STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505128	A. Building B. Wing	05/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences for two of nine sampled residents (71 & 53) reviewed for care conferences. This failure placed residents at risk of not being allowed to be involved in their long term care needs and a diminished quality of life. Findings included . 1) Resident 71 was admitted to the facility on [DATE]. The significant change Minimum Data Set (MDS), an assessment tool, dated 04/24/2022, showed the resident was moderately cognitively impaired and able to make needs known. The electronic health record showed the facility held a Baseline Care Conference on 08/25/2021. The next Care Conference was held on 03/28/2022, seven months later. On 05/04/2022 at 10:14 AM, Staff C, Social Services Director (SSD), said care conferences were done at admission, quarterly, with a significant change, or at the request of the family. 46244 2) Resident 53 was admitted to the facility on [DATE] with diagnoses including difficult verbal expression/communication. The quarterly MDS, dated [DATE], showed Resident 53 was moderately cognitively impaired and able to accurately answer yes/no questions. The electronic health record showed Collateral Contact 1 (CC 1) was Resident 53's emergency contact and responsible party. On 05/02/2022 at 8:59 AM, CC 1 said she used to participate in care conferences but had not been asked since COVID (an infectious disease caused by the SARS-CoV-2 virus) . CC 1 said she was not in the March 2022 conference and was not asked to attend. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/2022 at 11:16 AM, Staff C said she invited resident representatives and family to care conferences by calling or asking in-person when they stopped in. Staff C said about 50 percent of Resident 53's care conferences were conducted over the phone. Staff C said the meetings were documented in the computer. When asked to verify if Resident 53's representative was included in the March 2022 conference, Staff C said she was unable to locate the information. Reference WAC 388-97-1020(5)(f)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure procedures were in place to assist residents with completing advance directives (AD), and obtaining and maintaining Durable Power of Attorney (DPOA) documentation for eight of 11 sampled residents (4, 52, 226, 35, 71, 5, 74 & 228) reviewed for AD. This failure placed residents at risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included . 1) Resident 71 was admitted to the facility on [DATE]. The significant change Minimum Data Set (MDS), an assessment tool, dated 04/24/2022, showed the resident was moderately cognitively impaired and able to make needs known. Resident 71's electronic medical record showed no advanced directive or documentation an AD was reviewed in the file. 2) Resident 52 was admitted to the facility on [DATE]. The MDS, dated [DATE], showed the resident was severely cognitively impaired. Resident 52's electronic medical record showed no advanced directive or documentation an AD was reviewed in the file. 40916 3) Resident 5 was admitted to the facility on [DATE]. The significant change MDS, dated [DATE], documented the resident was cognitively intact. Resident 5's electronic medical record showed no advanced directive or documentation an AD was reviewed with the resident in the file. 4) Resident 4 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident was moderately cognitively impaired. Resident 4's electronic medical record showed no advanced directive or documentation an AD was reviewed in the file. 5) Resident 35 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident was cognitively intact. Resident 35's electronic medical record showed no advanced directive or documentation an AD was reviewed with the resident in the file. 42723 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) Resident 74 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was moderately cognitively impaired. Resident 74's electronic medical record documented the resident's daughter was the Power of Attorney (POA). The resident's electronic record did not show any POA paperwork or documentation of attempts to request it from Resident 74's daughter. 7) Resident 226 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact. Resident 226's electronic medical record showed no advanced directive or documentation an AD was reviewed with the resident in the file. 8) Resident 228 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact. Resident 228's electronic medical record showed no advanced directive or documentation an AD was reviewed with the resident in the file. On 05/04/2022 at 10:14 AM, Staff C, Social Services Director, said an AD should be in the electronic medical records and a process to follow-up on them needed to be in place. On 05/05/2022 at 10:51 AM, Staff C said the business office manager completed admission paperwork including advanced directives. Staff C said the next opportunity for the facility to review and discuss advanced directives was during the new admission evaluation and the baseline care plan meeting. Staff C said advanced directives should be reviewed quarterly during care plan conferences. At 2:18 PM, Staff B, Director of Nursing Services and Registered Nurse, said advanced directives should be reviewed and completed quarterly during care conferences. Staff B said the paperwork used by the facility to document care conferences did not address advanced directives, or gave guidelines on how staff should complete an advanced directive. Reference WAC 388-97-0280(3)(c)(i)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASARR), a screening tool used to identify mental health needs, was accurate for two of six sampled residents (19 & 35) reviewed for PASARR. This failure placed residents at risk for not receiving specialized mental health services, unidentified mental health needs and a decreased quality of life. Findings included . 1) Resident 19 was admitted to the facility on [DATE] with diagnoses including major depressive disorder. The quarterly Minimum Data Set (MDS), an assessment tool, dated 02/24/2022, documented the resident was moderately cognitively impaired. A notice of determination, dated 08/25/2021, documented Resident 19 had a mental health diagnosis, met the requirements for nursing home care, and required specialized behavior health services. A follow up for the notice of determination was not documented in Resident 19's electronic medical record. The medical record showed Resident 19 was diagnosed with psychotic disorder (disconnection from reality) with delusions (unshakable belief in something untrue) on 05/02/2022. A Level I PASARR, dated 05/02/2022, documented, No Level II evaluation indicated: Person does not show indicators of SMI [serious mental illness]. On 05/03/2022 at 10:06 AM, Staff C, Social Services Director, said the facility would identify newly evident mental health issues during the daily morning meetings. Staff C said the interdisciplinary team would talk about the change and would see if an evaluation was warranted. Staff C stated, Looking at the mental illness indicators, [Resident 19] has psychotic disorder with delusions. That should be a Level II evaluation. There will be a re-evaluation. At 10:31 AM, Staff B, Director of Nursing Services and Registered Nurse, said if a new diagnosis was found during admission in the facility, a new PASARR should be completed and a mental health evaluation completed to see if psychological services were appropriate. Staff B said Resident 19 should get a Level II evaluation based on a new mental health diagnosis. 2) Resident 35 was admitted to the facility on [DATE] with diagnoses including depression. The quarterly MDS, dated [DATE], documented the resident was cognitively intact. A physician progress note, dated 10/28/2021, documented, [Resident 35] continues to have problems with anxiety now with psychotic features. She has been screaming out, throwing things. She is oriented when asked but cannot explain the behavior. D/w [discussed with] nursing and she has been fairly constant in the screaming out for help, panic behaviors. Then cannot give an explanation. This is not her baseline mental functional status. [Resident 35] denies any physical complaints when asked. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Level I PASARR, completed 01/18/2022, documented, Did PASARR review with PASARR contractor and determined Level II indicated due to new behaviors. The evaluation documented a Level II evaluation referral was required for significant change. No Level II evaluation or a notice of determination was found in Resident 35's electronic medical record. A Level I PASARR, completed 05/04/2022, documented the resident had depression and psychosis (disconnection from reality). The Level I PASARR documented, No Level II evaluation indicated: Person does not show indicators of SMI. On 05/05/2022 at 10:51 AM, Staff C said Resident 35's PASARR, dated 01/18/2022, was sent to the State PASARR coordinator around February 2022. Staff C said she was unable to locate Resident 35's notice of determination from the State PASARR coordinator. Staff C said the resident's care plan should be updated with notice of determination recommendations as soon as possible. When asked why Resident 35's PASARR was repeated on 05/04/2022, Staff C said she did not do the PASARR evaluation and was not sure why the PASARR was redone. At 2:18 PM, Staff B said if a resident admitted to the facility was suspected of new mental illness symptoms, the facility should complete a Level II PASARR. Reference WAC 388-97-1915 (4)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASARR) was followed up for one of six sampled residents (13) reviewed for significant change in condition. This failure placed residents at risk for not receiving specialized mental health services, unidentified needs and a decreased quality of life. Finding included . Resident 13 was admitted to the facility on [DATE] with diagnoses including depression. The quarterly Minimum Data Set (MDS), an assessment tool, dated 02/16/2022, indicated the resident was alert and oriented and able to make needs known. The Level 1 Significant Change PASARR form, dated 01/18/2022, indicated Resident 13 required a Level II evaluation. The electronic chart did not have a Notice of Determination or a Level 2 PASARR evaluation. On 05/04/2022 at 10:14 AM, Staff C, Social Services Director, said the Level 2 referral should have been sent out immediately after it was determined Resident 13 required an evaluation. On 05/05/2022 at 9:43 AM, Staff B, Director of Nursing Service, said if the PASARR was completed for a significant change then it should have been referred out. Reference WAC 388-97-1060(1)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42723 Based on interview and record review, the facility failed to provide a summary of a baseline care plan within 48 hours of admission for four of four sampled residents (55, 226, 74, & 228) reviewed for baseline care plans. This failure placed residents or their representatives at risk of not being involved in their plan of care and a diminished quality of life. Findings included . 1) Resident 55 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS), an assessment tool, dated 04/12/2022, documented the resident was cognitively intact. Resident 55's baseline care plan summary, dated 04/07/2022, documented Resident/family did not request a copy of the baseline care plan summary. A review of Resident 55's electronic health record did not show documentation the facility staff attempted to provide Resident 55 a copy of the baseline care plan. 2) Resident 226 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact. Resident 226's baseline care plan summary, dated 04/28/2022, documented, Resident/family did not request a copy of the baseline care plan summary. On 05/03/2022 at 9:02 AM, Resident 226's family member said facility staff did not offered her a copy of Resident 226's baseline care plan. A review of Resident 226's electronic health record did not show documentation the facility staff attempted to provide Resident 226's representative a copy of the baseline care plan. 3) Resident 74 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was moderately cognitively impaired. Resident 74's baseline care plan summary, dated 04/22/2022, documented, Resident/family did not request a copy of the baseline care plan summary. On 05/02/2022 at 8:30 AM, Resident 74's family member said facility staff had not offered her a copy of Resident 74's baseline care plan. A review of Resident 74's electronic health record did not show documentation the facility staff attempted to provide Resident 74's representative a copy of the baseline care plan. 4) Resident 228 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 228's electronic health record did not show documentation of a baseline care plan summary. On 05/02/2022 at 11:30 AM, Resident 228's family member said facility staff had not offered her a copy of Resident 228's baseline care plan. A review of Resident 228's electronic health record did not show documentation facility staff attempted to provide Resident 228 or his representative a copy of the baseline care plan. On 05/05/2022 at 9:54 AM, Staff P, Resident Care Manager and Licensed Practical Nurse, said residents and/or resident representatives did not routinely receive a copy of the care plans unless they requested one. Reference WAC 388-97-1620(2)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on interview and record review, the facility failed to ensure care plan updates were completed for one of six sampled residents (5) reviewed for care plan revisions. This failure placed residents at risk of not receiving current interventions for their care needs and a diminished quality of life. Findings included . Resident 5 was admitted to the facility on [DATE] with diagnoses including pressure ulcer. The significant change Minimum Data Set, an assessment tool, dated 02/01/2022, documented the resident was cognitively intact. Resident 5's pressure ulcer care plan, dated 10/29/2021, documented the intervention Wound Vac [vacuum-assisted closure of a wound, a type of therapy to help wounds heal] per provider orders with wound team evaluation weekly. The intervention was initiated on 03/14/2022. On 05/01/2022 at 2:02 PM, Resident 5 said he used to have a wound vac for his pressure ulcer wound, but now used bandages to treat the wound. On 05/05/2022 at 9:36 AM, Staff P, Residential Care Manager (RCM) and Licensed Practical Nurse, said care plan interventions were reviewed for any status changes for example during wound progression or decline, and during quarterly evaluations. Staff P stated, In a perfect world we would be reviewing the care plan more than we are. I would not be surprised if interventions need to be updated. Currently there is no wound vac for [Resident 5]. At 9:50 AM, Staff I, RCM and Registered Nurse (RN), said Resident 5 had a pressure ulcer, and the facility attempted to use a wound vac but due to positional issues it was hard to get a seal on the wound vac. Staff I said the facility was no longer using the wound vac and was using wet-to-dry dressings for the wound. On 05/07/2022 at 10:29 AM, Staff F, Assistant Director of Nursing Services and RN, said interventions should come off the care plan immediately if they were no longer being implemented. Staff F said she would try to keep the orders section updated, not realizing old interventions and orders were still present in the care plan. Reference WAC 388-97-1020 (5)(b)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observation, interview and record review, the facility failed to ensure communication devices were available for one of one sample resident (53) when reviewed for communication. This failure placed residents at risk of not being able to expressed themselves, disturbances and a diminished quality of life. Findings included . Resident 53 was admitted to the facility on [DATE] with diagnoses including a stroke with difficult verbal expression/communication. The quarterly Minimum Data Set, an assessment tool, dated 01/07/2022, showed Resident 53 was moderately cognitively impaired and was able to answer yes/no questions. Baseline care plan, dated 05/16/2021, showed Resident 53 used picture and alphabet boards for communication. Care plan, dated 04/20/2022, showed an alteration in sensory/communication related to speech disturbance due to expressive aphasia (difficulty expressing self). Allow adequate time to respond. Ask yes/no questions if appropriate. Request feedback, clarification from the resident, to ensure understanding. Use gestures. On 05/02/2022 at 3:19 PM, a sign was observed above Resident 53's bed noting [Resident 53] is reliable for yes/no (simple and complex), provide picture board/alphabet board (@ bedside), will need extra time and some assist with alphabet board. The sign was dated 5/3, no year. Picture and alphabet boards were not visible in the room. On 05/03/2022 at 8:01 AM, Resident 53 was observed in a wheelchair in his room. No alphabet or picture board were available. Resident 53 indicated he had not seen them today or yesterday. On 05/06/2022 at 9:41 AM, Staff T, Certified Nursing Assistant, said she used yes/no questions with Resident 53. Staff T said Resident 53 could use a call light button, he did yesterday. Staff T said Resident 53 flagged her down but usually only called to be changed by pointing to his brief. Staff T said she had to ask what he needed. Resident 53 used thumbs up/down. When asked if Resident 53 could tell you what he needed, Staff T stated, No. Staff T said she did not recall seeing any communication boards. Staff T said she read something about it. Staff T said she had been here for six weeks. At 10:25 AM, Staff P, Resident Care Manager and Licensed Practical Nurse, said she was unsure if Resident 53 used communication boards. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:16 AM, Staff C, Social Services Director, said she used to be the Activities Director. Staff C said she had que cards and a white board. Staff C went to a drawer in the activity office to get laminated cards that had questions about activities. The que cards with the questions included pictures. Many cards correlated with the activity evaluation questions. Staff C said Resident 53 could read and could write but it had diminished. Resident 53 tried to write but it was hard to read now. I could read it before. Staff C said the cards worked well to communicate with Resident 53. His voice was soft now, it used to be louder. Resident 53 whispered now and did not use full sentences. Staff C said the cards were good to use during care. He responded well. Staff C said the cards were kept there and did not recall any alphabet communicate board. Reference WAC 388-97-1060(2)(a)(v)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to provide care with activities of daily living (ADL) for dependent residents including brushing teeth for one of three sampled residents (71) reviewed for ADLs. This failure placed residents at risk of not receiving the care and services needed for which they were unable to perform themselves and a diminished quality of life. Findings included . Resident 71 was admitted to the facility on [DATE]. The significant change Minimum Data Set, dated dated [DATE], showed the resident was moderately cognitively impaired, able to make needs known, and required extensive assistance with personal hygiene. The ADL care plan included perform personal hygiene tasks (apply . brush teeth, etc) with set up/supervision to limited assistance as needed at w/c (wheelchair) or seated at bedside level. The Personal Hygiene, dental/oral care task, dated 04/05/2022 to 05/04/2022, showed Resident 71 had her teeth brush on 04/12/22, 04/13/2022, 04/17/2022, 04/20/2022, and 05/04/2022, five days during a 30-day look back. There were no refusals for care indicated. On 05/02/2022 at 7:59 AM, Resident 71 said she did not remember the last time she had her teeth brushed. On 05/06/2022 at 1:35 PM, Staff G, Nurse Aide, said Resident 71 required assistance with ADLs. Staff G said Resident 71 refused care sometimes. Staff G said if the resident refused care; she would re-approach the resident later, let the nurse know about the refusal, and document the refusal. On 05/07/2022 at 1:26 PM, Staff F, Assistant Director of Nursing Services, said nursing staff should brush residents' teeth on morning and night shifts. If the resident refused, the refusal should be documented. Reference WAC 388-97-1060 (3)(j)(vii)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on observation, interview and record review, the facility failed to ensure there was an ongoing activity program to meet individual resident needs for three of four sampled residents (53, 226 & 19) reviewed for activities. This failure placed residents at risk for becoming bored and depressed when not provided meaningful engagement throughout the day, and a diminished quality of life. Findings included . 1) Resident 19 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 02/24/2022, documented the resident was cognitively intact. A life enrichment evaluation, dated 05/25/2021, documented the resident found it very important to have music to listen to. Resident 19's activity task, dated 04/03/2022 to 05/03/2022, did not document any activities for the last 30 days. On 05/02/2022 at 1:00 PM, Resident 19 was observed in his room, in bed, with no visual or auditory stimulation. At 2:57 PM, Resident 19 was observed in bed with no visual or auditory stimulation. On 05/03/2022 at 9:27 AM, Resident 19 was observed in bed with no visual or auditory stimulation. At 9:32 AM, Staff D, Activities Director, said residents were assessed for activity preferences quarterly, annually, and if there was a significant change. Staff D said Resident 19 liked to watch movies, listen to music, and attend the facility's coffee and donut social. Staff D said she was not aware of the log of activities in the electronic medical charting. Staff D referenced an activity tracker she developed and indicated Resident 19 had attended a coffee and donut social once, but was unable to find what date the resident attended. Staff D stated, I was flabbergasted when you showed me the activity task list. I know he's been engaged, but my documentation is not the best. Staff D said she liked for residents to receive three encounters with activities per week. At 10:31 AM, Staff B, Director of Nursing Services and Registered Nurse (RN), said she did not know about the activities log in the electronic medical charting to document activity encounters. Staff B said she told regional managers the facility needed education in the area of activities. Staff B said without documentation she could not say how often Resident 19 participated in activities. 42723 2) Resident 226 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident was cognitively intact. Resident 226's admission care plan, initiated 04/26/2022, did not address activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 226's Kardex, undated, did not contain activity preference or guidance for facility staff to follow. Resident 226's Life Enrichment Evaluation, dated 04/27/2022, documented the resident found it very important to do things with groups of people and to go outside to get fresh air when the weather was good. The evaluation documented the resident was highly involved in structured group activities. On 05/01/2022 at 9:35 AM, Resident 226 said he liked to play cards, watch Jeopardy, and really enjoyed getting out of his room. Resident 226 stated, Nobody has offered to take me out of the room to go to any activities. On 05/02/2022 at 9:10 AM, Resident 226 was observed sitting in his room alone after breakfast with no visual or auditory stimulation. At 3:25 PM, Resident 226 was observed sitting in his room alone with no visual or auditory stimulation. On 05/03/2022 at 9:02 AM, Resident 226 was observed sitting in his room alone after breakfast, with no visual or auditory stimulation. At 2:15 PM, Resident 226 was observed sitting in his room alone with no visual or auditory stimulation. On 05/04/2022 at 10:19 AM, Resident 226 was observed sitting in his room alone after breakfast, with no visual or auditory stimulation. On 05/05/2022 at 9:06 AM, Resident 226 was observed sitting in his room alone after breakfast, with no visual or auditory stimulation. 46244 3) Resident 53 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], showed Resident 53 was moderately cognitively impaired and was able to answer yes/no questions. Resident 53's care plan, dated 04/20/2022, showed Resident 53 would participate in three independent activities in his room or in the facility per week. Resident 53's care plan documented the resident participated in reading, watching TV, keeping up with the news, and watching sports; and documented his favorite activities included watching TV. Resident 53's activity's task, dated 04/03/2022 to 05/03/2022, did not document any activities for the last 30 days. On 05/02/2022 at 9:18 AM, Collateral Contact 1 (CC 1) said watching TV was the only thing Resident 53 did. CC 1 said TV was a big priority for the resident, and even if he could not hear it, it should be on. CC 1 said Resident 53 would not ask for it to be turned on. CC 1 said the TV should be turned on in the morning and off at night. CC 1 said her daughter got him a new TV at the facility. CC 1 said she did not know of any activities for him. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:19 PM, Resident 53 was observed in a dimly lit room with the TV off. No visual or auditory stimulation was present. On 05/03/2022 at 8:01 AM, Resident 53 was observed in a wheelchair in his room. The TV was off. No visual or auditory stimulation was present. Resident 53 indicated he had a remote control for the TV, but needed staff to help change channels. Resident 53 indicated staff did do not take him out of his room or do activities with him. Resident 53 indicated he was not happy, and felt the staff did not listen to him. On 05/04/2022 at 5:45 AM, 9:25 AM, 11:35 AM, and 12:28 PM, Resident 53 was observed in his room without the TV on or other activities. No visual or auditory stimulation was present. On 05/05/2022 at 7:44 AM, Resident 53 was observed in his room without the TV on or other activities. No visual or auditory stimulation was present. On 05/06/2022 at 8:02 AM, Staff AA, RN, said he did not know Resident 53 enjoyed TV. Staff AA stated, If I put it on, he would watch it. Staff AA said he had not seen Resident 53 do any activities. Staff AA said he used to do activities. Staff AA stated, Now we get him up, but he wants to get back to bed. That is his activity. At 11:16 AM, Staff C, Social Services Director, said she used to be the Activities Director. Staff C said Resident 53's favorite thing was watching TV. Staff C said Resident 53's family brought in a new TV that streamed a lot of channels. Staff C said as the Activity Director, she used to go to Resident 53's room to read his mail and have conversations with him. Reference WAC 388-97-0940 (1)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on interview and record review, the facility failed to ensure the Life Enrichment Director (Activity Director) had the appropriate qualifications to assess and care plan activities for one of four sampled residents (53) by one of one sampled staff (D) reviewed for activity profession qualifications. This failure placed residents at risk of having activity assessments and care plans completed and activities being supervised by an unqualified activity staff. Findings included . Resident 53 was admitted to the facility on [DATE] with diagnoses including stroke with left side weakness and difficulty with verbal expression and communication. The annual Minimum Data Set (MDS), an assessment tool, dated 04/09/2022, showed the resident was not interviewed for the assessment and showed the resident identified preferences for activities. Resident 53's care plan, dated 04/20/2022, did not show any activity or leisure preferences. On 05/06/2022 at 8:42 AM, Staff E, MDS Specialist and RN, said Resident 53 could respond and be interviewed. Staff E said she made sure other departments completed their portion of the MDS, but was not responsible for their data/assessment. Review of a therapeutic recreational specialist credentialing association website, https://www.atra-online.com/page/BecomeAnRT, showed 'Recreational therapists need a bachelor's degree, usually in recreational therapy or a related field such as recreation and leisure studies .' Review of facility employee roster showed Staff D, Activity Director, was hired on 03/03/2022. On 05/03/2022 at 9:32 AM, Staff D said she did quarterly, annual, and significant change assessments in the electronic health record (EHR), but had not learned how to do care plans yet. Staff D said she did not know about the documentation in the EHR for activities. Staff D said her documentation was not the best. Staff D said her training consisted of an orientation walk through and paperwork the first day, and on the job training with the prior activity director the following day. Staff D said she had just gotten her online training. Record review of Staff D's resume, undated, showed she had not completed a bachelor's degree or obtained a required license or credential to qualify for the activity position. On 05/06/2022 at 2:07 PM, Staff A, Administrator, said the activity director was hired by the previous administrator. Staff A said he was new and did not have time to check if all his staff were qualified. Staff A said he had a year to get her qualified. Staff A said that information was in the Federal Code (F tags) or [NAME] Administrative Code (WAC). Documentation was requested showing he had a year for her to be qualified, and any additional documentation showing Staff D was qualified. As of 05/10/2022, no additional documentation was provided by the facility. Reference WAC 388-97-0940 (3)(a-c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on interview and record review, the facility failed to identify and monitor non-pressure skin conditions including bruising for one of four sampled residents (23) reviewed quality of care. This failure placed residents at risk for discomfort, health complications and diminished qualify of life. Findings included . Resident 23 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set, an assessment tool, dated 02/27/2022, indicated the resident was alert oriented and able to make needs known. On 05/01/2022 at 3:24 PM, Resident 23 was observed lying in bed with discoloration on her right wrist. On 05/02/2022 at 3:00 PM, Resident 23 was observed lying in bed with discoloration on her right wrist. On 05/03/2022 at 1:50 PM, Resident 23 was observed lying in bed with discoloration on her right wrist. On 05/06/2022 at 1:39 PM, Resident 23 was observed lying in bed with discoloration on her right wrist. At 1:58 PM, Staff AA, Licensed Practical Nurse, said any new skin issues were documented. Staff AA said the condition would be monitored until it resolved. At 2:09 PM, Staff P, Resident Care Manager, said any new skin conditions were investigated. While looking in the electronic medical records, Staff P said Resident 23 had a bruise on her left hand, but could not find anything for Resident 23's right wrist. Staff P said any bruising would be monitored until it was resolved. At 2:09 PM, Staff AA said he observed the bruise on Resident 23's right wrist, and asked Resident 23 if she knew how it occurred. Reference WAC 388-97-1060 (1)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observation, interview and record review, the facility failed to prevent pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) development and promote wound healing by implementing and following care plans interventions for two of six sampled residents (31 & 53) reviewed for pressure wounds. This failure placed residents at risk for the development and worsening of pressure injuries and a diminished quality of care. This caused harm to Resident 31 when care the wound progressed from a Stage 2 to a Stage 3 and dressing changes were not completed when the dressing was soiled. Findings included . Review of facility policy titled, Pressure Injury Policy, undated, showed all residents would be assessed on admission and weekly for 4 weeks, quarterly, and with significant change in condition. Interventions included: manage moisture, manage nutrition, manage pressure: off load heels, use turning/repositioning. 1) Resident 31 was admitted on [DATE] with diagnoses including diabetes, abnormal blood sugar levels. The quarterly Minimum Data Set (MDS), a comprehensive assessment tool, dated 03/11/2022, documented the resident required extensive two-person assistance for bed mobility, transfer, personal hygiene and toileting. Resident 31's pressure ulcer care plan, dated 02/08/2022, documented a stage 2 [the sore area of skin has broken through the top layer of skin and some of the layer below] pressure wound was present to [Resident 31's] buttock/coccyx [tailbone]. The facility implemented an air mattress and a goal the pressure wound would show signs of healing and remain free from infection. The intervention turn side to side except when eating was added on 02/18/2022. A change in condition MDS, dated [DATE], showed Resident 31 had one stage 2 pressure wound requiring a pressure reducing device for her bed and chair, and pressure wound care. Resident 31 was assessed to not need a turning/repositioning program. Resident 31's electronic health records showed Resident 31 was transferred to the hospital for pain management on 02/10/2022 and returned to the facility on [DATE]. Resident 31's admission skin assessment, dated 02/16/2022, showed there was a pressure wound when Resident 31 returned from the hospital. A physician's order, dated 03/05/2022, documented float heel when in bed, every shift. A wound clinic note, dated 03/18/2022, showed Resident 31 was diagnosed with a new right heel wound. A physician's order, dated 03/20/2022, documented apply skin prep and apply border foam daily to both heels. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound clinic note, dated 04/07/2022, showed Resident 31's pressure ulcer on her buttocks/coccyx was assessed as a Stage 3 pressure ulcer (broken completely through the top two layers of the skin and into the fatty tissue below). A wound clinic note, dated 04/20/2022, showed Resident 31's pressure ulcer on her buttocks/coccyx was assessed as an unstageable ulcer (full thickness tissue loss in which the base of the ulcer is covered by a thick black scab). The note documented mild odor under wound description. On 05/04/2022 at 5:18 AM to 9:31 AM, Resident 31 was observed to remain in the same position, unmoved. A strong, foul odor, coming from Resident 31's room, could be smelt in the hallway. At 9:31 AM, Staff K, Certified Nursing Assistant (CNA), said Resident 31 had a pressure wound with a dressing on her bottom and stated, It's really bad. Resident 31's legs were observed on a thin pillow which allowed her heels to press into the mattress. Staff K identified Resident 31 needed an incontinence change due to a bowel movement and said he would get the nurse for a wound dressing change. At 9:39 AM, Staff K said the nurse was too busy to come check the wound. When asked what he would do if the dressing was soiled, Staff K said he would get the nurse to immediately change it. Staff K said he was going to change Resident 31 without the dressing change by the nurse. Resident 31's right heel was observed with the skin lifted around the edges of a pressure wound measuring 2 centimeters. No dressings were observed on the heels. Staff K said the open skin on Resident 31's right heel was new to him and he would tell the nurse of the new skin finding. Resident 31's dressing on the coccyx was observed to be saturated with dark material, was undated, had a strong odor, and had the bottom side of dressing uplifted. Staff K stated, It smells so bad. Staff K asked Staff X, CNA, to get the nurse. Staff Y, Registered Nurse (RN), came in and said she was too busy and scheduled the dressing change for later in the day. Staff Y left without assessing the wound. Staff K completed care and left Resident 31 with the soiled sacral wound dressing. At 11:39 AM, Staff T, CNA, said Resident 31 was supposed to be turned every two hours and have her heels floated because of the ulcers. Staff T said Resident 31 had some breakdown on her heels about two weeks ago. At 11:40 AM, Staff B, Director of Nursing Services and RN, was observed during wound care. Staff B removed a soiled dressing on the resident's coccyx and pulled out packing (gauze inserted into a wound) from a golf ball size hole in the center of the wound. The entire wound was black with the surrounding tissue red. There was a dark purple area the size of a golf ball on the right upper side of the wound. There was a strong odor. Staff B said she knew the treatments were effective because the wound would get smaller. This was her expectation. Staff B said Staff F, Assistant Director of Nursing Services, monitored and tracked wounds for the facility. Staff B said there was no dressing on the right heel wound. Staff B did not place a dressing on the right heel wound. Staff B said she expected nurses to change a soiled dressing as soon as possible. On 05/05/2022 at 8:00 AM, Staff Y said if an aide came to her with concerns of a soiled dressing, she would do the dressing change immediately or as soon as possible. Staff Y said the nurses were responsible to ensure the care plan and pressure ulcer interventions were done. Staff Y said Staff F was responsible for wound care and infection control. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 05/07/22 at 10:04 AM, Staff F said she worked with an out of state, tele-health wound provider to create wound treatment interventions. Staff F said the off-loading and repositioning aids were the air mattress and pillows to off load heels and the body. Resident 31 did not have heel protectors or other specific aids. Staff F said if there was a soiled dressing, non-intact dressing, or missing dressing, she expected the nurse to change or replace the dressing immediately. 2) Resident 53 was admitted to the facility on [DATE] with diagnoses including a stroke (blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen) with left side weakness. The quarterly MDS, dated [DATE], showed Resident 53 was moderately cognitively impaired and able to answer yes/no questions. Resident 53's care plan, dated 04/20/2022, showed Resident 53 required two-person assistance for bed mobility, used a hoyer for transfers, and staff assistance for basic hygiene care. Resident 53's pressure ulcer care plan, dated 07/22/2021, documented interventions to frequent repositioning, Monitor/document/report to MD PRN [physician as needed] change in skin status . Notify Nurse immediately of any new areas of skin breakdown. On 05/01/2022 at 3:03 PM, Resident 53 was observed to be slouched in bed on his back. Resident 53 indicated he had pain in his bottom and pointed to his buttocks. On 05/03/2022 at 8:01 AM, Resident 53 was observed up in a tilt-in-space wheelchair. Resident 53 indicated he was in pain and pointed to his buttocks. When asked if staff were not changing his brief enough, Resident 53 nodded yes. The resident indicated staff did not move him side to side when he was in the wheelchair. At 8:24 AM, Staff H, RN, was observed going into Resident 53's room where the resident indicated he wanted to lay down. Staff H said he had to wait 10-15 minutes for an aide to be free, then they would put cream on his bottom for the pain. Staff H said Resident 53 had a rash from being wet. At 9:06 AM, Resident 53 was observed in his wheelchair in the same position. At 9:28 AM, Resident 53 was observed being assisted to bed. At 9:48 AM, Staff H was observed rolling Resident 53 to his side to apply the cream to his buttocks. Staff H stated, That's why it hurts. Staff H indicated there were three new open areas on Resident 53's coccyx. Staff H estimated the open areas to be approximately one to one and a half centimeters in length. Staff H said she was estimating the size because she did not have anything to measure the wounds with. Staff H said she would ask another staff member to look at the wounds and recommend a dressing. The gluteal cleft (groove between the buttocks) appeared open, approximately two to three centimeters long. Resident 53's medical record did not show documentation Resident 53's physician or the facility wound nurse were notified of the new skin finding on 05/03/2022. On 05/04/2022 at 5:45 AM, 9:25 AM, 11:35 AM, and 12:28 PM, Resident 53 was observed laying on his back in the same position. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 05/05/2022 at 7:44 AM, Resident 53 was observed laying on his back. At 8:02 AM, Staff AA, RN, said if a nurse was notified of a new skin wound, they should do an assessment of the wound, try to prevent it, call the doctor, and start the doctor orders. Staff AA said a nurse should call the family and notify the wound nurse. Staff AA said the wound nurse was usually there, but he could call. Staff AA said staff should reposition Resident 53 every two hours. At 3:10 PM, Resident 53 indicated staff did not turn him and did not put pillows under his bottom. Resident 53 was observed laying on his back. On 05/06/2022 at 8:15 AM, Resident 53 was observed laying on his back. At 9:41 AM, Staff T, CNA, said she was not aware of any open areas on Resident 53's skin. Staff T said Resident 53 had not been changed yet today. Staff T said the facility had not implemented a turning program. At 10:25 AM, Staff P, Residential Care Manager and Licensed Practical Nurse, said it was everyone's responsibility to implement the care plan. Staff P said if there was a new skin wound, there would be an incident report. Staff P said they would update the care plan to actual, not potential skin issues, then add the new issue. Then the wound nurse would do an assessment. If the wound nurse had new interventions, they would update the care plan. Staff P said the updates should be completed immediately. Staff P said if the wound nurse was not available; the nurses needed to do something immediately, like initiate basic skin care. On 05/07/2022 at 9:42 AM, Staff F said she expected nurses to immediately notify her of a new skin issue, then she would go right away to assess the skin issue. Staff F said she had her cell phone number posted for the staff. Staff F said she did not get any notifications this last week while she was gone. Staff F said the Resident Care Managers and Director of Nursing Services were responsible for skin issues when she was gone. Staff F said for residents with a history of skin wounds, the following interventions should be in place: educate staff, use skin prep or barrier cream, repositioning program, and reposition every two hours if not more frequently. At 11:10 AM, Staff F said staff should have notified me and took pictures of the new skin issues. Staff F said Resident 53 should have had a skin assessment completed. Staff F said Resident 53 was supposed to be turned/repositioned no matter what, even if they were on an air mattress. Staff F said Resident 53 should have been placed on a turning schedule and assessed by the nurses. Staff F said an incident report should have been done. Staff F said the nurses, not aides, should be applying the cream because the nurses needed to be putting eyes on the skin, and the aids cannot assess. Staff F was observed turning Resident 53 and said she observed a new pressure wound and it was quite red. Staff F said it was a stage 2 pressure wound and could have developed in hours. Staff F identified two of the three previously viewed skin wounds as a stage 1 and the other wound as a stage 2 pressure ulcer. Reference WAC 388-97-1060 (3)(b)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on interview, observation and record review, the facility failed to ensure staff provided safe resident transfers using a hoyer (mechanical lift used to transfer residents) and were educated on hoyer use, and failed to implement fall risk interventions for four of five sampled residents (53, 3, 55 & 19) reviewed for accident hazards. This failure placed residents at risk for injury, falls and death. An Immediate Jeopardy was called on 05/03/2022 when the facility failed to ensure the safe use of mechanical lifts and slings when transferring three residents and failed to ensure facility staff had the competencies, skills and training needed for safe operation of Hoyer lifts and slings. The facility removed the immediacy on 05/05/2022 by training nurses and nursing assistants prior on proper use of the hoyer lift including sling placement, sling selection to support residents' head, resident positioning during transfer, stabilizing and locking the mechanical lift and/or wheelchair during transfers. Findings included . <Hoyer Lift Use> Review of Invacare Reliant 450 and 600 mechanical lift manual, undated, showed staff performing a transfer should be trained to perform the entire lift procedure several times with proper supervision. A resident's head should be supported by the sling and/or assistant. The lift legs should be always in the maximum open position, unless closing the legs to maneuver under a bed, then moved back into the maximum open position. Wheelchair brakes must be locked before lowering a resident into a wheelchair. Wheelchair brakes must be engaged to prevent movement of the chair. Divided leg slings should be removed once the resident is transferred into the wheelchair. 1) Resident 53 was admitted to the facility on [DATE] with diagnoses including a stroke with left side weakness, difficulty swallowing, and difficulty with verbal expression and communication. The quarterly Minimum Data Set, an assessment tool, dated 01/07/2022, showed the resident had moderate cognitive impairment and was able to make needs known. The care plan, dated 07/22/2021, showed Resident 53 required the use of a hoyer for transfers. On 05/03/2022 at 9:21 AM, Staff J, Certified Nursing Assistant (CNA), and Staff H, Registered Nurse (RN), were observed going to Resident 53 to transfer him from his wheelchair into his bed using a hoyer lift. The staff were not familiar with the type of sling under Resident 53, which was a divided leg sling. Staff J and Staff H made multiple attempts to adjust the sling under the resident although it was appropriately placed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 9:28 AM, Staff J was observed returning to the resident's room with Staff K, CNA, who identified the cross-leg sling, and was able to pull the straps through Resident 53's legs as he was positioned. Staff K showed Staff J how to attach the straps to the hoyer lift multiple times as staff kept attaching the straps incorrectly. Resident 53 was lifted and lowered into the bed without the hoyer brakes locked. Staff J said she had a lot of residents who required hoyer transfers in her section. On 05/06/2022 at 1:22 PM, Staff T, CNA, was observed leaving a room with a Hoyer lift. Staff T said the hoyer lift was used on Resident 53. There were no other staff members observed in the room to assist with the transfer. Staff T said Staff M, Nursing Assistant Registered in training, was the second person but was unsure if she was allowed. Staff T said she did hoyer lift transfers by herself quite often because she could not find anyone to help. 2) Resident 3 was admitted on [DATE], had a moderate cognitive impairment and was able to make needs known. On 05/03/2022 at 1:59 PM, Staff N, CNA, and Staff K were observed assisting Resident 3 into her wheelchair with the use of a hoyer lift. The lift brakes were unlocked while under the bed during the process of hooking up the sling. Staff K moved the lift to adjust positioning while lifting up the resident. While the lift was lifting the resident, Staff K locked the brakes. Staff N positioned the wheelchair in front of the lift while the lift brakes remained unlocked. The back arm of the lift was positioned against another bed. The position of the lift locks, slightly under the bed, made it difficult to engage. Staff N did not make attempts to adjust the location of the lift or lock the brakes. Staff K was standing behind the wheelchair with his feet wedged behind each wheel. Staff K adjusted the resident as she was lowered into the wheelchair. During the lowering, Staff K reached down to ensure the right wheelchair brake was off. The wheelchair and the lift moved during the lower as Resident 3 was placed into her wheelchair. When asked if he locked the brakes, Staff K stated, Yeah, I keep my feet here so I can adjust. Staff K demonstrated how he wedged his feet behind the wheelchair wheels and said this was helpful to adjust the resident while being lowered into position. 3) Resident 55 was admitted on [DATE] and was alert and oriented. On 05/03/2022 at 2:14 PM, Staff S, CNA, and Staff Q, NAR, were using a hoyer lift to transfer Resident 55. While lifting the resident out of bed, the base legs of the Hoyer lift, were not spread out for stability. As Staff S and Staff Q began to lift the resident up, the resident's head was unsupported and was in an awkward position. On 05/03/2022 at 1:40 PM, Staff L, CNA, said her hoyer training was the [AGE] years of experience she had. Staff L said she completed a check-off list [AGE] years ago but had not completed any annual or on-line training. Staff M said she was a new hire and had been at the facility for about one week and did not work independently. Staff M said she did not have any formal hoyer training, no new hire training, and had only been shown by staff how to complete hoyer transfers. When asked what safety instructions Staff L had taught Staff M, Staff L said to always lock it and keep the legs wide when moving. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/03/2022 at 2:20 PM, Staff S, CNA, said she had worked here since September and been a CNA since January. Staff S said she felt like she did not get adequate hoyer training. Staff S said she had an average of three Hoyer lift residents on her load per shift. Staff S said it depended on who was working if it was difficult to find a second person to assist. Staff S said she never had a nurse help her with a hoyer lift transfer so she did not know if they know how to use a Hoyer lift. At 3:48 PM, Staff S said she did not know what kind of sling to use, and said she did not know there were different slings for different weight limits. On 05/04/2022 at 5:33 AM, Staff R, CNA, said she had trouble finding people to help with Hoyer lift transfers. Staff R said today we only had three aides on the floor right now and she had 30 residents to take care of. Staff R said if you would have been here on Sunday night you would have seen we had two aides for the entire building. Staff R said because she could not find help when she needed it, there had been several times when she had transferred a resident by herself. Staff R said it was not safe for the residents. At 5:44 AM, Staff O, LPN, said the care aids worked very hard. They just do not have enough help. There were times when there were only two aids for the entire building. Staff O said they must do Hoyer lift transfers by themselves. Staff O said it was not safe for the residents at all. At 8:02 AM, Staff N said wheelchair brakes should be locked before lowering a resident into a wheelchair. Staff N said her hoyer training was from her Certified Nursing Assistant (CNA) class. Staff N said slings were chosen based on the size of the resident, based on the amount of extra fabric around them. Staff N said if a resident required total care or could not move, they required a full body sling. Staff N said leg slings were not really used in the facility. They were for toileting and should only be used on residents that were smaller and had strong legs. Staff N said she knew which sling to choose because it was on the care plan. Staff N said physical therapy made the decision on what transfer and sling to use. On 05/05/2022 at 10:25 AM, Staff P, LPN and RCM, said she was not aware the aides were doing hoyer transfers by themselves. Staff P said her expectation was they follow the policy and use two certified staff members when doing a Hoyer lift transfer. At 11:07 AM, Staff B, Director of Nursing Services, said staff were trained by experienced CNAs for two days and then they were checked off to make sure they were doing the transfers correctly. The check off included a return demonstration. Staff B said if they needed help, they were to ask another aide, ask a nurse, or wait for someone to be available so they could do a safe transfer. Staff B said her expectation was that staff always did what was safe for the residents and followed policy. Staff B said if they were doing Hoyer lifts and transfers without another certified/licensed staff in the room, they should not have been doing it. 40916 <Fall Interventions> Resident 19 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], documented the resident was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 19's fall risk care plan, initiated 12/14/2021 and revised on 03/02/2022, documented the intervention to ensure mat appropriately placed next to bed when resident [was] in bed. On 05/02/2022 at 1:00 PM, Resident 19 was observed in his room in bed. A fall mat was in the room, leaning on the wall across from the bed. It was not in position near the bed to prevent injury in the event of a fall. At 2:57 PM, Resident 19 was observed in his bed. The fall mat was observed across the room from the resident's bed, leaning on the wall. At 3:06 PM, Staff U, Certified Nursing Assistant (CNA), said Resident 19 was a fall risk. Staff U said Resident 19's fall risk interventions included the bed in low position, making sure the resident was comfortable, and a fall mat near his bed. On 05/03/2022, Staff B said a fall mat should be in Resident 19's fall risk interventions. When asked about the observations of the fall mat not in place, Staff B stated, That's not good. He should have a fall mat [in place]. Reference WAC 388-97-1060 (3)(g)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutrition when the facility failed to consistently monitor residents' weights, provide adequate assistance and/or set up with meal service and implement new interventions in a timely manner for one of six sampled residents (31) reviewed for nutrition. This failure placed residents at risk of weight loss, nutritional complications, and a diminished quality of life. This caused harm to Resident 31 when she experienced a severe weight loss of 24.79% in just over five months. Findings included . Resident 31 was admitted on [DATE] with diagnoses including diabetes and pain. The quarterly Minimum Data Set (MDS), a comprehensive assessment tool, dated 03/11/2022, documented the resident required extensive two-person assistance for bed mobility, transfer, personal hygiene and toileting. The MDS did not identify a weight loss for this resident and no nutritional issues were noted including swallowing. Resident 31's weights record showed the following: On 10/30/2021, the resident weighed 238 pounds (lbs). On 12/09/2021, the resident weighed 210 lbs. On 03/30/2022, the resident weighed 191.6 lbs. On 04/08/2022, the resident weighed 179 lbs. The weight record showed a 24.79% weight loss from 10/30/2021 to 04/08/2022, five months and nine days. Provider order, dated 01/31/2021, showed Resident 31 was ordered to be weighed once per week to monitor for weight loss and edema. The January 2022 Medication Administration Record (MAR) showed Resident 31 was weighed zero of five opportunities. The February 2022 MAR showed Resident 31 was weighed zero of four opportunities. The March 2022 MAR showed Resident 31 was weighed once of five opportunities. The April 2022 MAR showed Resident 31 was weighed once of four opportunities. Weight monitoring summary, dated 01/31/2021 to 04/08/2022, showed Resident 31 was weighed a total of 15 times in 14 months. The summary showed Resident 31's first significant weight loss occurred on 12/09/2021 with an 11.8% weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Nutritional risk assessment, dated 02/03/2022, showed Resident 31's intake was 51-75 percent for all three daily meals. Resident 31 was noted to be experiencing severe pain and refusing some meals. Staff reviewed the plan of care and documented it remained appropriate. Clinical summary note, dated 02/17/2022, showed Resident 31 was diagnosed with anorexia (lack of intake). Nutritional risk assessment, dated 03/07/2022, showed Resident 31's intake was poor for all three daily meals. Resident 31 was receiving Glucerna (nutritional supplement) three times a day and Juven (nutritional supplement) twice a day. The care plan, dated 03/09/2022, showed Resident 31 was able to feed herself and staff were to obtain a monthly weight. A nutritional risk intervention, revised 02/03/2022, showed staff were to monitor and record food intake at each meal. No additional interventions were included for weight loss or malnutrition (inadequate intake). On 05/03/2022 at 10:04 AM, an open Glucerna shake was observed on Resident 31's bedside tray, open with a straw. The May 2022 MAR showed on 05/02/2022, Resident 31 did not receive her evening Glucerna shake. On 05/03/2022, the resident only received her 2:00 PM Glucerna shake. On 05/04/2022, Resident 31 did not receive her morning Glucerna shake. On 05/04/2022 at 8:09 AM, Staff CC, Business Office Manager, was observed delivering a breakfast tray to Resident 31. Staff CC said she could not provide care and the care aides feed the residents. No assistance was provided for set up or meal assistance. Staff CC was not observed notifying a care aide that the resident's breakfast had been delivered. An opened Glucerna shake with a straw was on the bedside table. At 9:07 AM, Staff N, Certified Nursing Assistant, was observed going into Resident 31's room to provide feeding assistance. Staff N told Resident 31 it was time to eat and offered the opened Glucerna shake. Resident 31 moaned once when the head of bed was raised, and was not fully awakened. Staff N quickly ended the attempt without allowing time for the resident to wake up. The total time Staff N provided meal assistance was about one minute. Staff N said Resident 31 had not been responding lately. Staff N returned within a few minutes to remove Resident 31's untouched tray. No further attempts were made to offer nutrition to Resident 31. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 05/07/2022 at 8:54 AM, Staff DD, Licensed Practical Nurse, said prior to becoming non-responsive, Resident 31 required total assistance with meals beginning a month ago. Staff DD said Resident 31 had severe pain in her hip so they sent her to the hospital. In February 2022, when Resident 31 returned, she needed extensive eating assistance. Staff DD said meal intakes, supplements, and weights were documented on the MAR. Staff DD said Resident 31's weights were monthly but went to weekly. Staff DD said due to Resident 31 refusals, the staff did not monitor her weight regularly. Staff DD said a Hoyer lift was the only way to get Resident 31 up. Resident 31 yelled and screamed so staff did not weight her due to pain. Staff DD said the aids were supposed to chart Resident 31's intake every meal. Staff DD said if Resident 31 refused a meal, staff would come back to re-approach and give a supplement. Staff DD said Resident 31 lost weight because of not eating or drinking. The resident kept losing more and more weight. Staff DD said the dietitian said it was expected weight loss, but Staff DD did not agree. Staff DD said Resident 31 could have benefited from a magic cup (high protein, high calorie frozen supplement). Staff DD said the doctors knew about the weight loss; but did not do anything, just continue care. On 05/07/2022 at 9:42 AM, Staff F, Assistant Director of Nursing Services and Registered Nurse, said when there was a significant weight loss staff offered Juven, extra nutrition via supplements, and checked for food preferences. Staff F said staff would sit with Resident 31 and offer high calorie food as much as possible. Staff F said there was no other interventions. Staff F said prior to the recent decline, Resident 31 lost weight because she was struggling with heart issues. Staff F said the meal assistance provided to Resident 31 by Staff N on 05/04/2022 did not meet her expectations and that was not enough time. Staff F said she expected staff to re-attempt every 20 minutes and notify the nurse. Refer F686 Reference WAC 388-97-1060 (3)(h)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observation, interview and record review, the facility failed to ensure monitoring of the physician orders feeding tube (a medical device used to provide nutrition, not by month)were completed for one of one sample residents (53) reviewed for tube feeding. This failure placed residents at risk for adverse outcomes related to placement, infection, and a diminished quality of life. Findings included . Resident 53 was admitted to the facility on [DATE] with diagnoses including a stroke with left side weakness, difficulty swallowing, and difficult verbal expression/communication. The quarterly MDS, dated [DATE], showed the resident was moderately cognitively impaired and able to answer yes/no questions. Review of physician order, dated 05/17/2021, showed G-tube site- Clean with soap and water, pat dry. Apply drain sponge daily. Notify provider for signs or symptoms of infection at site. Review of physician order, dated 06/02/2021, showed to monitor tube site including marking of the tube every shift. The tube will be marked using a black line at insertion upon admission and verified with each medication/tube feeding administration. Notify provider if tube is greater than three centimeters from marking. Notify the provider of any redness, pain or excess drainage at tube feeding site. On 05/04/2022 at 5:49 AM, Staff BB, Registered Nurse (RN), said she checked the tube feeding throughout the night by monitoring the pump and for stomach trouble. Staff BB said she listened for placement when she came on and during the night. Staff BB described how to check for tube placement by listen with stethoscope to hear sounds in his stomach and lungs for issues. At 6:20 AM, Staff AA, RN, said there was no dressing around the PEG tube, a tube passed into a patient's stomach through the abdominal wall, insertion site. Staff AA said the skin was supposed to be cleaned then described the dried blood and thick accumulated material under Resident 53's PEG tube. Staff AA said the red area around the PEG tube was due to a previous dressing. Staff AA described how to check for placement in the stomach. When asked how to check for insertion length, Staff AA said the tube did not move. Staff AA said the tube feeding tube needed to be changed every 24 hours and date the label. On 05/05/2022 at 2:31 PM, Staff B, Director of Nursing Services, said tube feeding training was prior to her time. Staff B said the nurse checks the tube position. Staff B said nurses were expected to follow orders. She was aware of the tube feeding issues for Resident 53, including site condition, lack of dressing, and non-assessment of PEG placement. At 2:49 PM, Staff B said she observed Resident 53's PEG site. Staff B said it was not infected but agreed the site needed to be cleaned. Staff B took steps to ensure placement of the tube. Reference WAC 388-97-1060 (3)(f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42723 Based on observation, interview and record review, the facility failed to ensure oxygen was delivered according to physician orders, oxygen equipment was maintained and infection control practices for oxygen tubing were followed for three of seven sampled residents (74, 226, 31 & 55) reviewed for respiratory care. This failure placed residents at risk for infection, unmet care needs, and a diminished quality of care. Findings included . The facility's Respiratory Practice Manual, dated September 2018, contains an Oxygen Administration Policy documenting the following: The center requires that a physician's order be obtained prior to the administration of oxygen. In an emergency, oxygen may be administered as per physician-approved center protocol. All orders for oxygen therapy must include: . Duration of use . Liter flow or concentration . Mode of delivery . Specific weaning criteria (when applicable)- for example, maintain oxygen saturation between ___% and ___% . The Respiratory Practice Manual, dated September 2018, also contains an Oxygen Administration Procedure documenting the following: Standard precautions will be observed throughout the procedure 1. Verify physician's order. 2. Place oxygen delivery device in plastic bag, labeled with the date and resident's name when not in use. 3. Change tubing weekly. 4. Clean filters weekly on concentrator . 1) Resident 74 was admitted to the facility on [DATE]. The admission MDS, an assessment tool, dated 04/26/2022, documented the resident had shortness of breath when sitting at rest and when lying flat, and was receiving oxygen therapy while in the facility. Resident 74's admission orders did not document orders for the administration of oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 74's admission care plan did not address the use of oxygen. Resident 74's April 2022 Vital Signs record documented resident's oxygen saturations via nasal cannula on 04/22/2022, 04/24/2022, 04/25/2022, 04/27/2022, and 04/28/2022. Resident 74's May Vital Signs record documented resident's oxygen saturations via nasal cannula on 05/02/2022. On 05/01/2022 at 9:16 AM, Resident 74 was observed wearing oxygen. It was being administered from an oxygen concentrator with humidification, running through a nasal cannula, with no date on the oxygen tubing or humidification bottle. There was no sign on the door indicating oxygen was in use inside the room. On 05/02/2022 at 7:46 AM, Resident 74 was observed wearing oxygen. It was being administered from an oxygen concentrator with humidification, running through a nasal cannula, with no date on the oxygen tubing or humidification bottle. There was no sign on the outside of the door indicating oxygen was in use inside the room. On 05/03/2022 at 11:40 AM, Resident 74 was observed without the nasal cannula in her nose. The nasal cannula was sitting on the floor beside Resident 74's bed, not inside of a plastic bag and not labeled with the resident's name or date. The oxygen tubing was dated 5/3. There was no sign on the outside of the door indicating oxygen was in use inside the room. 2) Resident 226 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented the resident had asthma (a respiratory condition marked by spasms in the lungs, causing difficulty in breathing), respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide), and used oxygen outside and inside the facility. Resident 226's transfer orders, dated 04/26/2022, contained an incomplete provider order for oxygen therapy, with no diagnosis for oxygen administration and no orders for titration of oxygen. Resident 226's admission care plan, initiated 04/26/2022, did not document guidelines for titration of oxygen or when to discontinue oxygen therapy. Resident 226's baseline care plan, dated 04/28/2022, did not address directions for oxygen administration. On 05/01/2022 at 9:38 AM, Resident 226 was observed wearing oxygen. It was being administered from an oxygen concentrator with humidification, running through a nasal cannula, with no date on the oxygen tubing or humidification bottle. There was no sign on the outside of the door indicating oxygen was in use inside the room. On 05/02/2022 at 8:30 AM, Resident 226 was observed wearing oxygen. It was being administered from an oxygen concentrator with humidification, running through a nasal cannula, with no date on the oxygen tubing or humidification bottle. There was no sign on the outside of the door indicating oxygen was in use inside the room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/03/2022 at 9:02 AM, Resident 226 was observed wearing oxygen. It was being administered from an oxygen concentrator with humidification, running through a nasal cannula, with a date on the oxygen tubing of 5/2 and no date on the humidification bottle. There was no sign on the outside of the door indicating oxygen was in use inside the room. 3) Resident 55 was admitted to the facility on [DATE]. Resident 55's admission MDS, dated [DATE], documented the resident had coronary artery disease, hypertension (high blood pressure), asthma, respiratory failure, was using both CPAP and oxygen therapy prior to entering the facility and while in the facility. Resident 55's admission care plan, initiated 04/05/2022, did not document oxygen administration with CPAP therapy. Resident 55's baseline care plan, dated 04/07/2022, did not address CPAP administration. Resident 55's Kardex, a visual bedside care directive, did not document CPAP administration. On 05/02/2022 at 8:10 AM, Resident 55 was observed in her room with a CPAP mask sitting on her nightstand, not in a labeled plastic bag. It was being administered from an oxygen concentrator with undated oxygen tubing connecting to the CPAP machine. Resident 55 said her CPAP mask had not been cleaned since her admission, 27 days ago. There was no sign on the outside of the door indicating oxygen was in use inside the room. On 05/03/2022 at 8:28 AM, Resident 55 was observed in her room with a CPAP mask sitting on her nightstand, not in a labeled plastic bag, and oxygen tubing undated. Resident 55 said her CPAP mask had not been cleaned since her admission, 28 days ago. There was no sign on the outside of the door indicating oxygen was use inside the room. On 05/04/2022 at 10:19 AM, Resident 55 was observed in her room with a CPAP mask sitting on her nightstand, not in a labeled plastic bag, and oxygen tubing remained undated. Resident 55 said her CPAP mask had not been cleaned since her admission, 29 days ago. There was no sign on the outside of the door indicating oxygen was in use inside the room. On 05/05/2022 at 8:17 AM, Resident 55 was observed in her room with a CPAP mask sitting on her nightstand, not in a labeled plastic bag, and oxygen tubing was dated 5/5. Resident 55 said her CPAP mask had not been cleaned since her admission, 30 days ago. There was no sign on the outside of the door indicating oxygen was in use inside the room. On 05/07/2022 at 3:24 PM, Staff CC, Nursing Assistant Registered (NAR), said prior to oxygen being administered there needed to be an order, the equipment needed to be in good order, the environment had to be safe, and there should be new oxygen tubing. Staff CC said if they thought a resident needed oxygen they would put on the oxygen and then go get the nurse to check the resident. Staff CC was unable to state who was responsible for cleaning the CPAP masks. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:36 PM, Staff F, Assistant Director of Nursing Services, said prior to oxygen being administered, there needed to be a proper order and the facility needed to have the capacity to provide the level of oxygen needed for the resident. Staff F said they would expect an oxygen care plan to include a pop up for nurses to check if the resident is on oxygen, check the liter flow, assess the respiratory status, monitor the oxygen levels, and for trials of room air. Staff F said if the nurse felt the resident needed oxygen, they would do an assessment, get an order, and call 911 if needed. When asked who cleaned the CPAP masks, Staff F said some residents were independent and can clean the masks themselves. Staff F said nurses were responsible for cleaning the CPAP masks once a week. At 3:47 PM, Staff I, Registered Nurse (RN), said Nursing Assistants (NAs) were responsible for cleaning the CPAP masks and changing the oxygen tubing weekly. Staff I said the NAs knew which residents they needed to change tubing and clean masks on because it was on the Kardex. Staff F said the nurses were responsible for monitoring the NAs to ensure the care of the respiratory equipment was completed. 46244 4) Resident 31 was admitted on [DATE] with diagnoses including dementia. The quarterly MDS, dated [DATE], documented the resident required extensive two-person assistance for bed mobility and transfers and was not on oxygen. Provider orders, dated 09/28/2018, showed an order for oxygen at two liters per minute as needed for shortness of breath and dyspnea (difficulty breathing). The care plan, dated 03/09/22, did not address oxygen use. The April 2022 and May 2022 Treatment Administration Record Review showed no documented administration of oxygen. On 05/01/2022 at 5:31 PM, Resident 31's room was observed with an oxygen concentrator and a mask on the floor behind it. There was no date on the tubing or sterile water. A dirty glove was on top of the bottle of sterile water. Resident 31 was not using oxygen. On 05/02/2022 at 7:58 AM, Resident 31's room was observed. The resident was not using oxygen and the concentrator was turned off. On 05/05/2022 at 7:55 AM, Resident 31 was observed with an oxygen mask at five liters per minute. Resident 31's family member said the oxygen was not on when they arrived, but a nurse put it on when Resident 31 was having trouble, shallow breathing. At 8:00 AM, Staff Y, RN, said Resident 31's oxygen level was 71% so she put on oxygen. Staff Y said she would call to get an order for the oxygen. Staff Y said it was normal for oxygen to be used in comfort care. Staff Y indicated the family felt relieved with reduced labored breathing. On 05/05/2022 at 2:31 PM, Staff B, Director of Nursing Services, said she expected her nurses to follow provider orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/06/2022 at 2:28 PM, Staff I said when the tubing was off a resident, it should be wrapped in bag and taped to the machine, so it is not on the floor. Tubing should be changed every week and dated, usually on Sunday. Staff I said the provider's order told you the number of liters to use. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46244 Based on observation, interview and record review, the facility failed to ensure pain medications were provided to adequately control pain for one of one sample resident (31) reviewed for pain management. This failure placed residents at risk for uncontrolled pain and a diminished quality of life. This caused harm to Resident 31 when she did not receive pain medication prior to movement. Findings included . Review of facility policy entitled Pain Management Program, undated, showed staff should notify the provider if pain management goals were not met. Staff should re-evaluate with a significant change in condition. Non-verbal expressions of pain included: yelling, moaning, grimacing, refusal to eat and resistive to care. Resident 31 was admitted on [DATE] with diagnoses including pain, difficulty walking and dementia. The quarterly Minimum Data Set, a comprehensive assessment tool, dated 03/11/2022, documented the resident required extensive two-person assistance for bed mobility, transfer, personal hygiene, and toileting. Review of electronic health records showed Resident 31 was sent to the hospital on 02/10/2022 for uncontrolled pain where she was diagnosed with a pelvic fracture. The care plan, dated 03/09/2022, showed Resident 31 would be free from non-verbal indicators of pain and staff were to administer pain medication as ordered. Anticipate need for pain relief and respond to any complaint of pain. Identify precipitating factors which may increase pain and or discomfort. Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Notify Physician if interventions are unsuccessful or if current complaint was a significant change from resident's past experience of pain. Non-verbal indicators of pain were included. A pain assessment, dated 03/10/2022, showed Resident 31 was not able to be interviewed about her pain. On 05/02/2022 at 7:56 AM, Resident 31 said she was in pain, and that it was worse. Resident 31 was unable to provide additional information. Resident 31 was observed grimacing and whimpering. At 8:08 AM, Resident 31 could be heard moaning from the hallway. On 05/04/2022 at 9:07 AM, Resident 31 was observed moaning when the head of her bed was raised. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	At 9:31 AM, Resident 31 was observed to moan when the head of her bed was lowered. Staff K, Nursing Assistant (NA), lowered the bed in increments. Staff K said he did not like to move her because she was in so much pain. Staff K said pain was not a problem prior to comfort care. Resident 31 was observed to yell in pain when touched. Staff Y, Registered Nurse, entered the room at the request of Staff K, and left without providing pain relief or assessing Resident 31. Staff K said when Resident 31 yelled out like this, they would not get a response from nurses to get pain medication. Staff K said Resident 31 was not medicated prior to care being provided. Staff K said, She's in pain. The May 2022 Medication Administration Record showed Resident 31 did not receive a dose of morphine until 11:04 AM on 05/04/2022. No other as needed pain medications were given that morning. On 05/04/2022 at 11:06 AM, Staff B, Director of Nursing Services, was observed preparing to do a wound dressing change and said Resident 31 needed to be pre-medicated. At 11:39 AM, Resident 31 was observed moaning, grimacing and reaching out to staff with care and being moved. Staff B said Resident 31 was moaning in pain with care. Staff B said that was why they pre-medicated her. Resident 31 continued to moan with movement throughout the process. Staff B said she would expect a nurse to call the provider to increase the pain medication order. Staff B said she would expect the nurse to medicate for pain. On 05/05/2022 at 8:04 AM, Staff Y said when she was told about pain from care aides, she would assess the resident, call to get medication, and call the family. Staff Y said pain went first above other responsibilities. Review of physician note, dated 05/05/2022, showed the provider was notified by nursing staff that Resident 31's pain was out of control. Resident 31 was screaming uncontrollably with dressing change. Additional pain medication was ordered. Refer F686 Reference WAC 388-97-1060 (1)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on observation, interview and record review, the facility failed to ensure staff had the skills and competencies for dementia care for facility staff. This failure placed residents at risk for an unsafe environment, unmet care needs and a diminished quality of life. Findings included . The facility assessment, dated 08/2021, showed staff would be experts in Relevant dementia education resident ADL (activities of daily living). Interventions for dementia behavior management. Environment appropriate for dementia care. Safety awareness by staff caring for dementia. Individual interventions for behavior management. Interpersonal communication with dementia. Care provided consistent with dementia practice . The quarterly Minimum Data Set, dated dated [DATE], showed Resident 30 had a diagnosis of dementia. On 05/01/2022 at 5:26 PM, Resident 30 was observed in the Dungeness dining room. The resident started screaming help, and was trying to leave the dining room. Staff X, Nursing Assistant (NA), tried to stop Resident 30. After several minutes Resident 30 left the dining room. Staff EE left the dining room and brought Resident 30 back. Staff EE put Resident 30 in front of a table of food and locked Resident 30's wheelchair. Resident 30 started to yell help. Resident 30 was able to unlock the wheelchair break and started pushing herself away from the table. Resident 30 ran into another resident's wheelchair. Resident 30 pushed up against the other resident's wheelchair and yelled this blue is in my way, and screamed help. On 05/03/2022 at 2:42 PM, Staff A, Administrator, said they were not able to find any in-services or trainings for dementia care, but would keep looking. On 05/07/2022 at 1:49 PM, Staff A said they were not able to find any trainings or in-service records other than what was provided. The facility provided donning/doffing personal protective equipment in-services on 05/03/2022. The facility did not provide in-services or trainings for dementia care. Reference WAC 388-97-1680 (2)(b)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37934 Based on interview and record review, the facility failed to ensure nursing hours were accurately posted and updated for each shift for 28 of 30 days reviewed for nurse staff posting. This failure placed residents, resident representatives', and visitors at risk of not being fully informed of the current staffing levels and census information. Findings included . The nurse staff postings, dated 04/01/2022 to 04/30/2022, documented incorrect numbers of nurse aides providing care for resident on the following days and shifts: -On 04/01/2022 showed six nurse aides (NA) for the night shift; however, the shift had four. -On 04/02/2022 showed six nurses (registered nurse and/or licensed practical nurse) for the day shift; however, the shift had three. The posting showed five nurses for the night shift; however, the shift had four. -On 04/03/2022 showed five nurses for the day shift; however, the shift had three. -On 04/04/2022 showed four nurses for the day shift; however, the shift had three. -On 04/06/2022 showed six nurses and seven aides for the day shift; however, the shift had four nurses and six aides. The posting showed four aides for the NOC shift; however, the shift had three. -On 04/07/2022 showed six nurses for the day shift; however, the shift had three. -On 04/08/2022 showed seven nurses for the day shift; however, the shift had three. The posting showed five nurses for the night shift; however, the shift had four. -On 04/09/2022 showed seven nurses for the day shift; however, the shift had four. -On 04/10/2022 showed seven nurses for the day shift; however, the shift had four. -On 04/11/2022 showed seven nurses for the day shift; however, the shift had three. The posting showed five nurses for the night shift; however, the shift had four. -On 04/12/2022 showed eight nurses and nine aides for the day shift; however, the shift had four nurses and eight aides. The posting showed three nurses for the night shift; however, the shift had two. -On 04/13/2022 showed four nurses for the day shift; however, the shift had three. -On 04/14/2022 showed six nurses for the day shift; however, the shift had three nurses. The posting showed five nurses for the night shift; however, the shift had three. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	-On 04/15/2022 showed six nurses for the day shift; however, the shift had four nurses. The posting showed four nurses for the night shift; however, the shift had three. -On 04/16/2022 showed six nurses for the day shift; however, the shift had four nurses. The posting showed five nurses for the night shift; however, the shift had four. -On 04/17/2022 showed six nurses for the day shift; however, the shift had three nurses. The posting showed five nurses for the night shift; however, the shift had four. -On 04/18/2022 showed five nurses for the day shift; however, the shift had four nurses. The posting showed five nurses for the night shift; however, the shift had four. -On 04/19/2022 showed seven nurses for the day shift; however, the shift had three nurses. The posting showed five nurses for the night shift; however, the shift had four. -On 04/20/2022 showed six nurses for the day shift; however, the shift had three nurses. The posting showed four nurses for the night shift; however, the shift had two. -On 04/22/2022 showed six nurses for the day shift; however, the shift had four nurses. The posting showed five nurses for the night shift; however, the shift had three. -On 04/23/2022 showed six nurses for the day shift; however, the shift had three nurses. The posting showed five nurses for the night shift; however, the shift had three. -On 04/24/2022 showed six nurses for the day shift; however, the shift had three nurses. The posting showed five nurses and six aides for the night shift; however, the shift had four nurses and five aides. -On 04/25/2022 showed six nurses for the day shift; however, the shift had four nurses. The posting showed five nurses for the night shift; however, the shift had four. -On 04/26/2022 showed seven nurses for the day shift; however, the shift had four nurses. The posting showed five nurses for the night shift; however, the shift had four. -On 04/27/2022 showed five nurses for the day shift; however, the shift had three nurses. -On 04/28/2022 showed six nurses for the day shift; however, the shift had three nurses. -On 04/29/2022 showed six nurses for the day shift; however, the shift had two nurses. The posting showed six nurses for the night shift; however, the shift had three. -On 04/30/2022 showed six nurses for the day shift; however, the shift had three nurses. The posting showed five nurses for the night shift; however, the shift had four. On 05/03/22 at 1:11 PM, Staff II, Human Resource Manager and Staffing Coordinator, said she did the staff postings. Staff II said if she was not in the facility, a floor nurse was supposed to update them. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 05/07/2022 at 2:11 PM, Staff F, Assistant Director of Nursing Services and Registered Nurse, said if Staff II was not available, the posting would be done by the Director of Nursing Services, the Resident Care Manager or herself. No Associated WAC

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on interview and record review, the facility failed to provide behavioral health care and services for one of five sampled residents (5) reviewed for behavioral health services. This failure placed residents at risk for not receiving necessary services to meet their mental health needs and a diminished quality of life. Findings included . Resident 5 was admitted to the facility on [DATE]. The significant Change Minimum Data Set, an assessment tool, dated 02/01/2022, documented the resident was cognitively intact. A provider note, dated 04/21/2022, documented, PHQ-9 [a depression screening tool] score is =13 [indicating moderate depression]. Patient is currently on no treatment for depression. Score falls in moderate range today and reflects generalized symptoms associated with chronic state discussed initiating treatment and patient agreed. We will begin escitalopram [an antidepressant], 10 mg [milligrams] and re-evaluate. On 05/01/2022 at 2:13 PM, Resident 5 said he was seen by a new provider and was supposed to get a new depression pill, but had not seen the new pill yet. On 05/05/2022 at 10:08 AM, Staff I, Residential Care Manager and Registered Nurse (RN), said new orders for medications would show in the orders section of a resident medical record, and nursing staff would confirm the order in the pending orders section of the medical record. Staff I said she could not locate a consent for the antidepressant, and she could not tell if Resident 5 was started on the antidepressant or not. At 2:23 PM, Staff B, Director of Nursing Services and RN, said generally providers entered orders into the resident medical record, but nursing staff still entered paper orders as well. Staff B said she could not locate an order in the discontinued orders section or in complete orders section. Staff B stated, Not sure what happened there. No Associated WAC

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on interview and record review, the facility failed to implement Gradual Dose Reductions (GDRs) without an appropriate rationale and failed to discontinue an as needed (PRN) psychotropic medication (a medication that affects the mind) for two of five sampled residents (35 & 71) reviewed for unnecessary psychotropic medications. These failures placed residents at risk of receiving unneeded or improperly dosed medications and a diminished quality of life. Findings included . 1) Resident 35 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 03/14/2022, documented the resident was cognitively intact. A mood and behavior note, dated 01/11/2022, documented, IDT [interdisciplinary team] Review Pharmacy noted resident has a PRN for lorazepam [an anti-anxiety medication] with no stop date. Psych Provider reviewed and will discuss with resident an alternative on next F/U [follow up] on 01/13/2022. A pharmacy consultation report, dated 01/20/2022, documented, Please discontinue PRN Lorazepam . If the medication cannot be discontinued at this time, current regulations require that the prescriber document the indication for use, the intended duration of therapy, and the rationale for the extended time period. There was a hand-written note on the pharmacy consultation report documenting D/C'd [discontinued] 04/07/2022 by [psych provider], two months and 16 days after the pharmacy recommended the discontinuation. Resident 35's January 2022, February 2022, March 2022 and April 2022 Medication Administration Records (MAR) documented an order for Lorazepam every 8 hours PRN for anxiety was present until discontinuation on 04/07/2022. There were no documented uses of the PRN Lorazepam in the resident's MAR. On 05/06/2022 at 2:24 PM, Staff W, Chief Nursing Officer, said pharmacy consultation forms should be provided to the medical providers for review, and the facility should have a system that validated when pharmacy reviews had been reviewed by providers. Staff W stated, Honestly, it has been a project for the facility. On 05/07/2022 at 9:56 AM, Staff F, Assistant Director of Nursing Services and Registered Nurse, said the time between the pharmacy recommendation and the discontinuation of the order was not a decent turn around time. Staff F said the delay to discontinue the medication was not the norm, and she was not sure why there was a delay in discontinuing the order. Reference WAC 388-97-1060 (3)(k)(i)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42723 Based on observation and interview, the facility failed to consistently provide residents with meals served at the proper temperature and were palatable for one of five sampled residents (55) reviewed for food quality. This failure placed residents at risk for less than adequate nutritional intake and a diminished quality of life. Findings included . The Healthcare Services Group HCSG Policy 031, dated September 2017, documents in the Food: Safe Handling for Foods from Visitors: holding temperatures apply during preparation, chilling and service. The Holding Temperatures section directs potentially hazardous foods to be held at temperatures above 140 Fahrenheit (F) degrees or below 40 degrees F. Resident 55 was admitted to the facility on [DATE]. The admission Minimum Data Set, an assessment tool, dated 04/12/2022, documented the resident was cognitively intact. On 05/01/2022 at 4:09 PM, Resident 55 said the last couple of days the food temperatures have been correct, but otherwise, hot foods were not served hot and cold foods were not served cold. On 05/02/2022 at 8:54 AM, Resident 55 said her breakfast was cold (when it should have been hot). At 2:00 PM, Resident 55 stated, Lunch could have been hotter. On 05/03/2022 at 8:28 AM, Resident 55 said the toast was soggy. On 05/04/2022 at 7:40 AM, a test tray was obtained off the last hall cart, after the last resident was served. The food temperatures were measured by Staff FF, Dietary Aide. The food temperatures were as follows: -Apple Cinnamon French Toast Bake: 125 F -Oatmeal: 117 F -Milk: 42 F -Orange Juice: 50 F On 05/04/2022 at 12:38 PM, Staff GG, Dietary Manager, was provided the temperatures on the test tray. Staff GG said she was not aware of food complaints because Resident Council had not been meeting on a regular basis to provide feedback. Staff GG said she would adjust some recipes and do some audits of food temperatures. Staff GG said it would be her expectation to receive hot food hot and cold food cold. Reference WAC 388-97-1100 (1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42723 Based on observation, interview, and record review, the facility failed to ensure ice machines were maintained in a clean and sanitary manner. This failure placed resident at risk for cross-contamination and food-borne illness. Findings included . On 05/05/2022 at 2:35 PM, the North Hall ice machine was observed to have multiple scattered brown/blackened debris on the inside of the ice machine, on the back wall where the water ran down towards the stored ice. The tubes and inner workings of the ice machine were exposed inside the ice bin and were also covered with areas of light brown/black debris. Underneath the ice bin the floor was observed to be covered with black and brown dried debris. The front of the ice bin was not covered and was observed to be covered with light gray, feathery material. On 05/05/2022 at 2:45 PM, Staff EE, Maintenance Supervisor, observed the 100 Hall ice machine. Staff EE said the ice machine was a little dirty, and said it was just cleaned on 04/20/2022 by Staff HH, Maintenance Assistant. Staff E then observed the North Hall ice machine. When asked about the procedure for cleaning the ice machines, Staff EE said ice machines are cleaned monthly by maintenance. They remove the ice, wipe everything down with hot water and soap. When asked about her expectations of how the ice machines should look after being cleaned, Staff EE stated, I guess I will need to show Staff HH how to clean the ice machines again. Reference WAC 388-97-1100(3) & 388-97-2980

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40916 Based on observations, interview, and record review, the facility failed to ensure handwashing was performed appropriately during one of two dining observations (Dungeness) and failed to ensure Transmission Based Precautions (TBP) were implemented for one of two resident rooms (room [ROOM NUMBER]) on contact enteric precautions (precautions used when there is risk of transmitting bacteria through person to person or indirect contact with the resident or environment). These failures placed residents at risk of transmitting infectious diseases, becoming infected by disease, decreased health outcomes, and a diminished quality of life. Findings included . <Transmission Based Precautions> On 05/04/2022 at 8:07 AM, Staff Z, Medical Records, was observed entering room [ROOM NUMBER] wearing a surgical mask and eye protection. No other Personal Protective Equipment (PPE) was donned before entering. room [ROOM NUMBER]'s door had a sign that read, Doctors and staff must wear gown and gloves at door. There was another sign on the door with a picture of a stop sign on it. Below the stop sign read, Stop, please see nurse before entering room. Thank you. At 8:11 AM, Staff Z said usually the door was closed, but today it was open and she did not notice the signs on the door. Staff Z said she should have worn gloves, gown, and eye protection. On 05/05/2022 at 10:34 AM, Staff B, Director of Nursing Services (DNS) and Registered Nurse (RN), said she expected staff to abide by the directions on the doors of residents on TBP. On 05/07/2022 at 10:36 AM, Staff F, Assistant DNS and RN, said she would expect staff entering a room on contact enteric precautions to wear a gown, gloves, mask, and eye protection. 37934 <Dining Room> On 05/04/2020 at 7:57 AM, Staff K, Nursing Assistant, was observed dropping his name badge on the floor. Staff K reached down, picked it up, and clipped the badge to his shirt. Staff L did not wash or sanitize his hands. Staff K went to the hallway, pushed a resident into the dining room, grabbed a clothing protector and placed it around the resident. Staff K did not wash or sanitized his hands. At 7:58 AM, Resident 66 was observed asking Staff K for some cream for her coffee. Staff K picked up some cream, opened the packet and poured it into Resident 66's cup. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505128	A. Building B. Wing	05/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequim Health & Rehabilitation	650 West Hemlock St Sequim, WA 98382

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff K then pushed Resident 28 to the back of the dining room and pushed the wheelchair under the table. Resident 28 started to play with the tableware. Staff K asked the resident to give him the tableware, reached out with his left hand and removed them from her hand and placed them on the table. Staff K then went to the drink cart and began to make Resident 28 some hot chocolate. After placing the cup in front of Resident 28, Staff K patted the back of Resident 28 and went over to the food cart. Staff K did not wash or sanitize his hands. At 8:03 AM, Staff K was observed going over to the food cart and pulled a food tray. Staff K walked over to Resident 64 and placed the tray in front of her. Staff K did not wash or sanitize his hands. At 8:04 AM, Staff K was observed pushing Resident 28's chair back under the table. Staff K did not wash or sanitize his hands. Staff K then walked over to the food cart, pulled another tray from it and delivered it to Resident 66. Staff K did not wash or sanitize his hands. At 8:05 AM, Staff K was observed taking a tray over to Resident 33. Staff K did not wash or sanitize his hands. At 8:06 AM, Staff K was observed taking a tray to Resident 30. Staff K did not wash or sanitize his hands. At 8:09 AM, Staff K was observed taking a tray to Resident 226. Staff K did not wash or sanitize his hands. At 8:38 AM, Staff K said he should wash or sanitize his hands if he touched anything dirty or dropped and picked up something from the floor. Staff K said he was the only staff in the room at the time and felt he needed to get things done quickly. At 8:52 AM, Staff B said staff should wash or sanitized their hands if they touch anything dirty or a dirty surface. Staff B indicated Staff K did not wash or sanitize his hands. Reference WAC 388-97-1320 (1)(c)(2)(b) 42723