resident 11's care plans were incomplete, and they should have had included goals and interventions. 48298 RESIDENT 20 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Activities of Daily Living [ADL], Supporting, revised in March 2018, showed that appropriate care and services would be provided for resident who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, oral care). Resident 20 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (or diabetes- a disease that occurs when the body cannot properly regulate blood sugar levels) and legal blindness (loss of vision). Review of the admission MDS dated [DATE], showed Resident 20 had severe vision loss and required set-up assistance with personal hygiene. An observation and interview on 12/11/2024 at 10:42 AM, showed Resident 20 had long and untrimmed fingernails with brown debris underneath their nails. Resident 20 stated that their fingernails were long and had not been trimmed. Resident 20 stated that their fingernails were bothering them and that an aide said [they] will come back to cut my nails. In another observation and interview on 12/13/2024 at 8:29 AM, showed Resident 20 had long and untrimmed fingernails with brown debris underneath their nails. Resident 20 stated that they had a shower yesterday [12/12/2024] and [they were] supposed to cut my nails but [it] did not happen. In an interview on 12/13/2024 at 1:56 PM, Staff N, Certified Nursing Assistant, stated that shower aides cut and trimmed residents' fingernails. Staff N further stated that if residents had diabetes, the nurse will do [cut/trim] their nails. In an interview and joint observation on 12/13/2024 at 2:01 PM, Staff O, Licensed Practical Nurse, stated that Resident 20 had diabetes and that nurses were responsible to cut or trim their nails. A joint observation with Staff O showed Resident 20 had long and untrimmed fingernails with brown debris underneath their nails. Staff O stated, I will cut your nails to which Resident 20 responded, that would make me comfortable. A joint record review of Resident 20's ADL care plan initiated on 11/27/2024 showed, Nurse to trim nails. Staff O stated that they should follow and implement Resident 20's plan of care. In an interview and joint record review on 12/13/2024 at 2:55 PM, Staff E stated that Resident 20 had diabetes. A joint record review of Resident 20's ADL care plan initiated on 11/27/2024, showed, Nurse to trim nails. Staff E stated that Resident 20's plan of care regarding their nails should have been followed and implemented. In an interview on 12/13/2024 at 4:00 PM, Staff B stated that they expected staff to have followed and implemented Resident 20's plan of care regarding nail care. References: (WAC) 388-97-1020 (1)(2)(a)(c)(3)(5)(a) .

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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** 48298 Based on observation, interview, and record review, the facility failed to provide necessary assistance with nail care for 1 of 1 resident (Resident 20), reviewed for Activities of Daily Living (ADL) care. This failure placed the resident at risk for poor hygiene, decreased self-esteem, and a diminished quality of life. Findings included . Review of the facility policy titled, Activities of Daily Living, Supporting, revised in March 2018, showed, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Resident 20 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a disease that occurs when the body cannot properly regulate blood sugar levels) and legal blindness (loss of vision). Review of the Admission Minimum Data set (an assessment) dated 12/03/2204, showed Resident 20 had severe vision impairment and required set-up assistance with personal hygiene. Observation and interview on 12/11/2024 at 10:42 AM, showed Resident 20 had long and untrimmed fingernails with brown debris underneath their nails. Resident 20 stated that their fingernails were long and had not been trimmed. Resident 20 further stated that their fingernails were bothering them and that an aide said [they] will come back to cut my nails. In another observation and interview on 12/13/2024 at 8:29 AM, showed Resident 20 had long and untrimmed fingernails with brown debris underneath their nails. Resident 20 stated that they had a shower yesterday [12/12/2024] and that an aide was supposed to cut my nails but did not happen. In an interview on 12/13/2024 at 1:56 PM, Staff N, Certified Nursing Assistant, stated that shower aides cut and trimmed residents' fingernails. Staff N further stated that if residents had diabetes, the nurse will do [cut/trim] their nails. In an interview and joint observation on 12/13/2024 at 2:01 PM, Staff O, Licensed Practical Nurse, stated that Resident 20 had diabetes. A joint observation showed Resident 20 had long and untrimmed fingernails with brown debris underneath them. Staff O stated, I will cut your [referring to Resident 20] nails' to which Resident 20 responded, that would make me comfortable. In an interview and joint record review on 12/13/2024 at 2:55 PM, Staff E, Resident Care Manager, stated that Resident 20 had diabetes and should have an order [from a physician] for a nail trim. A joint record review showed Resident 20 did not have a physician order for nail trim. Staff E stated that Resident 20 should have had a physician order for a nail trim and had their fingernails trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/13/2024 at 4:00 PM, Staff B, Assistant Director of Nursing, stated that nurses provided nail care for residents with diabetes and I expect the CNAs to coordinate with the nurses to have nails cut for the residents [with diabetes] and not wait for weeks. Staff B further stated that Resident 20 should have had their fingernails trimmed. Reference: (WAC) 388-97-1060 (1)(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** 47218 Based on interview and record review, the facility failed to ensure physician orders were implemented and followed in accordance with professional standards of practice for 1 of 1 resident (Resident 11), reviewed for quality of care. This failure placed the resident at risk for not receiving necessary care services, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Medication Orders, revised in November 2014, showed that the facility established uniform guidelines in the receiving and recording of medication orders. Orders must be written and maintained in chronological order. When recording treatment orders, specify the treatment, frequency and duration of the treatment. Review of the face sheet printed on 12/12/2024 showed Resident 11 admitted to the facility on [DATE]. Review of the hospital discharge orders dated 11/25/2024 showed Resident 11 discharged with abdominal (stomach area) drains (tubes placed near surgical incisions to remove pus, blood or other fluid, preventing it from accumulating in the body). Further review of the hospital discharge orders showed orders to empty and record output for drain separately, at least once a day and bring this record when you return to clinic, and to call the clinic to schedule a nurse visit for drain removal when the following criteria were met: less than 30 cc (cubic centimeter - unit of measurement) [of body fluid drain from their abdomen] per 24 hours for two days in a row. Review of the November 2024 and December 2024 Medication Administration Record and Treatment Administration Record showed no orders or documentation to show that Resident 11's drain was emptied and/or that drainage output was documented at least daily (until 12/13/2024), 19 days after Resident 11 admitted to the facility. A joint record review and interview on 12/18/2024 at 1:58 PM with Staff E, Resident Care Manager, showed that Resident 11 had orders to empty, and document drain output at least daily from hospital discharge orders dated 11/05/2024. Staff E stated that the orders were started on 12/13/2024 and should have been started since Resident 11's admission to the facility. A joint record review and interview on 12/18/2024 at 2:24 PM with Staff B, Assistant Director of Nursing, showed no orders and/or documentation that Resident 11's drain output had been documented at least daily prior to 12/13/2024. Staff B stated, they [staff] should have followed the order, whatever the doctor's orders are. Reference: (WAC) 388-97-1060 (1)(3)(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on observation, interview, and record review, the facility failed to maintain, label/date, and properly store oxygen tubing, nasal cannula (flexible tubing that sits inside the nose and delivers oxygen), and nebulizer (device used to administer medication in the form of a mist that is inhaled into the lungs) mask for 3 of 7 residents (Residents 5, 32 & 120), reviewed for respiratory care. In addition, the facility failed to follow Resident 120's physician orders for oxygen use. These failures placed the residents at risk for unmet care needs, respiratory infections, and related complications. Findings included . A review of the facility's policy titled, Respiratory Treatment, revised in 08/21/2024, showed residents received respiratory treatments and monitoring per their physician orders, standard of practice and care plan. It showed that oxygen cannula and tubing would be changed as needed if soiled or damaged. It showed that when the nasal cannula and/or the nebulizer mask were not in use, they would be stored in a bag. The policy further showed that residents who received respiratory treatments were monitored per physician orders; and that the amount, method, and duration of oxygen usage and diagnosis were identified on the resident's treatment record per the physician orders (ex. continuous oxygen at 2 liters per nasal cannula. RESIDENT 5 A review of Resident 5's face sheet showed they admitted to the facility on [DATE]. A review of Resident 5's November 2024 Medication Administration Record (MAR) showed Resident 5 had an order for oxygen 2 liters (unit of measurement) via nasal cannula at bedtime for sleep apnea (a disorder that causes you to stop breathing while asleep) and an order to change oxygen tubing as needed for damage, soiling and non-function. There were no nurse's initials or documentation to indicate that the tubing was changed in the month of November 2024. A review of Resident 5's December 2024 MAR showed there were no nurse's initials/documentation to indicate Resident 5's oxygen tubing had been changed for December. In an observation on 12/11/2024 at 9:15 AM, a nasal cannula was hanging on the cork board in Resident 5's room. There was a thumb tack on the cork board where the prongs of the nasal cannula were hanging from. Resident 5's nasal cannula tubing was connected to a concentrator and was not labeled or dated. In an observation on 12/13/2024 at 10:13 AM, a nasal cannula was observed hanging on the cork board by the nasal prongs. Resident 5's unlabeled/undated nasal cannula was connected to the oxygen concentrator and was not properly stored. In an interview on 12/13/2024 at 10:13 AM, Resident 5 stated their oxygen tubing had not been changed since they admitted to the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a joint observation and interview on 12/13/2024 at 11:38 AM with Staff P, Licensed Practical Nurse (LPN), Resident 5's nasal cannula was observed hanging on the corkboard on the wall by its nasal prongs. Staff P stated that the nasal cannula/oxygen tubing was not dated and that it should have been in a bag. In an interview and joint record review on 12/13/2024 at 11:47 AM, Staff D, Resident Care Manager (RCM), stated that staff would change oxygen tubing when the tubing was dirty, damage, and not functioning properly. Staff D stated that when the oxygen tubing was changed, it would be signed off in the MAR. Joint record review of the November 2024 and December 2024 MAR did not show documentation that the oxygen tubing had been changed. Staff D stated that Resident 5's oxygen had not been changed because there had not been any issues. In an interview on 12/13/2024 at 4:38 PM, Staff B, Assistant Director of Nursing, stated that they expected staff to follow the physician order for oxygen tubing management, the nasal cannula would be stored in a bag when not in use, and that the nasal cannula would be changed as needed, not routinely. RESIDENT 32 A review of Resident 32's face sheet showed they admitted to the facility on [DATE]. A review of the December 2024 MAR showed Resident 32 had an order for oxygen at 2 liters per minute via nasal cannula. In an interview on 12/13/2024 at 10:03 AM, Resident 32 stated that they did not know when their oxygen tubing was last changed. In an observation on 12/13/2024 at 10:03 AM, Resident 32 was receiving oxygen via their nasal cannula. Resident 32's nasal cannula was unlabeled or undated and their oxygen concentrator had an undated bottle of distilled water attached that was halfway full. In a joint observation and interview on 12/13/2024 at 11:30 AM with Staff P, showed Resident 32's nasal cannula was undated. Staff P stated that Resident 32's nasal cannula should have been dated and that the facility had orange stickers that they used to label the oxygen tubing. In an interview and joint record review on 12/13/2024 at 11:47 AM, Staff D stated that staff would change tubing per physician orders and when soiled or damaged. Staff D stated that staff did not date the oxygen tubing when they change it because they mark if off in the MAR. A joint record review of Resident 32's December 2024 MAR did not show an order to change the oxygen tubing. Staff D stated that they would get that [the order] fixed. In an interview on 12/13/2024 at 4:38 PM, Staff B stated that they expected the staff to follow the physician order for changing oxygen tubing for residents. Staff B further stated that they did not expect oxygen tubing to be changed routinely but as needed. 47218 NEBULIZER USE (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 120 Resident 120 admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (insufficient oxygen in the blood). Review of the physician orders printed on 12/12/2024 showed Resident 120 had an order for an inhalation medication via nebulizer four times a day. Observation on 12/13/2024 at 11:34 AM, showed Resident 120's nebulizer mask was inside their nightstand drawer and was not properly stored. Joint observation and interview on 12/13/2024 at 12:33 PM with Staff P, showed Resident 120's undated nebulizer mask was inside their nightstand drawer and not properly stored. Staff P stated that Resident 120's nebulizer mask should have been dated and stored in a bag when not in use. OXYGEN ORDERS RESIDENT 120 Review of the physician orders printed on 12/12/2024, showed Resident 120 had orders for oxygen at 2 liters per minute via nasal cannula continuously. Observation on 12/11/2024 at 4:19 PM, showed Resident 120 was receiving oxygen via nasal cannula at a rate of 2 1/2 (two and one half) liters per minute from an oxygen concentrator. Resident 120's oxygen and nasal cannula were not dated or labeled. Resident 120 stated that their oxygen tubing and cannula were not dated. On 12/13/2024 at 11:34 AM, Resident 120's oxygen tubing and nasal cannula were undated. Further observation showed Resident 120 in sitting in their wheelchair in their room. Resident 120 was receiving 4 liters of oxygen from their oxygen tank. Resident 120 stated that their oxygen tubing and nasal cannula were not dated. Joint observation and interview on 12/13/2024 at 12:25 PM with Staff P, showed Resident 120's oxygen tubing and nasal cannula were undated and that Resident 120's oxygen tank was at 4 liters per minute. Resident 120 stated, Probably the guy from PT [Physical Therapy] turned it [the oxygen] up when I was doing activity. Staff P stated that the oxygen tubing and nasal cannula should have been dated. Staff P further stated that it was the first time that they saw Resident 120 getting 4 liters of oxygen per minute and that Resident 120 had an order for oxygen at 2 liters per minute. Joint record review and interview on 12/13/2024 at 12:41 PM with Staff E, RCM, showed Resident 120 had oxygen orders at 2 liters per minute continuously. Staff E stated that that Resident 120's physician orders did not show an order to increase their oxygen to 4 liters per minute during activity and it should have been. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/2024 at 12:54 PM, Staff B stated that they expected oxygen orders were in place and that they were carried out correctly. Staff B stated that there should have been an order to increase Resident 120's oxygen when they were doing therapy. Staff B further stated that Resident 120's nebulizer mask should have been stored in a plastic bag when not in use and that they did not expect residents' oxygen tubing, oxygen cannula, and/or nebulizer tube/mask were label/dated. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on interview and record review, the facility failed to ensure adequate monitoring were conducted for use of diuretics (medications that help move extra fluid and salt out of the body) for 2 of 7 residents (Residents 3 & 26), anticoagulants (medication that prevent blood clot) for 3 of 7 residents (Residents 26, 28 & 10), and antibiotic (medication that treats infections) for 1 of 7 residents (Resident 11), reviewed for unnecessary medications. These failures placed the residents at risk for receiving unnecessary medications, adverse side effects, and related complications. Findings included . A review of the facility's policy titled, Medication Administration General Guidelines, revised in January 2023, showed the last step in the process was to observe residents for medication actions/reaction and record in the nurse's notes as appropriate. The policy further showed that any noted adverse consequence should be reported to the prescriber and/or attending physician. A review of the facility's policy titled, Medication Therapy, revised in April 2007, showed that all medication orders will be supported by appropriate care processes and practices. The policy further stated that the medical director and consultant pharmacist shall collaborate to address issues of medication prescribing and monitoring with the practitioners and staff. RESIDENT 3 A review of Resident 3's face sheet showed they admitted to the facility on [DATE]. A review of the December 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed Resident 3 had an order for furosemide (a diuretic medication) 20 milligrams (mg-a unit of measurement) to treat congestive heart failure (CHF-when the heart is unable to pump blood efficiently to the body). The MAR did not show Resident 3 was adequately monitored for diuretic use. A review of the nursing progress notes from 11/16/2024 to 12/16/2024 did not show Resident 3 was not adequately monitored related to diuretic use. In a joint record review and interview on 12/17/2024 at 2:26 PM with Staff P, Licensed Practical Nurse (LPN), showed the December 2024 MAR did not show Resident 3 was monitored for diuretic use. Staff P stated that residents on diuretics were monitored for adverse side effects for three days after initiating the medication. In an interview on 12/17/2024 at 2:35 PM with Staff D, Resident Care Manager (RCM) and Staff C, RCM, Staff C stated that residents taking diuretics were placed on alert charting at the start of the medication. Staff D stated that for residents with CHF, they would monitor their weight if it were included with the physician order. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/17/2024 at 2:40 PM, Staff B, Assistant Director of Nursing, stated that they did not feel monitoring of diuretic use should be included in the MAR/TAR. Staff B stated that they expected diuretics to be monitored at the initiation of the medication and would be on alert for 72 hours. RESIDENT 26 A review of the Resident 26's face sheet showed they admitted to the facility on [DATE]. In a joint record review and interview on 12/17/2024 at 2:04 PM with Staff Q, Registered Nurse, showed Resident 26's December 2024 MAR had an order for furosemide 20mg to be given once daily and apixaban (an anticoagulant) 5 mg to be given twice a day. Staff Q stated that Resident 26's diuretic use was not monitored and that monitoring side effects for anticoagulants were not charted in the MAR/TAR. Staff Q stated that apixaban was included in the care plan and not in the MAR/TAR for everyday monitoring. A review of the nursing progress notes from 11/16/2024 to 12/16/2024 did not show Resident 26 was being monitored for anticoagulant use and/or diuretic use. In an interview on 12/17/2024 at 2:35 PM, Staff C stated that monitoring for anticoagulant use was included in the comprehensive care plan. Staff C stated that when residents start diuretic medications, they would be placed on alert charting for 72 hours. Staff C further stated that they would monitor a resident's weight if the physician ordered it. In an interview on 12/17/2024 at 2:40 PM, Staff B stated that they did not feel adverse side effect monitoring for diuretics and anticoagulants should be on the MAR/TAR. Staff B stated that diuretic use and anticoagulant use were included in the comprehensive care plan. Staff B further stated that when residents receive an order for a diuretic or anticoagulant medication, the resident would be placed on alert charting for 72 hours. RESIDENT 28 A review of Resident 28's face sheet showed they admitted to the facility on [DATE]. A review of the December 2024 MAR showed Resident 28 had an order for apixaban to be given twice a day to treat atrial fibrillation (an irregular and often very rapid heart rhythm). Resident 28's MAR/TAR had no documentation to show monitoring for anticoagulant use was conducted. A review of the nursing progress notes from 11/16/2024 to 12/15/2024 did not show Resident 28 was monitored related to anticoagulant use. In a joint record review and interview on 12/17/2024 at 2:04 PM with Staff Q, showed Resident 28's December 2024 MAR had a written order for apixaban (an anticoagulant) to be given twice a day to treat atrial fibrillation (an irregular and often very rapid heart rhythm). Further review of the MAR revealed no documentation to show monitoring was conducted related to anticoagulant use. Staff Q stated they did not find charting specifically for anticoagulant use. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/17/2024 at 2:19 PM, Staff Q stated that they had just spoken to their RCM and was told apixaban was not added in the MAR/TAR for everyday monitoring. Staff Q further stated that the apixaban was added in the care plans. In an interview on 12/17/2024 at 2:35 PM, Staff C stated that anticoagulant use was usually care planned and would not be in the MAR/TAR. Staff C further stated that Resident 28 was alert and was able to report any bleeding or excessive bruising. In an interview on 12/17/2024 at 2:40 PM, Staff B stated that they did not expect monitoring for anticoagulant side effects would be included in the MAR/TAR because it was in the care plan. Staff B further stated that when they receive a new order for apixaban, they would place the resident on alert charting for three days. 47218 RESIDENT 10 Resident 10 admitted to the facility on [DATE]. Review of the November 2024 and December 2024 MAR/TAR showed Resident 10 had an order for apixaban to be given twice a day for atrial fibrillation. The MAR/TAR did not show Resident 10 was being monitored related to anticoagulant use. Review of the nursing progress notes from 11/04/2024 to 12/12/2024 showed no documentation that Resident 10 was adequately being monitored related to anticoagulant use. On 12/16/2024 at 3:06PM, Staff T, LPN, stated that anticoagulant medications needed to be monitored for bleeding and bruising every shift and were placed on alert for 72 hours when the anticoagulant was started. Staff T stated that there were no orders to monitor for adverse side effects of anticoagulant use. In a joint interview on 12/16/2024 at 3:22 PM with Staff D and Staff F, Regional Clinical Nurse, Staff D stated that staff monitors for side effects of bleeding for anticoagulants through residents' care plans, not in the MAR or TAR. Staff F stated that staff documented side effects of anticoagulant use by exception and that the facility did not require adverse side effects monitoring were documented every shift. In an interview on 12/16/2024 at 4:09 PM, Staff B was asked for documentation to show that Resident 10 was being adequately monitored related to the anticoagulant use. Staff B stated, nurses know to monitor for signs and symptoms of bleeding, and that the facility monitors anticoagulant side effects in residents' care plans. RESIDENT 11 Resident 11 admitted to the facility on [DATE]. Review of the November 2024 and December 2024 MAR/TAR showed Resident 11 was on doxycycline (an antibiotic) 100 mg twice a day since 11/25/2024 without a stop date. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nursing progress notes from 11/25/2024 to 12/18/2024 showed no documentation that Resident 11 was adequately monitored related to antibiotic medication use. On 12/18/2024 at 9:27 AM, Staff T stated they monitor for side effects of antibiotic use and that if there were no side effects, they were not documented. Staff T further stated that antibiotic side effects were monitored through the duration of the antibiotic treatment. On 12/18/2024 at 2:03 PM, Staff E, RCM, stated that Resident 11 was on antibiotics since admission. Staff E stated that there was no active monitoring for adverse side effects for the antibiotic use. Staff E further stated that residents on antibiotics had a care plan for antibiotic use and for monitoring of side effects. Joint record review and interview with Staff E showed Resident 11 did not have a care plan for antibiotic use. Staff E stated that there should have been a care plan for Resident 11's antibiotic use with interventions of monitoring adverse side effects. On 12/18/2024 at 2:22 PM, Staff B stated that side effects to antibiotic use were documented by exception and the monitoring of the side effects were included in the residents' care plans. Joint record review and interview with Staff B showed Resident 11 did not have a care plan for antibiotic use and/or to monitor for side effects to anticoagulant use before 12/18/2024. Staff B stated that Resident 11 should have had a care plan for monitoring side effects of antibiotic medication. Reference: (WAC) 388-97-1060 (3)(k)(i) (4)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48298 Based on observation, interview, and record review, the facility failed to ensure the dishwasher temperature was checked and the sanitizing solution was tested routinely in accordance with professional standard for food service safety for 1 of 1 kitchen, reviewed for food services. These failures placed the residents at risk for food borne illness and a diminished quality of life. Findings included . Review of the facility policy titled, Dishwashing, adopted on 08/01/2024, showed, It is the policy of this center that dishes and other multi-use eating, preparation and serving items are cleaned and sanitized properly after each use. The policy further showed to log and check for proper temperatures. In an interview and joint observation on 12/16/2024 at 10:39 AM with Staff I, Dietary Director and Staff K, Dietary Aide, stated that they checked the dishwasher temperature and the sanitizer ppm [or PPM- parts per million - unit of measure for concentration] three times a day [breakfast, lunch and dinner]. Staff K stated that they logged daily the dishwasher temperature and the sanitizer ppm in separate columns using one form for each month. Joint observation showed the December 2024 Dishwasher Temperature/Sanitizer Log form was blank for 12/15/2024. Joint observation of the form showed the dinner columns for the dishwasher temperature and sanitizer ppm were blank on 12/14/2024. Staff K stated that the dishwasher temperatures were not logged. Staff K further stated that they ran out of test strips and were not able to test the sanitizing solution. In an interview on 12/16/2024 at 10:50 AM, Staff I stated that they had a low-temperature dishwasher which used chemicals to sanitize dishware. Staff I stated that they expected the staff to check the dishwasher temperature and conduct testing of the sanitizer three times a day and to log the information on the form. In an interview on 12/18/2024 at 10:07 AM, Staff A, Administrator, stated that they expected staff to check the dishwasher temperature and to test the sanitizing solution per the facility process. Reference: (WAC) 388-97-1100 (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP- precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections]) was followed for Resident 119 and failed to ensure clean linen were handled properly for room [ROOM NUMBER]. In addition, the facility failed to properly disinfect glucometers (a device to measure how much sugar is in the blood) for 2 of 2 residents (Residents 121 & 114) and sanitize medical equipment for 2 of 2 residents (Residents 211 & 3), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . Review of the facility policy titled, Enhanced Barrier Precautions, revised in March 2024, showed EBPs were used to reduce the transmission of MDRO to residents. EBPs required gown and glove use during high contact resident care activities dressing such as: bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting; and for device care or use that included feeding tube (flexible tube that delivers nutrients directly to the stomach). The policy further showed that signs were posted on the door or wall outside the resident room indicating the type of precautions and PPE required and that PPE would be available outside of the resident rooms. Review of the undated facility provided signage titled, Enhanced Barrier Precautions, showed that providers and staff must wear gloves and a gown for high contact resident care activities that included feeding tube care. ENHANCED BARRIER PRECAUTIONS RESIDENT 119 Review of the face sheet printed on 12/13/2024 showed that Resident 119 admitted to the facility on [DATE] with diagnosis that included dysphagia (difficulty swallowing). Review of the December 2024 Medication Administration Record (MAR) printed on 12/13/2024 showed Resident 119 had orders for nutritional supplements and medications to be given via enteral feeding tube dated 12/02/2024. Further review of the MAR did not show Resident 119 was placed on EBP precautions. Observations on 12/11/2024 at 9:05 AM and at 3:16 pm, on 12/12/2024 at 9:28 AM, and on 12/13/2024 at 9:53 AM, showed no EBP signage was posted and/or no PPE cart outside Resident 119's room. Observation on 12/11/2024 at 3:16 pm, showed Resident 119 was receiving a nutritional supplement via feeding tube. Resident 119 stated that they have had feeding tube since October 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 12/13/2024 at 3:17 PM, showed Staff P, Licensed Practical Nurse (LPN), was observed entering Resident 119's room and was not wearing a gown. Staff P stated they went in Resident 119's room to replace the feeding tube nutritional supplement. Staff P further stated that they did not wear a gown and that they used gloves because the resident is not on enhanced precautions [EBP]. On 12/13/2024 at 3:45 PM, Staff T, LPN, stated that EBP precautions were for residents who had wound care and urinary catheters (flexible tube that drains urine from the bladder). Staff T stated that Resident 119 had a feeding tube and that they received their supplements and medications via feeding tube. Joint record review of an undated EBP signage showed that residents on feeding tube required EBP with use of gloves and gown prior to providing care. Staff T stated that they worked with Resident 119 in two occasions prior to today [12/13/2024] and that they did not wear a gown due to Resident 119 was not on EBP. Staff T further stated that Resident 119 should have been on EBP precautions since admission. On 12/13/2024 at 4:02 PM, Staff E, Resident Care Manager (RCM), stated that EBP precautions were required for residents who had wounds, unhealed incisions, and urinary catheters. Joint record review of an undated EBP signage showed that gloves and gowns were required for residents on feeding tube. Staff E stated that Resident 119 was not placed on EBP precautions and should have been. Staff E further stated that there should have been an EBP signage and PPE cart outside Resident 119's room. On 12/13/2024 at 4:37 PM, Staff B, Assistant Director of Nursing/Infection Preventionist, stated that Resident 119 should have had an EBP in place with EBP signage and PPE cart with gowns outside their room since admission to the facility. 48298 CARRYING CLEAN LINEN room [ROOM NUMBER] Review of the facility policy titled, Infection Control Policies and Practices, adopted on 08/01/2024, showed, The Administrator .and the Infection Control Committees, have adopted our infection control policies and practices, as outlined herein, to reflect the Center's needs and operational requirements for preventing transmission of infections and communicable diseases as set forth in current .CDC [Centers for Disease Control] guidelines and recommendations. An observation on 12/13/2024 at 9:04 AM, Staff N, Certified Nurse Assistant, showed they took several clean white towels and some linens from a cart parked in front of room [ROOM NUMBER]. Staff N placed the clean towels/linens on their left arm, carried them close to their chest [touching their body] and then entered room [ROOM NUMBER]. In an interview on 12/13/2024 at 9:18 AM, Staff N stated that they were assigned to provide showers to the residents. When asked, Staff N stated that they did not realize that they carried the towels and linen close to their body. Staff N stated, I should have carried them this way [gestured both arms away from the body]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/13/2024 at 10:02 AM, Staff Q, Registered Nurse, stated that clean linens must be carried away from the body and should not touch their [staff] clothes. In an interview on 12/13/2024 at 11:23 AM, Staff C, RCM, stated that staff was expected to carry clean linens away from their body or clothes. In an interview on 12/13/2024 at 4:14 PM, Staff B stated that they expected staff to follow infection control guidelines, which included carrying clean linens away from their body and clothes. DISINFECTION OF GLUCOMETER MACHINE RESIDENT 121 Review of the facility's undated document titled, General Practice\3.05 Glucose [blood sugar] Monitor Cleaning-Disinfection, showed, CMS [Centers for Medicare & Medicaid Services- a government agency that provides healthcare insurance) guidelines read that blood glucose meters need to be cleaned and disinfected after each use. Observation on 12/16/2024 at 6:53 AM, showed Staff L, LPN, went in Resident 121's room and checked Resident 121's blood sugar level using a glucometer. Staff L went out of Resident 121's room and placed the glucometer on top of their medication cart. Staff L proceeded to continue their medication pass to the other side of the unit. Staff L did not disinfect the glucometer after they used it with Resident 121. In an interview on 12/16/2024 at 7:50 AM, Staff L stated that the glucometer should be sanitized after use with patients [residents]. Staff L stated that they did not disinfect/sanitize the glucometer after using it with Resident 121. RESIDENT 114 Observation and interview on 12/16/2024 at 7:57 AM, showed Staff M, LPN, went in Resident 114's room and checked their blood sugar level using a glucometer. Staff M went out of Resident 114's room, opened their medication cart and placed the glucometer inside the top drawer. Staff M then closed the drawer and did not disinfect the glucometer machine used with Resident 114. When asked, Staff M stated that they placed the glucometer back in the drawer [medication cart] and did not disinfect the glucometer machine. DISINFECTION OF VITAL SIGNS EQUIPMENT RESIDENT 211 Review of the facility policy titled, Infection Control Policies and Practices, adopted on 08/01/2024, showed, This Center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The policy further showed, The objectives of our infection control policies and practices are to .provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. (continued on next page)

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