STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A260	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48899 Based on observation, interview, and record review, the facility failed to provide care and services in a manner that maintained and promoted dignity while assisting with a meal for 1 of 18 residents (Resident 29), reviewed for dining observation. This failure placed the resident at risk for a diminished self-worth and over all wellbeing. Findings included . Review of Resident 29's quarterly minimum data set (an assessment tool) dated 10/03/2024, showed that the resident had moderately impaired cognition. Review of Resident 29's Activities of Daily Living (ADL) care plan, printed on 11/04/2024, directed staff to sit down at Resident 29's eye level when assisting with meals. Observation on 10/31/2024 at 12:04 PM, showed Resident 29 was seated upright in their wheelchair in the dining room with their lunch tray. Resident 29 was observed eating their lunch and dropped food. Further observation showed, Staff O, Attendant Counselor 1 assisted Resident 29 while standing over them. On 10/31/2024 at 12:33 PM, Staff O stated that Resident 29 was halfway through their lunch meal, and they started helping after observing them drop food. Staff O stated that they were not sitting next to Resident 29 while assisting them. Staff O stated that they were not supposed to assist while standing over the resident. Staff O further stated that the facility trained them to assist residents with meals while seated next to them. During an interview and joint record review of Resident 29's ADL care plan on 11/04/2024 at 2:00 PM, Staff P, Attendant Counselor Manager, stated that except for Resident 29, staff must sit when assisting residents with their meals. Staff P stated that Resident 29 used a high wheelchair, making it difficult for staff to sit at their eye level. Staff P stated that Resident 29's care plan specified that staff should not sit whey they assisted Resident 29 with meals. A joint record review of the ADL care plan showed that staff should sit down at Resident 29's eye level when they assist with their meals. Staff P stated the care plan should be updated. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Fircrest Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15th Northeast Seattle, WA 98155	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another interview on 11/05/2024 at 1:12 PM, Staff P stated that staff were supposed to use highchairs when assisting Resident 29 with their meal. Staff P further stated that since the highchairs were broken and unavailable, staff could assist residents while standing. On 11/07/2024 at 10:19 AM, Staff B, Registered Nurse 4, stated that staff should be seated when assisting residents with their meals. Staff B stated that if a resident had a care plan for dining/eating, staff must follow it. Staff B stated that if there was a shortage of chairs, it should have been communicated. Staff B further stated, If necessary, an appropriate chair should be ordered and assisting Resident 29 while standing is not the correct approach. On 11/07/2024 at 11:45 AM, Staff A, Nursing Facility Program Area Team Director, stated that they expected the staff to be seated at eye level with Resident 29 when assisting their meal. Staff A further stated that Resident 29's care plan should have been followed. Reference: (WAC) 388-97-0180(2)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, interview, and record review, the facility failed to inform residents and/or their representatives of risks and benefits before application of a restraint for 2 of 5 residents (Residents 41 & 12), reviewed for physical restraint. This failure placed the residents and/or their representatives at risk for not being fully informed before making decisions regarding their health care, alternative treatment options, and the right to refuse care. Findings included . Review of the facility's policy titled, Informed Consent, revised on 10/15/2024, showed that informed consent means agreement to proceed with a particular treatment or service based upon certain components including the name, relationship to the client, and signature of the person giving informed consent signifying that they do or do not grant consent. The Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their residents) shall obtain appropriate informed consent from individuals with capacity to give informed consent before starting a program or service, medication, or medical treatment that presents a risk to residents' safety, where such risk is not considered to be insignificant. Informed consent is obtained when there is recommendation to infringe on the resident's right. When an individual cannot give informed consent, the IDT shall seek consent from the appointed guardian of the resident or the resident's legal representative. The policy further showed that restraints used as part of a positive behavior support program as well as support devices that restraint voluntary or involuntary movements (such as wheelchair seatbelts, wheelchair trays, chest support for maintaining upright positioning) are treatment and services that would require informed consent. RESIDENT 41 Review of the annual Minimum Data Set (an assessment tool) dated 10/03/2024 showed Resident 41 had severely impaired cognition and was on trunk restraint during this assessment period. Observations on 10/31/2024 at 9:03 AM, on 11/01/2024 at 9:49 AM and at 1:40 PM, on 11/04/2024 at 9:11 AM, and on 11/05/2024 at 11:54 AM, showed Resident 41 was sitting in their wheelchair with their wheelchair seatbelt applied around their waist. Review of Resident 41's informed consent for the use of wheelchair with seatbelt showed that the consent was signed by Resident 41's representative on 01/31/2023. Further review of the informed consent showed, This consent is valid for one year from the date of the written consent unless otherwise stated. During an interview and joint record review on 11/06/2024 at 10:39 AM, Staff M, Registered Nurse (RN) 2, stated that informed consent would be obtained before an implementation of a restraint. Joint record review of Resident 41's informed consent for the use of wheelchair with a seatbelt dated 01/31/2023 showed the consent was valid for one year from the date of the written consent unless otherwise stated. Staff M stated that the consent was valid for one year from the date it was obtained. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 2:47 PM, Staff B, RN 4, stated that Resident 41's informed consent should have been updated annually. 46912 RESIDENT 12 Review of the face sheet printed on 11/01/2024, showed Resident 12 admitted to the facility on [DATE] with diagnoses that included athetoid cerebral palsy (a brain disorder that affects movement and includes involuntary muscle movements). Review of the physical supports to maintain client in an upright position care plan, printed on 11/01/2024, showed Resident 12 used a tilt in space manual wheelchair [a wheelchair that can reposition a person by tilting the chair in a way that lowers the seated person's head and raises their feet at the same time] .to provide back, trunk and upper leg support. Further review of the care plan showed Resident 12 used a padded seatbelt to stabilize the pelvis in the wheelchair and a padded shoulder harness to provide additional trunk support. Review of Resident 12's clinical record (electronic health record and paper chart) showed no documentation that Resident 12 or their representative were informed of the use of tilt in space wheelchair, shoulder harness or seatbelt. Observations on 11/01/2024 at 11:29 AM, on 11/05/2024 at 9:26 AM, and on 11/06/2024 at 9:29 AM, showed Resident 12 was sitting in their tilt in space wheelchair and wearing a seatbelt and shoulder harness. In an interview on 11/04/2024 at 1:08 PM, Staff G, RN 2, stated that there needed to be a physician's order, an assessment by occupational therapy, and a consent before a resident used a shoulder harness and a seatbelt. Staff G stated they were unsure if a consent was needed for a tilt in space wheelchair. In an interview and joint record review on 11/05/2024 at 11:27 AM, Staff DD, Occupational Therapist 3, stated that they do an evaluation prior to residents using a tilt in space wheelchair, shoulder harness, or a seatbelt. Staff DD stated they did not provide anything to the guardian that that they need to sign. Staff DD stated that risks and benefits were verbally discussed, but nothing officially signed. A joint record review of the Informed Consent policy showed that treatment and services requiring informed consent include . restraints used as .support devices that restrain voluntary or involuntary movement (such as wheelchair seatbelts, wheelchair trays, chest supports for maintaining upright positioning, etc.). In a follow up email at 2:48 PM, Staff DD, stated that based on how this policy is written and the specific examples included, then consent should have been obtained using the standardized form. A joint record review of the Informed Consent policy and interview on 11/07/2024 at 11:09 AM with Staff B, showed that treatment and services requiring informed consent include .restraints used as .support devices that restrain voluntary or involuntary movement (such as wheelchair seatbelts, wheelchair trays, chest supports for maintaining upright positioning, etc.). Staff B stated, I agree, there should be consent for those things [tilt in space wheelchair, seatbelt and shoulder harness]. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0260(2) (a-d) (3)(c)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 47680 Based on interview and record review, the facility failed to ensure annual Minimum Data Set (MDS-an assessment tool) was completed within 14 days from the Assessment Reference Date (ARD) for 1 of 22 residents (Resident 24), reviewed for comprehensive assessments. This failure placed the resident at risk for delayed and/or unmet care needs, and a diminished quality of life. Findings included . Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.19.1, revised in October 2024, showed that annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) and should be completed no later than 14 days from the ARD (ARD + [plus] 14 days). Review of the facility's policy titled, Roles and Responsibilities of Nursing Facility Interdisciplinary Team Members, with effective date of 01/23/2023, showed that the Heath Care Coordinator serves as the person designated for finalizing the MDS, ensure it was completed by the due date and responsible for the utilization and review of the MDS assessment tools. Review of Resident 24's annual MDS with an ARD of 01/25/2024, showed that it was completed on 02/14/2024 (six days late). In an interview and joint record review on 11/05/2024 at 2:41 PM with Staff E, Registered Nurse (RN) 2, stated that they followed the RAI manual for MDS completion. Staff E stated that the annual MDS was due 14 days from the ARD. Joint record review of Resident 24's annual MDS showed that it was completed on 02/14/2024. Staff E stated it was late and that it should have been completed within 14 days from the ARD. On 11/06/2024 at 1:32 PM, Staff B, RN 4, stated that the MDS completion should be timely and accurate. Reference: (WAC) 388-97-1000 (5)(a)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed for 1 of 2 residents (Resident 35), reviewed for SCSA. This failure placed the resident at risk for delayed care planning, unmet care needs, and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed that a SCSA is a comprehensive assessment for a resident that must be completed when determined that a resident meets the significant change guidelines for either major improvement or decline. The RAI manual showed a significant change is a major decline or improvement in a resident's status that impacts more than one area of the resident's health status. The RAI manual further showed emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days), a new pressure ulcer [or pressure injury] (bed sore) at Stage 2 or higher, a new unstageable (the stage is not clear due to the base of the wound is covered by a layer of dead tissue) pressure ulcer/injury, and a condition/disease in which a resident is judged to be unstable are areas of decline that required the completion of SCSA. The RAI manual defines the Stage 2 pressure ulcer as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough (dead tissue, yellow/white material in the wound bed) or bruising. Review of the annual MDS dated [DATE], showed Resident 35 had no significant weight loss or a condition or chronic disease that my result in a life expectancy of less than six months. Review of the clinical note dated 10/04/2024 showed Resident 35 had a pressure ulcer/injury to their left shoulder and right scapula (shoulder blade). Review of the provider's progress note dated 10/09/2024 showed that comfort focused treatment had been determined for Resident 35 as goal of care due to decline in condition. Review of the clinical note dated 10/09/2024 showed Resident 35 had unintentional [unplanned] significant weight loss of 6.8 pounds (6.1 percent) of their body weight in the last month. Review of the MDS look up page for Resident 35's Electronic Health Record (EHR) showed there was no SCSA MDS completed for Resident 35's multiple areas of decline. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 11/05/2024 at 10:51 AM with Staff E, Registered Nurse (RN) 2, stated that Resident 35 had a significant weight loss and placed on comfort care since their recent readmission. Staff E stated Resident 35 had unstageable pressure ulcer/injury on their left shoulder and stage 2 pressure ulcer on their posterior (back side) right shoulder. Staff E further stated that an SCSA MDS would be completed when there had a change in activities of daily leaving, conditions, and weight loss. A joint record review of Resident 35's clinical note dated 10/09/2024 showed that Resident 35 had a significant weight loss and had been placed on comfort measure. A joint record review of Resident 35's EHR showed no SCSA MDS completed for the resident. Staff E stated, I'm not sure if significant change assessment needed for the resident. On 11/06/2024 at 2:35 PM, Staff B, RN 4, stated that an SCSA MDS assessment should have been completed for Resident 35 due to multiple areas of decline. Reference: (WAC) 388-97-1000 (3)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on interview and record review, the facility failed to accurately assess 6 of 22 residents (Residents 348, 82, 45, 35, 97, & 12), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding capturing occurrences during the look-back period for anticoagulant (medication that helps to prevent blood clots from forming) use, tracheostomy (an opening into the trachea (windpipe) from outside the neck) care, timing of MDS sections completion, completion of a discharge assessment, placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.19.1, dated October 2024, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). Most MDS items themselves require an observation period, such as seven or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look-back period will be captured. In other words, if it did not occur during the look-back period, it is not coded on the MDS. The RAI's tracheostomy care coding instruction directed to code suctioning (removing secretions or fluids) and cleansing of the tracheostomy and/or cannula (a small plastic tubing that is inserted in the tracheostomy) in this item if during the 14-day look-back period the resident had received tracheostomy care and suctioning. RESIDENT 348 Review of Resident 348's Electronic Health Records (EHR) showed MDS assessments were completed and submitted in the order of a discharge MDS dated [DATE], an annual MDS dated [DATE] and an entry tracker MDS dated [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint record review and interview on 11/04/2024 at 9:23 AM with Staff L, Registered Nurse (RN) 2, showed Resident 348's EHR had a leave of absence from the facility starting on 10/02/2024 and returned to the facility on [DATE]. Staff L stated that Resident 348 was not at the facility during the assessment period of their annual MDS dated [DATE]. A joint record review and interview on 11/04/2024 at 9:25 AM with Staff L, showed sections of Resident 348's annual MDS dated [DATE], had an observation period of seven days from 10/05/2024 through 10/11/2024. These completed sections included Sections B (Hearing, Speech, and Vision), C (Cognitive Patterns), D (Mood - Staff Assessment for Resident Mood), E (Behavior), F (Preferences for Customary Routine Activities), GG (Functional Abilities), H (Bladder and Bowel), I (Active Diagnoses), J (Health Conditions), K (Swallowing/Nutritional Status), L (Oral/Dental Status), M (Skin Conditions), N (Medications), O (Special Treatments, Procedures, and Programs), P (Restraints and Alarms), and Q (Participation in Assessment and Goal Setting). Staff L stated that Resident 348 was not observed during the observation period of their annual MDS dated [DATE] because Resident 348 was not at the facility during the seven-day observation period. Staff L further stated that the annual MDS dated [DATE] was inaccurate and should not have been completed and submitted. In an interview on 11/06/2024 at 1:03 PM, Staff B, RN 4, stated the facility followed the RAI Manual, for the completion of accurate MDS assessments. Staff B further stated they expected Resident 348's annual MDS to be accurate and completed following the observation period. RESIDENT 82 Review of the RAI Manual's Coding Tips and Special populations, listed on page N-9, showed aspirin should not be coded as an anticoagulant. The RAI manual further specified that the antiplatelet medication like aspirin should not be coded in Section N. A joint record review and interview on 11/06/2024 at 2:45 PM with Staff L, showed Resident 82 was marked to have taken an anticoagulant in Section N (Medications) in their quarterly MDS dated [DATE], 05/29/2024 and 09/29/2024. Further record review of Resident 82's physician orders, printed on 11/07/2024, did not show that Resident 82 was prescribed an anticoagulant from February 2024 through September 2024. Staff L stated, I don't think [they have] taken [anticoagulants] before. Staff L stated that Resident 82 was prescribed aspirin (blood thinner). Staff L stated aspirin should not have been marked as an anticoagulant in Resident 82's quarterly MDS dated [DATE], 05/29/2024 and 09/29/2024. In an interview on 11/06/2024 at 1:03 PM, Staff B stated the facility followed the RAI Manual for the completion of accurate MDS assessments. Staff B further stated they expected aspirin not to be coded as an anticoagulant based on the RAI Manual. 45146 RESIDENT 45 Resident 45 admitted to the facility on [DATE] with diagnoses that included tracheostomy status. Review of the quarterly MDS dated [DATE], showed Resident 45's tracheostomy care and suctioning were not coded on the MDS assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2024 Treatment Administration Record (TAR) showed that Resident 45 had received tracheostomy care and suctioning. In an interview and joint record review on 11/05/2024 at 12:29 PM, Staff H, RN 2, stated that the MDS would be completed based on review of the resident's medication administration record, TAR, and progress note. A joint record review of Resident 45's July TAR showed the resident had received tracheostomy care and suctioning. Joint record review of the quarterly MDS dated [DATE], showed tracheostomy care and suctioning was not coded on Resident 45's MDS. Staff H stated the tracheostomy care and suctioning should have been coded on the MDS. RESIDENT 35 Review of Resident 35's annual MDS dated [DATE], showed that the assessment was signed completed on 08/26/2024. Further review of the assessment showed that Section GG was completed and signed on 08/13/2024 (5 days before the assessment's lookback period's start date), and Section K was completed and signed on 08/01/2024 (17 days before the lookback period's start date). In an interview and joint record review on 11/05/2024 at 10:51 AM, Staff E, RN 2, stated that MDS would be completed based on the ARD and lookback period. A joint record review of Resident 35's annual MDS dated [DATE] showed Section GG and K were completed before the assessment period. Staff E stated, Staff should have not completed [MDS sections] before the look back period. On 11/06/2024 at 2:35 PM, Staff B stated that staff should have followed the RAI Manual and that they should have not completed the sections of the MDS prior to the look back period. 46912 RESIDENT 97 Review of the discharge MDS dated [DATE] showed Resident 97's MDS was marked as discharged to acute hospital. Review of a nursing progress note dated 09/10/2024, showed Resident 97 discharged to their home on 09/10/2024. A joint record review and interview on 11/05/2024 at 2:33 PM with Staff Z, RN 2, showed Resident 97's EHR revealed they discharged to home. Staff Z stated that Resident 97's discharge MDS should have been coded as discharge to the community. In an interview on 11/07/2024 at 10:45 AM, Staff B stated that they expected the MDS to be accurate. 47680 RESIDENT 12 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 12's annual MDS with an ARD of 04/27/2024, showed it was completed on 04/27/2024. Further review showed Sections A (Identification Information), B, C, D, E, F, GG, H, I, J, L, M, N, O and P were completed on 04/19/2024, prior to the observation period. In an interview and joint record review on 11/07/2024 at 11:41 AM, Staff G, RN 2, stated they followed the RAI Manual for MDS completion. Staff G stated that they started the MDS after the observation period. When asked if they would complete the MDS prior to the observation period, Staff G stated, no. Joint record review of Resident 12's annual MDS Section Z (Assessment Administration) showed that it was completed on 04/27/2024. Staff G stated that staff must wait after the observation period to complete the MDS. Further joint record review showed Sections A, B, C, D, E, F, GG, H, I, J, L, M, N, O, and P were completed on 04/19/2024. Staff G stated that the seven day observation period was from 04/21/2024 through 04/27/2024 and that staff must wait to complete the MDS until after the observation period. Staff G further stated that Resident 12's annual MDS was completed inaccurately. In an interview and joint record review on 11/07/2024 at 12:05 PM, Staff B stated that they expected the MDS to be completed and coded accurately. Joint record review of Resident 12's annual MDS with an ARD of 04/27/2024, showed that the MDS was completed before the observation period and was signed as completed on the ARD date. Staff B stated that they expected Resident 12's MDS to be completed after the ARD. Reference: (WAC) 388-97-1000 (1)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A260	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 48899

Based on interview and record review, the facility failed to develop and/or implement comprehensive care plans for 5 of 22 residents (Residents 44, 88, 45, 24, & 77), reviewed for care planning. The failure to develop/implement care plans for antidepressant medication use, pressure ulcer (bed sore) care, antibiotic (medication to treat infection) use, refusal of care and use of antipsychotic medication (to treat symptoms of certain mental health disorders) placed the residents at risk for unmet care needs and a diminished quality of life.

Findings included .

Review of the facility's policy titled Roles and Responsibilities of Nursing Facility Interdisciplinary Team Members, dated 01/23/2023, indicated that a care plan is an individualized plan based on comprehensive assessment and professional recommendations. Further review of the policy showed that the care plan aims to promote the individual's highest level of functioning, with a focus on improvement where possible, maintenance of skills and abilities, and the prevention of avoidable decline.

RESIDENT 44

Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 09/23/2024, showed Resident 44 had unhealed pressure ulcers.

Review of Resident 44's record titled, Consult/Evaluation Request, dated 10/02/2024, showed Resident 44 had nonhealing stage three pressure ulcer/injury (that extends through the skin into deeper tissue and fat but do not reach muscle, tendon, or bone) of the coccyx (tailbone).

Review of Resident 44's comprehensive care plan printed on 11/05/2024, showed no care plan was initiated for pressure ulcer.

In an interview and joint record review on 11/06/2024 at 12:57 PM, Staff Z, Registered Nurse (RN) 2, stated that Resident 44 did not have a care plan for pressure ulcer care. Joint record review of the comprehensive care plan showed Resident 44 had no care plan for pressure ulcer care. Staff Z stated that Resident 44 had an alert care plan for their pressure ulcer and was not needed to include it in their comprehensive care plan.

On 11/07/2024 at 10:19 AM, Staff B, RN 4, stated that they were aware that Resident 44 had a pressure ulcer and expected a care plan for it.

RESIDENT 88

Review of the physician's order dated 10/16/2024, showed Resident 88 had an order for antidepressant (medication to treat symptoms of depression).

Review of the October 2024 and November 2024 Medication Administration Records (MAR) showed Resident 88 was on an antidepressant medication.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Fircrest Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15th Northeast Seattle, WA 98155	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 88's comprehensive care plan printed on 10/30/2024, showed no care plan was initiated for antidepressant medication use. In an interview and joint record review on 11/05/2024 at 9:51 AM, Staff Z stated that Resident 88 had an antipsychotic care plan. Joint record review of Resident 88 comprehensive care plan did not show a care plan for antidepressant medication use. Staff Z stated that they did not believe a separate care plan for antidepressants was necessary. On 11/07/2024 at 9:17 AM, Staff AA, Psychologist, stated that residents on antidepressant medication should have a care plan for it. Staff AA further stated that Resident 88 should have had a care plan for their antidepressant medication use. On 11/07/2024 at 10:19 AM, Staff B stated that residents on antipsychotic and antidepressant medications required separate care plans. Staff B further stated that Resident 88 should have had a care plan for their antidepressant medication use. 45146 RESIDENT 45 Review of the quarterly MDS dated on 07/23/2024, showed Resident 45 received an antibiotic. Review of the August 2024, September 2024 and October 2024 (MAR) showed Resident 45 received three antibiotic medications. Review of Resident 45's comprehensive care plan printed on 11/01/2024 showed no comprehensive care plan for the use of multiple antibiotics. In an interview and joint record review on 11/05/2024 at 12:13 PM, Staff H, RN 2, stated that long-term use of antibiotics would be addressed under comprehensive care plan. Joint record review of Resident 45's August 2024 through October 2024 MAR showed that the resident was receiving antibiotics. Joint record review of Resident's 45 comprehensive care plan printed on 11/01/2024, showed no care plan for antibiotics use. Staff H stated that they could not find a care plan for multiple antibiotic use. In an interview on 11/06/2024 at 2:25 PM, Staff B stated that there should be a comprehensive care plan for long-term antibiotic use. 47680 RESIDENT 24 Observations on 10/31/2024 at 12:42 PM, on 11/01/2024 at 9:31 AM and on 11/04/2024 at 1:43 PM, showed Resident 24 had facial hair (beard and mustache). Review of Resident 24's comprehensive care plan printed on 10/31/2024, did not show a care plan for behaviors/refusal of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint observation on 11/04/2024 at 1:50 PM, Staff RR, Attendant Counselor 1, stated that they shave residents every morning and that some residents were hard to shave like Resident 24. Staff RR stated that it takes two staff to shave them. Staff RR stated that Resident 24 was shaved at least twice a week and that they let the nurse know if they refused. Joint observation showed Resident 24 had facial hair (beard and mustache). Staff RR stated, it's long, especially his mustache and that they will try to shave them. At 1:57 PM, Staff RR stated that Resident 24 refused and was moving their hands over their face as they were trying to shave them. When asked where they documented if a resident declined care, Staff RR stated that Touchscreen [charting software] that they used to chart did not have a place for them to document refusals. Joint observation of the Touchscreen software did not show a place to document refusals. Staff RR stated there was no place to document refusal on Touchscreen and to check with the nurse. In an interview on 11/04/2024 at 2:05 PM, Staff E, RN 2, stated behaviors were documented in the behavioral logbook and Touchscreen. Staff NN, Attendant Counselor 3, stated that Resident 24 had been refusing care and was known to refuse care all the time. Staff NN stated that it should be documented. Staff NN looked at the behavioral logbook and was not able to find any documentation that Resident 24 refused care. Staff E and Staff RR stated that Resident 24 was difficult to provide care, required two person assistance and becomes aggressive. In an interview on 11/04/2024 at 2:28 PM, Staff E stated that Resident 24 did not have a care plan for behaviors/rejection of care and should have one. Staff E stated that staff had told them that Resident 24 was difficult to shave. Staff E further stated that staff should be documented when Resident 24 had refused care. In an interview on 11/06/2024 at 1:32 PM, Staff B stated that they expected residents who had behaviors/refuses care to be documented and should have an individualized care plan. 46912 RESIDENT 77 Review of the facility's undated policy titled, Quarterly Nursing Physical Exam and Monitoring of Side Effects system [[NAME]], showed that the [NAME] form is used for all residents receiving neuroleptics [also known as an antipsychotic medication] and that it was used to monitor residents for side effects of certain medications. Review of the November 2024 MAR showed Resident 77 had an order for Risperidone (an anti-psychotic medication) daily. Review of the Risk for Adverse side effects of Antipsychotic drug care plan printed on 10/31/2024, showed Resident 77 had an intervention for [NAME] every 6 month [s]. Review of the Resident 77's clinical record (electronic health record and paper chart) showed Resident 77 had a [NAME] assessment completed on 08/10/2024. It further showed that the previous [NAME] assessment had been completed on 10/30/2023. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 11/05/2024 at 10:35 AM, Staff G, RN 2, stated that if a resident was on an antipsychotic medication they had a [NAME] assessment completed every six months. A joint record review of Resident 77's Risk for Adverse side effects of Antipsychotic drug care plan showed that Resident 77 should have had a [NAME] assessment completed every six months. A joint record review of Resident 77's clinical record showed that Resident 77 had a [NAME] assessment completed on 08/10/2024 and the previous one was completed on 10/30/2023. Staff G stated it had been more than six months between the assessments and it should have been done in April 2024. Staff G further stated the care plan intervention for Resident 77 to have a [NAME] assessment completed every six months was not followed and it should have been. In an interview on 11/07/2024 on 10:45 AM, Staff B stated that they expected staff to follow and implement care plans. Staff B stated that the care plan should have been followed for Resident 77 to have their [NAME] assessment completed every six months. Reference: (WAC) 388-97-1020 (1)(2)(a)(b) .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure services were consistently provided to increase Range of Motion (ROM) and/or to prevent decrease in ROM for 2 of 5 residents (Residents 12 & 81), reviewed for restorative services. This failure placed the residents at risk for a decline in ROM, unmet care needs, and a diminished quality of life. Findings included . RESIDENT 12 Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 07/28/2024, showed Resident 12 had limited ROM to their upper and lower extremities on both sides. Review of the comprehensive care plan printed on 11/01/2024, showed an intervention that Resident 12 was on a right-hand soft splint/Therapy Aide program, which showed the application of right soft hand splints 5x[times]/week. Review of the facility's document titled, Therapy Aide Documentation for the month of October 2024, showed Resident 12 was on a therapy program to apply right hand soft splint .5x/week. It further showed the following documentations: -Week of 10/01/2024: 2 out of 5 days the program was not provided. -Week of 10/07/2024: 3 out of 5 days the program was not provided. -Week of 10/14/2024: 4 out of 5 days the program was not provided. -Week of 10/21/2024: 3 out of 5 days the program was not provided. -Week of 10/28/2024: 3 out of 5 days the program was not provided. Observations on 11/01/2024 at 11:29 AM, on 11/04/2024 at 12:47 PM, 11/05/2024 at 9:25 AM and on 11/06/2024 at 9:29 AM, showed Resident 12 did not have a splint on their right hand. In an interview and joint observation on 11/06/2024 at 9:45 AM, Staff V, Attendant Counselor (AC) 3, stated that Resident 12 wore splints and should be every day, haven't seen them on this week. Staff V stated that the Occupational Therapist (OT) or Physical Therapist (PT) were responsible for putting on Resident 12's splint. Staff V stated that therapy was very short staffed and if they're not available we should do it. A joint observation showed that Resident 12 was not wearing a splint on their right hand, and Staff V stated that they were supposed to. RESIDENT 81 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual MDS dated [DATE], showed Resident 81 had limited ROM on both sides of their upper and lower extremities. Review of the facility's document titled, Therapy Aide Documentation for the month of October 2024, showed Resident 81 was on a therapy program for B [bilateral-both sides] UE [upper extremity] PROM [Passive ROM-a type of ROM that is achieved by an outside force such as therapist] 3 times/week. It further showed the following documentations: -Week of 10/21/2024: 3 out of 5 days the program was not provided. -Week of 10/28/2024: 3 out of 4 days the program was not provided. Observations on 10/31/2024 at 9:24 AM, on 11/01/2024 at 9:16 AM, on 11/05/2024 at 9:30 AM, and on 11/06/2024 at 9:30 AM, showed Resident 81 in their wheelchair, arms crossed and hands in a fist. In an interview on 11/06/2024 at 9:31 AM, Staff HH, AC 1, stated I don't think [Resident 81] gets any OT, I haven't seen that. In an interview and joint record review on 11/06/2024 at 12:45 PM, Staff DD, OT 3, stated that the therapy aides were expected to carry out the therapy aide program and if there were no therapy aides then the OT or PT would cover. Staff DD stated that Resident 81 had limited ROM and was on a therapy aide program to prevent reduction in ROM and contracture [a permanent or temporary tightening of muscles, tendons, skin and nearby tissues that limits the normal movement of a joint or body part] management. Staff DD stated that Resident 12 was on a therapy aide program and wore a right-hand splint for contracture management. A joint record review of the Therapy Aide Documentation for the month of October 2024 for Resident 81 and Resident 12 showed that the therapy aide program was not provided consistently for Resident 81 and Resident 12. Staff DD stated the program was not carried out for Resident 81 and Resident 12. In an interview and joint record review on 11/07/2024 at 11:19 AM, Staff B, Registered Nurse 4, stated that they expected therapy aides to carry out the therapy aide program for residents. When asked what happened if the therapy aides or therapists were not available, Staff B stated, I would like the program to continue no matter what. A joint record review of the Therapy Aide Documentation for the month of October 2024 for Resident 81 and Resident 12 showed that the program was not provided for the above weeks. Staff B stated, the program was not being done, doesn't meet my expectation. Reference: (WAC) 388-97-1060 (3)(d)

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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. 51090 Based on observation, interview, and record review, the facility failed to ensure medical supplies used for medication administration were stored properly for 2 of 3 medication rooms (Cherry and Hickory Buildings), reviewed for accident hazards. This failure placed the residents at risk for ingestion or exposure to cleaning chemicals and potential negative outcomes. Findings included . Review of the facility's policy titled, Globally Harmonized System for Hazard Communication Written Hazard Communication Program, revised on 10/01/2024, showed that The Chemical Hazard Communication compliance program establishes systems to mitigate the risks of and properly handle hazardous chemicals and drugs by ensuring that employees know the hazards and identifies the chemicals and drugs with which they work. CHERRY BUILDING MEDICATION ROOM Joint observation and interview on 11/04/2024 at 11:12 AM with Staff L, Registered Nurse (RN) 2, showed an open box of tongue depressors [popsicle sticks used for mixing medications], an open box of plastic pill cups [shallow cups used to hold medications in a pill crusher device], a spray canister of Lysol [a brand of cleaning and disinfecting products], and a portable heater, stored under the hand washing sink, located in the medication room. Staff L stated that the tongue depressors and plastic pill cups should not have been stored under the sink with the Lysol spray. Staff L further stated that supplies used for medication administration [tongue depressors and plastic pill cups] should have been stored in the nurse supply room instead. HICKORY BUILDING MEDICATION ROOM Joint observation and interview on 11/05/2024 at 10:14 AM with Staff D, Licensed Practical Nurse 2, showed an open box of plastic spoons, a box of plastic pill cups, and a Clorox [a brand of cleaning and disinfecting products] spray bottle, stored together under the hand washing sink, located in the medication room. Staff D stated that supplies used to administer medications [plastic spoons and plastic pill cups] should be in the medical supply room because they can't be together [with chemicals]. In an interview on 11/05/2024 at 10:32 AM with Staff E, RN 2, stated they did not expect medication administration supplies to be stored with chemicals. Staff E further stated, there should be nothing under the sink. In an interview on 11/06/2024 at 11:05 AM with Staff C, RN 3, stated that they would not expect medication administration supplies would be stored with chemicals. Staff C further stated that there was the potential to expose residents to toxic chemicals when supplies used to administer medications and chemicals materials were stored together. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 1:03 PM, Staff B, RN 4, stated they expected supplies used for medication administration to be stored in wall cabinets above the hand washing sink located in the medication rooms. Staff B stated they would not expect supplies used for medication administration to be stored with chemical cleaning supplies. Staff B further stated that there is the potential to expose residents to toxic chemicals when supplies for medication administration were stored with chemicals and that they wouldn't want them together. Reference: (WAC) 388-97-1060(3)(g)

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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. 51090 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services related to gastrostomy tube (G-tube - a medical device used to provide nutrients through a tube directly into the stomach) were followed for 1 of 3 residents (Resident 9), reviewed for tube feeding management. The failure to check for G-tube placement by visual inspection of aspirated stomach content prior to medication administration placed the resident at risk for medical complications and negative health outcomes. Findings included . Review of the facility's policy titled, Enteral Feeding [method of providing nutrition directly into the stomach when a person is unable to eat by mouth] Administration and Hang Time using Open/Close System via Gravity and Pump, revised in March 2024, showed that when staff accessed the feeding tube, they should check enteral tube for correct placement by aspiration [using a syringe to gently draw back on the G-tube to see if any gastric contents (fluid or air) can be aspirated]. Review of Resident 9's face sheet printed on 11/05/2024, showed a diagnosis of gastrostomy status [a medical device inserted through the abdomen directly into the stomach to provide nutrition and medication to persons who cannot eat or swallow normally]. Review of Resident 9's tube feeding care plan, printed on 11/05/2024, showed an intervention for staff to check for G-tube placement by aspiration prior to start of each water flush and medication administration. A joint observation and an interview on 11/04/2024 at 12:20 PM, showed Staff Q, Licensed Practical Nurse 2, dissolved crushed medications into a cup of water. Staff Q then inserted a syringe in Resident 9's G-tube port and removed the plunger from the syringe. Staff Q then poured water into the syringe and held the syringe above Resident 9's abdomen that allowed water to flush through Resident 9's G-tube. Staff Q did not check the G-tube placement by aspiration prior to flushing Resident 9's G-tube with water. Further observation showed Staff Q attempted to pour a cup of dissolved medication in water, into Resident 9's G-tube. When asked if they checked for Resident 9's G-tube placement by aspiration before flushing and attempting to administer medications through their G-tube, Staff Q stated, I did not, I will do it now. In an interview on 11/04/2024 at 1:13 PM, Staff H, Registered Nurse (RN)2, stated that they expected nurses to aspirate to check for placement of a G-tube before giving water flushes and medications. In an interview on 11/06/2024 at 1:03 PM, Staff B, RN4, stated that they expected nurses to aspirate to check for placement of G-tubes before administering water flushes and medications. Reference: (WAC) 388-97-1060 (3)(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to ensure oxygen tubing were labeled and/or appropriately stored for 2 of 4 residents (Residents 4 & 80), reviewed for respiratory care. This failure placed the residents at risk for unmet care needs and potential negative outcomes. Findings included . Review of the facility's policy titled, Oxygen Administration and Safety Guidelines, revised in September 2023, showed, Change oxygen administration accessories (mask, tubing, humidifier [a device that adds moisture to the air], and concentrator filter) weekly and PRN [as needed]. The tubing's and the humidifier are dated. RESIDENT 4 Review of Resident 4's physician's order, dated 05/28/2024, showed an order for oxygen at two liters (a unit of measurement)/minute (flow rate of oxygen being delivered to a resident through a device like a nasal cannula [lightweight tube that splits into two prongs at one end and is inserted in the nostrils to deliver oxygen]) via nasal cannula with humidification. Observation on 11/01/2024 at 9:30 AM, showed Resident 4's nasal canula tubing was on the floor beside the oxygen concentrator. In a joint observation and interview on 11/01/2024 at 9:32 AM with Staff K, Attendant Counselor 2, showed Resident 4's nasal canula tubing was on the floor and that the nasal prongs were directly touching the floor. Staff K stated the nasal canula tubing should not be on the floor and that it should have been placed inside the Ziplock (brand of resealable plastic bag) adhered to Resident 4's oxygen concentrator for storage. In an Interview on 11/01/2024 at 9:40 AM, Staff J, Registered Nurse (RN) 2, stated that they expected oxygen supplies were kept clean and stored in a Ziplock when not in use by a resident. In an interview on 11/01/2024 at 10:04 AM, Staff I, RN 2, stated they expected oxygen supplies to be stored in a clean Ziplock and that [staff] can't use it [nasal canula tubing] once it has touched the floor. On 11/06/2024 at 1:03 PM, Staff B, RN 4, stated they expected oxygen therapy supplies to be stored in a baggy, usually adhered to the concentrator. Staff B further stated that they expected Resident 4's nasal canula tubing to have been disposed of immediately and replaced. 47680 RESIDENT 80 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the face sheet printed on 10/06/2024, showed Resident 80 admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a condition that blocks air flow and make it difficult to breathe). Review of the significant change in status assessment Minimum Data Set (an assessment tool) dated 04/29/2024, showed Resident 80 used oxygen therapy while a resident. Review of Resident 80's October 2024 treatment administration record showed the following orders: - Oxygen at two liters per minute via nasal cannula with humidification, dated 10/30/2024. - Change oxygen tubing and humidifier bottle weekly on Tuesdays, dated 05/29/2024. Observations on 10/30/2024 at 10:18 AM, on 10/31/2024 at 9:09 AM, and on 11/01/2024 at 2:07 PM, showed Resident 80 received oxygen via an undated nasal cannula tubing. In an interview and joint observation on 11/01/2024 at 2:18 PM, Staff F, Licensed Practical Nurse 2, stated that they changed the nasal cannula tubing and humidifier bottle weekly and dated it. Joint observation showed Resident 80's nasal cannula tubing was undated. Staff F stated that it was not dated and should have been. In an interview on 11/04/2024 at 2:23 PM, Staff E, RN 2, stated that the nasal cannula tubing had to be changed weekly and that it had to be dated. Staff E further stated that Resident 80's nasal cannula tubing should have been dated. On 11/06/2024 at 1:32 PM, Staff B stated that Resident 80's nasal cannula tubing should have been dated. Reference: (WAC) 388-97-1060(3)(j)(vi)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45146 Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information postings were posted on daily basis at the beginning of each shift. In addition, the facility failed to ensure the nurse staffing information postings were in prominent locations readily accessible to residents and visitors for 5 of 5 units ([NAME], Hickory, Elm, Cherry, and Birch), reviewed for Nurse Staffing Information. These failures placed residents and visitors at risk for not being fully informed of current nurse staffing levels and resident census information. Findings included . [NAME] UNIT Observations on 10/30/2024 at 10:46 AM, on 10/31/2024 at 8:33 AM, on 11/01/2024 at 8:52 AM, on 11/04/2024 at 9:05 AM, and on 11/05/2024 at 11:52 AM, showed the [NAME] Unit's nurse staffing information was not posted in a prominent place readily accessible to residents and visitors. Further observation showed the nurse staffing information form was placed on a clipboard and the clipboard was placed in the wall file holder with other files. Observation on 10/31/2024 at 8:33 AM, showed the [NAME] Unit's nurse staffing information for 10/30/2024 evening shift was not posted on the form, and it was blank. In an interview and joint observation on 11/05/2024 at 12:03 PM, Staff W, Attendant Counselor (AC) 3, stated they were responsible for completing the unit's nurse staffing information form. Joint observation showed the nurse staffing form was placed on a clipboard, and the clipboard was placed in the wall file holder. Staff W stated, They [the facility] used to post it [nurse staffing information] on the wall. HICKORY UNIT Observations on 10/30/2024 at 12:49 PM, on 10/31/2024 at 10:28 AM, on 11/01/2024 at 10:12 AM, on 11/04/2024 at 10:09 AM, and on 11/05/2024 at 9:23 AM, showed the Hickory Unit's nurse staffing information was not posted in a prominent place readily accessible to residents and visitors. Further observation showed the nurse staffing information form was placed on a clipboard labeled as Daily staffing hours and census, and the clipboard was placed in the wall file holder with other files. On 11/05/2024 at 9:32 AM, Staff S, AC Manager, stated that the unit's nurse staffing information form was always placed in the wall file holder. ELM UNIT Observations on 10/30/2024 at 1:05 PM, on 10/31/2024 at 10:38 AM, on 11/01/2024 at 10:21 AM, on 11/04/2024 at 10:01 AM, and on 11/05/2024 at 10:02 AM, showed the Elm Unit's nurse staffing information was not posted in a prominent place readily accessible to residents and visitors. Further observation showed the nurse staffing information form was placed in a blue file folder labeled as Daily staffing hours and census, and the file folder was placed in the wall file holder with other files. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

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Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 11/05/2024 at 10:02 AM, showed the Elm Unit's nurse staffing information for 11/04/2024 night shift was not posted, and it was blank. In an interview, joint observation/record review on 11/05/2024 at 10:05 AM, Staff U, AC 3, stated that they were responsible for completing the nurse staffing information form. Staff U stated after they completed the form, they would place it in the blue file folder and the file folder would be placed in the wall file holder. Joint observation showed the blue file folder was placed in the wall file holder. Staff U stated they did not know if the nurse staffing post was for visitors/residents or for the facility staff. Joint record review of the nurse staffing form showed that the nurse staffing information for 11/04/2024 night shift was not completed, and it was blank. Staff U stated the night shift might not receive the nurse staffing information, or they probably forgot to fill out the form. CHERRY UNIT Observations on 10/30/2024 at 1:30 PM, on 11/01/2024 at 2:03 PM, on 11/04/2024 at 10:19 AM, and on 11/05/2024 at 9:49 AM, showed the facility's Cherry Unit's nurse staffing information was not posted in a prominent place readily accessible to residents and visitors. Further observation showed the nurse staffing information form was placed in a green file folder labeled as Census, and the folder was placed in the wall file holder with other files. In an interview and joint observation on 11/05/2024 at 9:51 AM, Staff T, AC 2, stated they were responsible for completing the nurse staffing information form. Staff T stated that after they fill out the form, they would place it in green file folder and the file folder would be placed in the wall file holder. Joint observation showed the green file folder labeled as Census. Staff T stated that the folder was labeled as Census not the nurse staffing information. BIRCH UNIT Observations on 10/31/2024 at 1:34 PM, on 11/01/2024 at 2:12 PM, on 11/04/2024 at 10:32 AM, and on 11/05/2024 at 10:23 AM, showed the Birch Unit's nurse staffing information was not posted in a prominent place readily accessible to residents and visitors. Further observation showed the nurse staffing information form was placed on a clipboard labeled as Census, and the clipboard was placed in the wall file holder with other files. In an interview and joint observation on 11/05/2024 at 10:29 AM, Staff V, AC 3, stated they were responsible for completing the Birch Unit's nurse staffing form. Staff V stated after they completed the form, they would place it on a clipboard labeled as Census and the clipboard would be placed in the wall file holder. Joint observation showed the nurse staffing form was placed on a clipboard labeled as Census, and the clipboard was placed in the wall file holder with other files. Staff V stated the nurse staffing information form was for the facility staff and was not posted for visitors or residents. In an interview on 11/06/2024 at 1:26 PM, Staff A, Nursing Facility Program Area Team Director, stated that they expected the nurse staffing information to be posted daily, in prominent area, and readily accessible to residents and visitors. No associated WAC

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NAME OF PROVIDER OR SUPPLIER Fircrest Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15th Northeast Seattle, WA 98155	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to ensure expired medication was disposed of timely and a controlled substance (a drug or chemical that is regulated by the government because it can be addictive or harmful if misused) medication was handled and accounted appropriately for 1 of 3 medication carts ([NAME] Building), reviewed for medication storage. This failure placed the residents at risk for receiving compromised and/or ineffective medications and for potential diversion or misappropriation of controlled substance medication. Findings included . Review of the facility's policy titled, Preparation and Administration of Medications and Treatments, revised in 05/2024, showed that for medication in the original manufacturer's container (bottle), staff should check expiration dates of medication on manufacture's label .dispose of expired medications. Review of the facility's policy titled, Controlled Substance Medication Handling and Accountability, revised in 05/2023, showed that the facility's controlled substances perpetual inventory is a complete and accurate continuous record of controlled substance medications. Further review showed that the perpetual inventory of controlled substances schedule II through schedule V [controlled substances are classified into five schedules based on their potential for abuse, medical use, and risk of dependence] medications were maintained in nursing controlled substances [inventory] ledgers. EXPIRED MEDICATION IN MEDICATON CART Joint observation and interview on 11/04/2024 at 1:28 PM with Staff F, Licensed Practical Nurse (LPN) 2, showed a used bottle of over the counter (medication that can be bought directly from a store or pharmacy without needing a prescription from a doctor) liquid antacid (medication to relieve symptoms caused by stomach acid) had a manufacturer's label and expiration date of September 2024. Staff F stated that the medication was expired and that they have to take it out [of the medication cart]. In an interview on 11/06/2024 at 1:03 PM, Staff B, Registered Nurse (RN) 4, stated they expected expired medications stored in medication carts to be disposed of timely. CONTROLLED SUBSTANCE MEDICATION IN MEDICATION CART (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Fircrest Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15th Northeast Seattle, WA 98155	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation and interview on 11/04/2024 at 1:30 PM with Staff F and Staff N, LPN 2, showed the total count of lacosamide 200 milligram (mg- a unit of measurement) tablets (a controlled substance medication used to help control seizures) in a blister pack (packaging system for medications, used to seal each dose in its own individual bubble or compartment) for Resident 15, did not equal the total count of lacosamide 200 mg tablets recorded in the controlled substance inventory ledger. Staff F and Staff N stated that the 11/04/2024, 8:00 AM dose of lacosamide 200 mg for Resident 15 was not recorded in the controlled substance inventory ledger. Staff F and Staff N further stated that they expected medications withdrawn from the controlled substance inventory to be recorded once the medication was given and that Resident 15's 8:00 AM dose should have been recorded when the medication was given. In an Interview on 11/04/2024 at 2:02 PM, Staff H, RN 2, stated they expected the controlled substance inventory ledger to be accurate with the resident's name to Make sure that medication was given to that person. Staff H further stated that they expected nurses to record medications whenever they were withdrawn and administered to Resident 15. In an interview on 11/06/2024 at 1:03 PM, Staff B stated they expected nurses to record medication withdrawn in the controlled substance inventory ledger at the point of use and that nurses are expected to record it right away after they prepared the medication. Reference: (WAC) 388-97-1300 (2)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47680

Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 2 of 3 refrigerators (Walk-in Produce/Milk Refrigerator and Walk-in Preparation Salad Refrigerator), 1 of 1 dry storage room (Commissary Dry Storage Room), and for 3 of 8 staff (Staff NN, OO & PP), reviewed for food services. The failure to date and discard food items past the use by/discard date, perform hand hygiene and handle kitchen equipment appropriately placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life.

Findings included .

Review of the facility's policy titled, Facility Food Storage and Meal Preparation Policy, dated [DATE], showed, Remove all expired food items and Any food that appears spoiled, contaminated, or past its use-by date must be discarded immediately. The policy showed, Note that the use of disposable gloves is not a substitute for proper hand washing. Hands must be washed before putting on gloves and after removing gloves. The policy further showed, Ensure cleanliness and sanitation of cutting boards, utensils, equipment, and countertops, especially when transitioning between raw and cooked foods.

WALK-IN PRODUCE/MILK REFRIGERATOR

Observation on [DATE] at 8:40 AM, showed one plastic container of Chef Salad with a discard date of [DATE].

In an interview and joint observation on [DATE] at 8:59 AM, Staff KK, Office Assistant, stated that food items that were past the use by date/discard date would be thrown away. Joint observation showed that the chef salad had a discard date of [DATE]. Staff KK stated that it should have been thrown away because it was past the discard date.

In a joint observation on [DATE] at 10:30 AM with Staff LL, Food Service Manager, showed two opened bags of green shredded cabbage with use by date of [DATE]. Staff LL stated it was cabbage and should have been discarded.

WALK-IN PREPARATION SALAD REFRIGERATOR

In a joint observation on [DATE] at 8:54 AM with Staff KK, showed one unlabeled unknown food item inside a Ziplock (brand of resealable plastic bag) in a metal container. Staff KK stated that they would find the cook to ask what it was. Staff MM, [NAME] 1, stated it was roast beef from yesterday and that it should have been labeled.

A joint observation on [DATE] at 10:34 AM with Staff LL, showed one unlabeled Ziplock containing slices of bread. Staff LL stated it was raisin bread and that it should have been labeled.

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NAME OF PROVIDER OR SUPPLIER Fircrest Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15th Northeast Seattle, WA 98155	

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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	In a follow up interview on [DATE] at 11:17 AM, Staff LL stated that their policy was to put a preparation date and discard date on food items. Staff LL stated that food items past the use by date should have been discarded and that the bag of roast beef should have been labeled. COMMISSARY DRY STORAGE ROOM A joint observation on [DATE] at 10:36 AM with Staff LL, showed four cans of cream of mushroom dated [DATE]. Staff LL stated that they would have to check with their distributor as the container did not say if it was the use by date or expiration date. On [DATE] at 10:04 AM, Staff LL provided an email document dated [DATE] that showed that the date on the product indicated the expected shelf life. It further showed, We recommend using the product before this date to ensure the best flavor, texture, and overall quality. Staff LL stated that the four cans of cream of mushroom should have been discarded. HAND HYGIENE STAFF NN Observation on [DATE] at 12:12 PM, showed Staff NN, Attendant Counselor (AC) 3, was at the Hickory Kitchenette dishwashing station rinsing dirty dishes with gloves on. At 12:15 PM, with the same gloves that they used to rinse the dirty dishes, Staff NN took two crackers from the cabinet and gave it to Staff QQ, Speech Pathologist. Staff NN then touched a bottle of Hersey's (brand-chocolate syrup) that was in a metal container of ice and closed the cabinet door. Staff NN opened the meal cart, pulled a metal tray out of the meal cart, placed it back in, closed the meal cart and went back to the dish washing station with the same gloves they used to rinse the dirty dishes. Staff NN did not remove their gloves and performed hand hygiene after rinsing the dirty dishes. In an interview on [DATE] at 12:51 PM, Staff NN stated that they were taught to perform hand hygiene between glove use. Staff NN stated that they should have removed their gloves and performed hand hygiene. In an interview on [DATE] at 2:15 PM, Staff S, AC Manager, stated that they expected staff to perform hand hygiene before and after glove use. Staff S stated that they expected that Staff NN to remove their gloves after rinsing dirty dishes and perform hand hygiene. In an interview on [DATE] at 1:19 PM, Staff B, Registered Nurse 4, stated that Staff NN should have removed their gloves before touching anything. STAFF OO (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 9:02 AM, showed Staff OO, [NAME] 2, checked the temperature of the pureed vegetables with a thermometer and disinfected it after use. Staff OO removed their gloves and wrote the temperature in a log. Staff OO applied new gloves without performing hand hygiene. Staff OO placed eight labels onto eight foil and removed their gloves. Staff OO applied new gloves without performing hand hygiene and poured the pureed vegetables into the containers and covered it with foil. Staff OO did this eight times. When Staff OO was done, they poured the remaining pureed vegetables into a different metal container and covered it with foil. Staff OO rolled the cart to the warmer and placed all eight items into the warmer. Staff OO returned to their working station and took a plastic bag of vegetables from the bottom of the cart, labeled it and placed it in the Main Big Cooler. When Staff OO returned to their working station, they removed their gloves and applied new gloves without performing hand hygiene. Staff OO took a metal container of cooked vegetables from the steamer and placed the vegetables inside the puree machine. When they were done pureeing the vegetables, Staff OO placed the pureed vegetables in a metal container, took the temperature with a thermometer, disinfected it, covered it with foil and labeled it. Staff OO logged the temperature in their log, carried the metal container to the warmer and placed it inside. Staff OO removed their gloves, placed the used metal containers in the dishwashing room. Staff OO went back to their working station and applied gloves without performing hand hygiene. In an interview on [DATE] at 9:37 AM, Staff OO stated that they were taught to perform hand hygiene all the time after they touched meat/raw food and when they changed gloves. Staff OO stated that they were working in the same station, doing the same thing, and that they did not perform hand hygiene when they removed their gloves. In an interview on [DATE] at 11:48 AM, Staff LL stated that staff were to perform hand hygiene in between task and between glove use. Staff LL further stated that Staff OO should have performed hand hygiene especially in between task. KITCHEN EQUIPMENT STAFF PP Observation on [DATE] at 10:38 AM, showed Staff PP, Food Service Worker, were on their knees on the kitchen floor with one green plastic meal tray on the floor as they were placing food items in the meal cart. When Staff PP was done, they got up, picked up the green plastic meal tray from the floor, walked over to the tray line and placed the remaining food items on a tray in the tray line. Staff PP then placed the empty green plastic meal tray that they placed on the floor back onto a stack of clean plastic meal trays. In an interview on [DATE] at 11:42 AM, Staff PP stated that if something were to touch the floor, they would pick it up and place it in the big cart where they place dirty dishes. Staff PP stated that the food items that were on the green plastic meal tray were desserts. When asked if they should place the green plastic meal tray that they placed on the floor with the other clean trays, Staff PP stated, probably not. Staff PP further stated that they should have placed it in the cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER: Fircrest Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 15230-15th Northeast Seattle, WA 98155	

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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	In an interview on [DATE] at 11:48 AM, Staff LL stated that if a meal tray were to touch the floor, staff were to put it in the dish room. Staff LL stated that they placed dirty dishes in the cart and took it to the dish room. Staff LL stated, If it was something dirty, that's where they put it to get washed. Staff LL further stated that they expected Staff PP to place the plastic meal tray in the cart where they put dirty dishes. In an interview on [DATE] at 1:42 PM, Staff A, Nursing Facility Program Area Team Director, stated that they expected staff to follow their policy and procedures. Staff A stated that food items that are past the use by date/discard date should be discarded. Staff A stated that they expected food items to be labeled. Staff A stated that staff should follow policy, wash hands between glove use. Staff A further stated that if a kitchen equipment was dirty, staff were to not use them and to wash them. Reference: (WAC) [DATE] (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

46912

Based on observation, interview, and record review, the facility failed to ensure clinical records were complete and accurate for 1 of 3 residents (Resident 18), reviewed for resident medical records. This failure placed the resident at risk for unmet care needs and medical complications.

Findings included .

Review of the facility's policy titled, Supporting End of Life Decisions in Residential Habilitation Centers, dated 06/15/2018, showed a definition for Physician Orders for Life-Sustaining Treatment (POLST) that meant a portable medical order form that allows a person with a serious illness or frailty to summarize their wishes regarding life-sustaining treatment. It further showed that all direct care staff who work with the client must be shown the POLST and trained to implement it.

Review of Resident 18's hard chart showed a POLST form dated 05/14/2024 showed Resident 18's code status (instructions to their medical team about what to do if they have no pulse and was not breathing) was Do Not Attempt Resuscitation (DNAR).

Review of Resident 18's Electronic Health Record (EHR) under the Advance Directives tab, showed that Resident 18 was full code [means that all medical measures will be taken to resuscitate and maintain life].

In an interview and joint record review on 11/01/2024 at 9:23 AM, Staff BB, Attendant Counselor 2, stated they knew what code status a resident was by looking either in the computer or in the communication log. Staff BB stated that this information should match. In a joint record review of the 24-hour communication log, showed no documentation of Resident 18's code status. Staff BB stated I can't find it for [Resident 18].

In an interview and joint record review on 11/01/2024 at 9:37 AM, Staff CC, Licensed Practical Nurse 2, stated that they would look in the paper medication administration record or the EHR to find a resident's code status. Staff CC stated they could not find the code status for Resident 18 in those places. A joint record review of Resident 18's hard chart showed that Resident 18 had a POLST, and their code status was DNAR. Further joint record review of Resident 18's EHR, Staff CC stated they could not find Resident 18's code status. Staff CC further stated that it should have shown Resident 18's DNAR code status.

In an interview and joint record review on 11/01/2024 at 11:33 AM, Staff I, Registered Nurse (RN) 2, stated that they expected staff to look for a resident's code status in the 24-hour communication log or in the EHR and that they should match. A joint record review of Resident 18's hard chart, showed that Resident 18 had a POLST signed on 05/14/2024 and was DNAR. Staff I stated they would confirm with the EHR. In a joint record review of Resident 18's EHR, showed under the advance directive tab that Resident 18 was full code. Staff I stated that these two records should absolutely match and that they did not.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fircrest Nursing Facility	15230-15th Northeast Seattle, WA 98155

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/07/2024 at 10:45 AM, Staff B, RN 4, stated that they absolutely expected the POLST form to match the code status in the EHR. Reference: (WAC) 388-97-1720 (1)(a) (i-iv)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure staff were fit tested (a test protocol conducted to verify that a respirator provides the wearer with the expected protection) timely for N95 (a device/mask designed to protect the wearer against particles and help prevent the spread of germs) masks and used correctly for 2 of 6 staff (Staff EE & Staff FF), reviewed for infection control. In addition, the facility failed to ensure hand hygiene practices and/or proper use of gloves were followed before, during, and after resident care for 5 of 14 staff (Staff Z, L, JJ, Q & R), failed to disinfect medical equipment for 2 of 2 staff (Staff II & U), and failed to ensure that infection control practices were implemented with storage of sharp containers for 3 of 3 medication rooms (Cherry, Birch & Hickory). These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . N95 MASK USE Review of the facility's document titled, Respiratory Protection Program, revised in May 2024, showed that filtering facepiece respirators (FFR) (e.g., N95 or N100) are disposable, negative-pressure, air purifying respirators where an integral part of the facepiece or the entire facepiece is made of filtering material and that respirators rely on a tight facial seal. It showed, staff required to wear FFR, supervise the use of FFR, or issue FFR must undergo training prior to the work assignment and at least every 12 months thereafter. Re-training may be required if an individual has not retained training knowledge, or there are changes in the workplace or equipment, or to update prior training. It further showed that fit tests will be provided at the time of initial assignment and at least every 12 months thereafter. Observation and interview on 10/31/2024 at 1:20 PM, showed Staff EE, Attendant Counselor (AC) 3, was wearing an N95 mask (model 3M 1870+) with a surgical mask underneath while working in the Birch unit (on quarantine precautions [a strict isolation imposed to prevent the spread of disease] that require N95 mask). Staff EE stated that an N95 mask should have a good seal. When asked why they wore a surgical mask under their N95 mask, Staff EE stated, the one I used to use was smaller, but we don't have it right now, I use the surgical mask under, so it fits better. In an interview on 11/01/2024 at 10:00 AM, Staff FF, AC 1, stated they were hired in July 2023 and had been fit tested for their N95 mask. Staff FF stated they did not have a fit testing done in July 2024, and I think it's supposed to be done yearly. Review of the annual fit testing records showed that Staff EE had last been fit tested on [DATE] and had failed the fit testing for the 3M 1870+ model of N95 mask. Further review showed that Staff FF had been fit tested on [DATE] and did not show that they had been tested in the year 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 11/05/2024 at 3:32 PM, Staff GG, Safety Officer 3, stated they were responsible for N95 mask fit testing for staff and that fit testing should be done annually. Joint record review of the annual fit testing records [as of 10/15/2024], showed that Staff EE failed their test for the 3M 1870+ model. When asked if Staff EE should be using the 3M 1870+ mask, Staff GG stated, no, not at all. Further joint record review showed that Staff FF had fit testing done on 07/26/2023. Staff GG stated that they sent a list of staff needed fit testing to managers and maybe [Staff FF] didn't come for testing. In an interview on 11/06/2024 at 2:40 PM, Staff C, Registered Nurse (RN) 3, stated that staff should wear N95 masks when a unit was on quarantine precautions. Staff C stated that if staff failed their fit testing, they should not be working on a quarantine unit and may be reassigned to another unit. Staff C further stated that Staff EE, should not have been wearing a surgical mask under their N95 mask and should not have been working on a quarantine unit. In an interview on 11/07/2024 at 10:53 AM, Staff B, RN 4, stated they expected staff to have fit testing to ensure proper fitting of N95 masks. Staff B stated they did not expect staff to work on a quarantine unit if they had a failed fit test or would wear a surgical mask under their N95 mask. HAND HYGIENE/GLOVE USE Review of the facility's policy titled, Use of Disposable Gloves, reviewed in November 2018, showed that Gloves are removed after contact with body fluids, mucous membranes, or non-intact skin and properly discarded . When gloves are worn, staff shall wash their hands with soap/water, or use sanitizing gel, immediately before putting on gloves and after removal of the gloves . remove the gloves between contact with residents. Review of the facility's policy titled Handwashing/Hand Hygiene reviewed in March 2023, showed hand hygiene should be performed before applying gloves; hand hygiene should be performed after administering medications and treatments of each resident and [after] removing any personal protective equipment. STAFF Z Observation and interview on 11/06/2024 at 1:22 PM showed Staff Z, RN 2, performed a dressing change for Resident 44's pressure ulcer (bed sore). Staff Z donned gown and gloves and took off the old dressing. Staff Z took off their used gloves and put on new gloves to clean the pressure ulcer. Staff Z did not perform hand hygiene between glove change. After cleaning the wound, Staff Z applied skin prep around the wound, took off their gloves and put on new gloves without performing hand hygiene. Staff Z finished the dressing change and then removed their gloves and performed hand hygiene. Staff Z stated that their process was to perform hand hygiene between changing gloves. In an interview on 11/06/2024 at 2:45 PM, Staff C, stated they expected staff to perform hand hygiene before and after glove use. Staff C further stated that Staff Z should have performed hand hygiene between glove use. In an interview on 11/07/2024 at 10:53 AM, Staff B stated that they expected staff to perform hand hygiene before and after glove use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47680 STAFF L Observation on 11/06/2024 at 8:34 AM, showed Staff L, RN 2, applied gloves, removed Resident 95's sock and the dressing on their left heel, which had yellow colored drainage on it. Staff L removed their gloves, poured normal saline into a cup and applied gloves without performing hand hygiene. Staff L soaked a gauze (small squares of soft, absorbent fabric) into the cup, cleansed Resident 95's wound on their left heel with the gauze and applied skin prep (film-forming dressing that forms a protective film) to the surrounding area. Staff L removed their gloves, cut the Mepilex (absorbent foam dressing), applied gloves without performing hand hygiene, and continued to cut the Mepilex as instructed. Staff L then applied the dressing to Resident 95's left heel and covered it with a transparent dressing. Staff L removed their gloves and performed hand hygiene. In an interview on 11/06/2024 at 8:51 AM, Staff L stated that when they removed their gloves, they would perform hand hygiene before they would put on a new one. Staff L stated that they should have performed hand hygiene after they removed their gloves and that they forgot that part. In an interview on 11/06/2024 at 10:38 AM, Staff C stated that they expected staff to perform hand hygiene before and after glove use. Staff C further stated that Staff L should have performed hand hygiene between glove use. In an interview on 11/06/2024 at 1:19 PM, Staff B stated that Staff L should have performed hand hygiene between glove use. STAFF JJ Observation on 10/30/2024 at 12:10 PM, showed Staff JJ, Attendant Counselor (AC) 2, was assisting Resident 34 with their lunch meal. When Resident 34 was finished with their meal, Staff JJ wiped Resident 34's mouth and right hand with an orange cloth. Staff JJ then took a blue cloth, wiped the table with it and then placed it in a bin. Staff JJ then pushed Resident 34 out of the dining room into the right wing. Staff JJ did not perform hand hygiene after assisting Resident 34 with their meal and after wiping their mouth and right hand. In an interview on 10/30/2024 at 12:21 PM, Staff JJ stated that they were taught to perform hand hygiene before and after they provide care and between residents. Staff JJ stated that they took Resident 34 to the right wing and did not perform hand hygiene. In an interview on 11/05/2024 at 2:15 PM, Staff S, AC Manager, stated that they expected staff to perform hand hygiene between resident care, after removing gloves and between residents. Staff S stated that they expected Staff JJ to have performed hand hygiene after wiping Resident 34's mouth and hands. In an interview on 11/06/2024 at 1:19 PM, Staff B stated that they expected staff to perform hand hygiene after providing care. Staff B further stated that Staff JJ should have performed hand hygiene after they assisted Resident 34. STAFF Q (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 11/04/2024 at 12:20 PM showed Staff Q, Licensed Practical Nurse 2, had gloves on when they soaked gauze pads with water and cleansed the outside of Resident 2's eyes, before placing the used gauze pads in the trash can. Further observation showed Staff Q administered Resident 2's artificial tears [eye drops that help moisten dry eyes] and that they used the same gloves from handling used gauze pads. Staff Q stated they should have taken off their gloves after handing the used gauze pads and performed hand hygiene with alcohol-based hand sanitizer and donned new gloves before administering Resident 2 their eye drops. In an Interview on 11/04/2024 at 1:13 PM, Staff H, RN 2, stated they expected staff to perform hand hygiene whenever staff donned gloves. Staff H further stated that gloves should have been changed between tasks such as cleansing eyes and when eye drops are administered. STAFF R Observation and interview on 11/06/2024 at 8:04 AM showed Staff R, LPN 4, with gloved hands, wiped off mucus [gel-like substance produced by the body to line and protect the respiratory system] from Resident 41's face with a cloth towel. Staff R then removed the used gloves and donned gloves without performing hand hygiene. Staff R then placed Resident 41's medications in the pill crusher and measured out water from a pitcher into a disposable cup. Staff R documented and handled pages in the medication administration record binder. Without changing their gloves and performing hand hygiene, Staff R then took Resident 41's syringe [large syringe used to deliver liquids or medications directly into a person's stomach through a feeding tube (medical device used to provide nutrition to persons who cannot eat by mouth)] and administered Resident 41's medication through their Jejunostomy tube [a type of feeding tube]. Staff R then removed their used gloves and donned gloves without performing hand hygiene. Staff R administered a moisturizer ointment to Resident 41's right nostril using a Q-tip [small stick with a piece of soft cotton at the tip]. When asked about the facility's policy and procedure for hand hygiene and glove use during medication administration, Staff R stated they should have performed hand hygiene whenever they changed gloves. In an interview on 11/06/2024 at 8:22 AM, Staff X, RN 2, stated that before staff donned gloves, they have to sanitize [their hands]. In an interview on 11/06/2024 at 12:20 PM at 11:05 AM, Staff C stated gloves should be changed once contaminated such as moving from one task to another and that staff need to remove [used gloves] and [perform] hand hygiene, even if it is the same [resident]. Staff C further stated, no exception, whenever [staff] change gloves, they need to sanitize [their hands]. In an interview on 11/06/2024 at 1:03 PM, Staff B stated, Between tasks and when changing gloves, I expect [staff] to perform hand hygiene. DISINFECTING VITAL SIGN/MEDICAL EQUIPMENT Review of the facility's policy titled, Cleaning and Disinfecting, revised in February 2022, showed, Client equipment if shared such as vital sign equipment, oximeter [a device that measures blood oxygen levels and heart rate] is sanitized in between clients and allowed to dry per manufacture instructions. Staff II (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/31/2024 at 8:40 AM, showed Resident 27 place their thumb and second finger in their mouth. Staff II, AC 1, placed the oximeter on Resident 27's second finger. When Staff II was done with the oximeter, they placed it in a plastic container labeled with Resident 26's name and left it uncovered on top of a cabinet that was in the common area of the left wing. At 9:05 AM, Staff II applied gloves, covered the plastic container labeled with Resident 26's name and placed it inside the cabinet. Staff II did not disinfect the oximeter prior to placing it inside the cabinet. In an interview on 10/31/2024 at 9:20 AM, Staff II stated that each resident had their own vital sign equipment and that every morning they disinfected it with alcohol wipes. Staff II stated that they were concerned with Resident 27's condition that they took the wrong resident's vital signs equipment container. Staff II stated that they took the oximeter and placed it back without disinfecting it. In an interview on 11/05/2024 at 2:15 PM, Staff S stated that the residents had vital signs equipment kits that have their names on them. Staff S further stated that staff should not be using another resident's vital signs equipment and that if they had to use another resident's vital signs equipment, they would be sanitized. In an interview on 11/06/2024 at 10:50 AM, Staff C stated that they had a set of vital signs equipment for each resident to avoid contamination. When asked if they were to use another resident's vital signs equipment, Staff C stated that it needed to be disinfected. Staff C further stated that to avoid contamination, staff should grab the correct vital signs equipment and that if they took another resident's vital signs equipment, they need to disinfect it before they put it back. In an interview on 11/06/2024 at 1:25 PM, Staff B stated that if vital signs equipment were shared, it had to be cleaned between use. Staff B further stated that they expected staff to disinfect the vital sign equipment after use. 48899 Review of the facility's policy titled, Cleaning and Disinfecting, reviewed in May 2023, showed, Equipment which may become contaminated with blood or other potentially infectious material shall be checked routinely and disinfected immediately after use, both inside and outside, prior to servicing or shipping. The policy further showed all equipment, environmental, and working surfaces shall be properly cleaned and disinfected after contact with blood or other potentially infectious materials. Observation on 10/30/2024 at 10:13 AM, showed that Staff U, AC 3, and Staff Y, AC 1, transferred Resident 29 from their wheelchair to their bed using a Hoyer lift (mechanical lift that helps transfer residents with limited mobility). Staff U and Staff Y then went to Resident 21's room with the same Hoyer lift they used for Resident 29. Staff U and Staff Y transferred Resident 21 to their wheelchair using the same Hoyer lift. Staff U and Staff Y did not disinfect the Hoyer lift between use. In an interview on 10/30/2024 at 10:28 AM, Staff Y stated that they did not disinfect the Hoyer lift between resident use. Staff Y further stated that they did not disinfect the Hoyer lift because it was already cleaned by the night shift staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/2024 at 10:31 AM, Staff U stated that they did not disinfect the Hoyer lift between resident use. Staff Y further stated that they disinfected the Hoyer lift at the end of the shift. In an interview and record review on 11/04/2024 at 2:00 PM, Staff P, AC Manager, stated that if staff wore gloves and performed hand hygiene, the Hoyer lift did not need to be disinfected between resident use. Joint record review of the equipment NOC [night] Cleaning Checklist, showed that the Hoyer lift cleaning was scheduled weekly. Staff P stated that the Hoyer lift was being disinfected by the night shift. On 11/05/2024 at 9:26 AM, Staff Z stated, in my opinion, if the staff put on gloves and sanitize their hands, they don't need to clean the Hoyer lift as frequently. However, it should be cleaned at least at the end of each shift. On 11/06/2024 at 10:21 AM, Staff C stated that the facility had not instructed the staff to disinfect the Hoyer lift between resident use. Staff C acknowledged that when the Hoyer lift was shared among multiple residents, there was a possibility of contamination. Staff C stated that they needed to start cleaning it. On 11/07/2024 at 10:19 AM, Staff B stated that they considered the Hoyer lift as shared equipment and that it should have been disinfected between resident use. Staff B stated that there was always a risk of contamination, and staff should have disinfected the Hoyer lift between resident use. 51090 STORAGE OF SHARP CONTAINERS IN MEDICATION ROOMS Review of the facility's Infection Control Manual's policy titled, Biohazard Waste, revised in November 2018, showed sharps (device used to break the skin) once used was considered the highest risk item for Hepatitis B Virus (virus [infectious agent] that affects the liver) and Human Immunodeficiency Virus (virus that attacks the body's immune system [the body's defense against infection]) transmission. Further review showed that sharp containers once filled would be capped and transported to the designated area for disposal in accordance with county regulations. CHERRY BUILDING MEDICATION ROOM Joint observation and interview on 11/04/2024 at 11:12 AM with Staff L showed an open box of tongue depressors (popsicle sticks used for mixing medications), an open box of plastic pill cups (shallow cups used to hold medications in a pill crusher device), and a used biohazard sharps container (puncture-resistant container used to safely dispose of used needles and other sharp medical instruments), stored under the hand washing sink. Staff L stated that the tongue depressors and plastic pill cups should not have been stored under the sink with the biohazard sharps container. Staff L further stated that supplies used for medication administration (tongue depressors and plastic pill cups) should have been stored in the nurse supply room instead. BIRCH BUILDING MEDICATION ROOM (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation and interview on 11/05/2024 at 10:48 AM with Staff F, LPN 2, showed an open box of plastic spoons, an opened box of plastic pill cups, a box of tongue depressors, and two used phlebotomy (needles and other sharp instruments used in the process of drawing blood) containers, stored under the hand washing sink. Staff F stated that the plastic spoons, pills cups and tongue depressors were supplies used by staff to administer crushed and mixed medications to residents. Staff F stated they would not expect supplies used for medication administration to be stored with used phlebotomy sharp containers under the sink. Staff F further stated, We have a big storage there [separate area from the medication room] for nursing supplies, but sometimes they [staff] put it there [under the sink] to make it easier to get. In an interview on 11/05/2024 at 10:57 AM with Staff G, RN 2, stated they would not expect medication administration supplies to be stored with used biohazard phlebotomy sharp containers. Staff G further stated that they expected staff to obtain their supplies from the medical supply storage and to have stored supplies in the medication cart to be used for the day. HICKORY BUILDING MEDICATION ROOM Joint observation and interview on 11/05/2024 at 10:14 AM with Staff D, LPN 2, showed an open box of plastic spoons, a box of plastic pill cups and a used biohazard sharp container stored together under the hand washing sink. Staff D stated that the biohazard sharp container contained used needles and that supplies used to administer medications (plastic spoons and plastic pill cups) should be in the medical supply room because they can't be together [with biohazard sharps containers]. In an interview on 11/05/2024 at 10:32 AM, Staff E, RN 2, stated they did not expect medication administration supplies to be stored with biohazard sharp containers. Staff E further stated, there should be nothing under the sink. In an interview on 11/06/2024 at 11:05 AM, with Staff C stated they expected biohazard sharps containers to be attached to the medication carts while in use and once filled, they should be removed and taken to the biohazard disposal area, located outside of the nursing facility buildings. Staff C stated they would not expect medication administration supplies would be stored with biohazard containers. Staff C further stated that there was the potential to expose residents to biohazardous material when supplies used to administer medications and biohazardous materials were stored together. Staff B stated they would not expect supplies used for medication administration to be stored with biohazard sharps containers. Staff B further stated that there was the potential to expose residents to biohazard material when supplies for medication administration were stored with biohazardous containers and that they wouldn't want them together. Reference: (WAC) 388-97-1320 (1)(a)(c)(5)(c)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (used to prevent pneumonia [a lung infection]) was offered for 1 of 5 residents (Resident 80) reviewed for immunizations and infection control. This failure placed residents at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from pneumococcal and disease. Findings included . Review of the facility's policy titled, Immunizations for Clients, reviewed in May 2023, showed that clients will be provided immunizations per the standardized recommendations of the local health department, CDC [Centers for Disease Control and Prevention] and Advisory Committee on Immunization Practices (ACIP). Review of the CDC online document for Pneumococcal Vaccine for Adults Aged (greater than or equal to) [AGE] years: Recommendations of the Advisory Committee on Immunization Practices (ACIP), United States, 2023, dated 09/08/2023, showed In 2021, two new pneumococcal conjugate vaccines, . (PCV15 [vaccine that protects against 15 types of bacteria that cause pneumonia)] and PCV20 [vaccine that protects against 20 types of bacteria that cause pneumonia]), were licensed for use in U.S. adults aged [greater than or equal to] [AGE] years by the Food and Drug Administration. It showed that ACIP recommendations specify the use of either PCV20 alone or PCV15 in series with PPSV23 [vaccine that protects against 23 types of bacteria that cause pneumonia] for all adults aged [greater than or equal to] [AGE] years and for adults aged 19-[AGE] years with certain underlying medical conditions or other risk factors who have not received a PCV or whose vaccination history is unknown. ACIP recommends use of either a single dose of PCV20 or [greater than or equal to] 1 dose of PPSV23 for adults who have started their pneumococcal vaccine series with PCV13 but have not received all recommended PPSV23 doses. Review of the CDC online document, Adults 19-[AGE] years old with chronic health conditions complete pneumococcal vaccine schedules, dated October 2024, showed that if an adult had received the PPSV23 vaccine only and had risk factors, including Diabetes Mellitus (chronic disease that occurs when the body cannot properly regulate blood sugar levels), they should receive either the PCV20 or PCV15 vaccine, at least one year after receiving the PPSV23 vaccine. Resident 80 admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus and was [AGE] years old. Review of Resident 80's immunization records provided by the facility showed that Resident 80 had received the PPSV23 vaccine on 02/13/2001 and 01/19/2017. No other documentation was provided that showed Resident 80 received any further pneumonia immunizations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 11/07/2024 at 12:42 PM, Staff B, Registered Nurse 4, stated that the facility followed the CDC recommendations for offering immunizations to residents and that all new admissions were offered pneumonia vaccinations. Staff B stated that Resident 80 was admitted in July 2023, was in her 40's and had Diabetes Mellitus. A joint record review of the CDC online document, Adults 19-[AGE] years old with chronic health conditions complete pneumococcal vaccine schedules, dated October 2024, showed that Resident 80 could have the PCV15, PCV20 or the PCV 21 (newest recommended vaccine that protects against bacteria that causes pneumonia) vaccine. Staff B stated that Resident 80 should have been offered either the PCV15 or PCV20 vaccine at admission and that they could not find any documentation that it had been offered. Reference: (WAC) 388-97-1340 (2)