STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505531	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heron's Key	4340 Borgen Blvd NW Gig Harbor, WA 98332

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to ensure married residents were provided the right to share a room for 2 of 2 sampled residents (Residents 1 and 4) reviewed for room changes. This failure placed residents at risk for psychosocial stress and a diminished quality of life. Findings included . Resident 1 Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and heart failure. Resident 1 resided in room [ROOM NUMBER] and was able to make needs known. During an interview on 11/15/2024 at 9:55 AM, Resident 1 stated, I would prefer to share a room with my husband [Resident 212]. We assumed we would be able to, but they said we could not. Review of the care plan dated 09/05/2024 showed Resident 1 was at risk of decreased socialization due to cognitive decline. The care plan stated Resident 1 enjoyed spending time and eating meals with their spouse. Resident 1's recliner was relocated to their spouse's room to spend more time together. Resident 4 Review of the EHR showed Resident 4 admitted to the facility on [DATE] with diagnoses that included depression, dementia and heart failure. Resident 4 resided in room [ROOM NUMBER], required minimal assistance and was able to make needs known. During an interview on 11/15/2024 at 9:52 AM, Resident 4 stated they could not share a room with their spouse (Resident 1) because they were told it was one resident per room. During an interview on 11/15/2024 at 10:33 AM, Staff C, Social Services Coordinator (SSC), stated facility rooms were private and one resident per room. Staff C stated they did not know if two beds would fit in one room; however, they tried to accommodate Resident 1 by moving their recliner to Resident 4's room. (continued on next page)

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 11:00 AM, Staff A, Administrator, stated the facility rooms were single occupancy. Staff A stated Resident 1 or Resident 4 never expressed they wanted to live together; however, they did express they wanted to spend more time together. Reference WAC 388-97-0580(1)(b)(i)(ii)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. 46067 Based on interview and record review, the facility failed to periodically inform residents of their rights after residents were admitted to the facility for 8 of 8 sampled residents (Residents 1, 3, 6, 9, 13, 14, 15 and 16) when reviewed for resident rights. This failure placed residents at risk of not being informed of their rights and a diminished quality of life. Findings included . During an interview on 11/12/2024 at 9:15 AM, Staff A, Administrator (ADM), stated they did not have a Resident Council President. Staff A stated they did not believe there were any residents that attended resident council for the past couple of months. During an interview on 11/15/2024 at 10:00 AM, Resident 3 stated they did not recall discussing or being provided information related to resident rights since they admitted to the facility. During an interview on 11/15/2024 at 9:19 AM, Resident 1 stated they were not aware of the Resident Council, and they were not aware of their resident rights. Review of Resident Council Minutes for August, September and October 2024 showed no residents attended the meetings. Review showed resident rights were not alternatively communicated to residents. During an interview on 11/15/2024 at 10:58 AM, Staff P, Life Enrichment Assistant, stated they did not periodically provide any information on resident rights to residents. During an interview on 11/15/2024 at 11:20 AM, Staff A, Administrator, stated the expectation was that residents were informed at admission and throughout their stay of the resident rights. Staff A stated communication should have been by other means since residents were not attending resident council. Reference WAC 388-97-0280(2), (3)(a-d)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on interview and record review, the facility failed to determine if a resident had current advanced directives (AD), and if not, determine whether the resident wished to develop advanced directives for 1 of 4 sampled residents (Resident 9) when reviewed for AD. This failure potentially denied the resident the opportunity to direct their healthcare if they were to become unable to make decisions or communicate their health care preferences. Findings included . Review of a document titled, Advanced Directives, dated 08/18/2024, showed it was the policy of the facility to respect each resident's AD in accordance with state/federal law and facility policy. The facility's interdisciplinary team would review annually with the resident and/or representative their AD, upon the resident's request, when the residents condition warranted a review, and when there was a significant change in the resident's condition to ensure that such directives were still the wishes of the resident. Review of the admission minimum data set (MDS, a required assessment tool) dated 10/31/2024, showed Resident 9 admitted on [DATE] with multiple diagnoses to include cancer, anemia (a condition where the body does not produce enough red blood cells that can lead to a lack of oxygen in the body), dementia (a group of thinking and social symptoms that interferes with daily functioning), anxiety and depression. The MDS showed the resident was able to make needs known and had a change in condition to reflect being placed on hospice (care provided to people who are near the end of life and have stopped treatment to cure or control their disease). Review of Resident 9's electronic health record (EHR) showed they had no durable power of attorney (a legal document that gives someone the power to act on behalf of the resident if they ever became mentally incapacitated), which indicated the resident was responsible to make their own decisions. The resident's EHR showed an AD last dated for the month of March 2020; however, the residents change in condition on 10/31/2024 showed the MDS documented hospice care and no updated was documented to reflect this in the AD. During an interview on 11/13/2024 at 8:44 AM, Staff C, Social Services Coordinator, stated that the AD was in the chart; however, the form was last updated March 2020. During an interview on 11/13/2024 at 3:15 PM, Staff A, Administrator, stated the facility staff had conducted a recent audit to ensure all residents had a current AD; however, Resident 9 must not have had their records audited to ensure the AD was updated on a yearly basis and that their expectation would be that Resident 9 had a current AD in the EHR. Reference WAC 388-97-0300(3)(b)(c)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide written notification of the reason for transfer to the hospital to residents or responsible party for 1 of 1 sampled residents (Resident 1) reviewed for hospitalization . This failure placed the resident at risk for not knowing rights regarding transfer and discharge from the facility and diminished protection from being inappropriately discharged . Findings included . Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and heart failure. Resident 1 was able to make needs known. Review of Resident 1's EHR showed a hospitalization on [DATE], and readmission to the facility on [DATE]. There was no documentation regarding notice of transfer. During an interview on 11/14/2024 at 11:46 AM, Staff A, Administrator, stated they did not provide residents or resident representatives with written notice for reason of transfer to the hospital. Reference WAC 388-91-0120(2) (a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed to provide written bed hold notice at the time of transfer to the hospital for 1 of 1 sampled residents (Resident 1) reviewed for hospitalization . This failure placed the residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and heart failure. Resident 1 was able to make needs known. Review of Resident 1's EHR showed a hospitalization on [DATE], and readmission to the facility on [DATE]. There was no documentation regarding a bed hold being provided. During an interview on 11/14/2024 at 11:46 AM, Staff A, Administrator, stated they were not offering residents bed holds but should have been. Reference WAC 388-91-0120(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan about post-traumatic stress disorder (PTSD, a mental health condition that can develop after someone experiences or witnesses a traumatic event) for 1 of 8 sampled residents (Resident 6) reviewed for care planning. This failure placed the resident at risk for unidentified and unmet care needs and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 6 admitted to the facility on [DATE] with diagnoses that included PTSD, Parkinson's (a degenerative brain condition that gets worse overtime), dementia (loss of memory, problem solving and thinking abilities) and end of life care. The change of condition minimum data set (MDS, an assessment tool), dated 10/17/2024, showed Resident 6 was not able to make needs known and was dependent on staff for activities of daily living. Observation on 11/12/2024 at 9:45 AM showed Resident 6 with eyes closed, laying in a low bed. During an interview on 11/13/2024 at 2:11 PM, Collateral Contact 1 (CC1), stated Resident 6's behaviors had resolved and they were very weak. CC1 stated Resident 6 had PTSD and had specific triggers that affected them. CC1 stated being a previous [NAME] was Resident 6's identity. Review of Resident 6's EHR showed a care plan with no PTSD focus area, goals, or interventions. During an interview on 11/14/2024 at 2:16 PM, Staff C, Social Service Coordinator, stated they did the trauma assessment and then developed a care plan for each resident that had PTSD. Staff C was not able to locate a care plan that addressed PTSD for Resident 6 and stated it was not acceptable. During an interview on 11/14/2024 at 2:53 PM, Staff B, Director of Nursing Services, stated the expectation was for PTSD to be addressed in the residents' care plans. Reference WAC 388-97-1020(1), (2)(a)(b)

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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** 46067 Based on interview and record review, the facility failed to consistently implement the bowel program when needed for 1 of 5 sampled residents (Resident 15) reviewed for unnecessary medications. These failures placed the residents at risk for discomfort and a diminished quality of life. Findings included . Review of a document titled, Bowel Care Protocol-Standing House Orders dated 10/19/2022 showed a resident would be provided the following: (1) Milk of magnesia (MOM) suspension by mouth daily as needed for constipation. Give at bedtime or at resident preferred time if no bowel movement on 3rd day. (2) Dulcolax suppository as needed for constipation if no results from MOM after 12 hours. (3) Fleet enema every 24 hours as needed for constipation if no results from Dulcolax in four to six hours. (4) If no results from enema notify MD. Review of the electronic health record (EHR) showed Resident 15 admitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure), diabetes and dementia. Resident 15 had impaired communication relating to making self-understood and understanding others. Review of Resident 15's care plan dated 10/21/2024 showed the resident received an antipsychotic medication, and that staff were to observe for any side effects to include constipation. Review of Resident 15's task section in the EHR for bowel movement showed no bowel movement (BM) on 11/06/2024, 11/07/2024, 11/08/2024 and 11/09/2024. The EHR showed documentation that the resident was administered a Dulcolax suppository on 11/09/2024. During an interview on 11/14/2024 at 12:11 PM, Staff B, Director of Nursing Services, stated the expectation was that the facility's bowel protocol should have been implemented within the stated time frame and documented whenever a resident had no BM for three days. Reference WAC 388-97-1060(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 . Based on observation, interview and record review, the facility failed to ensure a safe environment was maintained related to a reclining chair for 1 of 2 sampled residents (Resident 14) and common area appliances were safe from resident use for 2 of 2 common area ovens (East and West) when reviewed for accidents. These failures placed residents at risk for avoidable injuries and a diminished quality of life. Findings included . <Reclining Chair> Review of the electronic health record (EHR) showed Resident 14 admitted to the facility on [DATE] with diagnoses that included left hip pain, muscle weakness and Guilian-Barre Syndrome (a condition in which the body's immune system attacks the nerves). Resident 14 was able to make needs known. Observation on 11/13/2024 at 9:29 AM showed Resident 14 slumped down in a recliner chair located in the corner of their room. Review of Resident 14's EHR showed no safety assessment or informed consent with risks and benefits for the use of a recliner chair. Review of Resident 14's provider's orders showed no order for the use of a recliner chair. During an interview on 11/13/2024 at 11:56 AM, Staff B, Directo of Nursing Services, stated they did not have a process for assessing if the recliners were safe for residents. Staff B stated they would unplug recliners in some resident's room based on their diagnosis. Staff B stated the expectation was that residents with reclining chairs had a provider's order, an initial and quarterly assessment and that risk and benefits would be provided. <Common Area Ovens> Observation on 11/12/2024 at 11:55 AM showed a common area stove on the east side of the building with an out of order sign. The stove had push buttons and was easily accessible for residents to turn on. Observation showed the oven was able to be turned on. Observation on 11/12/2024 at 12:15 PM showed a common area stove on the west side of the building. The stove had push buttons and was easily accessible for residents to turn on. Observation showed the oven was able to be turned on. During an interview on 11/12/2024 at 2:15 PM, Staff A, Administrator, stated the stove units were disconnected and not able to be used. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 11/12/2024 at 2:16 PM, Staff Q, Maintenance Supervisor, stated the electrical panel was distorted; therefore, the ovens did not work. Observation showed Staff Q was able to turn on the stoves in both the east and west common areas. Staff Q stated they were unaware the ovens continued to function and the ovens should have been disable but had not been. Observation on 11/12/2024 at 2:48 PM showed a Defective equipment, out of service sign on both the east and west common area stoves Reference WAC 388-97-1060 (3)(g)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40817 Based on interview and record review, the facility failed to post actual nurse staffing hours for 11 of 11 months reviewed (01/10/2024 through 11/14/2024) when reviewed for nurse staff posting. This failure placed residents and family at risk of not knowing the actual number of staff working within the facility. Findings included . Observation on 11/13/2024 at 11:11 AM showed a Daily Staffing sheet posted at the front of the facility which included a column for staff hours and a second column labeled Changes. Review of the nurse staff posting binder from 01/10/2024 through 11/14/2024 showed no daily staffing forms with any recorded changes in staffing. Review showed nurse staff postings were missing for 04/13/2024 through 04/15/2024 and 04/22/2024 through 04/23/2024. During an interview on 11/14/2024 at 2:31 PM, Staff F, Staffing Coordinator, stated they posted the daily staffing sheets. Staff F stated they did not update the posting with the actual hours worked by staff. During an interview on 11/14/2024 at 3:08 PM, Staff A, Administrator, stated Staff F was responsible for updating the nurse staff posting sheets with the actual hours worked by staff. Staff A stated the lack of actual hours worked by nursing staff on the nurse staff postings did not meet expectation. No Associated WAC

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on interview and record review, the facility failed initiate non-pharmacological interventions prior to the administration of as needed pain medication for 1 of 5 sampled residents (Resident 14) reviewed for unnecessary medications. This failure placed residents at risk for receiving unnecessary medications and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 14 admitted to the facility on [DATE] with diagnoses that included left hip pain, muscle weakness and Guilian-Barre Syndrome (a condition in which the body's immune system attacks the nerves). Resident 14 was able to make needs known. Review of the EHR showed Resident 14 had orders for Tramadol 25 milligrams (MG) and acetaminophen 325 MG to be given as needed for pain. Review of the October 2024 medication administration record (MAR) showed that Resident 14 was provided Tramadol eighteen times and acetaminophen twice; however, there was no documentation that non-pharmacological interventions were provided prior to the administration of the medications. Review of the November 2024 MAR showed that Resident 14 was provided Tramadol six times; however, there was no documentation that non-pharmacological interventions were provided prior to the administration of the medications. During an interview on 11/14/2024 at 11:45 AM, Staff B, Director of Nursing Services, stated the expectation was for staff to provide and document non-pharmacological interventions to all residents who had as needed pain medications. Reference WAC 388-97-1060(3)(k)(i)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40817 Based on observation and interview, the facility failed to sanitarily prepare food in the facility kitchen and failed to monitor resident refrigerators for 1 of 2 resident refrigerators (Front Refrigerator) when reviewed for kitchen. These failures placed residents at risk of consuming contaminated food, foodborne illness, and a diminished quality of life. Findings included . <Kitchen Observation> Observation on 11/13/2024 at 11:25 AM showed a peroxide cleaning spray hanging from food shelfing containing raw bananas and tortillas. Observation on 11/13/2024 at 11:28 AM showed Staff K, Cook, had an uncovered beard and was cutting pieces of pie at a preparation station. Observation on 11/13/2024 at 11:30 AM showed Staff L, Dietary Aide, wore a hairnet over the back portion of the head while leaving the bangs exposed. Observation on 11/13/2024 at 11:40 AM showed a personal cell phone on a shelf above a sandwich making station. A cell phone power cord was hanging over the edge of the shelving and dangling above the opened sandwich making station. Observation on 11/13/2024 at 11:45 AM showed Staff M, Dietary Aide, delivered trays to the main dining room and placed their hands on the legs and in their pockets while conversing with residents. Staff M then re-entered the kitchen and returned to tray service without performing hand hygiene. Observation showed Staff M move to the dining room and back into the kitchen without performing hand hygiene at 11:48 AM. During an interview on 11/13/2024 at 1:03 PM, Staff N, Dining Room Supervisor, stated cleaning supplies should not be stored near food items and the peroxide cleaner should not be hanging over the bananas and tortillas. Staff N stated that hair should be covered and Staff L having their bangs exposed did not meet expectation. Staff N stated beards should be covered once they were a certain length and Staff N was unsure whether Staff K's beard required a hair net. Staff N stated staff should wash their hands after returning from the dining room and Staff M's lack of hand hygiene after going to the dining room did not meet this expectation. Staff N stated staff personal items should be stored near the entrance to the kitchen and not be in the food preparation areas. Staff N stated the phone cord dangling over the sandwich making station did not meet expectation. During an interview on 11/13/2024 at 1:18 PM, Staff A, Administrator, stated cleaning products should not be stored near food items, hairnets should completely cover the hair or beard, personal items should not be in food preparation areas, and staff should perform hand hygiene whenever they returned to the kitchen from the dining area. Staff A stated the facility's kitchen had not met these expectations. (continued on next page)

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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 - Many	<Resident Refrigerator> Observation on 11/13/2024 at 9:34 AM showed the front resident refrigerator contained: (1) A plastic container of noodle salad without labeling, (2) A cardboard container of half-consumed garden salad without labeling, (3) A squeeze style guacamole labeled with Staff O's, Dietary Manager, name and a use by date of 09/09/2024, (4) A squeeze style salsa verde with Staff O's name and no date labeling (Expiration date was worn off), (5) A cardboard cup with a dark brown unidentifiable substance without labeling, (6) A plastic bag with two Tupperware containers of food without labeling, and (7) A jar of blackberry preserve with a use by date of 01/20/2024. During an interview on 11/13/2024 at 1:03 PM, Staff N stated the resident refrigerators' contents were monitored by nursing staff who would ensure items were labeled with a resident's name and date when placed in the refrigerator. Staff N stated food items were thrown away after three days. Staff N reviewed the facility's front resident refrigerator and stated that there were multiple items that needed to be thrown away due to a lack of dating or being over three days old. Staff N stated staff food items should not be stored in resident refrigerators and was unsure why Staff O had stored items in the refrigerator. Staff N stated the refrigerator did not meet their expectation for sanitary food storage. During an interview on 11/13/2024 at 1:18 PM, Staff A stated the resident refrigerators' contents were monitored and thrown away by the dietary staff and they should not contain staff food items. Staff A stated the lack of labeling, food not being thrown out, and staff food items being in the resident refrigerator did not meet expectation. Reference WAC 388-97-1100 (3), -2980

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505531	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heron's Key	4340 Borgen Blvd NW Gig Harbor, WA 98332

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation and interview, the facility failed to ensure a sanitary piece of equipment was available to 1 of 2 sampled residents (Resident 6) reviewed for safe and sanitary environment/equipment. This failure placed the resident at risk for infection and diminished quality of life. Findings included . Review of the electronic health record showed Resident 6 admitted to the facility on [DATE] with diagnoses that included Parkinson's (a degenerative brain condition that gets worse overtime), dementia (loss of memory, problem solving and thinking abilities) and end of life care. The change of condition minimum data set (MDS, an assessment tool), dated 10/17/2024, showed Resident 6 was not able to make needs known and was dependent on staff for activities of daily living. Observation on 11/12/2024 at lunch time showed Resident 6 visiting with their spouse and sitting in their wheelchair in the dining room. The armrests of the wheelchair were covered with multiple layers of black plastic tape and fabric tape and was showing frayed edges that were not a cleanable surface. During an interview on 11/15/2024 at 9:46 AM, Staff E, Central Supply, stated the process was for them to notify a company to come and repair the broken part. When asked about the condition of the armrest of Resident 6's wheelchair, Staff E stated they placed the tape on the armrest as Resident 6 had pulled out the cover from the armrests. Staff E stated the armrests were not a cleanable surface. During an interview on 11/15/2024 at 11:14 AM, Staff B, Director of Nursing Services, stated the expectation was to have wheelchairs in good condition and have cleanable surfaces. Reference WAC 388-97-3220(1)