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	09/19/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review the facility failed to ensure privacy for 1 of 1 resident (Resident 7) observed for medication administration via Gastric Tube (GT -tube inserted through the wall of the abdomen directly into the stomach). The failure to provide privacy during medication administration via GT placed residents at risk for a loss of privacy and a diminished quality of life.Findings included. <Policy>According to the facility policy titled, HIPPA - Organization - Requirements, revised 09/18/2025, showed the facility would ensure compliance with HIPPA requirements for securing protected resident health information.According to the facility policy titled, Resident Rights, dated 06/20/2024, the facility would ensure all direct and indirect care staff members, were educated on the rights of residents and the responsibility of the facility to properly care for its residents. The facility policy showed the resident had the right to a dignified existence.<Resident 7>Observation on 09/17/2025 at 7:46 AM Staff F (Registered Nurse) walked away from the medication cart without locking Resident 7's medical information on the computer, leaving it unsecured and viewable to all. Staff F entered Resident 7's room leaving the door wide open to the hallway and did not pull privacy curtain around the resident. Staff F pulled Resident 7's shirt up, exposing Resident 7's GT and abdomen area and proceeded to administer all of Resident 7's medications via GT.In an interview on 09/17/2025 at 7:47 AM Staff F stated it was important to protect residents' information to stay in compliance with HIPPA (Health Insurance Portability and Accountability Act - a law protecting sensitive resident health information aiming to ensure privacy and security in healthcare). Staff F stated they were expected to pull the privacy curtain when providing cares but did not. Staff F stated it was important to provide privacy when providing care for residents' rights. In an interview on 09/17/2025 at 8:34 AM Staff B (Director of Nursing) stated they expected staff to always protect resident identifiable health information for resident's rights to privacy. Staff B stated they expect staff to provide privacy for residents during cares by pulling the privacy curtain or closing the door. Staff B stated it was important to provide privacy for resident rights.Reference: WAC 388-97-0360

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to offer nonpharmacological interventions to 3 of 5 residents (Residents 3, 29, & 45), monitor specific target behaviors for 1 of 5 residents (Resident 45), complete an Abnormal Involuntary Movement Scale (AIMS - an assessment) for 1 of 5 (Resident 45), and monitor for adverse side effects from psychotropic medications for 1 of 5 residents (Resident 45) reviewed for unnecessary medications. Failure to monitor resident specific target behaviors, monitor for psychotropic medication adverse side effects, and provide nonpharmacological interventions placed residents at risk of mismanaged behaviors, discomfort, receiving unnecessary psychotropic medications, and a diminished quality of life.Finding included.<Facility Policy>According to the facility's Use of Psychotropic Medications policy, revised 02/19/2025, the facility would only use psychotropic medications when the practitioner determined the medication was appropriate to treat the resident's specific and diagnosed condition. The policy showed the facility would monitor and document the resident's response to the medication. The policy showed non-pharmacological interventions must be attempted unless contraindicated, to minimize the need for psychotropic medications. The policy showed residents who received an antipsychotic medication would have an AIMS completed upon admission.<Resident 3> According to a 08/18/2025 admission Minimum Data Set (MDS – an assessment tool) Resident 3 had a diagnosis of Depression. The MDS showed Resident 3 received an antidepressant medication during the assessment period. Review of Resident 3’s health records showed a 08/14/2025 physician order for two Antidepressant medications, both to be administered daily. Resident 3’s health records did not show a physician order for nonpharmacological interventions for the Antidepressant medications. <Resident 29> According to a 08/29/2025 admission MDS Resident 29 received an antidepressant medication during the assessment period. Review of Resident 29’s health records showed a 08/26/2025 physician order for an Antidepressant medication to be administered daily. Resident 29’s health records did not show a physician order for nonpharmacological interventions for the Antidepressant medications. In an interview on 09/18/2025 at 10:43 AM Staff G (Resident Care Manager) reviewed Resident 3 and 29’s records and stated there was not an order for nonpharmacological interventions for the psychotropic medications but they should have one. Staff G stated it was important to implement nonpharmacological interventions to ensure the facility was not unnecessarily administering psychotropic medications to residents when behaviors could be managed without pharmaceuticals. <Resident 45> According to the 09/16/2025 admission MDS Resident 45 had diagnoses including anxiety, depression, and a mood disorder. The MDS showed Resident 45 received an antipsychotic and an antidepressant medication during the lookback period. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 45’s physician orders showed a 09/11/2025 order directing staff to administer an antidepressant medication daily and an antipsychotic medication twice daily to the resident. Review of Resident 45’s assessments on 09/19/2024 showed staff did not complete an AIMS assessment for the resident related to the antipsychotic medication. Resident 45’s records showed staff were not monitoring the resident for adverse side effects, target behaviors, or attempting nonpharmacological interventions for the resident’s antidepressant medication. In an interview on 09/19/2025 at 9:39 AM, Staff B (Director of Nursing) was unable to provide documentation of an AIMS assessment related to the antipsychotic medication or documentation showing staff were monitoring Resident 45 for adverse side effects, target behaviors, or attempting nonpharmacological interventions related to the antidepressant medication. Staff B stated they expected staff to monitor residents for adverse side effects, target behaviors, and provide nonpharmacological interventions when residents were taking psychotropic medications. REFERENCE: WAC 388-97-0620. .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the resident and/or the resident's representative and Ombudsman with a written notice of the transfer/discharge, at the time of transfer or within 24 hours, for 2 of 4 sample residents (Resident 2 & 18) reviewed for hospitalization. This failure placed the residents and their representatives at risk of not being informed of their right while hospitalized that was necessary for decision-making.Findings included .<Facility Policy>According to the facility's 09/18/2025 revised Transfer and Discharge Policy, the facility would provide transfer/discharge notice to the resident and /or resident's representative in a language and manner they could understand including reason and basis, effective date, location for the transfer/discharge, and an explanation of the right to appeal. The policy showed the facility would maintain evidence that the transfer/discharge notice was sent to the Ombudsman office.<Resident 2>According to the 01/11/2025 and 05/01/2025 Discharge Return Anticipated Minimum Data Set (MDS - an assessment tool), Resident 2 discharged to the hospital on [DATE], on 01/11/2025, and again on 05/01/2025 related to a change in the resident's medical condition. The MDS showed Resident 2 had medical conditions including stroke (a medical condition prevents the brain from getting enough blood supply) and heart failure.Record reviews showed the facility staff provided Resident 2 or their representative with a written notification of the reason for transfer to the hospital as required only on 05/01/2025. In an interview on 09/17/2025 at 1:05 PM, Staff B (Director of Nursing) stated they expected the facility staff to notify resident's family about transferring residents to the hospital, sent e-interact forms to the hospital with residents, and provide a written notification with the reason for transfers to residents/representatives. Staff B reviewed Resident 2's record and stated the facility did not provide a written notification about the reason for transfer to Resident 2 and/or their representatives as required on 01/01/2025 and 01/11/2025 transfers to the hospital.In interview on 09/18/2025 at 10:14 AM, Staff E (Social Services Director) stated they were responsible for notifying the Ombudsman about resident's transfers, discharges, and hospitalizations as required. Staff E reviewed Resident 2's record and stated they did not notify the Ombudsman about Resident 2's hospitalization on 05/01/2025.<Resident 18>According to the 01/09/2025 and 01/27/2025 Discharge Return Anticipated, Resident 18 discharged to the hospital on [DATE] and again on 01/27/2025 related to a change in their condition. The MDS showed Resident 18 had medical conditions including heart failure.In an interview on 09/17/2025 at 1:15 PM, Staff B reviewed Resident 10's record and stated the facility did not provide a written notification about the reason for transfer to Resident 18 and/or their representatives as required on 01/09/2025 and 01/27/2025 to the hospital as required.REFERENCE: WAC 388-97-0120 (2)(a-d), -0140 (1)(a)(b)(c)(i-iii).

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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** Based on observation, interview, and record review the facility failed to ensure 3 (Residents 2, 8, & 5) of 12 sample residents Minimum Data Sets (MDS - an assessment tool) were completed accurately to reflect the resident's condition. This failure placed residents at risk for unidentified and/or unmet care needs.Findings included . <Resident 2> According to the 06/10/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 2 had diagnoses including a brain bleed with right side weakness. The MDS showed Resident 2 did not have a Restorative Nursing Program to maintain their functional limitations in range of motion. Review of the June 2025 RNP documentation showed restorative staff provided range of motion programs to Resident 2 up to five times a week. Review of the 05/09/2025 revised Activities of Daily Living Care Plan (CP) showed Resident 2 received range of motion for both of their arms and legs up to five days a week, to maintain their mobility. In an interview on 09/17/2025 at 9:17 AM, Staff L (MDS Coordinator) reviewed Resident 2’s record and stated the MDS was not accurate. <Resident 8> According to the 02/18/2025 Quarterly MDS, Resident 8 admitted to the facility on [DATE] and had a diagnosis of depression. The MDS showed Resident 8 received antidepressant medication every day during the assessment period. Review of Resident 8’s record showed an 11/21/2024 Preadmission Screening and Resident Review Level 1 with depression and anxiety marked under the “serious mental illness” section. According to the 01/02/2025 Psychiatrist note, Resident 8 had a diagnosis of depression and anxiety that had worsened gradually over time, and the resident needed treatment. In an interview on 09/17/2025 at 9:25 AM, Staff L reviewed Resident 8’s record and stated Resident 8 had depression and anxiety diagnoses. Staff L stated the anxiety diagnoses should be but was not identified accurately on the 02/18/2025 Quarterly MDS. <Resident 5> According to the 08/18/2025 admission MDS, Resident 5 had diagnoses including malnutrition and cancer. The MDS showed Resident 5 required substantial/maximal assistance from staff to roll left and right in bed, was dependent on staff for lying to sitting on the side of the bed and required partial/moderate assistance from staff for using the toilet or commode. The MDS showed Resident 5 did not have any pressure ulcers and was not at risk for developing pressure ulcers. Review of a 09/06/2025 incident report showed staff identified a pressure injury to Resident 5’s tailbone area. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/18/2025 at 10:31 AM showed Staff K (Licensed Practical Nurse) performing wound care for the pressure ulcer to Resident 5’s tailbone. In an interview on 09/19/2025 at 8:53 AM, Staff L stated it was unusual for a resident to be coded as “not at risk” for pressure ulcers. Staff L reviewed Resident 5’s records and stated the resident should be coded as “at risk” for pressure ulcer development and the MDS required modification. 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** Based on record review and interview, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR - a mental health screening required before transfer to a nursing home) assessments were revised to reflect mental health changes for 1 of 5 residents (Resident 8) reviewed for PASRRs. This failure left residents at risk for not receiving timely and necessary services to meet their mental health care needs. Findings included .<Facility Policy>According to the facility's 03/29/2025 revised Behavioral Health Services Policy, the facility would ensure all residents received necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial well-being. The policy showed the facility staff would review resident's medical records and obtain history from resident's family to complete PASRR screening. The policy showed PASRRs would be reviewed periodically for potential changes.<Resident 8>According to the 11/18/2024 admission 5 Day Minimum Data Set (MDS - an assessment tool), Resident 8 was admitted to the facility on [DATE] and had a diagnosis of depression. The MDS showed Resident 8 received antidepressant medication every day during the assessment period. Review of Resident 8's record showed a 11/21/2024 PASRR Level 1 with Depression and Anxiety marked under serious mental illness. This PASRR Level 1 showed Level 2 evaluation not indicated.According to the 01/02/2025 Psychiatrist note, Resident 8 had diagnosis of depression and anxiety, worsened gradually over time and needed treatment.In an interview on 09/18/2025 at 9:49 AM, Staff E (Social Services Director) stated they were responsible for reviewing resident's PASRR Level 1 and 2, correcting them upon admission and as needed. Staff E reviewed Resident 8's record including PASRR Level 1 and stated the PASRR level 1 was not accurate because Resident 8 received treatment for depression and anxiety. Staff E stated PASRR Level 2 evaluation was required for Resident 8, but the facility did not update PASRR Level 1. REFERENCE: WAC 388-97-1975(1)(4)

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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. Based on observation, interview, and record review, the facility failed to develop and/or implement comprehensive Care Plans (CP) for 3 of 16 residents (Resident 29, 7, & 3) whose CPs were reviewed. Failure to develop comprehensive, individualized CPs to address resident care needs placed residents at risk for unmet care needs, frustration, and other negative health outcomes.Findings included. <Policy>According to the facility policy titled, Documentation in Medical Record, dated 2024, the facility would ensure medical records were accurate, relevant, and complete, containing sufficient details about the resident's care.<Resident 29>According to a 08/29/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 29 received Oxygen (O2) therapy continuous and at a high concentration while a resident at the facility.Review of Resident 29's health records showed a 08/26/2025 physician order for O2 to be administered continuously. Review of Resident 29's records showed no CP for Covid 19 or oxygen therapy.Observation on 09/14/2025 at 9:22 AM showed staff removing Resident 29's transmission-based precautions sign and personal protective equipment cart for Covid 19. Resident 29 was receiving O2 via nasal canula at 2 liters/minute.In an interview on 09/18/2025 at 10:43 AM Staff G (Resident Care Manager) stated Resident 29 should have a CP for Covid 19 and the continuous use of O2 but did not. Staff G stated it was important to develop a Covid 19 and O2 CP to ensure the residents were receiving necessary respiratory care.<Resident 7>According to a 08/08/2025 Quarterly MDS Resident 7 required two-person assistance for rolling side to side in bed, sitting to lying, lying to sitting, sitting to standing, and with chair/bed to chair transfers. The MDS showed Resident 7 had diagnoses of stroke (occurs when blood flow to the brain is interrupted, leading to brain damage) with hemiplegia (complete paralysis of one side of the body).Review of Resident 7's records showed a 11/13/2024 Activities of Daily Living CP instructing two staff to reposition in bed, it did not instruct staff on when to reposition Resident 7 in bed. Resident 7's records did not show instructions to staff for reposition frequency or staff documentation of repositioning being offered/done.In an interview on 09/18/2025 at 10:43 AM Staff G stated they expected staff to reposition dependent residents at least every two to three hours. Staff G stated Resident 7's CP should reflect reposition frequency but did not. Staff G stated it was important, so care staff knew when to reposition the resident to ensure skin breakdown didn't occur and the resident was comfortable.<Resident 3>According to a 08/18/2025 admission MDS Resident 3 had a diagnosis of Diabetes (unstable blood glucose levels).Review of Resident 3's health records showed a 08/14/2025 and 09/06/2025 physician orders for two different insulins for Diabetes. Record review showed no CP for Resident 3's Diabetes.Observation on 09/14/2025 at 8:22 AM Resident 3 was sitting on edge of bed with breakfast tray in front of them and stated their blood glucose level was low and they were having symptoms, so they needed to eat to feel better. Resident 3 stated they experienced symptoms of low blood glucose often since being in the facility and thought their insulin orders might need to be adjusted.In an interview on 09/18/2025 at 11:24 AM Staff B (Director of Nursing) stated Resident 3 should have a Diabetes CP but did not. Staff B stated it was important to have a Diabetes CP to ensure proper care for the residents.Reference: WAC 388-97-1020(1), (2)(a)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to clarify physician orders to include medication dosing and pain medication parameters for 2 (Resident 45 & 3) of 5 residents reviewed for unnecessary medications and 2 (Resident 5 & 48) supplemental residents. The facility failed to obtain/monitor labs for medications requiring lab monitoring, failed to ensure pain management included nonpharmacological interventions, and failed to ensure staff monitored for signs and symptoms of low/high blood glucose levels for 2 (Residents 3 & 29) of 5 sample residents reviewed for unnecessary medications. These failures placed residents at risk for unmet needs, and ineffective and/or delayed treatments.Findings included. <Clarifying Physician Orders> <Resident 5> Review of Resident 5’s 09/2025 Medication Administration Record (MAR) showed an 08/11/2025 order for an over-the-counter pain medication to be administered every six hours as needed for a pain level of “1-3/10” on the pain scale. The MAR showed an 08/11/2025 order directing staff to administer an opioid pain medication (Medication A) every two hours as needed for a pain level of 4-10/10 on the pain scale. The MAR showed an 08/28/2025 order directing staff to administer a different opioid pain medication (Medication B) every four hours as needed. This order did not direct staff at what pain level to administer the pain medication for. Review of the 09/2025 MAR showed on one occasion, staff administered the over-the-counter medication to Resident 5 for a pain level of 4, despite the medication instructing staff to administer for a pain level of 1-3/10. Review of the 09/2025 MAR showed staff administered Medication B for pain levels of 0, 3, 4, 6, 7, & 8. The MAR showed staff did not administer Medication as ordered and did not clarify when Medication B should be administered to Resident 5. <Resident 45> Review of Resident 45’s 09/2025 MAR showed a 09/11/2025 order directing staff to administer an over-the-counter pain medication every six hours as needed. This order did not include directions to staff for what pain level to administer the pain medication to the resident. The MAR showed a 09/11/2025 order directing staff to administer an opioid medication every six hours as needed for pain. This order did not include directions to staff for what pain level to administer the pain medication to the resident. Review of the 09/2025 MAR showed staff administered the over-the-counter medication for pain levels of 4 and 5 on the 0-10 pain scale. The MAR showed staff administered the opioid medication for pain levels of 4, 6, 7, and 8 on the 0-10 pain scale. In an interview on 09/19/2025 at 9:29 AM, Staff B (Director of Nursing) stated the facility process was to have a pain scale with each as needed pain medication, so staff knew which medication for what pain level a resident was experiencing. Staff B reviewed Resident 5 and Resident 45’s records and confirmed a pain scale should be associated with the as needed pain medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 48> Review of Resident 48’s record showed Resident 48 admitted to the facility on [DATE] after they had back surgery. Review of the 09/2025 MAR showed Resident 48 had a 09/12/2025 physician order directing staff to administer two tablets of a pain-relieving medication to the resident every six hours for pain and not to exceed three grams in 24 hours. Another 09/12/2025 order directed staff to administer one tablet of a narcotic pain medication every six hours as needed for moderate pain and two tablets every six hours as needed for pain 7/10. There were no instructions to staff about which medication should be administered to Resident 48. In an interview on 09/17/2025 at 8:00 AM, Staff K (Licensed Practical Nurse) stated the physician order was not clear as to which medication should be administered for pain because there were no pain scale parameters. Staff K stated staff should clarify the order with the provider and receive orders with parameters, but they did not. <Resident 3> Review of Resident 3’s record showed Resident 3 admitted to the facility on [DATE] with multiple medical conditions including back pain, heart failure, and kidney failure. Review of the September 2025 MAR showed Resident 3 had an 08/16/2025 physician order directing staff to apply a medicated pain patch topically one time a day for pain and remove the patch “per schedule. ” The order did not include the strength for the pain patch and did not direct staff where the patch should be applied to Resident 3. In an interview on 09/17/2025 at 8:02 AM, Staff K stated the pain patch order did not have a dosage. Staff K stated staff should clarify the order with the provider to include the dosage and location to apply the patch, but they did not. In an interview on 09/18/2025 at 10:01 AM, Staff B stated it was their expectation nursing staff review the orders prior to administering medications to residents, clarify with the provider for dosage, parameters for pain medications, location for pain patches, and follow the orders, but they did not. <Lab Monitoring and Nonpharmacological Interventions> <Resident 3> According to the 08/18/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 3 had diagnoses of chronic pain, high cholesterol, diabetes (unstable blood glucose levels), and malnutrition. The MDS showed Resident 3 received scheduled and as needed pain medications, and non-medication interventions for pain management. The MDS showed Resident 3 experienced pain frequently and experienced a level 10/10 pain during the assessment period. The MDS showed pain occasionally interrupted Resident 3’s sleep and frequently interfered with their therapy activities and day-to-day activities. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3’s health records showed 08/14/2025 physician orders for cholesterol lowering medication and a high dose supplement order. Resident 3’s health records did not show cholesterol levels or a lab level for the high dose supplement being administered. Resident 3’s health records did not show physician orders for nonpharmacological pain interventions or documentation of staff monitoring the resident for signs and symptoms of low/high blood sugar levels. Observation on 09/14/2025 at 8:22 AM showed Resident 3 sitting on the edge of the bed with their breakfast tray in front of them and stated their blood glucose level was low and they were having symptoms, so they needed to eat to feel better. Resident 3 stated they experienced symptoms of low blood glucose often since being in the facility and thought their insulin (blood sugar lowering medication) orders might need to be adjusted. In an interview on 09/18/2025 at 11:24 AM Staff B stated Resident 3 did not have cholesterol levels or labs for the high dose supplement ordered but should. Staff B stated it was important to ensure the resident was at safe blood levels and required the medications. Staff B stated they expected staff to implement orders for nonpharmacological pain interventions and to monitor for signs and symptoms of low/high blood glucose levels for residents with diabetes every shift. Staff B stated it was important to offer nonpharmacological pain interventions and to not resort straight to pharmaceuticals, giving the resident unnecessary medications, when the pain could be managed without medicine. Staff B stated monitoring residents with diabetes for signs and symptoms of low/high blood glucose levels was important for overall management of diabetes and that some residents present these symptoms even when a blood glucose test showed normal range. <Resident 29> According to an 08/29/2025 admission MDS, Resident 29 admitted to the facility on [DATE]. The MDS showed Resident 29 had diagnoses including thyroid disorder and high cholesterol. Review of Resident 29’s health records showed an 08/26/2025 physician order for a cholesterol lowering medication and a 09/11/2025 physician order for a thyroid medication. Resident 29’s health records did not include a cholesterol level or a blood level lab for thyroid medication. In an interview on 09/18/2025 at 11:24 AM, Staff B stated Resident 29’s health records did not include a cholesterol level or a level of the thyroid medication but should. Staff B stated it was important to obtain these levels to ensure the medication was safe for the residents. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii), (6)(b)(i).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 2 of 2 residents (Resident 8 & 7) reviewed for English as a second language, were provided a functional communication system. Failure to provide and follow the services which enhanced and/or ensured effective communication placed the residents at risk for unmet care needs, social isolation and a diminished sense of well-being. Findings included .<Policy>According to the facility policy titled, Culturally Competent Care, dated 09/18/2025, showed the facility would treat each resident with dignity and respect. The policy showed the facility would identify unique cultural characteristics such as language and implement appropriate communication assistance methods. The policy showed staff would consistently implement the communication methods in place for resident with each interaction.<Resident 8> According to the 07/08/2025 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 8 admitted to the facility on [DATE] with multiple medical conditions including heart failure and kidney failure and had no memory issue. The MDS showed Resident 8 had clear speech and made self-understood and able to understand others. The MDS showed Resident 8’s preferred language was not English and needed interpreter to speak with health care staff. Review on 03/04/2025 revised communication Care Plan (CP) showed Resident 8 had communication problem related to language barrier and Resident 8 spoke their preferred language. Interventions included instructions for staff to use phone translator through google and to use the language line interpretive services. Observation and interview on 09/15/2025 at 8:55 AM, Resident 8 was lying in bed in their room, door was open, and Resident 8 was talking to this surveyor in their preferred language. Resident 8 did not understand English at all. Resident 8 talked in their language and interpreted in English on their phone. Resident 8 could not understand the surveyor in English. Observation on 09/15/2025 at 9:02 AM and 11:37 AM nursing staff visited Resident 8 in their room and did not use phone or interpreter while providing medications and care. Observation on 09/16/2025 at 9:41 AM showed Resident 8 was lying in their bed, their door was open, and Resident 8 was screaming loud in their language. Observation on 09/16/2025 at 9:45 AM showed Staff F (Registered Nurse) walked in the hallways and stayed in front of Resident 8’s room in hallways, told the resident in English to use the call light and went back to the medication cart. Observation on 09/16/2025 at 9:48 AM showed Staff F came back to Resident 8’s room, talked to the resident in English, gave them call light and bed controller to use. The observation showed Staff F did not use any device to communicate and Resident 8 was still screaming in their language. Finally Resident 8 stated, “Peepee” and pointed toward their incontinent brief. Staff F stated in English that they would send an aide to help them and left the room. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 09/16/2025 at 9:55 AM showed Staff H (Certified Nursing Assistant) came to Resident 8’s room, closed the door and start talking to the resident in English. Resident 8 was louder and kept talking in their language. Staff H kept saying they did not understand the resident. This surveyor knocked on the resident’s door and entered the room. Resident 8 was crying and talking in their language. Staff H stated they gave the resident call light already and did not understand what Resident 8 was saying. Resident 8 again said, “peepee”. When asked Resident 8 if they wanted to use the bathroom, Resident 8 stated, “yes”. Then Staff H provided care to Resident 8 to change their brief. Staff H did not use any communication device to talk to Resident 8 during the whole conversation. In an interview on 09/16/2025 at 10:15 AM, Staff H stated Resident 8 usually screams at times. Staff H stated Resident 8 used their phone to communicate but that day Resident 8’s phone was not working. When asked Staff H about how staff communicate with Resident 8 to meet their needs. Staff H stated they should use their personal phones to communicate with Resident 8, but they did not. In an interview on 09/17/2025 at 1:22 PM, Staff B (Director of Nursing) stated the facility staff should use phone translator services or interpretive services to communicate with Resident 8 but they were not using the services. <Resident 7> According to a 11/12/2024 Annual MDS Resident 7’s primary language was not English. The MDS showed Resident 7 wanted an interpreter to communicate with health care staff. Review of Resident 7’s communication CP, Resident 7’s primary language was not English with interventions for resident to use communication binder to communicate. In an interview on 09/15/2025 at 9:48 AM Resident 7’s representative stated Resident 7 was rarely confused, could get a little mixed up occasionally, but for the most part understood others and what was going on around her. Resident 7’s representative stated Resident 7’s primary language was Russian but had not seen staff attempt translation using an interpreter or a communication board. Observations on 09/15/2025 at 9:36 AM and 11:42 AM, 09/16/2025 at 12:16 PM, 09/17/2025 at 7:46 AM and 10:32 AM, 09/18/2025 at 9:49 AM showed no communication binder readily available for Resident 7. On 09/17/2025 at 7:46 AM Resident 7 was speaking to Staff F in a language other than English. Staff F did not offer Resident 7 interpreter services or use of a communication board and stated they always speak in their language but did not need anything. When Staff F was asked how they knew Resident 7 did not need anything, Staff F stated they were confused and had been in the facility for a long time. In an interview on 09/18/2025 at 10:43 AM G (Resident Care Manager) stated Resident 7 did not have a communication binder available for basic needs communication but should. Staff G stated it was important to provide interpretation services to non-English speaking residents to ensure good care and the residents needs are being met. Reference: WAC 388-97-1620(2)(a)(v).

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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. Based on observation, interview, and record review the facility failed to ensure residents who were dependent on staff for assistance with Activities of Daily Living (ADLs - i.e. grooming, bathing, eating, etc.) received the assistance they required for 3 of 7 sample residents (Residents 2, 8, & 7) reviewed for ADLs. The failure to provide nailcare, bathing, getting out of bed, and shaving left residents at risk of embarrassment, poor personal hygiene, decreased quality of life, and other negative health outcomes. Findings included .<Facility Policy>According to the facility's 09/18/2025 revised ADLs Policy, residents who were unable to perform ADLs independently would receive the necessary services to maintain mobility, good nutrition, grooming, and personal hygiene as they required. The policy showed based on resident's assessment, the facility would ensure resident's abilities in ADLs would not deteriorate unless deterioration was unavoidable. <Resident 2> According to the 06/10/2025 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 2 had weakness on right side of their body and was dependent on staff for their personal hygiene. Review of the 05/09/2025 revised ADLS Self Care Deficit Care Plan (CP) showed Resident 2 required one person assistance from staff for their personal hygiene needs. Observations on 09/15/2025 at 10:23 AM, on 09/16/2025 at 11:57 AM, and on 09/18/2025 at 10:50 AM showed Resident 2 was lying in their bed and had long fingernails with black debris under their fingernails. In an interview on 09/17/2025 at 10:29 AM, Staff B (Director of Nursing) stated they expected staff to provide ADL assistance to residents including personal hygiene during daily morning care. Staff B stated staff should clip Resident 2’s fingernails weekly on shower days and as needed, but they did not. <Resident 8> According to the 07/08/2025 Quarterly MDS, Resident 8 was admitted to the facility with weakness on both arms and required one person assistance from staff with personal hygiene. Review of the 07/28/2025 revised ADL Self Care Deficit CP showed Resident 8 required extensive one person assistance from staff with their personal hygiene including bathing, oral care and shaving. Observations on 09/16/2025 at 10:12 AM and on 09/17/2025 at 11:43 AM showed Resident 8 lying in their bed and had long facial hair. In an interview on 09/17/2025 at 1:27 PM, Staff B stated they expected staff to provide ADL assistance to residents including personal hygiene during daily morning care. Staff B stated staff should shave Resident 8’s facial hair per preference and document if the resident refused, but they did not. <Resident 7> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 08/08/2025 Quarterly MDS Resident 7 had impairment on one side of their upper and lower extremities. The MDS showed Resident 7 was dependent on two staff for hygiene, bathing, transfers, and positioning. Review of an 11/13/2024 ADL CP day shift staff would get Resident 7 out of bed daily. The ADL CP showed Resident 7 preferred showers in the morning. Review of Resident 7’s health records showed no documentation of showers offered. In an interview on 09/15/2025 at 9:48 AM Resident 7’s representative stated Resident 7 was bedridden. Resident 7’s representative stated staff told them the facility was short staffed so they were unable to get Resident 7 out of bed daily and for showers, but they would offer bed baths. Resident 7’s representative stated they wanted Resident 7 out of bed daily and given showers per Resident 7’s preference, “not bed baths for quality of life.” Observations on 09/15/2025 at 9:36 AM and 11:42 AM, 09/16/2025 at 12:16 PM, 09/17/2025 at 7:46 AM and 10:32 AM, 09/18/2025 at 9:49 AM showed Resident 7 lying on back in bed. In an interview on 09/18/2025 at 10:38 AM Staff M (Certified Nursing Assistant) stated they don’t get Resident 7 out of bed and offered them bed baths, not showers, when they were assigned to care for them. Staff M stated there was no place in Resident 7’s records for staff to document bathing or getting out of bed. In an interview on 09/18/2025 at 10:43 AM Staff G (Resident Care Manager) stated they worked for the facility for the last two months and had only seen Resident 7 out of bed once. Staff G was unable to provide documentation of staff offering Resident 7 assistance to get out of bed daily or up for showers. Staff G stated they expected staff to offer and document assistance with getting out of bed and offer and document showers per Resident 7’s preference. Staff G stated it was important to assist dependent residents to get up daily, attend activities, and provide assistance with showers for quality of life. Reference: WAC 388-97-1060(2)(c).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure weekly skin assessments were completed for 1 (Residents 15) of 1 residents reviewed and 1 (Resident 5) supplemental resident who were reviewed for skin impairments, ensure post fall assessments were completed for 1 (Resident 20) of 4 residents who were reviewed for falls, ensure the therapy department provided a referral for a restorative nursing program to maintain range of motion once a resident discharged from therapy services for 1 of 4 residents (Resident 31), and ensure accurate weight monitoring was done per physician orders for 1 of 1 residents (Resident 7) reviewed for nutritional status. These failures placed residents at risk for skin breakdown, injuries, malnutrition, decreased range of motion, and decreased quality of life.Findings included. <Weekly Skin Checks> <Resident 5> According to the 08/18/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 5 had diagnoses including malnutrition and cancer. The MDS showed Resident 5 required substantial/maximal assistance from staff to roll left and right in bed, was dependent on staff for lying to sitting on the side of the bed, and required partial/moderate assistance from staff for using the toilet or commode. The MDS showed Resident 5 did not have pressure ulcers and was not at risk for developing pressure ulcers. Review of Resident 5’s 08/11/2025 “Risk for Impaired Skin Integrity” Care Plan (CP) showed an intervention directing staff to perform weekly skin checks for Resident 5. Review of Resident 5’s weekly skin checks showed staff assessed the resident’s skin on 08/20/2025 and documented the resident had redness to their tailbone area. The next skin check was completed 09/10/2025, three weeks after the skin check completed on 08/20/2025. The 09/10/2025 skin check showed Resident 5 developed a pressure ulcer to their tailbone. Review of Resident 5’s August 2025 Treatment Administration Record (TAR) showed staff documented a skin check was completed on 08/27/2025. Review of Resident 5’s September 2025 TAR showed staff completed a skin check on 09/03/2025. Resident 5’s record showed staff did not complete skin assessment forms showing the results of the skin checks. Review of Resident 5’s progress notes from 08/20/2025 to 09/10/2025 showed staff did not document the resident refused the weekly skin checks. Observation on 09/18/2025 at 10:31 AM showed Staff K (Licensed Practical Nurse) providing wound care to Resident 5’s tail bone. In an interview on 09/18/2025 at 10:41 AM, Staff K stated skin checks were completed weekly for residents. Staff K stated if a resident refused a skin check, they would reapproach the resident and endorse to the next shift if the resident continued to decline. Staff K stated refusals were documented in the TAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/19/2025 at 9:32 AM, Staff B (Director of Nursing) stated skin checks were triggered on the TAR to alert staff as to when a skin check was due. Staff B stated it was their expectation staff completed the skin check assessment form and documented if a resident refused. Staff B reviewed Resident 5’s records and confirmed staff did not document a skin check assessment for 08/27/2025 and 09/03/2025. <Resident 15> Review of the 07/23/2025 admission MDS showed Resident 15 had major surgery prior to admission to the facility. The MDS showed Resident 15 did not have current pressure ulcers but was at risk for developing pressure ulcers. Review of Resident 15’s revised 08/04/2025 “…potential/actual impairment to skin integrity…” CP showed interventions to staff to perform weekly skin checks for Resident 15. Review of Resident 15’s weekly skin checks showed staff completed a skin assessment on 07/26/2025 showing the resident had bruising to the back of their hand. The next skin assessment documented was 08/29/2025, nearly five weeks later. In an observation and interview on 09/14/2025 at 9:52 AM, Resident 15 was sitting in their wheelchair in their room. They had scattered bruising to the back of both hands. Resident 15 stated they had a wound to their foot that staff were treating. In an interview on 09/19/2025 at 9:32 AM, Staff B reviewed Resident 15’s record and confirmed staff did not complete weekly skin checks as ordered. <Fall Assessments> <Resident 20> According to the 08/13/2025 admission MDS, Resident 20 had some memory issues and had recent falls. The MDS showed Resident 20 required substantial/maximal assistance for rolling left and right, sitting to lying, lying to sitting, and sitting to standing. Review of an 08/09/2025 Fall Risk Assessment showed Resident 20 was at moderate risk for falls. Review of a 09/07/2025 facility incident report showed Resident 20 had a fall in the bathroom while being assisted by staff. Per Resident 20’s request, staff stepped outside of the bathroom to provide privacy and heard the resident yell for help. Staff found the resident on the floor. Review of Resident 20’s records show staff did not complete an updated fall assessment at the time of the 09/07/2025 fall. In an interview on 09/19/2025 at 10:00 AM, Staff B stated it was their expectation that staff completed a fall assessment after each fall a resident had. Staff B was unable to provide a fall assessment for Resident 20’s fall on 09/07/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Restorative Nursing Program Referral> <Resident 31> According to the 08/21/2025 5 Day MDS, Resident 31 admitted to the facility on [DATE], was cognitively intact, and had multiple medically complex diagnoses including a right leg fracture with impairment of functional limitation in range of motion to one arm and leg. The MDS showed Resident 31 required substantial to maximum assistance from staff for rolling side to side in bed, sitting to stand, transferring, toileting, and showers. The MDS showed Resident 31 had no rejection of care during the assessment period. Observation and interview on 09/14/2025 at 12:13 PM showed Resident 31 was sitting up in a wheelchair in their room. Resident 31 stated they came to this facility for therapy because they had fractured their right leg. Resident 31 stated therapy stopped working with them more than two weeks ago because of their insurance. Observations and interviews on 09/15/2025 at 11:21 AM and on 09/16/2025 at 2:01 PM showed Resident 31 sitting in a wheelchair in their room. Resident 31 stated they wished therapy would work with them to make their leg stronger to walk again. Review of Resident 31’s 08/29/2025 Occupational Therapy (OT) discharge summary showed Resident 31 required partial to moderate assistance from staff with daily activities, showers, transfers, and toileting needs. The discharge summary did not have a referral for a restorative nursing program. In an interview on 09/17/2025 at 10:53 AM, Staff L (Restorative Coordinator) stated they were responsible for managing restorative nursing programs. Staff L stated when the therapy department discharged residents from therapy, they provided a referral form to a restorative program, and they initiated restorative programs in the resident’s plan of care and educated restorative aides. When asked for Resident 31’s restorative program, Staff L stated Resident 31 did not have a restorative program. Staff L stated a restorative program was very important to maintain the resident’s physical activities and range of motion. In an interview on 09/18/2025 at 9:42 AM, Staff S (Rehab Director) stated Resident 31 was discharged from therapy services on 08/29/2025 and was in process in getting authorization for more therapy from insurance. Staff S stated they referred Resident 31 for a restorative nursing program upon discharging from therapy services. Staff S reviewed Resident 31’s discharge summary and stated they did not refer Resident 31 to restorative program. Staff S stated they should refer Resident 31 to restorative program to maintain their range of motion, but they missed it. <Weight Monitoring> <Resident 7> According to the 08/08/2025 Quarterly MDS Resident 7 received more than 51% of their caloric and fluid intake via a gastric tube (tube inserted through the abdominal wall directly into the stomach). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7’s records showed a 12/12/2024 physician order to monitor the resident’s weight monthly for nutritional health. Resident 7’s records showed no weight monitor for February, May, and July of 2025. Resident 7’s records showed a 02/12/2024 nutrition at risk CP with an intervention of tube feeding and the facility would monitor Resident 7’s weight per order. In an interview on 09/19/2025 at 8:43 AM Staff B stated they expected staff to monitor Resident 7’s weights per physician orders. Staff B stated it was important to monitor residents’ weight to track nutritional and cardiac status. REFERENCE: WAC 388-97-1060(1).

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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. Based on observation, interview, and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach) was administered in accordance with physician orders and professional standards for 1 of 1 resident (Resident 7) reviewed for enteral nutrition. The facility failed to accurately document the amount of enteral formula (liquid food products) and fluids a resident received were reconciled with the amount they were ordered to receive and deliver per physician order. This failure placed residents at risk for inadequate nutrition, dehydration, and other adverse outcomes.Findings included.<Policy>According to the facility policy titled, Care and Treatment of Feeding Tubes, dated 09/18/2025, the facility would ensure tube feedings were administered per physician orders. The policy showed staff would evaluate the amount of feeding administered to ensure the resident received the correct enteral nutrition consistent with and following the physician orders. <Resident 7>According to a 08/08/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 7 had a tube feeding during the assessment period. The MDS showed Resident 7 received 51% or more of their total calories through the feeding tube with 501 Milliliters (ml) or more of fluids daily.Review of Resident 7's health records) showed a 07/25/2024 tube feeding order to run for 12 hours a day at 60ml/hour (total 720ml) congruent with water flush at 40ml/hour for 12 hours (total 480ml). The tube feeding order was scheduled to start at 8:00 AM and stop at 8:00PM.Observation and interview on 09/17/2025 at 7:25 AM showed Staff F (Registered Nurse) stop the tube feeding pump, which was set to 60ml/hour with a bag of water running at 40ml/hour. The tube feeding bottle showed no date or time that the bottle was started. The pump was reading 1038ml of feeding and 2409ml of water had been administered to Resident 7. Staff F returned to cart entering last used documentation when documented the amount of tube feeding and water the resident received. Staff F stated they did not calculate on the pump how much Resident 7 received and never did that because the order showed how much they should be receiving. When asked how they knew the tube feeding was started at 8:00 AM and Resident 7 had received the correct amount ordered, Staff F stated they never totaled the amount administered on the pump and that was a good question for the nurse that started the pump.In an interview on 09/17/2025 at 8:34 AM Staff B (Director of Nursing) stated they expected staff to total the pump each shift for amount of formula and water administered and document in the residents' records. It's important to ensure residents receive the ordered amount of formula and water to ensure adequate nutrition and hydration. Reference: WAC 388-97-1060(3)(f)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 1 of 2 staff (Staff F - Registered Nurse) observed during medication administration and proper labeling of medications on 1 of 1 medication carts (West Medication Cart) reviewed for medication storage. These failures placed residents at risk of injury, receiving expired medications, and a diminished quality of life.Findings included.<Policy>According to the facility policy titled, Medication Storage, dated 09/18/2025, the facility would ensure all medications and biologicals would be stored in locked compartments. The policy showed only authorized personnel would have access to the medications and keys to locked compartments. The policy showed the facility would ensure all outdated and mislabeled medications were destroyed in accordance with federal and state requirements. <Staff F>In an observation and interview on 09/15/2025 at 8:59 AM Staff F prepared medications for a resident by dispensing pills and liquid medications into a small pill cup and pulling two respiratory inhaled medications out and leaving them on top of the medication cart unsecured and walked away. Staff F stated they were expected to secure all medications in a locked medication cart before leaving them but did not.In an observation and interview on 09/17/2025 at 7:46 AM Staff F prepared medications for a resident by dispensing pills and liquid medications into a small pill cup and left them on top of the medication cart unsecured and walked away. Staff F stated they should not leave medications unattended and unsecured. Staff F stated it was important for residents' safety to secure all medications behind a lock to ensure a resident did not mistakenly ingest the medications.In an interview on 09/17/2025 at 8:15 AM Staff B (Director of Nursing) stated they expected staff to secure medications behind a lock before walking away from them. Staff B stated it was important to store and secure medications appropriately to ensure residents' safety. <West Medication Cart>In an observation and interview on 09/17/2025 at 10:24 AM the [NAME] medication cart had a bottle of a supplement with the expiration date of July 2024 crossed off with black ink and 11/25 written next to it. Staff K (Licensed Practical nurse) stated they believed the supplements were brought in by a family member and they crossed off the expiration date. Staff K stated staff should not except medications with an expired date crossed off and a new expiration date written in. Staff K stated the facility should provide the supplement for the residents.In an interview on 09/18/2025 at 11:24 AM Staff B stated they expected staff to discard medications upon expiration. Staff B stated it was important to ensure residents were receiving the correct potency as medications can lose their effectiveness upon expiration. Reference: WAC 388-97-1300(2), -2340

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	09/19/2025

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 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. Based on observation, interview, and record review the facility failed to ensure cold food was held at 41-degree Fahrenheit (F) or lower during lunch preparation. Failure by the facility to ensure food was at the proper temperature when served, placed residents at risk for food borne illness, less than adequate nutritional intake, dissatisfaction with meals, and other negative outcomes.Findings included <Facility Policy>According to the facility's 09/18/2025 revised Food Temperature Policy, the facility would record food temperatures daily to ensure food was at the proper serving temperature before trays were assembled. The policy showed potentially hazardous cold food temperatures would be kept at or below 41degrees F. <Facility Lunch Preparation>Observations of the unit kitchen pantry on 09/17/2025 at 12:00 PM showed staff distributing food from the steam table in trays to load the food cart to deliver lunch trays in the hallways. At 12:02 PM, Staff removed a tray with Jello (desert) cups from the pantry refrigerator and started placing the Jello on the trays. Another tray of Jello cups were sitting in the cart on ice, outside the pantry. At that time, Staff I (Dining Services) was asked to check the Jello temperature. Staff I checked the temperature which measured at 45 degrees F. At this same time, Staff J (Registered Dietitian) checked the temperature of the Jello containers sitting on ice in the cart outside the pantry. The temperature of this Jello measured at 50 degrees F.In an interview on 09/17/2025 at 12:57 PM, Staff J stated keeping cold food temperatures below 41 degrees F while serving to residents was important for food safety and reducing the risk of foodborne illness. Staff J stated cold food temperatures should be below 41degrees F when served to residents, but the Jello did not temp below 41 degrees F.REFERENCE: WAC 388-97-2980

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear, and gowns used to prevent exposure to infectious materials) for 3 residents (Resident 46, 7, & 19) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms), ensure staff used appropriate Hand Hygiene (HH) during resident care/resident contact (Staff D - Certified Nursing Assistant - CNA & Staff N - CNA) who were observed for care, and staff failed to provide sanitary practices when delivering meals to residents (Staff N) who were reviewed. These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases.Findings included .<Facility Policy>According to the facility's Enhanced Barrier Precautions policy, revised 12/07/2022, the facility would implement EBP to prevent transmission of multidrug-resistant organisms. The policy showed residents with urinary catheters (tube inserted into the bladder) would be placed on EBPs and gowns and gloves would be made available to staff immediately outside of the resident's room.According to the facility's Hand Hygiene policy, revised 10/01/2022, staff would perform proper HH to prevent the spread of infection to other personnel, residents, and visitors. The policy referred to a HH Table which showed staff would perform HH between resident contacts.<Enhanced Barrier Precautions> <Resident 46> According to the 09/08/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 46 admitted to the facility on [DATE] and had an indwelling urinary catheter (tubing inserted into the bladder to drain urine). Review of a 09/04/2025 nursing progress note showed staff documented Resident 46 admitted to the facility and the resident had a urinary catheter. Observation on 09/15/2025 at 8:56 AM showed Resident 46 sleeping in bed and they had a catheter hooked onto the bed. There was no EBP sign on the resident’s door or a cart inside or outside of the room containing gowns or gloves for staff to put on prior to providing direct care to Resident 46. In an interview on 09/18/2025 at 10:47 AM, Staff C (Infection Control Nurse) stated they expected residents with urinary catheters to be on EBP. Staff C stated a gown, and gloves should be worn for catheter care. <Resident 7> Observation on 09/17/2025 at 7:32 AM showed an EBP sign was posted outside Resident 7’s room instructed staff to wear gown and gloves while providing direct care to Resident 7. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 09/17/2025 at 7:46 AM Staff F (Registered Nurse) entered Resident 7’s room and administered medications via Gastric Tube (tube inserted in the abdominal wall straight to the stomach) without putting on personal protective equipment per direction on EBP signage posted on Resident 7’s door. Staff F stated Resident 7 was on EBP so they should wear a gown, mask, and gloves when providing all cares for Resident 7 but did not. Staff F stated they were expected to, and it was important to follow precaution signs for infection prevention when caring for residents. In an interview on 09/17/2025 at 8:34 AM Staff B (Director of Nursing) stated they expected staff to follow EBP per physician orders. Staff B stated it was important to follow EBP for residents that require precautions to ensure staff are not spreading infections to the vulnerable residents. <Resident 19> According to the 06/19/2025 admission 5 Day MDS, Resident 19 admitted to the facility on [DATE] and had an indwelling catheter in their bladder. Observation on 09/14/2025 at 8:32 AM showed an EBP sign was posted outside Resident 19’s room instructed staff to wear gown and gloves while providing direct care to Resident 19. Observation on 09/14/2025 at 9:02 AM showed Resident 19 was sitting in a wheelchair in their room and indwelling catheter bag was hanging under their wheelchair full of urine. Observation on 09/14/2025 at 9:38 AM showed Resident 19 was sitting in a wheelchair in their room and Staff R (CNA) was emptying Resident 19’s catheter bag, was not wearing a gown as instructed on the posted sign outside Resident 19’s room. In an interview on 09/14/2025 at 9:55 AM, Staff R stated they should wear a gown and gloves while emptying the catheter bag, but they forgot. In an interview on 09/17/2025 at 11:02 AM, Staff B stated their expectations from staff to follow the signs outside resident’s rooms to prevent spreading infections. Staff B stated Resident 19 had an indwelling catheter and EBP sign was posted outside the room. The staff should wear gown and gloves while taking care of Resident 19’s catheter bag, but they did not. <Hand Hygiene> <Staff D> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the lunch service on 09/14/2025 at 12:38 PM showed staff delivering all meal trays to resident rooms due to the facility being in a Covid (respiratory infection) outbreak. Staff D was observed delivering a lunch tray to the resident in room [ROOM NUMBER]. Staff D placed the lunch tray on the over-the-bed table and removed a used coffee cup from the table. Staff D left the room with the coffee cup, touching the lid of the cup, took it to the pantry, and set the cup on top of a cart that held meal trays to be delivered. Staff D put their hands in their pockets while waiting for a new cup of coffee. The pantry staff handed Staff D a fresh cup of coffee and delivers it to room [ROOM NUMBER]. Staff D did not perform HH. At 12:41 PM, Staff D returned to the pantry, did not perform HH, took a lunch tray from the pantry staff and delivered the tray to room [ROOM NUMBER]. Staff D moved a cup of water on the resident’s over-the-bed table and set the tray down. Staff D did not perform HH between the two resident rooms and after touching items in the rooms. In an interview on 09/18/2025 at 10:49 AM, Staff C stated it was their expectation staff performed HH prior to delivering meal trays and upon exiting the resident’s room after delivering a meal tray. <Staff N> Observation and interview on 09/14/2025 at 12:38 PM showed Staff N pass a lunch tray to a resident’s room, set the resident up and then exit the room without performing HH. Staff N collected another meal tray from the on-unit pantry and delivered it to another resident room. Staff N stated they were expected to perform HH between residents but forgot to. Staff N stated it was important to perform HH between resident’s care for infection prevention. <Sanitary Practices> <Staff N> Observation and interview on 09/14/2025 at 12:52 PM showed Staff N getting a mustard packet for a resident request. Staff N dropped the mustard packet on the floor of the main dining room and picked it up and delivered it to the resident without washing it off or getting a new one. Staff N stated they shouldn’t deliver the mustard packet that fell on the floor to the residents for infection prevention. Reference: WAC 388-97-1320(1)(a), (2)(b).