STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505528	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lea Hill Rehabilitation and Care Center	32049 109th Pl SE Auburn, WA 98092

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 43642 Based on interview and record review, the facility failed to obtain and/or have Advanced Directives (AD - a document describing a resident's wishes for care if they became incapacitated) readily available in resident records for 3 of 5 residents (Residents 240, 241, & 13) and 1 supplemental resident (Resident 238) reviewed for ADs. This failure left residents at risk for losing the right to have their preferences and choices honored during emergent and end-of-life care. Findings included . <Facility Policy> According to the facility's revised 03/23/2023 Residents' Rights Regarding Treatment and AD policy, if a resident had an AD in place upon admission, copies would be made and added to the chart, and communicated to the staff. <Resident 240> Resident 240 was admitted to the facility on [DATE]. According to the 06/24/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 240 was assessed with no memory impairment, clear speech, was understood by others, and able to understand others conversation. In an interview on 06/26/2024 at 11:10 AM, Resident 240 stated they had an AD and identified a family member as their Power of Attorney (POA). According to the uploaded 06/19/2024 Admission Documentation in Resident 240's records, Resident 240 was identified to have ADs. Review of records revealed no ADs were found for Resident 240. <Resident 241> Resident 241 was admitted to the facility on [DATE]. According to the 06/24/2024 Admission MDS, Resident 241 had medically complex diagnoses including heart failure, kidney disease, and lung disease. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Resident 241's uploaded 06/28/2024 Admission Agreement, Resident 241 was identified to have an AD and included documentation showing the resident's family member was their POA. Review of records revealed no ADs were found for Resident 241. On 07/01/2024 at 1:29 PM, Staff L (Office Manager) provided Resident 241's POA paperwork and stated they were found in a pile of records that needed to be uploaded into the resident's records. <Resident 238> Resident 238 was admitted to the facility on [DATE]. According to the 06/25/2024 Admission MDS, Resident 238 was assessed with no memory impairment, clear speech, to be understood and to be able to understand conversation. In an interview on 06/26/2024 at 10:48 AM, Resident 238 stated their family member was their POA and completed the admission documentation on their behalf. According to Resident 238's uploaded 06/25/2024 Admission Documents, Resident 238 was identified to have an AD. The documentation showed the resident's family member was their POA. The POA identified on the paperwork signed the admission agreements for Resident 238. Review of records revealed no ADs were found for Resident 238. In an interview on 07/02/2024 at 10:56 AM, Staff E (Resident Care Manager) stated ADs were important so staff were aware of and could follow what the resident's wishes were. Staff E stated ADs should be readily available in a resident's records. In an interview on 07/02/2024 at 1:01 PM, Staff H (Social Services Director) stated their expectation was if someone other than the resident was signing admission agreements, the facility would have a copy of the POA paperwork on file. Staff H stated ADs were usually scanned into the resident's records and should be readily available for staff to review. Staff H reviewed Resident 240, 241, and 238's records and stated they were unable locate their ADs. 46479 <Resident 13> Review of a 06/01/2024 Admission MDS, Resident 13 had difficulty hearing, was sometimes understood, and could sometimes understand others in conversation. This MDS showed Resident 13 had impaired thinking abilities. The MDS showed Resident 13 had diagnoses of traumatic brain dysfunction, heart failure, a progressive memory loss disorder, and a history of falling. Review of Resident 13's 05/28/2024 Admission Agreement showed Resident 13 had an identified legal health and financial care authority who signed Resident 13's admission paperwork. Record review on 06/27/2024 at 2:47 PM showed there was no ADs available in Resident 13's records identifying they had an established POA. In an interview on 06/28/2024 at 12:43 PM, Resident 13's family member stated they were Resident 13's POA. The family member stated they thought the staff requested copies of the POA documentation. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/01/2024 at 1:29 PM, Staff L provided a paper copy of the POA documentation. Staff L stated the facility did not have medical records, they were trying to get caught up with scanning documents. In an interview on 07/02/2024 at 10:06 AM, Staff B (Nursing Services Director) stated ADs should be readily available in the resident's record so staff knew who a resident's responsible party was. Staff B stated they expected AD's to be scanned into the resident's record within a couple of days of receiving the documents. REFERENCE: WAC 388-97-0280(3)(c)(i-ii).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review the facility failed to thoroughly investigate unwitnessed falls for 1 of 2 sampled residents (Resident 3) reviewed for falls, and 1 supplemental resident (Resident 13). Facility failure to complete thorough investigations placed residents at risk for further falls and other negative health outcomes. Findings included . <Facility Policy> According to the facility's revised 05/01/2024 Accidents and Supervision policy, the facility would implement a system to minimize the risk of resident accidents. The policy showed the facility would make a reasonable effort to identify the hazards and risk factors for each resident. The policy showed the facility would evaluate resident accident risk by examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents . The facility's 11/30/2022 Incidents and Accidents policy showed documentation and data to be collected after an accident should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders obtained or follow-up interventions. The facility's 11/01/2022 Fall Prevention Program policy showed when any resident experienced a fall, the facility would assess the resident, complete a post-fall assessment, and obtain witness statements in the case of injury. <Resident 3> According to the 05/15/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 3 had severe memory impairment and medically complex diagnoses including dementia, arthritis, malnutrition, muscle weakness, repeated falls, and difficulty walking. The revised 04/10/2024 fall risk Care Plan (CP) showed Resident 3 fell on [DATE], 05/02/2023, 04/06/2024, and 04/07/2024. A 04/06/2024 progress note showed Resident 3 had an unwitnessed, non-injury fall at 3:50 PM that day. The note showed Resident 3 stated they were trying to transfer from their wheelchair to another chair in their room and slipped. Review of the facility's investigation into the 04/06/2024 unwitnessed fall showed Resident 3 was found on the floor of their room at 3:50 PM. The investigation concluded Resident 3 fell when trying to transfer. The investigation did not identify when Resident 3 last used the toilet, if the call light was on, or when Resident 3 was last seen by staff prior to the fall. The investigation did not include a witness statement from the staff who found Resident 3 or from any other staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/02/2024 at 11:21 AM Staff B (Nursing Services Director) stated they expected an investigation to include witness statements and identify all pertinent information at the time of the fall. Staff B stated they would provide any further investigative information found. No further information was provided. 46479 <Resident 13> According to the 06/01/2024 Admission MDS, Resident 13 had a diagnosis of a progressive memory loss disease. This MDS showed Resident 13 had multiple falls prior to admission and had falls since admission to the facility. Review of Resident 13's revised 06/18/2024 Fall CP, showed Resident 13 had poor safety awareness and had actual falls in the facility on 05/31/2024 and 06/16/2024. Review of the 06/16/2024 fall incident report showed Resident 13 had their call light on and was found on the floor in their room by staff. This incident report contained several subsections to be completed by the staff at the time of the incident and post incident including the resident's level of pain, mental status, and predisposing environmental factors. Review of these subsections showed staff did not complete these sections and left them blank. In an interview on 07/02/2024 at 10:11 AM, Staff B stated they expected incident reports to be complete and thorough. Staff B stated they expected staff to complete each section of the incident report. REFERENCE: WAC 388-97-0640(6)(a)(b).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47836 Based on interview and record review, the facility failed to implement a system to ensure residents received required written notices at the time of transfer/discharge, or as soon as practicable for 2 (Residents 21 & 29) of 2 residents reviewed for hospitalization s. Failure to ensure written notification to the resident and/or the resident's representative of the reasons for the discharge in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care and preferences. Findings included . <Facility Policy> According to a revised 09/06/2023 facility Transfer and Discharge (including AMA [Against Medical Advice]), policy, the facility would provide a written transfer notification to the resident or resident representative in a language and way they could understand. The policy showed the notification would include the reason and basis for transfer, effective date of transfer, and the location to which the resident was transferred. The policy showed the notice would be provided to the resident or resident representative as soon as practicable. <Resident 21> Review of Resident 21's health records showed they were transferred emergently to the hospital on 04/03/2023 for lethargy (abnormal drowsiness) and diaphoresis (cold sweats), on 06/22/2023 for blood in their urine, on 08/22/2023 after a fall, and on 01/13/2024 and 02/08/2024 for blood in their stool. In an interview on 06/26/2024 at 12:55 PM, Resident 21 stated they were sent to the hospital several times but could not remember what they were sent for each time. In an interview on 07/01/2024 at 7:40 AM Staff H (Social Services Director) stated they did not know who was responsible for sending a written notice of discharge to the resident or their representative but thought possibly Staff G (Admissions Director) was responsible. In an interview on 07/01/2024 at 9:13 AM Staff G, stated nursing sent the written notices to residents or their representatives. 43642 <Resident 29> Review of Resident 29's 06/15/2024 Discharge Minimum Data Set (an assessment tool) showed the resident was transferred to an acute care hospital on 06/15/2024 with their return anticipated. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review showed no documentation staff provided the required written notification to Resident 29 and/or their representative regarding their discharge. In an interview on 07/02/2024 at 10:56 AM, Staff E (Resident Care Manager) stated they did not provide anything in writing to residents and/or their representatives for hospital discharges. In an interview on 07/02/2024 at 11:54 AM, Staff B (Nursing Services Director) stated they were not aware of any written discharge notices completed by nursing staff for hospitalization s. REFERENCE: WAC 388-97-0120 (2)(a-d).

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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 43642 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment accurately reflected the residents' mental health conditions for 1 (Resident 238) of 5 residents reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . <Resident 238> According to a 06/25/2024 Admission Minimum Data Set (an assessment tool), Resident 238 had multiple medically complex diagnoses including depression and required the use of an antidepressant medication. Review of a June 2024 Medication Administration Record showed Resident 238 received an antidepressant medication for depression. Review of a 06/20/2024 Level 1 PASRR, completed prior to admission showed Resident 238 had no Serious Mental Illness (SMI) indicators. Upon admission, facility staff did not update the Level 1 PASRR to include Resident 238's diagnosis of depression that required treatment with a medication. In an interview on 07/02/2024 at 1:01 PM, Staff H (Social Services Director) stated Level 1 PASRRs were important if a resident had a SMI, as the resident may qualify for additional services. Staff H stated Level 1 PASRRs should be accurate and updated as required. Staff H reviewed Resident 238's Level 1 PASRR and stated it was not accurate and needed to be updated. REFERENCE: WAC -1915 (1)(2)(a-c).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were updated as needed to reflect current care needs for 2 residents (Residents 3 & 21) of 13 sample residents reviewed. The failure to ensure CPs were updated as needed left residents at risk for unmet care needs, frustration, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's revised 11/01/2022 Comprehensive CPs policy, the facility would ensure the CP would describe the care and services each resident currently required. The policy showed the facility would develop resident-specific interventions to meet residents' care needs. <Resident 3> According to the 05/15/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 3 could hear with minimal difficulty using hearing aids, had impaired vision, and wore glasses. The MDS showed Resident 3 had severe memory impairment and wandered occasionally. The MDS showed Resident 3 required partial/moderate assistance to transfer from surface to surface including the toilet. The revised 04/10/2024 fall risk CP showed Resident 3 fell on [DATE], 05/02/2023, 04/06/2024, and 04/07/2024. This CP included a 05/12/2022 intervention to ensure Resident 3 stayed in public areas while awake as the resident allowed. Observation on 06/27/2024 at 8:28 AM showed Staff K (Certified Nursing Assistant - CNA) approach Resident 3 while they sat in their wheelchair by the fireplace in a common area near their room. Staff K asked the resident where they wanted to go. Resident 3 stated they wanted to go to their room and Staff K took Resident 3 to their room. There was no encouragement from Staff K for Resident 3 to stay in the common area. In an interview on 07/02/2024 at 9:27 AM, Staff E (Resident Care Manager) stated Resident 3 was less active the last few months. Staff E stated while it was important to supervise Resident 3 and ensure their safety, the resident was more tired now and the intervention was no longer appropriate. Staff E stated Resident 3's fall risk CP was not updated to reflect the resident's current needs. 47836 <Resident 21> According a 04/18/2024 Significant Change MDS, Resident 21 had moderate memory impairment. The assessment showed Resident 21 had diagnoses of non-Alzheimer's dementia and a blood clot. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a revised 04/18/2024 Anticoagulant (blood thinner medication) CP showed Resident 21 was on an anticoagulant medication. Review of a revised 05/17/2024 Activities of Daily Living CP showed, Resident 21 was to have a fall mat on the floor on each side of their bed. Review of Resident 21's medical records on 06/28/2024 showed no physician's order for the anticoagulant medication that was listed on the CP. The PO's showed an order for the fall mat to be on the left side of the bed only. Observations on 06/26/2024 at 12:59 PM, 06/27/2024 at 8:56 AM, 06/27/2024 at 12:37 PM, 06/28/2024 at 9:28 AM, and 07/01/2024 at 8:17 AM showed Resident 21 with a fall mat only to their left side of bed. In an interview on 07/01/2024 at 12:56 PM Staff E stated Resident 21's CP should be updated with the blood thinning medication removed and the fall mat to left side of the bed only, but it was not. Staff E stated it was important to keep the CPs updated so staff knew what should be monitored and to provide the appropriate care for Resident 21. REFERENCE: WAC 388-97--1020(2)(c)(d).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 42203 Based on observation, interview, and record review the facility failed to ensure Physician's Orders (POs) were clarified as needed for 3 residents (Residents 2, 242, 238) of 13 sample residents reviewed, followed for 6 residents (Residents 13, 240, 8, 28, 238, & 240) of 13 sample residents reviewed, and nurses signed only for care provided for 1 resident (Resident 8) of 13 sample residents. These failures left residents at risk for unmet care needs, unnecessary care, and other negative health outcomes. Findings included . <Clarifying POs> <Resident 2> According to the 05/24/2024 Significant Change Minimum Data Set (MDS - an assessment tool) Resident 2 had diagnoses including heart failure and dementia. The MDS showed Resident 2 received pain medication. Record review showed Resident 2 had two orders for pain medication: a 05/20/2024 PO for a non-narcotic pain medication, give 650 milligrams every six hours as needed for pain, and a 05/20/2024 PO for an opioid pain medication, give 0.25 milliliters as needed for pain. Neither PO had parameters directing staff when each medication would be appropriate to administer. In an interview on 07/02/2024 at 9:42 AM Staff E (Resident Care Manager) stated when a resident had more than one pain medication it was important for there to be parameters so nurses knew which medication to administer when. Staff E stated Resident 2's pain medication POs should have but did not have parameters for administration. 43642 <Resident 242> During observations of medication pass on 06/27/2024 at 12:33 PM, Staff S (Registered Nurse) prepared two grams of a non-steroidal ointment that reduced swelling for Resident 242. Staff S applied the two grams of ointment to Resident 242's right shoulder/upper back area, to their lower back, and to the resident's left shoulder, per the resident's directions. In an interview at this time, Staff S stated the resident directed which areas to apply the ointment. Review of Resident 242's June 2024 Medication Administration Records (MAR) showed an PO for the non-steroidal ointment to be applied to the affected areas four times a day for chronic right sided low back pain and gave directions to apply two grams to the localized area. In an interview on 07/02/2024 at 10:56 AM, Staff E reviewed the order and stated their expectation was for staff to apply the ointment to Resident 242's lower back, but was aware of their shoulders hurting as well. Staff E stated the order should be clarified. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 238> According to the 06/25/2024 Admission MDS, Resident 238 had multiple medically complex diagnoses including cancer and a hip fracture and required the use of pain medications during the assessment period. Review of Resident 238's June 2024 MAR showed a 06/21/2024 PO for a non-narcotic pain medication to be administered every 12 hours as needed for pain. A second 06/26/2024 order, for the same medication, was also ordered to be administered every four hours as needed for pain. Review of Resident 238's June 2024 MAR showed a 06/21/2024 PO for a medication to prevent nausea and vomiting. A second 06/21/2024 order for an antipsychotic medication was also ordered to prevent nausea and vomiting. There were no directions to staff to determine which medication should be administered versus the other if Resident 238 had nausea and vomiting. In an interview on 07/02/2024 at 10:56 PM, Staff E stated the duplicate orders needed to be clarified to reduce the risk of staff administering both POs and to know which medication to give to Resident 238 for pain and/or nausea and vomiting. 46479 <<Following Physician Orders> <Resident 13> According to the 06/01/2024 MDS, Resident 13 was unable to control their blood sugars and received insulin (medication that helped to control blood sugar levels in the body) injections during the look back period. Review of the 06/27/2024 order summary showed a 06/06/2024 PO instructing staff to check Resident 13's blood sugar levels three times per day and administer insulin to Resident 13 according to their blood sugar levels. This PO directed staff to administer 20 units of insulin and notify Resident 13's physician if their blood sugar was between 351 and 400. Review of Resident 13's June 2024 Medication Administration Record (MAR) showed Resident 13 had blood sugar readings between 351 and 400 on nine occasions. Review of Resident 13's records showed staff did not notify Resident 13's physician per the PO. In an interview on 07/01/2024 at 11:13 AM, Staff E stated it was their expectation nursing staff documented in the resident's progress notes if the physician was notified. Staff E stated they expected nursing staff to follow the PO and notify Resident 13's physician of the elevated blood sugar levels. <Resident 240> According to a 06/24/2024 Admission MDS, Resident 240 had medically complex diagnoses including pain in their right ankle and right foot and required the use of a narcotic pain medication during the assessment period. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 240's June 2024 MAR showed an order for a narcotic pain medication. This order showed staff were to administer the 10 mg medication every 4 hours as needed for a pain level of 7 out of 10 or higher. The June 2024 MAR showed on 06/23/2024 a nurse administered the medication for a pain of 4 out of 10. In an interview on 07/02/2024 at 10:56 AM, Staff E stated their expectation was for staff to follow the parameters of an order and administer the correct medication as instructed. <Pain Orders> <Resident13> Review of Resident 13's POs showed a 05/28/2024 PO directing staff to assess Resident 13's pain level every shift. This PO directed staff to document the pain level on the Medication Administration Record (MAR). Review of Resident 13's June 2024 MAR showed staff did not document Resident 13's pain level when assessed. Staff documented a check mark instead of the resident's pain level. <Resident 8> Review of Resident 8's POs showed a 06/10/2024 PO directing staff to assess Resident 8's pain level every shift. This PO directed staff to document the pain level on the MAR. Review of the June 2024 MAR showed staff did not document Resident 8's pain level when assessed. Staff documented a check mark instead of Resident 8's pain level. Review of Residents 28's, 238's, and 240's June 2024 MARs showed each resident had POs directing staff to assess their pain levels each shift. On Residents 28's, 238's, and 240's June 2024 MARs nurses added checkmarks instead of a numeric value. In an interview on 07/02/2024 at 10:23 AM, Staff B stated it was their expectation nursing staff documented a numerical value for a resident's pain level each shift. Staff B stated nursing staff should not document a check mark. <Signing for Orders not Completed> <Resident 8> According to the 05/22/2024 Quarterly MDS, Resident 8 had diagnoses including a stroke and weakness to one side of their body. This MDS showed Resident 8 was at risk for developing pressure injuries (bed sores) and utilized a pressure reducing device on their bed. Review of Resident 8's order summary showed a 07/28/2021 PO for an air mattress. This PO instructed staff to ensure the air mattress settings were on comfort level soft 3 each shift. Observation on 06/28/2024 at 9:11 AM showed Resident 8 lying in bed. Their air mattress was set to level 5 alternating. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the June 2024 treatment administration record on 06/28/2024 at 1:28 PM showed Staff F (Registered Nurse) signed that they verified the air mattress was on the correct setting. In an observation and interview at that time, Staff F confirmed the air mattress was on the incorrect setting. Staff F stated the air mattress should be set to comfort level 3 but was not. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 42203 Based on observation, interview, and record review the facility failed to ensure 1 resident (Resident 3) of 3 reviewed for vision and hearing were provided the assistance and/or adaptive devices they were assessed to require. This failure left Resident 3 at risk for unnecessary barriers to communication and frustration. Findings included . <Facility Policy> According to the facility's revised 11/07/2022 Hearing and Vision Services policy, the facility would ensure all residents had access to hearing and vision services, and received the adaptive equipment (such as glasses or Hearing Aids - HAs) they required. The policy showed facility staff would assist residents to use any adaptive equipment required. <Resident 3> According to the 05/15/2024 Annual Minimum Data Set (MDS - an assessment tool) Resident 3 had severe memory impairment and medically complex diagnoses including dementia. The MDS showed Resident 3 heard with minimal difficulty when using their HAs. The revised 05/25/2022 communication Care Plan (CP) included a goal for Resident 3 to maintain the ability to make their basic needs known and communicate with staff using hearing aids on a daily basis. This CP included interventions showing Resident 3: required HAs in both ears to communicate effectively, nursing staff should ensure Resident 3's HAs were in place every morning, HA's should be placed in the charger every night, and ensure the HAs were functioning properly. Observation on 06/26/2024 at 12:34 PM showed Resident 3 eating lunch in the dining room. Resident 3 was not wearing their HAs. Observation on 06/27/2024 at 8:11 AM showed Resident 3 was out of bed, sitting in their wheelchair. Resident 3's HAs were still in the charging case. Observation on 06/28/2024 at 8:15 AM showed Resident 3 was not wearing their HAs. Staff B (Nursing Services Director) entered the resident's room and announced themselves. Resident 3 did not hear what Staff B stated so Staff B repeated themselves to Resident 3. Staff B asked Resident 3 if they wanted to eat their oatmeal and needed to ask the resident a second time for understanding. Staff B and Resident 3 then spent several minutes organizing food from outside the facility placed on the counter next to the sink in Resident 3's room. Resident 3's HAs were located on the same counter where the food was placed. Staff B did not offer to help Resident 3 with their HAs. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/28/2024 at 8:52 AM showed Staff B and a physical therapist speaking with Resident 3 in the hall. Resident 3 was not wearing their HAs. Staff B asked Resident 3 if they wanted to attend a group activity. Resident 3 did not hear, and Staff B repeated their question. Resident 3 then left for their room. In an interview at that time Staff B stated Resident 3's HAs were not in but should be. Staff B stated it was important for staff to assist Resident 3 with their HAs to facilitate communication. Staff B stated they needed to repeat themselves when talking to Resident 3 without their HAs. Staff B stated staff should have provided Resident 3 assistance with their HAs on all three days they were observed without them. REFERENCE: WAC 388-97-1060(3)(a).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to provide adequate mealtime supervision for 1 (Resident 88) of 2 residents reviewed for nutrition, and failed to ensure fall interventions were in place for 2 (Residents 3 & 21) of 3 residents reviewed for accidents. These failures placed residents at risk for choking and swallowing difficulties, falls, injuries, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's 05/01/2024 Accidents and Supervision policy each resident would receive supervision to prevent accidents. The facility would identify hazards and risks, evaluate those hazards and risks, and implement interventions to reduce the risk. The policy showed an accident was any unexpected or unintentional incident, which resulted in injury or illness to a resident. The policy showed the facility would use various methods and sources to identify risks and hazards including Minimum Data Set (MDS - a resident assessment tool) data and residents' medical history. The policy defined supervision as an intervention and a means of mitigating accident risk and showed the facility would provide adequate supervision to prevent accidents. <Resident 88> According to the 06/21/2024 Admission Minimum Data Set (MDS - an assessment tool) Resident 88 admitted on [DATE] and had severely impaired memory. The MDS showed Resident 88 had diagnoses including a hip fracture requiring skilled nursing care, dementia, a history of stroke, and one-sided paralysis. The MDS showed Resident 88 had no swallowing difficulties but required an altered texture diet. The 06/15/2024 Activities of Daily Living (ADL) Care Plan (CP) showed Resident 88 required cuing and encouragement to eat their meals. The 06/18/2024 Speech and Language Pathologist (SLP) Evaluation included Resident 88's short term goal to improve their swallowing function by alternating between solids and liquids when eating. The evaluation showed Resident 88 was on a modified diet due to recent coughing. The evaluation concluded Resident 88 had moderate swallowing difficulties with likely aspiration (inhalation) of liquids requiring SLP treatment. Staff assessed Resident 88 to require close supervision when eating. The evaluation recommended using straws with thin liquids. A 06/19/2024 1:46 PM progress note showed Resident 88 had new onset coughing on thin fluids. A 06/21/2024 Skilled Evaluation note showed Resident 88 required one-to-one assistance with feeding. A 06/22/2024 1:52 AM progress note showed Resident 88 had a Change in condition. The note described Resident 88 audibly wheezing with coarse breathing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed a 06/18/2024 diet order to provide Resident 88 a mechanically softened texture diet with thin liquids. This order was discontinued and superseded on 06/25/2024 with a diet order for a mechanically softened texture diet with nectar-thick liquids. Review of the Physician's Orders (POs) showed a 06/22/2024 PO for an oral antibiotic. The PO showed the antibiotic was to treat developing pneumonia. The 06/24/2024 resident has [a] nutritional problem . CP included a goal for Resident 88 to be comfortable each day with their food and drink. This CP included interventions for staff to monitor, document, and report as needed any signs and symptoms of swallowing difficulties and to provide and serve a general diet with a mechanically softened texture and nectar-thick liquids as ordered. The 06/24/2024 SLP encounter note showed as of this date, [Resident 88] has a confirmed diagnosis of Right lung pneumonia. The evaluation showed NO straws should be provided to Resident 88 who now required thickened fluids with their meals but was assessed to be safe with thin liquids between meals. In an in interview on 06/26/2024 at 1:56 PM Resident 88's representative stated Resident 88 had swallowing difficulties that dated back to when they lived at home. Resident 88's representative stated Resident 88 acquired aspiration pneumonia (a lung infection caused by the inhalation of food or drink) while at the facility. Resident 88's representative stated Resident 88 now required antibiotic treatment, and that the facility's SLP worked with Resident 88 to address their swallowing difficulties. Review of the as of 06/28/2024 Kardex (care instructions for Nurse's Aides) showed Resident 88 required the assistance of a Certified Nurse's Assistant (CNA) when eating and small bites and sips. The 06/28/2024 Kardex showed NO STRAWS. Observation on 06/28/2024 8:57 AM showed Resident 88 eating their breakfast in bed without any supervision or assistance from staff. Straws were placed in all three of Resident 88's beverages. In an interview on 06/28/2024 at 9:10 AM Staff B (Nursing Services Director) reviewed the Kardex and stated Resident 88 should have no straws. The interview took place in Staff B's office located across the hall from Resident 88's room. At that time Resident 88 was heard coughing from Staff B's office. Staff B immediately went to Resident 88's room to provide care. There was no staff in the room when Staff B entered. Staff B stated there was not enough supervision in place for Resident 88 at the time. Staff B provided fluids to Resident 88. At 9:49 AM Staff B stated they were surprised SLP approved Resident 88 for thin liquids on admission. By 9:59 AM Resident 88 stopped actively coughing. In an interview on 07/02/2024 at 11:27 AM Staff B stated the dietary department provided straws to Resident 88 on 06/28/2024. Staff B stated Resident 88 was left unattended because the CNA assisting the resident left to help another CNA transfer a different resident. <Resident 3> According to the 05/15/2024 Annual MDS Resident 3 had severe memory impairment and medically complex diagnoses including dementia, arthritis, malnutrition, muscle weakness, repeated falls, and difficulty walking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The revised 04/10/2024 fall risk CP showed Resident 3 fell on [DATE], 05/02/2023, 04/06/2024, and 04/07/2024. This CP included an intervention to ensure a non-slip film was placed on the sitting surface of Resident 3's personal chairs in their room to prevent falls. The intervention showed staff should notify the nurse if the non-slip film was removed. Observation on 06/27/2024 at 8:32 AM, on 06/27/2024 at 10:02 AM, on 06/27/2024 at 2:59 PM, and on 07/01/2024 at 10:31 AM showed no non-slip film placed on either armchair in Resident 3's room. In an interview on 07/01/2024 at 10:47 AM Staff E (Resident Care Manager) stated it was important for fall interventions to be in place. Staff E stated the non-slip film should be in place on the armchairs in Resident 3's room. Staff E stated the non-slip film helped to prevent Resident 3 from slipping from the armchairs. In an observation at that time Staff E stated the non-slip film was not but should be in place in on Resident 3's armchairs. 47836 <Resident 21> According a 04/18/2024 Significant Change MDS, Resident 21 had moderate memory impairment. The assessment showed Resident 21 had a diagnosis of non-Alzheimer's dementia. Review of a revised 04/18/2024 Fall CP showed, Resident 21 was at risk for falls and had two unwitnessed falls since admission. The CP showed to keep the bed in the lowest position as a preventative fall intervention. Review of Resident 21's medical records showed a PO to keep bed in lowest position while resident was in bed initiated on 07/11/2023. Observations on 06/26/2024 at 12:59 PM, 06/27/2024 at 8:56 AM, 06/27/2024 at 12:37 PM, 06/28/2024 at 9:28 AM, and 07/01/2024 at 8:17 AM showed Resident 21 in bed with the bed raised halfway between medium and maximum height. In an interview on 07/01/2024 at 8:17 AM Staff M (CNA) stated the CP directed them to keep Resident 21's bed in the lowest position because they were a fall risk. Staff M stated the bed was not in the lowest position but should be. In an interview on 07/01/2024 at 12:34 PM Staff E stated they heard this surveyor ask the CNA about Resident 21's bed not being in the lowest position, so they discontinued the order to keep the bed in the lowest position. Staff E stated Resident 21 had a PO to keep the bed in the lowest position and this was care planned to direct staff to do so but they had not kept the bed in the lowest position because they could not slide the over the bed table under the bed unless it was raised up a couple of inches. Staff E stated it should not have been raised so high up and that no resident's bed should be kept at the height Resident 21's bed had been at. Staff E stated they would contact the Physician to get the order back and allow for the bed to be raised only a couple of inches while eating their meals. REFERENCE: WAC 388-97-1060 (3)(g).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47836 Based on observation, interview, and record review, the facility failed to ensure continent residents were provided toileting for 3 of 4 residents (Residents 339, 340, & 18) reviewed for Urinary Catheters (tube inserted into the bladder to empty the bladder) and Urinary Tract Infections (UTI). These failures placed residents at risk for UTI, dignity issues, and a decreased quality of life. Findings included . <Facility Policy> According to a facility policy titled, Activities of Daily Living (ADL's), revised [DATE], the facility would provide toileting care and services based on individual resident's comprehensive assessments and consistent with the resident's choices. According to a facility policy titled Helping a Resident with Toileting Needs, revised [DATE], the facility would assist residents with toileting needs to maintain the resident's dignity and proper hygiene. <Resident 339> According to a [DATE] Admission Minimum Data Set (MDS - an assessment tool), Resident 339 was dependent on staff for transfers and required maximum assistance with toileting. The assessment showed Resident 339 had a diagnosis of irritable bowel syndrome. Review of Resident 339's health records on [DATE] showed diagnoses of, but not limited to, retention of urine, intestinal obstruction, hydronephrosis (dilation of the renal pelvis due to urinary obstruction), colitis, and difficulty with walking. Review of the revised [DATE] ADL Care Plan (CP) showed Resident 339 required two-person extensive assistance with transfers. The revised [DATE] Fall CP showed Resident 339 would be assisted to the toilet after meals and prior to AM care and bedtime care. In an interview on [DATE] at 10:02 AM, Resident 339 stated staff directed them to go to the bathroom in their brief. On [DATE] at 8:12 AM, Resident 339 stated they knew when they needed to use the bathroom and preferred staff would get them up to the toilet but staff did not. During an observation on [DATE] at 8:38 AM Staff I (Certified Nursing Assistant - CNA) and Staff J (CNA) were changing Resident 339's brief and Resident 339 stated they needed to have a bowel movement. Staff I stated, just go in your brief and I will change it. During an interview on [DATE] at 9:01 AM, Staff I stated they directed residents to go to the bathroom in their brief until Physical Therapy cleared the resident to use the toilet. <Resident 340> (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a [DATE] Admission MDS, Resident 340 was dependent on staff for transfers and required maximum assistance with toileting. The assessment showed Resident 340 had a diagnosis of kidney failure and a UTI. Review of a [DATE] ADL CP showed Resident 340 required two-person extensive assistance with toileting and one to two staff for transfers using a walker to stand. In an interview on [DATE] at 12:28 PM, Resident 340 stated they were aware of when they needed to use the bathroom, but staff directed them to go in their brief when they first admitted to the facility. Resident 340 stated they did not want to go to the bathroom on themselves and they had a history of frequent UTI's. Resident 340 stated going in their brief would put them at risk of developing another UTI. Resident 340 stated they told staff about their history of UTI's and their risk for infection if they went to the bathroom in their brief. Resident 340 stated they had hip surgery and the staff told Resident 340 they could not take the resident to the toilet until therapy worked with them to become independent with toileting and until then, the resident needed to go in their brief. In an interview on [DATE] at 7:53 AM, Resident 340 stated they were supposed to discharge home on that day, but they were having UTI symptoms, so the facility extended their stay with a plan to discharge [DATE]. Resident 340 stated they had increased urinary urgency, frequency, and pain, and knew they had a UTI. Review of Resident 340's health records showed a [DATE] Physician Order (PO) to obtain a urine test to see if Resident 340 had a UTI. These records showed the urine was collected and sent to the lab in a urine collection container but the container was expired so the lab was unable to run the urinalysis. The records showed the physician entered a new PO on [DATE] to recollect another urine sample for Resident 340 and to administer an antibiotic injection immediately for their UTI symptoms. In an interview on [DATE] at 12:38 PM Staff E (Resident Care Manager) stated the expectations for staff were to assist continent residents to the toilet and not direct them to go in their brief. Staff E stated this was important for resident's dignity and having residents go in their brief would increase their risk of developing an infection. In an interview on [DATE] at 11:17 AM, Staff F (Registered Nurse) stated they collected the urine sample and did not check the expiration date on the collection container but should have. Staff F stated it was important to check the expiration date so the urine test could be performed timely, and the resident could be treated as soon as possible. In an interview on [DATE] at 11:28 AM, Staff E stated the expectations were for staff to check the lab containers expiration date prior to collection. Staff E stated this was important to diagnose whether the resident had an infection and to implement treatment timely. In an interview on [DATE] at 12:13 PM, Staff B (Nursing Services Director) stated they expected staff to assist continent residents to the bathroom to use the toilet. Staff B stated it was not the facility's policy to direct residents to use their brief because that would infringe on their dignity and increase their risk of infection. 50511 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Urinary Catheter> <Facility Policy> According to the facility policy titled, Catheter Care, dated [DATE], residents with indwelling catheters would be provided appropriate catheter care and maintain dignity and privacy when indwelling catheters were in use. Privacy bags would be available and catheter drainage bags would be covered at all times; attached leg bags would have enough slack on the tubing to minimize tension. <Resident 18> According to a [DATE] Quarterly MDS Resident 18 had a suprapubic (above the pubic) indwelling catheter. Review of Resident 18's CP revised on [DATE], showed the resident needed total assistance with cleaning their suprapubic catheter. The CP instructed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance of the room door and to monitor for pain or discomfort. During an interview and observation on [DATE] at 11:50 AM, Resident 18 stated the catheter hurt right here and pointed to their abdominal area. During observations on [DATE] at 9:02 AM and 11:25 AM, Resident 18's catheter bag was uncovered and touching the floor in their room. During an observation on [DATE] at 12:35 PM Staff N (CNA) provided toileting assistance to Resident 18. Staff N was observed to hand Resident 18 an incontinence wipe and told the resident to wipe themselves. Resident 18 was observed to wipe their genital area not their suprapubic area. Resident 18 also had loosened gauze around the catheter tubing which was not attached to the skin near the lower abdomen area. Staff N stated they did not know what the gauze was for and had to ask the nurse. During an observation on [DATE] at 12:43 PM Staff F checked the catheter bag and stated it was not in the privacy bag. Staff F checked the suprapubic area stoma (site of insertion of catheter tube) and told care staff the gauze bandage was for the stoma. Staff F observed there was a small amount of dried red-brown discharge on the gauze that was meant to cover the stoma. Staff F told Staff N the catheter bag leg strap was too low on the resident's thigh and was pulling on the catheter tubing. In an interview on [DATE] at 11:09 AM Staff N stated they were expected to empty the catheter bag and wipe down the catheter. Staff N reviewed the Kardex (care staff checklist) and stated instructions were to help the resident with suprapubic catheter care but they were unsure of what to do differently for suprapubic catheters. In an interview on [DATE] at 12:43 PM Staff F stated the privacy bag should be used while Resident 18 was sitting in the wheelchair for privacy. Staff F stated the catheter site around Resident 18's stoma should be checked every shift by staff to check for drainage and pain and was unsure why the gauze was not attached to the resident's skin. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:23 PM Staff E stated nursing and care staff should provide catheter care such as emptying the catheter bag, cleaning and observing the area of the catheter, to place the catheter bag correctly, and to provide privacy for dignity. Staff E stated care staff should check if the resident was able to do self-care of their catheter and if they were unable, then staff should assist. Staff E stated they were unsure on how to train staff on suprapubic catheters. In an interview on [DATE] at 12:06 PM Staff B stated for resident dignity, catheter bags should be covered and not visible and off the floor. Staff B stated care staff were expected to provide catheter care appropriately per facility policy and up to care staff skill level including suprapubic catheters. Staff B stated the facility should conduct another training as they were unsure of when last in-service for staff on catheter care was completed. REFERENCE: WAC [DATE] (3)(c).

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46479 Based on observation, interview, and record review the facility failed to assess, monitor, and record intake for 1 (Resident 8) of 1 resident reviewed for enteral feeding (a medical process used to provide nutrition for residents who cannot obtain nutrition orally) services. These failures placed Resident 8 at risk for inadequate nutritional support and adverse consequences. Findings included . <Resident 8> According to Resident 8's 05/22/2024 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 8 had impaired thinking abilities, was usually understood, and could usually understand others in conversation. This MDS showed Resident 8 had diagnoses including a stroke and was unable to move one side of their body. The MDS showed Resident 8 had difficulty swallowing and required enteral feedings via a feeding tube. Review of Resident 8's revised 03/12/2024 Nutritional Problem Care Plan (CP) showed Resident 8 was to receive 720 Milliliters (mL) of the enteral feeding formula over 12 hours. This CP showed Resident 8 was to receive 547 mL of free water administered congruently with the enteral feeding formula. This CP instructed staff to document mL administered. Review of the June 2024 Medication Administration Record (MAR) showed a 07/20/2021 Physician Order (PO) directing staff to check enteral feeding residuals (the amount of formula undigested from the previous feeding). This PO directed staff to hold the enteral feeding if the residuals were greater than 100 mL and restart the enteral feeding when the residuals were less than 100 mL. The MAR showed staff documented a check mark instead of the amount of residuals in mL. The June 2024 MAR showed a 10/14/2023 PO directing staff to start the enteral feeding at 8:00 PM along with the water flush for 12 hours. An additional 10/14/2023 PO directed the staff to stop the enteral feeding and congruent water flush at 8:00 AM. These POs showed Resident 8 would receive 1180 kilocalories of nutrition and 547 mL of free water. The MAR documentation showed staff documented a check mark indicating the enteral feeding was turned on or off. The MAR documentation showed staff did not document the total mL of enteral nutrition or water administered each day. Observation on 07/01/2024 at 7:50 AM showed Resident 8 receiving their enteral feeding. The feeding pump showed Resident 8 received 922 mL of the enteral formula and 680 mL of the water flush. Observation on the same date at 8:26 AM showed Resident 8 was still receiving the enteral feeding. In an observation and interview on 07/01/2024 at 9:12 AM showed Staff C (Licensed Practical Nurse) turning off Resident 8's enteral feeding. At that time, the feeding pump showed Resident 8 received 1004 mL of the enteral formula and 720 mL of water. In an interview at that time, Staff C confirmed the enteral feeding should be stopped at 8:00 AM. Staff C stated Resident 8 probably got a little more [formula] than normal. (continued on next page)

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	505528	A. Building B. Wing	07/02/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/01/2024 at 10:56 AM, Staff D (Registered Dietician) stated there was no PO directing staff to capture the totals of the feeding and water flush. Staff D stated it would be helpful to know how much formula and water Resident 8 actually received. In an interview on the same date at 11:03 AM, Staff E (Resident Care Manager) stated it was important to document the total amount of enteral formula and water administered so staff could track any weight changes or edema (swelling from retaining fluid). In an interview on 07/02/2024 at 10:30 AM, Staff B (Nursing Services Director) stated it was their expectation staff documented the total amount of enteral formula and water administered as well as the amount of residuals obtained. REFERENCE: WAC 388-97-1060(3)(f).

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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** 42203 Based on observation, interview, and record review, the facility failed to ensure 3 of 3 residents (Residents 2, 88, & 241) reviewed for oxygen were provided care consistent with professional standards of practice. Failure to provide oxygen treatments as ordered (Resident 2 & 241) and place oxygen signs outside the rooms of residents using supplemental oxygen (Residents 2, 88, & 241) left residents at risk for over or under oxygenation, respiratory discomfort, oxygen-related accidents, and a decreased quality of life. Findings included . <Facility Policy> According to the facility's 09/01/2023 Oxygen Administration policy, oxygen therapy required a Physician's Order (PO) for use. The policy showed Oxygen warning signs must be placed on the door . of the room for any resident receiving oxygen therapy. <Providing Oxygen as Ordered> <Resident 2> According to the 05/24/2024 Significant Change in Status Minimum Data Set (MDS - an assessment tool) Resident 2 had cardiorespiratory diagnoses including heart failure, high blood pressure, Chronic Obstructive Pulmonary Disease (COPD - a respiratory disease that could cause fluid in the lungs), fluid in the lungs, and respiratory failure. The MDS showed Resident 2 required oxygen therapy. The POs included a 05/09/2024 PO for continuous oxygen at 1-5 Liters Per Minute via nasal cannula (tubing that delivered oxygen to the nostrils). The PO showed if Resident 2's oxygen saturation surpassed 92% nurses should hold the oxygen therapy. Review of the May 2024 Medication Administration Record (MAR) showed on 47 of 54 opportunities when the resident was available in the facility, Resident 2 was provided oxygen therapy when their oxygen saturation was 93% or higher. Review of the June 2024 MAR showed on 59 of 90 opportunities Resident 2 was provided oxygen therapy when their oxygen saturation was 93% or higher. In an interview on 06/28/2024 at 11:57 AM Staff E (Resident Care Manager) stated it was important to provide oxygen as ordered. Staff E stated a risk with supplemental oxygen therapy for residents with COPD was excess carbon dioxide (the gas exhaled when people breathe out) levels. < Resident 241> According to the 06/20/2024 Baseline Care Plan (CP - an initial CP developed within 48 hours of admission to ensure the resident's most critical care needs were met) dated 06/20/2024, Resident 241 had chronic respiratory failure with low oxygen and difficulty breathing related to COPD. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 06/26/2024 Admission MDS Resident 241's had medically complex conditions including COPD. Review of a 06/30/2024 PO showed staff should change Resident 241's oxygen tubing every week on Sundays. Observations on 06/28/24 08:20 AM and 07/01/24 11:57 AM showed no date on oxygen tubing. The June 2024 Treatment Administration Record showed staff last signed they replaced Resident 241's oxygen tubing on 06/30/2024. In an interview on 07/01/2024 at 12:05 PM Resident 241 stated the oxygen tubing was not changed since they admitted to the facility on [DATE]. In an interview on 07/02/2024 at 12:06 PM Staff B (Nursing Services Director) stated it was important to change out and date oxygen tubing as scheduled to prevent infections in residents with oxygen. <Oxygen Signage> <Resident 2> Observation on 06/26/2024 at 1:08 PM, 06/27/2024 at 8:57 AM, 06/28/2024 at 8:19 AM, 06//27/2024 at 8:59 AM, and 07/01/24 08:33 AM showed no sign in place outside Resident 2's room indicating oxygen was in use. <Resident 88> Record review showed Resident 88 had a 06/22/2024 PO for oxygen at 2 Liters Per Minute via a nasal cannula. Observation on 06/26/2024 at 12:48 PM, 06/27/2024 at 8:27 AM, and 06/28/2024 at 9:10 AM showed no sign in place outside Resident 88's room indicating oxygen was in use. 50511 <Oxygen Signage> <Resident 241> Observations on 06/28/2024 at 8:20 AM and on 07/01/2024 at 8:33 AM showed Resident 241's room was not labeled for oxygen use. In an interview on 07/01/2024 at 12:05 PM Staff C (Licensed Practical Nurse) stated an oxygen sign should be placed on Resident 241's door. Staff C stated an oxygen sign was important to easily identify from the hallway which residents were on oxygen in the event of an emergency. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff B on 07/02/2024 at 12:06 PM Staff B stated oxygen signs should be on the doors of residents on oxygen. Staff B stated oxygen signage was important to let people know that oxygen was in use for emergency response because oxygen was combustible. 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 - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 46479 Based on interview and record review, the facility failed to ensure, 1 of 5 (Resident 13) residents reviewed for unnecessary medications was adequately monitored to prevent excessive duration of medication use. These failures placed residents at risk to receive unnecessary medications and/or adverse side effects. Findings included . <Resident 13> According to the 06/01/2024 Admission Minimum Data Set (MDS - an assessment tool), Resident 13 had diagnoses including a progressive memory loss disease. This MDS showed Resident 13 was usually understood and could usually understand others in conversation. Review of Resident 13's 06/27/2024 order summary showed a 05/31/2024 Physician Order (PO) directing staff to administer an over-the-counter sleep aid medication every day. This PO showed Resident 13 was prescribed the medication for difficulty sleeping. Review of the 06/27/2024 order summary showed no directions instructing staff to monitor the amount of hours Resident 13 slept each night. Review of Resident 13's comprehensive Care Plan (CP) showed a CP goal was not developed regarding Resident 13's sleeping problem. There were no interventions directing staff on non-pharmacological ways to attempt to help Resident 13 sleep or interventions directing staff to monitor the effectiveness of the over-the-counter sleep aid medication. In an interview on 07/01/2024 at 11:11 AM, Staff E (Resident Care Manager) stated a sleep monitor should be in place to help track the effectiveness of the over-the-counter sleep aid medication. Staff E stated there should be directions to staff to provide non-pharmacological interventions to Resident 13 but there was not. In an interview on 07/02/2024 at 10:23 AM, Staff B (Nursing Services Director) stated a sleep monitor and non-pharmacological interventions should be in place for Resident 13 but they were not. REFERENCE: WAC 388-97-1060(3)(k)(i).

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47836 Based on interview and record review, the facility failed to ensure 2 (Residents 21 & 238) of 5 residents reviewed for unnecessary medications were free from unnecessary psychotropic medications. Facility staff failed to identify/monitor target behaviors or attempt a Gradual Dose Reduction (GDR) for an Antidepressant (AD) medication. These failures placed residents at risk to receive unnecessary psychotropic medications and experience adverse side effects. Findings included . <Facility Policy> According to facility policy titled Gradual Dose Reduction of Psychotropic Drugs revised 11/09/2022, the facility would gradually reduce the dose of psychotropic medications in an effort to discontinue those drugs. The policy showed the facility would attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year of the resident being admitted or within the first year of a resident starting a psychotropic medication. <Resident 21> According to the 04/18/2024 Significant Change Minimum Data Set (MDS - an assessment tool) Resident 21 had moderate memory impairment. The assessment showed Resident 21 had diagnoses of depression and adult failure to thrive. The assessment showed Resident 21 took an AD medication. Review of a revised 04/18/2024 AD Care Plan (CP) showed Resident 21 took an AD for depression. Review of Resident 21's Physician's Orders (POs) showed an AD was initially ordered on 05/30/2023 for 15 milligrams (mg) once daily. These records showed the same AD for Resident 21 was increased to 30 mg once daily on 08/09/2023 and then increased to 45 mg once daily on 12/26/2023. Review of Resident 21's May and June 2024 Medication Administration Records (MAR) showed no episodes of behavioral issues documented on the behavior monitor. Review of an 08/04/2023 psychiatry consultation note showed Resident 21 did not present with symptoms of depression and was calm, smiling, with an even mood, and was pleasant and cooperative. The evaluation showed no medication changes were recommended at that time. Review of a 01/11/2024 psychiatry consultation note showed Resident 21's mood was pleasant, they denied any feelings of depression, and they were surprised to hear that anyone thought they had depression. The evaluation showed no medication changes were recommended at that time. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/01/2024 at 12:56 PM Staff E (Resident Care Manager) stated a GDR should be attempted twice a year within the first year of the resident taking the medication or a justification should be documented for continuing the dose or increasing the dose related to behavioral concerns but was not. Staff E stated Resident 21 did not have any behavior concerns. Staff E stated a GDR should be attempted but was not. 43642 <Resident 238> According to a 06/25/2024 Admission MDS, Resident 238 had multiple medically complex diagnoses including depression and required the use of an AD medication. Review of a revised 06/26/2024 AD medication CP showed Resident 238 received an AD medication related to depression and gave directions to staff to, monitor/document side effects and effectiveness every shift. Review of a June 2024 MAR showed Resident 238 received an AD medication for depression. Record review on 07/02/2024 revealed no evidence that staff monitored or documented individualized behaviors and/or effectiveness for the AD medication Resident 238 received. In an interview on 07/02/2024 at 10:56 AM, Staff E stated their expectation was for staff to monitor the resident's behaviors in order to determine if the medication administered was effective. Staff E stated Resident 238 should have behavior monitoring for the use of their AD medication. REFERENCE: WAC 388-97-1060(3)(k)(i).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42203 Based on observation and interview, the facility failed to ensure resident meals were prepared in accordance with professional standards of food safety for 2 of 2 facility kitchens. The failure to ensure surface sanitizer solutions were maintained at effective concentrations, food was stored in a manner to preserve its quality, and food preparation areas were free from potential contaminants, placed residents at risk for food contamination, food borne illnesses, and spoiled food. Findings included . Observation on 06/26/2024 at 9:12 AM showed dietary staff cleaning up after breakfast service. At that time Staff P (Dining Services Director) reached for a test strip to verify the kitchen's surface sanitizer was at the correct consistency (100-440 PPM - Parts Per Million). The test strip package was empty. Staff P then looked in the desk drawer of their office before departing the kitchen. Staff P returned at 9:16 AM. Staff P tore off a strip of orange test paper from the container and held it in a sanitizer bucket for over 10 seconds. The strip remained orange and did not turn green indicating the fluid in the bucket was not at an effective concentration. Staff P retested the bucket with another strip. The second strip remained orange. Staff P tested a second bucket with a new strip. The third strip did not change color after being held in the fluid, indicating this fluid was also not an affective concentration. In an interview on 07/02/2024 at 10:02 AM Staff P stated it was important to ensure the kitchen surface sanitizer was maintained at the correct concentration. Staff P stated if the sanitizer was not at the correct concentration, it was less effective. Staff P stated it was important to ensure the sanitizer test strips were readily available. Observation on 06/26/2024 at 9:14 AM showed a small chest freezer with a glass lid contained four large tubs of ice cream. The lids of all four ice cream tubs sat crookedly and loose on top of the tubs with visible gaps showing the ice cream inside. At that time Staff P stated the lids should be fastened securely to ensure the ice cream did not deteriorate (i.e. freezer burn). Staff P stated the lids did not close easily but staff should make sure they were fully closed. Observation of the facility's dry storage area on 06/26/2024 at 9:23 AM showed two large, dented cans of fruit cocktail and a large, dented can of peaches stored with the other cans. In an interview at that time Staff P stated dented cans should be returned to the vendor as the contents may be spoiled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of lunch service on 07/01/2024 at 11:59 AM showed lunch was served from a small kitchen located between the two dining rooms after being prepared in a larger kitchen in a different area of the campus. Meals were prepared from a steam table behind an open window through which a cook passed the plates to other dietary staff who assembled other items for the residents' trays. Attached to the window was as a slatted metal door that rolled up on to a spool when the kitchen was open. The door and closing mechanism were open at this time and noted to covered in a layer of dust and grime. The spooled, slatted door and mechanism were directly above the steam table where resident meals were prepared. In an interview at this time Staff P stated the buildup of dust and grime combined with the location of the door created a contamination risk. Staff P stated the door and mechanism needed to be cleaned. REFERENCE: WAC 388-97-2980.

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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** 47836 Based on observation, interview, and record review, the facility failed to consistently perform Hand Hygiene (HH) before and after resident care/contact, change gloves after dirty care/before clean care, and failed to ensure glucometers were maintained clean and sanitary. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . <Facility Policy> According to a facility policy titled, Hand Hygiene, revised 10/01/2022, showed the facility would perform proper HH procedures to prevent the spread of infection. The policy showed HH applied to all staff working in all locations within the facility. The policy showed that using gloves does not replace HH and staff would perform HH before and after care provision, prior to donning gloves, and immediately after removing them. The policy showed HH would be performed between resident contacts, after handling contaminated objects, and when, during resident care, moving from a contaminated body site to a clean body site. <Glove Change> During an observation and interview on 06/28/2024 at 8:38 AM showed Staff I (Certified Nursing Assistant - CNA) and Staff J (CNA) providing pericare with a brief change after Resident 339 had an episode of diarrhea in their brief. After providing personal care, Staff I was observed wiping visible diarrhea from one of the fingers on their glove and proceeded to grab a clean brief and bed pad. Staff I put the clean brief on the resident and placed the clean bed pad under the resident all while still wearing the dirty gloves. Staff I stated they should have changed their gloves and performed HH between dirty and clean care, but they did not. In an interview on 06/28/2024 at 10:00 AM Staff O (Infection Control Nurse) stated they expected staff to change gloves and perform HH between clean and dirty care. Staff O stated this was important to prevent infections. <Glucometers> During a medication pass observation on 07/02/2024 at 12:03 PM, Staff F (Registered Nurse) was preparing to check Resident 21's blood sugar levels and administer insulin (a medication that helped to control blood sugar levels in the body). Resident 21 was observed to be on Enhanced Barrier Precautions related to having a colostomy (a surgical opening in the belly). Staff F donned personal protective equipment and entered the room. Staff F placed a shared glucometer (device used to check blood sugar levels) directly on Resident 21's over-the-bed table. Staff E then took a retracting lancet (device used to prick a finger for a blood sample) and pricked Resident 21's finger. Staff F placed the used lancet directly on Resident 21's table, picked up the glucometer, checked the residents blood sugar, and put the glucometer directly on the over-the-bed table. Staff F did not place a barrier between the glucometer and the surface of the over-the-bed table. Staff F completed their task and exited the room without cleaning the over-the-bed table. (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 07/02/2024 at 12:10 PM, Staff F confirmed they should use a barrier between the glucometer and surfaces in a resident's room but they did not. 43642 <Hand Hygiene> On 06/27/2024 at 9:26 AM, Staff Q (Lead Housekeeping Aide) was observed wearing gloves while cleaning the public bathroom next to the dining room. Staff Q cleaned the sink, then the toilet before return to clean the sink further. Staff Q then cleaned the mirror, all while wearing the same soiled gloves they started with. Staff Q then used their hand with the contaminated glove to move their glasses from their face to the top of their head. Staff Q then continued to clean the bathroom more using the same soiled gloves, touching the toilet paper dispenser, handrails, their mop handle, the sink faucet handle, and a door handle before removing the soiled gloves and performing hand hygiene. On 06/28/2024 at 12:54 PM, Staff Q put on gloves, picked up a toilet scrubber and container from the housekeeping cart, and brought them into room [ROOM NUMBER]'s bathroom. Staff Q cleaned the resident's toilet seat riser using the shower nozzle, left it to dry in shower, and then began cleaning the sink with the same soiled gloves used to clean the toilet seat. Staff Q then used their hand with the contaminated glove to move their glasses from their face to the top of their head. Staff Q, without removing the soiled gloves or performing hand hygiene, then cleaned the sink and handrails, used the toilet brush in the toilet, and used a cleaning cloth to wipe the toilet rim. Staff Q returned to their housekeeping cart with the toilet brush, did not remove their gloves or perform hand hygiene, and returned to the room [ROOM NUMBER] to wipe down the toilet seat riser. At 1:07 PM Staff Q, still wearing the same soiled gloves, left room [ROOM NUMBER] carrying a mop handle and two soiled mop pads. Staff Q placed the mop handle on their cart and discarded the soiled mop pads. Staff Q removed their gloves, performed hand hygiene, but did not disinfect the mop handle prior to going back into room [ROOM NUMBER] to continue cleaning. REFERENCE: WAC 388-97-1320 (1)(a)(c)(2)(a)(3).