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	11/07/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written bed hold notice at the time of transfer to the hospital for 3 of 4 residents (Residents 1, 2 & 86), and failed to provide a written transfer notice and notify the Office of the State Long-Term Care Ombudsman (an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations) of the transfer, as required for 1 of 4 residents (Resident 2), reviewed for hospitalization. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital, protection of resident rights during transfers, and a diminished quality of life. Findings included. Review of the facility's policy titled, Nursing Facility Bed Hold Policy, dated 04/11/2023, showed, In case of an emergency transfer to hospital or hospital admission, the guardian will be provided prompt notification of this policy and that the Ombudsman will be notified utilizing the Notification of Transfer or Discharge Notice form for additional notification. The policy further showed, Notices will be sent for all hospitalizations that are in excess of 24 hours. RESIDENT 1Review of the nursing progress notes dated 07/18/2025, showed that Resident 1 was transferred to the hospital for a change in condition. Review of the discharge Minimum Data Set (MDS-an assessment tool) dated 07/18/2025, showed that Resident 1 had an unplanned discharge to a Short-term General Hospital. Review of Resident 1's Electronic Health Record (EHR) showed no documentation that a bed hold notice was provided to Resident 1 and/or their representatives. In an interview on 11/04/2025 at 9:40 AM, Staff D, Registered Nurse (RN) 2, stated that they would email and notify the residents' representatives of their bed hold policy. Joint record review of Resident 1's progress notes did not show documentation that a bed hold notice was provided to Resident 1's representative. Staff D stated that they did not see a progress note that it was provided. RESIDENT 2Review of the nursing progress notes dated 08/09/2025, showed that Resident 2 was transferred to the emergency room for a change in condition. Review of the discharge MDS dated [DATE], showed that Resident 2 had an unplanned discharge to a Short-term General Hospital. Review of Resident 2's EHR did not show documentation that a bed notice and a written notice of transfer/discharge were provided to Resident 2 and/or their representative. Further review of the (continued on next page)

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

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EHR did not show documentation that the Ombudsman was notified of Resident 2's transfer. A joint record review and interview on 11/04/2025 at 9:48 AM with Staff D showed Resident 2's EHR had no documentation that a bed hold notice was given to Resident 2 and/or their representative. Staff D stated that they could not find a progress note that a bed hold notice was provided to Resident 2's representative. In an interview on 11/06/2025 at 9:41 AM, Staff B, RN 4, stated that when a resident was transferred to the hospital, they would complete a transfer/discharge notice form, provide one to the residents' representative and send a copy of the notice to the Ombudsman. Staff B stated that they would provide bed hold notices to the residents' representatives. Staff B stated that they could not find a copy of Resident 2's transfer/discharge notice form and that the Ombudsman was not notified of Resident 2's transfer to the hospital. Staff B further stated that they expected that bed bold notices would have been provided to Resident 1 and Resident 2's representatives. RESIDENT 86Review of the nursing home transfer or discharge notice dated 09/11/2025 showed Resident 86 was transferred to the hospital. Further review of Resident 86's EHR showed no documentation that Resident 86's guardian was notified of the facility's bed hold policy. In an interview and joint record review on 11/05/2025 at 2:00 PM, Staff H, RN 2, stated that the facility's bed hold policy would be provided to the resident's guardian upon hospital transfer/discharges and would be documented. Joint record review of Resident 86's clinical record (EHR and hard chart) showed no documentation that the facility notified Resident 86's representative of the facility's bed hold policy. During an interview on 11/06/2025 at 2:01 PM, Staff B stated that they expected the facility's bed hold policy would be provided to the resident's guardian and documented when a resident was transferred to the hospital. Reference WAC 388-97-0120 (2) (a-d) (4) .

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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** Based on observation, interview, and record review, the facility failed to accurately assess 4 of 18 residents (Residents 4, 12, 9 & 5), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure resident assessments were completed accurately on the MDS regarding pressure ulcer (injury to the skin caused by prolonged pressure), antipsychotic (medications used to treat symptoms of psychotic [mental health condition characterized by a loss of touch with reality]) medication review, restraint (devices or methods that limit a resident's freedom of movement), and diagnosis 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 1.20.1, dated in October 2025, 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). Review of the facility's policy titled, Individual Plan of Care Process Requirement, dated 12/10/2024 showed, The RAI assessment must accurately reflect the resident's status. RESIDENT 4Review of the quarterly MDS dated [DATE], showed in Section M (skin conditions) that Resident 4 had a Stage 3 (a deep wound that extends through the skin and into the fat layer) pressure ulcer. It further showed that under Section M1200 (skin and ulcer/injury treatments) that pressure ulcer/injury care was not marked. Review of the wound clinic note dated 09/16/2025, showed that Resident 4 had a Stage 3 pressure ulcer on their coccyx (tailbone). Review of a nursing progress note on 09/24/2025, showed treatment order applied on coccyx for Resident 4. In an interview and joint record review on 11/06/2025 at 11:26 AM, Staff V, Registered Nurse (RN) 2, stated that they used the RAI manual for completing MDS assessments. Staff V stated that they would code for pressure ulcer/injury care if staff were doing dressing changes. Staff V stated that Resident 4 had a Stage 3 pressure ulcer and was unsure if pressure ulcer/injury care should be marked. Joint record review of the RAI manual showed pressure ulcer care includes any intervention for treating pressure ulcers. Joint record review of the quarterly MDS dated [DATE], showed Section M1200 was not marked for pressure ulcer/injury care. Staff V stated, no, it's not [marked for (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the assessment period. Observations on 10/31/2025 at 9:30 AM, on 11/03/2025 at 8:37 AM and at 1:43 PM, on 11/04/2025 at 8:01 AM, on 11/05/2025 at 8:13 AM and at 1:14 PM, showed Resident 9 had a black hand mitten applied on both their hands. Further observation on 11/03/2025 at 1:43 PM, showed Resident 9 was trying to touch their face with their mittened right hand. Review of the skin integrity care plan revised on 08/02/2025 showed an intervention to apply mittens to Resident 9's hands at all times to prevent them from rubbing and scratching their face. In an interview and joint record review on 11/05/2025 at 1:40 PM, Staff J, RN 2, stated that hand mittens could be considered as restraints if the resident was unable to remove them. Joint record review of Resident 9's quarterly MDS dated [DATE] showed that Section P (Restraints and Alarms) was not marked. Staff J stated that Resident 9's hand mittens were not coded on the MDS, and that they would talk to their supervisor and would modify the MDS. During an interview on 11/06/2025 at 2:01 PM, Staff B stated that the facility follows the RAI manual for completion of MDS assessments. Staff B further stated if a resident was using hand mittens, and they were unable to remove them, it would be considered a restraint and should be coded on the MDS. RESIDENT 5Review of Resident 5's face sheet printed on 10/31/2025, showed Resident 5 had a diagnosis of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive declines). Review of the quarterly MDS dated [DATE], showed Resident 5 was not marked for Alzheimer's Disease in Section I (Active Diagnoses – under I4200). In an interview and joint record review on 11/06/2025 at 10:46 AM, Staff G, RN 2, stated that they would follow the RAI Manual for MDS accuracy. Joint record review of Resident 5's quarterly MDS dated [DATE] showed that Alzheimer's disease was not marked in Section I4200. Joint record review of Resident 5's face sheet, active diagnosis list, and Psychiatry consultation dated 08/27/2025 showed that Resident 5 had an active diagnosis of Alzheimer's disease. Staff G stated Resident 5's quarterly MDS was not accurate and that Alzheimer's Disease should have been marked in Section I4200. In an interview on 11/07/2025 at 10:15 AM, Staff B stated that they expected the quarterly MDS for Resident 5 to be completed accurately. Reference: (WAC) 388-97-1000(1)(b) .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure foods were stored and handled in accordance with professional standards of food safety for 1 of 2 kitchen walk-in refrigerators (Kitchen Main Preparation Walk-In Refrigerator), and 2 of 10 staff (Staff M & N), reviewed for food services. The failure to cover and label food items in the kitchen walk-in refrigerator and perform hand hygiene when assisting residents with their meals 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, revised in December 2024 showed that the facility is committed to upholding safe food handling, storage, and consumption protocols for the meals provided to our clients and residents. Food Storage: Retain food in its original packaging until needed.If transferred, use food-safe containers, and clearly mark them with contents and date. The policy further showed, Food Service: Staff responsible for handling food must ensure their hands are cleaned using soap and water for a minimum duration of 20 seconds prior to handling food and following any activity that may lead to contamination. Review of the facility's policy titled, Handwashing/Hand Hygiene, dated in March 2023, showed that the purpose was to avoid the spread of infection through cross-contamination. It showed that hand hygiene was to be performed before feeding clients, eating, and touching clients. It further showed that hand hygiene was to be performed after feeding a client and after working with a client. KITCHEN MAIN PREPARATION WALK-IN REFRIDGERATORIn an interview and joint observation on 11/03/2025 at 8:52 AM with Staff F, Food Service Manager, showed one uncovered/labeled tuna casserole in metal pan, one uncovered/unlabeled pan of noodles with chopped onions, three uncovered/unlabeled trays with 40 individual pie pans filled with broccoli, cauliflower, and cheese on an uncovered metal cart in the kitchen main preparation walk-in refrigerator. Staff F stated that food items should have been covered and labeled with what the food item was and the date it was prepared. In an interview on 11/07/2025 at 9:05 AM, Staff A, Superintendent, stated that they expected the food items in the kitchen main preparation walk-in refrigerator to have been covered and labeled. HAND HYGIENESTAFF MObservation on 10/30/2025 at 12:26 PM, showed Staff M, Attendant Counselor 1 (AC1), assisted Resident 56 with their lunch in the dining room. Staff M wiped food off Resident 56's mouth with an orange washcloth. When Staff M was done assisting Resident 56 with their meal, Staff M placed the resident's plate and orange washcloth on the return counter by the kitchenette. Staff M then wheeled Resident 56 to the day room. Staff M went back to the dining room and took an orange wash cloth in a basket on the table that Resident 11 was sitting in. Staff M wiped Resident 11's mouth with the orange washcloth and placed it on the sink counter in the kitchenette. Staff M exited the kitchenette and wheeled Resident 11 to the day room. Staff M did not perform hand hygiene before and after they assisted Resident 56 and Resident 11 with their meals. In an interview on 10/30/2025 at 1:12 PM, Staff M stated that they would perform hand hygiene all the time, before and after they assisted the residents to eat, when they touched the residents and/or their wheelchairs. When Staff M was informed of the above observation, Staff M stated that they should have performed hand hygiene before and after they assisted Resident 56 and Resident 11. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	STAFF NObservation on 11/05/2025 at 8:42 AM, showed Staff N, AC1, assisted Resident 45 with their meal in the dining room. Staff N wiped Resident 45's mouth multiple times with an orange washcloth when food got around their mouth. When Staff N finished assisting Resident 45 with their meal, Staff N placed the dishware on the return counter by the kitchenette. Staff N took a clean orange washcloth, wiped Resident 45's hands, and wheeled Resident 45 to the day room. Staff N did not perform hand hygiene after they assisted Resident 45 with their meal and before they assisted the resident to the day room. In an interview on 11/05/2025 at 8:50 AM, Staff N stated that they would perform hand hygiene before/after resident care, meals, applying personal protective equipment (gloves, gowns) and between resident care. Staff N further stated that they should have performed hand hygiene before they assisted Resident 45 out of the dining room. In an interview on 11/05/2025 at 9:02 AM, Staff E, Attendant Counselor Manager, stated that Staff M should have performed hand hygiene between resident care and after they assisted residents with their meals. Staff E further stated that Staff N should have performed hand hygiene prior to taking Resident 45 to the day room and prior to touching their wheelchair handle. In an interview on 11/05/2025 at 9:09 AM, Staff D, Registered Nurse (RN) 2, stated that they expected ACs to perform hand hygiene before/after they assisted residents with their meals and between resident care. Staff D stated that Staff M should have performed hand hygiene before/after dining assistance and between resident care. Staff D further stated that Staff N should have performed hand hygiene after assisting Resident 45 with their meal and before they touched their wheelchair. In an interview on 11/05/2025 at 2:57 PM, Staff B, RN 4, stated that they expected staff to perform hand hygiene before/after assisting residents with their meals and between resident care. Staff B stated that Staff M should have performed hand hygiene before and after resident care. Staff B further stated that Staff N should have performed hand hygiene prior to assisting Resident 45 to the day room. Reference: (WAC) 388-97-1100 (3)

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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. Based on observation, interview, and record review, the facility failed to ensure hand hygiene and proper glove use were followed for 2 of 16 Staff (Staff N & K) and failed to ensure Enhanced Barrier Precautions (EBP- precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections]) practices were followed for 2 of 13 Staff (Staff O & I), reviewed for infection control. These failures placed the residents, staff, and visitors at an increased risk for infection and related complications.Findings included. Review of the facility's policy titled, Handwashing/Hand Hygiene, dated March 2023 showed, the purpose was to avoid the spread of infection through cross-contamination. The policy further showed, Hand Hygiene performed before .applying gloves . and Hands hygiene performed after.handing [handling] contaminated objects.removing gloves. HAND HYGIENE/GLOVE USESTAFF NObservation on 11/03/2025 at 1:34 PM, showed Staff N, Attendant Counselor 1 (AC 1), was outside the laundry room with a double compartment cart in front of the laundry room and was wearing gloves. Staff N removed the trash bag from the cart and threw the trash bag in a dumpster outside of the building. Staff N went back inside the building wearing their gloves. Staff N then removed the glove on their right hand and pushed the cart to the bathroom with their gloved left hand. Staff N placed the cart against the wall and removed the glove from their left hand. Staff N did not remove their gloves and perform hand hygiene after they threw the trash bag in the dumpster outside the building. Another observation on 11/06/2025 at 1:51 PM, showed Staff N, took a trash bag from a room by the foyer and walked down the hallway to the laundry room wearing gloves. Staff N took bags of linens/clothing out from a cart that was outside the laundry room. Staff N removed their gloves and applied new gloves without performing hand hygiene. Staff N went inside the laundry room and took clothes out of the washing machine and the dryer. When Staff N was done, they took a bag of soiled linens into the soiled utility room and placed it in a large bin. Staff N removed their gloves, applied new gloves and pushed the cart to the bathroom. Staff N did not perform hand hygiene between glove use. In an interview on 11/06/2025 at 1:58 PM, Staff N stated that they would perform hand hygiene before and after resident care, laundry task, between glove use, and when they get in contact with anything dirty. Staff N stated they were separating the bags of linens and had changed their gloves. When asked if they should have performed hand hygiene between glove use, Staff N stated, yes. Staff N further stated they should have thrown away their gloves and perform hand hygiene after they threw out the trash in the dumpster. In an interview on 11/06/2025 at 2:14 PM, Staff D, Registered Nurse (RN) 2, stated that they expected staff to perform hand hygiene when their hands were soiled, before/after resident care and glove use. Staff D further stated that they expected Staff N to perform hand hygiene between glove use and to remove their gloves after they threw the trash in the dumpster. STAFF KObservation and interview on 11/07/2025 at 7:25 AM showed Staff K, RN 2, was in Resident 6's room wearing a gown, gloves and face shield. Staff K took Resident 6's suction (a device used to clear body fluids) canister/tubing that was on their table and took the items to the bathroom. Staff K removed their gloves and applied new gloves without performing hand hygiene. Staff K took the suction canister/tubing and washed it in the bathroom sink wearing their gloves. Staff K then wiped (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the canister/tubing with a clean towel using the same gloves. When Staff K was done, they placed the dirty towel in a bin and removed their gloves. Staff K went to the bathing room, got a clean towel and went back to the bathroom. Staff K applied new gloves and placed the canister/tubing back to Resident 6's table. Staff K did not perform hand hygiene between glove use and did not change gloves between tasks. In an interview on 11/07/2025 at 7:45 AM, Staff K stated that they would perform hand hygiene between glove use and before/after any procedure. Staff K further stated that they should have performed hand hygiene before they applied new gloves and that after they cleaned the suction canister/tubing, they should have disposed of their gloves, performed hand hygiene and applied new gloves prior to drying it with a clean towel. In an interview on 11/07/2025 at 10:19 AM, Staff C, RN 2, stated that they expected staff to perform hand hygiene between residents, between glove use, between dirty/clean tasks, before serving food, and if their hands become soiled/dirty. Staff C stated that they expected Staff N and Staff K to have performed hand hygiene between glove use. Staff C further stated that Staff K should have removed their dirty gloves, performed hand hygiene and applied new gloves after cleaning the suction canister/tubing. In an interview on 11/07/2025 at 11:00 AM, Staff B, RN 4, stated that their expectation was for staff to perform hand hygiene and to do it properly and follow the guidelines. EBPReview of the facility's procedure titled, Enhanced Barrier Precautions, reviewed in October 2025 showed, Staff will don [put on] gowns and gloves.when engaging in high-contact resident care activities with residents known to be colonized or infected with a MDRO as well as those with wounds or indwelling devices [that is inserted into the body to drain fluids or introduce medication]. Indwelling medical device: Provides direct pathway for pathogens [a tiny organism that causes disease, often called a germ] in the environment to enter the body such as indwelling urinary catheters [a thin, flexible tube inserted into the bladder to drain urine when a person cannot urinate on their own], feeding tubes [a flexible tube used to deliver nutrition to the stomach], and tracheostomy tubes [a medical device inserted into a surgically created opening in the neck to provide a breathing pathway]. STAFF OObservation on 10/31/2025 at 10:22 AM, showed Staff O, AC 1 and Staff P, AC 1, were preparing to transfer Resident 9 with a mechanical lift. Resident 9 was receiving nutrition via feeding tube. Staff O and Staff P transferred Resident 9 from their wheelchair to their bed using the mechanical lift. Staff P was wearing a gown and gloves, but Staff O was not wearing a gown during the transfer. In an interview on 10/31/2025 at 10:27 AM, Staff O stated that wearing gown and gloves were required to transfer residents with tube feeding. When asked why they were not wearing a gown during Resident 9's transfer, Staff O stated that they should have worn a gown during the transfer. STAFF IObservation on 11/05/2025 at 8:25 AM, showed Staff I, Licensed Practical Nurse 2, was preparing to administer medication to Resident 33 via feeding tube. Staff I prepared and administered Resident 33's medication via feeding tube wearing gloves and was not wearing a gown. In an interview on 11/05/2025 at 10:38 AM, Staff I stated that they were required to wear gown and gloves to administer medications via feeding tube. Staff I further stated they should have worn a (continued on next page)

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	50A260	A. Building B. Wing	11/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gown prior to Resident 33's medication administration. In an interview on 11/06/2025 at 1:35 PM, Staff C stated that staff were expected to apply a gown and gloves prior to transferring residents with a feeding tube and administering medications via feeding tube. In an interview on 11/06/2025 at 1:51 PM, Staff B stated that their expectation was for staff to wear gown and gloves prior to transferring residents with a feeding tube and administering medications via feeding tube. Reference: (WAC) 388-97-1320(1)(a)(c) .

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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** Based on interview and record review, the facility failed to ensure an informed consent explaining the risks/benefits for psychotropic medication (alters mood, perception, and behavior) was completed prior to medication administration for 1 of 5 residents (Resident 5), reviewed for unnecessary medications. This failure placed the residents and/or their representative at risk of not being fully informed of the risks and benefits before making decisions about medications prior to administration.Findings included .Review of the facility's policy titled, Use of Psychoactive Medications [used to control or manage challenging behaviors], revised on September 2021, showed, As appropriate, the client, parent and/or client representative, shall be provided with information on the psychoactive medications used or proposed in their individual case, and assisted in understanding the information supplied. Informed consent is required when psychoactive medications are used.Resident 5 was admitted to the facility on [DATE] with diagnoses that included insomnia (a sleep disorder that can make it hard to fall asleep or stay asleep).Review of physician orders printed on 11/03/2025 showed that Resident 5 was prescribed an antidepressant (medication to treat mood disorder that causes persistent feeling of sadness and loss of interest in activities) on 07/03/2025 for insomnia.Review of the October 2025 Medication Administration Record printed on 10/30/2025, showed that Resident 5 received Trazodone (antidepressant medication) daily.Review of Resident 5's clinical records (electronic health record and hard chart) showed no documentation that the resident and/or representative were informed of the risks/benefits of Trazodone use.In an interview and joint record review on 11/05/2025 at 1:55 PM, Staff G, Registered Nurse (RN) 2, stated that they expected an informed consent explaining the risks/benefits for psychotropic drug use would have been completed in the resident's clinical records. Joint record review of Resident 5's clinical record showed no documentation that the resident and/or representative were informed of the risks/benefits of Trazodone use. Staff G stated that they expected an informed consent explaining the risks/benefits should have been obtained prior to Resident 5 receiving the first dose of Trazodone.In an interview on 11/07/2025 at 10:10 AM, Staff B, RN 4, stated that they expected an informed consent explaining the risks/benefits for any psychotropic medication including Trazodone, to be completed with the resident/representative prior to the medication use.Reference: (WAC) 388-97-0260 (2) (a-d).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a care plan for 2 of 18 residents (Residents 4 & 86), reviewed for comprehensive care plans. The failure to implement the care plans for tube feeding (a way to deliver liquid nutrition through a flexible tube into the body) and indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine) placed the residents at risk for unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy titled, Individual Plan of Care Process Requirements, dated 12/10/2024, showed the process for Individual Plan of Care for residents included, Care Plan Development which establishes a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the how of resident care. It further showed the process of Care Plan Implementation which included putting that course of action.into motion by staff knowledgeable about the resident's care goals and approaches; carrying out the how and when of resident care. RESIDENT 4Review of the facility's policy titled, Gastrostomy [feeding tube inserted through a surgical opening directly into the stomach] Tube Replacement/Maintain the Patency of G/J or Jejunostomy Tube [feeding tube inserted through a surgical opening directly into the small intestine], and Stoma [surgically created opening into the abdomen] Care, reviewed in March 2024, showed that there were guidelines for holding and running the enteral [provides nutrients through a feeding tube] feeding. The guidelines included that the Attendant Counselor (AC) staff will place the feeding pump on hold during personal care, wait at least 15 minutes prior to laying the client [resident] down flat in bed. Then perform the task, when the task is completed elevate the head of the bed up 30 or 45 degrees [a unit of measurement] as per care plan. Review of Resident 4's nutrition/tube feeding care plan, reviewed on 10/04/2025, showed an intervention to always elevate head of bed 30 degrees.when client is in bed, except during personal care and transfers to prevent aspiration [when something other than air gets in the lungs]. Observation on 11/05/2025 at 8:44 AM, showed Resident 4 was lying in bed, was connected to their feeding pump, and the enteral formula was infusing. It further showed that the bed control panel displayed the head of bed at 11 degrees. Observation on 11/06/2025 at 11:08 AM, showed Resident 4 was lying in bed, was connected to their feeding pump, and the enteral formula was infusing. It further showed that the bed control panel displayed the head of bed was at 21 degrees. In an interview and joint observation on 11/06/2025 at 11:53 AM, Staff T, AC 1, stated that the residents can't [cannot] lay flat if getting feeds [enteral formula]. Joint observation showed Resident 4 was connected to their feeding pump with the enteral formula infusing and the bed control panel displayed the head of bed was at 21 degrees. Staff T stated that it's [it is] ok. In an interview and joint observation on 11/06/2025 at 12:00 PM, Staff U, Licensed Practical Nurse 2, stated that when a resident was getting tube feedings that they expected the head of bed to be at 30 degrees. Joint observation showed Resident 4 was connected to their feeding pump with the enteral formula infusing and the bed control panel displayed the head of bed was at 21 degrees. Staff U (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adjusted the head of bed to 30 degrees and stated that the head of bed should have been at 30 degrees. In an interview and joint record review on 11/06/2025 at 2:18 PM, Staff U stated that I'm [I am] familiar with care plans. Joint record review of Resident 4's nutrition/feeding tube care plan showed the intervention to always elevate head of bed 30 degrees.when client is in bed, except during personal care and transfers to prevent aspiration. Staff U stated, I'm responsible for making sure to keep [the head of bed] at 30 degrees. In an interview and joint record review on 11/06/2025 at 2:40 PM, Staff V, Registered Nurse (RN) 2, stated that they expected staff to follow care plans. Joint record review of Resident 4's nutrition/feeding tube care plan showed the intervention to always elevate head of bed 30 degrees.when client is in bed, except during personal care and transfers to prevent aspiration. Staff V stated yes, has to be 30 degrees with feeds on. In an interview on 11/07/2025 at 10:50 AM, Staff B, RN 4, stated that you have to follow the care plan. When asked if the care plan showed to elevate the head of bed 30 degrees during tube feedings, Staff B stated, I would expect that they [residents] would not be flat, would expect it [head of bed] to be elevated without a doubt. RESIDENT 86Review of the facility's policy titled, Individual Plan of Care Process Requirement, dated 12/10/2024 showed, Care Plan Implementation: Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident's care goals and approaches; carrying out 'how' and 'when' of resident care. Review of the electronic health record showed Resident 86 admitted to the facility on [DATE] with diagnosis that included neurogenic bladder (a condition where the nerves that control the bladder function abnormally, leading to problems with urine storage and/or release). Review of the annual MDS dated [DATE] showed Resident 86 was severely impaired with cognition and dependent on staff with all aspects of Activities of Daily Living (ADL). The assessment further showed Resident 86 had indwelling urinary catheter. Review of the urinary care plan last reviewed on 09/07/2025 showed intervention instructions for AC to perform peri care (cleaning of the private areas) and catheter care for Resident 86 every two hours and as needed. Observations on 11/03/2025 at 9:12 AM, 11/04/2025 at 8:18 AM, and at 11/05/2025 at 8:24 AM, showed Resident 86 had an indwelling urinary catheter. Review of the clinical notes dated on 10/20/2025 showed Resident 86 was diagnosed with bladder infection and prescribed antibiotic (type of medication that fight bacterial infections by killing bacteria or stopping them from multiplying) medication. Review of the Treatment Administration Record (TAR) for the months of September 2025, October 2025, and November 2025 did not show implementation of catheter care plan. Review of the ADL verification sheet for the Month of November 2025 printed on 11/06/2025 did not show documentation that catheter care plan was implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/05/2025 at 1:53 PM, Staff R, AC1 and Staff S, AC1, stated that they would provide catheter care with incontinent care but there was no area to document the catheter care being provided. In an interview and joint record review on 11/05/2025 at 2:15 PM, Staff H, RN 2, stated that catheter care would be provided by AC staff every shift and would be documented in the TAR. Joint record review of Resident 86's November 2025 TAR showed no documentation of catheter care. During an interview on 11/06/2025 at 2:04 PM, Staff B, RN 4, stated that catheter care would be care planned with step-by-step instructions on how to provide the care. Staff B stated that catheter care would be provided by checking every two hours and during incontinence care. Staff B further stated their expectation was catheter care plan would be implemented and the care documented. Reference: (WAC) 388-97-1020(1)(2)(a)(b) .

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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** Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted professional standards of practice for 1 of 1 resident (Resident 83), reviewed for respiratory care. The failure to change the AIRVO 2 (a humidifier with an integrated flow generator that delivers warmed, humidified, high-flow air and/or oxygen) chamber placed the resident at risk for respiratory infections, and related complications.Findings included.Review of the facility's policy titled, Preparation and Administration of Medication and Treatment, dated July 2025, showed, To ensure the prompt and safe administration of medication and treatments ordered for clients.Review of a face sheet printed on 11/03/2025 showed that Resident 83 was admitted to the facility on [DATE] with diagnoses that included tracheostomy (a surgical hole in the windpipe that helps with breathing) status.Review of Resident 83's November 2025 Treatment Administration Record (TAR) showed an order to Change Airvo [AIRVO 2] Chamber Kit, Tubing, and Water Chamber Every 2 [two] months on NOC [night] Shift Sunday. Write Date and Initial on AIRVO chamber kit, tubing and water chamber with an order date of 05/07/2025.Observations on 10/30/2025 at 10:53 AM, on 10/31/2025 at 8:53 AM and at 2:59 PM, on 11/03/2025 at 9:28 AM and on 11/04/2025 at 9:56 AM, showed an AIRVO 2 machine on top of a table by Resident 83's bed. Further observation showed that the AIRVO 2 chamber was dated 07/21/2025.In an interview and joint observation on 11/04/2025 at 10:40 AM, Staff L, Licensed Practical Nurse 4, stated that Resident 83 used AIRVO 2 every night to humidify their tracheostomy. Staff L stated that the AIRVO 2 chamber was changed every two months on night shift. Joint observation of Resident 83's AIRVO 2 chamber, showed that it was dated 07/21/2025. Joint record review of Resident 83's November 2025 TAR showed an order to change the AIRVO 2 chamber kit every two months. Staff L stated that they were not sure why the AIRVO 2 chamber was dated 07/21/2025 and that they would change it.A joint record review and interview on 11/04/2025 at 10:52 AM with Staff D, Registered Nurse (RN) 2, showed Resident 83's September 2025 MAR had an order to change the AIRVO 2 chamber kit, tubing, and water chamber every two months and that it was scheduled to be changed on 09/21/2025. Further review showed that it was marked with an = [equal] sign on 09/21/2025 which indicated as previously scheduled. Staff D stated that they did not know what previously scheduled meant but that staff should have changed the AIRVO 2 chamber kit as ordered.In an interview and joint record review on 11/04/2025 at 3:05 PM, Staff B, RN 4, stated that they expected staff to follow physician orders. Joint record review of Resident 83's September 2025 MAR showed an order to change the AIRVO 2 chamber kit, tubing, and water chamber every two months and that it was scheduled to be changed on 09/21/2025. Further review showed that it was marked with an = [equal] sign on 09/21/2025 which indicated as previously scheduled. Staff B stated that they did not know what that meant but would ask Staff Q, RN 3. Staff Q stated that the equal sign meant that it was scheduled but was not signed that it was completed. Staff B stated that they expected staff to change the AIRVO 2 chamber as ordered.Reference: (WAC) 388-97-1060 (3)(j)(vi).