STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Village Nursing Facility	State Highway 902 & Salnave Road Medical Lake, WA 99022

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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 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. 37544 Based on interview and record review, the facility failed to ensure 1 of 5 sampled residents (72), reviewed for unnecessary medications, was informed of the potential risks associated with the use of psychotropic medications (medications that can affect the mind, emotions, and behaviors). This failure placed the resident and/or their representative at risk of not being fully informed of the potential risks and benefits of taking the medications. Findings included The 07/01/2024 quarterly assessment documented Resident 72 had diagnoses which included psychotic disorder, a severe mental illness that caused a person to lose touch with reality and experience abnormal perceptions and thinking. In addition, the assessment documented the resident had received psychotropic medication. Reviews of the September 2024 Physician Order Sheet and the September 2024 Medication Administration Record documented on 03/27/2024, a psychotropic medication, Duloxetine, had been prescribed and Resident 72 had received the medication daily. Review of Resident 72's record found no documentation and/or an informed consent form had been completed that explained the risks and benefits of taking a psychotropic medication were discussed, either verbally or written, with the resident and/or their representative prior to the resident receiving the medication. In an interview on 09/26/2024 at 10:04 AM, Staff B, Director of Nursing, stated informed consents for psychotropic medications needed to be completed before the resident received the medication, and confirmed an informed consent had not been done for the Duloxetine. Reference (WAC) 388-97-0260

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47328 Based on interview and record review the facility failed to encode and transmit resident assessment data to the Centers for Medicare & Medicaid Services (CMS) within the required timeframe for 2 of 3 sampled residents (Residents 12 and 60), reviewed for timeliness in encoding and transmission of Minimum Data Set (MDS - an assessment tool). This failure affected federal health information data gathering and placed residents at risk for inaccurate monitoring of the residents' progress over time, untimely comprehensive review of residents' health data/information, and a diminished quality of life. Findings included . Review of the Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 revised October 2023, showed the RAI consisted of three basic components: the Minimum Data Set (MDS), the Care Area Assessment (CAA) and the RAI utilization guidelines. The utilization of the three component of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offered guidance on further assessment once problems were identified. All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications. For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS Completion Date. <Resident 12> Review of the quarterly assessment, dated 07/10/2024, showed Resident 12 admitted to the facility on [DATE] with diagnoses including idiopathic hydrocephalus (condition that caused accumulation of brain fluid to build up in the brain) and autistic disorder (condition that affects how a person communicates, interacts, and learns). Resident 12 had severe cognitive impairment and required substantial assistance of staff to complete most activities of daily living (ADLs). The assessment further showed it was completed 07/20/2024 at 12:43 PM. Review of Resident 12's electronic health record showed a 07/10/2024 quarterly MDS assessment with the status listed as completed, it did not show accepted. In an interview on 09/26/2024 at 11:03 AM, Staff R, Case Manager Registered Nurse (CMRN), explained the MDS process and acknowledged a completed MDS should be submitted to CMS within two weeks. Staff R reviewed Resident 12's record. Staff R acknowledged the 07/10/2024 quarterly MDS assessment status showed it was completed, it did not show accepted. Staff R reviewed CMS' iQIES but was unable to find a submission for the 07/10/2024 quarterly MDS. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 60> Review of the annual assessment, dated 07/10/2024, showed Resident 60 admitted to the facility on [DATE] with diagnoses including tuberous sclerosis (rare genetic disorder that caused tumors to grow in the brain and other organs) and mental disorders due to known physiological condition. Resident 60 had severe cognitive impairment and required substantial assistance of staff to complete most ADLs. The assessment further showed it was completed on 07/20/2024 at 10:40 AM. Review of Resident 60's electronic health record showed a 07/10/2024 annual MDS assessment with the status listed as completed, it did not show accepted. In an interview on 09/26/2024 at 11:14 AM, Staff R, CMRN, reviewed Resident 60's record. Staff R acknowledged the 07/10/2024 annual MDS assessment status showed it was completed, it did not show accepted. In an interview on 09/26/2024 at 11:19 AM, Staff B, Director of Nursing, stated MDS assessments should be submitted to CMS per the required timeframe. In a follow-up interview on 09/26/2024 at 12:18 PM, Staff R, explained Resident 12's and Resident 60's MDS assessments were compressed into a batch file that was sent to CMS through iQIES on 07/22/2024 but for unknown reasons both of the assessments were lost and not accepted. Staff R acknowledged they had no documentation to show Resident 12's 07/10/2024 quarterly MDS or Resident 60's 07/10/2024 annual MDS assessment were accepted by CMS. Reference WAC 388-97- 1000 (4)(b), (5)(b)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50027 Based on observation, interview, and record review the facility failed to implement interventions to prevent and heal pressure ulcer/injury for 1 of 1 sampled resident (Resident32). This failure placed other residents at risk for development of pressure ulcers, medical complications, and unmet care needs. Findings included . The National Institutes of Health (NIH) website nih.govshowed a pressure injury was localized damage to the skin and underlying soft tissues usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 pressure injury: intact skin with a localized area of non-blanching erythema [redness that does not disappear when pressure is applied to the area] Stage 2 pressure injury: partial thickness [involving epidermis and/or dermis] loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister Stage 3 pressure injury: full thickness [wound that extends below the epidermis and dermis into the subcutaneous tissue or deeper] skin loss, in which adipose (fat) or granulation [new connective tissue] tissue is visible in the ulcer Stage 4 pressure injury: full thickness skin and tissue loss with exposed or directly palpable fascia [connective tissue], muscle, tendon [strong cords of tissue that connect muscle to bones], ligament [bands that connect bones and joints], cartilage [tough, flexible connective tissue that protects bones and joints, and provides structure to the nose and ears], or bone in the ulcer . unstageable pressure injury: full thickness skin and tissue loss in which the extent of the tissue damage within the ulcer cannot be confirmed because it is obscured by slough [dead skin or tissue that can appear in a wound] or eschar [dead tissue that forms over healthy skin and eventually falls off] Deep Tissue Pressure Injury [DTPI]: intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation reveling a dark wound bed or blood filled blister The NIH website showed it is essential that the intended staging or classification system be used for each type of injury to ensure appropriate treatment. Review of the facility's policy titled, Pressure Ulcers, revised April 2022, documented all residents will be evaluated at least quarterly for a skin ulcer/pressure ulcer/wound, care would be provided to assess, classify staging, treat, heal, and prevent further development of pressure ulcers. The policy documented that a pressure ulcer was defined as any lesion caused by unrelieved pressure that results in damage to underlying tissue. The policy documented that a Stage 1 wound was non-blanchable (area of redness on the skin that does not disappear under applied pressure). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 01/29/2022 care plan documented Resident 32 was at risk for skin breakdown and instructed the nursing staff to assist with ADL care (bathing, grooming, toileting), ensure an anti pressure mattress was in place, utilize reusable cloth incontinent pads only and assist the resident with turning and repositioning. Further review of the careplan found no documentation that Resident 32 had a pressure ulcer. Review of the 05/23/2024 skin assessment documented Resident 32 had a red and blanchable area to their coccyx that measured 1 cm (centimeter) x 1 cm, but the skin was intact with no open areas. The assessment incorrectly identified the skin issue as a pressure ulcer. Review of a progress note dated 05/23/2024 at 11:19 AM, documented a pressure ulcer was found on Resident 32's coccyx area measuring 1 cm x 1 cm after returning from the hospital on the same day. A progress note dated 05/24/2024 at 2:32 PM, documented that the area to Resident 32's coccyx was now open and a plan of care was initiated that staff were to monitor and keep the area covered with a dressing. The 05/26/2024 skin assessment documented that Resident 32's pressure ulcer had decreased in size (0.2 cm x 0.1 cm), but now a faint small black scab with pinkish red tissue surrounding the wound. The 05/29/2024 skin assessment documented that Resident 32's pressure ulcer increased measured 0.5 cm x 0.5 cm, an increase in size from the previous assessment and the wound bed was now white in color. A progress note dated 06/14/2024 at 2:00 PM, documented that Resident 32's coccyx wound was red and yellow with a thin dark red scab measured at 1 cm x 1.2 cm. Review of the 06/25/2024 comprehensive assessment showed Resident 32 had a pressure ulcer on their coccyx (small triangular bone at the base of the spine that supports body weight and helps with balance while sitting). On 09/20/24 at 08:46 AM, Resident 32 was observed in their room and alert with a flat affect. The resident was dressed, sitting in their wheelchair, a gray hoyer sling was under them and a cloth pad was under the sling. This created multiple layers and increased the risk of pressure. Similar observations were made of Resident 32 sitting upon multiple layers on 09/23/2024 at 8:54 AM and 11:46 AM, 09/25/2024 at 9:56 AM. In an interview on 09/27/2024 at 10:32 AM, Staff AA, Attendant Counselor, stated after transferring a resident to their wheelchair, it was important to remove the Hoyer sling from underneath a resident because the sling can cause pressure. Staff AA confirmed that they do keep the Hoyer lift sling underneath the residents while sitting in their wheelchairs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/27/2024 at 12:10 PM, Staff BB, Case Manager stated that Resident 32 returned from the hospital on 05/23/2024 with a red blanchable area of skin on their coccyx. Staff BB confirmed that skin described as red and blanchable was not considered a pressure ulcer. Staff BB stated that laying cloth pads on top of a mattress and leaving a Hoyer lift sling directly underneath a resident would interfere with pressure relief. Staff BB stated that removing them would improve healing of Resident 32's pressure ulcer. In an interview on 09/27/2024 at 12:53 PM, Staff B, Director of Nursing, stated that a resident should not sit on or lay on cloth pads or Hoyer lift slings because it reduced the pressure relief from the cushion and mattress, delayed wound healing and worsens the pressure ulcer. Reference: WAC 388-97-1060 (3)(b)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46115 Based on observation, interviews and record review, the facility failed to ensure all staff had food handler's cards (a certification that showed staff had completed training on food safety) to prepare food for facility residents. Specifically, in 6 of 7 cottages, the staff were occasionally preparing and cooking some foods, without food handler's cards. In addition, 1 of 24 dietary staff (C) had an expired food handler's card. This failed practice had the potential risk for unsafe food handling practices and placed all residents at risk for developing foodborne illness. Findings included . <Cottage Staff> On [DATE] at 9:06 AM, two flats of uncooked, pasteurized eggs were observed in the Ponderosa Cottage refrigerator, and at 9:24 AM uncooked, pasteurized eggs were observed in another refrigerator in the Ponderosa Cottage. On [DATE] at 9:24 AM, a flat of uncooked, pasteurized eggs were observed in the Rosewood Cottage refrigerator. During an interview on [DATE] at 4:56 PM, Staff W, Attendant Counselor Manager (ACM), stated that some residents wanted eggs made in the cottages, as they would be cold and rubbery by the time they arrived from the kitchen. Resident 15 wanted eggs instead of meatloaf that night, and Resident 57 often liked scrambled eggs with cheese. Staff W further stated that all the attendant counselors (AC's) take food handler's training upon hire and annually, but they weren't required to get the food handlers card from the State. During an interview on [DATE] at 10:20 AM, Staff I, ACM, stated that they cooked food for residents when they requested. During a phone interview on [DATE] at 12:02 PM, a staff member from the food program at Spokane Regional Health District stated that any staff that cooked eggs, made a salad or sandwich needed a food handler' card. During an interview on [DATE] at 1:15 PM, Staff X, Licensed Practical Nurse (LPN), stated they cooked a lot on the cottages. One resident loved eggs with cheese, or grilled cheese. Staff X further stated that they got food service training, but did not have a food handler's card. During an interview on [DATE] at 9:43 AM, Staff B, Director of Nursing stated that the staff did not have food handler's cards for staff working in the cottage, as they were not preparing food, were just serving. They further stated that some cottage staff got training similar to the food handlers and acknowledged awareness that raw eggs were in the cottages. During an interview on [DATE] at 10:57 AM, Staff A, Administrator, acknowledged that if staff were preparing food, they should have food handler's cards. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Dietary Staff> A review of the dietary cards on [DATE] at 2:51 PM, showed Staff C, Dietary Aide (hire date [DATE]) did not have a current Washington State Food Handler's card. On [DATE] at 11:30 AM, Staff C was observed preparing food in the main kithen for the lunch service. During an interview on [DATE] at 12:44 PM, Staff D, Dietary Manager, stated a Washington State Food Handler's card was required for all kitchen staff working with food and acknowledged Staff C's card had expired. Staff D added it was important to have a current card to keep updated on food safety. Reference: WAC [DATE]

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety 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** 47328 Based on observation, interview, and record review the facility failed to test modified fluid consistencies after preparation and before serving to vulnerableresidents at risk for aspiration (inhalation of food, liquid, or other material into the airway or lungs) in accordance with professional standards of practice and resident needs for 3 of 9 sampled residents (Residents 8, 30 and 43), reviewed for food and nutrition services. In addition, the facility failed to ensure that foods were stored and prepared in a safe manner, and dishwasher temperatures met the required standard which placed residents at risk for food borne illness and diminished quality of life for all 75 residents. The failure if the facility to make sure that residents at risk of aspiration received the correct fluid consistency represented an immediate jeopardy (IJ). On [DATE] at 8:01 PM, the facility was notified an IJ was identified related to F812 CFR S483.60 Food Procurement/Store/Serve/Sanitary. The facility removed the immediacy on [DATE] with an onsite verification by surveyors ensuring the facility tested thickened fluids after preparations and before serving to the residents, completed audits and training for staff. Findings included . <MODIFIED FLUID CONSISTENCY> Review of the facility policy titled, Liquid Consistencies, revised ,d+[DATE], showed the facility followed the International Dysphagia (swallowing difficulties) Standardization Initiative (IDDSI) for texture descriptions and terminology. The policy categorized liquids into 4 levels from ,d+[DATE]; Level 0- thin: liquid consistency that has not been altered. Level 2- nectar thick/mildly thick: liquids that in their natural state were similar to a nectar consistency or other liquids that have been thickened to that consistency. When poured from a spoon, the nectar thick would coat the spoon then quickly drain off, but slower than thin liquid. Level 3- honey thick/moderately thick: liquids were thickened to a consistency similar to honey. When poured from a spoon, honey thick/moderately thick liquids would not stick to the spoon. Honey thick/moderately thick liquids drip slowly in dollops through the prongs of a fork and could be drank from a cup or glass. Level 4- spoon thick/extremely thick: this consistency was also called pudding thick because these liquids were thickened until they resemble a pudding texture. These liquids do not pour and show only slow movement under gravity. This consistency fell off of a spoon and held its shape when dropped onto a plate without spreading out. The policy instructed staff to use commercially prepared thickened liquids or create different thickened liquid consistencies by using a thickening gel thickener via a pump dispenser. The policy directed staff to use one pump of gel thickener in four ounces of thin liquid to produce a nectar thick liquid, use two pumps of gel thickener in four ounces of thin liquid to produce a honey thick liquid, and use four pumps of gel thickener in four ounces of thin liquid to produce a spoon thick consistency. The policy further showed a resident could chose a more modified liquid but not one that was less modified and included the example a resident on a honey thick liquid could choose a spoon thick liquid but not a nectar thick or thin liquid. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The International Dysphagia Diets Standardization Initiative website, IDDSI.org showed with regard to modified drink thicknesses showed some people have problems feeding, chewing or swallowing. This means some food and drinks are a danger for choking or for material to 'go down the wrong way' and into the airway. The International Dysphagia Diet Standardization Initiative, through consultation and following best practice principles, has developed a global standardized way of describing food and drinks that are safest for people with feeding, chewing or swallowing problems Simple measurement methods are included in the framework. These methods confirm the IDDSI level a food or drink belongs to, or if it is unsafe for people with feeding, chewing or swallowing problems The IDDSI Funnel [a 10-millimeter (ml) syringe with a larger whole on the top syringe end with a funnel attached to pour fluid into and a small nozzle hole on the lower end to allow fluid to flow through, and syringe labeled from bottom to top with zones for level ,d+[DATE] fluid thickness] is intended to check the flow rate of a liquid. The IDDSI level depends on liquid remaining after 10 seconds flow: cover [small lower] nozzle with finger, pour [liquid] to fill line, remove finger from nozzle as you start the stopwatch, stop at 10 seconds [plug small nozzle whole with finger] . Fluids are categorized by thickness from ,d+[DATE]; Level 0 - thin fluids, flow like water, fast flow, can drink through any typer of teat/nipple, cup or straw. Less that 1 ml remaining in the 10ml slip tip syringe after 10 seconds of flow. Level 1- slightly thick, thicker than water, requires a little more effort to drink than thin liquids, flows through a straw, syringe, teat or nipple. ,d+[DATE] mls remain in the syringe after 10 seconds of flow. Level 2- mildly thick, flows off a spoon, skippable, pours quickly from a spoon, but slower than thin liquids. Mild effort is required to drink this thickness through standard bore straws. ,d+[DATE] mls remain in the syringe after 10 seconds of flow. Level 3- moderately thick, moderate effort is required to suck through a standard bore straw, cannot be eaten with a fork because it drips slowly in dollops through the prongs, can be eaten with a spoon. Over 8 mls remain in the syringe after 10 second of flow. Drips slowly in dollops through the prongs of a fork, easily pours from spoon when tilted; does not stick to spoon. Level 4- extremely thick, usually eaten with a spoon (a fork is possible), cannot be drunk from a cup because it does not flow easily, cannot be sucked through a straw, falls off spoon in a single spoonful when tilted and continues to hold shape on plate, not sticky. Cannot test using the IDDSI flow test, must use the fork drip test or spoon tilt test. When a fork is pressed on the surface of a level 4 extremely thick liquid, the tines/prongs of a fork can make a clear pattern on the surface, and/or the food retains the indentation from the fork. Fork drip test, sample sits in a mound/pile above the fork; a small amount may flow through and form a short tail below the fork tines/prongs, but it does not flow or drip continuously through the prongs of a fork. Using the spoon tilt test, a spoonful must plop off the spoon if the spoon is tilted or turned sideways; a very gentle flick (using only fingers and wrist) may be necessary to dislodge the sample from the spoon, but the sample should slide off easily with very little food left on the spoon. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The National Institute of Health (NIH) website nih.gov showed with regard to aspiration showed aspiration occurs secondary to swallowing dysfunction, reflux [when stomach contents such as food or acids flow back into the throat], or inability to protect the airway adequately. The presence of foreign material in the lungs subsequently initiates an inflammatory response. On physical exam, early signs can include wheezing [high-pitched whistling sound that occurs when air moves through narrowed or blocked airways in the lungs], chronic cough, nocturnal [occurring at night] cough, and/or recurrent pneumonia [lung infection], as well as abnormal lung sounds, including rhonchi [low-pitch snoring or gurgling noises caused by generalized obstruction in the airway] or crackles [bubbling, rattling, or clicking lung sounds caused by air passing through fluid, mucus, or pus] on auscultation [listening to body sounds during examination]. Decreased or lack of breath or sounds can be a finding if a complete obstruction [blockage] has occurred. Desaturation [blood oxygen levels drop below normal levels] on pulse oximetry [a way to measure the amount of oxygen in one's blood] can demonstrate a worsened aspiration syndrome, given that a significant portion of the respiratory tract must be knocked out to cause overall hypoxemia [condition that occurs when there is not enough oxygen in the body's tissues or cells]. <Resident 8> Review of the quarterly assessment, dated [DATE], showed Resident 8 had diagnoses including cerebral palsy (condition that affects muscle tone, movement, and coordination), microcephaly (when a baby's head is smaller than normal), and legal blindness. Resident 8 was dependent on staff assistance to perform most activities of daily living (ADLs) including eating. Resident 8 had severe cognitive impairment and needed a mechanically altered diet that required a change in food texture or liquid consistency. The assessment further showed Resident 8 did not show signs and/or symptoms of a possible swallowing disorder such as loss of liquids/solids from mouth when eating or drinking, holding food in mouth or cheeks, coughing or choking during meals, or complaints of difficulty or pain with swallowing. Review of the [DATE] comprehensive nutritional assessment showed Resident 8's diet consistency was puree for solid foods and pudding/spoon thick liquids. The assessment showed Resident 8 required feeding assistance to be at a slow rate to minimize coughing, allow time between bites for oral clearance, and staff were to encourage a second swallow for each bite. Staff were to encourage fluid intake. The assessment further showed Resident 8 had no changes in appetite or fluid intake, but staff noted increased coughing. Review of the [DATE] Resident Diet Cardex showed Resident 8's diet was puree for solids and level 4 extremely thick liquids. Resident 8 was to receive 16 ounces (oz) of water/flavored water with meals, three times daily. Review of [DATE] provider progress note showed Resident 8 had diffuse rhonchi, and decreased oxygen saturation levels that resolved within 24 hours that was likely related to position or possible mild aspiration. Review of [DATE] nutrition notes showed Resident 8's diet consistency was puree for solids and spoon thick (level 4) liquids. Resident 8 was observed eating breakfast. Staff prepared and served Resident 8's meal then provided 1:1 feeding assistance. Resident 8 ate all of their meal and drank almost all of their fluids. Resident 8 had occasional coughing throughout the meal and staff encouraged Resident 8 to clear their throat. (continued on next page)

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Lakeland Village Nursing Facility	State Highway 902 & Salnave Road Medical Lake, WA 99022

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of [DATE] provider orders showed Resident 8's diet consistency was puree texture with spoon thick level 4 liquids. During observation, interview, and record review on [DATE] at 11:25 AM, Staff J, Attendant Counselor (AC), was observed preparing thickened fluids using a gel thickener via a pump dispenser. Staff J stated the side of the thickening agent bottle had directions on how many pumps to use when making 4 oz, 6 oz, and 8 oz of thickened fluids. Staff J stated that some fluids reacted to the thickening agent and required either more or less pumps of thickener. Staff J further stated cottage staff made thickened fluids every meal and used approximately one 55oz bottle of gel thickener a day because staff made so many thickened fluids. Staff J was asked to verify the thickened fluid consistency created was accurate. Staff J stated they had not done that in a long time, pulled out a quick reference guide card, and a fork. Review of the directions for use on the side of the thickening agent gel bottle directed staff to follow and use the usage chart to dispense appropriate amount of gel thickener into beverages. The directions included a strokes per beverage chart for 4 oz, 6 oz, and 8 oz. For nectar thick consistency, the chart showed one pump was required to make 4 oz of nectar thick, no pump guidelines were included for 6 oz of nectar thick fluid, and showed two pumps was required to make 8 oz of nectar thick fluids. For honey thick consistency, the chart showed two pumps were required to make 4 oz of honey thick, no pump guidelines were included for 6 oz of honey thick fluid, and showed four pumps were required to make 8 oz of honey thick fluids. For pudding thick consistency, the chart showed four pumps were required to make 4 oz of pudding thick fluid, no pump guidelines were included for 6 oz of pudding thick fluid, and eight pumps were required to make 8 oz of pudding thick fluids. The directions did not specify some fluids reacted to the thickening agent differently and would require either more or less gel thickener to create the appropriate desired consistency. During an observation on [DATE] at 11:32 AM, Resident 8 had a clear cup of red and orange thickened fluids on the table in front of them. Staff K, AC, assisted Resident 8 with their meal and Resident 8 began to cough. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During continuous observation, interview, and record review on [DATE] from 5:20 PM until 05:55 PM, Staff L, AC, was observed pumping gel thickener into different size cups, placing them on the kitchen counter, pouring colored fluids into the cups, and mixed fluids. Staff L was not observed verifying or testing any fluids made for accurate consistency. At 5:39 PM, Staff K, served Resident 8 a plate of food and two cups of thickened fluids without testing or verifying the liquid consistency was accurate, one cup contained a red thickened fluid, and one cup contained an orange thickened fluid. At 5:41 PM, Staff K, spooned the red thickened fluid into Resident 8's mouth, the red thickened fluid dripped down the front of Resident 8's mouth down to their chin. Review of Resident 8's Diet Cardex used by staff for reference when they made the thickened fluids during this meal service, showed Resident 8 was to be served extremely thick fluids. At 5:45 PM, Staff K was asked if they verified the thickened fluid consistency was accurate prior to serving Resident 8, Staff K stated they could tell what consistency a fluid was by looking at it, as they mixed the red thickened fluid in the cup with a spoon and red thickened fluid dripped off the spoon when turned over. Staff K stated Resident 8 was to receive extremely/pudding thick fluids while they continued to stir the red thickened fluid in front of them, turned a spoonful of red thickened fluid over and red fluid dripped off the spoon. Staff K was asked to test and verify the thickened fluid consistency was accurate for the fluid they were assisting Resident 8 drink. Staff K was prompted to pull out their name badge that contained a quick reference guide on modified liquid consistencies and how to test/verify consistency using the syringe drip flow, fork drip or spoon tilt tests. Staff K placed the red thickened fluid they had given to Resident 8 on top of fork prongs, the red thickened fluid proceeded to slowly drip through the fork prongs into the cup in a long continuous drip. Staff K was then asked to test and verify the orange thickened fluid consistency was accurate. Staff K placed the orange thickened fluid on top of fork prongs, and it immediately dripped through the fork prongs, quicker than the red thickened fluid that was just tested . Resident 8 was observed coughing. Staff K stated they were unsure how to determine what size a cup was. Review of [DATE] nursing progress notes showed on [DATE] Resident 8 coughed during their dinner meal related to possibly having the incorrect liquid consistency. A 11:23 PM, Resident 8 had some rhonchi to their right lung. In an interview on [DATE] at 10:37 AM, Staff B, Director of Nursing (DNS), stated the facility used a variety of cup sizes and direct care staff were trained by their managers on how to identify a cup's size. In a follow-up interview on [DATE] at 10:45 AM, Staff B, stated they expected staff to appropriately thicken fluids and verify proper consistency each time fluids were thickened. <Resident 30> Per the [DATE] quarterly assessment, Resident 30 had diagnoses which included profound intellectual disabilities, seizures and arthritis. Resident 30 had severe cognitive impairment, needed total assistance for eating and required moderately thickened fluids. Per the [DATE] nutrition assessment, Resident 30 was to be given one bite/sip via spoon, wait for swallow and then provide them with an empty spoon bite to elicit dry swallow to assist with residue clearance and decrease risk of aspiration. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the [DATE] Diet Cardex documented Resident 30's diet was puree for solids and level 3 moderately thick liquids. Resident 30 was to be offered an 8 to 12 oz glass of water prior to food and 8 oz of water with meals, three times daily. Review of [DATE] provider orders showed Resident 30's diet consistency was puree texture with moderately thick level 3 liquids. During an observation on [DATE] at 5:50 PM, Staff Y, AC, was observed making thickened fluids using a gel thickener via a pump dispenser. Staff Y tested the crystal light drink with a fork and the fluid trickled through the fork prongs very quickly (Faster than moderately thickened fluids) and Resident 30 was served the fluid. In an interview on [DATE] at 5:50 PM, Staff Y stated the fluid was moderately thick and it could be checked for the correct consistency by using a fork or a dropper. Staff Y stated if the fluid went through the fork tongs, it was considered moderately thick. During an interview on [DATE] at 5:51 PM, Staff Z, ACM, stated they have thickened fluids for so long that they can eyeball the fluids for the correct consistency, or they can check the fluids with a spoon or the dropper. Staff Z stated the fluids could be checked by using a fork and for moderately thickened fluids it would look like honey falling off the fork. Staff Z added it was important to thicken fluids to the correct consistency to prevent aspiration. <Resident 43> Per the [DATE] annual assessment, Resident 43 had diagnoses which included intellectual disabilities and serious mental illness. Per the [DATE] nutrition assessment, Resident 43 required moderately thickened liquids and fluids served in a cup with a straw. The resident needed staff assistance to maintain the straw in the cup and intermittent supervision for eating. Resident 43 was to alternate bites of solids with liquids, decrease bite size, slow down while eating, and take a break between every one to two sips of liquids from the straw. During the initial dining observation in the kitchen and dining area on [DATE] at 11:24 AM, Staff CC, AC, prepared thickened liquids for Resident 43. Staff CC was observed stirring thin liquids mixed with thickener with a spoon in two different cups (red and blue). After they finished stirring the liquids, Staff CC did not test the consistency of either fluid cups. At 11:26 PM, Staff CC placed the lids on the cups. At 11:29 AM, Staff DD, Attendant Counselor, placed the now covered blue and red cups in front of Resident 43 on the table and put a straw in each cup. At 11:31 AM, Resident 43 picked up one of the cups, sipped from the straw and immediately coughed. The resident coughed at various time while drinking from the straw. FOOD STORAGE AND LABELING (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled, Food Storage updated ,d+[DATE], showed when food was stored improperly it could allow harmful bacteria to grow and cause illness. Food must be stored at appropriate temperature for those that require temperature control and foods must only be stored for a certain amount of time for both product safety and quality. Marking the date on food items was essential so that others knew when items should be discarded. The policy showed each cottage refrigerator (fridge) and freezer would be monitored continuously via use of an electronic thermometer with a display outside of the cold-holding unit in which an alarm would sound if the temperature(s) traveled outside of appropriate pre-set ranges. Additionally, refrigerators and freezers would have a secondary internal thermometer to use as a backup. The policy instructed staff to check the back up thermometer, if the temperature was found to be out of parameters (between 32 and 41 degrees Fahrenheit (F) for refrigerators and 32 degrees F or below for freezers). The policy included a food algorithm decision tree chart to help staff identify and assign food discard dates. The policy specified food delivered from the facility's main kitchen was to be discarded by midnight the day it was received, read-to-eat foods brought by residents or leftovers brought back to campus were to be discarded within 24 hours of arriving on campus, food items delivered from an outside retailer or packaged food from a retailer should be verified for manufacturer's best by dates. The policy further showed unopened foods may be stored until the manufacturer's best by date and stored in the refrigerator, freezer, or other food-safe area for shelf-stable items as appropriate. If an item did not require refrigeration after opening, it was to be used within 3-months of opening or the manufacturer's best by date, whichever came first. If an item required refrigeration after opening it was to be dated and used within seven days of opening or the manufacturer's best by date, whichever came first. For items that required freezing were to be used within one month of opening or the manufacturer's best by date, whichever came first. <Main Kitchen> During an observation on [DATE] at 10:01 AM, the main kitchen refrigerator had a roux (Mixture of fat and flour used in making sauces) dated [DATE], and a cake that had no date. Staff G, Cook, stated items were looked at weekly for expiration dates and the roux was missed. Staff G further stated it was important to discard expired foods to prevent bacteria. In an interview on [DATE] at 10:22 AM, Staff D, Dietary Manager, verified there was no date on the cake. Staff D stated food should be labeled with the date it was prepared and a use by date to prevent bacteria and illness. <Ponderosa Cottage> During observation on [DATE] at 9:06 AM, the cottage fridge contained an undated white to go container labeled with ,d+[DATE] cup apricots lunch, and a square box of prune juice labeled in black sharpie with O- , d+[DATE] and X- ,d+[DATE]. During observation and interview on [DATE] at 9:13 AM, Staff M, Cottage Manager, stated prune juice box labeled with O was for the open date and the X was the expiration date. Staff M explained refrigerator and freezer temperatures were checked every shift and documented on the back of the cottage shift exchange form. Staff M reviewed [DATE] through [DATE] shift exchange form documentation with the surveyor. Staff M acknowledged the refrigerator and freezer temperature verification line was not transferred over from [DATE] to [DATE]. Staff M was unable to locate refrigerator or freezer temperature verification documentation for [DATE]. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	<Tamarack Cottage> During observation on [DATE] at 9:25 AM, the cottage refrigerator had a digital thermometer attached to the side with two cords, one ran into the fridge and the second ran into the freezer. Probe one read 29 F and probe two read 82 F, no visual alarm on the thermometer was seen nor an audible alarm heard. Upon opening the fridge, the temperature probe was noted to be attached to the inside of the fridge with a suction cup. Upon opening the freezer, the thermometer probe was missing the suction cup and probe dangled below the freezer door seal. The freezer contained an undated and unlabeled bag of green beans and French toast that were frozen solid. In an interview on [DATE] at 9:29 AM, Staff N, AC, and Staff O, Licensed Practical Nurse (LPN), acknowledged the thermometer attached to the side of the refrigerator read 81 F and there was no visual alarm seen nor audible alarm heard. Staff O obtained a different thermometer to verify temperatures. Staff N acknowledged the freezer thermometer probe was not attached to the freezer and dangled outside the freezer right above the floor. During observation, interview, and record review on [DATE] at 9:41 AM, Staff P, Cottage Manager, stated freezer items were to be labeled the day they arrived on the cottage. Staff P was shown the freezer thermometer probe dangled outside the freezer. Staff P stated fridge and freezer temperatures were checked by staff every shift and initialed on the back of the shift exchange form. Staff P reviewed [DATE] through [DATE] refrigerator and freezer temperature verification documentation. Staff P acknowledged there were only staff initials for one shift on [DATE] and [DATE]. <Harvest Cottage> During an observation on [DATE] at 2:03 PM, the cottage refrigerator had an undated open bag of frozen waffles, no open or use by date was found. In an interview on [DATE] at 2:03 PM, Staff K, LPN, acknowledged there should be an open date on the package of waffles. <[NAME] Cottage> During an observation on [DATE] at 11:22 AM, the cottage refrigerator contained tater tots and chicken nuggets dated [DATE], two containers of prune juice, one container of prune juice was labeled as opened on [DATE] and the second had no open date. Staff I, ACM, stated the tater tots and chicken nuggets were good for three months and the prune juice was good for seven days after it was opened. Staff I stated the food, and juice should have been discarded as it could cause illness. <Dishwasher Temperatures> During an observation of the kitchen on [DATE] at 3:43 PM, Staff D, Dietary Manager, ran the dishwasher twice and the final rinse was 167 degrees, not 180 degrees as required. Staff D stated they thought the dishwasher was a high temperature dishwasher but would have to check. In an interview on [DATE] at 3:32 PM, Staff D stated when the dishwasher temperature was out of range, the staff needed to let it cool down and run it again. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the dishwasher temperature logs from August through [DATE] documented the following: [DATE] 160 degrees in AM [DATE] 165 degrees in AM, 175 degrees in pm [DATE] 160 degrees in AM [DATE] 160 degrees in AM [DATE] 165 degrees in PM [DATE] 160 degrees in PM [DATE] 175 degrees in AM [DATE] 175 degrees in AM [DATE] 175 degrees in AM [DATE] 177 degrees in AM [DATE] 175 degrees in AM, 176 degrees in PM [DATE] 178 degrees in PM In an interview on [DATE] at 1:48 PM, Staff D confirmed the dishwasher was a high temperature dishwasher. Staff D stated it was important for the dishwasher to reach the final rinse temperature of 180 degrees to kill the bacteria. <Facial and hair coverings> During the initial kitchen tour on [DATE] at 9:21 AM, it was observed that Staff E, Food Service Supervisor, had a long goatee and was baking cookies. Staff E's goatee was not covered by a hair net. During an observation on [DATE] at 10:16 AM, Staff F, Cook, had a beard and was preparing food for lunch. Staff F's beard was not covered by a hair net. During an interview on [DATE] at 12:35 PM, Staff D, Dietary Manager, stated hair nets were to be worn on facial hair when working with food. Staff D added this was important to prevent contamination and bacteria. Reference WAC: [DATE] (3), -2980 46115

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 47328 Based on observation, interview, and record review the facility failed to review policies yearly as required, perform hand hygiene and/or glove changes when indicated, handle, store, and transport laundry in a manner to prevent the spread of infection. In addition, the facility failed to place signage in a conspicuous location outside the residents' room to clearly identify transmission based precautions implemented and appropriate personal protective equipment (PPE) to be used, and implement enhanced barrier precautions to prevent the spread of multidrug-resistant organisms (MDROs) for 1 of 3 sampled residents (Resident 14), reviewed for infection control. This failure placed residents at risk of development of a MDROs, communicable diseases, and diminished quality of life. Finding included . POLICIES Review of facility policy titled, Antibiotic Stewardship Program showed the policy was last reviewed 08/24/2022. In an interview on 09/26/2024 at 1:12 PM, Staff Q, Infection Preventionist, stated infection control policies were typically reviewed yearly, and the last review date would be documented on the policy itself. In an interview on 09/26/2024 at 2:39 PM, Staff B, Director of Nursing (DNS), stated nursing related policies and procedures were reviewed yearly and as needed. Staff B further stated the last review date would be documented on the policy itself. In a follow-up interview on 09/26/2024 at 2:54 PM, Staff B, reviewed the Antibiotic Stewardship Program policy and acknowledged it was last reviewed 08/2022. Review of facility policy titled, Infection Prevention and Control Program showed the policy was last reviewed and/or updated on 08/24/2022. In a follow-up interview on 09/26/2024 at 2:57 PM, Staff B, reviewed the Infection Prevention and Control Program policy and acknowledged it was last reviewed 08/2022. Review of facility policy titled, Resident Health Program showed the policy was last reviewed 11/22/2022. In a follow-up interview on 09/26/2024 at 3:03 PM, Staff B, reviewed the Resident Health Program policy and acknowledged it was last reviewed 11/2022. Review of facility policy titled, Surveillance for Healthcare Acquired Infections showed the policy was last reviewed/updated on 03/03/2023. In a follow-up interview on 09/26/2024 at 3:02 PM, Staff B, reviewed the Surveillance for Healthcare Acquired Infections policy and acknowledged it was last reviewed 03/03/2023. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Review of facility policy titled, Handling and Washing Soiled Laundry revised 05/26/2022, showed all used linen and/or laundry was considered contaminated. Laundry was defined as a resident's personal clothing, linens (sheets, blankets, pillows), towels, and washcloths. The policy showed staff were to use PPE that was adequate to prevent exposure while handling or sorting. The policy required staff to wear gloves and clothing protection when sorting soiled laundry.

In a follow-up interview on 09/26/2024 at 3:05 PM, Staff B, reviewed the Handling and Washing Soiled Laundry policy. Staff B stated staff were required to wear gloves and clothing protection when sorting soiled laundry. Staff B acknowledged the policy was last reviewed 05/26/2022.

LAUDNRY

<Ponderosa>

During observation and interview on 09/20/2024 at 10:12 AM, Staff M, Cottage Manager, walked through the laundry room with the surveyor. The laundry room had a yellow taped line to separate the dirty side of the laundry room with the washers and the clean side of the laundry room with the dryers. A large barrel full of dirty clothes, above the rim without a lid was observed next to the washer. Numerous cabinet and cupboard doors were open, with piles of clean folded clothes sitting inside open cabinets, on the counters, on top of the dryer and on top of the washer. Staff M stated resident's personal clothing and mechanical lift transfer slings were washed in the cottage. Staff M stated staff were only required to wear gloves when sorting dirty laundry. Staff M acknowledged the laundry room was not very organized and began to shut cabinet doors.

<Tamarack>

During observation and interview on 09/23/2024 at 9:16 AM, Staff N, Attendant Counselor (AC), walked through the laundry room with the surveyor. The laundry room did not have a visual line to separate the dirty side of the laundry room with the washers and the clean side of the laundry room with the dryers. Staff N stated the laundry room was not separated by clean or dirty, it was separated by right and left side of the cottage. Staff N explained that the washer and dryer on the left side were used to wash resident's personal clothing from the left side of the cottage and the washer and dryer on the right side were used to wash resident's personal clothing from the right side of the cottage. Staff N further stated staff were only required to wear a pair of gloves when sorting dirty laundry. Staff N explained clean clothes was either hung up or folded per load then delivered to each resident individually and acknowledged staff did not cover clean clothing when it was transported back to the resident's room.

In an interview on 09/26/2024 at 12:28 PM, Staff R, Case Manager Registered Nurse (CMRN), stated they were unsure of the laundry process but expected staff to wear appropriate PPE for handling soiled laundry and handle, store, and transport laundry in a way to prevent infection.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 09/26/2024 at 1:17 PM, Staff Q, Infection Preventionist, explained laundry rooms should be separated by clean and dirty side to prevent cross contamination, air should not flow from the dirty side to the clean side, staff should wear gloves and a gown if soiled laundry may touch staff's clothing, once washed clean laundry should be stored and transported covered to be shielded from recontamination. Staff Q was unsure of the laundry process on the cottages and acknowledged they had not assessed the cottage laundry rooms to ensure staff followed appropriate infection control procedures. Staff Q acknowledged clean clothing should not sit out exposed and uncovered. Staff Q expected staff to follow appropriate infection control procedures when handling, storing, processing, and transporting laundry. In an interview on 09/26/2024 at 3:06 PM, Staff B, DNS, stated resident's personal laundry was washed on the cottages. Staff B reviewed the handling and washing soiled laundry policy and acknowledged staff should wear gloves and a gown when sorting soiled laundry. Staff B further stated laundry rooms had to be separated by clean and dirty sides, once clean laundry should be stored and transported covered. Staff B acknowledged the washer was considered dirty and clean laundry should not be stored on the dirty washer. Staff B expected staff to wear appropriate PPE when handling soiled laundry and handle, store, process, and transport laundry in a manner to prevent the spread of infection. HAND HYGIENE The website CDC.gov - in which CDC refers to Centers for Disease Control and Prevention- with regard to hand hygiene showed, hand hygiene protects both healthcare personnel and patients. Hand hygiene means handwashing with water and soap or antiseptic hand rub (alcohol-based foam or gel hand sanitizer) . gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning [applying] gloves and touching the patient or the patient's surroundings recommendations for hand hygiene in healthcare settings . immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal cleaning hands at key times with soap and water or hand sanitizer that contains at least 60% alcohol is one of the most important steps you can take to avoid getting sick and spreading germs to those around you. There are important differences between washing hands with soap and water and using hand sanitizer When washing hands with soap and water rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet to use alcohol-based hand sanitizer, put product on hands and rub hands together cover all surface and rub until hands feel dry, this should take around 20 seconds. During observation on 09/18/2024 at 11:07 AM, Staff S, AC, served food onto a red divided plate, checked the temperature, rinse the thermometer with water, wiped the thermometer with a brown paper towel, then discarded the paper towel in the trashcan touching the trashcan lid. Staff S did not perform hand hygiene then proceeded to deliver resident meals. At 11:09 AM, Staff S returned to the kitchen to serve up more food without performing hand hygiene, checked food temperature, rinsed the thermometer with water, wiped the thermometer with a brown paper towel, then discard the paper towel in the trashcan, again touching the trashcan lid. Staff S did not perform hand hygiene and returned to the kitchen to place the thermometer in a protective sheath. At 11:13 AM, Staff S assisted a resident with their mobile device, washed their hands with soap and water, discarded the paper towel in the trashcan, again touching the trashcan lid, did not perform hand hygiene, proceeded to check food temperature, then used alcohol-based hand rub (ABHR) on the palm of their hands for five seconds. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Village Nursing Facility	State Highway 902 & Salnave Road Medical Lake, WA 99022

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 09/20/2024 at 10:59 AM, Staff M, Cottage Manager, put a pair of purple gloves on without performing hand hygiene prior. During observation on 09/23/2024 at 11:33 AM, Staff T, AC, did not perform hand hygiene, adjusted a resident's wheelchair, removed the residents protective arm sleeves, placed a spoon in the resident's right hand, and assisted them with their lunch meal. During observation on 09/23/2024 at 3:19 PM, Staff U, Licensed Practical Nurse, rolled a gray rolling cart into the living room with an uncovered jug of water, placed a pair of purple gloves without performing hand hygiene, pulled out and unfolded a rolling white privacy curtain without removing gloves or performing hand hygiene, then proceeded to administer water via a feeding tube to a Resident. In an interview on 09/26/2024 at 12:32 PM, Staff R, CMRN, stated hand hygiene was cleansing hands with soap and water for at least 20 seconds or using alcohol-based hand rub (ABHR). Staff R further stated hand hygiene should be performed in between residents, between care, or when moving from a dirty site to a clean site on the same residents. Staff R stated if hand hygiene was not performed when indicated there was a potential for infection to spread and expected staff to perform hand hygiene when indicated. In an interview on 09/26/2024 at 1:35 PM, Staff Q, Infection Preventionist, stated hand hygiene was washing hands with soap and water or using ABHR. Staff Q explained hand hygiene was the first and last step when applying or removing PPE such as putting on and removing gloves. Staff Q stated staff should perform hand hygiene after they perform any task that is considered dirty such as using the bathroom, eating, or dealing with trash. Staff Q acknowledged if hand hygiene was not performed when indicated it could cause cross contamination, spread multi-drug-resistant organisms, and infections. Staff Q expected staff to perform hand hygiene when indicated. In an interview on 09/26/2024 at 3:16 PM, Staff B, stated hand hygiene was washing hands with soap and water for at least 20 seconds or use of ABHR with proper techniques. Staff B stated hand hygiene should be performed before and after contact with a resident or their immediate environment, before and after eating, and if moving to a contaminated body area to a clean area on the same resident. Staff B expected staff to perform proper hand hygiene when indicated because proper hand hygiene prevents the spread of infection. TRANSMISSION BASED PRECAUTIONS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The website CDC.gov - with regard to enhanced barrier precautions showed, Enhanced Barrier Precautions [EBP] are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents know to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) . Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated EBP is a less restrictive approach to MDRO prevention that places fewer limitations on resident activities Enhanced Barrier Precautions are currently recommended to be used broadly, in all units across the whole facility, for resident who meet the above criteria. This broader application includes facilities where targeted MDROs have not yet been identified and is intended to minimize the transmission of MDROs in nursing homes Indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBP for all resident with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but not limited to, indwelling urinary catheters, feeding tubes, peripherally inserted central catheters [PICC] Enhanced barrier Precautions is primarily intended to apply to care that occurs within a resident's room where high-contact resident care activities, including transfers, are bundled together with other high-contact activities, such as morning or evening care Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure precautions are followed. Signs should not include information about the resident's diagnosis or the reason for precautions. CDC has created exampled of signs that can be used by facilities to communicate information about Transmission-Based and Enhanced Barrier Precautions. Review of facility policy titled, Enhanced Barrier Precautions dated 05/14/2024, defined high contact care activities as dressing, bathing/showering, transferring in a resident's room (common areas not included since duration is anticipated to be short), providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care. Indwelling medical devices were defined as indwelling catheters, feeding tubes, and PICC lines. The policy instructed staff to perform hand hygiene prior to applying PPE, apply a gown and gloves before entering a EBP identified resident's room to perform high-contact activity, remove gown and gloves immediately after activity and before exiting the room, dispose of used PPE in the garbage can, use ABHR after removing gloves or wash hands with soap and water if visibly soiled. The policy further showed CDC EBP signage would be posted in a designated common area close to a PPE source supply for staff reference but were not to be placed on a resident's room door, a laminated blue glove sign would be hung above the resident's bed to direct staff the need for EBP. <Resident 14> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the quarterly assessment, dated 07/03/2024, showed Resident 14 diagnoses included spastic quadriplegic cerebral palsy (condition that affects muscle tone, movement, and coordination) and gastritis stomach lining is inflamed or irritated). Resident 14 was dependent on staff to perform all of their activities of daily living (ADLs). The assessment further showed Resident 14 received nutrition via a feeding tube (flexible tube that provides nutrition to people unable to eat or drink enough by mouth). Review of the nutrition care plan showed Resident 14 was not to have oral intake by mouth, fluids, nutrition, and medications were to be administered via a J-Tube (flexible tube inserted through the abdomen into the small intestine). The care plan further showed Resident 14 also had a G-tube (flexible tube inserted through the abdomen into the stomach). Review of the 12/05/2023 annual health assessment showed Resident 14 required assistant of two staff to transfer using a mechanical lift using a specialized supine (lying on back with face up) sling. Resident 14 received hydration, nutrition, and medications via a J-Tube. The assessment further showed Resident 14 intermittently had rust-colored or coffee ground like output from their G-Tube. Review of the 12/29/2023 comprehensive nutrition assessment showed Resident 14 was received hydration, nutrition, and medications via a J-Tube. During continuous observation on 09/20/2024 from 8:51 AM until 9:06 AM, Staff V, AC, exited Resident 14's room wearing a yellow gown and purple surgical mask. Staff V walked across the hall wearing the yellow gown to dispose of a pair of purple gloves they removed while exiting the room, briefly used ABHR, unlocked a hygiene cabinet that contained toothbrushes, grabbed an item, handed the item to Staff N, AC, who was in Resident 14's room, briefly used ABHR, applied a new pair of purple gloves, then reentered Resident 14's room to assist Staff N. No transmission-based precaution or EBP signage was observed posted on or near Resident 14's room entrance. At 8:55 AM, Staff N, exited Resident 14's room wearing a yellow gown and walked down the hall past the kitchen to the area to the area where the nurse kept their medication cart. At 8:56 AM, Staff N returned to Resident 14's room wearing the same yellow gown, holding a cup with a dollop of tan colored semi translucent cream, and entered the room. At 8:59 AM, Staff V exited Resident 14's room removed their gloves but did not remove their gown. Staff N was heard telling Staff V you do not need to remove your gown because we are still taking care of [Resident 14]. Staff V walked down the hall wearing the yellow gown. At 9 AM, Staff V returned to Resident 14's room holding a mechanical lift sling. At 9:05 AM, Staff V exited Resident 14's room, walked across the hall to common resident grooming/hygiene area to remove their gown and gloves. At 9:06 AM, Staff N exited Resident 14's room wearing a yellow gown and gloves, pushed Resident 14 across the hall to the common resident grooming/hygiene area to perform oral care on Resident 14's. Resident 14 had a blue privacy bag covering a plastic collection bag hanging on an elevated footrest and a feeding tube formula delivery machine attached to their wheelchair. In an observation and interview on 09/20/2024 at 9:14 AM, Staff O, LPN, stated the facility posted EBP signage in a common area near a PPE source supply but did not post EBP signage outside a resident's room for privacy reasons, instead a picture of a blue glove was hung at the bedside. Staff O demonstrated where PPE was stored in the common resident bathing/hygiene area and an CDC EBP sign was posted on the closet door that contained PPE. Staff O then demonstrated the picture of a blue glove posted at the bedside. Staff O stated Resident 14 had a drainage collection bag because they had a J-tube to drain out extra gastric fluids. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 09/20/2024 at 9:27 AM, a picture of a blue glove was hung at the bedside in Resident 14's room, right above the head of the bed. The sign did not contain any wording or direction for staff to follow. In an interview on 09/20/2024 at 9:34 AM, Staff P, Cottage Manager, stated the facility posted a CDC EBP sign in a common area near a PPE supply source and posted a picture of a blue glove at the bedside to indicate the resident was on EBP. Staff P further stated staff were trained that a picture of a blue glove hung at the bedside indicated the resident was on EBP, and staff needed to wear gloves and a gown when providing care. Staff P stated staff were to remove gloves, gown, and perform hand hygiene prior to exiting a room of a resident on EBP. Staff P was informed of the PPE observation from earlier that morning. Staff P asked Staff N if she exited Resident 14's room wearing a gown. Staff N acknowledged they left Resident 14's room wearing a yellow gown to obtain bag balm. Staff P informed Staff N they would grab items for them if needed when providing care to a resident on EBP, so they did not have to leave the room. During observation on 09/23/2024 at 3:01 PM, Staff T, AC, had a purple surgical mask on with their nose exposed, the mask only covered their mouth. During observation on 09/23/2024 at 3:07 PM, Staff L, AC, exited a resident's room holding a yellow gown bunched up into a ball against their blue shirt, walked across the hall to the common resident bathing/grooming area, placed the gown in the trashcan touching the lid, did not perform hand hygiene, then walked to the living room to pick toys off the floor and place them in a square cloth basket. In an interview on 09/26/2024 at 12:34 PM, Staff R, CMRN, was unsure what the facility process was for EBP. In an interview on 09/26/2024 at 1:38 PM, Staff Q, Infection Preventionist, stated EBP required staff to wear gloves and a gown when providing high contact care activities. Staff Q explained that a gown was not required if staff were only transferring a resident in the common area but was required if the transfer occurred in the resident's room because typically more than one care activity occurred in the resident's room. Staff Q further explained the purpose of EBP was to prevent the transmission of an MDRO from one resident to another via staff hands and/or clothing. Staff Q stated CDC EBP signage was posted in a common resident area near a PPE supply source and a blue glove picture was posted right above a resident's bed that was determined to require EBP. Staff Q acknowledged if transmission-based precautions were not followed then infection transmission could occur and expected staff to follow any precautions implemented. In an interview on 09/26/2024 at 3:22 PM, Staff B, reviewed the EBP policy. Staff B explained EBP expanded the use of gowns and gloves during high contact resident care in addition to standard precautions when other transmission-based precautions did not apply. Staff B further explained the facility posted CDC EBP signage in a common area near a PPE supply source but posted a picture of blue hand above a resident's bed determined to require EBP during cares. Staff B acknowledged staff should not leave an EBP resident room wearing a gown, should remove PPE prior to exiting the room, and perform hand hygiene. Staff B stated they expected staff to follow any precautions implemented because not following precautions could lead to the unnecessary spread of disease. Reference WAC 388-97-1320 , (1)(a), (1)(c), (3) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	46115 <Hand hygiene> During an observation on 09/23/2024 at 9:38 AM, Staff H, Licensed Practical Nurse, applied gloves, removed a dressing and cleansed the wound on Resident 32's coccyx. Staff H placed a new dressing over the coccyx wound without removing their soiled gloves or performing hand hygiene. In an interview on 09/23/2024 at 9:51 AM, Staff H stated they should have changed their gloves and performed hand hygiene after cleansing the wound and this was important to prevent the spread of bacteria.