STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505530	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington State Walla Walla Veterans Home	92 Wainwright Drive Walla Walla, WA 99362

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939 Based on observation, interview and record review, the facility failed to conduct a complete and thorough assessment for self-administration of medications for 1 of 2 residents (Resident 39) reviewed for safe self-medication administration. This deficient practice placed residents at risk for medication errors and adverse medication interactions. Findings included . Review of the facility policy, dated December 2012, titled Administering Medications showed residents were able to self-administer their medications once the resident was assessed by the Interdisciplinary Care Planning Team, including the physician, and determined to have the decision-making capacity to do so safely. <Resident 39> Review of the medical record showed Resident 39 admitted to the facility on [DATE] with diagnoses of chronic lung disease, heart disease, and dizziness. Review of the comprehensive assessment, dated 11/21/2024, showed Resident 39 had an intact cognition and required the assistance of one person for Activities of Daily Living (ADLs). During a concurrent observation and interview, on 12/13/2024 at 8:07 AM, Staff U, Registered Nurse, was providing medication administration assistance to Resident 39 when they noted an over the counter (OTC) bottle of Vitamin D 800 International Units [(IU) unit of measure] supplement at the resident's bedside. Staff U asked Resident 39 if they had been self-administering their Vitamin D supplement. Resident 39 stated yes, they had, and asked Staff U, how many times a day am I supposed to take it? Two or three? Staff U told Resident 39 they would obtain clarification on the directions for their Vitamin D Supplement. Staff U did not remove the bottle of Vitamin D supplement from Resident 39's bedside. During a follow-up interview, on 12/13/2024 at 8:12 AM, Staff U stated they were unaware Resident 39 was self-administering the Vitamin D supplement. Staff U stated Resident 39's record showed they self-administered their prescribed inhalers for chronic lung disease, and they were unaware of any other medications Resident 39 kept at their bedside. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Self-Medication Administration Assessment, completed on 11/13/2024, showed Resident 39 was safe and capable of self-administering the following medications: prescription mouth wash, OTC muscle rub (topical cream used to relieve sore muscles), respiratory inhalers, calcium with Vitamin D supplements, and as needed Meclizine (a medication given to relieve dizziness and nausea). Review of the physician's orders for Resident 39 showed, as of 12/13/2024, the orders for Vitamin D supplement and Meclizine did not include a directive for Resident 39 to self-administer the medications or keep it at their bedside. Review of Resident 39's comprehensive care plan showed no goals or interventions for self-medication administration. During an interview, on 12/16/2024 at 1:00PM, Staff B, Director of Nursing (DNS), stated the process for residents to self-administer their medications included a complete and thorough assessment to determine if the resident was capable and safe, education provided regarding the medication directions and its use, an order from the physician, and a care plan to direct staff on how to support the resident. After reviewing Resident 39's medical record, Staff B stated the process for self-medication administration for Resident 39 was not followed. Reference: WAC 388-97-0440

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45939 Based on observation, interview and record review, the facility failed to provide an environment that reflected the physical needs and preferences of 1 of 2 residents (Resident 6) reviewed for accommodation of needs. This deficient practice placed the resident at risk for a diminished quality of life and increased dependence on staff. Findings included . <Resident 6> Review of the medical record showed Resident 6 admitted to the facility on [DATE] with diagnoses of chronic kidney disease, chronic lung disease and muscle weakness. Review of the comprehensive assessment, dated 09/30/2024, showed Resident 6 had intact cognition, required the assistance of two people for transfers, toileting, and used an electric wheelchair for mobility. During a concurrent observation and interview, on 12/10/2024 at 11:33 AM, Resident 6 stated they were unable to access things on the side of their bed that was near the window. There was a pathway of less than two feet between Resident 6's bed and desk, and Resident 6 stated they would like to access and clean off their bulletin board (which hung in the window in front of the desk). Resident 6 stated their current room arrangement was not a set up that allowed them access. During a concurrent observation and interview, on 12/11/2024 at 2:35 PM, Resident 6 demonstrated their inability to maneuver their electric wheelchair around the end of their bed to access their desk. Resident 6 was able to reach the nearest corner of the desk but was unable to roll up to the desk to appropriately sit at the desk. Observations showed all items on the desk, including the bulletin board and all furniture to the left of the desk, were inaccessible to Resident 6. Resident 6 stated they asked their family to clear off the bulletin board, as they were unable to do so themselves, so they may hang up Christmas cards they receive. During an interview, on 12/13/2024 at 1:30 PM, Staff E, Psychiatric Social Worker, stated they assisted with the planned use of furniture for the residents when they admitted , but it was not their process to follow up with residents on their furniture needs after admission. Staff E stated they relied on the resident or staff for an adjustments of their furnture needs. During an interview, on 12/13/2024 at 2:30 PM, Staff V, Registered Nurse (RN), stated they had not noticed Resident 6's inability to access their desk or bulletin board and they relied on the residents or their families to request any accommodations. During an interview, on 12/16/2024 at 10:45 AM, Staff W, Resident Care Manager (RCM) stated they were unaware Resident 6 was unable to access areas in their room. Staff W stated they relied on the residents or their representatives to request an accommodation of needs. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/16/2024 at 12:30 PM, Staff B, Director of Nursing (DNS), stated they were unaware Resident 6 could not access areas in their room. Staff B stated the expectation was for staff to observe and report issues and/or concerns regarding residents' environment. Staff B stated Resident 6 should have access to all areas of their room. Reference: WAC 388-97-0860 (2)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on interview and record review, the facility failed to ensure accuracy for the Pre-Admission Screening and Resident Review [(PASARR) a federally required form that is used to help ensure individuals were not inappropriately placed in nursing homes for long term care] and Level II comprehensive evaluations were obtained for 2 of 6 residents (Resident 10 and 70) reviewed for PASARR. This failure placed residents at risk for not receiving necessary mental health care and services. Findings included . <Resident 10> Resident 10 was admitted to the facility with diagnoses including major depressive disorder (MDD - a mood disorder of persistent feelings of sadness, loss of interest, changes in sleep affecting how a person feels, thinks and behaves), dementia (a progressive disease that destroys memory and other important mental functions), anxiety, and hallucinations. The 09/27/2024 comprehensive assessment showed Resident 10 was dependent on one to two staff members for activities of daily living (ADLs) and had a severely impaired cognition. Review of Resident 10's PASARR, updated 10/16/2023, showed the resident had serious mental illness indicators of MDD, anxiety, and hallucinations and a diagnosis of dementia. The form showed a Level II Behavioral Health Assessment was not indicated. <Resident 70> Resident 70 was admitted to the facility on [DATE], with diagnoses including anxiety, insomnia (difficulty falling asleep and/or staying asleep), and dementia. On 04/02/2024, Resident 70 was diagnosed with MDD. The 09/12/2024 comprehensive assessment showed Resident 70 required substantial/maximal assistance of one to two staff members for ADLs and had a severely impaired cognition. Review of Resident 70's PASARR, completed on 03/08/2024, showed the resident had a serious mental illness indicator of anxiety and a diagnosis of dementia. The form showed a Level II Behavioral Health Assessment was not indicated. Additional review showed Resident 70 did not have an updated PASSAR that included the diagnosis of MDD and the need for the required Level II Behavioral Assessment. During an interview on 12/16/2024 at 11:55 AM, Staff D, Psychiatric Social Worker, stated the process for updating PASSAR's included a quarterly review, when a resident had a significant change, and/or a new diagnosis in physical or mental conditions. Staff D stated Resident 10 should have had an updated PASSAR and sent for a Level II Behavior Health Assessment evaluation based on the resident's diagnoses. Staff D further stated Resident 70 should have had a new PASSAR completed when they were diagnosed with a new serious mental illness indicator of MDD and then sent for a Level II Behavioral Assessment evaluation. Reference WAC: 388-97-1975(1)(4)(9)

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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** 45939 Based on interview and record review, the facility failed to review and revise the care plan related to urinary tract infection (UTI) treatment and prevention for 1 of 3 residents (Resident 17) review for care plan accuracy and revision. This deficient practice placed residents at risk for unmet and unidentified care needs. Findings included . <Resident 17> Review of the medical record showed Resident 17 was admitted to the facility on [DATE] with diagnoses of neuromuscular dysfunction of the bladder (a condition that occurs when the nerves and muscles of the urinary system are damaged, resulting in bladder control issues), diabetes (disease that occurs when body is unable to regulate the amount of sugar in the blood), and presence of a suprapubic catheter (a tube that's inserted into the bladder through a small incision in the lower abdomen to drain urine). Review of the comprehensive assessment dated [DATE] showed Resident 17 had moderate cognitive impairment and required the assistance of one person for Activities of Daily Living (ADLs) including catheter care. Review of Resident 17's care plan showed the focus area relating to the suprapubic catheter and history of UTIs and the goal for Resident 17 to show no signs or symptoms of UTI was initiated on 08/15/2023 Review of the interventions in place to meet the goal were last revised and/or added on 11/13/2023. Review of the medical record showed Resident 17 was treated for UTIs with antibiotic (medications used to treat infections caused by bacteria) on 03/11/2024, 07/10/2024, 10/04/2024, and 11/16/2024 (a total of four times in the last year.) During an interview, on 12/16/2024 at 10:30 AM, Staff W, Resident Care Manager (RCM), stated they were aware Resident 17 developed UTIs, but did not realize the frequency they were being treated for infections. Staff W stated it was a part of the interdisciplinary team's responsibility to review recurring issues and identify new or revised goals and interventions for the resident. Staff W stated this process had not been completed in relation to Resident 17's frequent UTIs. During an interview, on 12/16/2024 at 11:45 AM, Staff C, Infection Control Registered Nurse (ICRN), stated they were aware Resident 17 had been treated for UTIs frequently, and they had not completed a deep dive into the cause of them. Staff C stated they had provided the nursing staff with infection control education in a general form, and education regarding UTIs and catheter care had not been provided. Staff C stated the nursing team was responsible for identifying areas on the residents' care plans that needed revision and updating, and it did not appear that process was followed regarding Resident 17's UTIs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 12/16/2024 at 12:05 PM, Staff B, Director of Nursing Services, stated it was a collaborated effort of the nursing team to revise and update care plans. Staff B stated this was recurring UTIs would be a concern that needed a deeper look and this did not happen regarding Resident 17. Reference: WAC 388-97-1020 (5)(b)

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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** 45939 Based on observation, interview, and record review the facility failed to comprehensively assess and determine potential causative factors for recurrent urinary tract infections (UTIs) and provide UTI treatment consistent with professional standards of practice for 1 of 3 residents (Resident 17) reviewed for continuous urinary catheter (a flexible tube that inserted into the bladder to drain urine) use. This deficient practice placed residents at risk of unnecessary UTIs, antibiotic (medication used to fight infections caused by bacteria) use and delays in UTI treatment. Findings included . <Resident 17> Review of the medical record showed Resident 17 was admitted to the facility on [DATE] with diagnoses of neuromuscular dysfunction of the bladder (a condition that occurs when the nerves and muscles of the urinary system are damaged, resulting in bladder control issues), diabetes (disease that occurs when body is unable to regulate the amount of sugar in the blood), and presence of a suprapubic catheter (a tube that's inserted into the bladder through a small incision in the lower abdomen to drain urine). Review of the comprehensive assessment, dated 09/26/2024, showed Resident 17 had a moderate cognitive impairment and required the assistance of one person for Activities of Daily Living (ADLs) including catheter care. During an observation, on 12/09/2024 at 12:45 PM, Resident 17 was sitting in the recliner in their room and their urinary drainage bag (a bag attached to the urinary catheter to collect the urine drained from the bladder) was placed in a basin on the floor next to the chair (appropriately below the level of the bladder for drainage). The urinary bag had yellow urine inside and large pieces of mucous with sediment (solid material pieces) was observed in the tubing. There was a strong odor of urine in the room, but no indication of leakage from the urinary catheter or drainage bag. During an interview, on 12/09/2024 at 1:15 PM, Resident 17 stated they had been treated for a UTI on several occasions and their suprapubic catheter leaked frequently around the insertion site. Record review showed a urine sample was collected on 03/11/2024 and the resulted urine culture, dated 03/14/2024, showed the presence of Proteus mirabilis (the specific bacteria). Antibiotic treatment was initiated on 03/11/2024 (three days before the resulted culture was available). Record review showed a urine sample was collected on 07/03/2024 and the resulted urine culture, dated 07/08/2024, showed the presence of Proteus mirabilis. Antibiotic treatment was initiated on 07/10/2024 (two days after the resulted culture was available). Record review showed a urine sample was collected on 09/25/2024 and the resulted urine culture, dated 09/30/2024, showed the presence of Proteus mirabilis. Antibiotic treatment was initiated on 10/04/2024 (four days after the resulted culture was available). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed a urine sample was collected on 11/10/2024 and the resulted urine culture, dated 11/13/2024, showed the presence of Proteus mirabilis. Antibiotic treatment was initiated on 11/16/2024 (three days after the resulted culture was available). During an interview, on 12/16/2024 at 10:30 AM, Staff W, Resident Care Manager (RCM), stated the facility's process was to notify the medical provider with urgent lab results, and completed urine cultures were not considered urgent. Staff W stated the medical provider would initiate new orders electronically when they had reviewed the resulted non-urgent labs. Staff W stated resulted urine cultures showing bacterial growth was considered abnormal and should be reviewed with the medical provider right away. During an interview, on 12/16/2024 at 11:45 AM, Staff C, Infection Control Registered Nurse (ICRN), stated the facility's medical provider had directed nursing staff to notify them via phone with urgent lab results and they would review other labs, including urine cultures at their next convenience. Staff C stated they were aware Resident 17 had several UTIs this year, and they had not completed a deep dive into the cause of them. Staff C further stated they had not provided infection control and prevention education for suprapubic catheter care. During an interview, on 12/16/2024 at 12:05 PM, Staff B, Director of Nursing Services (DNS), stated they were unaware the Licensed Nurses had been informed that resulted urine cultures were not considered urgent lab results that required a review timely. Staff B stated the process was to call the medical provider right away when abnormal lab results, including resulted urine cultures with bacterial growth, were available. Staff B stated the expectation for initiating antibiotic treatment for UTIs was right away. During an interview, on 12/16/2024 at 1:11 PM, Staff A, Administrator, stated the expectation was for a UTI treatment to be initiated as soon as possible, and no delay is acceptable. Reference: WAC 388-97-1060 (3)(c)

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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** 45939 Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted standards of practice for 2 of 2 residents (Resident 17 and 6) reviewed for respiratory care related to CPAP (Continuous Positive Airway Pressure) and BiPAP [(Biphasic Positive Airway Pressure) medical devices used to maintain an open airway while sleeping] use. This deficient practice placed residents at risk for respiratory status complications and potentially contributed to a recently treated sinus infection for Resident 17. Review of the facility policy, titled CPAP /BiPAP Support showed device pieces such as mask and tubing were to be cleaned with soap and water daily, and the filter and water chamber cleaned weekly. <Resident 17> Review of the medical record showed Resident 17 admitted to the facility on [DATE] with diagnoses of sleep apnea (a sleep disorder that causes breathing to repeatedly stop and start while asleep), diabetes (a disease resulting from the body's inability to process sugar effectively), and heart failure. Review of the comprehensive assessment, dated 09/26/2024, showed Resident 17 had moderate cognitive impairment and required the assistance of one person for Activities of Daily Living (ADLs). During a concurrent observation and interview, on 12/09/2024 at 12:10 PM, Resident 17's BiPAP machine with tubing and mask were laying on top of bed. The mask had areas of oil like white residue in places and the water chamber was filled hallway. Resident 17 stated they use their BiPAP mask every night while sleeping and staff clean their BiPAP mask and tubing sometimes, but not every day. An observation, on 12/11/2024 at 10:04 AM, showed Resident 17's BiPAP machine with tubing and mask were laying on top of their bed. The water chamber had water condensation on the sides and water level was empty. The mask had smears of an oily substance. An observation, on 12/12/2024 at 11:57 AM, showed Resident 17's BiPAP machine with tubing and mask were on top of the resident's bed. An observation, on 12/13/2024 at 1:10 PM, showed Resident 17's BiPAP machine on the bed, the tubing and mask next to it, and smears of oily residue inside of the mask. Review of the medical record showed Resident 17 was evaluated by the facility provider on 11/11/2024 for nasal congestion and drainage and was prescribed an antibiotic (a medication that kills bacteria) for treatment of a bacterial sinus infection. <Resident 6> Review of the medical record showed Resident 6 admitted to the facility on [DATE] with diagnoses of chronic kidney disease, chronic lung disease and muscle weakness. Review of the comprehensive assessment, dated 09/30/2024, showed Resident 6 had intact cognition, required the assistance of two people for transfers, toileting, and used an electric wheelchair for mobility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 12/10/2024 at 11:43 AM, Resident 6's CPAP machine was on the beside table with tubing and mask placed on top of the machine. The water chamber was filled halfway. Resident 6 stated the staff used to clean the machine frequently, but it had not been cleaned in a long time. Resident 6 stated their family provided a device used to clean the parts of a CPAP machine, but it sits on the bottom shelf, and no one ever uses it. During a concurrent observation and interview, on 12/11/2024 at 2:24 PM, Resident 6's CPAP machine was on the bedside table with mask and tubing laying on top. The water chamber showed condensation drops on the sides and the water level was below the lowest level measurement. Resident 6 stated staff had not cleaned the CPAP mask or tubing today. An observation, on 12/12/2024 at 10:50 AM, showed Resident 6's CPAP machine was on the bedside table with mask and tubing connected to the machine, hanging off the side of the table. The water chamber was filled halfway. An observation, on 12/13/2024 at 12:15 PM, showed Resident 6's CPAP machine on the bedside table with mask and tubing connected to the machine. The mask had a small amount of white, oily residue on the inside. During an interview, on 12/13/2024 at 3:17 PM, Staff AA, Nursing Assistant (NA) stated the NAs were responsible for rinsing CPAP and BiPAP masks and tubing daily, washing the masks and water chamber weekly, and change the filter monthly. Staff AA stated it was important to keep the machine and their parts clean, especially for the residents who wear them regularly. During an interview, on 12/13/2024 at 3:20 PM, Staff V, Registered Nurse (RN), stated the NAs were responsible for the day-to-day care of the CPAP and BiPAP machines. Staff V stated it was not their process to verify the cleaning tasks were completed. During an interview, on 12/16/2024 at 10:30 AM, Staff W, Resident Care Manager (RCM), stated the NAs were responsible for cleaning the CPAP and BiPAP machines, but was uncertain of the specific frequency. Staff W stated they recalled being informed of Resident 6's family providing a device for cleaning their CPAP machine parts, but they never followed up on it. During an interview, on 12/16/2024 at 12:15 PM, Staff C, Infection Control Registered Nurse (ICRN), stated the NAs were responsible for regular cleaning of the CPAP and BiPAP machines and parts. After reviewing the NAs tasks in Resident 17 and Resident 6's medical record, Staff C stated the directions for cleaning did not match the facility's policy. Staff C stated cleaning the CPAP and BiPAP machines and parts was significant infection control practices. During an interview, on 12/16/2024 at 12:30 PM, Staff B, Director of Nursing Services (DNS), stated the NAs were responsible for the routine cleaning of the CPAP and BiPAP machine and parts. Staff B stated regular cleaning of these were important to maintain respiratory health, and the expectation was for the cleaning to be done per facility policy. Reference: WAC 388-97-1060 (3)(j)(vi)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to prepare palatable, appetizing, and appealing meals for 8 of 15 residents (Resident 78, 48, 46, 39, 6, 20, 71, and 38) who voiced concerns regarding food quality during a Resident Council (a group of residents from each of the neighborhoods who meet to discuss and address concerns) meeting and other interviews. This deficient practice placed residents at risk for dissatisfaction with the food, a diminished dining experience and the potential for less than adequate nutritional intake. Findings included . Review of the facility document, titled Resident Council Minutes September 2024, showed meeting minutes documented multiple complaints regarding the food quality including the food needed more taste. Review of the facility document, titled Resident Council Minutes October 2024, showed complaints of food quality including reports of cold food. <Resident 78> Review of the medical record showed Resident 78 admitted to the facility on [DATE], and the comprehensive assessment, dated 11/20/2024, showed they had an intact cognition. During an interview, on 12/09/2024 at 2:40 PM, Resident 78 stated their diet was vegetarian, and the facility did not offer many options for this diet. Resident 78 stated the alternate offered to them instead of the menu meal at lunch and dinner was most often a baked potato and green salad. Resident 78 stated the cooks did not show a high skill level or critical thinking to create other alternatives. <Resident 48> Review of the medical record showed Resident 48 admitted to the facility on [DATE], and the comprehensive assessment, dated 10/21/2024, showed they had a moderately impaired cognition. During an interview, on 12/09/2024 at 3:28 PM, Resident 48 stated they did not like how most of the food was prepared because it has no flavor. <Resident 46> Review of the medical record showed Resident 46 admitted to the facility on [DATE], and the comprehensive assessment, dated 10/07/2024, showed they had a moderately impaired cognition. During an interview, on 12/09/2024 at 3:42 PM, Resident 46 stated the food is no good and they had discussed this with the dietician. Resident 46 stated they would prefer more plant-based alternatives. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 39> Review of the medical record showed Resident 39 admitted to the facility on [DATE], and the comprehensive assessment, dated 11/21/2024, showed they had an intact cognition. During an interview, on 12/10/2024 at 9:38 AM, Resident 39 stated some of the food served at the facility does not taste good and the vegetables were usually overcooked. <Resident 6> Review of the medical record showed Resident 6 admitted to the facility on [DATE], and the comprehensive assessment, dated 09/30/2024, showed they had an intact cognition. During an interview, on 12/10/2024 at 10:46 AM, Resident 6 stated they did not like a lot of the food because it did not taste good. Resident 6 stated the facility serves a lot of chicken and they would like to see more of a variety. <Resident 20> Review of the medical record showed Resident 20 admitted to the facility on [DATE], and the comprehensive assessment, dated 09/06/2024 showed they had a moderately impaired cognition. During an interview, on 12/10/2024 at 12:57 PM, Resident 20 stated .the food doesn't have any flavor, and they provided their own condiments to help with palatability. During a Resident Council meeting, on 12/11/2024 at 11:14 AM, residents gathered to discuss concerns regarding quality of care and quality of life at the facility. The following concerns regarding the facility's food quality were stated during interviews: Resident 71 stated the facility serves .too many heats and eats (meals made of processed and/or frozen foods) .which is not healthy. Resident 71 stated, our meals are full of preservatives, and we shouldn't have to eat that stuff. Resident 38 stated the facility serves canned fruit instead of fresh, and they had recently been served canned pineapple pieces on their warm breakfast plate. Resident 38 stated, fruit like that should be served cold. During an interview, on 12/12/2024 at 1:36 PM, Staff E, Dietary Manager (DM), stated residents had complained about the lack of flavor in the food. During an observation, on 12/13/2024 at 12:21 PM, the posted meal for lunch was fish, fries, and mixed vegetables. A test tray was provided with the regular meal and an alternative meal. The regular meal plate showed a breaded fish fillet, previously frozen and white in color, with the breading layer being moist and soggy from sitting in vegetable water. The vegetables were previously frozen cauliflower, green beans, lima beans, and zucchini with an overcooked texture (mushy). The French fries were previously frozen, undercooked (cool to touch and grainy texture) and white in color. The alternative meal was a hamburger patty on a bun and a side salad (served on a warm plate). The lettuce in the salad was wilted and the tomato was warm to touch. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 12/13/2024 at 12:37 PM, Staff E stated meal preparation should be done an hour before mealtime and plated 30 minutes before serving out. Staff E confirmed the test tray did not look appealing, and the regular menu meal was comprised of all previously frozen foods and were considered dull in color. Staff E stated the breaded fish should not have been served on the plate with excess moisture (from the vegetables), and the side salad should not have been served on a warm plate. Reference: WAC 388-97-1100 (1), (2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45642 Based on observation, interview, and record review, the facility failed to ensure staff followed proper food handling and storage practices for 2 of 3 residents' (Resident 20 and 72) personal refrigerators and 2 of 3 dining areas ([NAME] House and Cayuse House) reviewed for food safety. The failure to obtain and record refrigerator temperatures and store residents' personal condiments based on manufacturers' recommendations placed residents at risk for consuming expired food and food borne illness. Findings included . Review of the facility policy, titled Resident Personal Food Storage, dated [DATE], showed all refrigeration units would have an internal thermometer to monitor for safe food storage temperatures and residents' personal refrigerators would be monitored by designated staff for food safety. Review of the Food and Drug Administration, Food Safety Code 2022, dated [DATE], showed food products that are packaged are not all shelf-stable and must be refrigerated. If not, temperature controlled could cause bacterial growth. Therefore, special controls are in place to assist consumers to control bacteria growth: a label statement Must be Refrigerated on a food product, and refrigeration temperature guidelines of 41 degrees Fahrenheit (a unit of measure for temperature) or less as a barrier to bacteria growth. Additionally, continous monitoring of temperatures and visual examination to verify refrigeration temperatures are important. <Dining Tables> During an observation, on [DATE] at 11:27 AM, Table One, in the [NAME] House, had tray of opened condiments including: a bottle of teriyaki marinade--half used (on the bottle showed must be refrigerated after opening), a bottle of [NAME] barbeque sauce--more than half used (on the bottle showed must be refrigerated after opening), a bottle of A1steak sauce-- a third of the bottle used (the bottle showed must be refrigerated after opening), a bottle of Heinz 57 sauce--more than half used (the bottle showed must be refrigerated after opening). During a concurrent observation and interview, on [DATE] at 12:29 PM, Resident 20 was sitting at Table One with the tray of opened condiments within reach Resident 20 stated all of the condiments on the tray at Table One belonged to them, and they have let other residents use them occasionally. During an interview, on [DATE] at 11:30 AM, Staff P, Nursing Assistant (NA), stated the condiments on the tray of Table One belonged to Resident 20 who resided in the [NAME] house, and they were particular about their condiments. Staff P stated in the Cayuse house, the condiments on Table Two belonged to Resident 37. Staff P stated the condiments stay on the dining tables all the time. During an observation, on [DATE] at 8:42 AM, Table Two in the Cayuse house had a tray of opened condiments including: a new bottle of ketchup, a bottle of tabasco sauce, a bottle of Heinz 57 sauce-- half used (the bottle showed refrigerate after opening), a bottle of Worcestershire sauce--half used (the bottle showed refrigerate after opening). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on [DATE] at 8:53 AM, Table One in the [NAME] House, had the same tray of opened condiments accessible by any resident. During an observation, on [DATE] at 8:02 AM, Table Two in the Cayuse house had the same tray of opened condiments accessible by any resident. <Personal refrigerators> During an observation, on [DATE] at 8:45 AM, showed a personal refrigerator in Resident 20's room had an unopened bottle of Coca-Cola, a bag of chocolate candy, two bananas, an orange and a thermometer. There was no temperature log record available in the room for review. During an observation, on [DATE] at 8:59 AM, showed a personal refrigerator in Resident 1's that had three bottles of vanilla Ensure (a nutritional meal replacement shake), an orange, an unopened chocolate candy bar, and a thermometer. There was no temperature log record available in the room for review. During an observation, on [DATE] at 8:35 AM, showed a personal refrigerator in Resident 72's room with an open butter packet, a banana, and two chocolate Ensures. There was no thermometer inside the refrigerator and no temperature log record available for review. During an interview, on [DATE] at 7:53 AM, Staff M, NA, stated they were responsible for cleaning the personal refrigerators such as throwing away expired food and wiping them out. Staff M stated Their process did not include monitoring or recording refrigerator temperatures, and they were unsure of who was responsible for this. During an observation, on [DATE] at 8:01 AM, a refrigerator in Resident 1's room had three Ensure drinks, two apples and a brown banana. There was no thermometer inside refrigerator and no temperature log records available for review. During an interview, on [DATE] at 8:06 AM, Staff U, Registered Nurse (RN), stated they were aware that residents were allowed to have a refrigerator. Staff U stated they were unsure who monitored the personal refrigerators. Staff U stated they had not seen a temperature monitoring log for the personal refrigerators. During an interview, on [DATE] at 8:10 AM, Staff Y, RN, stated monitoring of the personal refrigerators was done by the NAs. Staff Y stated the NAs clean the refrigerators out once a month and monitor the temperatures. Staff Y stated they were not sure if they document the temperatures. During an interview, on [DATE] at 8:30 AM, Staff Z, NA stated some residents have refrigerators, and if they saw something was wrong with the refrigerator they would make a work order to have them checked. Staff Z stated they did not clean the refirgerators or monitor the temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on [DATE] at 1:36 PM, Staff E, Dietary Manager stated most residents have a refrigerator in their room, and they highly encouraged residents to have one so they could have things from home. Staff E stated that the kitchen staff were not responsible for the personal refrigerators and that the NAs check them for the residents. Staff E further stated Resident 20 had trouble with the flavor of the food and the solution was to have the tray of condiments available to them. Staff E stated they periodically checked the tray to identify if there was something that needed to be thrown away or placed in the refrigerator. Staff E stated they were not aware of condiments that needed to be in the refrigerator, and they had not checked the condiments in a couple of weeks. During an interview, on [DATE] at 12:41 PM, Staff K, Resident Care Manager, stated they were unsure why there were condiments kept on the table and that they did not realize some of the condiments needed to be refrigerated. Staff K stated that the process for the condiments needed to be fixed. Staff K stated that the personal refrigerators were cleaned and monitored by nursing staff. Staff K stated they were unaware that the personal refrigerator temperatures were not being monitored or documented. Reference: WAC [DATE] (3)

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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** 46722 Based on observation, interview, and record review, the facility failed to ensure staff followed infection prevention and control measures for the use of Personal Protective Equipment (PPE) and hand hygiene with contact enteric precautions (safety measures used by healthcare workers to prevent the spread of infectious agents that pose an increased risk for transmission through direct or indirect contact) for 6 of 7 staff (Staff G, H, I, L, J, and K) reviewed for infection control. These failures placed residents, staff, and visitors at risk of exposure and cross contamination of an infectious disease. Findings included . Review of the 08/03/2023 Washington State Department of Health guidance titled, Contact Enteric Precautions, showed prior to entering a room of a Clostridioides Difficile [(C-diff), a highly contagious bacterium that causes diarrhea and inflammation of the colon], resident, staff were required to perform hand hygiene, don (put on) an isolation gown, secure the straps/ties, and don gloves. The guidance further showed, upon exit from the room, all staff were to doff (remove) gloves and gown, and wash hands with soap and water. <Resident 7> Resident 7 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Parkinson's disease (a progressive movement disorder that causes tremors, stiffness, and impaired balance), and heart and kidney failure. The 10/08/2024 comprehensive assessment showed Resident 7 required one to two staff members for toileting, bathing, and transfers. The assessment also showed Resident 7 had a moderately impaired cognition. An observation and interview on 12/09/2024 at 11:28 AM, showed a sign posted outside Resident 7's room titled, Contact Enteric Precautions, and everyone who entered Resident 7's room were to perform hand hygiene, don an isolation gown and secure the ties/straps, don gloves, and use soap and water when exiting the room. Below the sign was a PPE cart with gloves, gowns, and masks for use. Staff F, Nursing Assistant (NA), stated all staff were required to follow the signage as Resident 7 currently had C-diff. An observation on 12/10/2024 at 9:44 AM, showed Staff G, NA, obtain a gown and gloves without performing hand hygiene. Staff G donned the gloves and gown without securing the gown behind their back. Staff G entered Resident 7's room and assisted with eating and transfer from their wheelchair to their recliner. Staff G's gown was consistently falling forward onto the resident when they bent over during cares. Upon exit from the room, Staff G removed their gloves and gown and placed them into the trash and used alcohol-based hand sanitizer (ABHS) upon exit. Staff G did not wash their hands with soap and water as required. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 12/11/2024 at 9:31 AM, Staff H, NA, donned a gown, gloves, face mask, and shoe covers, without performing hand hygiene and entered Resident 7's room. Staff H assisted them by arranging their bedside tray table, gathered trash, and put the trash into the trash can. Staff H then removed one glove, gown, and shoe covers and put them into the trash can. Staff H carried the trash with the gloved hand to the soiled utility room, opened the door and placed the trash into a large black trash bin and removed their glove. Staff H used ABHS and did not wash their hands with soap and water as required. Staff H proceeded to the kitchen, obtained a hair net, placed it over their head, donned new gloves, and began washing dishes. An observation on 12/12/2024 at 8:43 AM, showed Staff I, NA, don gloves without performing hand hygiene and enter Resident 7's room without a gown. Staff I returned to the entry of the resident's room, removed their gloves, and put them into the trash. Staff I exited the resident's room without performing hand hygiene and donned new gloves, gown, and face mask, and re-entered the resident's room. Staff I assisted Resident 7 with ambulation and eating. Staff I removed the soiled PPE and placed it into the trash can, used ABHS, and picked up the resident's food tray from the counter in their room. Staff I exited Resident 7's room and placed the tray onto the kitchen counter across the hall. Staff I proceeded to enter the kitchen and wash their hands in the kitchen sink. An observation on 12/13/2024 at 7:41 AM, showed Staff L, NA, don a gown and gloves without performing hand hygiene and enter Resident 7's room. Staff L exited the room while wearing their PPE, reached into the PPE cart, obtained shoe covers, and placed them over their shoes. Staff I reached into the PPE cart a second time, as the shoe covers did not cover their entire shoe and retrieved another pair and put them onto their shoes. Staff L re-entered Resident 7 room and provided care. Upon Staff L's exit they doffed their PPE, placed it into the trash can, used ABHS, proceeded to the kitchen, and washed their hands in the kitchen sink. An observation on 12/13/2024 at 7:59 AM, showed Staff J, Registered Nurse (RN), enter Resident 7's room without reviewing the contact precautions sign or donning PPE. Staff K, RN, stated to Staff J they needed to exit the room and don PPE as the Resident was on precautions for C-diff. Staff J exited the room donned a gown, then used ABHS and donned gloves. Staff J re-entered the room and provided medications to Resident 7. Staff K used ABHS and donned a gown and gloves. Staff K did not secure the gown ties behind their back. Staff K entered the room to assist Staff J with medications for Resident 7. After providing medications to Resident 7, Staff J and Staff K removed their soiled PPE and placed it in the trash can. Both Staff J and Staff K used ABHS and exited the room. Neither Staff J nor Staff K washed their hands with soap and water as required. Staff J returned to the medication cart and prepared medications for another resident. Staff J pushed the medication cart down the hall, donned gloves, and entered the resident's room and provided them their medication. During an interview on 12/16/2024 at 11:00 AM, Staff C, Infection Control Registered Nurse, stated all staff were to use ABHS, then don a gown and gloves prior to entering a resident's room when on isolation precautions. Staff C stated Resident 7 was on contact enteric precautions which required staff to wash their hands with soap and water after removal of PPE. Staff C stated the expectation for all staff was to remove all soiled PPE in Resident 7's room upon exit, use ABHS, and then proceed to the nearest sink, which would be the staff restroom, and wash their hands with soap and water. Staff C stated staff should not have used the kitchen sink to wash their hands after contact with residents on contact enteric isolation. Reference WAC: 388-97-1320(1)(c)(5)(b)